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# **Assessment of Legal, Regulatory & Policy Environment for HIV and AIDS in Malawi**

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**July 2012**

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## Abbreviations and Acronyms

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
ART	Antiretroviral Treatment
BSS	Behavioural Surveillance Surveys
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee for Economic, Social and Cultural Rights
CEDEP	Centre for the Development of People
CHRR	Centre for Human Rights and Rehabilitation
COWLHA	Coalition of Women Living with HIV and AIDS
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of People with Disabilities
DNHA	Department of Nutrition, HIV and AIDS
FBO	Faith-Based Organisations
GBV	Gender-Based Violence
GCHL	Global Commission on HIV and the Law
GF R10	Global Fund Round 10 proposals
HRC	Human Rights Commission
HRCC	Human Rights Consultative Committee
HSA	Health Surveillance Assistants
HTC	HIV Testing and Counselling
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	Information, Education and Communication
ILO	International Labour Organisation
LEA	Legal Environment Assessment
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
MANET+	Malawian Network of People living with HIV or AIDS
MCP	Multiple and Concurrent Partnerships
MSM	Men who have sex with men
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Framework
NICE	National Initiative for Civic Education
OHCHR	Office of the High Commission for Human Rights
PLHIV	People living with HIV or AIDS
STI	Sexually Transmitted Infection
SW	Sex workers
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Programme

UNFPA United Nations Population Fund  
UNGASS United Nations General Assembly  
VSU Victim Support Units  
WHO World Health Organisation

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## Executive Summary

People living with HIV or AIDS (PLHIV) as well as key populations at higher risk of HIV exposure worldwide report stigma, discrimination and limitations of their rights both in law and in practice. In Malawi, a recent study amongst PLHIV provided strong evidence of various forms of individual and systemic human rights abuses.

It is widely accepted locally, regionally and internationally that a protective legal and regulatory framework is crucial to reduce stigma and discrimination and to promote effective national responses to HIV and AIDS.

The Constitution of Malawi, the supreme law of the land, is built upon human rights principles. It contains a bill of rights that includes protection of the rights to equality and non-discrimination, the right to gender equality, the right to privacy, the right to dignity, the right to security of the person, the right to information and the right to work, amongst others. The Constitution also mandates the state to enact laws and develop policies that meet the health needs of Malawians. In addition, Malawi is party to and has ratified various regional and international conventions, declarations, covenants and treaties that safeguard the rights of all people. All people, including PLHIV and other vulnerable and key populations are accorded human rights and protection from discrimination in Malawi.

HIV and AIDS are not specifically listed as protected grounds for non-discrimination in the Constitution, nor is there specific HIV and AIDS legislation in Malawi. Applying broad laws and rights to HIV and AIDS is possible, but is argued to create gaps, challenges and uncertainties within the current legal and regulatory framework. As a result of similar challenges, a number of countries in Eastern and Southern Africa have enacted laws to deal specifically with aspects of HIV and AIDS, either in various pieces of legislation<sup>1</sup> or in a specific statute.<sup>2</sup>

The Department of Nutrition and HIV and AIDS (DNHA) and Ministry of Justice, in collaboration with the United Nations Development Programme (UNDP), commissioned this Legal and Regulatory Environment Assessment (LEA) with the overall objectives of assessing the legal, regulatory and policy environment in relation to HIV and AIDS in Malawi. Specifically, the LEA aimed at assessing to what extent the current legal, regulatory and policy environment protects and promotes the rights of all people, including people living with HIV and other key populations as well as vulnerable populations<sup>3</sup> and promotes universal access to HIV prevention,

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<sup>1</sup> E.g. South Africa where for instance employment equity legislation (as well as other laws) specifically mention HIV and AIDS.

<sup>2</sup> E.g. the Mauritius HIV and AIDS Act, 2006.

<sup>3</sup> See Section 4, below, for a discussion of key populations and of vulnerability.

treatment, care and support. This included an assessment of the key HIV, law and human rights issues in Malawi (including stigma, discrimination, inequality as well as discriminatory and punitive laws that create barriers to the national response and challenges with access to justice and law enforcement issues), the identification of key populations affected and an analysis of the extent to which the current laws and policies as well as those under development are able to respond to these issues.

Between December 2011 and March 2012, a team of legal and public health experts (the Legal Environment Assessment [LEA] Team) implemented this assessment by reviewing relevant documents (literature, laws, bills, reports, policies etc.) and conducting Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with important stakeholders at national and district level. A total of 66 KIIs and 21 FGDs were conducted in Blantyre, Lilongwe, Zomba, Mangochi and Mzimba.

The LEA identified a number of on-going challenges relating to HIV, law and human rights in Malawi. First, there are a number of vulnerable and key populations including women, children, young people, people with disabilities, men who have sex with men, sex workers, prisoners and employees, amongst others, who have been shown to be at higher risk of HIV exposure and/or to experience the impact of HIV and AIDS more severely. Second, HIV-related stigma and discrimination was found and was reported to exacerbate the negative impact of HIV. Thirdly although protective provisions in Malawian law and policy were identified (such as criminal laws to protect women from sexual violence, children's laws that protect the rights of orphaned children and employment laws that protect all employees from unfair discrimination), many laws pre-date and do not specifically deal with HIV and AIDS or the various inequalities and human rights abuses experienced by people living with HIV and other key populations at higher risk of HIV exposure. In addition, access to justice and law enforcement for human rights violations is limited. Populations are not fully aware of their rights and how to enforce these rights and enforcement mechanisms are not always accessible and well resourced. Fourthly, there were a number of punitive or coercive provisions in law, many of which pre-date AIDS but which are now recognised as creating barriers to the response to HIV and AIDS. For instance, laws that criminalise sex between men and criminalise aspects of sex work block access to services for key populations. Lastly, the LEA team noted that there are various health and sectoral laws and policies, including the national HIV and AIDS policy, which promote the health rights of all people. However, resource constraints means that policies are not always fully implemented and, in some cases, do not adequately provide for individual patient's rights as well as access to appropriate HIV prevention, treatment, care and support. In addition, there was limited use of flexibilities within international trade agreements (the TRIPS Agreement) in Malawi to promote access to treatment.

The Law Reform Commission's proposals for developing HIV and AIDS legislation propose a number of forms of protection for people in the context of HIV and AIDS,

which are commended and endorsed. However, a number of provisions were proposed that limit rights, such as HIV testing without consent for a range of populations, possible disclosures of HIV status by health care workers and the enactment of specific offences to criminalise HIV transmission, which require re-evaluation in the light of more recent public health and human rights evidence.

Based on its assessment of the legal and regulatory framework in Malawi in accordance with national, regional and international human rights commitments made by Malawi, public health and human rights evidence found in a review of relevant literature, the views of key informants and focus groups with selected populations, the LEA calls for the enactment of the following protections in law for HIV:<sup>4</sup>

1. The law must protect and promote human rights in the context of HIV and AIDS and prohibit all forms of discrimination on the basis of actual or perceived HIV status, with specific prohibitions on discrimination in key sectors such as health care, employment, education and social assistance, amongst others. HIV-specific anti-discrimination provisions must be developed and existing human rights and constitutional guarantees should be enforced.
2. There must be specific protection in law for the health rights of all people in the context of HIV and AIDS, including
  - the right to HIV testing with voluntary and informed consent and pre- and post-test counselling
  - a prohibition on HIV testing without consent
  - the right to medical confidentiality
  - a prohibition on disclosure of a person's confidential HIV status, with the exception of disclosure by a qualified health professional to an identified 3<sup>rd</sup> party at risk in certain circumstances and following step-by-step procedures
  - the right to access appropriate prevention, treatment, care and support services, including psycho-social support, for all people without discrimination, including populations at higher risk of HIV exposure.
3. The law must set out state responsibilities to take all reasonable measures to provide for the regulation of and access to affordable, quality health care services for the prevention, treatment, care and support of HIV, the details and implementation of which are to be enumerated in policies and operational

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<sup>4</sup> See Section 8 for detailed recommendations. Note that a large number of these recommendations have similarly been endorsed by the Malawi Law Commission's *Report of the Law Commission on the Development of HIV and AIDS Legislation*; selected recommendations find differently than the Law Commission in the light of more recent public health evidence. The Law Commission's proposals are discussed throughout Section 6 and in specific detail in Section 7 of this report.

plans. Legal, policy and/or administrative barriers to the provision of effective health care services for HIV should be removed in order to ensure provision of health care for all, including criminalised populations. Law should set out the principles of the state's obligations to provide for, amongst other things:

- targeted services for vulnerable populations and key populations
  - provision for recent and future medical and scientific advancements, and
  - a commitment to measures to increase awareness of and to use the flexibilities under the TRIPS Agreement to increase access to medicines.
4. Law, including occupational safety and health law, and policy must include provision for the management of HIV within *all* working environments, including for members of the armed forces, domestic workers and those in the informal sector, to ensure:
    - Equality and non-discrimination on the basis of HIV and AIDS
    - Voluntary and confidential HIV testing and counselling
    - A prohibition on pre-recruitment HIV testing in all working environments
    - Procedures to ensure safety within the working environment
    - Access to post-exposure prophylaxis and compensation for occupational infection.
  5. The law must define and include specific protection for vulnerable populations and key populations at higher risk of HIV exposure and in particular those commonly identified by the LEA such as women, children, people with disabilities, migrants, refugees and internally displaced persons, prisoners, sex workers and men who have sex with men. In addition, other provisions within law, such as provisions regarding HIV-related information, education, prevention, treatment, care and support as well as human rights education, should make specific mention of the need to identify and target the needs of key populations.
  6. The law must include protection for the rights of research participants in all health research, including protection for the specific vulnerabilities of participants in HIV research.
  7. Criminal laws relating to violence, including sexual violence, as well as policies to manage those who have been sexually violated, should be strengthened. Crimes relating to rape and non-consensual sex in the Penal Code and Prevention of Domestic Violence Act should be strengthened to be gender-neutral and to apply to all domestic partnerships.
  8. Specific offences to criminalise HIV transmission should be excluded from law. Existing criminal laws should be applied to specific cases of malicious and intentional HIV transmission. Knowledge of HIV status should be

considered an aggravating factor in sexual assault cases that pose a significant risk of transmission or that cause transmission. Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably.

9. Harmful cultural and religious practices that increase HIV risk must be reviewed, in collaboration with communities, with a view to prohibition as recommended by the Law Commission.
10. Laws in the Penal Code acting to prohibit aspects of consensual sex work must be reviewed with a view to repeal and 'public nuisance' laws must not be used to punish, penalise or harass sex workers.
11. Laws criminalising consensual sex between adults of the same sex must be reviewed with a view to repeal. The Law Commission's review of these provisions should be supported by national debate that considers the Malawian context, values, health and human rights evidence.
12. The Immigration Act must be reviewed to ensure that its provisions are not inappropriately applied to HIV and to review the travel restrictions on men who have sex with men and sex workers alongside the on-going review of relevant punitive laws relating to same-sex relationships and sex work.
13. The promulgation of the Marriage, Divorce and Family Relations Bill should be expedited to create a uniform system of rights within marriage and to prohibit early marriages.
14. Current and future processes to review statutes that may impact on HIV and AIDS (such as the Public Health Act, the Patents Act and the Penal Code in the case of unnatural sex offences) should take into account the findings of this LEA, in order to ensure the inclusion of provisions that protect rights, reduce stigma and discrimination and promote universal access to HIV prevention, treatment, care and support.
15. International, regional and sub-regional human rights instruments should be signed, ratified and/or domesticated.
16. Various measures should be taken to strengthen access to justice and law enforcement, including the strengthening of stigma and discrimination campaigns; law and human rights information on existing and new laws, education and training for all, including key populations and key service providers such as health workers; strengthening legal support services and mechanisms for enforcing HIV-related human rights complaints and

sensitising law-makers, judicial officers and law enforcers on HIV, law and human rights

## 1. Introduction: Background to Legal Environment Assessment

Stigma, discrimination and human rights abuses in law and practice remain an on-going challenge to an effective response to HIV and AIDS in Malawi. Reports of discrimination against people living with HIV (PLHIV) and key populations at higher risk of HIV exposure are wide-ranging. People affected by HIV report being denied access to necessary services, unfair discrimination within the working environment, violence, sexual assault and arbitrary arrests and marginalisation and exclusion within their relationships, families and communities.<sup>5</sup>

Malawi's Constitution recognises the inherent dignity and worth of each human being and requires that *"the State and all persons shall recognise and protect fundamental human rights and afford the fullest protection to the rights and views of all individuals, groups and minorities"*.<sup>6</sup> The Constitution's Bill of Rights protects a range of basic human rights and prohibits discrimination on the basis of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status.<sup>7</sup> This broad protection extends to the rights of people living with HIV as well as all populations vulnerable to or at higher risk of HIV exposure. However, in the absence of HIV-specific legislation, the current legal, regulatory and policy environment appears to provide inadequate protection for the rights of people in the context of HIV and AIDS.

In 2006, The National AIDS Commission (NAC) and the Department of HIV, AIDS and Nutrition (DNHA) requested the Malawi Law Commission to develop a legislative framework to govern HIV and AIDS. A Special Law Commission was established in 2007 with representation from the public and private sectors to conduct a review of national law and international guidance in relation to HIV and AIDS and to make recommendations for the development of HIV law. The *Report of the Law Commission on the Development of HIV and AIDS Legislation, 2008* proposed the development of HIV and AIDS legislation to *"strengthen institutional structures dealing with HIV and AIDS, to entrench human rights protection with respect to HIV and AIDS for those affected and infected, to introduce criminal sanctions related to infection or conduct and acts that promote HIV infection and to consider entrenching the public concerns relating to HIV and AIDS as a disease."*

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<sup>5</sup>Stigma, discrimination and human rights violations against people affected by HIV and AIDS are described in greater detail in Section 4, below.

<sup>6</sup>The Republic of Malawi (Constitution) Act, Chapter III s12(iv).

<sup>7</sup>The Republic of Malawi (Constitution) Act, Chapter IV, s20(i).

Various submissions have been made in response to the Malawi Law Commission's *Report* in favour of the protection provided to people living with HIV. Key stakeholders have praised the protection for the rights of people in the context of HIV and AIDS. However, issues of on-going contention in the report include:

- Punitive or coercive provisions intended to curb the HIV epidemic, such as those calling for compulsory HIV testing of specified populations, disclosures of a patient's HIV status by health care workers and provisions that aim to criminalise HIV transmission, and
- The limited reference in the *Report* to key populations at higher risk of HIV exposure and populations vulnerable to HIV and AIDS.<sup>8</sup>

To date, the HIV law recommendations of the Malawi Law Commission have yet to be adopted. There remains limited and unspecific legal protection in the context of HIV and AIDS in Malawi.

In moving forward and building on the work of the Law Commission, the government of Malawi (in particular, the DNHA and the Ministry of Justice), with support from the United Nations Development Programme (UNDP), seeks to undertake a Legal Environment Assessment (LEA) of the current legal, regulatory and policy framework. In this way, they hope to further identify and clarify key legal and human rights issues acting as barriers to the national response to HIV and to guide the development, implementation and enforcement of laws, regulations and policies that protect rights and promote universal access to services in the context of HIV and AIDS.

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<sup>8</sup> See, for instance, UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*. UNAIDS, Geneva, 2010 and United Nations Country Team (UNCT) *Advocacy Brief*, 2009, amongst others.

## 2. Terms of Reference for Legal Environment Assessment

The specific objectives of the Assessment are as follows:

- To analyse international, regional and national human rights obligations relating to HIV and AIDS and related rights that Malawi as a state party has committed to
- To review relevant national laws and policies and recent and on-going law reform initiatives, including laws that impact on vulnerable and key populations
- To assess the *Report of the Law Commission on the Development of HIV and AIDS Legislation, 2008*, including submissions to the *Report*
- To review findings from research studies relating to law, human rights, stigma, discrimination and HIV in Malawian society
- To analyse access to justice and law enforcement on matters related to HIV and human rights, including a review of the awareness and understanding of rights amongst affected populations and key service providers, access to legal support services, law enforcement mechanisms and other key issues raised
- To assess the key human rights issues affecting people living with HIV as well as vulnerable and key populations and the extent to which these issues are addressed by the current environment.

The outcome of the Legal Environment Assessment has resulted in this Report which aims to use the information to

- Assess the current legal and policy environment to respond to HIV in Malawi
- Identify strengths, weaknesses and gaps in the current legal and policy environment, including the extent to which the current environment responds to the local context and complies with public health and human rights obligations
- Make recommendations for strengthening the legal and policy environment in Malawi so as to ensure a response which
  - complies with international, regional and national human rights obligations
  - addresses key human rights issues in the context of HIV, including the rights of all affected populations
  - promotes universal access, and
  - balances public health and human rights imperatives.

### **3. Methodology for Legal Environment Assessment**

#### **Overview**

The Legal Environment Assessment is centred on a human rights-based approach to health, using international, regional and local human rights commitments made by Malawi as the starting point for framing the enquiry, designing the tools for analysis, analysing the findings and developing the recommendations. This approach is guided by principles such as equality and non-discrimination, participation and inclusion, accountability and capacity building. It recognises the inter-relationship between all rights, including health rights and equality rights, and seeks to balance public health and human rights goals in developing the rights of all people.

To address the specific objectives of this assessment, the LEA team conducted a literature review of public health and human rights documentation. This included a review of all laws, regulations and policies directly or indirectly related to HIV and AIDS. In addition, the team conducted a qualitative study utilising Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with relevant stakeholders and members of the community to identify key HIV, law and human rights issues affecting people living with HIV and other key populations at higher risk of HIV exposure.

The literature review, KIIs and FGDs provided background information for analysis such as:

- The background to the HIV epidemic in Malawi, including an understanding of populations who are at higher risk of HIV exposure and/or are particularly vulnerable in the Malawian context, and the kinds of HIV-related human rights issues affecting these populations (See Section 4)
- Human rights principles, norms and standards to guide the response, based on national standards set out in the Constitution and in HIV policies as well as regional and international human rights documents to which Malawi has committed itself (See Section 5)
- Laws and policies regulating HIV-related issues, including laws and policies that impact on key populations at higher risk of HIV exposure and populations vulnerable to HIV and AIDS (See Section 6), and
- Proposed laws for regulating HIV and AIDS, and responses to these laws (See Section 7).

Laws, regulations and policies were then analysed to determine the extent to which they in fact protect the rights of people in the context of HIV and AIDS and promote

universal access to HIV prevention, treatment, care and support (as well as where they fail to protect, and in fact block effective responses). This involved reviewing current and proposed laws in terms of:

- Their alignment with recognised human rights principles at an international, regional and national level (including whether proposed limitations of rights were reasonable and justifiable limitations, in accordance with legally recognised principles)
- The impact of current laws, as well as the potential impact of proposed laws, on both human rights and on public health objectives, based on available public health, legal and human rights evidence and the qualitative findings of the KIIs and FGDs
- Recommended legal and regulatory approaches to HIV that respected both public health and human rights objectives.

## **Human Rights Based Approach to HIV**

A human rights-based approach to development uses human rights commitments as a framework for the analysis of issues and for guiding the response.<sup>9</sup> In the context of HIV, this approach examines the inequalities, discriminatory practices and unjust power relations driving the HIV epidemic in Malawi and uses rights and state obligations to frame the response.

Internationally, organisations such as the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the World Health Organisation (WHO) recognise HIV as a human rights issue for various reasons, including the following:

- *Failure to safeguard human rights is associated with vulnerability to HIV:* Marginalised populations who live with inequality, prejudice and limited access to basic services such as education, nutrition and health care are often at higher risk of HIV infection and feel the impact of HIV and AIDS more severely
- *People infected and affected by HIV experience stigma and discrimination which leads to further marginalization:* Once affected, people living with HIV and those affected by HIV and AIDS are stigmatised, discriminated against and denied access to services because of their HIV status.
- *HIV and AIDS leads to further impact on human rights:* the impact of HIV and AIDS on affected populations in turn leads to further violations of basic human

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<sup>9</sup>WHO, *A Human Rights Based Approach to Health: Policy Brief*. World Health Organisation, 2009. See also <http://www.cedha.org.ar/docs/doc78.htm> [Accessed 29th February 2012].

rights<sup>10</sup> as families and communities struggle to cope with the various difficulties brought on by stigma, illness and death.<sup>11</sup>

*“HIV transmission is not a random event: the spread of the virus is profoundly influenced by the surrounding social, economic and political environment. Wherever people are struggling against adverse conditions such as poverty, oppression, discrimination and illiteracy, they are especially vulnerable to being infected by HIV.”<sup>12</sup>*

Since stigma, discrimination and human rights abuses have a direct influence on a person’s risk of exposure to HIV, vulnerability and ability to access appropriate services, UNAIDS, UNDP, WHO and other international agencies argue for human rights based approaches to public health responses to HIV. Public health and human rights share the common goal of protecting and promoting the well-being of all people. However, the differences in their approaches to achieving these goals are often argued to create an inevitable tension, since public health methods that aim to promote the greatest good for the greatest number may involve limitations of individual human rights.<sup>13</sup> The individual’s rights are limited for the sake of the rights of the group.<sup>14</sup> However, the HIV epidemic has demonstrated that public health and human rights approaches may, and should be complementary and mutually supportive. The failure to protect the rights of PLHIV and other vulnerable populations and key populations at higher risk of HIV exposure and the use of coercive or punitive responses may increase the spread and exacerbate the impact of HIV and AIDS.

*“Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with HIV and AIDS”<sup>15</sup>*

The Global Commission on HIV and the Law has reiterated the crucial role of the law in creating this supportive environment, having spent the past 18 months conducting extensive research into the negative impact of punitive and discriminatory law and the crucial role of protective law and policy in HIV. The GCHL’s July 2012 Report, *HIV and the Law: Risks, Rights and Health* emphasises that human rights-based laws, regulations and policies are vital to balancing public health and human rights

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<sup>10</sup>For example, children may lose the right to parental care as a result of parents dying from AIDS; this may also lead to further impoverishment and loss of rights such as the right to education. See, for instance, UNICEF, *Enhanced Protection for Children Affected by AIDS*. UNICEF, New York, 2007.

<sup>11</sup>UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006.

<sup>12</sup>UNAIDS, *2004 Report on the global AIDS epidemic*. UNAIDS, Geneva, 2004.

<sup>13</sup>For instance, an individual with an infectious disease such as influenza may be isolated since he or she is considered dangerous to the health of others.

<sup>14</sup>International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights, “The Public Health – Human Rights Dialogue” in Mann, J et al (eds), *Health and Human Rights: A Reader*. Routledge, New York, 1999.

<sup>15</sup>UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006.

priorities to reduce HIV transmission, manage the impact of the epidemic and to create effective and appropriate responses to HIV.<sup>16</sup>

#### **Global Commission on HIV and the Law and Africa Regional Dialogue Aug 2011**

The Global Commission on HIV and the Law, made up of 14 distinguished individuals who advocate on issues of HIV, public health, law and development, spent a period of 18 months examining the role of the law in effective HIV responses. Their extensive research, consultations, analysis and deliberations included reviewing global scholarship on HIV, health and the law and considering submissions from over 700 people most affected by HIV from across the world as well as experts on HIV, health, law and human rights, during dialogues in 7 regions of the world. The Commission's findings and recommendations are set out in their report, *HIV and the Law: Risks, Rights & Health*.<sup>17</sup>

The Africa Dialogue on HIV and the Law, held in Pretoria in August 2011, drew participants from across Africa, including Malawi, to give evidence of and discuss the relationship between law, policy, human rights and HIV.<sup>18</sup>

For instance, individuals and organisations working with women and girl children in Malawi gave evidence of how harmful gender norms and practices, such as those that allow for early marriages and that condone marital rape increased the risk of HIV exposure amongst women and young girls.<sup>19</sup> Women's rights organisations in Malawi and in other countries submitted that customary and statutory laws limited women's property rights, making them economically dependent upon others for survival. They explained how this increased their vulnerability, made them dependent upon male sexual partners and limited their ability to negotiate the terms and conditions of their sexual relationships and to negotiate safer sex.<sup>20</sup> People living with HIV spoke of the stigma and discrimination they experienced relating to HIV and AIDS. This made them feel isolated, rejected, marginalised and reluctant to use health care services. Stigma and discrimination created barriers to their access to HIV prevention, treatment, care and support services and exacerbated the impact of HIV on their mental, physical and emotional well-being.<sup>21</sup> Key populations at higher risk of HIV exposure in Malawi and other countries, such as men who have sex with men and sex workers, reported how laws criminalising their behaviour lead to violence and abuse from law enforcement officials and health care workers, and the fears they had of accessing services such as HIV prevention services.<sup>22</sup>

<sup>16</sup>UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006.

<sup>17</sup> GCHL, *HIV and the Law: Risks, Rights & Health*, UNDP, New York, 2012. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 11 July 2012].

<sup>18</sup> See [www.hivlawcommission.org](http://www.hivlawcommission.org) for the report of the Africa Regional Dialogue and for a compilation of submissions made to the *Africa Regional Dialogue on HIV and the Law, Aug 3-4, 2011*.

<sup>19</sup> Submission by Centre for Community Organisation and Development: Malawi; Submission by Individual: Malawi; Submission by Malawi Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (MANERELA+): Malawi; Submission by National Youth Council of Malawi: Malawi; Submission by Individual: Malawi, *Africa Regional Dialogue on HIV and the Law, Aug 3-4, 2011*. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 16 July 2012].

<sup>20</sup> Submission by Women and Law in Southern Africa Research and Educational Trust: Malawi; Women and Law in Southern Africa Research and Educational Trust: Zambia; Women and Law in Southern Africa Research and Educational Trust: Zimbabwe; Submission by Southern African Litigation Centre: South Africa, *Africa Regional Dialogue on HIV and the Law, Aug 3-4, 2011*. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 16 July 2012].

<sup>21</sup> See for instance submission by Malawi Children's Village: Malawi; Submission by Legal Resources Centre: South Africa; Submission by Network of People Living with HIV: Nigeria, *Africa Regional Dialogue on HIV and the Law, Aug 3-4, 2011*. The submissions from people living with HIV in Africa are echoed by others across the globe at other regional dialogues. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 16 July 2012].

<sup>22</sup> Submission by Individual: Malawi; Submission by Save the Children in Malawi: Malawi; Submission by Centre for Community Organisation and Development: Malawi; Submission by Global Hope Mobilization: Malawi;

The Global Commission's *HIV and the Law: Risks, Rights and Health* found that:

*"Punitive laws, discriminatory and brutal policing and denial of access to justice for people with and at risk of acquiring HIV are fueling the epidemic. These legal practices create and punish vulnerability. They promote risky behaviour, hinder people from accessing prevention tools and treatment, and exacerbate the stigma and social inequalities that make people more vulnerable to HIV infection and illness."*

It urges governments to repeal bad laws and to create legal environments that defend and promote internationally recognised human rights norms.

## Literature Review

Before implementing the qualitative study, the LEA team reviewed the following categories of documents in order to understand the HIV epidemic in Malawi, the legal and policy framework related to HIV and AIDS at local, regional and international levels and key HIV, law and human rights issues:

- The Republic of Malawi (Constitution) Act
- National statutes including health laws, children's laws, employment laws, personal laws and criminal laws
- Case law of the courts of Malawi
- *The Report of the Law Commission on the Development of HIV and AIDS Legislation, 2008*
- Customary laws and practices
- Policies and plans relating to HIV and related areas of law and human rights
- Reports to UN agencies
- Health and human rights research reports and other related documentation
- International & regional human rights commitments signed and ratified by Malawi.

The LEA team collected additional documents for review during and after the implementation of the qualitative study.

*Annexure 1 (References) provides a comprehensive list of all documents that were reviewed.*

## Qualitative Study

Based on issues emanating from the literature review, the LEA team conducted 66 Key Informant Interviews (KIIs) using semi-structured interview guides with representatives of organisations and institutions mostly based in Lilongwe, Blantyre and Zomba working in areas of health, HIV and AIDS, law and/or human rights. The

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Submission by Journalists Association Against AIDS: Malawi; Submission by Centre for Rights and Development: Nigeria; Submission by Southern African Litigation Centre: South Africa; *Africa Regional Dialogue on HIV and the Law*, Aug 3-4, 2011. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 16 July 2012].

report distinguishes consultations with key informants, or 'national level stakeholders', from those with focus groups at central and district level. The categories of institutions that were consulted included:

- Key government ministries
- Statutory commissions
- Regulatory authorities of health professionals
- Academia
- Societies or associations of health and legal practitioners
- Civil society organisations (CSOs)
- United Nations (UN) Agencies
- International and development partner organisations.

*Annexure 2 (Key Informants) contains a list of organisations and institutions consulted during key informant interviews.*

In addition, the LEA team conducted 21 focus group discussions (FGDs) at central and district levels. FGDs were conducted in two districts selected on the basis of their diversity in culture, matrimonial structure and religion: Mangochi district (Yao, Muslim) and Mzimba district (Ngoni / Tumbuka, Christian). Focus group discussions were made up key populations and populations particularly vulnerable in the context of HIV such as pregnant women, young people, people living with HIV, people with disabilities, men who have sex with men, sex workers and married and/or sexually active men and women. Parliamentarians participating in the Parliamentary Committee on HIV/AIDS, Health and Legal Affairs were also consulted. Additionally, chiefs, as gate keepers of customary laws, were also consulted in focus group discussions in Mangochi and individually in Mzimba.

*Annexure 3 (Focus Groups) contains a list of the groups consulted during FGDs.*

The main themes explored during the KIIs and FGDs included:

- Identifying and describing populations at higher risk of HIV exposure or particularly vulnerable to the impact of HIV and AIDS
- Assessing and describing the types of stigma, discrimination and human rights abuses experienced by PLHIV and key populations at higher risk of HIV exposure
- Assessing respondent's perspectives, where possible, on the extent to which current and proposed laws and policies protect and promote rights, or deny rights and block universal access to prevention, treatment, care and support
- Assessing access to justice and law enforcement in the context of HIV and AIDS

## **Data Management**

The LEA took notes from KIIs conducted at central level and tape recorded proceedings of all FGDs conducted at district and national levels. Two independent research assistants transcribed tape recordings in verbatim and the LEA team checked the transcripts for comprehensiveness and accuracy. The final corrected copies of the transcripts were used for analyses.

## **Validation and Dissemination of Study Findings**

To validate findings of this assessment, the LEA held consultative meetings, during the course of data collection, with a National Reference Group (NRG) set up to steer the LEA. During the meetings, the NRG reviewed and critiqued the content and validity of preliminary findings and provided advice to the LEA team for further collection of data and review of additional literature.

The findings and recommendations of the final draft report were shared with a wide range of involved and affected stakeholders at a National Stakeholder's Workshop in Lilongwe, Malawi on the 20<sup>th</sup> June for feedback and validation. Feedback from this process has been incorporated into the final recommendations of this report.

## 4. Background to HIV, AIDS and Key Human Rights Issues in Malawi

### HIV Epidemic in Malawi

#### ***Overview of the burden, trend and impact of HIV and AIDS in Malawi***

Since 1985, when the first AIDS case was diagnosed in Malawi, HIV prevalence increased significantly especially among persons aged 15-49 and peaked at 16.2% in 1999. After 1999, HIV prevalence has declined steadily, stabilizing at 11-12% in 2004 and 2010. However, HIV prevalence has persistently remained higher in females than males with the largest disparity in the 15-19 year old age group.<sup>23</sup> By the end of 2011, the Ministry of Health (MoH) estimated that over 900,000 people were living with HIV of whom 176,000 were children aged less than 15 years. The estimated number of HIV-related deaths and orphans remains unacceptably high (*Table 1*). Heterosexual intercourse accounts for 88% of all new HIV infections, while mother-to-child transmission accounts for ~10% of the infections. Approximately 2% of infections are believed to be transmitted through blood transfusions, contaminated medical and skin piercing instruments.

**Table 1: Burden of HIV and AIDS in 2010-2011**

INDICATOR	VALUE	YEAR	SOURCE*
<b>Epidemiology</b>			
Estimated HIV prevalence (15-49 years) (%)	10.6	2010	MDHS 2010
Number of people living with HIV	917,000	2011	MoH
Deaths due to AIDS	46,172	2011	MoH
Children orphaned by HIV AND AIDS	597,000	2011	MoH

#### ***Overview of the distribution of HIV and AIDS in Malawi***

Although Malawi has a generalized HIV epidemic, Behavioural Surveillance Surveys (BSS) conducted in 2004 and 2006 indicate that specific occupational groups have higher HIV prevalence than the general population.<sup>24</sup> These include female sex workers, female border traders, long-distance truck drivers, police officers, estate workers and fishermen (*Figure 1*). Men who have sex with men (MSM) in Malawi also have a high HIV prevalence (21%), as demonstrated in a recent study.<sup>25</sup> The rate of new HIV infections (HIV incidence) is also estimated to be very high in key

<sup>23</sup> NSO/MACRO, *Malawi Demographic and Health Survey, 2004*; NSO/MACRO, *Malawi Demographic and Health Survey, 2010*.

<sup>24</sup> *Malawi Biological and Behavioural Surveillance Survey and Comparative Analysis, 2004 and 2006*.

<sup>25</sup> Baral S et al., 'HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana'. *Plos One*, Vol 4(3), 2009.

populations at higher risk of HIV exposure such as sex workers, clients of sex workers and MSM.<sup>26</sup> The contribution of these key populations to the number of new infection has been estimated to be low; however the research by Baral et al notes that concurrency of sexual relationships may be a key driver of heterosexual transmission in the region.<sup>27</sup> Cohabiting HIV-discordant partners, previously assumed to be at low risk, account for 47% of all new HIV transmissions in Malawi.

### Key Populations and Vulnerable Populations

The term '**key populations**' or '**key populations at higher risk of HIV exposure**' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs and sex workers and their clients are at higher risk of HIV exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.<sup>28</sup>

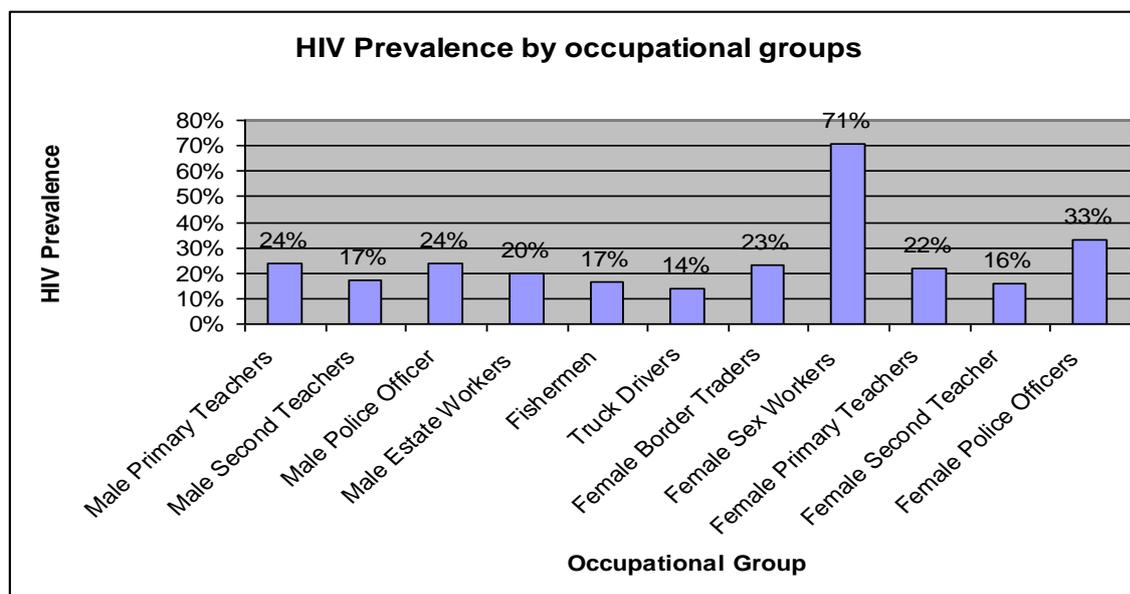
Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV. **Vulnerability** refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. These factors may include: lack of the knowledge and skills required to protect oneself and others; accessibility, quality, and coverage of services; and societal factors such as human rights violations or social and cultural norms. These norms can include practices, beliefs, and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.<sup>29</sup>

<sup>26</sup> Department of Nutrition, HIV and AIDS, *National HIV Prevention Strategy 2009-2013*.

<sup>27</sup> A significant proportion of MSM in the study identified as heterosexual or bisexual and were married or had at least one female sexual partner in the preceding six months. Baral S et al., 'HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana'. *Plos One*, Vol 4(3), 2009.

<sup>28</sup> See UNAIDS, *2011-2015 Strategy: Getting to Zero*. UNAIDS, Geneva, 2010.

<sup>29</sup> See UNAIDS, *Terminology Guidelines*. UNAIDS, Geneva, October 2011.

**Figure1: HIV prevalence in vulnerable and key populations**

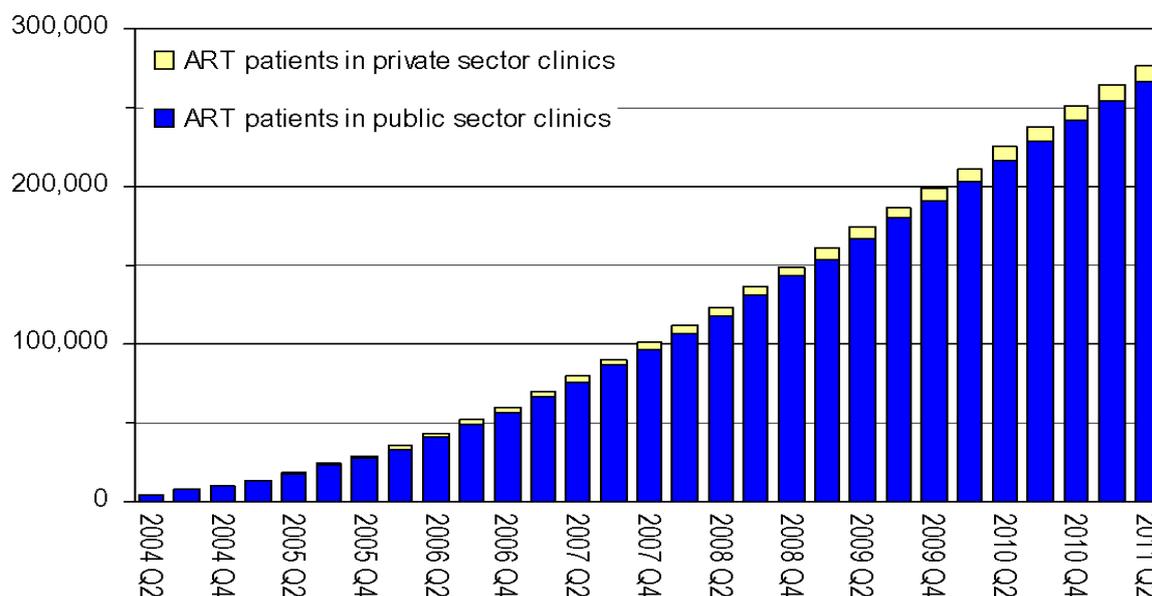
### **Overview of coverage and impact of HIV and AIDS Interventions**

Since the early 2000s, Malawi has made great strides in improving the coverage of key HIV and AIDS interventions (*Table 2*). Notably, from April 2004 to mid-2011 the number of people living with HIV receiving antiretroviral treatment (ART) had increased exponentially from about 50, 00 to 276, 897 (*Figure 2*). As shown in *Table 2*, by mid-2011 a large number of people underwent HIV Testing and Counselling (HTC) and many pregnant women were receiving Prevention of Mother-to-Child Transmission of HIV (PMTCT) interventions. Estimates from the MoH indicate that the annual number of new HIV infections and deaths in Malawi has declined from 85,000 and 70,000 respectively in 2007 to about 52,000 and 49,000, respectively in 2010. These successes are due to a number of factors including Malawi's favourable HIV policy and strategic framework, which attracted funding from local and external partners and fostered effective collaboration among partners implementing HIV and AIDS interventions.

**Table 2: Coverage of interventions**

INDICATOR	VALUE	YEAR	SOURCE*
<b>Coverage of HIV and AIDS interventions</b>			
# of people who had an HIV test in the last 12 months and who know their results	1,773, 267	07/2010 to 06/2011	MoH
Number of patients receiving ART who are alive	276,897	06/2011	MoH
ART coverage (as % of patients with advanced HIV infection)	67%	2011	MoH
% of pregnant women attending Antenatal Clinic who were tested for HIV and received their results	76%	Q2 2011	MoH
% of HIV-positive pregnant women attending antenatal clinic who received ART to reduce the risk of mother-to-child transmission	85%	Q2 2011	MoH
% of children born to HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission	94%	Q2 2011	MoH

Data Source: Ministry of Health, Quarterly HIV Unit Report, Q2 2011

**Figure 2: Patients alive and on Antiretroviral Treatment in public and private sector clinics in Malawi**

## HIV-Related Stigma, Discrimination and Human Rights Issues in Malawi

Malawi continues to experience on-going, high levels of stigma, discrimination and human rights abuses against people living with HIV or AIDS, key populations at higher risk of HIV exposure and vulnerable populations. Literature reviews as well as discussions with key informants and focus groups during the LEA, confirmed this to be the case.

### ***Vulnerable Populations and Key Populations***

Certain populations are recognised in literature (including scientific publications, reports as well as Malawi policy and strategic documents<sup>30</sup>) as well as by key informants as being at higher risk of HIV exposure or particularly vulnerable in the context of HIV within Malawi. The particular susceptibility or risk of HIV exposure of identified populations is discussed in further detail, below.

In addition to people living with HIV, vulnerable and key populations in Malawi are said to include the following:

- Children (*including orphaned children, street children, girl children as well as children living in child-headed households, babies and infants*)
- Women (*including pregnant women, young women, women living in poverty and young women*)
- Sex workers
- Prisoners, including young offenders
- Men who have sex with men
- Employees (*with particular mention of domestic workers, as well as health workers, estate workers, mobile workers, members of the armed forces (soldiers and the police), truck drivers, mine workers, junior workers, professional workers, teachers and fishermen*)
- Young people
- People with disabilities
- Lesbian, gay, bisexual, transgender and intersex (LGBTI) populations

During the LEA, key informants also made mention of other populations such as married people, people in polygamous unions, surviving spouses, people married in matrilineal and patrilineal societies, tuberculosis (TB) patients, people who inject drugs, rape survivors, rural communities, homeless people, migrant populations, tenants, people engaged in informal trade, tour guides, curio sellers, bar girls, truck drivers, educated people and the 'elite', junior workers, the elderly living with orphaned children and carers of people with HIV.<sup>31</sup> Some informants identified reasons for people's higher risk of exposure or vulnerability such as inequality (including unequal power relationships), existing marginalisation, poverty, working conditions, access to services and harmful cultural norms.

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<sup>30</sup> E.g. the *Malawi HIV and AIDS Extended National Framework: 2010-2012* and the *Malawi Zero Draft National HIV and AIDS Policy 2010-2015*

<sup>31</sup> Interviews with key informants and focus groups conducted during December 2011 to April 2012.

### ***Discrimination against People Living with HIV or AIDS***

The recent 'Stigma Index' study conducted in Malawi<sup>32</sup> found high levels of HIV-related stigma and discrimination against PLHIV in various sectors of society from the health care sector and workplace to within people's own communities, families and homes. The research findings confirm that stigma and discrimination remain a major stressor for PLHIV in Malawi, exacerbating self-stigma and impacting on universal access to HIV prevention, treatment, care and support.

*"When I was diagnosed HIV positive, some of my relatives, including my parents, were not happy to hear that I was HIV positive. They even failed to help me in some ways when I became ill. They could not care for me. They even said things like 'leave my home; I do not want you here. Go and die elsewhere with your AIDS.' This was very painful for me, that it was happening in my life; that my own parents, my relatives could stigmatize me in such a way."*<sup>33</sup>

Various forms of stigma and discrimination were highlighted by the 'Stigma Index' research as well as by key informant interviews and focus group discussions.<sup>34</sup> A small number of key informants at national level<sup>35</sup> as well as focus groups at district level<sup>36</sup> argued that levels of stigma and discrimination were declining; however people living with HIV themselves as well as with other populations in these same districts reported on-going discrimination.<sup>37</sup>

Stigma, discrimination, marginalisation and rejection from partners, family members and community members was reported most commonly, although generally PLHIV reported being discriminated against outside of their households more than within. Stigma and discrimination takes various forms including breaches of confidentiality (being gossiped about), rejection by partners (including sexual rejection, being thrown out of their homes or being divorced), denial of use of household and community facilities, exclusion from social gatherings and community development projects, discrimination in access to coupons and subsidies as well as verbal assaults, threats and harassment, physical harassment and physical assault.<sup>38</sup> This

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<sup>32</sup> Chirwa M., Kamkwamba D. and Umar E., *Stigma and Discrimination Experienced by People Living with HIV and AIDS in Malawi*. MANET+, Malawi, 2011.

<sup>33</sup> Ibid., pg 47.

<sup>34</sup> See, for instance, Key Informant Interviews, MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWLHA, Lilongwe, 7 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011.

<sup>35</sup> See, for instance, Key Informant Interview, NAC, Lilongwe, 6 and 22 Dec, 2011; MSF, Blantyre, 20 Jan 2012; UNICEF, Lilongwe, 5 Dec 2011.

<sup>36</sup> See, for instance, Focus Group Discussions, Chiefs, Mangochi; Married Men and Women, Mangochi; Chiefs, Mzimba; Married Men and Women, Mzimba.

<sup>37</sup> See, for instance, Focus Group Discussions, People Living with HIV or AIDS, Mangochi; Youth, Mangochi; Pregnant Women, Mangochi; People Living with HIV or AIDS, Mzimba; Youth, Mzimba; HSA, Mzimba; Clinicians, Mzimba.

<sup>38</sup> Chirwa M., Kamkwamba D. and Umar E., *Stigma and Discrimination Experienced by People Living with HIV and AIDS in Malawi*. MANET+, Malawi, 2011, pg 39-44. Stigma and discrimination at household and community level was confirmed in a number of key informant interviews and focus group discussions. See, for instance, Focus Group Discussions, Sexually Violated Girls, Lilongwe; Male Sex Workers, Lilongwe; Commercial Sex Workers, Lilongwe; Chiefs, Mzimba; Married Men and Women, Mzimba; HSA, Mzimba; Clinicians, Mzimba; Youth, Mzimba; People living with HIV, Mangochi, Youth, Mangochi; DAC, Mangochi.

results in feeling of worthlessness, withdrawal and increased marginalisation of people living with HIV or AIDS.<sup>39</sup>

Discrimination within the health care sector was reported within the literature review<sup>40</sup> as well as by key informants and focus group discussions.<sup>41</sup> It included treating patients with HIV with disrespect<sup>42</sup>, differential treatment or denial of access to family planning, sexual and reproductive health and dental health services,<sup>43</sup> forced or coerced terminations of pregnancy and sterilisation in the case of women with HIV,<sup>44</sup> HIV testing without informed consent<sup>45</sup> particularly of pregnant women<sup>46</sup> and breaches of confidentiality.<sup>47</sup>

*“They are first told the advantages of PMTCT and if ready we test them. This is after counselling. However, if this step is not followed the women are not allowed to start antenatal. We can therefore say they are forced.”<sup>48</sup>*

*“I have seen where women say I don’t want to be tested, during delivery when the woman has all these pains a nurse comes and says now we are going to test you and she just draws the blood.”<sup>49</sup>*

*“Just last week a certain lady who is HIV+ and on ART went to the hospital to deliver as labour date was due. The health personnel delayed to assist the lady, the reason being why she fell pregnant when she knew in advance that she was HIV-positive. Due to the delays she lost a baby in the process.”<sup>50</sup>*

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<sup>39</sup> *Ibid.* See also Key Informant Interview, MANET+ and NAPHAM, Lilongwe, 6 Dec 2011.

<sup>40</sup> *Ibid.*, p54-62.

<sup>41</sup> Health authorities, however, said they receive few reports HIV-related health rights violations. Key Informant Interviews, Medicines, Pharmacy and Poisons Board, Lilongwe, 13 Jan 2012; Medical Council, Lilongwe, 12 Jan 2012.

<sup>42</sup> See, for instance, Key Informant Interview, Ministry of Health, Lilongwe, 6 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWLHA, Lilongwe, 7 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011.

<sup>43</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2012; Ministry of Health, Lilongwe, 7 Dec 2011; CHANCO, Zomba, 20 Feb 2012. See also Focus Group Discussion, Clinicians, Mzimba; Clinicians, Mangochi; Youth, Mangochi; DAC, Mangochi.

<sup>44</sup> Some women with HIV reported being coerced into terminating pregnancies or using contraception in order to access ART and coerced or forced sterilisations. They also reported not receiving counselling on reproductive options and being advised not to have children. Chirwa M., Kamkwamba D. and Umar E., *Stigma and Discrimination Experienced by People Living with HIV and AIDS in Malawi*. MANET+, Malawi, 2011. See also Key Informant Interview, MANET+ and NAPHAM, Lilongwe, 6 December 2011, Focus Group Discussion, DAC, Mangochi. Clinicians in focus group discussions said that they may advise women with HIV against pregnancy for health reasons, but did not coerce women into terminating pregnancies; see for instance, Focus Group Discussion, Clinicians, Mzimba; Clinicians, Mangochi. In Mangochi, people living with HIV also reported that they were given a choice on pregnancy; see Focus Group Discussion, People Living with HIV, Mangochi.

<sup>45</sup> See, for instance, Focus Group Discussions with Male Sex Workers, Lilongwe; Youth, Mangochi.

<sup>46</sup> A number of national key informants explained that HIV testing for pregnant women was ‘opt-out’ and not compulsory. However, focus group discussions indicated that in practice, HIV testing of pregnant women is viewed as and/or implemented as compulsory in many instances. See Focus Group Discussion, Parliamentary Health and HIV Committee; Sex Workers, Lilongwe; PLHIV, Mzimba; Married Men and Women, Mzimba; HSA, Mzimba.

<sup>47</sup> See Key Informant Interviews, Law Commission, Lilongwe, 6 December 2011; MANET+ and NAPHAM, Lilongwe, 6 December 2011; Society of Medical Doctors, Lilongwe, 23 Jan 2012. Focus Group Discussions, HSA, Mzimba; Clinicians, Mzimba; Pregnant Women, Mangochi; Married Men & Women, Mangochi.

<sup>48</sup> Focus Group Discussion, HSA, Mzimba.

<sup>49</sup> Respondent, Focus Group Discussion, Parliamentary Health and HIV Committee, Lilongwe.

<sup>50</sup> Respondent, Focus Group Discussion, DAC, Mangochi.

Other public health limitations reported were inadequate access to safe blood supplies<sup>51</sup> as well as inadequate access to ART and treatment for opportunistic infections (OI) in some cases due to distant treatment sites,<sup>52</sup> inadequate medical staff and unreliable drug supplies.<sup>53</sup>

Some key informants at national level working in and with the health sector felt it was important to note the severe constraints on health care providers themselves who are overloaded with a health system that has too few health care workers to meet the needs of patients adequately.<sup>54</sup>

A range of discriminatory actions were also reported within the working environment including the stigmatising attitudes of co-workers and employers, pre-employment HIV testing, denial of employment on the basis of a person's HIV status and dismissals on the basis of an employee's HIV status. See the full discussion of employees as a vulnerable population for further detail, below.

There were also limited reports of discrimination within education including discrimination, denial of admission to and/or suspension of children with HIV,<sup>55</sup> as well as discrimination and dismissals of teachers with HIV.<sup>56</sup>

### ***Women, including pregnant women:***

There is general agreement that women are vulnerable in the context of HIV and AIDS for various reasons.<sup>57</sup> Women in Malawi live with gender inequality and harmful gender norms that reinforce their lower socio-economic status, increase poverty and give them limited control over their lives (including sexual relationships).<sup>58</sup> Property-grabbing after the death of a husband exacerbates the economic vulnerability of women and their children.<sup>59</sup> Gender-based violence is also common,<sup>60</sup> as are harmful cultural practices<sup>61</sup> that place women at direct risk of HIV exposure.

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<sup>51</sup> Key Informant Interview, NAC, Lilongwe, 6 Dec and 22 Dec, 2011.

<sup>52</sup> Key Informant Interview, Ministry of Health, Lilongwe, 7 Dec 2011.

<sup>53</sup> See, for instance, Key Informant Interview, UNAIDS, Lilongwe, 5 Dec 2011; Focus Group Discussion, Married Men and Women, Mangochi. The 'Stigma Index' research notes, however, that the majority of PLHIV interviewed did have access to and were on ART.

<sup>54</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; NOAM, Lilongwe 7 Dec 2011; Medical Council of Malawi, Lilongwe, 12 Jan 2012; MHEN, Lilongwe, 9 Dec 2011.

<sup>55</sup> See Key Informant Interview, Administrator General's Office, Blantyre, 16 Dec 2011.

<sup>56</sup> Focus Group Discussion, Youth, Mangochi.

<sup>57</sup> See, for instance, Key Informant Interviews, UNFPA, Lilongwe, 5 Dec 2011; Law Commission, Lilongwe, 6 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; COWLHA, Lilongwe, 7 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; WHO, Lilongwe, 13 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012; MSF, Blantyre, 20 Jan 2012, amongst others.

<sup>58</sup> See, for instance, Key Informant Interviews, UNFPA, Lilongwe, 5 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; Law Commission, Lilongwe, 6 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; COWLHA, Lilongwe, 7 Dec 2011; WHO, Lilongwe, 13 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012. See also Focus Group Discussion, Clinicians, Mzimba.

<sup>59</sup> See for instance Key Informant Interviews, Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; Department of Nutrition, HIV and AIDS, Lilongwe, 22 Dec 2011; Ministry of Justice and Constitutional

Women with HIV also experience various forms of stigma, discrimination and human rights violations at family and community level such as assault, being thrown out of the family home when they test HIV-positive,<sup>62</sup> being denied community resources<sup>63</sup> and property grabbing.

*“When you are found to be HIV-positive and your husband has died, it is difficult for people in the village to support you, because they feel if they support you, it will be easy for you to find someone and therefore spreading the disease. Therefore they take away everything and you and your children suffer.”<sup>64</sup>*

Discrimination within the health care sector was commonly reported, as set out above. There is widespread agreement that pregnant women are often subjected to compulsory HIV testing, and are not made aware of the possibility of ‘opting out’ of HIV testing. Women also report coerced sterilisation as well as being persuaded or coerced not to have children. Although clinicians reported that women are given information and advised against pregnancy rather than coerced, in many cases it appears that women experience their treatment as coercive.

### **Young people and children**

Children (in particular orphaned and street children)<sup>65</sup> as well as young people have been identified as one of the most important populations vulnerable to HIV for various reasons including gender-based violence<sup>66</sup> and harmful cultural practices that placed girl children at higher risk of HIV exposure,<sup>67</sup> limited access to accurate and appropriate HIV information and education to prevent HIV transmission<sup>68</sup> and to

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Affairs, Lilongwe, 12 Jan 2012. See also Focus Group Discussions, Sexually Violated Girls, Lilongwe; Sex Workers, Lilongwe; Married Men and Women, Mzimba.

<sup>60</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; Malawi Police Services, Lilongwe, 8 Dec 2011; Judiciary, Blantyre, 16 Dec 2011.

<sup>61</sup> Such as *chokolo* and *kulowa fumbi*, according to a Key Informant Interview with COWLHA, Lilongwe, 7 Dec 2011. See also mention of *kulowa kufa* during a Focus Group Discussion with Sexually Violated Girls, Lilongwe.

<sup>62</sup> Key Informant Interviews, COWLHA, Lilongwe, 7 Dec 2011. See also Focus Group Discussions, Sexually Violated Girls, Lilongwe; Clinicians, Mzimba.

<sup>63</sup> See Focus Group Discussion, Youth, Mzimba.

<sup>64</sup> Respondent, Focus Group Discussion, Pregnant Women, Mzimba.

<sup>65</sup> See, for instance, Key Informant Interviews, UNFPA, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Development, Lilongwe, 6 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; Medical Council of Malawi, Lilongwe, 12 Jan 2012; WHO, Lilongwe, 13 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012; MSF, Blantyre, 20 Jan 2012 and Irish Aid, Lilongwe, 24 Jan 2012, amongst others.

<sup>66</sup> See, for instance, Key Informant Interview, Irish Aid, Lilongwe, 24 Jan 2012

<sup>67</sup> For example, the practice of *fisi* during initiation ceremonies, where a man is secretly hired to have sex with a young girl or woman, was cited in a Key Informant Interview with WHO, Lilongwe, 13 Jan 2012.

<sup>68</sup> For instance, it was argued that children do not receive adequate information at their schools or within their family environments due to cultural norms against discussing issues of sexuality with children in a Key Informant Interview with John Hopkins, Blantyre, 20 Jan 2012. See also Key Informant Interview, Judiciary, Blantyre, 16 Dec 2011.

treatment and care,<sup>69</sup> limited participation in HIV and human rights education,<sup>70</sup> and cross-generational sexual relationships.<sup>71</sup>

The impact of HIV and AIDS exacerbates children's vulnerability. For instance children, especially girl children leave school to care for sick household members and children with HIV and orphaned children face HIV-related discrimination<sup>72</sup> and are less able to realise rights to alternative care, education and medical care.<sup>73</sup>

*"Spouses of people who have died of HIV, orphans who are HIV positive, spouses of men who have died of HIV in most cases the extended family does not want her to get anything because to them she will die soon"*<sup>74</sup>

### **Sex Workers**

Literature reviews and interviews with key informants and focus group discussions with sex workers identified sex workers as a key population,<sup>75</sup> based on various factors including their risk of HIV exposure and perceived HIV status,<sup>76</sup> the fact that health services failed to meet their particular health needs<sup>77</sup> and laws criminalised aspects of sex work which made it difficult for them to organise, create support structures<sup>78</sup> and access services<sup>79</sup> and increased their vulnerability to violations of their rights. Respondents reported that sex workers experience a range of serious human rights violations including rape, assault, arbitrary arrests, intimidation, and extortion at the hands of law enforcement official and clients,<sup>80</sup> HIV testing without consent on arrest<sup>81</sup> as well as discrimination within the community<sup>82</sup> including from religious and political leaders. They also report degrading treatment by health

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<sup>69</sup> See Focus Group Discussions, Sex Workers, Lilongwe; Youth, Mzimba.

<sup>70</sup> Key Informant Interview, WHO, Lilongwe, 13 Jan 2012

<sup>71</sup> Key Informant Interview, WLSA, Blantyre, 13 Dec 2011.

<sup>72</sup> Such as being physically abused and neglected, or being denied inheritance rights.

<sup>73</sup> See, for instance, Key Informant Interviews, Law Commission, Lilongwe, 6 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; NOVOC, Lilongwe, 23 Jan 2012; Administrator General's Department, Blantyre, 16 Dec 2011. See also Focus Group Discussions, Commercial Sex Workers, Lilongwe; Clinicians, Mzimba; Youth, Mzimba.

<sup>74</sup> Respondent, Key Informant Interview, Administrator General's Department, Blantyre, 16 Dec, 2011.

<sup>75</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec, 2011; MHEN, Lilongwe, 9 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; WHO, Lilongwe, 13 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; Irish Aid, Lilongwe, 24 Jan 2012; World Bank, Lilongwe, 25 Jan 2012 amongst others. See also Focus Group Discussions, Sex Workers, Lilongwe and DAC, Mangochi.

<sup>76</sup> See, for instance, Key Informant Interview, CHANCO, Zomba, 20 Feb 2012.

<sup>77</sup> See, for instance, Key Informant Interviews, Centre for Human Rights and Rehabilitation, Lilongwe, 12 January 2012; Ministry for Information and Civic Education, Lilongwe, 13 January 2012.

<sup>78</sup> See, for instance, Key Informant Interviews, Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; World Bank, Lilongwe, 25 Jan 2012. See also Focus Group Discussion, Sex Workers, Lilongwe.

<sup>79</sup> See Key Informant Interview, Judiciary, Blantyre, 16 Dec 2011.

<sup>80</sup> See, for instance, Key Informant Interviews, Malawi Police Services, Lilongwe, 8 Dec 2011; High Court, Blantyre, 16 Dec 2011; WHO, Lilongwe, 13 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012.

<sup>81</sup> See Focus Group Discussion, HSA, Mzimba.

<sup>82</sup> See for instance, Focus Group Discussions, Male Sex Workers, Lilongwe; Sexually Violated Girls, Lilongwe; Sex Workers, Lilongwe.

workers and breaches of confidentiality.<sup>83</sup> They lack legal protection and report being unable to access justice to enforce their rights.<sup>84</sup>

*“When we get sick or when someone beats us up or insults us...People look at us like we are nothing important and its OK if we get such treatment. Usually we get beaten up after we have fulfilled our client’s needs and when it’s time to pay us they refuse. ...the owners of the bar refuse to help us. Even when we go to the police it’s even worse.”<sup>85</sup>*

### **Men who have sex with men**

Men who have sex with men (and reported to a lesser extent, the LGBTI community as a whole<sup>86</sup>) were identified as a key population at high risk of HIV exposure.<sup>87</sup> Same-sex sexual relations are not only criminalised but also highly stigmatised in Malawian society<sup>88</sup> resulting in MSM being forced to remain ‘invisible’ or ‘underground’,<sup>89</sup> creating self-stigma and creating obstacles to their access to services.<sup>90</sup> Although HIV prevalence is high amongst MSM,<sup>91</sup> criminal laws prevent health services from meeting their particular needs (e.g. they fail to provide appropriate HIV and AIDS messages and lubricants)<sup>92</sup> and MSM report experiencing stigmatising and discriminatory behaviour from health care workers.<sup>93</sup>

<sup>83</sup>Submission by Individual working for CSO, Malawi, *Africa Dialogue on HIV and the Law*, Aug 3-4, 2011. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 15 July 2012]. See also Focus Group Discussion with Sex Workers, Lilongwe.

<sup>84</sup> See Focus Group Discussion, Sex Workers, Lilongwe; DAC, Mangochi.

<sup>85</sup> Focus Group Discussion, Sex Workers, Lilongwe.

<sup>86</sup> Some respondents identified transgender people as well as women who have sex with women, due to the failure to meet their health needs in service delivery. See, for instance, Key Informant Interviews, Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; GIZ, Lilongwe, 25 January 2012.

<sup>87</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; UNFPA, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; MHEN, Lilongwe, 9 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; WHO, Lilongwe, 13 Jan 2012; Ministry of Information and Civic Education, 13 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; Irish Aid, Lilongwe, 24 Jan 2012; GIZ, Lilongwe, 25 Jan 2012; CHANCO, Zomba, 20 Feb 2012. See also Focus Group Discussions, MSM, Blantyre; MSM, Lilongwe.

<sup>88</sup> See, for instance, Key Informant Interviews, UNFPA, Lilongwe, 5 Dec 2011; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; SWAPS, Lilongwe, 24 Jan 2012; Member of Parliament, Lilongwe, 15 Feb 2012. See also Focus Group Discussions with Male Sex Workers, Lilongwe; MSM, Blantyre.

<sup>89</sup> Focus Group Discussions, MSM, Blantyre. In a focus group discussion with Chiefs in Mzimba district, a respondent said of MSM: “Here it cannot happen because people do not involve themselves in this practice. That practice does not exist here.” Organisations providing services to MSM are reported to have been raided by police and ‘covert government operatives’; Key Informant Interview, CEDEP, Lilongwe, 13 Jan 2012.

<sup>90</sup> See, for instance, Key Informant Interviews, Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012; World Bank, Lilongwe, 25 Jan 2012

<sup>91</sup> Baral S et al., ‘HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana’. *Plos One*, Vol 4 (3), 2009.

<sup>92</sup> See, for instance, Key Informant Interviews, Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; World Bank, Lilongwe, 25 Jan 2012; GIZ, Lilongwe, 25 January 2012. See also Focus Group Discussion, MSM, Blantyre; MSM, Lilongwe. CEDEP reported a police raid of an organisation which was charged with possession of pornographic material for having educational materials on safe sex between men; see Key Informant Interview with CEDEP, Lilongwe, 13 Jan 2012.

<sup>93</sup> See, for instance, Key Informant Interviews, Ministry of Health, Lilongwe, 7 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 January 2012; CEDEP, Lilongwe, 13 January 2012; World Bank, Lilongwe, 25 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012. See also Focus Group Discussions, MSM, Blantyre;

*“Cases of advanced STIs [sexually transmitted infections amongst MSM] are reported to us because people have no information on where to access health services. When they do visit health services, they experience negative attitudes from service providers.”<sup>94</sup>*

*“The health sector is part and parcel of government and cannot provide lubricants when the practice that lubricants are used for is illegal. We cannot effectively provide targeted services for people who are engaged in illegal practices.”<sup>95</sup>*

Some key informants at national level<sup>96</sup> stated that health policies provided for treatment for all people<sup>97</sup> and that health care providers did not differentiate between or actively deny treatment services to MSM,<sup>98</sup> as a result they held that reports of discrimination with the health sector were unwarranted. However, these respondents simultaneously acknowledged the barriers created in access to services for MSM by the laws criminalising sex between men, the stigmatising attitudes towards MSM, self-stigma and/or the fear of possible reports to the authorities as well as their own confusion whether reporting was necessary and whether non-reporting would make them liable to prosecution.<sup>99</sup> MSM also complained of being unable to report discrimination to law enforcement agencies, due to fear of arrest.<sup>100</sup>

*“People who are gay cannot disclose because of criminal sanctions. When they get ill or have anal infections they find it hard to disclose and get treatment because they are afraid of being asked so many questions.”<sup>101</sup>*

*“In some cases you find that someone engages in a sexual activity and gets an STI, we fail to properly explain to the doctors where we got the STI from because they wouldn’t understand and they would call the policemen and get us arrested.”<sup>102</sup>*

*“As a doctor you feel awkward on what to do when you treat a homosexual with an STI. Because this is classified as criminal behaviour, potentially one might be expected to report the same to the police... On the other hand one may accuse the doctors of aiding a person treating a person engaged in homosexual practices when they are apprehended...”<sup>103</sup>*

Responses at district level towards MSM showed very high levels of stigmatisation and discrimination towards MSM and a reliance on the criminalisation of sex

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MSM, Lilongwe; DAC, Mangochi. Note that there was a minority opinion that HIV prevention messages did not specify sexual acts and therefore did not discriminate against MSM. See Key Informant Interview, Malawi Law Commission, Lilongwe, 6 Dec 2011.

<sup>94</sup> Key Informant Interview, CEDEP, 13 Jan 2012.

<sup>95</sup> Key Informant Interview, Ministry of Health, Lilongwe, 24 Jan 2012.

<sup>96</sup> See, for instance, Key Informant Interviews, DNHA, Lilongwe, 22 Dec 2011; Society of Medical Doctors, Lilongwe, 23 Jan 2012; MIAA, Lilongwe, 7 Dec 2011; Malawi Law Commission, Lilongwe, 6 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; MHEN, Lilongwe, 9 Dec 2011; Magistrates Courts, Blantyre, 16 Dec 2011. See also Focus Group Discussion, Clinicians, Mzimba.

<sup>97</sup> For example, sexually transmitted infection (STI) policies require all people to bring their partner for treatment.

<sup>98</sup> See, for instance, Key Informant Interviews, Society of Medical Doctors, Lilongwe, 23 Jan 2012; Ministry of Health, Lilongwe, 24 Jan 2012.

<sup>99</sup> See, for instance, Key Informant Interviews, CEDEP, Lilongwe, 13 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Ministry of Health, Lilongwe, 24 Jan 2012. See also Focus Group Discussions with Male Sex Workers, Lilongwe; MSM, Blantyre; MSM, Lilongwe; DAC, Mangochi.

<sup>100</sup> Focus Group Discussions, MSM, Blantyre; MSM, Lilongwe.

<sup>101</sup> Respondent, Key Informant Interview, John Hopkins, Blantyre, 20 Jan 2012.

<sup>102</sup> Respondent, Focus Group Discussion, MSM, Blantyre.

<sup>103</sup> Respondent, Key Informant Interview, Society of Medical Doctors, Lilongwe, 23 Jan 2012.

between men, the belief that sex between men was wrongful and the need to discourage the practice as arguments for the denial of health care services to MSM.<sup>104</sup>

*“Government should not provide with them the lubricants and special condoms as it will be against the law. But if there will be law that legalizes homosexuality will have no problem government giving them lubricants and special condoms.”<sup>105</sup>*

*“By providing lubricants it will be acknowledging them and allowing the practice.”<sup>106</sup>*

### **Prisoners**

Prisoners (including specific mention of young offenders) were identified as a key population at higher risk of HIV exposure.<sup>107</sup> There was general consensus that sex between men occurs in prisons.<sup>108</sup> Respondents cited the overcrowded conditions, lack of basic necessities, sexual violence and limited access to HIV prevention, treatment, care and support services as examples of human rights violations.<sup>109</sup> Laws criminalising sex between men prohibit the distribution of condoms in prisons and thus act as a barrier to service delivery.<sup>110</sup>

### **Employees**

Employees were identified as vulnerable either due to their work circumstances which placed them at higher risk of HIV exposure (e.g. in the case of health care workers, teachers and members of the armed forces)<sup>111</sup> or due to HIV-related workplace stigma and discrimination which exacerbated the impact of HIV on their lives.<sup>112</sup> Domestic workers were identified as being particularly vulnerable<sup>113</sup> for

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<sup>104</sup> See, for instance, Key Informant Interview, Ministry of Health, Lilongwe, 24 Jan 2012. See also Focus Group Discussions with Male Sex Workers, Lilongwe; Sexually Violated Girls, Lilongwe; Married Men and Women, Mzimba; HSA, Mzimba. Some respondents in focus group discussions argued that providing health care to MSM would be ‘encouraging’ criminal behaviour.

<sup>105</sup> Focus Group Discussion, Clinicians, Mzimba.

<sup>106</sup> Focus Group Discussion, Male Sex Workers, Lilongwe.

<sup>107</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; Judiciary, Blantyre, 16 Dec 2011; CEDEP, Lilongwe, 13 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012.

<sup>108</sup> See, for instance, Key Informant Interviews, CEDEP, Lilongwe, 13 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012.

<sup>109</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; Judiciary, Blantyre, 16 Dec 2011; CEDEP, Lilongwe, 13 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012; High Court, Blantyre, 16 Dec 2011; CHANCO, Zomba, 20 Feb 2012.

<sup>110</sup> See, for instance, Key Informant Interviews, CEDEP, Lilongwe, 13 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012.

<sup>111</sup> For example, the police were mentioned as a population with high HIV prevalence as were professionals, teachers, soldiers, estate workers in tea, tobacco and sugar cane estates as well as fishermen, tour guides and junior workers. See Key Informant Interviews, MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; NOAM, Lilongwe, 7 Dec 2011; Ministry of Labour, Lilongwe, 7 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; Malawi Law Society, Blantyre, 12 Dec 2011; DNHA, Lilongwe, 22 Dec 2011 and WHO, Lilongwe, 13 Jan 2012 amongst others.

<sup>112</sup> Such as being dismissed on the basis of a person’s HIV-positive status or being discriminated against by co-workers. See Key Informant Interviews, Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; NOAM, Lilongwe, 6 Dec 2011; Industrial Relations Court, Blantyre, 16 Dec, 2011; High Court, Blantyre, 16 Dec 2011. See also Key Informant Interviews with UNAIDS, Lilongwe, 5<sup>th</sup> December 2011; ILO, Lilongwe, 5<sup>th</sup>

reasons such as the poverty, power inequalities between employer and employee, the lack of a union and sexual abuse by employers.<sup>114</sup> Workers in the informal work sector were also identified as being vulnerable due to their unique needs, limited organisational support and the fact that they fell beyond the scope of workplace policies and programmes.<sup>115</sup> Members of the armed forces are subjected to pre-employment HIV testing and are denied employment in the defence force if testing HIV-positive.<sup>116</sup> Anecdotal evidence from respondents suggested that other private employers also conducted pre-employment HIV testing and denied employment to those testing HIV-positive.<sup>117</sup> Workplace discrimination is reported to have a serious impact on people's lives resulting in low self-esteem, low work performance and loss of income.<sup>118</sup>

### ***People with Disabilities***

The Legal Environment Assessment identified people with disabilities as a vulnerable population due to their already marginalised status and vulnerability to human rights violations<sup>119</sup> and their limited access to employment and HIV prevention, treatment and care services.<sup>120</sup>

*“Places or materials used for disseminating HIV and AIDS information are not disability-friendly. At times, even facilitators or communicators exclude persons with disabilities during presentations because of either the methodologies or materials they use.”<sup>121</sup>*

People with disabilities are also at high risk of HIV exposure due to their limited ability to negotiate safer sex<sup>122</sup> and their risk of rape and sexual abuse.<sup>123</sup> The organisation of people with disabilities reported that sexual abuse was exacerbated by a myth that sleeping with a person with a disability cures them of HIV or brings other blessings.<sup>124</sup>

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December 2011; John Hopkins, Blantyre, 20 Jan 2012 and Focus Group Discussions with Male Sex Workers, Lilongwe; People living with HIV, Mangochi; Married Men and Women, Mangochi.

<sup>113</sup> See, for instance, Key Informant Interviews, Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Judiciary, Blantyre, 16 Dec, 2011.

<sup>114</sup> See, for instance, Key Informant Interviews, ILO, Lilongwe, 5 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; WHO, Lilongwe, 13 Jan 2012.

<sup>115</sup> Key Informant Interview, ILO, Lilongwe, 5<sup>th</sup> Dec 2011.

<sup>116</sup> See, for instance, Key Informant Interview, Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012.

<sup>117</sup> Key Informant Interview, CHANCO, Zomba, 20 Feb 2012.

<sup>118</sup> Key Informant Interview, Industrial Relations Court, 16 Dec 2011.

<sup>119</sup> See, for instance Focus Group Discussions, Youth, Mzimba; People with Disabilities, Blantyre.

<sup>120</sup> Focus Group Discussion, People with Disabilities, Blantyre.

<sup>121</sup> Respondent, Focus Group Discussion, People with Disabilities, Blantyre.

<sup>122</sup> Focus Group Discussion, People with Disabilities, Blantyre.

<sup>123</sup> See Key Informant Interview, WHO, Lilongwe, 13 Jan 2012; Focus Group Discussion, People with Disabilities, Blantyre.

<sup>124</sup> Focus Group Discussion, People with Disabilities, Blantyre.

Like women with HIV, women with disabilities report being stigmatised at health care services and being advised not to fall pregnant and to undergo sterilisation. Many women with disabilities prefer to deliver at home with traditional birth attendants.<sup>125</sup>

*“There are also two disabled women who went to a hospital and they were both reprimanded for being pregnant and were advised to go under tubal litigation.”<sup>126</sup>*

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<sup>125</sup> Focus Group Discussion, People with Disabilities, Blantyre.

<sup>126</sup> Respondent, Focus Group Discussion, People with Disabilities, Blantyre.

## 5. Legal, Regulatory, Policy and Strategic Framework for Responding to HIV: Key Principles

A number of countries in Southern and Eastern Africa, including Angola, Burundi, Democratic Republic of Congo (DRC), Kenya, Madagascar, Mauritius, Mozambique, South Africa and Tanzania, have enacted HIV laws (or in the case of South Africa, HIV-specific provisions in a number of laws) to protect and promote rights in the context of HIV and AIDS.

Currently in Malawi there is no specific HIV and AIDS legislation. However, there are a number of important and relevant principles set out in the Constitution, as well as in regional and international human rights instruments signed and ratified by Malawi. There are also a number of national, regional and international guidelines, declarations of commitment, plans and strategies to guide priority responses to HIV and AIDS and which provide a useful guiding framework for a recommended response.

In this section we set out these key principles and how they apply in the context of HIV and AIDS to guide an appropriate and effective response. These principles will serve as the framework for analysis of the current response, in terms of the public health objectives and human rights issue identified in the LEA.

### Constitution of Malawi as supreme law to guide HIV response

The Republic of Malawi (Constitution) Act, ('the Constitution') provisionally came into force on 18<sup>th</sup> May 1994, effectively entered into force on 18 May 1995<sup>127</sup> and has subsequently been amended most recently in 2010. It is the supreme law of the land and any act of government or any law that is inconsistent with its provisions is invalid to the extent of the inconsistency.<sup>128</sup> In the development, application and interpretation of all laws, including Acts of Parliament, the common law and customary law, the provisions of the Constitution are to be upheld as the "*supreme arbiter and ultimate source of authority*."<sup>129</sup> The Constitution binds all executive, legislative and judicial organs of the State at all levels of Government. All the peoples of Malawi are entitled to its equal protection and the laws made under it,<sup>130</sup>

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<sup>127</sup>Section 212(1) of the Constitution.

<sup>128</sup>Section 5 of the Constitution; section 199 further states that "this Constitution shall have the status as supreme law and there shall be no legal or political authority save as is provided by or under this Constitution." See also section 88(1) which describes the President's obligation to uphold the constitution as the supreme law of the Republic.

<sup>129</sup>Section 10(1) and (2) of the Constitution.

<sup>130</sup>Section 9 of the Constitution.

and it thus provides an important overarching framework for national laws, policies and regulations relating to HIV.

**Important constitutional principles** include the following:

- Dignity: *“The inherent dignity and worth of each human being requires that the State and all persons shall recognise and protect fundamental human rights and afford the fullest protection to the rights and views of all individuals, groups and minorities whether or not they are entitled to vote”*<sup>131</sup>
- Equality: *“As all persons have equal status before the law, the only justifiable limitations to lawful rights are those necessary to ensure peaceful human interaction in an open and democratic society”*<sup>132</sup>
- Supremacy of the Constitution: *“All institutions and persons shall observe and uphold the Constitution and the rule of law and no institution or person shall stand above the law”*<sup>133</sup>

Chapter IV of the Constitution includes a comprehensive Bill of Rights that lists the human rights to which all persons in Malawi are entitled to without discrimination and which are required to be upheld by the executive, legislature, judiciary, all organs of government and its agencies and all natural and legal persons in Malawi, where applicable.<sup>134</sup> The Constitution also provides for duties of the State, as well as duties of the individual towards others, so that all rights and freedoms are exercised with due regard for the rights of others and the common interest.<sup>135</sup> Important constitutional principles relevant to HIV are discussed further below.

## Guidance from international and regional human rights instruments

International and regional human rights law is set out in the various charters, treaties and conventions signed and ratified by member states.<sup>136</sup><sup>137</sup> Once a state has signed and ratified a treaty or convention, it agrees to be legally bound by that convention and to ensure that the principles and provisions of that instrument are met at a national level. It is required to report periodically to the relevant treaty monitoring body on its compliance with the provisions of each treaty.

<sup>131</sup>Section 12(iv) of the Constitution.

<sup>132</sup>Section 12(v) of the Constitution

<sup>133</sup>Section 12(vi) of the Constitution.

<sup>134</sup>Section 15(1) of the Constitution.

<sup>135</sup> Section 12(2) of the Constitution (as amended).

<sup>136</sup>‘Signature’ of a treaty is an act by which a state provides a preliminary endorsement of an agreement.

Signing does not create a binding legal obligation but does demonstrate the state’s intent to examine the agreement and consider ratifying it. Whilst signing does not commit a state to ratification, it does oblige the state to refrain from acts that would defeat or undermine the treaty’s objective and purpose. ‘Ratification’ is an act by which a state signifies an agreement to be legally bound by the terms of a particular treaty. To ratify a treaty, the state first signs it and then fulfils its own national legislative requirements.

<sup>137</sup>Even where states have not signed or ratified conventions or treaties, these can still be binding if their principles form part of what is known as customary international law. See Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S.331, entered into force on Jan 27, 1980, article 18(1). Available at [http://untreaty.un.org/ilc/texts/instruments/english/conventions/1\\_1\\_1969.pdf](http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf) [Accessed 6 March 2012]

In monist countries international human rights instruments automatically form part of national law; in dualist countries these instruments require to be domesticated within national laws in order to apply. Malawi is a dualist system requiring domestication of international instruments; however, the situation to date is complicated by changes brought about by the Constitution and conflicting court judgements. In one case the Supreme Court has advocated for the self-executing nature of some international treaties in domestic law; whereas in another case the court has ruled that international treaties become part of the law of Malawi only when domesticated.<sup>138</sup> The Constitution provides that international agreements entered into force after 1994 form part of national law if the Act of Parliament ratifying the agreement provides for this.<sup>139</sup> However, binding international agreements entered into force prior to the Constitution and customary international law<sup>140</sup> continue to form part of Malawian law unless and until Parliament decides otherwise.<sup>141</sup>

Domestication notwithstanding, Malawi as a nation has committed to uphold the principles in these treaties. So, the human rights principles and provisions in international instruments ratified by Malawi form a further, important guiding framework for national laws, policies and regulations relating to HIV.

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<sup>138</sup>The Malawi Supreme Court of Appeal (MSPA) has rendered conflicting decisions on the requirement to domesticate conventions. In *Chakufwa Tom Chihana v The Republic* M.S.C.A Criminal Appeal No. 9 of 1992, which was decided under the 1966 Constitution, the court held that the African Charter on Human and Peoples' Rights was not part of the municipal law of Malawi because the State had not taken legislative measures to adopt it. However, in *Malawi Telecommunications Limited V Makande and Omar* M.S.C.A. Civil Appeal No. 2 of 2006 (unreported) the court partly overruled itself on the above position to the extent that it was understood that all international treaties required domestication first before they could be relied upon as law in local courts. The court opined that in addition to section 211 of the Constitution, one has to consider also the language of the treaty and its provisions to determine whether it requires domestication before it could be relied upon in a domestic court. It was further observed that in some cases the provisions of treaties would not require domestication because they are self-executing. In *In the matter of the Adoption of Children Act and In the Matter of Chifundo James* M.S.C.A. Adoption Appeal No. 28 of 2009 (unreported) the court held that international treaties become part of the law of Malawi if they have been domesticated. This being a more recent case, it would take precedence over the other two cases discussed above notwithstanding that the court did not cite or discuss them. In our view, the *Makande and Omar* position is the more favourable and progressive approach.

<sup>139</sup>Section 211(1).

<sup>140</sup> Customary international law is law which becomes internationally accepted (as 'custom') due to the practice of States over time. The 'practice of states' means official governmental conduct reflected in a variety of acts, such as official statements at international conferences and in diplomatic exchanges.

<sup>141</sup>Section 211(2) and (3) of the Constitution.

**Key international and regional instruments** signed and ratified by Malawi include the following:

- The Universal Declaration of Human Rights (UDHR) 1948
- The International Covenant on Civil and Political Rights (ICCPR) (1966)<sup>142</sup>
- The International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966)<sup>143</sup>
- The African Charter on Human and People's Rights (ACHPR) 1981<sup>144</sup>
- The Protocol to the African Charter on the Rights of Women<sup>145</sup>
- The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) 1979<sup>146</sup>
- The Optional Protocol To The Convention On The Elimination Of All Forms Of Discrimination Against Women<sup>147</sup>
- The Convention on the Rights of the Child (CRC) 1989<sup>148</sup>
- The African Charter on the Rights and Welfare of the Child<sup>149</sup>
- The Convention Against Torture and other Forms of Cruel, Inhuman or Degrading Treatment or Punishment (CAT)<sup>150</sup>
- The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)<sup>151</sup>
- The Convention on the Rights of Persons with Disabilities (2006)<sup>152</sup>
- International Labour Organisation (ILO) Discrimination (Employment and Occupation) Convention<sup>153</sup>
- ILO Convention Concerning Termination of Employment<sup>154</sup>

In addition, there are a number of important international and regional declarations, commitments and guidelines which deal specifically with HIV, human rights and gender equality. While not strictly legally binding, they are generally reflections of the application of accepted international and regional human rights principles to the HIV epidemic. In addition, many international and regional strategies and plans include guidance on law and policy responses to HIV and AIDS. As such, they provide important and persuasive guidance for Malawi's national response.

<sup>142</sup> Ratification/accession by Malawi on 22/12/1993

<sup>143</sup> Ratification /accession by Malawi on 22/12/1993

<sup>144</sup> Ratification/accession by Malawi on 17/11/1989

<sup>145</sup> Ratification/accession by Malawi on 20/05/2005

<sup>146</sup> Ratification/accession by Malawi on 12/03/1987.

<sup>147</sup> Signature by Malawi on 07/09/2000.

<sup>148</sup> Ratification/accession by Malawi on 2/1/1991.

<sup>149</sup> Ratification/accession by Malawi on 16/09/1999.

<sup>150</sup> Ratification/accession by Malawi 11/06/1996.

<sup>151</sup> Ratification/accession by Malawi on 11/06/1996.

<sup>152</sup> Ratification by Malawi on 27/08/2009.

<sup>153</sup> Ratification by Malawi on 22/03/1965.

<sup>154</sup> Ratification by Malawi on 01/10/1986.

**Key international and regional HIV and human rights documents** include the following:

- The UNGASS *Political Declaration on HIV/AIDS, 2011* whereby countries commit to national HIV and AIDS strategies that promote and protect human rights, eliminate gender inequalities, review inappropriate laws and address the specific needs of vulnerable populations.
- The UNGASS *Millennium Development Goals Resolution, 2010* which reaffirms the importance of the respect for human rights and gender equality in achieving the Millennium Development Goals.
- The Human Rights Council Resolution 12/27/2009 on *The Protection of Human Rights in the Context of HIV and AIDS* which calls on member states to ensure respect, protection and fulfilment of human rights in the context of HIV and AIDS and encourages the repeal of punitive laws that block effective responses to HIV.
- The UNAIDS *International Guidelines on HIV/AIDS and Human Rights, 2006* which urge governments to use its 12 guiding principles to develop enabling legal and regulatory frameworks for HIV and AIDS. The *Guidelines* contain specific guidance on a) the creation of effective structures to manage the national response to HIV and AIDS in a manner that promotes full and equal participation b) the enactment of laws to protect basic human rights, reduce vulnerability to HIV and mitigate the impact of HIV on people's lives and c) the promotion of access to justice through legal literacy campaigns, legal support services and monitoring and enforcement of human rights.
- *The Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, 2001* that commits member states to prioritise HIV and AIDS and recognises the impact of social and economic inequalities on women and girls as well as the impact of and barriers created by stigma, silence, denial and discrimination.
- The African Commission on Human and Peoples' Rights *Resolution on HIV/AIDS, 2001* which recognises HIV as a human rights issues and calls on states to ensure protection for rights in the context of HIV.
- The Southern African Development Community Parliamentary Forum (SADC PF) *Model Law on HIV & AIDS in Southern Africa, 2008* which provides a 'model' law on HIV and AIDS for SADC countries.<sup>155</sup>

The UNAIDS *2011-2015 Strategy: Getting to Zero*<sup>156</sup> for the global HIV response includes, as one of its three strategic directions, the goal of advancing human rights and gender equality in the HIV response, "to get to zero discrimination". The Strategy recommends that countries take steps to realise and protect HIV-related human rights, including those of women and girls, implement protective legal environments for PLHIV and key populations and ensure HIV coverage for the most underserved and vulnerable communities.

**UNAIDS 2011-2015 Strategy: Getting to Zero Human Rights & Gender Equality goals for 2015:**

- Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses are reduced by half.
- HIV-related restrictions on entry, stay and residence are eliminated in half of the countries that have such restrictions.
- The HIV-specific needs of women and girls are addressed in at least half of all national HIV responses, and
- There is zero tolerance for gender-based violence.

<sup>155</sup>See Malera G, *Supporting Information for the Development of a Common UNCT Position on the Draft Malawi HIV and AIDS Legislation, 2011* for further discussion of international and regional guidance on HIV.

<sup>156</sup>UNAIDS, *2011-2015 Strategy: Getting to Zero*, UNAIDS, 2010. Available at [www.unaids.org](http://www.unaids.org) [Accessed 21<sup>st</sup> January 2012].

## Important human rights principles for HIV and AIDS

Important human rights principles enshrined within the Constitution's Bill of Rights as well as within applicable international, regional and sub-regional human rights and their application to HIV law and policy, are dealt with below.

Both the Malawian Constitution<sup>157</sup> and international human rights instruments<sup>158</sup> recognise that rights may be limited in specific circumstances.<sup>159</sup> Public health is an important public interest, and protecting public health may require limiting rights. However, limitations of a right should only take place in accordance with recognised principles. For instance, section 44 of Malawi's Constitution provides for the limitation of certain (but not all) rights under certain circumstances: *"no restrictions or limitations may be placed on the exercise of any rights and freedoms provided for in this Constitution other than those prescribed by law, which are reasonable, recognised by international human rights standards and necessary in an open and democratic society. Laws prescribing restrictions or limitations shall not negate the essential content of the right or freedom in question, shall be of general application."*<sup>160</sup> International norms require that a restriction of human rights requires careful consideration, based on strict criteria to determine its justifiability, and should be a last resort. For example a limitation of rights should be prescribed by law, applied in a non-discriminatory manner, be necessary and "proportional" and only used when no less intrusive measures are available to protect public health.<sup>161</sup>

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<sup>157</sup>Section 44, Republic of Malawi (Constitution) Act. See also section 12(2) of the Constitution regarding rights and duties.

<sup>158</sup> United Nations Economic and Social Council: UN Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Siracusa Principles on the Limitation and Derogation of Provisions within the International Covenant on Civil and Political Rights*. Annex, UN Doc E/CN.4/1984/4, 1984.

<sup>159</sup> Although certain rights, such as the right to life, are considered absolute or 'non-derogable' and may not be limited.

<sup>160</sup> Section 44(2) and (3), Republic of Malawi (Constitution) Act.

<sup>161</sup>International Federation of Red Cross and Red Crescent Societies and Francois-Xavier Bagnoud Center for Health and Human Rights, 'Human Rights: An Introduction' in Mann J et al (eds), *Health and Human Rights: A Reader*. Routledge, New York, 1999.

**Limiting Human Rights in the interests of Public Health:**

- The goal of limiting rights may not be contrary to the purposes and principles of the United Nations Charter.
- The limitation must be justified by the protection of a legitimate goal such as national security, public safety, protection of public health or public order.
- Limitations can be allowed only in a democratic society which presumes a participatory decision process and capacity for redress.
- A right may be restricted only if the limitation is provided for by law.
- The limitation of rights must be strictly necessary in order to achieve the public good, which must be carefully assessed on a case-by-case basis.
- The limitation of individual rights must be proportional to the public interest and its objective.
- The limitation must be the least intrusive and least restrictive measure available which will accomplish the public health goal.
- The limitation of rights must not be applied in a discriminatory manner.<sup>162</sup>

***Right to equality and freedom from discrimination***

The right to equality and non-discrimination is protected in the national Republic of Malawi (Constitution) Act as well as in international and regional instruments. Section 20 of the Constitution<sup>163</sup> as well as Articles 2 and 7 of the UDHR<sup>164</sup>, Article 2 of the ICCPR, Article 2(2) of the ICESCR and Articles 2 and 3 of the ACHPR<sup>165</sup> all protect the right to equality and freedom from discrimination.

Discrimination is prohibited on a number of grounds such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Discrimination on any of these grounds can create conditions that place people at higher risk of HIV infection. For example, populations that experience discrimination – such as women, children, migrants, people living in poverty, people with disabilities, men who have sex with men – may be at higher risk of HIV exposure or less able to adequately protect themselves from HIV transmission. In addition, people affected by HIV and AIDS experience various forms of HIV-related discrimination.

Although the Constitution's provisions do not specifically list HIV as a prohibited ground of discrimination, the Malawian courts have elaborated the right to equality in a number of cases. For example, in *Malawi Congress Party et al v Attorney General*

<sup>162</sup> *Ibid.*

<sup>163</sup> "Discrimination of persons in any form is prohibited and all persons are, under any law, guaranteed equal and effective protection against discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, disability, property, birth or other status or condition."

<sup>164</sup> Article 2 states that "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status"; Article 7 states that "all persons are equal before the law and are entitled without any discrimination to equal protection of the law".

<sup>165</sup> Article 2 provides that "every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status."

*et al*<sup>166</sup> the court held that “*the right to equality prohibits an impermissible criterion or classification or a classification arbitrarily used to burden a group of individuals*”. This suggests that the equality provision is broad enough to protect a range of key populations, including people living with HIV, from various forms of discrimination.

Similarly, in international law the Committee on Economic, Social and Cultural Rights (CESCR) has specifically stated that the list of prohibited grounds of discrimination is not exhaustive. “*Other status*” may include several other prohibited grounds for discrimination including health status, such as HIV and AIDS. The CESCR urges states to “*ensure that a person’s actual or perceived health status is not a barrier to realising the rights under the Covenant*”.<sup>167</sup>

In some jurisdictions, the right to equality has been closely linked to the right to dignity – a right also protected in section 19 of the Malawian Constitution. For instance, Canadian case law has interpreted human dignity as meaning “*that an individual or group feels self-respect and self-worth*” and recognises that human dignity is harmed by acts of unfair discrimination. “*Human dignity is harmed when individuals and groups are marginalised, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.*”<sup>168</sup> This suggests that equality and dignity rights should not only protect all people from unfair discrimination but should pay special attention to the rights of marginalised populations.

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<sup>166</sup> (1996) MLR 244.

<sup>167</sup> CESCR, General Comment No. 20, 42<sup>nd</sup> Session, 2009, para 27 and 33. Available at <http://www2.ohchr.org/english/bodies/cescr/comments.htm> [Accessed 24th January 2012].

<sup>168</sup> *Law v Canada* (1999) 1 SCR 497, para 53.

**Protecting equality and prohibiting non-discrimination in the context of HIV and AIDS**

Guideline 5 of the UNAIDS *International Guidelines on HIV/AIDS and Human Rights*, 2006 suggests that states should “enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors.” This can be done by enacting or reviewing:

- **Anti-discrimination laws** to prohibit discrimination on the basis of HIV and AIDS in various areas including health care, social security, welfare benefits, employment, education and education and access to services.
- **Traditional and customary laws** that affect the status and treatment of vulnerable populations, such as women and children.
- **Workplace laws**, regulations and collective agreements to guarantee workplace rights.
- **Laws to reduce human rights violations against vulnerable and key populations at higher risk of HIV exposure** such as women, children, people with disabilities, migrants, men who have sex with men, prisoners, sex workers and people who inject drugs, amongst others.
- **Laws to allow for freedom of movement** and the repeal of laws restricting the movements or associations of members of key populations in the context of HIV and AIDS.

Guideline 4 further recommends that states review and reform criminal laws and correctional systems to ensure that their provisions do not unfairly discriminate against or target key populations. This guideline recommends ensuring that, amongst other things:

- **Criminal and public health laws** not create specific offences against HIV transmission but rather apply general criminal offences to such cases.
- **Criminal laws prohibiting sexual acts between consenting adults in private** including laws criminalising sex between men, be reviewed with the aim of repeal.
- **Prison laws and policies** be reviewed to prohibit unfair discrimination against prisoners with HIV, protect prisoners from HIV transmission and provide access to HIV-related prevention, treatment, care and support services.

The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 provides model provisions on anti-discrimination in the context of HIV and AIDS for SADC countries.<sup>169</sup>

***Right to privacy***

Section 21(1) of the Constitution entrenches the right to privacy with regard to the person, home, property, private possessions as well as private communications; the right may be limited where appropriate, in accordance with the principles set out in the Constitution. Laws that violate the right to privacy may be declared invalid due to their unconstitutionality.

In international human rights treaties, Article 12 of the UDHR protects the right to privacy. The ICCPR, Article 17(1) states that “no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation” as does Article 37 of the CRC and Article 10 of the ACRWC.

<sup>169</sup> Available from <http://www.chr.up.ac.za/index.php/ahrru-news.html>

In international, regional and national law, the right to privacy extends to physical privacy as well as privacy of personal property and of personal information. This right can effectively be used to protect people from actions that invade their physical privacy (such as HIV testing without consent), as well as acts that invade their rights to hold information private (such as disclosures of HIV status).<sup>170</sup> The Human Rights Committee has also found that privacy rights protect people from criminal laws that impose obligations upon their physical privacy relating to private and consensual sexual relationships, such as laws that criminalise sex between men.<sup>171</sup>

### ***The right to personal liberty and security***

Sections 18,<sup>172</sup> 19(5) and (6)<sup>173</sup> of the Malawian Constitution provide for the right to liberty and security of the person, as do Article 3 of the UDHR and Article 9 of the ICCPR. This right is also protected by article 6 of the ACHPR, which provides that “*every individual shall have the right to liberty and to the security of his person*”.

In Malawi, a generous interpretation of this and other constitutional provisions has been emphasised by the Supreme Court. Chirwa argues that personal liberty is inclusive of “*other rights and freedoms that give expression to autonomy*” including privacy rights, rights to freedom of movement and expression, the right to engage in any economic activity, the right to found a family and women’s rights to autonomy, amongst others.<sup>174</sup> This suggests that any HIV-related laws that limit a person’s autonomy (such as quarantine, isolation, travel restrictions for people with HIV or the denial of employment opportunities to people with HIV) may arguably be unconstitutional, unless such limitations are justifiable in an open and democratic society.<sup>175</sup> HIV testing without consent may also constitute a deprivation of liberty

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<sup>170</sup>UNAIDS and OHCHR *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006. Available at [www.unaids.org](http://www.unaids.org) [Accessed 2 March 2012]. See also the Report of the Special Rapporteur on Trafficking in Persons, Especially Women and Children, A/HRC/4/23/Add.2, 25 April 2007 which states that “given that the right to privacy is restricted by mandatory HIV/AIDS testing, public health, criminal and anti-discrimination legislation should prohibit mandatory HIV testing of targeted groups, including migrant workers.” Similar statements relating to the violation of privacy rights by mandatory HIV testing have been made by the Committee on the Elimination of All Forms of Discrimination Against Women, the Committee on the Rights of the Child and the Committee on the Protection of the Rights of All Migrant Workers and Members of their Families.

<sup>171</sup>The Human Rights Committee has found that the right to privacy is violated by laws that criminalise private homosexual acts between consenting adults and has noted that “the criminalisation of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS...” Communication No 488/1991, *Nicholas Toonan V. Australia* (views adopted on 31 March, 1994, fiftieth session), *Official Records of the General Assembly, Forty-ninth Session, Supplement No. 40* (A/49/40), vol. II, annex IX EE, para.8.5.

<sup>172</sup>Section 18 states that “every person has the right to personal liberty.”

<sup>173</sup>Section 19 provides for the right to dignity and personal freedoms. Section 19(5) provides that “no person shall be subjected to medical or scientific experimentation without his or her consent” and section 19(6) provides every person with the right to freedom and security of the person.

<sup>174</sup>Chirwa DM, *Human Rights under the Malawian Constitution*. Juta, 2011, p112.

<sup>175</sup>In terms of section 12(v) of the Constitution.

and a violation of the right to security of the person. Respect for rights to privacy, liberty and security of the person furthermore requires HIV testing to be carried out on the basis of voluntary and informed consent.<sup>176</sup>

**Protecting rights to privacy, liberty and security of the person in the context of HIV and AIDS**

Guideline 3 of the *International Guidelines* recommends that states “review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS...and that they are consistent with international human rights obligations.” According to the *Guidelines*, public health laws should, amongst other things:

- Provide for HIV testing only with voluntary and informed consent (apart from surveillance and other unlinked epidemiological testing) and with pre- and post-test counselling
- Protect the right to confidentiality
- Authorise (but not require) disclosures of a person’s HIV status by a health care worker in defined circumstances where a real risk of HIV transmission exists, following counselling and discussions with the person with HIV

The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 provides model provisions on HIV testing, disclosure and confidentiality in the context of HIV and AIDS for SADC countries.<sup>177</sup>

***Right to health and to life***

The right to health is well protected in international human rights instruments: Article 25 of the UDHR, Article 12 of the ICESCR, Article 12 of CEDAW and Article 24 of the CRC all protect health rights. The Committee on Economic, Social and Cultural Rights (CESCR) interprets it as the right to have access to health care services with a corresponding state duty to make such services accessible to all. It also contains freedoms and entitlements, including the right to be free from non-consensual medical treatment and experimentation and the entitlement to a system of health that provides “equality of opportunity for people to enjoy the highest attainable level of health.”<sup>178</sup> In regional treaties, Article 16 of the ACHPR says that “every individual shall have the right to enjoy the best attainable state of physical and mental health.” The African Commission has held that the right to health be applied without discrimination.<sup>179</sup>

The Malawi Constitution does not include the right to health in Chapter IV, with the other human rights. Instead, it classifies the promotion of health as a goal under the section in the Constitution dealing with Principles of National Policy. The Principles of National Policy enshrined in the Constitution enjoin the state to adopt and implement policies and laws to, amongst other things, “provide adequate health care commensurate with the health needs of Malawian society and international

<sup>176</sup>UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006, para 113.

<sup>177</sup> Available from <http://www.chr.up.ac.za/index.php/ahrru-news.html> [Accessed 17 July 2012]. See also Section 8, below, for extracts from the SADC PF *Model Law*.

<sup>178</sup> CESCR, 22<sup>nd</sup> Session, 2000, General Comment No. 14, at paras 88-12. Available at <http://www2.ohchr.org>.

<sup>179</sup> *Purohit and Moore v The Gambia*, Comm. 241/01, para 80. Available at <http://caselaw.ihrda.org>

*standards of health care*".<sup>180</sup> Section 30(2) provides for the right to development and furthermore obliges the State to ensure equal opportunity in access to health services, among other things.<sup>181</sup>

It remains debatable whether this classification in the Constitution does indeed accord adequate protection to the right to health.<sup>182</sup> It has also been argued that the Chapter IV protection of the right to life,<sup>183</sup> also found in international human rights instruments such as the UDHR<sup>184</sup> and ICCPR,<sup>185</sup> may be sufficient to protect health rights. Malawian courts have interpreted the right to life as the most important of all rights. In *Rep v Joshua Cheuka*<sup>186</sup>, the court stated that the right to life is "*the most fundamental of all rights in that it is a prerequisite for the enjoyment or exercise of all other rights.*" In the case of health, it is clear that the right to health is closely allied to, and may be enforced through the right to life. All human rights are recognised as "*indivisible, interdependent, interrelated and of equal importance for human dignity.*"<sup>187</sup> Failure to provide access to HIV-related prevention, treatment, care and support (such as the means of HIV prevention or ART) limits the right to life; it leads to the loss of life or a serious reduction in the quality of life. However to date the courts have not used the right to life to increase access to health care services for PLHIV and affected populations.

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<sup>180</sup>Section 13(c) of the Constitution.

<sup>181</sup>"The state shall take all necessary measures for the realisation of the right to development. Such measures shall include, amongst other things, equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure."

<sup>182</sup> Section 14 of the Constitution (as amended) provides that "principles of national policy contained in this Chapter shall be directory in nature but courts shall be entitled to have regard to them in applying any of the provisions of this Constitution or of any law or in determining the validity of decisions of the executive and in the interpretation of the provisions of the Constitution.

<sup>183</sup>Section 16 of the Constitution provides that "Every person has the right to life and no person shall be arbitrarily deprived of his or her life: Provided that the execution of the death sentence imposed by a competent court on a person in respect of a criminal offence under the laws of Malawi of which he or she has been convicted shall not be regarded as arbitrary deprivation of his or her right to life."

<sup>184</sup> Article 3

<sup>185</sup> Article 6.

<sup>186</sup>Criminal Case No 73 of 2008(High Court) (Lilongwe District Registry) (Unreported).

<sup>187</sup>The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1998) 20 *Human Rights Quarterly*, para 4.

**Protecting health rights in the context of HIV and AIDS**

Guideline 6 of the *International Guidelines* recommends that health law and policies ensure access to a range of HIV prevention, treatment, care and support services including for marginalised and key populations at higher risk of HIV exposure. They say that “states should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.” For example, they should:

- Enact laws to provide for universal access to HIV-related prevention, treatment, care and support services
- Review or repeal laws that block universal access to HIV-related health care services and that discriminate on the basis of HIV and AIDS
- Provide for positive steps to address factors that increase the vulnerability or reduce the access to services for vulnerable and marginalised populations
- Provide for community participation in the design, development and implementation of services
- Enact laws to provide for quality control of HIV-related products and services, including timely and adequate access to treatment for HIV, accurate information regarding HIV treatment, access to quality HIV testing and counselling, condoms and other prevention products and services, HIV information and education
- Enact laws to encourage HIV-related research and development, increase international and regional co-operation and access to resources for HIV and AIDS and encourage the domestication and use of flexibilities within international trade agreements (such as TRIPS), amongst other things.<sup>188</sup>

Guidelines 3 and 4 also recommend the review of public health laws, criminal laws and correctional systems to ensure that coercive and discriminatory laws are not applied inappropriately to HIV and AIDS in a way that blocks universal access to HIV prevention, treatment, care and support. The *Guidelines* recommend, amongst other things, that:

- Public health laws not subject people living with HIV to isolation, detention or quarantine on the basis of their HIV status
- Criminal and public health laws not include specific offences to criminalise HIV transmission
- Criminal laws prohibiting same-sex relations be repealed and not be allowed to impede HIV-related prevention, treatment, care and support
- Laws criminalising adult sex work be reviewed and not be allowed to impede HIV-related prevention, treatment, care and support
- Criminal laws relating to injecting drug use be reviewed to allow for harm reduction programmes as well as treatment, care and support for people who inject drugs

The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 provides model provisions on regulating access to health care in the context of HIV and AIDS for SADC countries.<sup>189</sup>

<sup>188</sup> See Guideline 6, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006 for full details of the recommendations.

<sup>189</sup> Available from <http://www.chr.up.ac.za/index.php/ahrru-news.html> [Accessed 17 July 2012]. See also Section 8, below, for extracts from the SADC PF *Model Law*.

**Right to work**

Section 31 of the Malawi Constitution provides every person with the right to fair, non-discriminatory and safe labour practices. Article 23 of the UDHR says that “*everyone has the right to work ...[and] to just and favourable conditions of work.*” This right to fair conditions of work is further protected in key ILO conventions, as well as the ACHPR.<sup>190</sup>

The right to fair work conditions gives every person the right to access to employment without preconditions that unfairly discriminate except on the basis of occupational qualifications. Pre-employment HIV testing for purposes of denying employment (or refusing access to employee benefits) to those who test HIV positive violates the right to work.<sup>191</sup>

**Protecting the right to work in the context of HIV and AIDS**

Guideline 5 of the *International Guidelines on HIV/AIDS and Human Rights* requires states to review workplace laws to protect the rights of employees in relation to HIV and AIDS. It recommends the enactment of workplace laws, regulations and agreements to guarantee the following workplace rights:

- The development of a national policy on HIV and AIDS agreed to by employers and employees
- A prohibition on HIV testing as a prerequisite for employment, promotion, training or benefits
- Confidentiality regarding HIV status
- Employment security for workers living with HIV, including reasonable accommodation in the working environment
- Access to HIV-related prevention, treatment, care and support
- Protection from HIV-related stigma and discrimination
- Protection from occupational infection with HIV

The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 provides model provisions on HIV workplace rights for SADC countries.<sup>192</sup>

**Right of Freedom of Expression and Information**

The right to freedom of opinion (including the right to hold opinions without interference and to receive and impart opinions), freedom of expression and the right of access to information are all protected in the Malawi Constitution.<sup>193</sup> The right to access to information gives every person the right to all information held by the state

<sup>190</sup> Article 15 of the Charter states that “every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work”

<sup>191</sup> UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, 2006 at para 127.

<sup>192</sup> Available from <http://www.chr.up.ac.za/index.php/ahrru-news.html> [Accessed 17 July 2012]. See also Section 8, below, for extracts from the SADC PF *Model Law*.

<sup>193</sup> Section 34, 35 and 27 of the Constitution.

or any of its organs of government at any level.<sup>194</sup> As with many other rights, this right is not absolute and may be restricted by an Act of Parliament.

Article 19 of the ICCPR provides every person the right to hold opinions without interference. It says that “*everyone shall have the right to freedom of expression; this right shall include the freedom to seek, receive and impart information and ideas of all kinds...*” Article 9 of the ACHPR also protects the right to information.

In the context of HIV, this right includes the right to seek, receive and impart HIV-related prevention and care information as a means of preventing the spread of HIV and providing health care to those affected. The *International Guidelines* recommend that, in keeping with the right to freedom of expression and information as well as the right to health, HIV-related information should not be wrongfully censored in terms of censorship laws, obscenity laws or laws making those imparting the information liable for aiding and abetting criminal offences.<sup>195</sup>

#### **Protecting the right of freedom of expression and information in the context of HIV and AIDS**

Guideline 2 of the *International Guidelines* recommend community consultation in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organisations are enabled to carry out their activities including in the field of ethics, law and human rights effectively. In particular, it recommends that laws and policies provide for:

- Formal and regular mechanisms for ongoing dialogue with community representatives in HIV-related policies and programmes
- Funding to sustain the HIV-related work community organisations, including work in the field of ethics, human rights and law.

Guideline 6 furthermore recommends that laws and regulations provide for the widespread provision of HIV-related information aimed at the general public and vulnerable populations. Such information should not be inappropriately subject to censorship where this damages the right to information vital to life, health and human dignity.

Guideline 8 recommends that governments provide support to community groups representing the interests of vulnerable populations through various measures such as financial support, capacity building and empowerment, measures to increase their participation and measures to improve their social and legal status.

The SADC PF *Model Law on HIV & AIDS for Southern Africa*, 2008 provides model provisions to protect rights to freedom of expression and information for all, including vulnerable and key populations.<sup>196</sup>

<sup>194</sup>Section 37 of the Constitution. This right is not absolute and may be restricted by an Act of Parliament.

<sup>195</sup> For instance, where same-sex relationships are criminalised, countries may prohibit HIV-related prevention information for men who have sex with men. See UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006, para 116.

<sup>196</sup> Available from <http://www.chr.up.ac.za/index.php/ahrru-news.html> [Accessed 17 July 2012]. See also Section 8, below, for extracts from the SADC PF *Model Law*.

### ***The rights of vulnerable populations & key populations***

International, regional and national human rights documents protect the rights of marginalized and vulnerable populations and key populations at higher risk of HIV exposure. Since the discrimination and inequality experienced by certain populations increases vulnerability and risk, rights protection for all populations is important to the HIV response.

Specific rights protection for vulnerable populations includes the following:

- ***Women's Rights:*** Section 24 of the Malawian Constitution provides detailed protection for women's rights to equality<sup>197</sup> and to protection from discriminatory and harmful practices such as sexual abuse, harassment and violence, discrimination in work, business and public affairs and the deprivation of property (including inherited property).<sup>198</sup> Internationally, the UDHR, ICCPR, ICESCR and CEDAW include protection for women's equality rights. CEDAW aims to eliminate all forms of unfair discrimination against women and protects a wide range of women's rights including women's health rights.<sup>199</sup> The Committee on the Elimination of Discrimination Against Women has specifically recommended that HIV responses should give special attention to the health rights of women (and children) and to factors relating to the reproductive role of women and children and their subordinate position in society which make them especially vulnerable to HIV infection.<sup>200</sup> At a regional level, the ACHPR also protects women's rights. The Protocol to the African Charter on the Rights of Women is particularly significant in that it specifically addresses women's equality and reproductive health rights in respect to HIV and AIDS.<sup>201</sup>
- ***Children's Rights:*** Section 23 of the Malawian Constitution includes detailed protection for the rights of children to equality, to a name and nationality, to parental care and to protection from exploitation and harm. It also provides for special consideration for the rights of children in the right to development.<sup>202</sup> Both the CRC and the ACRWC provide children with many of the same rights as adults.<sup>203</sup> In particular, these instruments protect children's rights to equality, non-discrimination, development, participation and to have their best interests promoted. The Committee on the Rights of the Child has issued a General

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<sup>197</sup>Including the right to enter into contracts, own property, including marital property, and exercise guardianship over their children. See section 24(1) of Constitution.

<sup>198</sup>Section 24(2), Republic of Malawi (Constitution) Act.

<sup>199</sup>Article 12 of CEDAW

<sup>200</sup>Committee on the Elimination of Discrimination Against Women, *General Recommendation 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of AIDS*, UN Document CEDAW, A/45/38, 2 February 1990.

<sup>201</sup>Articles 14(1) and (20) provide for women's right to make decisions regarding their sexual and reproductive health including the right to self-protection from HIV, access to information about reproductive health including HIV and AIDS and access to reproductive health services.

<sup>202</sup>Section 30(1), Republic of Malawi (Constitution) Act.

<sup>203</sup>Such as the rights to life, non-discrimination, integrity of the person, liberty and security, privacy, expression, association and assembly, education and health.

Comment that includes specific and detailed guidance on the rights of the child in the context of HIV and AIDS.<sup>204</sup>

- *People with disabilities:* In Malawi, the Constitution's Principles of National Policy oblige the state to enact laws and policies and take measures to actively promote the welfare and development of people with disabilities, including their rights to adequate and suitable access to public places, rights, fair opportunities in employment and full participation in society.<sup>205</sup> It also provides specific protection for people with disabilities to equality and non-discrimination<sup>206</sup> and development<sup>207</sup> and for the rights of children with disabilities.<sup>208</sup> Internationally, the CRPD provides extensive protection for the rights of people with disabilities, and encourages states to take positive steps to protect the equality and health rights of people with disabilities. In Africa, the ACHPR, Protocol to the African Charter on the Rights of Women and the ACRWC all protect the rights of people with disabilities.

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<sup>204</sup>Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the Rights of the Child*, 2003.

<sup>205</sup>Section 13(g), Republic of Malawi (Constitution) Act.

<sup>206</sup>Section 20, Republic of Malawi (Constitution) Act.

<sup>207</sup>Section 30(1), Republic of Malawi (Constitution) Act.

<sup>208</sup>Section 23(4), Republic of Malawi (Constitution) Act (as amended, 2010) provides that the state take measures to ensure that children, particularly orphans, children with disabilities and other children in situations of disadvantage live in safety and security and receive state assistance, where appropriate.

**Protecting the rights of specific populations in the context of HIV and AIDS**

Guideline 5 of the *International Guidelines on HIV/AIDS and Human Rights* recommends that enact or strengthen anti-discrimination and other protective laws that protect vulnerable and key populations.

In addition, Guideline 8 of the *International Guidelines on HIV/AIDS and Human Rights* recommend that states “*promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.*”

Suggested laws and policies to protect the rights of key populations include:

- **Protecting women’s rights** to equality regarding property, marital relations, access to employment and economic opportunity and access to appropriate HIV-related health care. In addition, there should be legal provisions against marital rape, the age of consent to sex for men and women should be consistent and women should have the right to refuse marriage and sexual relations. Laws should protect women from violence, sexual abuse, harmful traditional practices, exploitation, early marriage and female genital mutilation.
- **Laws to reduce human rights violations against children** such as sexual abuse, mandatory HIV testing and property grabbing. Laws should furthermore provide for children’s access to HIV-related information, education and means of prevention, access to voluntary HIV testing in accordance with their evolving capacity and sexual and reproductive health care services, as well as protection for children orphaned by AIDS.
- **Laws to reduce human rights violations against men who have sex with men** such as laws to protect same-sex relationships and to prohibit discrimination, harassment and abuse of sexual minorities.
- **Laws and policies to provide for prisoners’ rights to health care** such as protection from rape and sexual violence, provision of HIV-related prevention information, education and voluntary testing and counselling, means of prevention, treatment and care.
- **Laws to promote HIV prevention and care programmes for all populations** who have less access to mainstream programmes due to language, poverty, social or legal or physical marginalisation such as minorities, migrants, indigenous peoples, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, men having sex with men and injecting drug users.
- **Laws to prohibit mandatory HIV testing of targeted populations** at higher risk of HIV exposure.

Other key rights relevant to HIV and AIDS include but are not limited to the following:

- The right to marry and found a family and the protection of the family<sup>209</sup> which arguably protects all people from mandatory pre-marital HIV testing and the denial of marriage to those testing HIV-positive, as well as protects women from forced or coerced sterilization.<sup>210</sup>

<sup>209</sup> Section 22 of the Republic of Malawi (Constitution) Act, Article 16 of the UDHR; Article 18 of the ACHPR.

<sup>210</sup> People living with HIV should be able to marry and engage in sexual relations that do not pose a risk of infection to their partners; women should be provided with adequate information and services relating to mother-to-child transmission to make their own reproductive health choices and should also have equal rights within the family. UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS: 2006 at para 96.

- The right to freedom of assembly and association<sup>211</sup> which allows organisations (such as AIDS service organisations and support groups) to represent the interests and needs of various populations affected by HIV and AIDS.
- The right to education<sup>212</sup> which protects the rights of children with HIV to attend educational institutions without discrimination, protects children's rights to receive HIV-related information and education within and outside of schools and also promotes the overall development of children, reducing their vulnerability.<sup>213</sup>
- The right to cultural life<sup>214</sup> which protects each person's cultural heritage

#### **Additional guidance from the *International Guidance on HIV/AIDS and Human Rights***

In addition to describing the key laws and policies required to protect rights in the context of HIV, the UNAIDS and OHCHR *International Guidelines* contain recommendations regarding institutional responsibilities and processes as well as support services required to make these rights real:

- Guideline 1 recommends that states establish effective national frameworks for the national response to HIV to ensure “a co-ordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government”
- Guideline 2 recommends supporting community consultation in all phases of HIV/AIDS policy design, programme implementation and evaluation
- Guideline 7 recommends the provision of legal support services to educate people about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and use means of protection in addition to the courts
- Guideline 9 recommends the wide and ongoing distribution of education, training and media explicitly designed to change attitudes of discrimination and stigmatization associated with HIV and AIDS
- Guidelines 10 and 11 recommend that states develop and strengthen monitoring and enforcement mechanisms to guarantee HIV-related human rights in the public and private sector.

## **Policies and Strategic Plans guiding the National HIV Response**

In addition to the abovementioned legal principles, Malawi has also developed a number of policies and plans relevant to HIV, health and human rights issues. While these do not have the force of law, many contain important and sometimes aspirational principles in relation to health, HIV, human rights and gender equality.

### ***National Strategic Framework***

The *National Strategic Framework, (NSF) 2000-2004* was launched to guide the implementation of HIV and AIDS activities. It set out key strategic interventions to reduce HIV incidence and HIV-related mortality, including its impact on society, prevention, advocacy and behavioural change; treatment, care, and support; sectoral

<sup>211</sup>Sections 32 and 38 of the Republic of Malawi (Constitution) Act, Article 20 of the UDHR.

<sup>212</sup>Section 25 of the Republic of Malawi (Constitution) Act, Article 26 of the UDHR.

<sup>213</sup>UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006, para 114 and 115.

<sup>214</sup>Section 26 of the Republic of Malawi (Constitution) Act, Article 15(1)(a) of the ICESCR.

mainstreaming; impact mitigation; and surveillance and monitoring. The NSF also focussed on addressing cross-cutting issues of gender inequality, human rights, legal and ethical issues. Key strategic action points include:

- Discouragement of harmful cultural practices
- Incorporating issues of gender equity and equality in all public programmes
- Promoting the enforcement of laws relating to rape, sexual harassment, and discrimination of PLHIV
- Strengthening mechanisms and capacity for enforcement of existing gender and human rights legislation
- Initiating debate and seeking broad consensus on crucial legal and policy areas such as legislation of sex work and the criminalisation of 'wilful' HIV transmission
- The elimination of all forms of discrimination of PLHIV through increased Information, Education and Communication (IEC) and law and human rights codes.

### ***National HIV and AIDS Policies and National Action Framework***

To facilitate and guide the implementation of the NSF, the government of Malawi developed the *National HIV Policy* in 2003. The policy acknowledged the impact of discrimination on vulnerability to HIV infection and on access to health care. It included a number of guiding principles, including the promotion and protection of human rights as well as the need for sound, current and empirically based research to guide the response. It committed the government to "*promote and protect human rights in accordance to the Constitution of Malawi and international human rights conventions which Malawi has endorsed to effectively address the social, political and economic factor that increase vulnerability to HIV infection and negatively affect people living with HIV/AIDS*". The policy identified a range of vulnerable and key populations including women and young girls, orphans, widows and widowers, children and young people, the poor, sex-workers, prisoners, mobile populations, persons engaged in same sex relationships, people with disabilities and PLHIV.

Following the launch of the *National HIV Policy*, the National AIDS Commission developed a detailed implementation plan for the NSF, the *National HIV and AIDS Action Framework (NAF) (2004/05 - 2008/09)*. The NAF focussed on eight priority areas including that of mitigating the impact of HIV and AIDS.

The NAF was later aligned and harmonized with the Malawi Growth and Development Strategy (MGDS) (2006-2011), an overarching national development strategy in Malawi for achieving sustainable economic growth and development. This alignment resulted in the development of the *Extended National HIV and AIDS Action Framework (2010-2012)*. The NAF, guided by the *National HIV Policy* has assisted the government of Malawi in mobilizing resources from local and external developmental partners to support the implementation of HIV activities.

The *National HIV Prevention Strategy (2009-2013)* outlines broad interventions to prevent HIV transmission in the general public focussing on abstinence, mutual faithfulness, condom use and male circumcision. In addition, the strategy includes specific interventions targeted at key populations at higher risk of HIV exposure including MSM and their female partners, sex workers and prisoners. Further, the strategy addresses 'cross-cutting issues', such as gender, human rights, culture and legal issues, to create an enabling environment for Malawians to change and sustain their positive behaviours. Activities include addressing harmful cultural practices that promote HIV transmission, reduction of stigma and discrimination against PLHIV, promoting disclosure of HIV serostatus to sexual partners and the enactment of an HIV law following international best practices. These activities are consistent with the spirit of the existing *National HIV/AIDS Policy 2003-2008* and the *Draft National HIV and AIDS Policy 2010-2015*, currently under development at the time of writing this report.

The new draft HIV policy, while maintaining similar principles to the 2003-2008 HIV policy so as to consolidate previous achievements, also attempts to incorporate new research evidence on HIV prevention, treatment and care. Specifically, the draft policy seeks to underpin the scale-up of evidence-informed interventions such as male circumcision, early infant diagnosis of HIV and targeted nutritional support for PLHIV, amongst other things. In addition, the draft policy endeavours to balance and affirm both human rights and public health considerations in managing HIV and AIDS; it recognises public health strategies for responding to HIV as well as the legal and human rights framework promulgated by the Constitution, national legislation and international instruments. One of the broad objectives of the policy is "*to respect, promote and protect human rights, fundamental freedoms and human dignity for all infected and affected including vulnerable groups*". The policy highlights the need to respect the human rights and dignity of people infected and affected by HIV and AIDS as well as populations vulnerable in the context of the HIV epidemic.

### ***Other sectoral policies affecting vulnerability to and impact of HIV and AIDS***

Besides the HIV and AIDS-specific policies and strategies, various sectors have formulated policies that, if implemented, may directly or indirectly reduce vulnerabilities to HIV and AIDS and its impact among specific groups of people:

- The *National Policy on Early Child Development, 2003* aims at protecting children against abuse, exploitation and discrimination,<sup>215</sup> providing support to children living in HIV and AIDS affected families and those in 'difficult' circumstances.<sup>216</sup>

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<sup>215</sup> Section 4.3.9

<sup>216</sup> Section 4.3.7

- The *Policy on Orphans and Vulnerable Children*, 2003 aims at enhancing the teaching of basic and technical life skills to stimulate orphans and vulnerable children to poverty reduction efforts and overall development.<sup>217</sup>
- The *National Gender Policy*, 2011 aims to, amongst other things, reduce poverty among women and vulnerable populations through economic empowerment,<sup>218</sup> gender mainstreaming in all HIV responses,<sup>219</sup> elimination of gender-based violence<sup>220</sup> and a reduction in child abuse and trafficking.<sup>221</sup>
- The *Sexual and Reproductive Health Policy*, 2009 which has several goals including reduction of STIs and HIV,<sup>222</sup> including young people,<sup>223</sup> reduction of harmful cultural practices and domestic violence among women, men and young people<sup>224</sup> and increased male involvement in reproductive health.<sup>225</sup>
- The *National Social Support Policy*, 2012 that aims at addressing the vulnerabilities of the very poorest members of society such as the elderly, infirm, persons with disabilities, chronically ill and orphans and other vulnerable children (OVC) living in households with no adults fit for productive work. The policy focuses on four priority areas including the creation welfare support programme, prevention of the erosion of their assets due to external shocks, increasing income and accumulation of assets and reducing social exclusion and marginalization.<sup>226</sup>
- The *National Economic Empowerment Policy*, 2004 which, among other things, aims to support the economic empowerment of rural communities, women, youth and people with disabilities.<sup>227</sup>
- The *National HIV/AIDS Workplace Policy*, 2010 which provides a set of guidelines to employers and employees on how to address HIV and AIDS in the workplace. The policy focuses on reduction of stigma and discrimination for PLHIV and those perceived to have HIV, mitigating the impact of HIV and AIDS and preventing the spread of HIV. The policy derives its principles from regional and international declarations, norms and standards as stipulated in the ILO *Code of Practice on HIV and AIDS and the World of Work*, 2001, the ILO *Recommendation on HIV and AIDS and the World of Work*, No. 200 of 2010 and the SADC *Code of Good Practice on HIV/AIDS and Employment*, 1997. In addition the policy takes into account national laws dealing with non-discrimination and workplace rights such as the Constitution, the Employment

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<sup>217</sup> Section 5.1.1

<sup>218</sup> Section 3.6

<sup>219</sup> Section 3.7

<sup>220</sup> Section 3.8

<sup>221</sup> Section 2.5

<sup>222</sup> Section 3.3

<sup>223</sup> Section 3.6

<sup>224</sup> Section 3.8

<sup>225</sup> Section 3.9

<sup>226</sup> Sections 3.1 to 3.4

<sup>227</sup> Sections 3.7 to 3.10

Act,<sup>228</sup> the Labour Relations Act,<sup>229</sup> the Workers Compensation Act,<sup>230</sup> and the Occupational Safety, Health and Welfare Act.<sup>231</sup> The policy includes provisions on HIV testing, confidentiality and disclosure of HIV status, gender and sexual harassment and employees welfare programmes. The policy expressly prohibits compulsory pre-employment HIV testing (except for the Army, Police, Prisons and Immigration) and using employees' confidential HIV results or gender in making decisions on training, career advancement, benefits, promotion or dismissal. In addition, the policy encourages employers to adapt the workplace to accommodate employees with illness by applying measures such as re-arrangement of working times, job sharing, modification of employees duties, flexible leave, time off for medical appointments, leave for care of sick dependants and part-time work, amongst other things.

- The *National Nutrition Policy and Strategic Plan (NNPSP) 2007 to 2012*, among other things, aims at scaling up the provision of nutrition, care, support and treatment of PLHIV, TB and chronically ill patients and supporting optimal feeding practices for infants born to HIV-positive women. The policy is guided by human rights principles and undertakes to base all nutrition initiatives on sound research. For example, the policy highlights the rights of all people to have access to safe and nutritious diets, in accordance with the fundamental basic rights of citizens to be free from malnutrition and related disorders and equity in nutrition for all vulnerable populations including those with HIV and AIDS.
- Consistent with the NNPSP, the *Infant and Young Child Nutrition Policy* was developed in 2010 with the aim of promoting practices that improve nutritional status of infants and young children in various circumstances including HIV and AIDS. One the primary objective of the policy is “to contribute to the reduction of Mother to Child Transmission of HIV, especially through breast milk”. The policy is aligned with 2010 World Health Organization (WHO) guidelines for the feeding of HIV exposed infants and young children and the *National PMTCT Strategic Plan*. The policy takes into account emerging research findings and leaves room for further revision incorporating future research findings.

In general, all of the above policies adopt the principles set out in international conventions, treaties, and covenants signed by Malawi, international human rights standards and the Malawi Constitution. They contain detailed policy frameworks that can be used to manage HIV and AIDS and minimize its social and economic consequences. However many are still broad and subject to wide interpretation while others appear aspirational and unsupported with comprehensive strategies and feasible implementation plans.

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<sup>228</sup> Cap 55:01

<sup>229</sup> Cap 54:01

<sup>230</sup> Cap 55:03

<sup>231</sup> Cap 55:04

***Health Workers and Patients' Policies, Codes and Guidelines***

Activities of medical practitioners in Malawi are regulated by the Malawi Medical Council which has published the *Code of Ethics and Professional Conduct*, 2009. Among other things, this Code outlines how medical practitioners will conduct themselves in their relationship with patients and professional peers and colleagues. While the code emphasizes the importance of maintaining patient confidentiality and informed consent, it provides conditions under which confidentiality may be breached.<sup>232</sup> This includes situations where “*public interest persuades a practitioner that his duty to the community overrides that to his patient*”.

The Ministry of Health has also published a *Charter on Patients and Health Services Providers' Rights and Responsibilities*. The Charter outlines various rights of the patient including access to health care, adequate information and education, respect and dignity and privacy and confidentiality. However, the Charter also states that patients' information can be disclosed for “*public health reasons*”. Further, the Charter imposes responsibilities to a patient including that of “*ensuring or maintaining his and her own health and that of the society by refraining from irresponsible sexual activity and other lifestyles that are hazardous to health*”. These provisions represent limitation of rights within the broader scope of protective laws, policies and plans which require examination within the broader framework.

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<sup>232</sup> Section 5.7

## **6. Analysis of legal and regulatory framework for HIV and AIDS in Malawi**

### **Introduction**

Currently, in Malawi there is no specific HIV and AIDS legislation. There are a number of HIV-specific policies that provide clear and protective guidance, although they are not, strictly speaking, legally enforceable. There are also a number of provisions within the current legal regime which can and have been utilised to provide protection for HIV and AIDS related issues. While these laws are generally not HIV specific, they cut across civil, criminal and constitutional law. It appears that the lack of specificity and certainty and the wide range of potentially applicable protective as well as punitive laws have posed various challenges for the legal system as a whole, including for affected populations, the health system, the judiciary and law enforcement agents.

This section examines various aspects of existing laws, including health laws, criminal laws, laws affecting property, marriage and inheritance rights and children's laws, amongst others, to determine whether they adequately protect rights and responsibilities, address the key HIV, law and human rights issues identified as issues of concern in Malawi and promote health in the context of HIV and AIDS.

Firstly, it sets out feedback from key informants and focus groups regarding what they consider to be protective, as well as punitive laws in the context of HIV and AIDS. It then goes on to examine these and other laws in more detail, considering both the public health and the human rights evidence in light of the background information regarding HIV, AIDS and human rights in Malawi (Section 4) and the national, regional and international human rights framework (Section 5).

### **Feedback from Key Informants**

Key informants<sup>233</sup> identified what they believed to be various challenges and limitations within the current legal and regulatory framework for managing an effective response to HIV. The feedback from key informants is set out below; the issues raised are analysed in further detail throughout this section of the Report.

#### ***Protective Laws and Policies***

Key informants recognise that there is broad protection in existing law and policy that can and has been applied to the context of HIV and AIDS. For instance, there are a number of strong policies that protect rights in the context of HIV and AIDS, including

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<sup>233</sup> Focus Group Discussions revealed that, at district level, there was limited detailed knowledge and understanding of HIV-related law and policy, although there was useful feedback on the lived experiences of people affected by HIV and AIDS.

the rights of key populations and vulnerable populations. Respondents mentioned various policies such as the *National HIV/AIDS Policy*, the *National HIV and AIDS Workplace Policy and Programme*, the *Sexual and Reproductive Health Policy*, the *Gender Policy*, the *Orphan Policy*, the *Social Protection Policy*, the *Public Sector HIV/AIDS Policy* and the *Policy on National Equalisation of Opportunities of Persons with Disability*.<sup>234</sup>

Likewise, there are a number of laws that key informants recognised as providing broad protection for all people. The Constitution's equality clause provides broad protection from discrimination, which many key informants, particularly those working within the legal profession, recognised would apply equally to people living with HIV or AIDS.<sup>235</sup> Other important constitutional principles include the right to gender equality, children's rights, the rights of people with disabilities, the right to dignity, the right to privacy, the right to be protected from medical experimentation without consent and the obligation upon the state to promote health as reflected in the Constitution as well as the various regional and international human rights instruments signed and ratified by Malawi.<sup>236</sup>

In addition, key informants recognised a range of other statutes that they reported provided protection to people living and affected by HIV such as:

- Laws protecting doctor-patient confidentiality.<sup>237</sup>
- Employment laws such as the Employment Act and Labour Relations Act that protect the rights of all employees from unfair dismissals within the working environment as well as the Occupational Safety, Health and Welfare Act that protects employees' rights to a safe working environment and the Workers Compensation Act.<sup>238</sup>

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<sup>234</sup> See, for instance, Key Informant Interview, UNAIDS, Lilongwe, 5 Dec 2011; ILO, Lilongwe, 5 Dec 2011; UNFPA, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; Legal Aid Offices, Lilongwe, 7 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; WHO, Lilongwe, 13 Jan 2012; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; GIZ, Lilongwe, 25 Jan 2012 amongst others. See also Focus Group Discussion, People with Disabilities, Blantyre.

<sup>235</sup> See, for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; Legal Aid Offices, Lilongwe, 7 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; High Court, Blantyre, 16 Dec 2011; MANASO, Blantyre, 13 Dec 2011; WILSA, Blantyre, 13 Dec 2011; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012 amongst others.

<sup>236</sup> See, for instance, Key Informant Interview, UNAIDS, Lilongwe, 5 Dec 2011; WLSA, Blantyre, 13 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011; WHO, Lilongwe, 13 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; Industrial Relations Court, Blantyre, 16 Dec, 2011 amongst others.

<sup>237</sup> Key Informant Interview, Malawi Law Society, Blantyre, 12 Dec 2011.

<sup>238</sup> See, for instance, Key Informant Interview, ILO, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; High Court, Blantyre, 16 Dec 2011; Ministry of Justice and Constitutional Development, Lilongwe, 12 Jan 2012; Industrial Labour Court, Blantyre, 16 Dec 2011.

- The Child Care, Protection and Justice Act and the Trafficking in Persons Bill which has increased protection for children.<sup>239</sup>
- The Marriage, Divorce and Family Relations Bill, Prevention of Domestic Violence Act and Deceased Estate (Wills and Inheritance) Act which has strengthened women's equality rights, rights to be protected from violence and to inherit property.<sup>240</sup>
- The Penal Code which criminalises sexual offences such as rape, defilement and incest.<sup>241</sup>

### ***Gaps & Limitations in Law and Policy***

Key informants also identified various punitive provisions, gaps and limitations within the current legal framework that may act to block effective responses to HIV and AIDS<sup>242</sup> such as:

- Laws relating to unnatural sexual offences that criminalise sex between men. These laws are argued to create barriers to the provision of appropriate health care services for MSM and intensify stigma and discrimination against MSM.<sup>243</sup>
- Laws criminalising aspects of sex work and nuisance laws (the 'rogue and vagabond' laws) that are used to penalise sex work. These laws are argued to exacerbate stigma, discrimination and human rights violations against sex workers, including by law enforcement officials, and heighten their risk of HIV exposure.<sup>244</sup>
- Some respondents also raised the coercive public health provisions in the Public Health Act (such as those that allow for quarantining and prohibiting from employment people with specified illnesses) that may be inappropriately applied

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<sup>239</sup> See, for instance, Key Informant Interviews, MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012.

<sup>240</sup> See, for instance, Key Informant Interviews, MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; WLSA, Blantyre, 13 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011; WHO, Lilongwe, 13 Jan 2012; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; Industrial Relations Court, Blantyre, 16 Dec 2011.

<sup>241</sup> Key Informant Interview, Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; Industrial Relations Court, Blantyre, 16 Dec 2011.

<sup>242</sup> Note that some key informants did not find laws criminalising sex between men and/or sex work to be punitive provisions and instead argued that they were protective. See Key Informant Interview, Malawi Law Society, Blantyre, 12 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Magistrate's Court, Blantyre, 16 Dec 2011.

<sup>243</sup> Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; CEDEP, Lilongwe 13 Jan 2012; GIZ, Lilongwe, 25 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012

<sup>244</sup> Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011; CEDEP, Lilongwe, 13 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; SWAPS, Lilongwe, 24 Jan 2012; High Court, Blantyre, 16 Dec 2011.

to HIV and AIDS<sup>245</sup> as well as the provisions criminalising the spread of infectious diseases in the Penal Code.<sup>246</sup>

- Police and defence force policies provide for pre-employment HIV testing and exclusion of those testing HIV-positive.<sup>247</sup>

In addition, respondents reported that many laws are outdated on various levels or are inadequate to deal with HIV since they were developed pre-AIDS; others are in conflict with one another. They said that:

- The Public Health Act, for instance, pre-dates and includes no reference to HIV,<sup>248</sup> the Pharmacy, Medicines and Poisons Act does not adequately deal with false claims of cures for HIV and regulation of herbal medications<sup>249</sup> and the flexibilities within the TRIPs Agreement are not being used to increase access to treatment.<sup>250</sup>
- The Prevention of Domestic Violence Act fails to provide adequate protection against marital rape<sup>251</sup> and early marriage.<sup>252</sup>
- The dual legal system of customary and statutory law creates difficulties for women's rights and conflicts that particularly affect women in the context of HIV.<sup>253</sup>

Finally, key informants recognised that despite the fact that Malawi has signed and ratified a number of international and regional human rights instruments such as the African Charter on Human and Peoples' Rights and the African Charter on the Rights and Welfare of the Child, many of the principles within these instruments have not been domesticated or implemented at national level.<sup>254</sup> In particular, some key informants commented on the fact that there is no clear right to health in the

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<sup>245</sup> See, for instance, Key Informant Interviews, UNICEF, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011. Note that a relatively small number of key informants did not find these to be punitive provisions and instead argued that they were protective. See Key Informant Interview, Malawi Law Society, Blantyre, 12 Dec 2011.

<sup>246</sup> Key Informant Interview, CEDEP, Lilongwe, 13 Jan 2012.

<sup>247</sup> Key Informant Interviews, Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Irish Aid, Lilongwe, 24 Jan 2012.

<sup>248</sup> See, for instance, Key Informant Interviews, UNICEF, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; Malawi Police Service, Lilongwe, 7 Dec 2011;

<sup>249</sup> Key Informant Interview, Pharmacy, Medicines and Poisons Board, Lilongwe, 13 Jan 2012.

<sup>250</sup> Key Informant Interviews, Ministry of Justice and Constitutional Affairs, 12 Jan 2012; Registrar Generals Department, Blantyre, 20 Jan 2012.

<sup>251</sup> Key Informant Interviews, COWLHA, Lilongwe, 6 Dec 2011; MANASO, Blantyre, 13 Dec 2011; WLSA, Blantyre, 13 Dec 2011.

<sup>252</sup> Key Informant Interview, NOVOC, Lilongwe, 23 Jan 2012.

<sup>253</sup> See, for instance, Key Informant Interviews, UNFPA, Lilongwe, 5 Dec 2011; WHO, Lilongwe, 13 Jan 2012

<sup>254</sup> Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWLHA, Lilongwe, 6 Dec 2011.

Constitution,<sup>255</sup> and that rights are not exhaustively stated in the Constitution and require interpretation.<sup>256</sup>

Although there are good policies, the equality and non-discrimination clause and very few laws are HIV-specific.<sup>257</sup> Additionally, there is no broad anti-discrimination law.<sup>258</sup> A large number of respondents felt that an HIV specific law would be useful to provide detailed clarity and guidance on all aspects of HIV, strengthen protection against HIV-related discrimination, fill gaps in the current framework, improve enforcement and guide judicial interpretation.

*“...It will sort of consolidate the law on HIV/AIDS. In the interim, the policies do seem to be working administratively. Be that as it may, there are some substantive issues that need to be enforced e.g. confidentiality and that can only be done through a law”.*<sup>259</sup>

In addition, respondents stated that protections in law are not always implemented or enforced, due to various constraints.<sup>260</sup> Various issues relating to the law enforcement and access to justice are dealt with in further detail, below.

## 6.1 Do laws and policies protect people in the context of HIV& AIDS?

### ***Anti-Discrimination Laws***

There are no broad HIV-specific laws expressly prohibiting discrimination on the basis of HIV and AIDS. As set out in section 6, above, the Constitution does provide protection for the right to equality and non-discrimination on a number of grounds, including “*other status*” and “*condition*”.<sup>261</sup> Although it is generally agreed by legal

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<sup>255</sup> See, for instance, Key Informant Interviews, Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011.

<sup>256</sup> Key Informant Interview, WLSA, Blantyre, 13 Dec 2011.

<sup>257</sup> See, for instance, Key Informant Interviews, ILO, Lilongwe, 5 Dec 2011; Legal Aid Offices, Lilongwe, 7 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; High Court, Blantyre, 16 Dec 2011; Member of Magistrate’s Court, Blantyre, 16 Dec 2011; MANASO, Blantyre, 13 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; Administrator Generals Department, Blantyre, 16 Dec 2011; John Hopkins, Blantyre, 20 Jan 2012

<sup>258</sup> Key Informant Interview, Medical Council of Malawi, Lilongwe, 12 Jan 2012.

<sup>259</sup> Respondent, Key Informant Interview, Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012.

<sup>260</sup> See for instance, Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; ILO, 5 Dec 2011; UNICEF, Lilongwe, 5 Dec 2011; COWLHA, Lilongwe, 6 Dec 2011; Ministry of Labour, Lilongwe, 7 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; High Court, Blantyre, 16 Dec 2011; MANASO, Blantyre, 13 Dec 2011; Malawi Law Society, Blantyre, 12 Dec 2011; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012 amongst others.

<sup>261</sup> Section 20(1) of Constitution (as amended, 2010) says that “Discrimination of persons in any form is prohibited and all persons are, under any law, guaranteed equal and effective protection against discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, disability, property, birth or other status or condition.”

authors as well as international guidance, that “*other status*” includes HIV and AIDS,<sup>262</sup> express protection against HIV-related discrimination is lacking.

*The Constitution protects the equality rights of all people, which arguably includes people living with HIV and key populations at higher risk of HIV exposure and vulnerable populations. However, the protection is broad and HIV or AIDS is not specifically listed as a ground for non-discrimination, as with other grounds such as race, sex or disability. Given the high levels of stigma and discrimination found by the LEA, combined with countless reports of limited awareness of rights as well as limited access to justice, it may be argued that specific anti-discrimination protection for HIV and AIDS is required. A number of key informants from the legal profession argued likewise,<sup>263</sup> as did the Law Commission in its review of the need for HIV and AIDS legislation. This is also in keeping with international guidance on HIV and human rights<sup>264</sup> and is a recent trend in the laws of a number of countries in Southern Africa.<sup>265</sup> It is furthermore recommended by the SADC PF Model Law on HIV & AIDS for Southern Africa. HIV legislation could seek to expressly prohibit the various forms of HIV-related discrimination described by literature, key informants and focus groups in this Assessment, as proposed by the Malawi Law Commission’s Report.*

### **Workplace Laws**

Labour rights and employment issues are protected by the Constitution and other complementary legislation listed below:

- The Employment Act<sup>266</sup>
- The Labour Relations Act<sup>267</sup>
- The Occupational Safety, Health and Welfare Act<sup>268</sup>
- The Workers’ Compensation Act<sup>269</sup>, and

<sup>262</sup> The Commission on Human Rights and the Committee on Economic, Social and Cultural Rights have recognized that “*other status*” includes health status, such as HIV and AIDS, in its General Comment No. 14 (2000). This was recognized by the Malawi Law Commission in its *Report of the Law Commission on the Development of HIV and AIDS Legislation*, 2008 at pg 38. The Malawian court, in the *Neffie Mangani* case, did not deal expressly with the right to non-discrimination on the basis of HIV or AIDS but did hold that people with HIV are entitled to the same treatment as other patients, therefore pronouncing legal protection within legal jurisprudence for HIV patients.

<sup>263</sup> See, for instance, Key Informant Interviews, Judiciary, Blantyre, 16 Dec 2011, Ministry of Justice and Constitutional Affairs, 12 Jan 2012, Malawi Law Commission, Lilongwe, 6 Dec 2011 and 12 Feb 2012; Industrial Relations Court, Blantyre, 16 Dec 2012.

<sup>264</sup> Guideline 4, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006.

<sup>265</sup> See, for instance, the Angola Law 8/04 on HIV and AIDS, 2004; Madagascar Law 2005-040 on the Fight Against HIV/AIDS and the Protection of Rights of People Living with HIV, 2006 and the Mauritius HIV and AIDS Act 31 of 2006, amongst others.

<sup>266</sup> Cap 55:01

<sup>267</sup> Cap. 54:01

<sup>268</sup> Cap.55:07

<sup>269</sup> Cap.55:03

- The Public Service Act and the Malawi Public Service Regulations.

There are also HIV-specific policies relating to HIV and AIDS in the working environment, such as the *Code of Conduct on HIV/AIDS and the Workplace* and the Ministry of Labour's *Malawi Policy on HIV/AIDS in the Workplace*.<sup>270</sup> These contain protective provisions against, for example, unfair discrimination in the working environment and a prohibition on pre-employment HIV testing.

### *Employment Act*

The Employment Act, like the Labour Relations Act, sets out core principles that must be observed in employment contracts within the private sector and the Government, including any public authority or enterprise. It does not apply to members of the armed forces, the prison services or the police, except those employed in a civilian capacity.<sup>271</sup> The principles within the Act relate to fundamental rights that cannot be taken away from any employee such as the right to non-discrimination, equal pay and protection from unfair dismissals. If these fundamental rights are violated, the employee can take the matter to court for an order to protect employee rights such as the reinstatement of an employee who was unfairly dismissed, an order giving the employee a benefit or advantage that the employee has been withholding, or an order for the payment of compensation.

Section 5 of the Employment Act prohibits discrimination so that an employer may not treat workers who perform work of equal value differently, based on differences in race, colour, sex, language, political or other opinion, nationality, ethnicity, social origin, disability, property, birth, marital or other status, or family responsibility. An employer may not discriminate on any of the above-mentioned grounds in deciding whether to employ a person, train an employee, promote an employee, give employee benefits or terminate an employee's contract.

*As with the Constitution, the Employment Act does not expressly prohibit discrimination in employment on the grounds of HIV or AIDS. Legal commentators have argued that it is unclear whether HIV or AIDS is a recognized ground for non-discrimination in the Employment Act.<sup>272</sup> However, it's important to note that in the Industrial Court case of *Banda vs Lekha*,<sup>273</sup> discrimination on the basis of HIV was*

<sup>270</sup> Although it appears from a key informant interview with the Ministry of Labour that the Policy is yet to be launched; Key Informant Interview, Ministry of Labour, Lilongwe, 7 Dec 2011.

<sup>271</sup> Section 2(1) and (2), Employment Act.

<sup>272</sup> The Malawi Law Commission's *Report of the Law Commission on the Development of HIV and AIDS Legislation*, 2008 argues that "marital or other status" in the Employment Act refers specifically to other forms of status relating to partnerships – that is, it links 'other status' to other forms of 'marital status' (such as domestic and sexual partnerships and family) rather than health status. For this reason, they recommended the enactment of specific provisions prohibiting discrimination in the working environment.

<sup>273</sup> IRC 277 of 2004. The complainant was employed by Lekha in June 2003. She was dismissed for reasons relating to her health status. She went for HIV voluntary counselling and testing and tested HIV-positive. When

*prohibited using the basis of the constitutional right to equality, indicating that judicial activism and strategic litigation may help to consolidate specific protection to employees living with HIV against workplace discrimination over time. The courts may also take cognisance of protection provided in policy, such as the Code of Conduct on HIV/AIDS and the Workplace and the Malawi Policy on HIV/AIDS in the Workplace, as has happened in other jurisdictions.<sup>274</sup>*

*However, the Legal Environment Assessment indicates that workplace discrimination against employees with HIV is one of the more common forms of HIV-related discrimination. It also takes various forms including mandatory pre-employment HIV testing, denial of employment, dismissals, denial of benefits<sup>275</sup> and promotion. Discrimination based simply on a person's HIV status fails to take into consideration an employee's ability to perform the inherent requirements of a job. It also denies people living with HIV a livelihood, which exacerbates the socio-economic impact of HIV and AIDS on their lives.<sup>276</sup>*

*Pre-employment HIV testing continues in practice, and in policy in the case of the armed forces. It is questionable whether a court of law would find HIV testing for purposes of exclusion reasonable and justifiable on various grounds.<sup>277</sup> This is discussed in further detail, with specific reference to the Law Commission proposal's to allow continued pre-recruitment HIV testing of the armed forces and to provide for pre-recruitment HIV testing of domestic workers, in Section 7, below.*

*However, until the courts are called upon to adjudicate further, employees may not be specifically protected in law from acts of HIV-related discrimination despite*

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she reported for duties after the test, the respondents immediately and without any formality dismissed the applicant. It was held by the IRC that her dismissal was unfair and amounted to discrimination because it was based on the prohibited ground of HIV status. Although HIV status is not clearly included in section 20 of the Constitution (and also section 5 of the Employment Act), the court reasoned that the same was covered under the general statement of anti-discrimination in 'any form'.

<sup>274</sup> See, for instance, *Diau v Botswana Building Society (BBS)* 2003 (2) LR 409 (BwIC) where the court used the protection against HIV-related workplace discrimination in the National HIV/AIDS Policy to protect the applicant. It held as follows: "It is not law. It therefore does not impose any direct legal obligations. However, to the extent that its provisions are consistent with the values espoused by the constitution, breach of its provisions may, in an appropriate case, constitute evidence of breach of constitutional provisions."

<sup>275</sup> In particular, there is no legislation governing medical schemes to prohibit HIV-related discrimination in the provision of medical benefits. See Centre for Human Rights: AIDS and Human Rights Research Unit, *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*, University of Pretoria, Pretoria, 2007.

<sup>276</sup> See the South African case of *Hoffmann v South African Airways* 2001 (1) SA 1 (SACC 2000) at para 28 where the court held "the impact of discrimination on HIV-positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living."

<sup>277</sup> See for instance, the Namibian case of *Nanditume v Minister of Defence* (2002) AHRLR 119 (NaLC 2000). See also Stoltz L, Jurgens R and Patterson D, 'Mandatory HIV testing in the military: legal and human rights issues.' *XIV International AIDS Conference*, Barcelona, 7-12 July 2002, a research paper presented at the 2002 AIDS Conference analysing the decisions of courts and military tribunals worldwide, which argues that a policy of mandatory HIV testing of military recruits cannot be justified under established human rights principles. A Malawian court of law would take international guidance as well as foreign case law into account when adjudicating on this issue.

*constitutional protection to equality and to fair, non-discriminatory and safe labour practices. Additionally, as set out in this section of the report, below, the LEA also found that people struggle to access justice through the court systems, including the Industrial Court.*

*The need for HIV-specific laws prohibiting various acts of employment discrimination has been recognised in regional and international guidance on HIV and AIDS<sup>278</sup>, as well as in a number of HIV laws in Southern Africa<sup>279</sup> and the SADC PF Model Law on HIV & AIDS in Southern Africa, 2008.<sup>280</sup> Prior to the Law Commission report, Malawi's National HIV/AIDS Policy 2003 – 2008 made specific recommendations for amendments to the Constitution and the Employment Act to include HIV as a protected ground for non-discrimination and to prevent unfair dismissals on the basis of HIV status. The Law Commission in its Report relating to the development of HIV legislation has further recommended specific protection from HIV-related discrimination in the workplace. This will strengthen protection in law for workplace rights in relation to HIV and help to address the issue of pre-employment HIV testing including within the armed forces.*

#### *Occupational Safety and Health Laws*

Neither the Occupational Safety, Health and Welfare Act nor the Workers Compensation Act specifically mention HIV and AIDS. In particular, HIV is not included in the list of scheduled diseases for which compensation for occupational infection is available, in terms of the Workers' Compensation Act.

*The constitutional right to safe working conditions is not expressly protected, in the context of HIV and AIDS, in occupational safety and health laws. It is desirable that specific protection for all matters relating to HIV in the workplace, including occupational safety and health, be set out in relevant laws. This will help to create binding legal obligations to protect employees from occupational infection with HIV, in keeping with international and regional guidance on HIV in the workplace such as the ILO Recommendations concerning HIV and AIDS and the World of Work 200 of 2010 and the SADC Code of Good Practice on HIV/AIDS in Employment, 1997. The Law Commission recommended similarly in their Report.<sup>281</sup>*

<sup>278</sup> See, for instance, the UNAIDS and OHCHR *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006; the ILO *Recommendations on HIV/AIDS and the World of Work* No 200 of 2010 as well as the SADC *Code of Good Practice on HIV/AIDS and Employment*, 1997.

<sup>279</sup> See, for instance, the Angola Law 8/04 on HIV and AIDS, 2004 and the Madagascar Law 2005-040 on the Fight Against HIV/AIDS and the Protection of Rights of People Living with HIV, 2005.

<sup>280</sup> Southern African Development Community Parliamentary Forum, 24th Plenary Assembly, 2008.

<sup>281</sup> See Malawi Law Commission, *Report of the Law Commission on the Development of HIV and AIDS Legislation*, Malawi, 2008, p67.

*Public Service Laws*

The Public Service Act and the Malawi Public Service Regulations enacted in terms of the Act govern the conditions of employment within the public service. The Regulations are constantly reviewed by circulars issued by the Department for Public Service Management under the Office for President and Cabinet. The LEA found no circulars that directly provide legal employment protection for HIV related cases. The Malawi Public Service Code of Conduct and Ethics contains limited reference to HIV. It sets out a code of behaviour required of public servants, including the prohibition of discrimination against any person on a number of grounds including HIV and AIDS.

*Current employment laws and regulations governing the public service do not adequately provide for HIV-related workplace issues. Since people within the public service (particularly specific occupations such as health workers and educators) were identified by the LEA as a vulnerable population, it is imperative that they are accorded protection within their Regulations and/or within an HIV law.*

**Laws protecting the rights of women and girl children**

The Legal Environment Assessment identified a range of social, economic and cultural issues, including gender inequality, harmful gender norms and gender-based violence as a key issue increasing the risk of HIV exposure amongst women and girls.<sup>282</sup> Thus, women and girls require special legal and social protection to help reduce vulnerability and manage the impact of HIV and AIDS.

Various policies at national and international level have strengthened the social position of women, as set out in Section 5, above. For instance, the *National Gender Policy*, 2011 aims to, amongst other things, reduce poverty among women and vulnerable populations through economic empowerment, mainstreaming gender in all HIV and AIDS responses, eliminating gender-based violence<sup>283</sup> and reducing child abuse and trafficking.<sup>284</sup> In addition, plans such as the *National Plan of Action on Women, Girls and HIV/AIDS 2005-2010* add to policy protection. The National Plan of Action specifically aims to reduce HIV infection amongst women and girls and provides for a range of objectives including the eradication of gender-based violence, the modification of harmful cultural practices and unequal gender relations to place women and girls at higher risk of HIV exposure, increased access for young people to gender-sensitive HIV information and skills and improving women's economic and property rights. However, legal mechanisms are necessary to concretise women's legitimate expectations into law, obliging the state machinery to provide adequate legal protection. Laws relevant to gender rights that are potentially applicable to HIV include the following listed below:

<sup>282</sup> See section 4 of the LEA, above.

<sup>283</sup> Sections 3.6 to 3.8

<sup>284</sup> Section 2.5

*Constitutional Protection of Equality and Non-Discrimination*

All people have the constitutional right to equality. In addition, women have been provided with detailed equality rights and a commitment to eliminate customs and practices that discriminate against them in terms of section 24(1) and (2) of the Constitution. Although the Constitution also protects each person's right to participate in the culture of his or her choice,<sup>285</sup> this is not an absolute right which can be enjoyed without limitation.<sup>286</sup> Cultural practices that harm women's rights should be reviewed for their validity in accordance with section 24.

*Constitutional protection for women's rights to gender equality, and to protection from harmful gender norms and gender-based violence is strong. The Constitution also requires the interpretation and application of all law, including customary law, to have due regard to constitutional provisions. The juxtaposition of customary and civil law in Malawi has played a crucial role in the limitation of the enjoyment of crucial human rights, particularly for women in society.*

*For instance, customary laws relating to land ownership and inheritance discriminate against women. Dispossession of widows by a deceased spouse's relations (otherwise known as 'property grabbing') may occur where property of the deceased is shared amongst a wide range of 'customary heirs', and is tacitly condoned in many communities. However, the Wills and Inheritance (Amendment) Act No 22 of 1998 criminalised property grabbing. The more recent Deceased Estates (Wills, Inheritance and Protection) Act (passed into law in 2011) has further criminalised and increased the penalty for property grabbing. The new law has in essence removed discrimination in the distribution of intestate property.*

*The criminalisation of the cultural practice of property grabbing by an Act of Parliament indicates the state's commitment to limiting cultural rights, where reasonable and necessary in an open and democratic society, to protect equality rights. The Malawi Law Commission's Land Report,<sup>287</sup> currently before Cabinet furthermore recommends enacting provisions to recognise women as a vulnerable population in terms of land ownership and to protect women's rights and provide mechanisms for their participation in committees and tribunals to determine land issues especially at grassroots level. The recommendations ensure that women are not discriminated against, and enjoy equal rights as men regards land ownership .*

*It is crucial that this same approach is used to examine various provisions of customary law and practice, including harmful cultural norms that place women and*

<sup>285</sup>Section 26, Republic of Malawi (Constitution) Act.

<sup>286</sup>As it is not listed under s44(1) of the Republic of Malawi (Constitution) Act.

<sup>287</sup> Malawi Law Commission, *Land Report*, Malawi, 2010. The Commission reviewed all land-related laws in Malawi and made recommendations to Government.

*girl children at higher risk of HIV exposure or that increase the vulnerability of women and children orphaned by AIDS, against the constitutional protection of equality. It is furthermore imperative that wide information and education programmes take place to increase awareness of changes to customary laws and practices.*

*Penal Code: Protection from sexual assault*

Section 132 of the Penal Code criminalises rape (non-consensual sex) as a felony. It provides that “any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force or means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or in the case of a married woman, by personating her husband, shall be guilty of the felony termed rape”.

In addition, indecent assault and defilement is committed by “any person who unlawfully and indecently assaults any woman or girl; it shall not be a defence to a charge for an indecent assault on a girl under the age of thirteen years to prove that she consented to the act of indecency”. It should be noted that the Penal Code under section 137 (2) has raised the age for consensual sex from 13 to 16 years. This means any child below 16 years is incapable of giving consent to sex.

*The Penal Code provides protection to women and girl children from rape, indecent assault and defilement by raising the age for consensual sex and providing harsh penalties for sexual offences described above. The death sentence is the highest penalty for rape, whilst defilement is a felony punishable by life imprisonment. This may arguably reduce women’s exposure to HIV through sexual offences. In the case of *R v Cidrick*<sup>288</sup> the court held that if there was proof that an accused has transmitted HIV to the complainant in a rape case, or was HIV-positive at the time of the rape, his sentence may be increased; in the particular case the court refused to increase the sentence in the absence of proof of the accused’s HIV status.*

*However, there are various limitations in the protection provided by these provisions in the Penal Code:*

- *The rape provision is gender-specific (that is, it does not protect men or transgender people from rape)*<sup>289</sup>
- *The rape provision does not specifically criminalise rape within marriage, and courts generally view rape as taking place outside of marriage.*<sup>290</sup> *Non-consensual sex within marriage is dealt with in the Prevention of Domestic*

<sup>288</sup> 1995 MLR 695 (High Court of Malawi 1994)

<sup>289</sup> See below for a full discussion on the need for legal protection for sexual minorities such as MSM.

<sup>290</sup> Raphael Tenthani ‘Row over Malawi Marital Rape Bill’. *BBC News Africa*, 26 December 2001. Available at <http://news.bbc.co.uk/2/hi/africa/1728875.stm> [Accessed 15 July 2012].

*Violence Act (see further, below).*

- *Despite the raising of the age of consensual sex to 16 years, section 22(7) of the Constitution, as supreme law, still allows for a person of 15 years to marry with the consent of a parent or guardian (and for the state to ‘discourage’ marriage below the age of 15 years).*

*The LEA found that women are an extremely vulnerable population in the context of HIV and AIDS. The desk review and information provided by key informants and focus groups showed that not only do women experience high levels of HIV-related discrimination; they are also placed at direct risk of HIV exposure through harmful cultural practices and gender-based violence. In addition, they express an inability to access justice, e.g. in the case of rape.<sup>291</sup> It is imperative that women are afforded strong protection in law against sexual violence, in accordance with the commitments set out in international guidance such as the UN Political Declaration on HIV/AIDS, 2011 and the UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights, 2006. This may require a review of laws and policies relating to sexual offences, including sexual offences that occur within marriage and other partnerships, as well as strengthening access to justice for rape survivors. HIV laws may need to specifically identify women as a vulnerable population, in order that specific measures can be taken to reduce their vulnerability to sexual offences, amongst other things, and to strengthen access to post-exposure prophylaxis, access to justice and law enforcement in the case of a sexual offence. HIV testing of an accused in a sexual offence should not be used as a means of identifying the need for post-exposure prophylaxis. The potential time delays involved, the possibility of an accused testing HIV-negative while in the window period and the fact that the accused has not been convicted of an offence suggest it is both an ineffective and potentially unjustifiable means of protecting women from HIV transmission. A less restrictive and more effective measures would be to ensure that women are immediately referred for appropriate health care services. This and the question of criminalisation of HIV transmission is dealt with in further detail in Section 7, below.*

*The Prevention of Domestic Violence Act (PDVA), 2005<sup>292</sup>*

The PDVA came into force on 29th December 2006 and is therefore recognized as law in all courts in Malawi. It aims to protect women and children from violence within their home lives and to provide effective remedies and access to social services for domestic violence.

Domestic violence is defined under this law as “*any criminal offence arising out of physical, sexual, emotional or psychological, social, economic or financial abuse that*

<sup>291</sup> See Section 4 of the LEA, above, as well as the discussion on Access to Justice in this section, below.

<sup>292</sup> Cap 7:05

*occurs within a domestic relationship*". Frequently the family home incorporates extended family members so it is noteworthy that the Act includes and also goes beyond spousal relationships. Most victims of domestic violence are women, the elderly and children who are abused by other members of the family in the home.

The PDVA also includes, for the first time in Malawian legislation, a definition of sexual abuse which is defined as *"any sexual conduct that abuses, humiliates, degrades or otherwise violates the dignity of a person."* Sexual abuse within the PDVA includes:

- Sexual contact of any kind against the will or without the consent of a person
- Rape
- Defilement (having sex with a girl who is not above the age of 16 years)
- Refusal by a partner to cooperate in using contraception when the woman reasonably requires it
- Forcing a partner who fears they might be at risk of contracting HIV to have unprotected sex
- Incest
- Some cultural practices such as sexual cleansing rituals which require a woman to sleep with other men without her consent.<sup>293</sup>

Legal remedies are also outlined in the legislation, which directly restrains a partner from engaging in behaviour falling within the definition of sexual abuse. The Act outlines processes to be followed when a person who has been abused requires medical attention, including attending at a hospital or health centre for an inspection for sexual offences, an HIV test as well as other tests for sexually transmitted infections (STIs), and the administration of post-exposure prophylaxis (PEP) free of charge at government health centres or hospitals.

*As with the Penal Code, the PDVA contains various protections from violence, including sexual violence (as described above). It also contains legal remedies for women to restrain a partner from engaging in behaviour defined as sexual abuse. This is important since research suggests that women who experience partner violence, in all its forms, are at higher risk of HIV exposure.<sup>294</sup> It is significant that legal provision is also made for supporting women who have been sexually abused with free public health care services to reduce the risk of HIV transmission.*

*The PDVA does not, however, specifically criminalise rape within marriage, since in terms of the Act, non-consensual sex within marriage falls within the broader definition of 'sexual abuse' and thus carries a lesser penalty to that of rape. The*

<sup>293</sup> A broad range of cultural practices may be prohibited by the provision, but not all harmful cultural practices are specifically mentioned.

<sup>294</sup> See, for instance, Dunkle KL, Jewkes R, Brown H, Grey G, McIntyre J and Harlow S, 'Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.' *The Lancet*, Vol 363(9419), 2010 at p1415.

*reluctance of the legislature to explicitly criminalise rape within marriage is understood to be on the basis that the maximum penalty for rape (i.e. death) may not be appropriate within a family setting.<sup>295</sup> The SADC PF Model Law on HIV & AIDS in Southern Africa, 2008 recommends the enactment of provisions that specifically prohibit marriage, or other relationships, from constituting a defence to a charge of rape.<sup>296</sup>*

*In the context of HIV and AIDS, it is important that laws not only protect women from domestic violence and sexual abuse, but also from all harmful gender norms and harmful cultural practices that perpetuate inequality against women and increase their vulnerability to HIV.<sup>297</sup> While there has been on-going engagement with traditional leaders, religious leaders and communities on harmful cultural practices and their impact on human rights and HIV, their impact is difficult to measure as some may continue in secret.<sup>298</sup> The PDVA has provided important protection for women in this respect by specifically prohibiting harmful practices. National constitutional commitments furthermore protect women's right to equality and international and regional guidance recommend that women be protected from harmful practices.<sup>299</sup> However it may be important to specifically list practices that are considered harmful in the context of HIV and that, amongst other things, increase women's socio-economic vulnerability or place women (and others) at higher risk of HIV exposure within the PDVA and/or within an HIV law. The Malawi Law Commission's Report of the Law Commission on the Development of HIV and AIDS Legislation recommended prohibiting a range of harmful cultural practices which are mentioned by name, in keeping with commitments set out in section 24 of the Constitution, government's gender policies and plans as well as international and regional human rights norms.<sup>300</sup>*

*In addition, while the Penal Code has increased the age of consensual sex, the PDVA has not prohibited early marriage which may still be entered into at age 15,*

<sup>295</sup> Key Informant Interview, Administrator General's Department, Blantyre, 16 Dec 2011.

<sup>296</sup> See section 27(2).

<sup>297</sup> Research in 2002 identified various harmful cultural practices in the context of HIV and AIDS including *chokolo* (wife inheritance), polygyny, *mbirigha* (a practice of rewarding a man's good behaviour by offering him another wife from the same family), arranged marriages, *mbulu* (a practice forbidding sex between a man and wife for 6 months after childbirth) and early marriages; Women's Voice, *An Assessment of Women's Vulnerability to HIV/AIDS in Nkhata Bay, Malawi*, 2002. Malawi's 2004 Report to the Committee on the Elimination of Discrimination Against Women furthermore recognised the impact of cultural practices on women's vulnerability to HIV; Government of Malawi, *Combined second, third, fourth and fifth periodic report of state parties to the CEDAW Committee*, CEDAW/C/MWI/2-5, 2004. The Malawi Law Commission's Report suggested outlawing a wide range of cultural practices in relation to HIV and AIDS.

<sup>298</sup> Kanyongolo NR and Chirwa D, *SADC Gender Protocol Barometer Baseline Study: Malawi*, 2009.

<sup>299</sup> See, for instance, the UNGASS, *Political Declaration on HIV and AIDS*, 2011 as set out above. See also section 27(1) of the SADC PF Model Law on HIV and AIDS in Southern Africa, 2008 which specifically states that "the state shall ensure that women and girls are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health".

<sup>300</sup> Such as Article 3 of CEDAW and Article 5 of the Protocol.

*with parental consent, as discussed above. Likewise, the Law Commission recognised early marriage as a key concern and noted the important work of the Commission on the Review of Laws on Marriage and Divorce, which recommended raising the age of marriage to 18 years. It is important that the findings of this LEA highlight the negative impact of early marriage on risk of HIV exposure, and support the inclusion of a prohibition on early marriage within the Marriage Bill.*

*Finally, it is important that protections in law are able to be enforced. The LEA noted the concerns of those who made written submissions to the Law Commission regarding the criminalisation of harmful cultural practices. This is discussed in further detail, in Section 7, below. The concerns suggest that open and on-going dialogue with traditional leaders and communities is crucial in the event of legislating against harmful cultural practices. It may be equally important to address the regulation or adaptation of cultural practices through customary laws, alongside any prohibition of harmful practices.*

#### *The Deceased Estates (Wills, Inheritance and Protection) Act, 2011*

The Deceased Estates (Wills, Inheritance and Protection) Bill of 2004 was passed into law in 2011. The new law has in essence:

- Reduced the number of beneficiaries to those in the nuclear family
- Removed discrimination in the distribution of intestate property i.e. with regard to the type of customary marriage, and with regard to a male spouse who is now entitled to inherit a wife's property.
- Removed the loss of inheritance for widows who remarry
- Incorporated the criminalisation of property grabbing and increased the fine for property grabbing to 1 million kwacha
- Increased the threshold of cases which can be settled by the District Commissioner to 1 million kwacha, decentralising the handling of deceased estates and access to remedies for people in the districts.

*Inheritance rights help to strengthen women's economic positions and reduce their vulnerability to HIV. Recent reforms to inheritance law in the Deceased Estates Act have strengthened the rights of women to inherit property and prohibited property-grabbing; in addition focus group discussions revealed a growing knowledge and understanding of the prohibition against property-grabbing.*

*However, the LEA revealed that 'property-grabbing' continues to occur, and the heightened effect of HIV-related stigma and discrimination results in increased vulnerability to 'property-grabbing' of widows whose husbands have died of AIDS.<sup>301</sup>*

<sup>301</sup> See, for instance, McPherson D, *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*, 2005.

*Also where inheritance rights are ignored or denied in communities, the law provides limited relief for women. The Administrator General is able to protect the rights of widows and children, where complaints are brought to its offices. Women report having limited access to justice and are fearful of community responses to laying charges for violations of their rights in cases of 'property-grabbing' or sexual assault.<sup>302</sup> An HIV law should specifically recognise the effect of 'property-grabbing' on families affected by AIDS, and reinforce the protection of the property and inheritance rights of women and the prohibition against 'property-grabbing'.*

### **Marriage & Divorce law**

There are three types of marriages in Malawi:

- Marriages contracted under the Marriage Act (said to be 'English' as they are essentially governed by principles of English law)
- Customary Law Marriages, which vary from one region to another. They are contracted between families, the formalities vary across cultures and they are not registered. In most cases customary marriages are registered with respective religious institutions including churches and according to Islamic rites; for this reason church or *ndowa* marriages may also be considered customary marriages as the customary nature of these marriages is still maintained.
- Marriages by permanent cohabitation or by repute, recognised under section 22(5) of the Constitution. There are no express statutory or constitutional procedural guidelines on how they can be contracted; they are in fact not contracted (and thus not registered) and often arise, with respect to constitutional law, on death or dissolution.

#### *Marriages under the Marriage Act:*

Under the Marriage Act a marriage can only be registered after compliance with the formalities of the Act. A notice has to be issued before the Registrar of Marriages expressing the intention of the parties to get married. The marriage is registered in the marriage register. A divorce is regulated by the Divorce Act. Section 5 of the Divorce Act provides for 5 grounds of divorce, namely adultery, desertion, cruelty, incurable unsoundness of mind of a continuous nature for at least five years, and being found guilty of rape, sodomy and bestiality on the part of the husband. Polygamy is an offence under the Marriage Act.

#### *Customary Law Marriages*

Customary law is recognised as a source of law in Malawian legal jurisprudence alongside the common law, statute law and constitutional law,<sup>303</sup> although it is

<sup>302</sup> See Section 4 of the LEA, above and the discussion on Access to Justice in this section, below.

<sup>303</sup> See section 200 of the Constitution as well as section 26 which provides for the right to culture.

required to be consistent with the Constitution.<sup>304</sup> In order to be recognised as customary law, a practice that has been followed in a particular locality must be reasonable in nature and it must have been followed continuously, and as of right, since the beginning of legal memory (or time immemorial).<sup>305</sup> It is established, accepted and binding on a given society or tribe in its social relations; it may be uniform to a number of societies or it may vary from one area to area.

Section 22(5) of the Constitution recognises marriages by custom. Customary law marriages are a union of two families rather than between two individuals. Two systems of customary marriages are prevalent in Malawi: matrilineal and patrilineal.<sup>306</sup> In patrilineal system, dowry or bride price or *lobola* is paid to the parents or family of the bride. These marriages are potentially polygamous,<sup>307</sup> allowing a husband to marry more than one wife with the consent of the first wife (but not a wife to marry more than one man). A first wife may obtain a divorce where consent is lacking, on the grounds of cruelty.

Customary law marriages may allow for various harmful cultural practices that arguably discriminate against women. For instance, in cases of suspected impotence or barrenness a *fisi* (man) may be hired to have sexual intercourse with the woman; at times this may occur without the women's consent and is pre-arranged by the families. Customary law marriages at times also encourage practices such as widow inheritance and property grabbing which are harmful to women.

#### *Marriage by repute and permanent cohabitation*

The Constitution recognises marriages by repute and permanent cohabitation.<sup>308</sup> This provides legal recognition to the rights of couples living together (co-habiting) or in a relationship perceived to be a legally valid marriage (repute). In such unions, the court can sometimes allow a woman to inherit as if she was legally a wife in the event of death or separation/divorce, where certain conditions are fulfilled.

*The Divorce Act only provides for 5 specific grounds of divorce; where one of these recognised grounds is not met, a court will not grant the dissolution of the marriage. There is no provision for termination of a marriage on the grounds of "irretrievable breakdown of marriage," so it is not always easy to formally terminate a marriage where the particular grounds cannot be proven. However, customary law marriages include no restriction as to grounds for divorce, allowing a marriage to be terminated*

<sup>304</sup> Section 10(2) of the Malawi Constitution says that "In the application and formulation of an Act of Parliament and in the application and development of the common law or customary law, the relevant organs of the State shall have due regard to the principles and provisions of this Constitution.

<sup>305</sup> Dictionary of Law, 4<sup>th</sup> edition, p122.

<sup>306</sup> Chigawa M, *Customary law and Social Development: De jure marriages vis-a-vis de facto marriages at Customary Law in Malawi*, Chancellor College, Zomba (Unpublished), 1984.

<sup>307</sup> Mwambene L, 'Marriage under African Customary Law in the face of the Bill of Rights and International Human Rights Standards in Malawi.' *African Human Rights Law Journal* 10 (1) (2010) 78, p101.

<sup>308</sup> Section 22(5).

*due to an irretrievable breakdown of marriage. However, in terms of inheritance, customary law marriages are not necessarily beneficial to the widow due to the extensive list of customary heirs entitled to a deceased estate. While the new inheritance laws have eliminated discriminatory inheritance practices, practices are said to continue because these are new and still relatively unknown laws in need of extensive civic education. The LEA further observes that polygamous customary law marriages may increase the risk of HIV exposure.*

*Marriages by repute and permanent cohabitation require a court determination in order to be legally recognised as valid, and are easily terminated where not recognised. While the recognition of these marriages may provide additional protection to women, the ease with which this partnership may be terminated, if not formally recognised by court, may adversely impact on the rights of women.*

*The Special Law Commission on the Review of the Laws on Marriage and Divorce concluded that the current status of marriage law is unsatisfactory as rights are determined by the type of marriage entered into, each of which provides for different rights and obligations.<sup>309</sup> This commission recommended the consolidation of both customary and statutory marriages into a single Marriage, Divorce and Family Relations Bill which proposes uniform rights and obligations of parties to a marriage, regardless of how a marriage was contracted.<sup>310</sup> The Law Commission furthermore recommended the continued recognition of marriages by repute or permanent cohabitation due to the increased protection it provided to women. It furthermore recommended a prohibition of polygamy – this recommendation was also acknowledged by the Report of the Law Commission on the Development of HIV and AIDS Legislation.*

*The work of the Special Law Commission should be supported and supplemented, to draw attention to the particular vulnerabilities of women within marriage and on termination of marriage, and to ensure that that the Marriage, Divorce and Family Relations Act is passed into law. In addition, amendments to the rights and obligations of parties to a customary marriage require careful implementation, including education, in order to be effective.*

### **Children's Rights**

Children and young people are recognised as a vulnerable population in the context of HIV and AIDS. They are also granted special protection in the Constitution both in the children's clause<sup>311</sup> and as a population requiring prioritisation in terms of the right to development.<sup>312</sup> The Children and Young Persons Act was repealed and

<sup>309</sup>The Malawi Law Commission, Law Commission Report on Review of Marriage and Divorce laws. Report No. 6, 2006, p20

<sup>310</sup> Kanyongolo NR and Chirwa D, *SADC Gender Protocol Barometer Baseline Study: Malawi*, 2009.

<sup>311</sup> Section 23.

<sup>312</sup>Section 30.

replaced by the Child Care Protection and Justice Act, a comprehensive statute that covers both vulnerable children and children in conflict with the law. The recent Child Care, Protection and Justice Act, 2010 has provisions for better care and protection of children, including vulnerable children (such as children orphaned by AIDS). It also contains clear provision for adoption and fostering, custody and maintenance of minor children and protection of children from undesirable practices both cultural and otherwise. Under the CCPJ Act, a child is a person under the age of sixteen years old in line with the Constitution. Child protection refers to the prevention and response to violence, exploitation and abuse against children including commercial sexual exploitation, trafficking, child labour, harmful traditional practices and child marriage. This protects children from early and forced marriages as well as harmful practices that increase the risk of HIV exposure.

*The Child Care, Protection and Justice Act, 2010 provides a range of protections for children relevant to HIV and AIDS. Children orphaned by AIDS who lose parental care as a result of the HIV epidemic are provided with rights to alternative care. The Legal Environment Assessment noted that children experience HIV-related stigma and discrimination, they may be marginalised from appropriate alternative care as a result of HIV-related discrimination, they may be excluded from educational opportunities and they may lose property when a parent dies of AIDS.<sup>313</sup> The Child Care Protection and Justice Act has taken steps to include specific protection for children from acts of discrimination, including property-grabbing. However the law contains limited provision for the health rights of children to ensure their independent access to appropriate HIV-related health care services (in accordance with the evolving capacities of the child) such as voluntary HIV testing, HIV-related prevention information and education and the means of prevention, as well as appropriate HIV treatment, care and support services for children. The Committee on the Rights of the Child has developed detailed guidance on the various forms of legal protection required to protect children affected by HIV and AIDS,<sup>314</sup> as have the UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights.<sup>315</sup> In addition, the SADC PF Model Law on HIV & AIDS in Southern Africa proposes the recognition of children as a vulnerable population and the inclusion of a specific clause on the rights of children in HIV law.<sup>316</sup>*

<sup>313</sup> See discussion of children as a vulnerable population in Section 4 of the LEA, above.

<sup>314</sup> See Committee on the Rights of the Child, *General Comment No.3: HIV/AIDS and the Rights of the Child*, 2003 for a full exposition of international guidance on protecting children's rights in the context of HIV and AIDS.

<sup>315</sup> See, for instance, Guideline 5 and Guideline 8, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006 at para 30(g) and para 38(g), (h) and (i) respectively.

<sup>316</sup> See section 3 definition of "vulnerable and marginalised populations"; see also Chapter II: Children Living with of Affected by HIV, *SADC PF Model Law on HIV & AIDS in Southern Africa*, 2008.

**People with Disabilities**

There is limited data on people with disabilities and HIV; however the data available suggests that people with disabilities are at higher risk of HIV exposure as well as vulnerable to inequality, human rights violations and poor access to essential services.<sup>317</sup> *The National HIV/AIDS Policy 2003 - 2008* further recognises that discrimination on the grounds of disability increases vulnerability to HIV infection and lists people with disabilities as a vulnerable population in need of accessible and appropriate HIV services.

The Handicapped Persons Act No 48 of 1971 provides for people with disabilities in various ways including through the improvement of care, assistance and education of persons with disabilities and the inspection of facilities providing services to people with disabilities by public officers (those who prevent inspections or fail to register services commit an offence). While the Act does not specifically refer to HIV and AIDS, these provisions could certainly be argued to protect the rights of people with disabilities to appropriate services. Likewise the recently enacted Disability Act, passed by Parliament on 24 May 2012, furthermore strengthens broad protection for the rights of people with disabilities.

*People with disabilities and children with disabilities are protected from discrimination and prioritised for promotion of their welfare and development, on the basis of their disability. They are also specifically noted as a vulnerable population in the National HIV/AIDS Policy, 2003. However, there is limited guidance in current disability law on the translation of these broad principles to protection in the context of HIV and AIDS.*

*Given the marginalised status of people with disabilities, their risk of HIV exposure and their limited access to services,<sup>318</sup> there is a need to increase specific legal protection for people with disabilities in the context of HIV and AIDS. This is in keeping with international guidance on the rights of people with disabilities,<sup>319</sup> as well as the national commitment to progressively adopt and implement policies and legislation to achieve various goals, including the goal of promoting the welfare and development of people with disabilities and children with disabilities.<sup>320</sup> HIV law should consider the inclusion of people with disabilities as a vulnerable population, as well as the provision for protection of specific important rights in the context of HIV and AIDS, as was done in the draft Eastern African Community (EAC) HIV & AIDS Prevention and Management Bill, 2010.<sup>321</sup>*

<sup>317</sup> HEARD, *Disability Rights in Eastern and Southern Africa*, University of KwaZulu-Natal, Durban, 2009.

<sup>318</sup> See the discussion of people with disabilities as a vulnerable population, in Section 6, above.

<sup>319</sup> See, for instance, the *Convention on the Rights of People with Disabilities*, 2008 as well as the UNAIDS, *Disability and HIV Policy Brief*, 2009, which translates the rights in the CRPD into recommendations for states in the context of disability, HIV and AIDS.

<sup>320</sup> See, for instance, section 13 and section 23(4) of the Constitution.

<sup>321</sup> Section 36 of the EAC HIV & AIDS Prevention and Management Bill. Available at <http://www.eannaso.org> [Accessed 15 July 2012].

**Other key populations**

The Legal Environment Assessment recognised a range of vulnerable populations and key populations at higher risk of HIV exposure in Malawi, many of whom are not specifically protected in current law particularly in the context of HIV and AIDS. In some cases, these populations are in fact subject to punitive laws that may act as further barriers to universal access to HIV prevention, treatment, care and support (discussed further in this section, below). An HIV law should recognise vulnerable populations and key populations and protect their rights in the context of HIV and AIDS.

## 6.2 Do laws and policies promote access to quality HIV-related goods, services and information?

In policy and plans, HIV-related health rights are set out in detail. A range of government guidelines, policies and plans expressly provide for the HIV-related health care services and for the protection and promotion of rights in the context of HIV and AIDS, as set out in section 5, above.

However, health law is less clear on the rights of people in the context of HIV and AIDS to prevention, treatment (including traditional medicines), food and nutrition and other forms of HIV-related support. Health laws also do not deal specifically with patient's rights in the context of HIV testing and confidentiality of medical information.

**Republic of Malawi (Constitution) Act**

There is no clear protection of a right to health in Chapter IV of the Constitution, although promoting health is a Principle of National Policy, as discussed in Section 5, above. Furthermore, there is limited jurisprudence on the issue. In the Malawian High Court case of *Neffie Mangani v Register Trustees of Malamulo Hospital*<sup>322</sup> the court recognised the right of a patient with HIV to the same treatment as other patients; however it did not deal expressly with health rights.

The Constitution also protects other key rights important for health such as the right to privacy,<sup>323</sup> the right to security of the person<sup>324</sup> (which also includes the right to be protected from medical and scientific experimentation without consent) and the right to freedom of expression and information.<sup>325</sup>

*It appears that provision in policy for health rights is sound. For instance, issues relating to HIV testing are set out in a number of guidelines including the Guidelines*

<sup>322</sup> *Neffie Mangani v Register Trustees of Malamulo Hospital* 5, High Court of Malawi, Principal Registry, Civil Case No 193 of 1991.

<sup>323</sup> Section 21, Republic of Malawi (Constitution) Act.

<sup>324</sup> Section 19, Republic of Malawi (Constitution) Act.

<sup>325</sup> Sections 35 and 37, Republic of Malawi (Constitution) Act.

on HIV/AIDS Counselling and Testing, 2004 (which provided for voluntary HIV testing with pre-test and post-test counselling) and the Ministry of Health Guidelines for Expanded HIV Testing, 2005 (which incorporated routine and diagnostic testing into the national HIV testing strategy). However, the Constitution fails to provide unambiguous protection for the right to health, despite international and regional standards, to which Malawi is a signatory, which provide for the rights of all people to health care. Access to appropriate and non-discriminatory health care services is a key law and human rights issue identified by the Legal Environment Assessment. The Assessment found that health care services are overwhelmed, with inadequate resources (including human resources) to fulfil health needs. It also found that stigma, discrimination and human rights violations are reported to create barriers to access to health care services for people affected by HIV and AIDS.<sup>326</sup> However given the importance of this issue the LEA recommends the need to create a clear, unambiguous and justiciable exposition in law of the right of all people to health care, and the meaning of this right in the context of HIV and AIDS. This is recommended by the UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights, 2006<sup>327</sup>, as well as the SADC PF Model Law on HIV & AIDS in Southern Africa, 2008.<sup>328</sup>

In addition, privacy rights and rights to security of the person, while recognised at an international level as protection against compulsory HIV testing and breaches of confidentiality,<sup>329</sup> have yet to be specifically tested in a Malawian court of law. Policy guidelines dictate that routine and diagnostic HIV testing should take place with informed consent, based on the constitutional protection for each person's right to privacy and security of the person; however discussions with focus groups during the LEA suggest routine HIV testing is overwhelmingly viewed as and/or implemented as compulsory HIV testing in the case of pregnant women at present.<sup>330</sup> Given the numerous reports of unlawful HIV testing and breaches of confidentiality in the health care sector, the debates regarding what should be considered as reasonable and justifiable limitations of privacy and security of the person rights in the context of HIV and AIDS and the controversy surrounding the Malawi Law Commission's proposals in this regard,<sup>331</sup> it is important that an HIV law clearly sets out HIV testing and confidentiality rights and any justifiable limitations to such rights, in keeping with

<sup>326</sup> See discussion of stigma and discrimination experienced by people living with HIV or AIDS, in Section 4, above.

<sup>327</sup> Guideline 3 and Guideline 6, UNAIDS, Geneva, 2006.

<sup>328</sup> Part V, section 36, 2008.

<sup>329</sup> See, for instance, the UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006 which state that "the right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information" at para97, and "compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of the person" at para 113.

<sup>330</sup> See discussion of discrimination against people living with HIV or AIDS, as well as discrimination against women, in Section 4, above.

<sup>331</sup> See, for instance, MANET + (undated) *People Living with HIV & AIDS Sector Position on the Draft HIV & AIDS Legislation*; UNAIDS, *Comments to the HIV & AIDS (Prevention and Management) Bill, 2008*, Geneva, 2010.

*national, regional and international human rights principles and guidance and the Constitution of Malawi. The UNAIDS International Guidelines on HIV/AIDS and Human Rights argue that there is no public health justification for compulsory HIV testing,<sup>332</sup> and the right to HIV testing only with informed consent (save for in the case of blood donations) is protected in the SADC PF Model Law.<sup>333</sup> This issue is dealt with in further detail in Section 7, below, which looks at proposed recommendations made by the Law Commission.*

*Likewise, rights of freedom of expression and access to information are argued to protect a person's right to access to HIV-related information and have been recognised internationally as being particularly crucial for vulnerable and key populations.<sup>334</sup> However, without specific explanation of the meaning of this right in the context of HIV and AIDS – e.g. how this right will be made available to vulnerable populations and to key populations at higher risk of HIV exposure who report experiencing difficulties accessing appropriate information<sup>335</sup> as well as how the right applies in the context of regulating HIV and AIDS information - the right may have limited impact on the lives of those affected. The UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights, provide detailed guidance on the regulation of health information in the context of HIV,<sup>336</sup> and the SADC PF Model Law on HIV & AIDS in Southern Africa, 2008 recommends the inclusion of a specific clause on Information, Education and Communication that includes provision for the needs of “vulnerable and marginalised groups”.<sup>337</sup> The Report of the Law Commission furthermore noted the guarantee of the right to information and the need to regulate HIV-related information.<sup>338</sup> The specific recommendations are dealt with in further detail in Section 8, below.*

<sup>332</sup> “[Compulsory HIV testing] is often utilised with regard to groups least able to protect themselves because they are within the ambit of government institutions or the criminal law, e.g. soldiers, prisoners, sex workers, injecting drug users and men who have sex with men. There is no public health justification for such compulsory HIV testing. Respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent,” UNAIDS and OHCHR *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2008, para113.

<sup>333</sup> Part III, *SADC PF Model law on HIV & AIDS in Southern Africa*, 2008.

<sup>334</sup> See, for instance, the Committee on the Elimination of Discrimination Against Women's concluding observations to the government of Malawi's 2004 report, which recommended wide promotion of sexuality education for girls and boys with special attention to early pregnancy, the control of sexually transmitted infections and HIV; Government of Malawi, *Combined second, third, fourth and fifth periodic report of state parties to the CEDAW Committee*, CEDAW/C/MWI/2-5, 2004.

<sup>335</sup> See, for instance, human rights issues relating to children, people with disabilities and men who have sex with men, amongst others, in Section 4, above.

<sup>336</sup> Guideline 6, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006.

<sup>337</sup> Part II: Prevention, sections 4 to 7.

<sup>338</sup> Malawi Law Commission, *Report of the Law Commission on the Development of HIV and AIDS Legislation*, 2008, p60

## ***Health and Medical Laws and Policies in Malawi***

### *Public Health Act of 1948*

The Public Health Act, 1948 (amended in 2000) aims to preserve public health. It includes a range of measures for dealing with infectious diseases, epidemic diseases and venereal diseases.<sup>339</sup>

Infectious diseases are defined as “*any disease that can be communicated directly or indirectly by any person suffering there from to any other person,*”<sup>340</sup> and measures include the isolation of people with infectious diseases with the aim of treatment and prevention of spreading the disease. The Act does not deal specifically with HIV or AIDS at all, and the diseases dealt with under the Act do not share the characteristics of HIV and AIDS.<sup>341</sup>

Additionally, the Public Health Act was enacted in a time when the constitutional order did not provide extensively for the protection of human rights and freedoms. In particular, the Act does not deal with issues such as patient’s rights in the context of HIV and AIDS.<sup>342</sup> It also contains a range of coercive measures, such as section 54(1) which criminalises the employment of any person suffering from any venereal disease in a communicable form and section 57 which stipulates that “*no person shall wilfully or by culpable negligence infect any other person with venereal disease or do or permit or suffer any act likely to lead to the infection of any other person with such disease.*”

Section 11 of the Act contains a list of notifiable infectious diseases (such as anthrax, human trypanosomiasis and others), however HIV and AIDS has not been listed as a notifiable disease, even with recent reforms to the Act (although the Minister has the power to do so).<sup>343</sup>

*The Public Health Act was enacted many years ago, and is inadequate to deal with the range of health rights issues in the context of HIV set out in this report.*

*International guidance recommends that regulation of a number of HIV-related health issues including access to quality prevention, treatment, care and support, information and services (including regulation of false or inaccurate information on HIV and AIDS), rights to food and nutrition and patients’ rights (including rights to*

<sup>339</sup>See Part III, Part IV, Part V, Part VI and Part VII, Public Health Act.

<sup>340</sup>Section 2, Public Health Act.

<sup>341</sup>Malawi Law Commission, *Report of the Law Commission on the Development of HIV & AIDS Legislation*, Report No.20, 2008, p15.

<sup>342</sup> *Ibid.*, p56

<sup>343</sup> Note that section 12 of the Public Health Act empowers the Minister of Health to declare any infectious disease other than those specified in Section 11 to be made notifiable.

*voluntary HIV testing and confidentiality) in the context of HIV and AIDS require to be addressed within law.<sup>344</sup>*

*At present, a number of these issues are addressed in the various policies of the health sector, but are not legally binding. A range of key informants, including those working in the health sector and the legal sector, identified it as an outdated law in need of review and as inadequate to deal with HIV-related issues in its current form.<sup>345</sup> Similarly, the Report of the Law Commission on the Development of HIV and AIDS Legislation, 2008 found the Public Health Act inadequate and also inappropriate for managing HIV and AIDS.*

*The Law Commission is currently undertaking a review of the Public Health Act,<sup>346</sup> and has produced a draft Discussion Paper No. 10 on the review of the Act (not yet public). The Discussion Paper looks at issues relating to the public health system and the right to health in the Malawian and international human rights and public health norms.<sup>347</sup> It will be critical to ensure that the review of the Public Health Act is informed by the work of the Law Commission's work on the review of HIV & AIDS legislation and this report, to include provision for the rights of people in the context of HIV and AIDS and to ensure consistency with the provisions recommended for an HIV and AIDS law.*

#### *The Pharmacy, Medicines and Poisons Act & the Patents Act*

The Pharmacy, Medicines and Poisons Act does not include any specific reference to HIV or AIDS. The Act does regulate clinical trials,<sup>348</sup> but does not deal specifically with the rights of trial participants, such as the right to informed consent to research (although the Constitution protects the right of every person from being subjected to medical or scientific experimentation without consent).<sup>349</sup>

The Pharmacy, Medicines and Poisons Board also regulates the manufacturing of generic drugs.

The Patents Act<sup>350</sup> provides intellectual property protection for patents, including pharmaceutical patents. Section 10 provides for protection of inventions communicated under international agreements; local patents are also protected by

<sup>344</sup> Guideline 6, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006.

<sup>345</sup> There were some concerns expressed about creating laws to deal with each specific disease rather than reviewing the Public Health Act as a whole; however for the most part key informants were firmly in favour of an HIV-specific law.

<sup>346</sup> See Malawi Law Commission, General Notice: Notice of Work Programme for 2012. *The Nation*, 6 March 2012, p14.

<sup>347</sup> Key Informant Interview, Malawi Law Commission, Lilongwe, 15 Feb 2012.

<sup>348</sup> Section 42.66.

<sup>349</sup> Section 19(5) of the Constitution.

<sup>350</sup> Cap 49:02.

the Act. Section 29 provides for patent protection for a period of sixteen years. Section 41 of the Act provides for the power to “make, use, exercise and vend” any invention during a “period of emergency” to safeguard the life and well-being of the community.<sup>351</sup>

Malawi has been a member of the World Trade Organisation (WTO) since March 1995 and is a party to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement).<sup>352</sup> The TRIPS Agreement protects copyright and related rights, trademarks, geographical indications, industrial designs and patents among other forms of intellectual property. Malawi is required to implement the minimum standards set by the TRIPS Agreement, which requires, among other things, a 20-year mandatory patent protection for pharmaceutical products and processes from the filing date of a patent application. The implication of that protection is well summarised by SisuleMusungu (as quoted by B. K. Twinomugisha) when he observed that: *“The grant of a patent over processes for the manufacture of medicines or with respect to medicines themselves as products has the effect of giving the patent holder a monopoly over the use of the process and or the manufacture and sale of the medicines. ...For medicines, the high prices of new medicines resulting from the mandatory requirements for patent protection under TRIPS in developing countries have seriously compromised the ability of communities, governments and other players in the health sector effectively to manage infectious and other diseases.”*<sup>353</sup>

In spite of the mandatory patent protection, least developed countries (LDCs) such as Malawi were exempted from immediately complying with the provisions of TRIPS Agreement for 10 years until 1 January 2006.<sup>354</sup> The TRIPS Council extended the transition period through the Doha Declaration on TRIPS Agreement until 1 January 2016.<sup>355</sup>

*The Pharmacy, Medicines and Poisons Board provisions in relation to clinical trials are inadequate to protect research participants' rights. At present these are primarily set out in guidelines and in the HIV/AIDS Research Strategy for Malawi 2005-2007. The Research Strategy contains specific protection for participants involved in HIV-related research in order to protect the dignity and human rights of research participants irrespective of HIV status. It reiterates the need for informed consent for research participation as well as publication of any research data, as well as respect*

<sup>351</sup> Section 41 (1) and (2)(b) and (c) of the Patents Act.

<sup>352</sup> Mphepo T, 'The relevance of the WTO Dispute Settlement Procedures and Jurisprudence in Malawi'. *Malawi Law Journal*, 1(2), 2007, p202.

<sup>353</sup> Twinomugisha BK, 'Implications of the TRIPS Agreement for the Protection of the Right of Access to Medicines in Uganda'. *Malawi Law Journal*, 2(2), 2008, p254.

<sup>354</sup> Art. 66(1) of the TRIPS Agreement.

<sup>355</sup> WTO, *Extension of the transition period under article 66.1 of the TRIPS Agreement for least developed country members for certain obligations with respect to pharmaceuticals products*, Decision of the Council of TRIPS, IP/C/25, June 2002.

for confidentiality. In addition, it stipulates that research that leads to discrimination against people living with HIV shall not be approved by a research ethics committee.<sup>356</sup> Although the Legal Environment Assessment did not identify the rights of research participants as a key issue emanating from literature, key informant interviews or focus group discussions, it is important to ensure participant's rights are protected in HIV-specific legislation. This is in keeping with the constitutional protection against medical and scientific experimentation without consent.

Furthermore, Malawi has not demonstrated having taken advantage of the existing flexibilities such as parallel importation and compulsory licensing, among others in the TRIPS Agreement and the extension in the Doha Declaration to ensure access to essential medicines for HIV and AIDS.<sup>357</sup> If Malawi was to issue a compulsory license it would first have to declare a national emergency before manufacturing anti-retroviral medicines for local consumption only and also take measures to reasonably compensate the patent owner for loss of use; at present it has limited capacity to do so.<sup>358</sup> The Patent Act<sup>359</sup> also requires review, in order to make it TRIPS compliant, since its provisions regarding licensing conflict with those agreed in the TRIPS Agreement.

The Law Commission will review the Patents Act in 2012.<sup>360</sup> The review need to take into account access to treatment for HIV and AIDS and to ensure that the law makes full use of this extension, albeit for few years, and other existing flexibilities in the TRIPS Agreement, in line with international and regional guidance.<sup>361</sup> It should be informed by the LEA and link with recommendations within an HIV law, to ensure consistency. This will furthermore require strong linkages between those dealing with intellectual property rights and access to generic medicines amongst various state institutions such as the Registrar General's Department, Ministry of Trade and Industry, Ministry of Health and perhaps the Office of the Directorate of Public Procurement.

<sup>356</sup> Centre for Human Rights: AIDS and Human Rights Research Unit, *Human Rights Protected? Nine Southern African Country Reports on HIV/AIDS and the Law*, University of Pretoria, Pretoria, 2007

<sup>357</sup> Key Informant Interview, Registrar General's Department, Blantyre, 20 Jan 2012.

<sup>358</sup> As above. See also Lettington R and Banda C, *A Survey of Policy and Practice on the use of Access to Medicines-related TRIPS Flexibilities in Malawi* [Available at <http://www.dfid.gov.uk/pubs/files/dfidmalawireport.pdf>] Accessed 26 Feb 2012; Chapulapula T and NkhomaSomba W, 'HIV/Aids Plant in Limbo'. *Malawi News*, 10-16 March 2012, p6.

<sup>359</sup> Cap 49:02.

<sup>360</sup> See Malawi Law Commission, 'General Notice: Notice of Work Programme for 2012'. *The Nation*, 6 March 2012, p14.

<sup>361</sup> See, for instance, Guideline 6, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006. See also SADC PF *Model Law on HIV & AIDS in Southern Africa*, 2008, section 36(a) which states that "the State shall take relevant measures to provide access to affordable, high quality anti-retroviral therapy and prophylaxis to treat or prevent HIV or opportunistic infections for people living with HIV including children living with HIV and members of vulnerable and marginalised groups. These relevant measures shall include the use of all flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the Doha Declaration on the TRIPS Agreement and Public Health as well as measures to encourage the local production of medicines."

### 6.3 Are there punitive laws that may discourage access to health care services?

Law can play a proscriptive, protective or instrumental role in responding to any issue, including HIV.<sup>362</sup> The proscriptive role entails imposing sanctions for certain forms of conduct, such as criminal sanctions for behaving and acting in a certain way. This approach in many ways infringes the rights of a few to protect the rights of many. A protective approach seeks to protect rights while an instrumental approach necessitates regulation of the relationships between individuals and society at large. It has been heralded as the suitable approach, in its attempt to alter social patterns of behaviour.

In this section we consider statutes considered to be proscriptive in nature which in practice may have the effect of perpetuating discrimination and discouraging users from accessing health care services in the context of HIV and AIDS.

#### ***Criminal law under the Penal Code and other related legislation***

'Unnatural sexual offences' are criminalised under section 137A<sup>363</sup> and 153 of the Penal Code, including sex between men, and sex between women. The following unnatural offences are included:

*“Any female person who, whether in public or private, commits any act of gross indecency with another female person, or procures another female person to commit any act of gross indecency with her, or attempts to procure the commission of any such act by any female person with herself or with another female person, whether in public or private, shall be guilty of an offence and shall be liable to imprisonment for five years.”*

*“any person who*

*(a) has carnal knowledge of any person against the order of nature; or*

*(b) has carnal knowledge of an animal; or*

*(c) permits a male person to have carnal knowledge of him or her against the order of nature, shall be guilty of a felony and shall be liable to imprisonment for fourteen years”.*

Additionally, it criminalises “*indecent practices between males*” in section 156 which states as follows:

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<sup>362</sup>Hamblin J, 'The role of Law in HIV and AIDS Policy'. *HIV and Development UNDP Issues Paper*, No. 11

<sup>363</sup> The Penal Code (Amendment) Act No 1 of 2011 amended the Penal Code by the insertion of section 137A relating to indecent practices between females.

*“any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, shall be guilty of a felony and shall be liable to imprisonment for five years, with or without corporal punishment”.*

In the case of *Republic v Steven Monjeza Soko & Tionge Chimbanga Kachepa*<sup>364</sup> the accused persons, two adult men conducted a traditional celebration of their union. They were subsequently arrested and brought before a court of law and sentenced to 14 years imprisonment in terms of section 156.

*The criminalisation of adult, consensual same-sex relations violates numerous human rights principles protected in national, regional as well as international law including the right to equality and non-discrimination, the right to dignity and the right to privacy.*<sup>365</sup> *The LEA found high levels of stigma and discrimination against sexual minorities, and in particular against men who have sex with men in Malawi. MSM reported a range of human rights violations and harassment and abuse by law enforcement officials. The LEA also found that criminal laws created obstacles to universal access to and the provision of appropriate prevention, treatment, care and support services, including for prisoners. MSM reported how the fear engendered by police practices and the recent prosecution (although criticised in the more recent case of *Rep v Davis Mpanda*<sup>366</sup>) forced them to remain invisible, living secretive lives. The inability to live openly and to access services places them at higher risk of HIV exposure.*<sup>367</sup>

*Given the high prevalence of HIV between MSM and the barriers created by criminal laws to access to health care, decriminalisation of same-sex relationships has been identified as a key strategy to improve national responses to HIV.*<sup>368</sup> *Decriminalisation refers to the removal of criminal penalties for sexual relations between consenting adults of the same sex. Decriminalisation means that adults engaging in consensual sex cannot be prosecuted or harassed by the police.*

<sup>364</sup> Criminal Case No 359 of 2009 (Unreported).

<sup>365</sup> See, for instance, UN Human Rights Committee, *Nicholas Toonan v Australia*, Communication No 488/1991 (views adopted on 31 March, 1994, fiftieth session). The Human Rights Committee to the ICCPR found that the protection against discrimination on the grounds of ‘sex’ included ‘sexual orientation’. It further held that the right to privacy is violated by laws which criminalise private homosexual acts between consenting adults. The Committee noted that “...the criminalisation of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS...by driving underground many of the people at risk of infection...[it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.”

<sup>366</sup> Criminal Appeal No. 333 of 2010 (High Court) (Principal Registry) (Unreported).

<sup>367</sup> See discussion of MSM and other sexual minorities as a key population, in Section 6, above.

<sup>368</sup> See, for instance, UNAIDS *2011-2015 Strategy: Getting to Zero*; one of the goals is that “countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses are reduced by half.”

*Decriminalisation is not the same as the legalisation of same-sex relationships. Instead it relates to the removal of criminal offences in the criminal law (e.g. in Malawi, the Penal Code). It has no impact on the nature and definition of marriage and family in personal and family law (e.g. in Malawi, the Marriage Act). Many countries throughout the world decriminalise same-sex relations but do not necessarily legalise same-sex marriage.*

*The UNAIDS International Guidelines on HIV/AIDS and Human Rights recommend that “criminal laws prohibiting sexual acts between consenting adults in private should be reviewed, with the aim of repeal.”<sup>369</sup> The SADC PF Model Law recommends that an HIV law include provision that “the State shall consider the decriminalisation of commercial sex work and consensual sexual relationships between adult persons of the same sex as specific measures that may enhance HIV prevention.”<sup>370</sup> It is recommended that Malawi consider the decriminalisation of sex between men as part of creating an effective national framework for the response to HIV.*

### **Laws that allow criminalisation of harmful HIV-related behaviour**

The following criminal laws are noted for their possible application to harmful HIV-related behaviour:

- Spreading of disease dangerous to life: Section 192 of the Penal Code<sup>371</sup> creates a serious offence in the event that any person “*negligently or recklessly does something which he or she knows or has reason to believe is likely to spread an infection dangerous to life*”. The maximum sentence for the offence is 14 years in prison.
- Manslaughter<sup>372</sup> and murder<sup>373</sup> are both classified as felonies in Malawian criminal law. This makes them serious offences that can be punished by death or life imprisonment.
- Attempted murder<sup>374</sup> occurs where any person attempts to unlawfully cause the death of another.

<sup>369</sup> Guideline 4, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*. UNAIDS, Geneva, 2006.

<sup>370</sup> Section 11(4), *SADC PF Model Law on HIV & AIDS in Southern Africa*, 2008.

<sup>371</sup> Section 192 of the principal Act was amended (a) by deleting the words “or negligently” and substituting them with the words “negligently or recklessly” (b) by deleting the words “shall be guilty of a misdemeanour” and substituting them for the words “shall be guilty of an offence and shall be liable to imprisonment for fourteen years.”

<sup>372</sup> “Any person who by an unlawful act or omission causes the death of another person shall be guilty of the felony termed ‘manslaughter’. An unlawful omission is an omission amounting to culpable negligence to discharge a duty tending to the preservation of life or health, whether such omission is or is not accompanied by an intention to cause death or bodily harm.” Section 208, Penal Code.

<sup>373</sup> “Any person who of malice aforethought causes the death of another person by an unlawful act or omission shall be guilty of murder.” Section 209, Penal Code.

<sup>374</sup> Any person who—(a) attempts unlawfully to cause the death of another; or (b) with intent unlawfully to cause the death of another does any act, or omits to do any act, which it is his duty to do, such act or omission

- Assault and assault occasioning bodily harm<sup>375</sup> are criminal offences (“misdemeanours”) relating to situations where unlawful harm is caused to another person.

*It has been argued that the various sections of the Penal Code, such as section 223, can be used to criminalise the transmission of HIV.<sup>376</sup> Legal scholars within Malawi and jurisprudence from other common law jurisdictions<sup>377</sup> have demonstrated how criminal offences such as these can be used to convict a person of intentional or reckless HIV transmission or exposure.<sup>378</sup>*

*At the same time, however, it is important to note that various legal authors, including within Africa, have also demonstrated the difficulties of proving the various standard elements of a criminal offence in a case of intentional or reckless HIV transmission in a court of law, including the HIV status of the accused at the time of the offence, the state of mind of the accused (that is, whether he or she acted intentionally), whether the sexual act held a significant risk of HIV transmission and whether HIV was in fact transmitted by means of the specific act from the accused to the complainant. Legal commentators have also raised concerns regarding the need to take into account the circumstances of each situation (for example, the accused’s age, gender or disability, access to health care services or the complainant’s consent).<sup>379</sup> The complexities of adjudicating cases of HIV transmission show that judicial guidance is imperative in supporting the use of existing laws to criminalise intentional HIV transmission.*

### **Criminalisation of Sex Work**

Although sex work *per se* is not unlawful, the Penal Code (sections 145<sup>380</sup> through to 147<sup>381</sup>) criminalises the exploitation of sex work; this means that practices such as

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being of such a nature as to be likely to endanger human life, shall be guilty of a felony, and is liable to imprisonment for life. Section 223, Penal Code.

<sup>375</sup> “Any person who unlawfully assaults another is guilty of a misdemeanour, and, if the assault is not committed in circumstances for which a greater punishment is provided in this Code, shall be liable to imprisonment for one year.” Section 253, Penal Code. “Any person who commits an assault occasioning actual bodily harm is guilty of a misdemeanour, and shall be liable to imprisonment for five years with or without corporal punishment.” Section 254, Penal Code.

<sup>376</sup>Kainja G, *Malawi HIV/AIDS Policy and Development report*, 72, 2005 referred to in the *MLJ*, Vol 1, Issue 1, 2007.

<sup>377</sup>See, for instance, *R V Cuerrier* (1998) 2 S.C.R 371 Supreme Court of Appeal Canada.

<sup>378</sup>Kainja G, *Malawi HIV/AIDS policy and Development report*, 72, 2005 as referred to in *MLJ*, Vol 1, Issue 1, 2007.

<sup>379</sup> See, for instance, ARASA, *Ten Reasons to Oppose Criminalisation of HIV Exposure or Transmission*, 2008. Available at [www.arasa.info](http://www.arasa.info) [Accessed 12 May 2012].

<sup>380</sup> “Male person living on earnings of prostitution or persistently soliciting - (1) Every male person who (a) knowingly lives wholly or in part on the earnings of prostitution; or (b) in any public place persistently solicits or importunes for immoral purposes, shall be guilty of a misdemeanour. In the case of a second or subsequent conviction under this section the court may, in addition to any term of imprisonment awarded, sentence the offender to corporal punishment.”

procuring women, solicitation, living off the earnings of prostitution and running a brothel are criminalised as misdemeanours.<sup>382</sup>

Although the involvement of men in sex work also falls within the scope of the provisions, it is generally women who are affected by the operation of the laws. Sex workers in Malawi are arrested for a variety of offences often relating to public nuisance laws. For instance, section 180, criminalising 'idle and disorderly conduct'<sup>383</sup> and section 183 relating to offences likely to cause a breach of the peace<sup>384</sup> are used as the basis for arresting sex workers.

*The arrest of female sex workers has successfully been challenged in Malawian Courts on the grounds of sex discrimination. In the case of Bridget Kaseka et al v Rep<sup>385</sup>, the court ruled that there was sex based discrimination where the police had arrested and prosecuted women suspected of sex work while allowing their male counterparts to go scot-free. However, despite this ruling, the LEA found that the criminal laws and the actions of law enforcement agents lead to on-going human rights violations, including sexual and physical abuse, and create barriers to access to services for sex workers, exacerbating their vulnerability and increasing their risk of HIV exposure.<sup>386</sup> Despite their recognition as a key population in need of protection in the National HIV Policy, 2003 many sex workers report being unable to report violations of their rights, or being unaware of channels for reporting rights. It is vital that efforts to strengthen the legal and regulatory framework for HIV in Malawi consider the impact of criminal laws on universal access to HIV services for sex workers and consider reviewing and repealing these laws in line with national constitutional protection for the rights of all, and international and regional guidance on effective responses to HIV.<sup>387</sup> The assessment furthermore reinforces the fact that there is a great need for specific HIV legislation that sets out protective provisions for vulnerable populations to reduce stigma and discrimination.*

<sup>381</sup> "Brothels - Any person who keeps a house, room, set of rooms, or place of any kind whatsoever for purposes of prostitution shall be guilty of a misdemeanour."

<sup>382</sup> AIDS and Human Rights Research Unit, Centre for Human Rights, *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*, University of Pretoria, Pretoria, 2007.

<sup>383</sup> "Idle and disorderly persons - The following persons — (a) every common prostitute behaving in a disorderly or indecent manner in any public place; (d) every person who without lawful excuse publicly does any indecent act; (e) every person who in any public place solicits for immoral purposes"

<sup>384</sup> "Conduct likely to cause a breach of the peace- Every person who in any public place conducts himself in a manner likely to cause a breach of the peace shall be liable to a fine of K50 and to imprisonment for three months"

<sup>385</sup> Criminal Appeal No 2, 1999.

<sup>386</sup> See discussion of sex workers as a key population in Section 4, above.

<sup>387</sup> See, for instance, Guideline 4 of the UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006 as well as section 11(4), *SADC PF Model Law on HIV & AIDS in Southern Africa*, 2008 as discussed in the section on same-sex relations, above.

**Immigration law**

Immigration in Malawi is regulated by the Immigration Act.<sup>388</sup> The Immigration Act has not yet been reviewed. It defines prohibited immigrants who may be prohibited from entering the country or whose presence in Malawi shall be unlawful, which includes persons with infectious diseases,<sup>389</sup> as well as men who have sex with men and sex workers<sup>390</sup> although it does not apply to any person who is a citizen of Malawi.<sup>391</sup>

*The Immigration Act discriminates against persons on various grounds, including that of national origin, sex<sup>392</sup> and 'other status'. The purpose of the limitation is not entirely clear in all cases, and it is possible that the Act may be used to deny entry unjustifiably to people on the basis of HIV or AIDS. The LEA is concerned with the lack of progressive action made towards the review of this Act, and its inconsistency with national, regional and international human rights standards. The Act should be reviewed to ensure that travel restrictions are not applied to people living with HIV or AIDS, and that restrictions on the entry of criminalised populations (such as MSM) are reviewed simultaneously with reviews of the applicable criminal laws.*

## 6.4 Are people able to access justice and enforce rights?

**Introduction**

A major issue raised in literature, in key informant interviews as well as focus group discussions is the limited ability of Malawians to access justice and enforce HIV-related human rights. Key issues include the limited knowledge and understanding of law and human rights and how to enforce them, the limited availability and accessibility of legal support services and redress mechanisms, including the courts and statutory institutions, as well as problems with law enforcement.

Even where structures exist, it appears that people struggle to access or use the existing structures set out below. For instance, people living in small communities do not know how to use, or are reluctant to use complaints mechanisms, including

<sup>388</sup> Cap. 15:03 of the Laws of Malawi.

<sup>389</sup> Section 4(3) of the Act refuses entry to "any person who is infected, afflicted with or suffering from a prescribed disease, unless he is in possession of a permit issued by the Minister, or any person authorized by the Minister, to enter and remain in Malawi issued upon prescribed conditions and complies with such conditions."

<sup>390</sup> Section 4(g) refuses entry to "any prostitute or homosexual, or any person, male or female, who lives or has lived on or knowingly receives or has received any part of the earnings of prostitution or homosexuality, or has procured men or women for immoral purposes."

<sup>391</sup> Section 4(2) of the Immigration Act.

<sup>392</sup> See *Toonen v Australia*, Communication No. 488/1992, CCPR/C/50/D/488/1992 where the Human Rights Committee interpreted 'sex' to include 'sexual orientation'.

health complaints mechanisms, where they fear loss of benefits or intimidation.<sup>393</sup> Key informants and focus groups reported that vulnerable populations, such as women and people with disabilities, and key populations at higher risk of HIV exposure appear to experience increased difficulties accessing and using structures for various reasons, including their status in society.<sup>394</sup> In the case of women, women fear reporting violence and sexual abuse due to social and cultural factors that entrench their inequality,<sup>395</sup> and often withdraw cases due to economic dependence upon their spouses or pressures from their families and communities.<sup>396</sup> Orphaned children have limited ability to claim their rights, when abused.<sup>397</sup>

Criminalised populations such as MSM and sex workers are unable to use most existing mechanisms,<sup>398</sup> although some focus group discussions reported on receiving good treatment at Victim Support Units.<sup>399</sup> HIV-related stigma and discrimination is said to discourage access to justice for people living with HIV.<sup>400</sup>

*“Some of us know about these laws, but we do not have enough power to fight...power to express ourselves in front of the chiefs.”<sup>401</sup>*

*“We don’t have enough freedom. We are scared that if we say something then people in the village will be against us.”<sup>402</sup>*

In this section we look at some of the key institutions available to support people to access and enforce their rights in relation to HIV and AIDS. A complete assessment of the Malawian justice system is beyond the scope of this report and has been conducted by other organisations.<sup>403</sup> However, this report hopes to highlight some of the challenges and gaps in the justice system for people living with HIV and AIDS and key populations at higher risk of HIV exposure.

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<sup>393</sup> See, for instance, Key Informant Interview, Irish Aid, Lilongwe, 24 Jan 2012; NOVOC, Lilongwe, 23 Jan 2012. See also Focus Group Discussion, Clinicians, Mzimba.

<sup>394</sup> Key Informant Interviews, Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; COWHLA, Lilongwe, 7 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; Focus Group Discussions, People with Disabilities, Blantyre; Pregnant Women, Mzimba.

<sup>395</sup> See Key Informant Interview, WLSA, Blantyre, 13 Dec 2011. See also Key Informant Interview, Malawi Police Service, Lilongwe, 7 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011.

<sup>396</sup> Key Informant Interview, Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012.

<sup>397</sup> See Key Informant Interview, NOVOC, Lilongwe, 23 Jan 2012.

<sup>398</sup> “We have nowhere to complain”, Respondent, Focus Group Discussion, Male Sex Workers, Lilongwe. See also Focus Group Discussion, MSM, Blantyre; MSM, Lilongwe.

<sup>399</sup> See, for instance, Focus Group Discussions, Female Sex Workers, Lilongwe; People Living with HIV, Mangochi.

<sup>400</sup> Key Informant Interview, Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011.

<sup>401</sup> Respondent, Focus Group Discussion, Pregnant Women, Mzimba.

<sup>402</sup> Respondent, Focus Group Discussion, Pregnant Women, Mzimba.

<sup>403</sup> See, for instance, Open Society Initiative, *Malawi Justice Sector and the Rule of Law*, 2007.

*“Of those whose rights were abused, only 13.6% tried to get the legal redress for any of their abused rights, 70.3% did not seek legal redress, and 16.% were not sure. Just over one third of participants had confronted, challenged or educated someone who was stigmatizing them. Less than half of participants (41.8%) reported they knew of an organization or group they could go to for help if they experienced stigma. Of those who sought legal redress, 31% reported that the matter had been dealt with, while 59.2% said that nothing had happened.”<sup>404</sup>*

### **Awareness of the Law and Legal Remedies**

By most accounts there is limited awareness of law and human rights issues, particularly HIV-related human rights. The majority of key informants stated that most people are unaware of their rights, what constitutes a violation of their rights and how to access legal remedies to enforce rights,<sup>405</sup> although selected key informants argued that there is a growing awareness of rights and abuses of rights,<sup>406</sup> in particular of civil and political rights.<sup>407</sup> Lack of knowledge of law and rights relating to HIV was confirmed during focus group discussions at district level where respondents reported or indicated limited understanding of laws, human rights and important international human rights instruments relevant to HIV apart from those they had received specific training on.<sup>408</sup> Although a few focus group in Lilongwe mentioned educational radio campaigns,<sup>409</sup> elsewhere it appears that education and training on human rights issues such as HIV-related human rights tends to happen in a piecemeal fashion in certain areas through CSOs or statutory institutions such as the Malawi Human Rights Commission.<sup>410</sup>

*“There is a need for civic education on issues of HIV and AIDS. People should be told that those who are positive can work like everyone else. I believe this can help reduce this type of discrimination.”<sup>411</sup>*

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<sup>404</sup> Chirwa M., Kamkwamba D. and Umar E., *Stigma and Discrimination Experienced by People Living with HIV and AIDS in Malawi*. MANET+, Malawi, 2011.

<sup>405</sup> OSI, *Malawi Justice Sector and the Rule of Law*, 2007. See also, for instance, Key Informant Interviews, Industrial Court, Blantyre, 16 Dec 2011; MANASO, Blantyre, 13 Dec 2011; WHO, Lilongwe, 13 Jan 2012; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; CECEP, Lilongwe, 13 Jan 2012; NOVOC, Lilongwe, 23 Jan 2012; UNAIDS, Lilongwe, 5 Dec 2011; ILO, Lilongwe, 5 Dec 2011; UNICEF, Lilongwe, 5 Dec 2011; UNFPA, Lilongwe, 5 Dec 2011; Malawi Law Commission, Lilongwe, 6 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011; MIAA, Lilongwe, 7 Dec 2011. See also Focus Group Discussion, Male Sex Workers, Lilongwe.

<sup>406</sup> Key Informant Interviews, WLSA, Blantyre, 13 Dec 2011; Malawi Law Commission, Lilongwe, 6 Dec 2011 amongst others.

<sup>407</sup> Key Informant Interviews, Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; Ministry of Information and Civil Education, Lilongwe, 13 Jan 2012

<sup>408</sup> “Most people only know section 65 out of all laws.” Respondent, Focus Group Discussion, Chiefs, Mangochi. See also Focus Group Discussions, Pregnant Women, Mzimba; People with Disabilities, Blantyre; Male Sex Workers, Lilongwe; Female Sex Workers, Lilongwe.

<sup>409</sup> Focus Group Discussion, Sexually Violated Girls, Lilongwe, MSM, Lilongwe; Female Sex Workers, Lilongwe.

<sup>410</sup> See, for instance, Key Informant Interviews, MANASO, Blantyre, 13 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; NOVOC, Lilongwe, 23 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012; UNAIDS, Lilongwe, 5 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011.

<sup>411</sup> Respondent, Focus Group Discussion, Male Sex Workers, Lilongwe.

Key informants as well as clinicians interviewed in focus group discussions reported that doctors and health care workers also had limited awareness of laws, policies and human rights and were in need of further training.<sup>412</sup>

*“Information is only found on posters, there isn’t anything like people coming to talk to us about it. We need people who understand these things to actually come and talk to us instead of expecting us to read and understand on our own.”<sup>413</sup>*

*“We are not aware of the rights of patients that is why sometimes we neglect them. The training that is offered to us on human rights is very shallow.”<sup>414</sup>*

Even at national level, health care service providers were unaware of their own HIV-related sectoral policies:

*“..... I have never heard about the HIV and AIDS Policy or seen the document, I see posters on patient and health workers rights but have not taken interest in these..... nobody has visited us to talk about human or patient rights.....we simply depend on the knowledge from school in our practice...but we know guidelines on how to treat patients”<sup>415</sup>*

Some argued that it would take “a social and cultural transformation” to resolve this problem since human rights issues need to be inculcated into people’s minds at a young age. Without this, even educated people, judicial officers and law enforcers will remain largely ignorant about human rights issues.

*There is an urgent need to increase awareness and understanding of HIV and human rights issues, including the rights of vulnerable populations and of key populations at higher risk of HIV exposure. Mass awareness-raising campaigns are required to not only inform communities of HIV and human rights, but also to reduce HIV-related stigma and discrimination. Additionally, human rights training is vital to ensure that all key service providers (such as health and social welfare workers) as well as law enforcement officials are trained on HIV and human rights issues.*

### **Legal Support Services**

Malawi has a limited number of qualified, private lawyers to serve a large population. Key informants felt that private lawyers were not available to most people due to the

<sup>412</sup> Key Informant Interviews, John Hopkins, Blantyre, 20 Jan 2012; UNAIDS, Lilongwe, 5 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; Malawi Law Commission, Lilongwe, 6 Dec 2011; COWHLA, 7 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011. Note that a KII with the National Organisation of Nurses and Midwives in Malawi stated that training on human rights issues was not the major problem within the health sector, but rather that health care workers were under-resourced and overwhelmed, see Key Informant Interview, NOAM, Lilongwe, 6 Dec 2011. See also Focus Group Discussions, Clinicians, Mangochi; Clinicians, Mzimba.

<sup>413</sup> Respondent, Focus Group Discussion, Clinicians, Mangochi.

<sup>414</sup> Respondent, Focus Group Discussion, Clinicians, Mzimba.

<sup>415</sup> Respondent, Focus Group Discussion, Clinicians, Mangochi.

high costs and limited numbers of lawyers.<sup>416</sup> There were also reports of their limited updated knowledge of newer laws.<sup>417</sup>

The Ministry of Justice's Legal Aid Department was set up to provide legal representation to those who cannot afford a private lawyer. However, it has limited staff and only three offices – in Blantyre, Mzuzu and Lilongwe – with no presence in the districts. Key informants felt that legal Aid services are overwhelmed, with few lawyers, high turnover (disturbing the continuity of cases) and inaccessibility at district level.<sup>418</sup> The Legal Aid services tend to refer HIV-related disputes to the Malawi Human Rights Commission.

There are insufficient CSOs funded to provide information on law and human rights, legal advice and legal representation,<sup>419</sup> particularly in the case of vulnerable populations and of key populations at higher risk of HIV exposure.<sup>420</sup> There are a small number of CSOs providing legal support services for people whose rights are violated such as the Women's Legal Resource Centre, WLSA Malawi and the Civil Liberties Committee. These CSOs depend on donor funding and are not present in every district.

*There is extremely limited access to legal support services for HIV-related human rights violations. Organisations working on HIV related human rights and support groups tend to provide limited legal support in the form of information and education on rights; however there is limited support for accessing justice from courts or other institutions.<sup>421</sup>*

### **The Courts**

Malawi has a number of courts available to adjudicate upon HIV-related human rights violations. Lower courts include Magistrates Courts, with judicial officers made up of trained lay persons and Residential Magistrates Courts with qualified lawyers; these courts have the power to hear criminal and civil cases. There are also Commercial Courts which are a division of the High Court delegated to adjudicate over Commercial cases which are presided over by High Court judges.

<sup>416</sup> Key Informant Interview, Law Society, Blantyre, 12 Dec 2011

<sup>417</sup> Key Informant Interview, Administrator Generals Department, Blantyre, 16 Dec 2011.

<sup>418</sup> Key Informant Interview, Law Society, Blantyre, 12 Dec 2011; Industrial Court, Blantyre, DATE; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; Legal Aid, Lilongwe, 8 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011

<sup>419</sup> Key Informant Interview, CEDEP, Lilongwe, 13 Jan 2012; UNFPA, Lilongwe, 5 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011

<sup>420</sup> Key Informant Interview, CEDEP, Lilongwe, 13 Jan 2012. The informant stated that organisations providing information and advice to MSM had been raided by police and charged with distribution of pornographic materials (information on MSM).

<sup>421</sup> See Chirwa M., Kamkwamba D. and Umar E., *Stigma and Discrimination Experienced by People Living with HIV and AIDS in Malawi*. MANET+, Malawi, 2011.

The Industrial Relations Court is a special court for hearing labour disputes. Matters may go from the Industrial Relations Court and other subordinate courts on appeal to the High Court. The High Court sits in Blantyre, Lilongwe, Zomba and Mzuzu and only convenes in districts for murder cases, where funding is obtained from development partners. There is also a Constitutional Court, an *ad hoc* arm of the High Court but specifically for hearing and adjudicating over cases relating to constitutional matters. Finally, there is a Supreme Court of Appeal to hear appeals of High Court judgements.<sup>422</sup>

The LEA found that the justice system as a whole needed to be strengthened. Generally, the judiciary has had limited formal training on human rights.<sup>423</sup> They need to be further sensitised to human rights issues and the application of principles of international law broadly,<sup>424</sup> and more specifically to HIV and human rights issues.

*Judges are required to look at international laws when passing judgements...however the truth is that they are not aggressive at applying international law. In general the use of international law depends on the capacity of the lawyer to bring up the issues. Note that human rights issues are fairly new in our country and judges (magistrates) need some sort of orientation so that they can take recourse to human rights issues when making judgements.*<sup>425</sup>

Judgements in disputes, including HIV-related disputes were reported to be inconsistent, particularly at magistrate's court level,<sup>426</sup> and punishments were said to be inadequate.<sup>427</sup> The judiciary themselves stated that HIV and human rights cases are difficult to adjudicate due to the lack of HIV specific laws and the difficulties of proving that discrimination is based on HIV status.<sup>428</sup> Measures to support HIV-related litigation, such as ensuring the confidentiality of parties to the dispute and expediting proceedings, are not uniformly applied. Generally, most respondents agreed that high-level structures such as the High Court and Industrial Court were inaccessible at district level due to location, prohibitive costs and the lengthy process.<sup>429</sup>

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<sup>422</sup> Ibid.

<sup>423</sup> Key Informant Interview, High Court, Blantyre, 16 Dec 2011. Note that key informants from the Industrial Court reported that there was some training on human rights, and a key informant from WLSA reported that they had done some training with the judiciary. See Key Informant Interviews, Industrial Court, Blantyre, 16 Dec, 2011; WLSA, Blantyre, 13 Dec 2011.

<sup>424</sup> Key Informant Interviews, High Court, Blantyre, 16 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; NOVOC, Lilongwe, 23 Jan 2012

<sup>425</sup> Respondent, Key Informant Interview, Judiciary, Blantyre, 16 Dec 2011.

<sup>426</sup> Key Informant Interviews, UNFPA, Lilongwe, 5 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; Malawi Law Commission, Lilongwe, 6 Dec 2011; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011.

<sup>427</sup> Key Informant Interview, MIAA, Lilongwe, 7 Dec 2011.

<sup>428</sup> See, for instance, Key Informant Interviews, High Court, Blantyre, 16 Dec 2011; Magistrate's Court, Blantyre, 16 Dec 2011.

<sup>429</sup> Key Informant Interviews, Industrial Court, Blantyre, 16 Dec 2011; Law Society, Blantyre, 12 Dec 2011; Administrator Generals Department, Blantyre, 16 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011.

*The Legal Environment Assessment found that for the most part the courts are not viewed as an accessible mechanism for accessing justice in the case of HIV-related human rights abuses. Although there is a sense that many more people are aware of their broad rights, knowledge of rights is still very low and access to justice and law enforcement is hampered by physical inaccessibility, prohibitive costs, language barriers, long delays (of particular concern for people living with HIV), fears relating to confidentiality and judicial insensitivity to HIV issues as well as limited access to legal support services, such as legal aid and private lawyers.*

### **The Office of the Ombudsman**

The Office of the Ombudsman is set up by the Constitution to provide remedies to those who experience any forms of human rights violations in circumstances “*where there is no judicial or other remedy available.*” The Ombudsman has, since its inception, investigated a range of complaints and is considered a popular means of access to justice.<sup>430</sup> Despite this, respondents generally reported that the Office of the Ombudsman was not an accessible and well supported mechanism for complaints.<sup>431</sup>

*The Office of the Ombudsman faces a number of challenges in that it only has offices in Blantyre, Lilongwe and Mzuzu and is therefore not generally accessible to districts. This was noted by various respondents in Key Informant Interviews and Focus Group Discussions. Also, it is overwhelmed by the number of complaints received through its offices. It can also only grant limited legal remedies.*

### **The Malawi Human Rights Commission**

The Constitution establishes the Human Rights Commission with the mandate to protect human rights and investigate violations of rights. It is empowered to receive applications from individuals or groups of people for a wide range of injustices, including HIV-related human rights violations and violations against key populations. However, as with the Office of the Ombudsman, respondents generally reported that the HRC was inaccessible, overwhelmed with cases and not well supported as a mechanism for resolving HIV-related disputes.<sup>432</sup>

*The major challenges to the Malawi Human Rights Commission include its location in Lilongwe, which makes it inaccessible to many people in the districts, and its limited access to resources. Although it has expressed a commitment to deal with HIV-related human rights violations, and is referred cases by Legal Aid, it has limited capacity to fulfil this commitment.*

<sup>430</sup> OSI, *Malawi Justice Sector and the Rule of Law*, 2007.

<sup>431</sup> Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; UNFPA, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011; MIAA, Lilongwe, 7 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011.

<sup>432</sup> Key Informant Interviews, UNAIDS, Lilongwe, 5 Dec 2011; UNFPA, Lilongwe, 5 Dec 2011; Ministry of Justice and Constitutional Affairs, Lilongwe, 6 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011; MIAA, Lilongwe, 7 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011.

### **Other Mechanisms**

District Labour Offices are also available to hear labour disputes at district level, but are under-resourced,<sup>433</sup> with some allegations of corruption expressed in focus group discussions:

*“.....I did not have the will to complain... when you lodge complaints to the labour offices, the employer simply pays off the labour official and that the end of the matter. The employer can afford even paying even MK50,000 at once but I can't.”<sup>434</sup>*

Health complaints mechanisms appear to be not well known or well used for HIV-related complaints. They were not mentioned by focus groups, and key informant interviews with the Medical Council of Malawi and the Pharmacy, Medicines and Poisons Board reported that they had never received HIV-related law or human rights complaints at their offices.<sup>435</sup>

### **Traditional Dispute Resolution Mechanisms**

The Constitution provides Parliament with the power to make provision for traditional or local courts to hear civil cases involving customary law. The Local Courts Act was passed in 2010. Many people do not rely on formal court systems to deliver justice, and tend to use traditional leaders, traditional family counsellors (*ankhoswe*), religious leaders, and community, non-governmental and faith-based organisations to deal with disputes such as those relating to land marriage and domestic violence.<sup>436</sup>

Although it is said that some chiefs are trained in human rights issues,<sup>437</sup> generally remedies are based on customary laws and beliefs<sup>438</sup> which key respondents argued impacts negatively on the rights of vulnerable and key populations such as people living with HIV or AIDS<sup>439</sup>, women,<sup>440</sup> children<sup>441</sup> and people with disabilities.<sup>442</sup>

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<sup>433</sup> Key Informant Interview, ILO, Lilongwe, 5 Dec 2011.

<sup>434</sup> Respondent, Focus Group Discussion, People Living with HIV, Mzimba.

<sup>435</sup> The Medical Council has a programme to inform the public about lodging complaints if their rights are abused, and tends to receive cases relating to negligence and malpractice. See Key Informant Interview, Medical Council of Malawi, Lilongwe, 12 Jan 2012. See also Key Informant Interviews, Pharmacy, Medicines and Poisons Board, Lilongwe, 13 Jan 2012; Ministry of Health, Lilongwe, 7 Dec 2011.

<sup>436</sup> OSI, *Malawi Justice Sector and the Rule of Law*, 2007. See also Key Informant Interviews, WLSA, Blantyre, 13 Dec 2011, WHO, Lilongwe, 13 Jan 2012; NOVOC, Lilongwe, 23 Jan 2012; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011. See also Focus Group Discussions, People Living with HIV or AIDS, Mangochi; Married Men and Women, Mzimba; Male Sex Workers, Lilongwe.

<sup>437</sup> Key Informant Interview, WLSA, Blantyre, 13 Dec 2011.

<sup>438</sup> Key Informant Interviews, WLSA, Blantyre, 13 Dec 2011; WHO, Lilongwe, 13 Jan 2012; UNAIDS, Lilongwe, 5 Dec 2011; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011.

<sup>439</sup> Key Informant Interviews, MANET+ and NAPHAM, Lilongwe, 6 Dec 2011. See also Focus Group Discussion, People Living with HIV or AIDS, Mangochi.

<sup>440</sup> See, for instance, Key Informant Interviews, WHO, Lilongwe, 3 Jan 2012; COWHLA, Lilongwe, 7 Dec 2011

*“In marriage settings they would access justice from either the “ankhoswe” or local chiefs who adjudicate their cases. The problem with the ankhoswes and local chiefs is that they do not understand human rights issues. For example, a member of NAPHAM said that her husband divorced her for testing HIV-positive through the PMTCT. The husband claimed that the woman was promiscuous, that was the reason she tested HIV-positive. The husband was not reported to the police or human rights organisations for redress. People in the village rarely report human rights cases to the police or the courts.”<sup>443</sup>*

*“Chiefs usually trivialise issues of human rights violations in the village setting. They take human rights issues as a minor mainly where you have not been injured physically. They do not take into account that a person is affected psychologically by a mere fact of calling him or her HIV-positive.”<sup>444</sup>*

*“Many of the chiefs when you tell them that someone has offended you they usually don’t do anything about it. They just tell us to forgive the person who has wronged us. So we prefer not to say anything. It’s better we just live our own lives with the virus.”<sup>445</sup>*

*“We can go [to the chief], but not because of issues relating to discrimination.”<sup>446</sup>*

*Traditional dispute resolution mechanisms are available and accessible to people in Malawi. However, they are not integrated into the justice system as a whole. Literature reviews and responses from KIIs and FGDs showed that decisions are adjudicated by those who may not have expertise in human rights issues, particularly HIV-related human rights issues, or an understanding of the need to protect the rights of all marginalised populations in order to respond effectively to HIV and AIDS. Of particular concern is the entrenched gender inequality in cultural norms and practices, and the need to ensure traditional leaders promote gender equality, reduce harmful gender norms and eradicate gender-based violence.*

### **The Police Service**

The Constitution establishes the Malawi Police Service as an independent organ of the executive responsible for providing for the protection of public safety and the rights of persons according to the law. Members of the police are required to exercise their powers as *“impartial servants of the general public and the Government of the day”* in terms of section 158 of the Malawi Police Act 1946<sup>447</sup> which was amended recently and is also up for review by the Law Commission. More recently, Victim Support Units (VSU) were set up at police stations across the country in an attempt to create accessible and supportive mechanisms for complaints.

<sup>441</sup> For instance, cases of defilement may be handled by chiefs and are not necessarily resolved in a manner that meets criminal law requirements; Key Informant Interview, NOVOC, Lilongwe, 23 Jan 2012.

<sup>442</sup> Focus Group Discussion, People with Disabilities, Blantyre.

<sup>443</sup> Respondent, Focus Group Discussion, DAC, Mangochi.

<sup>444</sup> Respondent, Focus Group Discussion, DAC, Mangochi.

<sup>445</sup> Respondent, Focus Group Discussion, People Living with HIV or AIDS, Mangochi.

<sup>446</sup> Respondent, Focus Group Discussion, Pregnant Women, Mzimba.

<sup>447</sup> OSI, *Malawi Justice Sector and the Rule of Law*, 2007.

The police are often people's next recourse to justice after chiefs and community structures.<sup>448</sup> However, they need to be sensitised on law and human rights issues,<sup>449</sup> particularly on the rights of vulnerable populations and key populations at higher risk of HIV exposure,<sup>450</sup> and to co-ordinate their responses (in the case of sexual offences) with the health sector.<sup>451</sup> There are also allegations of corruption:

*"... when people complain about domestic abuse, nothing much happens. After all, the husbands drink [beer] with the police officers and are sometimes friends...they give them money..... poor women have not money to give to a police officer. The level of corruption is too much."<sup>452</sup>*

MSM and sex workers report being unable to report violations of their rights to the police:

*"When the policemen see us chatting they just come up and arrest us. The laws in Malawi are in other people's hands, they are not in the Law Office."<sup>453</sup>*

*"If I go to the police, the police will not see that fact that I have come to complain. The police just rush to the fact I sleep with another man and they lock you up... Once they know you are gay they lock you up. Not even because they have caught you in the act."<sup>454</sup>*

*"When a sex worker has been abused by the sex partner and wants to report the matter to the police, the police officers say they they cannot help her because she is a prostitute."<sup>455</sup>*

The Police Service reported that the introduction of community police services, Child Protection Officers and the VSUs was improving access to justice<sup>456</sup> and the use of mediation to resolve disputes was argued to be effective and efficient.<sup>457</sup>

*"At first these people were scared of going because they thought that even there they wouldn't be treated properly but now they have come to realise that the victims support unit is there to help us."<sup>458</sup>*

*"They are people [who] receive us well. They don't shout at us and let us talk and they listen to us."<sup>459</sup>*

However, key informants also reported various challenges with these services<sup>460</sup> including the location of VSUs at police stations, which does not promote user-

<sup>448</sup> See, for instance, Focus Group Discussions, People Living with HIV or AIDS, Mangochi; Male Sex Workers, Lilongwe; Sexually Violated Girls, Lilongwe.

<sup>449</sup> Key Informant Interviewa, High Court, Blantyre, 16 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; UNAIDS, Lilongwe, 5 Dec 2011; Ministry of Health, Lilongwe, 7 Dec 2011; MIAA, Lilongwe, 7 Dec 2011.

<sup>450</sup> See section 4, above, for further discussion of the human rights violations experienced by sex workers and men who have sex with men at the hands of law enforcement officials. See also Key Informant Interview, NOVOC, Lilongwe, 23 Jan 2012 regarding children's rights.

<sup>451</sup> Key Informant Interviews, MIAA, Lilongwe, 7 Dec 2011; MHEN, Lilongwe, 9 Dec 2011.

<sup>452</sup> Respondent, Focus Group Discussion, HSA, Mzimba.

<sup>453</sup> Respondent, Focus Group Discussion, MSM, Lilongwe.

<sup>454</sup> Respondent, Focus Group Discussion, MSM, Lilongwe.

<sup>455</sup> Respondent, Focus Group Discussion, DAC, Mangochi.

<sup>456</sup> Malawi Police Services, Lilongwe, 7 Dec 2011. This was confirmed in two Focus Group Discussions with People Living with HIV, Mangochi and Female Sex Workers, Lilongwe.

<sup>457</sup> Key Informant Interview, Judiciary, Blantyre, 16 Dec 2011.

<sup>458</sup> Focus Group Discussion, Female Sex Workers, Lilongwe.

<sup>459</sup> Respondent, Focus Group Discussion, People Living with HIV or AIDS, Mangochi.

<sup>460</sup> See, for instance, Key Informant Interview, UNICEF, Lilongwe, 5 Dec 2011

friendliness,<sup>461</sup> the human resource capacity problems in the VSUs and the need for further training of officials,<sup>462</sup> the tendency of VSU officials to mediate all disputes rather than forwarding appropriate matters for adjudication by the judiciary,<sup>463</sup> corruption,<sup>464</sup> victimization<sup>465</sup> and the use of customary values and principles (as opposed to legal and human rights principles) to decide on cases, much to the detriment of female complainants:

*“...some officers manning Victim Support Unit need serious orientation and training. When a woman complains about domestic abuse, their approach is the “ankhoswe” type. They emphasize on the need for the woman to persevere and tolerate some little abusive behaviour from their spouses.”<sup>466</sup>*

*The LEA notes the governments efforts to update the Police Act, and the fact that it is currently up for further review with the Law Commission. The issues of concern with law enforcement identified by the LEA tend to suggest that problems relate less to the legal framework but to training and sensitisation of law enforcement officials, the development and implementation of policies linking law enforcement to health sector strategies and to general limitations within the justice sector as a whole.*

*Existing research shows that the police services tend to treat certain populations less favourably than others (e.g. women are treated less favourably than men). Literature reviews as well as focus group discussions with MSM and SW confirmed abusive practices, including arbitrary arrests, violence, intimidation and sexual assault by police officers.<sup>467</sup>*

*It certainly appears that VSUs have improved access to justice for those in the districts. However, KIIs and FGDs indicate there remain challenges with the use of these services such as their inadequate capacity to deal with human rights violations, their focus on resolving disputes through negotiation and customary law values and even charges of corruption. As with the police system as a whole, the failure to respond to gender issues such as domestic violence appear to be a commonly reported weakness with VSUs. Since dealing with gender inequality, harmful gender practices and gender-based violence are key to reducing vulnerability to HIV, this is a serious challenge in the context of HIV and AIDS.*

### **The Prisons**

Prisons are governed primarily by the Constitution and the Prisons Act of 1955. A process of review of the Prisons Act began in 2003 and is still underway by the Department of Prisons, with the technical assistance of the Law Commission.

<sup>461</sup> Key Informant Interview, COWHLA, Lilongwe, 7 Dec 2011

<sup>462</sup> Key Informant Interviews, High Court, Blantyre, 16 Dec 2011; WLSA, Blantyre, 13 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011.

<sup>463</sup> Key Informant Interview, High Court, Blantyre, 16 Dec 2011; WLSA, Blantyre, 13 Dec 2011; COWHLA, Lilongwe, 7 Dec 2011.

<sup>464</sup> Focus Group Discussion, Pregnant Women, Mzimba.

<sup>465</sup> Key Informant Interview, Ministry of Health, Lilongwe, 7 Dec 2011

<sup>466</sup> Respondent, Key Informant Interview, Lilongwe, 5 Dec 2011. See also Key Informant Interview, WLSA, 13 Dec 2011.

<sup>467</sup> See the discussion of MSM and sex workers in Section 4, above.

While there is no specific reference to HIV and AIDS in the legislation, the Constitution obliges the Chief Commissioner of Prisons to ensure “*proper and efficient administration of penal institutions*” in the country in a manner which protects prisoners’ rights. It furthermore creates an Inspectorate of Prisons to monitor the conditions within and general functioning within prisons, in terms of international standards.

*The conditions within prisons should provide for the health needs of prisoners. However, research shows that prison conditions are bad, with severe overcrowding and poor services such as nutrition and health care.<sup>468</sup> While there is limited information on HIV in prisons in Africa, existing research shows higher levels of HIV prevalence amongst prison populations.<sup>469</sup> Prisoners in Malawi do not have access to condoms to protect themselves from HIV infection, despite constitutional protection to conditions consistent with human dignity.<sup>470</sup> Laws prohibiting sex between men appear to act as a barrier to the provision of condoms in prisons and were also cited by some key informants and a number of focus group discussion participants as justification for denial of condoms to men who have sex with men, including within prisons.<sup>471</sup> This issue requires urgent intervention in the form of law or policy review in order to ensure effective HIV responses.*

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<sup>468</sup> OSI, *Malawi Justice Sector and the Rule of Law*, 2006.

<sup>469</sup> See, for instance, Jolofani D and DeGabrielle J, ‘A Study of HIV transmission and the care of prisoners with HIV/AIDS in Zomba, Blantyre and Lilongwe prisons’. *Penal Reform International*, 1999, cited in UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010, p5.

<sup>470</sup> Section 42, Republic of Malawi (Constitution) Act.

<sup>471</sup> See the discussion on services for men who have sex with men and prisoners in Section 4, above.

## 7. Law reform proposals made by the Malawi Law Commission

The Law Commission's review led to the production of the *Report of the Law Commission on the Development of HIV and AIDS Legislation, 2008* with draft recommendations for an HIV law (the HIV and AIDS Prevention and Management Act Draft Bill) to enforce substantive laws specific to HIV and AIDS. Respondents and various stakeholders have presented various opinions on the Law Commission's recommendations. This section of the assessment focuses specifically on some of the contentious provision, in terms of the key issues identified by the LEA (Section 4), the current legal and regulatory framework and human rights commitments (Section 5), and public health and human rights evidence (including feedback from key informants and focus group discussions). It does not purport to be a full, technical review of all of the draft proposals<sup>472</sup> but rather focuses on key substantive issues.

It must further be noted and understood that, in terms of feedback during interviews, the views of key informant interviews were often more complex and nuanced than those of focus groups, since the informants were often aware of the provisions of the Law Commission's *Report* and current debates for and against the provisions. Focus groups with specific populations revealed low levels of understanding of HIV law and human rights in general, and virtually no knowledge of the Law Commission's *Report* and its proposed provisions.

The proposed law provides for, amongst other things:

- An institutional framework to oversee and coordinate all issues of HIV and AIDS in the country.
- Responding to gender and HIV and AIDS
- The dissemination of education and accurate information on HIV and AIDS
- A prohibition of HIV-related discrimination, including within employment and education
- A prohibition of harmful cultural practices that increase risk of HIV exposure
- Provision for health rights including voluntary HIV testing and counselling and protection of confidentiality as well as provision for circumstances in which HIV testing and disclosures may take place without consent
- The co-ordination of efforts to control and manage HIV and AIDS as a public health issue, and
- The criminalisation of transmission of HIV.

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<sup>472</sup> For a comprehensive review of all provisions within the draft proposals, including a technical review in terms of legal drafting, please refer to the UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*. UNAIDS Secretariat, Geneva, 2010.

## Institutional Framework

Currently the DNHA is the key government institution responsible for formulating policy relating to HIV and AIDS. It plays a supervisory and oversight role in the national response to HIV and AIDS. NAC, on the other hand, is mandated to coordinate and facilitate the national response.

Part XI of the Law Commission's proposed HIV law recommends establishing the National AIDS Commission (NAC) under statute, as a statutory institution under the Office of the President and Cabinet (or any other Ministry as the President may direct), in order to secure its existence and permanence. It furthermore recommends that the Chairperson of NAC report to the Minister responsible for HIV and AIDS.

*The LEA was tasked with reviewing the recommendations regarding the institutional framework for the national response to HIV and AIDS. The Law Commission's Report included a review of existing arrangements as well as a review of possible arrangements for the status of a national AIDS commission.<sup>473</sup> A review of literature as well as responses from key informants indicated no serious concerns with the recommendations made by the Law Commission, save for a recommendation that the NAC ensure the meaningful involvement of people living with HIV and members of key populations at higher risk of HIV exposure.<sup>474</sup> This recommendation should be incorporated in statute in terms of the composition of the Commission. The establishment of NAC as a statutory institution is similar to that in a number of African countries (e.g. Ghana and Tanzania were noted by the Law Commission).*

## Compulsory Testing

The Law Commission's *Report* creates provision for four types of testing: voluntary HIV testing, routine HIV testing, diagnostic HIV testing and compulsory HIV testing (which is discussed as a form of obligatory testing, or testing without consent, and also differentiated from another form of obligatory testing - mandatory HIV testing - in the *Report*).<sup>475</sup> Respondents did not recognise the technical differentiation made by the Law Commission between the various types of testing, particularly between compulsory and mandatory testing (which terms were generally used interchangeably by key informants); however the crucial issue noted by respondents was that obligatory testing, whether 'compulsory' or 'mandatory', allowed for HIV testing without obtaining voluntary and informed consent.

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<sup>473</sup> See Law Commission, *Report of the Malawi Law Commission on the Development of HIV and AIDS Legislation*. Malawi, 2008, p19-22.

<sup>474</sup> UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*. UNAIDS Secretariat, Geneva, 2010

<sup>475</sup> See Law Commission, *Report of the Malawi Law Commission on the Development of HIV and AIDS Legislation*. Malawi, 2008, p51-53.

*The Law Commission describes mandatory testing as an obligatory test which is a precondition for obtaining a service or benefit, whereas compulsory testing is an obligatory test where a person has no choice in being tested and is required to provide a blood or other bodily fluid sample. The Report prohibits compulsory HIV testing, but nevertheless provides for certain instances where compulsory HIV testing may take place. The key issue in the recommendations is to differentiate between HIV testing with consent, and HIV testing without consent. Written submissions to the Report have recommended describing only 3 types of testing: client-initiated and provider-initiated testing, which must be clearly specified as forms of voluntary testing, and compulsory testing, which must be clearly specified to be HIV testing without consent.<sup>476</sup>*

### **Compulsory HIV Testing**

The Law Commission's *Report* and proposed HIV bill provided for compulsory testing in section 19, as set out below.

#### **“EXCEPTIONS FOR PROHIBITION OF COMPULSORY TESTING**

(2) Notwithstanding subsection (1), compulsory testing for HIV infection shall be permissible in the following instances

- (a) under an order of the court, for any person who is charged with a sexual offence;
- (b) for commercial sex workers;
- (c) for persons intending to enter into polygamous unions;
- (d) for pregnant women and their sexual partners or spouses; and
- (e) for donors of blood and tissues.”

Compulsory HIV testing violates the right to equality and non-discrimination,<sup>477</sup> dignity, privacy, liberty and security of the person, and the right to health.<sup>478</sup> It is also argued to violate the right to freedom from cruel and inhuman treatment<sup>479</sup> and the right to marry.<sup>480</sup> The LEA found it to be an unjustifiable limitation of rights for various reasons, in particular the following:

<sup>476</sup> See UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*. UNAIDS Secretariat, Geneva, 2010, p17-18.

<sup>477</sup> See, for instance, the *Kaseka* precedent which noted the unfair impact of the arrest of sex workers on women.

<sup>478</sup> Malera, G., *Background Paper: Supporting Information for the Development of a Common UNCT Position on the Draft Malawi HIV and AIDS Legislation*, Malawi, 2011.

<sup>479</sup> Including the right to be free from medical or scientific experimentation; see Currie I and de Waal J, *The Bill of Rights Handbook*, South Africa, 2005, p310 where this interpretation was argued in relation to a similar worded provision in the South African Constitution.

<sup>480</sup> UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010.

*Public Health Purpose:* The Law Commission proposes compulsory HIV testing as a measure to prevent HIV transmission. However, there are various limitations to the proposals.

In the case of a compulsory HIV testing of a person charged with a sexual offence,<sup>481</sup> section 19 requires an order of court, presumably to ensure that there is at least a *prima facie* case against the accused and that the sexual offence in question carries a significant risk of HIV exposure or transmission. Access to PEP will be delayed by the time taken to arrest and bring the accused before court for an order. Effective prevention of HIV transmission requires immediate access to PEP for complainants in a sexual offence matter and an HIV law should clearly provide for such.<sup>482</sup> The proposed provision will not support this public health goal.

In the case of testing of sex workers, it is unclear from the Law Commission's *Report* how compulsory HIV testing of sex workers will be used to prevent HIV transmission. In order to achieve the stated public health goal, it would need to be undertaken on a regular basis and would need to include *all* sex workers (some of whom operate from domestic residences) as well as their clients. Of the limited key informants who commented specifically on compulsory HIV testing of sex workers, most were opposed to such testing on this and other grounds.<sup>483</sup> Unconfirmed anecdotal evidence from health workers suggests that compulsory HIV testing of sex workers takes place and is not used to provide HIV-related health care services to sex workers:

*"I am asking because when prostitutes are arrested they are sent to the hospital to be tested. Usually those found negative, they are given bail but those found positive are sent to jail."*<sup>484</sup>

Regarding pregnant women (and their partners), studies show that HIV testing is already viewed as acceptable by the vast majority of pregnant women attending antenatal care services particularly where women are aware of the benefits of PMTCT.<sup>485</sup> This was confirmed by a number of key informants during interviews, the majority of whom opposed compulsory HIV testing in general,<sup>486</sup> and for pregnant

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<sup>481</sup> Note that key informants and focus groups did not discuss this proposal at any length.

<sup>482</sup> WHO / ILO, *Post Exposure Prophylaxis to Prevent HIV Infection*, 2005. Available at [www.who.int](http://www.who.int) [Accessed 23 July 2012]; the guidelines recommended the provision of PEP as soon as possible and no later than 72 hours after the exposure. PEP is not recommended once 72 hours have passed.

<sup>483</sup> See, for instance, Key Informant Interviews, MANASO, Blantyre, 13 Dec 2011; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012. Note also that in the few focus group discussions who discussed this issue, there were also divided opinions. See for instance, Focus Group Discussions with Youth, Mangochi; Clinicians, Mangochi; Youth, Mzimba. Many opinions were guided by the criminal laws relating to sex work, resulting in limited understanding of discussions of sex workers' rights.

<sup>484</sup> Focus Group Discussion, HSA, Mzimba.

<sup>485</sup> UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010, p21.

<sup>486</sup> Reasons for opposing compulsory HIV testing included the discriminatory nature of compulsory testing (and in particular its impact on women), the excessive resources required for its implementation, the potentially

women in particular.<sup>487</sup> Some respondents in focus group discussions said that compulsory HIV testing was important to prevent mother-to-child transmission of HIV;<sup>488</sup> however evidence shows that this purpose is currently well served by the provider-initiated HIV testing policy.

Finally, there is no evidence that compulsory HIV testing of partners to a polygamous union helps to reduce HIV transmission, nor can it prevent pre-marital sexual intercourse or HIV exposure as a result of extra-marital intercourse.<sup>489</sup> The Parliamentary Committee on Health and HIV opposed pre-marital HIV testing of partners to a polygamous union. Chiefs in both Mangochi and Mzimba felt that HIV testing prior to polygamous marriages was important (and often takes place voluntarily) but noted that pre-marital sex takes place in any event.<sup>490</sup>

*“In most of these TAs people are encouraging each other to get tested before they get married to another woman because of the dangers of contracting HIV or passing it on to other people. Nowadays if you sleep with someone you don’t know without a condom you always live your life in doubt, it’s better if you want to get involved with anyone you use a condom...”<sup>491</sup>*

Compulsory HIV testing may in fact deter access to health care services, particularly in the case of vulnerable populations and key populations who fear punitive or discriminatory outcomes. There are a number of less restrictive public health measures that may effectively achieve similar aims, including increased access to

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negative impact on public health and the less restrictive measures (including vigorous information and testing campaigns) available to better achieve public health goals. See, for instance, Key Informant Interviews, Ministry of Health, Lilongwe, 24 Jan 2012; MANET+ and NAPHAM, Lilongwe, 6 Dec 2011; MHEN, Lilongwe, 9 Dec 2011; MHRC, Lilongwe, DATE; High Court, Blantyre, 16 Dec 2011; MANASO, Blantyre, 13 Dec 2011; WLSA, Blantyre, 13 Dec 2011; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012; CEDEP, Lilongwe, 13 Jan 2012; NOVOC, Lilongwe, 23 Jan 2012; Irish Aid, Lilongwe, 24 Jan 2012.

<sup>487</sup> See, for instance, Key Informant Interviews, NAC, Lilongwe, 6 Dec and 22 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; World Health Organisation, Lilongwe, 13 Jan 2012; Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012. See also Focus Group Discussion, Parliamentary Committee on Health and HIV, Lilongwe.

<sup>488</sup> See, for instance, Focus Group Discussions, Parliamentary Committee on Legal Affairs, Lilongwe; Male Sex Workers, Lilongwe; Female Sex Workers, Lilongwe; DAC, Mangochi; Clinicians, Mangochi; Pregnant Women, Mangochi; People Living with HIV, Mangochi; Chiefs, Mzimba.

<sup>489</sup> Pre-marital HIV testing of partners wishing to enter a polygamous union was not specifically discussed by many key informants, the majority of whom broadly opposed all forms of compulsory HIV testing discussed above. Of those who discussed it, some participants stated it would help to prevent HIV transmission (see, for instance, Focus Group Discussions, Sexually Violated Girls, Lilongwe; Clinicians, Mzimba; People Living with HIV, Mzimba; Married Men and Women, Mzimba) while others argued it did not prevent HIV exposure through sex before and during marriage (see for instance, Focus Group Discussions, DAC, Mangochi; Chiefs, Mangochi, Married Men and Women, Mangochi). See also Open Society International, *Women and HIV Testing: Policies, Practices and the Impact on Health* cited in UNAIDS *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010, p22

<sup>490</sup> See Focus Group Discussion, Parliamentary Committee on Health and HIV, Lilongwe; Chiefs, Mangochi; Chiefs, Mzimba.

<sup>491</sup> Focus Group Discussion, Chiefs, Mangochi.

voluntary HIV counselling and testing as well as access to appropriate HIV-related information, education and the means of prevention.

*Potential for exacerbating discrimination:* The LEA has already recognised the high levels of HIV-related stigma and discrimination in Malawi, as well as the particular vulnerabilities of women and sex workers to discrimination, violence and abuse.<sup>492</sup> Compulsory HIV testing creates the possibility of further stigmatising targeted populations as ‘vectors’ of the disease (further reducing the public health benefits of testing) as well as increasing their risk of being targeted by punitive provisions proposed in the *Report* such as disclosures of HIV status and criminalisation of HIV transmission. It may also lead to the fear of or actual HIV-related stigma, discrimination and human rights violations against those testing HIV-positive and may thus further dissuade access to health care services.

*Contrary to national, regional and international human rights norms:* Compulsory HIV testing involves an unjustifiable limitation on various rights protected by the Constitution, and takes away the essential content of key rights such as those to dignity and privacy. Other less restrictive measures may achieve similar public health goals without derogating from rights.<sup>493</sup> The compulsory HIV testing provisions proposed in the Law Commission’s *Report* are contrary to international and regional guidance which strongly recommends against HIV testing without voluntary and informed consent as an effective means of responding to HIV.<sup>494</sup> The SADC PF *Model Law* provides for voluntary HIV testing and counselling in all instances, including for donors of bodily fluids and products.<sup>495</sup>

### ***Pre-recruitment HIV testing of people intending to join the uniformed forces and domestic workers***

The Law Commission’s *Report* proposes pre-recruitment HIV testing for members of the uniformed forces and for domestic workers in section 28.

#### **“Prohibition of Pre-recruitment Testing**

An employer shall not require any person to undergo HIV testing as a pre-condition for recruitment:

Provided that pre-employment HIV testing may be permissible for

- (a) purposes of assessing fitness to serve in
  - (i) the Defence Force;
  - (ii) the Police Service;
  - (iii) the Prison Service;

<sup>492</sup> See the discussion on key populations in Section 4, above.

<sup>493</sup> See Malera G, *Background Paper: Supporting Information for the Development of a Common UNCT Position on the Draft Malawi HIV and AIDS Legislation*, Malawi, 2011 for a full discussion of the constitutionality of compulsory HIV testing in terms of the Constitution.

<sup>494</sup> See, for instance, Guideline 3, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006. See also UNAIDS, *Policy on HIV Testing and Counselling*, UNAIDS, Geneva, 1997.

<sup>495</sup> Section 14, SADC PF *Model Law on HIV & AIDS in Southern Africa*, 2008.

(iv) the Immigration Department; and  
 (b) purposes of assessing the health status of a domestic worker.”

Pre-recruitment HIV testing violates the right to fair conditions of work.<sup>496</sup> The LEA found pre-recruitment HIV testing of members of the uniformed forces to be an unreasonable limitation of rights, as did the vast majority of key informants interviewed during the LEA,<sup>497</sup> for the various reasons set out below:

*Occupational Health and Safety:* There is a negligible risk of HIV transmission in the working environment, including the domestic working environment when working with small children, which risk can be dealt with by the use of basic, universal infection control procedures. In addition, pre-employment HIV cannot exclude all people living with HIV from employment since a person may test negative on an HIV-antibody test while in the ‘window period’ and others could become HIV-positive after employment.<sup>498</sup> It is therefore preferable to take measures to deal with the remote possibility of HIV exposure within the workplace.

*Inherent Requirements of the Job:* An HIV test and an applicant’s HIV-positive status do not determine the applicant’s ‘fitness to work’ or ‘health status’, particularly in the context of access to ART when HIV has become a manageable condition allowing people to enjoy good health for many years. Many people living with HIV are in good health and able to carry out the duties required for most positions, including the strenuous duties required for the armed forces.<sup>499</sup>

*Discrimination:* The burdening of a certain class of persons with pre-recruitment HIV testing during recruitment for employment (such as those applying for employment in the armed forces) and the exclusion of those testing HIV-positive is discriminatory. It classifies HIV-positive people as unemployable or unworthy of employment in some professions, without due regard for their health, and denies people with HIV fair

<sup>496</sup> UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010; Malera G, *Background Paper: Supporting Information for the Development of a Common UNCT Position on the Draft Malawi HIV and AIDS Legislation*, Malawi, 2011.

<sup>497</sup> See, for instance, Key Informant Interviews, Ministry of Information and Civic Education, Lilongwe, 13 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 12 Jan 2012; John Hopkins, Blantyre, 20 Jan 2012; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; Magistrate’s Court, Blantyre, 16 Dec 2011; MANASO, Blantyre, 13 Dec 2011; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Irish Aid, Lilongwe, 24 Jan 2012; COWLHA, Lilongwe, 7 Dec 2011; World Health Organisation, Lilongwe, 13 Jan 2012 amongst others. The Parliamentary Committee on Health and HIV argued in favour of pre-recruitment HIV testing for the armed forces while the Committee on Legal Affairs had conflicting views. Few focus group discussions with targeted populations discussed the issues.

<sup>498</sup> See the case of *Hoffmann v South African Airways* 2001 (1) SA 1 (SACC 2000) in South Africa for a discussion of the irrationality of pre-employment HIV testing for purposes of occupational health and safety. See also *Diau v Botswana Building Society (BBS)* 2003 (2) BLR 409 (BwIC) and *Jimson v Botswana Building Society* (2005) AHRLR 3 (BwIC 2003).

<sup>499</sup> See, for instance, *Nanditume v Minister of Defence* (2002) AHRLR 119 (NaLC 2000) in Namibia where the court held that an HIV test alone was not able to determine an applicant’s fitness to work and that the exclusion of an applicant simply on the basis of his or her HIV status was discriminatory.

conditions of work. In particular, people living with HIV and domestic workers are recognised by the LEA as a vulnerable population, in particular need of protection in law. Differential treatment should be justifiable, reasonable and comply with the standard of limitation set by the Constitution in an open and democratic society. Pre-employment HIV testing for purposes of excluding a person from the military is arguably unreasonable, given that the discrimination fails to achieve a reasonable purpose and the impact of the discrimination is severe.

*“The impact of discrimination on HIV-positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living.”<sup>500</sup>*

*International and regional guidance* additionally recommends the prohibition of pre-employment HIV testing in all workforces, including the military.<sup>501</sup> The UN Expert panel on HIV Testing in UN Peacekeeping Operations unanimously rejected pre-recruitment HIV testing and endorsed voluntary HIV counselling and testing for UN peacekeeping operations.<sup>502</sup> Section 23(5) of the SADC PF *Model Law* provides that *“fitness to work shall be the relevant standard in all matters related to employment”* and section 23(6) states that *“HIV testing of a job seeker or an employee for the purpose of recruitment, promotion or any other reason is prohibited.”*

## Prohibition of Publication of False information

The Law Commission’s proposals provide for the prohibition of the publication of false information relating to HIV and AIDS (such as false claims of a ‘cure’) in Part VII, section 25 of the proposed HIV law:

### **“Accrediting authority**

(1) The Commission shall be the accrediting authority of information on HIV and AIDS disseminated to the public.

(2) Any information on HIV and AIDS developed by any person other than the Commission shall be screened and verified by the Commission to establish its accuracy before dissemination.

(3) A person in charge of information on HIV and AIDS has a duty to ensure that the information

(a) is accurate; and

(b) is accredited by the Commission.

### **Publication of misleading information**

Any person who gives or publishes false or inaccurate information concerning HIV and AIDS

<sup>500</sup> *Hoffmann v SAA* 2001 (a) SA 1 (SACC 2000) at para28.

<sup>501</sup> See, for instance, Guideline 5 of the UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006 See also section 23 of the SADC PF *Model Law on HIV & AIDS in Employment*, 2008.

<sup>502</sup> UNAIDS, *HIV Testing of Specific Populations: Recruits of the Armed Forces*, Available at <http://data.unaids.org/topcis/humanrights> [Accessed 5th April 2012].

to any person or the public shall be guilty of an offence and shall be liable to:

(a) in the case of an individual, to a fine of K100,000 and imprisonment for five years; or

(b) in the case of a body corporate, organization or association, to a fine of K1,000,000.”

The Law Commission proposes limiting the right to freedom of expression, by making all information on HIV and AIDS subject to accreditation by the NAC. The LEA found that this provision was a reasonable limitation of rights in an open and democratic society. It served an important public health purpose of ensuring access to accurate information about HIV and AIDS, would no doubt be viewed as a reasonable limitation of the right in terms of the Malawi Constitution and was in accordance with international and regional guidance which recommends that states enact laws to regulate HIV-related information.<sup>503</sup> Although few key informants and focus groups discussed the issue at length, there was resounding support for the provision amongst those that did.<sup>504</sup> It is recommended, however, that the law (or regulations in terms of the law) provide details regarding how such accreditation is to take place so as not to cause unnecessary delays in the dissemination of information.

### **Disclosure of HIV status to sexual partner by a health services provider**

The Law Commission’s proposals provide for a breach of the right to privacy in certain circumstances at the discretion of a health worker in section 10 of the proposed HIV law:

**“Disclosure by health service provider**

10 (1) A health service provider may disclose information relating to any person’s HIV status where he reasonably believes that it is medically appropriate to

(a) any person he reasonably believes has been or will be exposed to the risk of infection in the course of his duties or emergency services; or

(b) the spouse or sexual partner of the infected person.

(2) A health service provider shall not disclose any information under subsection (1) unless he

(a) has first counselled the infected person regarding the need to notify the spouse or sexual partner and he reasonably believes that the infected person will not inform the spouse or sexual partner; and

<sup>503</sup> See, for instance, Guideline 6 of the UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006. See also Part II of the SADC PF *Model Law on HIV & AIDS in Southern Africa*, 2008.

<sup>504</sup> See, for instance, Key Informant Interviews, Pharmacy, Medicines and Poisons Board, Lilongwe, 13 Jan 2012; Ministry of Justice and Constitutional Affairs, Lilongwe, 12 Jan 2012; WHO, Lilongwe, 13 Jan 2012; CHANCO, Zomba, 20 Feb 2012. See also Focus Group Discussions with Parliamentary Health and HIV Committee, Lilongwe; Youth, Mangochi, Married Men and Women, Mangochi; People Living with HIV, Mangochi; People Living with HIV, Mzimba; Clinicians, Mzimba and Chiefs, Mzimba.

(b) has informed the infected person of this intent to make such disclosure to the spouse or the sexual partner.”

Disclosure violates the right to privacy and dignity<sup>505</sup> and may result in the infringement of other rights due to HIV-related stigma and discrimination against those whose status becomes known. The LEA found the disclosure provision, as presently formulated, to be an unreasonable limitation of rights for the reasons set out below:

*Disclosure for occupational health and safety purposes:* The Commission’s proposals recommend disclosure in circumstances where a person may be exposed to the risk of HIV infection in the course of his duties or emergency services (e.g. the police, defence force or fire brigade). The risk of occupational infection with HIV in any working environment is negligible and can be dealt with by the use of universal infection control procedures, as discussed previously. This has been recognised by the courts of various countries<sup>506</sup> as well as by international and regional guidance of HIV in the working environment.<sup>507</sup> In addition, it is unclear how this provision would be implemented in practice in a way that would serve to reduce the risk of HIV transmission.<sup>508</sup>

*Disclosure to a spouse or sexual partner:* Disclosure to a spouse or sexual partner is recommended by the Law Commission, for the purpose of preventing new infections.<sup>509</sup> However, it is important to recognise that alongside any benefits to public health prevention aims, disclosure of a person’s HIV status may have negative public health outcomes (e.g. by discouraging people, particularly vulnerable populations and key populations, from accessing health care services) and may also lead to HIV-related stigma, discrimination and even violence – for instance against women with HIV.

Most key informants (including those in the health sector) interviewed during the LEA recognised the complexities of disclosures by a health worker without consent,<sup>510</sup>

<sup>505</sup> UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010; Malera G., *Background Paper: Supporting Information for the Development of a Common UNCT Position on the Draft Malawi HIV and AIDS Legislation*, Malawi, 2011.

<sup>506</sup> As early as 1992, the American case of *John Doe v District of Columbia and Others*, 796 F.Supp. 559 (1992) found that “the risk of HIV transmitting the disease through the performance of firefighting functions ‘is like getting struck by a meteor while walking down Constitution Avenue’ in Washington, D.C.”

<sup>507</sup> See, for instance, the ILO, *Recommendations concerning HIV and AIDS and the World of Work*, No. 200 of 2010.

<sup>508</sup> See, for instance, UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010 in this respect at p15.

<sup>509</sup> Malawi Law Commission, *Report of the Law Commission on the Development of HIV and AIDS Legislation*, Malawi, 2008 at p43.

<sup>510</sup> For instance, key informants noted that it was a breach of privacy that may well discourage access to health care, created onerous responsibilities for health care workers and lead to discrimination, including violence

and were opposed to the proposed provision in the bill.<sup>511</sup> Those in favour of disclosure tended to recommend specific conditions and circumstances for such disclosures to take place.<sup>512</sup> The Parliamentary Committee on Health and HIV stated that disclosure to a spouse or sexual partner should only take place in specific circumstances, should be carried out by well-trained health personnel and should be complemented by sensitisation of men.<sup>513</sup> In focus group discussion with selected populations including at district level, a number of populations were in favour of disclosure to a sexual partner or spouse, although discussions and divided opinions within groups also reflected the complexities of issues such as fear of disclosure, the fact that disclosure required a careful process, the impact of disclosure on relationships and the advantages and disadvantages of disclosure by a health care worker.<sup>514</sup>

As a result of these complexities and the need to balance the rights and responsibilities of all parties, international and regional guidance recognises limitations to the right to privacy to protect an identified third party as being reasonable *in very strictly specified circumstances*,<sup>515</sup> some of which are also reflected within the Law Commission's proposed provisions. The SADC PF *Model Law* recommends that disclosures by a health care worker, without consent, only take place in circumstances where there is an immediate risk of HIV transmission to the third party, the person living with HIV has been counselled and is unwilling to disclose, and the health care worker has informed the patient of the disclosure and ensured the patient is not at risk of physical violence.<sup>516</sup>

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against women. Many argued for less restrictive means to be employed to encourage disclosure such as counselling, couple counselling and giving patients more time.

<sup>511</sup> See, for instance, Key Informant Interviews, COWLHA, Lilongwe, date; Ministry of Health, Lilongwe, 24 Jan 2012; Malawi Human Rights Commission, Lilongwe, 9 Dec 2011; Nurses and Midwives Council of Malawi, Lilongwe, 9 Dec 2011; MANASO, Blantyre, 13 Dec 2011; WLSA, Blantyre, 13 Dec 2011; NAC, Lilongwe, 6 Dec and 22 Dec, 2011; World Health Organisation, Lilongwe, 13 Jan 2012; Centre for Human Rights and Rehabilitation, Lilongwe, 13 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Malawi Prisons Service, Zomba, 18 Jan 2012.

<sup>512</sup> See, for instance, Key Informant Interview, Medical Council of Malawi, Lilongwe, 12 Jan 2012 where the respondent stated that counselling was necessary prior to disclosure, and Key Informant Interview with the Ministry of Health, Lilongwe, 7 Dec 2011 who argued for disclosure only in the event of there being an identified party at risk.

<sup>513</sup> See Focus Group Discussion, Parliamentary Committee on Health and HIV, Lilongwe.

<sup>514</sup> See, for instance, Focus Group Discussions, Parliamentary Committee on Health and HIV, Lilongwe; Male Sex Workers, Lilongwe; Female Sex Workers, Lilongwe; Sexually Violated Girls, Lilongwe; Clinicians, Mzimba; Pregnant Women, Mzimba; People Living with HIV, Mzimba. A number of focus groups recognised both the advantages and disadvantages of disclosure by a health worker to a spouse or sexual partner; see for instance Focus Group Discussions, DAC, Mangochi, Chiefs, Mangochi, Married Men and Women, Mangochi, Pregnant Women, Mangochi and People Living with HIV, Mangochi. A few focus groups were primarily opposed to disclosures; see Focus Group Discussions with Chiefs, Mzimba, Youth, Mzimba and Clinicians, Mangochi.

<sup>515</sup> See, for instance, Guideline 3 of the UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, 2006; see also the UNAIDS *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010.

<sup>516</sup> Section 15(4)(b), SADC PF *Model Law on HIV & AIDS in Southern Africa*, 2008. It also provides for disclosure to a sexual partner who is or was at risk in the event that a patient is dead, unconscious or otherwise unable to consent.

The detailed guidance not only supports health workers but also circumscribes the health worker's discretion in determining whether a disclosure is "medically appropriate" in the circumstances. It may also be useful to provide for a counsellor to refer to his or her supervisors to support decision-making regarding disclosure. This guidance is also vital to the interests of justice, since the Law Commission's proposed HIV law provides that a health worker who contravenes this provision may be fined, imprisoned or have his or her license revoked.<sup>517</sup>

## Criminalization of harmful cultural practices

The Law Commission's *Report* proposes that an HIV law criminalises all harmful cultural practices listed in a schedule to the Act, including *chimwanamaye, fisi, hlazi, chijura mphinga, kuchotsa fumbi, chiharo, kuika mwana kumalo, kujura nthowa, kulowa kufa, kulowa ku ngozi, kupimbira, kupondera guwa, kusamala mlendo, kutsuka mwana, mbirigha, gwamula, mwana akule, bulangete la mfumu*.<sup>518</sup>

### "Prohibition of Harmful Practices

4. (1) Any harmful practice listed in the First Schedule is hereby prohibited  
 (2) Any person who contravenes subsection (1) shall be guilty of an offence and shall be liable to a fine of K100,000 and imprisonment for five years.  
 5. Any person who subjects another person to a harmful cultural practice shall be guilty of an offence and shall be liable to a fine of K100,000 and imprisonment for five years."

The Law Commission's proposal restricts the section 26 constitutional right to culture in terms of practices which are considered to be 'harmful' in the context of HIV. The limitation of the right is proposed for purposes of preventing the spread of HIV transmission, as well as for protecting women's and girl children's rights. The LEA found that key informant interviews and focus group discussions supported this proposal,<sup>519</sup> although some key informants advised a cautionary approach, in order

<sup>517</sup>See UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010 regarding the need to review all mandatory sentences in the proposed bill to provide judges with discretion to appreciate the circumstances in each case, at p13. This is supported by the LEA.

<sup>518</sup> See Part III read with First Schedule of the proposed HIV Bill; Malawi Law Commission, *Report of the Law Commission on the Development of HIV and AIDS Legislation*, Malawi, 2008.

<sup>519</sup> See, for instance, Key Informant Interviews, World Health Organisation, Lilongwe, 13 Jan 2012; WLSA, Blantyre, 13 Dec 2011 and NOVOC, Lilongwe, 23 Jan 2012. See also Focus Group Discussions, Sexually Violated Girls, Lilongwe; DAC, Mangochi, Youth, Mangochi; Married men and Women, Mzimba; Pregnant Women, Mzimba. A focus group discussion with chiefs in argued that some cultural practices such as *kulowakufa* or *chokolo* which seemed harmful in fact provided social and financial safety nets for widows in patrilineal marriage systems; they argued that in these cases, HIV testing should be encouraged before engaging in such practices. See Focus Group Discussion, Chiefs, Mzimba; Chiefs, Mangochi.

to ensure that practices were not simply continued ‘underground’ in secret.<sup>520</sup> Suggestions were made to ensure that any regulation or prohibition involved traditional leaders. Integrated approaches to provide widespread education to community members, village elders and traditional authorities on the HIV-related harms of certain practices, and to find ways to adapt and find alternatives to harmful customary laws and practices were recommended.

## Criminalization of HIV transmission

The Law Commission’s *Report* proposes criminalising the intentional and the negligent (or ‘reckless’) transmission of HIV to another person in Part X of the proposed HIV bill.

### “Deliberate Infection with HIV

44. Any person who deliberately infects another person with HIV shall be guilty of an offence and shall be liable to imprisonment for fourteen years.

### Negligent and reckless infection with HIV

45. (1) A person who recklessly or negligently infects another person with HIV shall be guilty of an offence and shall be liable to imprisonment for ten years.

(2) Where the offence under subsection (1) arises out of exposure to infection in the course of employment, then lack of provision of preventive measures by the employer shall be a defence.”

The criminalisation of HIV transmission has been discussed widely at international and regional level and many of the complexities inherent in criminalisation of HIV transmission provisions were recognised by the Law Commission.<sup>521</sup> At national level, criminalisation of HIV transmission it is generally driven by legitimate concerns to respond to the on-going spread of HIV in many countries in face of the perceived failure of HIV prevention efforts, and to punish individuals. Some advocate for criminalisation due to the high levels of HIV infection amongst women, through sexual violence or by partners who fail to disclose their HIV status. While these issues need urgent attention, a closer analysis of the complexities of criminalisation shows that it is unlikely to prevent new infections or reduce women’s vulnerability. In fact, it may harm women and may negatively impact on both public health and human rights.<sup>522</sup>

<sup>520</sup> See, for instance, Key Informant Interview, COWLHA, Lilongwe, 7 Dec 2011. Youth in Mzimba said that some practices already take place in secret, as it is. See Focus Group Discussion, Youth, Mzimba.

<sup>521</sup> Malawi Law Commission, *Report of the Law Commission on the Development of HIV and AIDS Legislation*, Malawi, 2008, p74-75.

<sup>522</sup> ARASA, *Ten Reasons to Oppose Criminalisation of HIV Exposure or Transmission*, 2008. Available at [www.arasa.info](http://www.arasa.info) [Accessed 12 May 2012].

Of the key respondents who commented on criminalisation provisions within the Law Commission's *Report*, most were opposed to it.<sup>523</sup> The Parliamentary Committees on Health and HIV and on Legal Affairs discussed in detail many of the difficulties with criminalising HIV transmission and had divided opinions on the proposals.<sup>524</sup> Issues raised included the possible negative public health impact of provisions, the difficulties of proving transmission of HIV offences and the overburdening on the justice system.

Discussion during focus groups on the issue was not well informed in many instances. Some focus groups supported the use of criminal laws to prosecute transmission of HIV, primarily for purposes of preventing the spread of HIV.<sup>525</sup> Others were more ambivalent and recognised some of the difficulties in criminalising HIV transmission and in particular in criminalising negligent or reckless transmission.<sup>526</sup>

Kanyongolo argues that “*some of the criminal offences created by the various penal statutes restrict the freedom of action of individuals to an extent inconsistent with constitutional and international human rights standards*” and that “*although it is accepted that there may be legitimate grounds on which to limit the enjoyment of human rights, the Constitution requires that limitations of human rights be reasonable, recognised by international human rights standards, necessary in an open and democratic society, and not such as to negate the essential content of a right.*”<sup>527</sup>

In considering the reasonableness or otherwise of the proposed provisions in the Law Commission's *Report*, which limits rights to equality, dignity and privacy, amongst others, it is important to consider various issues:

*Public Health:* There is no evidence that criminalisation of HIV transmission reduces HIV transmission.<sup>528</sup> Instead, there is a real concern that provisions to criminalise HIV transmission may deter people from accessing HIV testing and health care services, particularly since knowledge of HIV status attracts a greater penalty. Prevention services focus on providing information, education and services to all people, in order to encourage responsible sexual behaviour amongst all; however

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<sup>523</sup> See for instance, Key Informant Interviews, MANASO, Blantyre, 13 Dec 2011; CEDEP, Lilongwe, 13 Jan 2012; Society of Medical Doctors, Lilongwe, 23 Jan 2012; Irish Aid, Lilongwe, 24 Jan 2012.

<sup>524</sup> Focus Group Discussions, Parliamentary Committee on Health and HIV, Lilongwe; Parliamentary Committee on Legal Affairs, Lilongwe.

<sup>525</sup> See, for instance, Focus Group Discussions, Youth, Mangochi; Clinicians, Mzimba; Married Men and Women, Mzimba; Sexually Violated Girls, Lilongwe; Pregnant Women, Mzimba, Female Sex Workers, Lilongwe.

<sup>526</sup> See, for instance, Focus Group Discussions, Married Men and Women, Mangochi; People Living with HIV, Mangochi; Youth, Mzimba; Chiefs, Mzimba; People Living with HIV, Mzimba; Male Sex Workers, Lilongwe.

<sup>527</sup> Kanyongolo EF, *Malawi Justice Sector and the Rule of Law*. OSI, 2006.

<sup>528</sup> Global Commission on HIV and the Law, *Risks, Rights & Health*. UNDP, New York, 2012. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 24 July 2012].

criminalisation provisions create the impression that the responsibility for preventing HIV transmission is borne by an HIV-positive person. This undermines HIV prevention efforts.<sup>529</sup>

*“...if one person accuse another person he/she did not disclose his/her HIV status before engaging in sexual intercourse, the accused person also has a right to ask his accuser whether he/she disclosed his/her HIV status. If the sexual intercourse was consensual and nobody disclosed, where is the intended harm?”<sup>530</sup>*

*Stigma and Discrimination:* The LEA found high levels of HIV-related stigma and discrimination. Provisions to criminalise HIV transmission create criminals of people living with HIV, further stigmatising people living with HIV as ‘blameworthy’ individuals in the epidemic. The application of these laws often target vulnerable populations (such as women) and key populations at higher risk of HIV exposure (such as sex workers).<sup>531</sup> Rather than protecting women from HIV infection, criminal laws may in fact impose an additional burden and risk of discrimination or violence upon women, since they are often first to know their HIV status within their relationships when they are tested for HIV at antenatal facilities.<sup>532</sup>

*Legal Application:* Finally, the application of laws to criminalise HIV transmission is extremely difficult. The difficulties inherent in proving the various elements of the criminal offence (including the state of mind of the accused, whether an act exposed a person to HIV and whether HIV was in fact transmitted by one person to the other) lead to inconsistent and sometimes arbitrary judgements.<sup>533</sup> There are also various justifications that may be raised to a charge of transmission such as the fact that the other person consented to the risk (which was recognised by the Law Commission in section 43(1)), amongst others.

In order to deal with these various complexities and to balance health and human rights, international and regional level legal and public health experts have argued that criminalisation of HIV transmission should use existing criminal laws (e.g. assault, murder or public health laws) to prosecute individual cases of malicious and intentional transmission of HIV.<sup>534</sup>

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<sup>529</sup> See ARASA, *Ten Reasons to Oppose the Criminalisation of HIV Exposure or Transmission*, 2008. Available at [www.arasa.info](http://www.arasa.info) [Accessed 12 May 2012]. This issue was also raised by key informants, as set out above.

<sup>530</sup> Respondent, Focus Group Discussion, Parliamentary Committee on Legal Affairs, Lilongwe.

<sup>531</sup> In Europe and the USA, there are many examples of criminal laws being used against minority populations including immigrants from African countries. See Global Commission on HIV and the Law, *Risks, Rights & Health*, UNDP, New York, 2012. Available at [www.hivlawcommission.org](http://www.hivlawcommission.org) [Accessed 15 July 2012].

<sup>532</sup> For a full discussion of the harmful effects of criminalisation of HIV transmission on women, see AIDS Legal Network, ARASA, ATHENA Network, *Ten Reasons why Criminalisation of HIV Exposure or Transmission Harms Women*, ATHENA Network, 2009. Available at [www.arasa.info](http://www.arasa.info) [Accessed 23 July 2012].

<sup>533</sup> *Ibid.*

<sup>534</sup> *Ibid.* At a regional level, see also ARASA, *Ten Reasons to Oppose Criminalisation of HIV Exposure or Transmission*, 2008. Available at [www.arasa.info](http://www.arasa.info) [Accessed 12 May 2012].

Judicial guidance should be provided to the judiciary on evaluating elements of the offence (such as whether the act itself involves a reasonable certainty of transmitting HIV and whether there is proof beyond reasonable doubt that HIV was transmitted from the accused to the complainant during the act) to ensure that high standards of evidence and proof are used in all cases. In addition, a range of other factors should be considered where criminal sanctions are not applicable, such as:

- Where the act itself poses no risk of HIV infection
- Where a barrier method (e.g. male or female condom) was used during sexual intercourse
- Where a person with HIV lacked understanding of how HIV is transmitted at the time of the offence
- Where a person did not disclose his or her HIV status due to a real fear of harm
- In cases of HIV transmission from mother to child during birth or breastfeeding,<sup>535</sup>
- Where there are any other factors (e.g. age, gender, disability, lack of access to services) that may limit a person's ability to reduce the risk of HIV transmission.

### **Additional issues not dealt with in the Law Commission's proposals**

Additional issues outside of the Law Commission's proposals, identified by the literature review, key informants and focus groups included the following:

- The need to provide specific protection for vulnerable populations and key populations at higher risk of HIV exposure, such as women, children, people with disabilities, migrants, sex workers, men who have sex with men and prisoners, amongst others, as is done in the *SADC PF Model Law on HIV and AIDS in Southern Africa, 2008*.
- The need to consider other punitive provisions in law (such as punitive provisions that criminalise sex between men) that exacerbate stigma and discrimination against MSM and block effective responses to HIV and AIDS.
- The need to specifically include protection from a broader range of discriminatory acts found to be commonplace in Malawi, and
- The regulation of HIV-related goods and services, including the use of flexibilities within international intellectual property law to increase access to medicines.<sup>536</sup>

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<sup>535</sup> See UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010 for discussion of proving the various elements of the offence.

<sup>536</sup> See also UNAIDS, *Comments to the HIV and AIDS (Prevention and Management) Bill, 2008 of Malawi* for further details of omissions.

## 8. Conclusions and Recommendations

### What are the major strengths, weaknesses, challenges and gaps within the current legal and regulatory framework?

The need for comprehensive, HIV-specific protection in law that meets both public health and human rights norms and standards cannot be underestimated. The LEA identifies and highlights crucial issues in relation to HIV, law, human rights and public health that require legal responses that are sensitive to as well as responsive to the needs of people.

The LEA examined the legal and regulatory framework in terms of human rights principles, norms and standards established in international, regional and national human rights documents as well as public health and human rights evidence. It found that the current legal and regulatory framework has a number of protective laws and provisions that can apply to HIV and AIDS and to vulnerable and key populations. These various laws have been used to complement each other, in the absence of comprehensive and HIV-specific guidance. The LEA also found that there are a number of laws that pre-date HIV which, although having legitimate aims, are inappropriate for an effective and sustainable HIV response. Based on this, the LEA found that the current legal framework has a number of strengths, as well as gaps and challenges. It underscores the urgent need for clear and specific guidance for HIV, health and human rights.

#### Strengths

The LEA noted the following strengths within the current legal and regulatory framework:

- The existence and application of a practical and protective national, regional and international human rights framework that promotes the rights of all people, especially through the Bill of Rights in the Constitution and the ratification of international and regional human rights instruments by Malawi.
- The existence of a dynamic process of amending the Constitution as and when required, as seen by, for example, the recent constitutional amendment to include the rights of people with disabilities.<sup>537</sup>
- The existence of a dynamic law reform process<sup>538</sup> which has resulted in the passing of the Prevention of Domestic Violence Act (PDVA), 2005, the Deceased Estates (Wills, Inheritance and Protection) Act in 2011 to protect inheritance

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<sup>537</sup> Amendment of 14<sup>th</sup> January, 2010.

<sup>538</sup> Including through the efforts of the legislature, the executive and the Law Commission.

rights and the Child Care Protection and Justice Act in 2012 to protect vulnerable children. Current and planned law reform processes include a review of marriage laws, a review of the Public Health Act as well as a review of various penal provisions, including those relating to unnatural sexual offences.

- The existence of a number of policies and plans that promote rights in the context of HIV and AIDS and/or promote the rights of vulnerable populations and key populations at higher risk of HIV exposure.
- The constructive and healthy dialogue among stakeholders that resulted in the *Report of the Law Commission on the Development of HIV and AIDS Legislation* and continues to encourage increased awareness and on-going discussions amongst stakeholders of legal and regulatory responses for HIV and AIDS.

## Gaps

The assessment of the current legal and regulatory frameworks shows the following gaps and limitations:

- The Constitution protects against discrimination broadly and also includes specific grounds for non-discrimination; however at the time of drafting there was no specific inclusion of HIV and AIDS as a ground for non-discrimination nor is there a clear, justiciable right to health in Chapter IV of the Constitution. Access to health services is a Principle of National Policy within the Constitution but is not listed as a human right.
- Although there are policies that aspire to protect people living with HIV, there is no specific legal protection for people with HIV in various key sectors such as employment, health, education and social assistance. There is no HIV-specific anti-discrimination law, nor is there a broad anti-discrimination law<sup>539</sup> to give effect to constitutional rights to equality and non-discrimination.
- Health laws that pre-date HIV, such as the Public Health Act (currently under review) and the Pharmacy, Medicines and Poisons Act fail to adequately provide for HIV and AIDS.
- Criminal laws continue to be inadequate, in substance and in implementation, in protecting women from all forms of harmful gender norms and gender-based violence, including rape within marriage.
- There are a number of punitive laws that block effective responses to HIV and AIDS specifically for key populations at higher risk of HIV exposure such as laws that criminalise sex between men and laws that allow for the arrest of sex workers.
- Existing complaints and redress mechanisms such as the courts, the Ombudsman, and the Human Rights Commission are inaccessible to the majority of the population. Communities tend to seek justice from traditional structures, which may be based on customary values and principles rather than on human

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<sup>539</sup> Such as the Promotion of Equality and Prevention of Unfair Discrimination Act No 4 of 2000 in South Africa.

rights norms and are therefore sites where stigma and discrimination may be reinforced.

## Challenges

The LEA identified the following challenges:

- There is an urgent and growing need to respond to the HIV epidemic in a way that promotes the health and human rights of all people. Health laws and policies need to be responsive to the needs of the HIV epidemic in Malawi as well as reflective of the strong framework of human rights protected both nationally and in terms of regional and international instruments signed by Malawi.
- While there is growing awareness of human rights in general, there is less specific awareness around HIV-related human rights.
- Religious and cultural values and norms that promote gender inequality and strong attitudes of discrimination against key populations are not sufficiently addressed in the existing discourse around human rights.
- The importance of working with customary systems in addressing laws and practices that have a strong grounding in cultural beliefs cannot be underestimated.

## Recommendations

Based on the analysis of the current and proposed legal and regulatory framework in sections 6 and 7, in terms of human rights principles to which Malawi has committed itself, public health as well as human rights evidence, we recommend the following:

### ***Law Review and Reform:***

The Law Commission has recommended the need for an HIV and AIDS law. The LEA found similarly that there is a need for HIV and AIDS to be specifically provided for in law.

1. The law must protect and promote human rights in the context of HIV and AIDS and prohibit all forms of discrimination on the basis of actual or perceived HIV status. Protection from HIV-related discrimination should be included within any proposed HIV law as was recommended by the Law Commission. Existing human rights and constitutional guarantees should be enforced. The State may also wish to consider an amendment to the Constitution to include HIV as a prohibited ground of non-discrimination.
2. In particular, an HIV law should specifically prohibit common forms of HIV-related discrimination, as was recognised by the Law Commission in the

case of discrimination within the health, education and employment sector.<sup>540</sup> The law should consider specifically prohibiting:

- All forms of discrimination within the health care sector
- All forms of discrimination within the employment sector
- All forms of discrimination within the education sector
- All forms of discrimination in access to social assistance (such as grants, subsidies, loans and services)
- Discrimination in terms of access to goods and services
- Discrimination in terms of access to property and inheritance, and
- Discrimination in terms of custody of children.<sup>541</sup>

3. There must be specific protection in law for the health rights of all people in the context of HIV and AIDS. This protection may be included in an HIV-specific law and may also be integrated within the review of the Public Health Act and the Pharmacy, Medicines and Poisons Act. The Patents Act should be amended in order to comply with the TRIPs Agreement and include specific directives on utilising TRIPS flexibilities in relation to public health for increased access to good quality and affordable generic medicines. In addition, the State may wish to consider a constitutional amendment to provide for a clear right to health within the Constitution.
4. Patient's health rights must include, amongst others:
  - the right to HIV testing only with voluntary and informed consent and pre- and post-test counselling
  - the right to medical confidentiality and
  - the right to access appropriate prevention, treatment, care and support services, including psycho-social support, for all people without discrimination, including populations at higher risk of HIV exposure
5. HIV testing without voluntary and informed consent must be prohibited.
6. Law must include provision for the disclosure of a person's HIV status only in carefully defined circumstances in terms of which a qualified health care professional may disclose the HIV status of a patient to an identified, third party at risk after following step-by-step procedures, and after ensuring that there is no risk of harm to the patient.<sup>542</sup>

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<sup>540</sup> Appendix A, Part VI, VIII and IX, HIV and AIDS Prevention and Management Bill; Malawi Law Commission, *Report of the Law Commission on the Development of HIV & AIDS Legislation*, Malawi, 2008.

<sup>541</sup> See, for instance, Part IV, Chapter 1, SADC PF, *Model Law on HIV & AIDS in Southern Africa*, 2008.

<sup>542</sup> Guideline 3, UNAIDS and OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS, Geneva, 2006.

**SADC PF Model Law on HIV & AIDS for Southern Africa, 2008**

Section 15 provides as follows:

“(3) A person providing treatment, care or counselling services to a person living with HIV may encourage that person to inform his or her sexual partner(s) of his or her HIV status. That person shall, upon request, receive or be referred for psychological, social or legal support to facilitate disclosure.

(4) A person providing treatment, care or counselling services to a person living with HIV may notify a third party of the HIV status of that person only where:

(a) the notifying person is requested by the person living with HIV to do so; or

(b) all the following circumstances exist:

(i) the third party to be notified is at immediate risk of HIV transmission; and

(ii) the person living with HIV, after appropriate counselling, does not personally inform the third party at risk of HIV transmission; and

(iii) the person providing treatment, care or counselling services has:

(aa) properly and clearly informed the patient that he or she intends to notify the third party under the circumstances; and

(bb) ensured that the person living with HIV is not at risk of physical violence resulting from the notification; or

(c) all the following circumstances exist:

(i) the person living with HIV is dead, unconscious or otherwise unable to give consent to the notification; and

(ii) is unlikely to regain consciousness or the ability to give consent; and

(iii) in the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner(s).

(5) In the case of notification provided under subsection (4), the person providing treatment, care or counselling services shall ensure that follow-up services in the form of counselling are provided to those involved, as necessary.”

7. The law must set out state obligations and responsibilities to provide for the regulation of and access to affordable, quality health care services for the prevention, treatment, care and support of HIV, the details and implementation of which are to be enumerated in policies and operational plans. Legal, policy and/or administrative barriers to the provision of effective health care for HIV should be removed, in order to ensure provision of health services for all, including criminalised populations. State responsibilities should include taking all reasonable measures to provide important goods, services and information including targeted services for vulnerable populations (e.g. prevention of mother-to-child transmission, post-exposure prophylaxis for occupational exposure and sexual abuse) and key populations (e.g. targeted health services for men who have sex with men, criminal laws notwithstanding) and provision for recent and future medical and scientific advancements (such as medical male circumcision). It should furthermore include reference to measures to

increase awareness of and to use the flexibilities under the TRIPS Agreement to increase access to medicines.

8. Law must include provision for the management of HIV within *all* working environments, including for members of the armed forces, domestic workers and those in the informal sector. Provision for HIV in the workplace in law must be in accordance with principles of equality, non-discrimination, confidentiality, voluntary HIV testing and counselling, procedures to ensure safety within the working environment (including access to post-exposure prophylaxis in the event of an occupational exposure<sup>543</sup>) and compensation for occupational infection. Consideration should be given to what may be set out in law, and what may be detailed in policies and programmes, with the principles and legal obligations carefully set out in law, and the details of HIV workplace responses set out in a workplace policy and programmes. This may be done by:
- Including a section on HIV and employment issues within an HIV law, as was recommended by the Law Commission in their *Report of the Law Commission on the Development of HIV & AIDS Legislation*,<sup>544</sup> setting out the obligations of employers and employees with respect to equality, non-discrimination, confidentiality, voluntary HIV testing with informed consent and counselling, protection from and compensation for occupational infection.
  - Ensuring that there is a prohibition of pre-recruitment HIV testing in all workplaces, including those of the armed forces, in law and in policy
  - Reviewing the Employment Act and Public Service Act to include HIV as a prohibited ground for non-discrimination in the working environment and to prohibit pre-employment HIV testing, denial of employment and unfair dismissals on the basis of actual or perceived HIV status
  - Reviewing the Occupational Safety and Health Act and the Worker's Compensation Act to integrate measures to reduce the risk of HIV transmission within the working environment and to provide for compensation in the event of occupational infection with HIV
  - Enacting the Workplace Policy on HIV and AIDS, possibly in the form of regulations to the Employment Act and Public Service Act in order to strengthen their legal status, to provide for the management of HIV and AIDS in all working environments in accordance with obligations and recommendations.

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<sup>543</sup> See UNAIDS, *Comments to the HIV & AIDS Prevention and Management Bill, 2008 of Malawi*, UNAIDS Secretariat, Geneva, 2010.

<sup>544</sup> See Appendix A, Part VIII, proposed HIV and AIDS Prevention and Management Bill, Malawi Law Commission, *Report on the Development of HIV and AIDS Legislation*, Malawi, 2008.

**SADC PF Model Law on HIV & AIDS in Southern Africa, 2008****“23. The right to work**

(1) Any form of discrimination in the workplace against a person, his or her partner(s) or close relatives on the sole account of his or her actual or perceived HIV status, shall be prohibited.

(2) Employers shall initiate disciplinary procedures against any employee who discriminates against another employee on the account of the latter’s actual or perceived HIV status. The person who suffered the discrimination may also undertake legal proceedings against that employee.

(3) The employer shall take all necessary measures to implement the universal precautions to reduce the risk of HIV infection through accidental exposure to HIV in the workplace.

(4) In case of accidental exposure to HIV infection occurring in the workplace, the employer shall ensure free access to post-exposure prophylaxis and counselling for the employee in accordance with [relevant national and international guidelines].

(5) A person’s HIV status, the status of his or her partners, or that of his or her close relatives alone shall not constitute a reason for refusal of employment or termination of employment. Fitness to work shall be the relevant standard in all matters related to employment.

(6) HIV testing of a job seeker or an employee for the purpose of recruitment, promotion or any other reason is prohibited.

(7) The employer and other staff members shall not disclose the HIV-status of a job seeker, employee or co-worker if they are aware of that HIV status.

(8) Employers, in consultation with the employee and its representative, shall take measures to reasonably accommodate employees with AIDS-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks and time off for medical appointments.

(9) When employees with AIDS-related illness are no longer able to fulfil their duties on the account of poor health, they shall benefit from rights pertaining to employees affected by a long-term illness.”

10. The law must define and include specific protection for vulnerable populations and key populations at higher risk of HIV exposure and in particular those commonly identified by the LEA such as women, children, people with disabilities, migrants, refugees and internally displaced persons, prisoners, sex workers and men who have sex with men.
11. Separate clauses within HIV law may assist in setting out the specific rights and measures to respond to the needs of vulnerable populations and key populations at higher risk of HIV exposure.
12. For example, in the case of women, it is important that an HIV law contains the following explicit provisions set out below, amongst other things:
  - Recognition of women as a vulnerable population

- Specific protection of the rights of women to equality and non-discrimination on the basis of HIV and AIDS, and equality within employment and economic opportunity, marriage, access to and ownership of property, inheritance and custody of children
  - Protection from harmful cultural practices that place women at higher risk of HIV exposure including early marriages
  - Protection from gender-based violence, including sexual violence and all forms of rape, and access to appropriate and timely health care services (including post-exposure prophylaxis) in the event of sexual assault.
  - Specific protection of the rights of women to sexual and reproductive health care without discrimination
13. In the case of children, it is important that an HIV law provides for, amongst other things:
- The recognition of children as a vulnerable population in need of specific protection and targeted services
  - Protection of children's rights to equality and non-discrimination on the basis of HIV and AIDS, and equality in terms of access to health services, social services, inheritance and property rights.
  - Children's rights to access to appropriate HIV information, education and prevention services without discrimination
  - Children's rights to access to treatment, care and support for HIV without discrimination, including care and support for children orphaned by AIDS.
  - The right to access independent and voluntary consent to HIV testing and to obtain related health care services when a child has the capacity to understand and appreciate so doing (13 years is recommended by the Law Commission.<sup>545</sup>)
14. People with disabilities should be specifically provided for in an HIV law to ensure, amongst other things:
- Their recognition as a vulnerable population in need of special protection and targeted health care services
  - The protection of their right to equality and non-discrimination on the basis of their actual or perceived HIV status as well as in terms of access to health care services, social services, employment and economic opportunity and other rights
  - The protection of people with disabilities from violence, including sexual violence, and access to appropriate and timely health care

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<sup>545</sup> See Appendix A, Section 13, HIV and AIDS (Prevention and Management) Bill, Malawi Law Commission, *Report of the Law Commission on the Development of HIV & AIDS Legislation*, Malawi, 2008.

- services (including post-exposure prophylaxis) in the event of sexual assault.
- Specific provision for the rights of people with disabilities to accessible and appropriate health care services, including HIV-related prevention, treatment, care and support and access to sexual and reproductive health care without discrimination
15. Other key populations at higher risk of HIV exposure, such as prisoners, men who have sex with men and sex workers, should be specifically provided for in an HIV law to ensure, amongst other things:
- Their recognition as a key population at higher risk of HIV exposure, in need of special protection and targeted health care services
  - Protection from all forms of violence, including sexual violence, targeted at key populations
  - The protection of their rights to equality and the prohibition of discrimination on any grounds, including protection for their equality rights in access to health care and social services
  - Provision for their access to appropriate and accessible HIV-related health care, including prevention, treatment, care and support services, without discrimination, to meet their particular needs.
16. In addition, other provisions within law, such as provisions regarding HIV-related information, education, prevention, treatment, care and support, should make specific mention of the need to identify and target the needs of key populations. Likewise, provisions regarding information and education campaigns to reduce stigma and discrimination and to increase awareness of rights should include a focus on the rights of all vulnerable and key populations as well as targeting these populations for education.

**SADC PF Model Law on HIV & AIDS in Southern Africa, 2008:**

**“3. Interpretation**

In this Model Law:

“Vulnerable or marginalised groups” refers to members of groups such as children, women and girls, sex workers, injecting drug users, refugees, immigrants, sexual minorities, prisoners, internally displaced persons, indigenous and mobile populations.

**CHAPTER II: CHILDREN LIVING WITH OR AFFECTED BY HIV**

**24. Protection of rights**

(1) Children living with or affected by HIV, including orphans, shall enjoy all the rights under the law and in international instruments pertaining to children, in particular the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

(2) When exercising their rights, children may not be subjected to any discrimination on the account of their actual or perceived HIV status, the status of their parents or legal guardians or close relatives.

(3) The State shall ensure the protection of children against abuse and exploitation and adopt specific measures to safeguard inheritance rights, land tenure and property rights for children.

#### **25. Care of children orphaned by AIDS**

(1) The State shall ensure that any surviving children of persons deceased due to AIDS-related illnesses are given appropriate alternative care, including through foster care or adoption. If these are not available, children shall be cared for in public or private institutions registered with and regulated by the State.

(2) In deciding what type of alternative care shall be ensured to children orphaned by AIDS, the best interest of the children shall be the primary consideration.

(3) The State shall ensure that quality public and private institutional care facilities are available and function effectively for the purpose of subsection (1).

(4) When in spite of all these measures, children are living in a child-headed household, they shall be placed under the supervision of an adult person designated by [the relevant court].

(5) Children orphaned by AIDS and children living in child-headed household shall receive the necessary support and assistance from the State. This assistance and support shall include access to health care, education and the facilitation of their access to all other social assistance schemes available in the State.

### **CHAPTER III: PROTECTION OF WOMEN AND GIRLS**

#### **26. Information and education**

(1) Notwithstanding the provisions of Part II of this Model Law, women and girls, regardless of their marital status, shall have equal access to adequate and gender sensitive HIV-related information and education programmes, means of prevention and health services including women-specific and youth-friendly sexual and reproductive health services for all women of reproductive age and women living with HIV.

(2) Information and education programmes provided under subsection (1) shall ensure the sensitisation of men on HIV prevention, gender-based violence, gender inequality and challenge dominant / traditional conceptions of masculinity.

#### **27. Protection against violence**

(1) The State shall ensure that women and girls are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health.

(2) No marriage or other relationship shall constitute a defence to a charge of rape.

(3) Women have the right to refuse sexual acts, including those that put them at risk of infection with HIV or any other sexually transmitted infection. No marriage or other relationship shall deprive them of that right.

#### **28. Equality and non-discrimination**

(1) Women shall have equal legal rights in all areas including in matters such as marriage, divorce, inheritance, child custody, property and employment, and shall not be discriminated against on the ground of their sex, or their actual or perceived HIV status.

(2) The [Ministries responsible for health, gender and/or women affairs] in collaboration with and key national and local stakeholders, must develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of women and girls in the context of HIV. With the aim of promoting gender equality and the full enjoyment by women and girls of their human rights, these strategies, policies and programmes shall address issues such as:

- (a) equality of women and men, and girls and boys in all aspects of public and private life;
- (b) the sexual and reproductive rights and responsibilities of women and men, including women's right to refuse sex and the right and ability to negotiate safer sex and the right to access health and reproductive services independently;
- (c) men's responsibilities to take equal responsibility for sexual and reproductive health and outcomes and to avoid rape, sexual assault and domestic violence, inside and outside marriage;
- (d) strategies for increasing educational, economic, employment and leadership opportunities for women;
- (e) sensitising service providers and improving health care and social support services for women; and
- (f) strategies for reducing inequalities entrenched in formal, customary and religious laws and customs with respect to marriage, divorce, property, custody of children, inheritance and others.

#### **CHAPTER IV: PRISONERS**

##### **29. Prevention of HIV transmission**

(1) Notwithstanding the provisions of Part II of this Model Law, prison authorities shall ensure access to information and education about the causes, modes of transmission, means of prevention and management of HIV and AIDS messages on HIV and AIDS, as well as the actual provision of means of HIV prevention, including condoms, water-based lubricants and clean injecting drug equipments to prisoners.

(2) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this Model Law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

##### **30. HIV testing and counselling**

(1) No prisoner may be subjected to compulsory HIV testing.

(2) The rules related to informed consent, pre-test information and post-test counselling in this Model Law apply equally to prisoners.

##### **31. Rights of prisoners living with HIV**

(1) A prisoner living with HIV shall enjoy the same rights recognised to prisoners living with other illnesses. Prisoners living with HIV are entitled to free health care services including antiretroviral therapy and medication for the management of all opportunistic infections.

(2) All information on the health status and health care of prisoners shall be confidential. All health care procedures shall be designed to preserve the confidentiality of prisoners. Health information, including HIV status, shall only be disclosed in accordance with section 18(2) of this Model Law.

(3) Prison authorities shall ensure that the health of people living with HIV in prisons is regularly monitored by health authorities and that they receive medical follow-up, as well as adequate treatment when necessary.

##### **32. Prohibition of isolation**

(1) Subject to subsection (2), no prisoner may be isolated from prisoners on the account of his or her actual or perceived HIV status.

(3) In the event of violence and abuse or real risk thereof, a prisoner living with HIV may be temporarily isolated from other prisoners. The decision by the [Official in charge of the prison or detention facility] to temporarily isolate a prisoner shall be confirmed by the [competent judicial authority] within a [reasonable period], failing which the measure of isolation shall be lifted.

**33. Protection against violence**

(1) Any prisoner shall be entitled to be protected against violence, including sexual violence, and shall retain his or her right to institute legal proceedings, notwithstanding disciplinary sanctions against the author of the act of violence. The competent authorities shall ensure that the necessary measures are taken to that end.

(2) Prison authorities shall investigate and resolve all complaints of rape and sexual violence in prisons.

**34. Compassionate release on medical grounds**

(1) Any person serving any sentence in a prison and who, based on the written evidence of the medical practitioner treating him or her, is diagnosed as being in the final stage of the AIDS disease should be granted compassionate early release by [the relevant authority] to die a consolatory and dignified death.

(2) Prison authorities should expeditiously identify those persons whose state of health may qualify for compassionate release under subsection (1) and inform them of the possibility of early release. Prison authorities shall assist prisoners who are unable to apply for compassionate release themselves with such applications

(3) [The relevant authorities] shall, without delay, process applications for compassionate release.

**35. HIV and AIDS policy for prisons**

The [relevant ministries and government departments responsible for prisons and health] shall formulate and ensure the effective implementation of policies and guidelines to address HIV in prisons in accordance with this Model Law.

**East African Community HIV & AIDS Prevention and Management Bill, 2010<sup>546</sup>****“36. Persons with disabilities**

(1) Notwithstanding the generality of other provisions of this Act, the Government shall ensure that persons with disabilities living with or affected by HIV are protected from all forms of discrimination and are provided with appropriate support, care and treatment.

(2) The Minister, in consultation with relevant stakeholders shall develop and implement strategies, policies and programmes to promote and protect the health of persons with disabilities living with or affected by HIV including-

- (a) increasing access by persons with disabilities to reproductive health information, programmes and services;
- (b) recognizing the different types of disabilities and their different requirements as pertains to HIV related information, prevention, treatment, care and support services
- (c) adopting a framework, policies and strategies to support persons with disabilities to ensure respect for their human rights and access to quality HIV and AIDS information services, social protection and livelihood programmes;
- (d) ensuring the active participation of persons with disabilities in the design, development, implementation and review of HIV and AIDS programmes and services;
- (e) maintaining up to date gender and age disaggregated data on persons with disabilities in order to adequately plan for them; and
- (f) putting in place measures that challenge negative concepts and attitudes about disability and working to eradicate the marginalization of persons with disabilities.”

<sup>546</sup> The Bill was passed by the East African Legislative Assembly on April 23, 2012; the Bill in its final form is not yet available, however its contents are substantially those of the 2010 draft bill cited here.

17. Health law must include protection for the rights of all research participants, including provision for the specific vulnerabilities of participants in HIV research. The specific rights of research participants in HIV research may be specified in an HIV law; these rights should also be integrated into broader protection of research rights within the review of the Public Health Act, and/or an amendment of the Pharmacy, Medicines and Poisons Act.

**SADC PF Model Law on HIV & AIDS in Southern Africa, 2008**

**“37. Requirements for research and clinical trials**

No person may undertake HIV-related human biomedical research or a clinical trial on another person, or on any tissue or blood removed from such person, unless such research conforms to the requirements under this Model Law and [relevant national regulation].

**38. Consent to research and clinical trial**

(1) No person may undertake HIV-related human biomedical research or clinical trial on another person or on any tissue or blood removed from such person except:

- (a) with the written informed consent of that other person; or
- (b) if that other person is a child or a mentally incapacitated person, with the written informed consent of a parent or the legal guardian of the child or that person.

(2) The person whose consent is to be obtained under subsection (1) shall be adequately informed of the aims, methods, anticipated benefits and the potential risks and discomforts of the research.

(3) No research or clinical trial referred to under subsection (1) shall take place without the approval of the ethical research body established under section 39 of this Model Law or under [relevant national legislation].

**39. Ethical research body**

(1) The State shall establish an ethical research body constituted, among others, by persons with relevant expertise and experience in the field of biomedical, social and clinical research.

(2) The mandate of the ethical research body established under subsection (1) shall include reviewing and, when appropriate, approving applications for conducting HIV-related human biomedical research or a clinical trial on persons, or on any tissue or blood removed from such persons.

(3) When reviewing applications under subsection (2), the ethical research institution shall take into account the provisions of this Model Law and relevant national legislation, as well as international human rights and ethical norms and principles applicable to human biomedical research or clinical trial.”

18. Criminal laws relating to violence, including sexual violence, as well as policies to manage those who have been sexually violated, should be strengthened. The Prevention of Domestic Violence Act’s definition of sexual abuse and the Penal Code’s definition of rape should be reviewed to ensure that crimes relating to non-consensual penetrative sex are gender-neutral and that they apply and are enforced within all domestic partnerships and marriages. Policies and referral mechanisms between law enforcement

agents and health care providers should be strengthened to ensure timely access to post-exposure prophylaxis in the event of a sexual assault.

19. Specific offences to criminalise HIV transmission should be excluded from law, as recommended internationally as well as within the *SADC PF Model Law on HIV & AIDS in Southern Africa, 2008* and the *EAC HIV and AIDS Prevention and Management Bill, 2012*.<sup>547</sup> Existing criminal laws should be applied to specific cases of malicious and intentional HIV transmission.
20. In the event of sexual violence such as rape, sexual assault or defilement that results in the transmission of HIV or creates a significant risk of HIV transmission, the HIV-positive status of the offender may be considered an aggravating factor in sentencing if the person knew he or she was HIV-positive at the time of committing the offence. Provision in law for compulsory HIV testing of an accused or an offender should not be considered to constitute evidence of knowledge of HIV status.
21. Guidelines should be developed to support law enforcement agents and the judiciary to ensure that criminal sanctions are applied reasonably, where elements of foreseeability, intent, causality and consent are clearly and legally established and where considerations and circumstances that mitigate against criminal prosecutions (such as the age, gender or disability) or aggravation of sentence are considered.

**UNAIDS Policy Brief: Criminalisation of HIV Transmission, 2008**

“Criminal law should not be applied to cases where there is no significant risk of transmission or where the person:

- did not know that s/he was HIV positive;
- did not understand how HIV is transmitted;
- disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
- did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
- took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts; or
- previously agreed on a level of mutually acceptable risk with the other person.”

22. The detailed review of various other provisions within the Law Commission’s proposed HIV bill including technical suggestions for strengthening legislative drafting of proposed provisions contained within the *UNAIDS Comments on the HIV & AIDS Prevention and Management Bill, 2008 of Malawi* should be referred to in the development of HIV law.

<sup>547</sup> Passed by the East African Legislative Assembly on 23<sup>rd</sup> April, 2012. The Bill has specifically excluded the criminalisation of HIV transmission or exposure.

23. Harmful cultural and religious practices that increase HIV risk must be reviewed, in collaboration with communities, with a view to prohibition as recommended by the Law Commission. This should be pre-empted by a process of consultation and sensitisation of traditional authorities, in order to seek ways to adapt customary practices to promote health and human rights. Specific provision for on-going education with communities should be made in law.
24. Laws in the Penal Code that act to prohibit consensual sex work must be reviewed with a view to repeal and 'public nuisance' laws must not be used to punish, penalise or harass sex workers. Efforts should be taken to ensure that sex workers are supported to access appropriate and non-discriminatory health care services in the interim, that sex workers have safe working conditions and that training and sensitisation of law enforcement officials takes place to ensure they do not violate the rights of sex workers.
25. Laws criminalising consensual sex between adults of the same sex must be reviewed with a view to repeal. Current processes underway in the Law Commission to review the laws criminalising unnatural sexual offences within the Penal Code should be supported by the LEA, and participatory national debate on the issue should be encouraged to explore the context, cultural and religious values and human rights issues around same-sex relationships. Efforts should be taken to ensure that men who have sex with men are supported to access appropriate and non-discriminatory health care services in the interim and that law enforcement officials do not violate their rights or create barriers to their organisations.
26. The Immigration Act must be reviewed to ensure that its provisions are not inappropriately applied to HIV, and to review the travel restrictions on men who have sex with men and sex workers alongside the review of relevant punitive laws relating to same-sex relationships and sex work. The Law Commission's review of the Immigration Act should be supported by the LEA, to ensure that considerations relevant to HIV are integrated into the review.
27. The promulgation of the Marriage and Divorce Bill should be expedited to create a uniform system of rights within marriage and to prohibit early marriages.
28. Current and future processes to review statutes that may impact on HIV and AIDS (such as the Public Health Act, the Patents Act and the Penal Code in the case of unnatural sex offences) should take into account the findings of this LEA, in order to ensure the inclusion provisions that protect rights, reduce stigma and discrimination and promote universal access to HIV prevention, treatment, care and support.

29. The LEA recommends that Malawi, as a state party to international, regional and sub-regional human rights instruments ensure that important human rights instruments are ratified and are domesticated.

## **Access to Justice and Law Enforcement**

30. Stigma and discrimination reduction campaigns should be strengthened amongst communities as well as amongst service providers (e.g.. health care workers) and law enforcement officials, to reduce HIV-related discrimination as well as discrimination against vulnerable and key populations at higher risk of HIV exposure.
31. Community awareness and education campaigns on HIV, law and human rights (“Know Your Rights” campaigns) should be intensified, including the development of media in local languages on HIV and human rights issues. Programmes should ensure that they also specifically target and include information on issues and laws relevant to all vulnerable and key populations and on new, protective laws and policies (e.g. the Disability Act).
32. Human rights education and training should be strengthened in various sectors including in the school curricula, in the health system, within the working environment and amongst law enforcement officials.
33. Information and sensitisation campaigns should be introduced for judicial officers, to ensure on-going and updated information for all judicial officers on HIV and human rights issues.
34. Information and sensitisation campaigns should be introduced for law and policy-makers, to support the efforts of all decision-makers to develop supportive and effective legal and regulatory frameworks for HIV and AIDS.
35. All existing and planned processes to strengthen access to justice need to take into account and integrate the findings of the LEA; for instance:
- Legal support services to provide HIV, law and human rights information and assistance with bringing complaints before courts and other mechanisms need to be increased. CSOs currently providing such services need on-going support, and other CSOs and mechanisms need capacity building and resource allocation in order to provide likewise. The Legal Aid Bureau legislation should be implemented to increase access to legal support.
  - Lawyers, legal support services and judicial officers require capacity building on the rights of people in the context of HIV and AIDS

- Traditional leaders and traditional justice systems require information, education and training on HIV, law and human rights issues and on the rights of vulnerable and key populations
  - Judicial officers require training and sensitisation on the difficulties people living with HIV and AIDS, as well as vulnerable and key populations at higher risk of HIV exposure, face in accessing services such as fear of stigma and discrimination, fear of breaches of confidentiality and fear of worsening health care during long and stressful court cases.
  - Protection of confidentiality within HIV-related court cases should be provided for. HIV-related litigation should be expedited where possible.
36. All existing and planned processes to strengthen law enforcement need to take into account and integrate the findings of the LEA; for instance:
- Law enforcement officials and staff of Victim Support Units need information, education, training and sensitisation on the rights of people in the context of HIV and AIDS, as well as the rights of all vulnerable and key populations.
  - Law enforcement officials need increased information, education, training and strengthened referral mechanisms to ensure appropriate responses to crimes that increase vulnerability to and risk of exposure such as rape, sexual assault, gender-based violence, harmful cultural practices and property-grabbing.
  - Law enforcement officials who abuse the rights of vulnerable and key populations (e.g. women, sex workers, men who have sex with men) should be held accountable for their actions.

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7. DFID
8. Dignitas International
9. European Union Office, Malawi
10. Federation of People with Disability in Malawi (FEDOMA)
11. GIZ, Malawi Office
12. ILO Office, Malawi
13. Industrial Relations Court
14. Irish Aid, Malawi Office
15. Johns Hopkins Project, College of Medicine
16. Kamuzu College of Nursing
17. Law Commission
18. Law Department, Chancellor College
19. Legal AID
20. MACRA
21. Malawi Health Equity Networks
22. Malawi Human Rights Commission
23. Malawi Interface AIDS Agency (MIAA)
24. Malawi Judiciary, High Court
25. Malawi Judiciary, Magistrate Court
26. Malawi Law Society
27. Malawi Network for AIDS Service Organizations (MANASO)
28. Malawi Prisons Services
29. MANET+
30. Mangochi District Assembly
31. Medical Council of Malawi
32. Medicin Sans Frontieres
33. Ministry of Health, Department of Clinical Services
34. Ministry of Health, Department of HIV and AIDS
35. Ministry of Home Affairs, Malawi Services Police
36. Ministry of Information & Civic Education
37. Ministry of Justice and Constitutional Affairs
38. Ministry of Labour
39. Ministry of Labour
40. NAPHAM

41. National AIDS Commission
42. National Organization of Nurses and Midwives
43. Norwegian Embassy, Malawi Office
44. NOVOC
45. Nurses and Midwives Council of Malawi
46. Parliamentary Committee on Health
47. Parliamentary Committee on HIV and AIDS
48. Parliamentary Committee on Legal Affairs
49. Pharmacy, Medicines and Poisons Board
50. Registrar Generals Office
51. Retired Senior Member of Cabinet and Parliamentary Committee on HIV and AIDS
52. Society of Medical Doctors
53. UNAIDS
54. UNFPA Office, Malawi
55. UNICEF Office, Malawi
56. WHO Office, Malawi
57. WLSA Malawi
58. World Bank, Malawi Office

## **11. Annexure 3: Focus Group Discussions**

1. Chiefs (Mzimba)
2. Chiefs (Mangochi)
3. Clinicians (Mangochi)
4. Clinicians (Mzimba)
5. Female Sex Workers (Lilongwe)
6. Health Surveillance Assistants (HSAs) (Mangochi)
7. Health Surveillance Assistants (HSAs) (Mzimba)
8. Male and Female Youth (Mangochi)
9. Male Sex Workers (Lilongwe)
10. Married Men & Women (Mzimba)
11. Married Men and Women (Mangochi)
12. Men who have sex with men (Blantyre)
13. Men who have sex with men (Lilongwe)
14. People Living with HIV or AIDS (Mangochi)
15. People Living with HIV or AIDS (Mzimba)
16. People with Disabilities (Blantyre)
17. Pregnant Women (Mangochi)
18. Pregnant Women (Mzimba)
19. Sexually Violated Girls (Lilongwe)
20. Youth (Mzimba)