



We Will Still Live

Confronting Stigma and Discrimination Against
Women Living with HIV/AIDS in Malawi



Leitner Center
for International Law and Justice

AT FORDHAM LAW SCHOOL, NEW YORK CITY

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“The protection of the uninfected majority is inextricably bound to upholding the rights of people living with HIV/AIDS.”

Jonathan Mann

Introduction

Worldwide, 60% of new HIV transmissions are to women.¹ This is most evident in sub-Saharan Africa, home to three quarters of all HIV-positive women 15 years and older.² Women and girls in Africa make up 59% of adults and 75% of young people between the ages of 15 and 24 living with HIV/AIDS.³ Internationally, the annual female AIDS death toll is projected to rise to almost 1.9 million by 2015, eclipsing the male death toll by over 23%.⁴

In Malawi, the feminization of HIV/AIDS is particularly evident. Over 14% of Malawian adults aged 15–49 are HIV positive, one of the highest HIV prevalence rates in the world.⁵ Malawian women account for 57% of HIV/AIDS cases.⁶ In the 15–24 age group, more than twice as many women are infected as men (14.5% vs. 6.5% respectively).⁷ The average life expectancy of women has fallen to 39.6 years slightly below that of Malawian men.⁸

Twenty-five years after the AIDS epidemic exploded onto the world stage, HIV/AIDS-related stigma and discrimination continue to flourish. Women living with HIV/AIDS (WLWHA) in Malawi experience verbal attacks, social isolation, and discrimination in access to social welfare resources such as federal fertilizer subsidies, food-for-work and cash-for-work public works programs, and micro-credit loans. Women living with HIV/AIDS also report positive experiences of empathy, support and acceptance from their families and communities. These reports, however, are exceptions to the more common treatment of people living with HIV/AIDS (PLWHA) as “useless,” “weak” and “already dead.”

These conditions persist despite Malawi’s commitments under international law to protect people

living with HIV/AIDS from discrimination. Malawi has signed and ratified the International Covenant on Civil and Political Rights (ICCPR),⁹ the International Covenant on Economic, Social, and Cultural Rights (ICESCR),¹⁰ the Convention on the Elimination of all forms of Discrimination against Women (CEDAW),¹¹ and the African Charter on Human and People’s Rights,¹² which guarantee people living with HIV/AIDS freedom from discrimination. Taken together, these instruments reflect Malawi’s obligation to confront discrimination against women living with HIV/AIDS in Malawi, who disproportionately suffer the devastating effects of HIV/AIDS.

This report culminates a year-long project undertaken by the Leitner Center for International Law and Justice at Fordham Law School to study the impact of stigma and discrimination on the lives of women living with HIV/AIDS in Malawi in light of these international commitments. In July 2007, the Malawian government launched an HIV-testing campaign, distributing over 300,000 testing kits throughout the country and urging all sexually active people, especially those in rural areas, to take an HIV test.¹³ Despite the government’s efforts to encourage HIV testing, stigma blocks prevention programs.¹⁴ Fear of

1 International Labour Organization, *Women, girls, HIV/AIDS and the world of work*, 1,

<http://www.ilo.org/public/english/protection/trav/aids/publ/women-iloaids-brief.pdf> [hereinafter ILO Brief].

2 UNAIDS, Joint Programme on HIV/AIDS, *2006 Report on the Global Aids Epidemic*, at 15. (2006) [hereinafter UNAIDS Report].

3 *Id.*

4 ILO Brief, *supra* note 1 at 4.

5 See UNAIDS, *Women, Girls and HIV/AIDS in Malawi Fact Sheet*, available at <http://womenandaids.unaids.org/documents/factsheetmalawi.pdf> [hereinafter UNAIDS Fact Sheet].

6 *Id.*

7 *Id.*

8 Malawian men have a life expectancy of 40 years. United Nations Development Programme, *Human Development Report 2006: Malawi Data Sheet*, § 24, available at http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_MWI.html [hereinafter *Malawi HDR Data Sheet*].

9 International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 [hereinafter ICCPR]. The Covenant was adopted on December 19, 1966, and entered into force on March 23, 1976.

10 International Covenant on Economic, Social and Cultural Rights, 999 U.N.T.S. 3 [hereinafter ICESCR]. The Covenant was adopted on December 19, 1966, and entered into force on January 3, 1976.

11 Convention on the Elimination of all Forms of Discrimination Against Women, G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46 (1980) [hereinafter CEDAW]. The Convention was adopted on December 18, 1979, and entered into force on September 3, 1981.

12 African [Banjul] Charter on Human and Peoples’ Rights, O.A.U. Doc. CAB/LEG/67/3 Rev.5 (1981) [hereinafter African Charter]. The Charter was adopted on June 27, 1981, and entered into force on October 21, 1986.

13 *Malawi urges national AIDS test*, BBC News, Jul. 16, 2007.

14 UNAIDS report, *supra* note 2 at 8.

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These conditions persist despite Malawi's commitments under international law to protect people living with HIV/AIDS from discrimination.



In May 2007, the Leitner Center teams traveled to Chilumba, Nkhata Bay, Salima, Mchinji, Lilongwe, Blantyre, and Mangochi to interview women living with HIV/AIDS.

becoming a target of HIV/AIDS-related stigma and discrimination discourages people from seeking testing and discussing safer sex practices which are often associated with HIV/AIDS and promiscuity.¹⁵ Stigma and discrimination also impede care, support, and treatment programs.¹⁶ Participation in HIV/AIDS support groups and attendance at anti-retroviral (ARV) clinics often spark stigma and discrimination from community members,¹⁷ which can result in PLWHA delaying care until it is too late.

The Fordham delegation was led by Professors Chi Mgbako, Tracy Higgins, and Jeanmarie Fenrich, and included Professor Paolo Galizzi; Mr. James Leitner; eight second-year law students, Anjali Balasingham, Doug Goggin-Callahan, Carolyn Houston, Katherine Hughes, Maria Kuriakose, Gabriel Mass, Grace Pickering, Felice Segura; and Evan Leitner, a Yale University undergraduate student. Prior to the mission, the delegation participated in an intense program of study throughout the academic year, including a seminar on human rights in Malawi and the intersection between gender, human rights, and HIV/AIDS led by Professors Mgbako, Higgins, and Fenrich. While in Malawi, the delegation interviewed over 300 women living with HIV/AIDS in rural and urban areas of Malawi's Northern, Central, and Southern regions and documented widespread community-level stigma and HIV/AIDS-related discrimination. The delegation also interviewed men living with HIV/AIDS, traditional leaders, men and women in rural villages, commercial sex workers, police officers, secondary school students, peer educators, lawyers, government officials, health workers, and representatives of non-governmental organizations (NGOs) and inter-governmental institutions. The delegation conducted approximately 500 interviews in all.¹⁸

This report presents the findings of this research effort. Part I sets out Malawi's obligations under international and domestic law regarding the right of

women living with HIV/AIDS to be free from discrimination and also explores non-binding international documents that provide guidance to governments in confronting discrimination against PLWHA. Part I then explores the ways in which lack of sexual autonomy, economic dependency, physical and sexual abuse, harmful traditional practices, commercial sex work, sexual exploitation of girls and young women, and conceptions of male sexuality increase women's vulnerability to HIV/AIDS in Malawi.

Part II documents widespread community-level stigma against women living with HIV/AIDS in the form of verbal attacks; social exclusion; and the interpretation of HIV status as an indicator of sexual immorality. Part II also explores how fear of stigma discourages women from disclosing their HIV status and how denial of HIV/AIDS-related stigma and discrimination further handicaps communities. Part II then documents the ways in which discriminatory notions regarding HIV-positive peoples' labor capacities limits the participation of WLWHA in the federal fertilizer subsidy program, public works projects, and microfinance programs. Part II ends by suggesting community-level interventions and policy reforms to confront stigma and discrimination.

Finally, Part III explores possible legal interventions. Part III begins by documenting women's lack of access to justice in response to their experiences of stigma and discrimination. Part III then offers recommendations to address this lack of judicial recourse, including linking health and legal services through the establishment of referral networks in health clinics to legal aid and paralegal service providers and the integration of these services directly into the health setting; the drafting of HIV/AIDS anti-discrimination legislation coupled with awareness raising campaigns and strong enforcement mechanisms; and the encouragement of public interest litigation to raise awareness of HIV/AIDS-related issues.

15 International Center for Research on Women (ICRW), *Disentangling HIV/AIDS Stigma in Ethiopia, Tanzania and Zambia* 2(2003) [hereinafter *Disentangling HIV/AIDS Stigma*].

16 *UNAIDS report*, *supra* note 2 at 8.

17 See, e.g., *infra* notes 230 and 231.

18 The delegation conducted interviews in Chilumba, Nkhata Bay, Mchinji, Salima, Blantyre, Mangochi, and Lilongwe. See Annex. Because of the consequences of HIV/AIDS-related stigma and discrimination, the full names of HIV-positive interviewees in this report have been withheld, unless the interviewee explicitly stated that she had publicly revealed her HIV status to her community.



Professor Chi Mgbako and Crowley Scholars Carolyn Houston and Maria Kuriakose following a community meeting in Salima.

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The Leitner Center benefited from the contributions and assistance of individuals and organizations in Malawi and the United States. First, we would like to thank Daphne Gondwe, president of the Coalition of Women Living with HIV/AIDS in Malawi and the Coalition's regional and district coordinators, including central region chair Victoria Kalumba; Salima vice-chair Kwangu Makhuwiro; Karonga district chair Margaret Mwamlima; Nkhata Bay district chair Ellen Mhone;

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We thank the hundreds of men and women in Malawi who took the time to meet with us. We are grateful to them for generously sharing their insights and experiences. Finally, and most importantly, we thank the hundreds of women living with HIV/AIDS throughout the country who shared the most intimate details of their lives with us. Their unwavering courage in the face of great challenges continues to inspire us.

I. Background

A. Malawi's Obligations Under International and Domestic Law

1. INTERNATIONAL LAW

Malawi is a party to many international human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR),¹⁹ the International Covenant on Economic, Social, and Cultural Rights (ICESCR),²⁰ the Convention on the Elimination of all forms of Discrimination against Women (CEDAW),²¹ and the African Charter on Human and People's Rights (African Charter),²² which guarantee people living with HIV/AIDS freedom from discrimination. While none of these treaties expressly identifies HIV/AIDS, the broad rights to non-discrimination and equality contained in these treaties²³ also protect persons from discrimination based on HIV status. For example, Article 26 of the ICCPR provides that

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.²⁴

The UN Human Rights Commission²⁵ has confirmed that "discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term 'or other status' in non-discrimination provisions in international human rights texts can be interpreted to cover health status, including HIV/AIDS."²⁶

Although there is no binding international treaty specific to HIV/AIDS, there are several important documents that provide guidance to governments on legal and policy issues related to HIV/AIDS. *The International Guidelines on HIV/AIDS and Human Rights* identify measures that governments should take to respond to HIV/AIDS in order to comply with their obligations under international and regional human rights treaties.²⁷ The *International Guidelines* were issued jointly by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office of the High Commissioner for Human Rights (OHCHR) following an expert consultation in 1996 and revised in 2006 to reflect developments in the intervening 10 years.²⁸ Among other things, the *International Guidelines* provide that states should enact anti-discrimination laws that protect people living with HIV and provide for "speedy and effective" administrative and civil remedies,²⁹ implement legal support services that educate PLWHA about their rights and provide free legal services to enforce those rights,³⁰ promote a supportive environment for women "by addressing underlying prejudices and inequalities

19 International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 [hereinafter ICCPR]. The Covenant was adopted on December 19, 1966, and entered into force on March 23, 1976.

20 International Covenant on Economic, Social and Cultural Rights, 999 U.N.T.S. 3 [hereinafter ICESCR]. The Covenant was adopted on December 19, 1966, and entered into force on January 3, 1976.

21 Convention on the Elimination of all Forms of Discrimination Against Women, G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46 (1980) [hereinafter CEDAW]. The Convention was adopted on December 18, 1979, and entered into force on September 3, 1981.

22 African [Banjul] Charter on Human and Peoples' Rights, O.A.U. Doc. CAB/LEG/67/3 Rev.5 (1981) [hereinafter African Charter]. The Charter was adopted on June 27, 1981, and entered into force on October 21, 1986.

23 ICCPR, *supra* note 9, art. 26; Article 2(1) of the ICCPR states:

Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present covenant, 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.

ICESCR, *supra* note 10, art. 2(2) states:

The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. *Id.* The African Charter, *supra* note 12, arts. 2, 3. Article 2 states:

Every individual shall be entitled to the enjoyment of the rights and freedoms recognized 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 other status.

Id. art. 2. Article 3 states:

(1) Every individual shall be equal before the law;

(2) Every individual shall be entitled to equal protection of the law.

Id. CEDAW, *supra* note 11, arts. 2, 3.

24 ICCPR, *supra* note 9, art. 26.

25 The Human Rights Commission was the primary mechanism to promote human rights compliance at the United Nations until March 2006 when it was replaced by the Human Rights Council. See G.A. Res. 251, U.N. GAOR, 60th Sess., U.N. Doc. A/Res/60/252 (2006).

26 See Commission on Human Rights, "The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)," Resolution 1995/44, adopted without a vote, March 3, 1995; see also U.N. Comm. on H.R., 56th Sess., ¶ 1, U.N. Doc. E/CN.4/RES/1999/49 (Apr. 27, 1999) (reiterating that a prohibition of discrimination based on "other status" in non-discrimination provisions prohibits discrimination based on HIV/AIDS).

through community dialogue,³¹ and promote education and media programs designed to counter discrimination and stigma associated with HIV.³²

The Declaration of Commitment on HIV/AIDS, adopted at the United Nations General Assembly Special Session held on June 25-27, 2001, similarly calls on governments to enact legislation and other measures "to eliminate all forms of discrimination against...people living with HIV/AIDS...to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection...and develop strategies to combat stigma and social exclusion connected with the epidemic."³³ The Declaration also calls upon governments to implement measures to promote and protect "women's full enjoyment of all human rights" and reduce "their vulnerability to HIV/AIDS through the elimination of all forms of discrimination...against women and girls, including harmful traditional and customary practices."³⁴ The Declaration sets forth time-bound targets for achieving its stated objectives and the General Assembly reviews the progress governments have made in implementing the Declaration.³⁵

Malawi's general obligation to eliminate discrimination against women is also relevant to the issues addressed in this report because, as discussed below, women in Malawi are disproportionately vulnerable to contracting HIV/AIDS and more vulnerable to human rights abuses based on positive status. Biological factors³⁶ alone do not explain women's

increasing vulnerability to the epidemic;³⁷ rather, the feminization of HIV/AIDS is rooted in gender inequality that pervades the economic, legal, and cultural sectors of society.³⁸

Malawi has ratified a number of international and regional treaties that contain guarantees of women's equality under and through the law. The Universal Declaration of Human Rights,³⁹ the United Nations Charter,⁴⁰ the ICCPR, the ICESCR, the African Charter and CEDAW all contain guarantees of equal rights without regard to sex.⁴¹ International law also requires Malawi to adopt measures aimed at eliminating discrimination against women in all areas, including the domestic, economic, cultural and political fields.⁴² Malawi's failure to eliminate gender-based discrimination that makes women more vulnerable to HIV/AIDS and less able to mitigate its effects also violates Malawi's obligation to fulfill the right to health. Article 12(1) of the ICESCR generally proclaims the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁴³ Thus, the right to health and the right to gender equality overlap and reinforce each other.

To comply with its international obligations, Malawi must "modify the social and cultural patterns of conduct of men and women...to achiev[e] the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."⁴⁴ Accordingly, Malawi must identify discriminatory practices

27 Office of the U.N. High Comm'r for Human Rights & Joint U.N. Programme on HIV/AIDS [UNAIDS], *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, HR/Pub/06/9, U.N. Sales No. E.06.XIV.4 (2006) [hereinafter *International Guidelines*] (updating C.H.R. Res. 1997/33, U.N. Doc. E/CN.4/1997/150 (1997)) at 9-10 & 13 at para. 3.

28 See *International Guidelines* at Foreword.

29 See *International Guidelines*, Guideline 5, ¶22.

30 See *International Guidelines*, Guideline 7, ¶¶54-55.

31 See *International Guidelines*, Guideline 8, ¶ 60.

32 See *International Guidelines*, Guideline 9, ¶62.

33 *Declaration of Commitment on HIV/AIDS*, at ¶ 58, available at <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

34 *Id.* at ¶ 61.

35 G.A. Res. 60/262, U.N. GAOR, 60th Sess. (2006), available at

http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf [hereinafter 2006 Political Declaration on HIV/AIDS].

36 Biological factors that increase women's vulnerability to HIV infection include the fact that the female reproductive tract has larger exposed mucosal surfaces than the male reproductive tract and that semen contains higher concentrations of HIV pathogens than vaginal secretions. See Katy Backes, Anna Forbes, and Chelsea Polis, *One Choice Is No Choice: The need for female controlled HIV prevention tools for women and girls worldwide*, 19 *Harv. Health Pol. Rev.*, Vol. 6, No. 1.

37 See *Id.* at 19.

38 See United Nations Population Fund, *State of World Population* (2002) available at <http://www.unfpa.org/swp/2002/english/ch4/page4.htm> (further explaining that "[g]ender inequality deprives women of the ability to refuse risky practices, leads to coerced sex and sexual violence, keeps women uninformed about prevention, puts them last in line for care and life-saving treatment, and imposes an overwhelming burden on them to care for the sick and dying"); see also *Declaration of Commitment* ¶ 14 ("stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS").

39 Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/180, at 71 (1948).

40 U.N. Charter. The Charter was signed on June 26, 1945, and entered into force on October 24, 1945.

41 Universal Declaration of Human Rights, *supra* note 40, art. 7; U.N. Charter, *supra* note 41, art. 55; ICCPR, *supra* note 9, arts. 2(1), 26; ICESCR, *supra* note 10, art. 3; CEDAW, *supra* note 11, arts. 2, 3, 5, 15, 16; African Charter, *supra* note 12, arts. 2, 3.

42 See African Charter, *supra* note 12, art.1; CEDAW, *supra* note 11, arts. 2, 3, 15, 16.

43 ICESCR, *supra* note 10, art. 12(1).

44 CEDAW, *supra* note 11, art 5(a).

and enact legislation to abolish those practices.⁴⁵ In addition to enacting legislation, Malawi must also devote the resources necessary for enforcement and must undertake education efforts and any additional steps necessary to ensure equal rights for women.⁴⁶

2. DOMESTIC LAW

Although domestic law in Malawi does not yet address directly the issue of stigma and discrimination against PLWHA, both the constitution and federal statutes contain broad anti-discrimination provisions. The 1994 Malawi Constitution provides protection against discrimination on the grounds of race, color, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status.⁴⁷ The Malawi Employment Act of 2000 promotes non-discrimination in the workplace on these same grounds.⁴⁸

Domestic law in Malawi also addresses directly the issue of gender discrimination. On its face, the Malawi Constitution confirms the right of women to be free from discrimination and to full and equal protection of the law.⁴⁹ The Constitution also provides a foundation for legal challenges to ensure women's rights. Article 24(2) states that "Any law that discriminates against women on the basis of gender...shall be invalid and legislation shall be passed to eliminate customs and practices that discriminate against women."⁵⁰

The Malawi Human Rights Commission, a national institution established under Chapter XI of the Constitution, investigates human rights violations.⁵¹ The Commission's Enabling Act states that attention must be focused on human rights abuses against vulnerable groups.⁵² Individuals, NGOs, and other groups can file complaints with the commission which, if accepted, proceed to alternative dispute resolution and in some cases litigation.⁵³

Although the more general provisions of the Constitution, anti-discrimination statutes, and Malawi

Human Rights Commission have not yet been invoked to address stigma and discrimination against PLWHA and do not alleviate the need for comprehensive legislation on HIV/AIDS, they do provide an existing basis for the legal claims of WLWHA.

B. Women's Vulnerability to HIV/AIDS in Malawi

Gender inequality has facilitated the spread of HIV/AIDS in Malawi. This inequality manifests itself through women's lack of sexual autonomy, economic dependency and violence against women, all of which render women unable to negotiate safer sex practices. Harmful traditional practices; poverty which often forces women and young girls to engage in commercial sex work and transactional sex; and socially accepted notions of masculinity that encourage high-risk behavior, converge to create a social framework that subordinates women and makes them vulnerable to HIV.

1. CONDOMS AND NEGOTIATING POWER

Although consistent and correct condom use is highly effective in preventing HIV transmission,⁵⁴ Malawian women are often economically, culturally and sexually disempowered in their intimate partner relationships, impeding their ability to negotiate safer sex practices and safeguard their health. Condoms are especially unacceptable within marriage and "remain a foreign 'intruder' in the domestic sphere."⁵⁵ In addition, condoms are often stigmatized in Malawi, associated with sexual immorality and prostitution.⁵⁶

Chief Mduwa of Mchinji, a progressive traditional leader who has tried to impart the importance of condom use to villagers in his traditional authority area, believes that religious and cultural beliefs have stigmatized condom use in marriage: "People believe that it is not good to use condoms with your

45 See, e.g., CEDAW, *supra* note 11, at arts. 2(b), (f), 3.

46 See, e.g., CEDAW, *supra* note 11, at arts. 2(c), (e), (f); African Charter, *supra* note 12, art. 1 (obliging Malawi to "recognize the rights, duties, and freedoms enshrined" in the Charter and to "undertake to adopt legislative or other measures to give effect to them"); art. 25 (requiring countries to "promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that these freedoms and rights as well as corresponding obligations and duties are understood").

47 MALAWI CONST. art. 20(1).

48 Employment Act, No. 6 of 2000 (2000).

49 MALAWI CONST. art. 24(1).

50 *Id.* at 24(2).

51 MALAWI CONST. arts. 129 - 131.

52 Interview with Redson Kapindu, Director of Legal Services, Malawi Human Rights Commission, Lilongwe (May 29, 2007).

53 *Id.*

54 See Center for Disease Control (CDC), "Fact Sheet for Public Health Personnel: Male Latex Condoms and Sexually Transmitted Diseases," available at <http://www.cdc.gov/nchstp/od/condoms.pdf>.

55 Susan Cotts Watkins, *Navigating the AIDS Epidemic in Rural Malawi*, 30 Pop. and Dev. Rev., 673, 690 (2004) [hereinafter *Navigating the AIDS Epidemic*].

Gender inequality has facilitated the spread of HIV/AIDS in Malawi. This inequality manifests itself through women's lack of sexual autonomy, economic dependency and violence against women, all of which render women unable to negotiate safer sex practices.

wife; that there is no place for it in marriage.”⁵⁷ Floness P. of Salima learned she was HIV positive in 2006, after the discovery of an ARV treatment hospital card among her deceased husband's belongings prompted her to go for testing. Her husband drank excessively, was physically abusive, had extra-marital affairs, and refused to use condoms: “I was afraid that I would get HIV. When I would ask him to wear a condom he would ask me why I was telling him that. He would say, ‘You are my wife. Why would I use a condom?’ I kept asking him, but I could not succeed.”⁵⁸ During a community meeting in a rural village in Chilumba, several men remarked that if a woman refused sex because her husband rejected requests for condom use that would be sufficient grounds for divorce. They further noted that a man's refusal to wear condoms would not be cause for a woman to divorce her husband.⁵⁹

A wife's request for condom use is often interpreted as an indication that either she has been unfaithful or that she suspects her husband of being unfaithful.⁶⁰ Rural villagers in community meetings in Salima echoed this idea, noting that condom use in marriage signifies mistrust and is interpreted as a mark of infidelity.⁶¹ Although a group of men in Kudaize village in Salima bemoaned the fact that the 30 kwacha (.22 USD)⁶² they must pay for a pack of

three condoms is financially beyond their reach, they also noted that it would be a “very new” idea for their wives to demand condom use. One man remarked that such a request from his wife would cause him to question, “Why today should we use a condom? What has happened?”⁶³ A group of married women in a rural village in Salima noted that their husbands often use “trust” as a defense against requests for condom use.⁶⁴

Men also often refuse to wear condoms because they believe that it decreases sexual stimulation. Maria M. of Nkhata Bay, who discovered she was HIV positive in 2004, has been married for 34 years to a man who refuses to wear condoms and argues that sex with a condom is “like a sweet in a paper,” a phrase that many women interviewed identified as a commonly-used objection to condom use.⁶⁵ Both Maria's husband and his two other wives refuse to be tested for HIV despite her positive status.⁶⁶ Rose M., also of Nkhata Bay, has been married for 17 years and related a similar experience: “My husband said, ‘I will get nothing from sex with a condom. You must go back to your home if you insist that I use a condom.’”⁶⁷

Not only is HIV/AIDS highly stigmatized, but ironically, condoms—the most effective method of preventing the virus among sexually active individuals—

56 Condoms Get a Bad Rap, *Irin News*, Nov. 14 2005, at <http://irinnews.org/PrintReport.aspx?ReportId=71023>.

57 Interview with Chief Mduwa, Traditional Authority of T.A. Mduwa, Mchinji (May 22, 2007).

58 Interview with Floness P., Salima (May 23, 2007).

59 Interview with rural men, Chilumba (May 22, 2007).

60 See Kathewera-Banda et al., *A Rights Issue*, *supra* note 32, at 656; see also HRW, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* 24 (2003) [hereinafter *Just Die Quietly*].

61 Interviews with rural men and women, Salima (May 24, 2007).

62 1.00 USD = 139.025 MWK as of Sept. 29, 2007. See <http://www.xe.com/ucc/convert.cgi>.

63 Interviews with rural men, Salima (May 24, 2007).

64 Interview with rural women, Salima (May 24, 2007).

65 See, e.g., Interview with Maria M., Nkhata Bay (May 23, 2007); see also Interview with Memory K., Blantyre (May 21, 2007);

Interview with Molly M., Blantyre (May 21, 2007).

66 Interview with Maria M., *supra* note 65.

67 Interview with Rose M., Nkhata Bay (May 23, 2007).

have themselves become stigmatized, often associated with sexual immorality and prostitution. Grace M., a 32-year-old HIV-positive woman from Chilumba, reports that her migrant worker husband refused to wear condoms when he would return to their village, often saying “Are you a bar girl? Condoms are only for bar girls.”⁶⁸ Maria G. of Chilumba first heard of HIV and ways to prevent it as early as 1985, but requests that her husband use condoms often made him furious and he too called her a “bar girl.” “People have a negative attitude [about condoms],” Maria noted. “They think it markets sexual activity.”⁶⁹

Although some HIV-positive women report that their husbands agreed to begin using condoms after HIV was discovered in the relationship, still others noted that their inability to negotiate condom use and practice “positive prevention” thereby reducing their risk of HIV re-infection⁷⁰ remained a serious issue. Agatha, a 30-year-old HIV-positive mother of three from Mchinji, notes that she and her husband, who is also positive, have access to free condoms at the hospital where they receive ARVs, yet her husband often refuses to practice safe sex: “I want to [use condoms] and I ask him to. The problem lies with my husband. He says it doesn’t feel good to use condoms. Sometimes he gets angry. When he gets angry he doesn’t assist me in financial ways. He just walks out.”⁷¹ Although Cecilia Tembo, an HIV-positive 35-year-old school teacher from Mchinji praised her husband for stopping his philandering and abuse of alcohol in 2001, she also noted that condom use remains a contentious issue in their otherwise good relationship, despite the fact that they receive counseling about the importance of positive prevention: “We know we should always be using condoms but sometimes it is difficult. Sometimes he gets mad when I ask. It’s his decision whether we use them or not.”⁷²

a. Economic Dependency

Poverty exacerbates women’s dependency on men thereby lessening their ability to negotiate safer sex practices in their relationships. Almost 42% of Malawians live on less than \$1 per day and over 76% live on less than \$2 per day.⁷³ Malawi ranks 166 out of 177 countries on the Human Development Index and 83 out of 102 countries on the Human Poverty Index.⁷⁴ Even though poverty is ubiquitous in Malawi, economic opportunity is more limited for women than men. Malawi ranks 127 out of 137 nations on the Gender-Related Development Index, which measures women’s relative level of empowerment.⁷⁵ Malawi’s low ranking is due in part to significant gender disparity in earned income. On average, women earn an estimated income of \$547 annually, 27% less than men.⁷⁶

Women’s low educational and economic status reinforces gender hierarchies, undermines women’s autonomy, and facilitates dependence on men in the context of familial, marital, and community relationships. “If you don’t talk about the economic implications [of gender inequality and HIV/AIDS], then you’re missing the point,” remarked Audrey Lewans of the United Nations Development Program (UNDP), noting that statistically the more educated and economically sufficient a Malawian woman is, the less likely she is to have HIV/AIDS.⁷⁷

Men control land, household assets, and other productive resources, engendering women’s financial and material dependence and thereby lessening their control of when and how they have sex.⁷⁸ A relationship with a man is often the only viable option for women to sustain themselves economically. “If you don’t have unprotected sex, the man won’t provide food for the family. You will get nothing,” noted Daphne Gondwe, president of the Coalition of Women Living with HIV/AIDS in Malawi. “How are you going to live?”⁷⁹ A group of traditional leaders

68 Interview with Grace M., Chilumba (May 21, 2007).

69 Interview with Maria G., Chilumba (May 21, 2007).

70 “HIV reinfection or *superinfection* as it is sometimes called, is a consequence of unprotected sexual encounters between two HIV infected people. Simply put, reinfection occurs when a person living with HIV gets infected a second time while having unprotected sex with another HIV infected person.” <http://aids.about.com/cs/safesex/a/reinfection.htm> (last visited Sept. 29, 2007).

71 Interview with Agatha, Mchinji (May 21, 2007).

72 Interview with Cecilia Tembo, Mchinji (May 21, 2007).

73 *Malawi HDR Data Sheet*, *supra* note 8 at § 3.

74 *Id.*

75 *Id.* at § 24.

76 *Id.*

77 Interview with Audrey Lewans, Program Analyst, United Nations Development Program (UNDP), Lilongwe (May 29, 2007).

78 *ILO Brief*, *supra* note 1, at 2.

79 Interview with Daphne Gondwe, President, Coalition of Women Living with HIV/AIDS, Lilongwe (May 28, 2007).

from Mchinji linked the presence of AIDS in their communities and its disproportionate gender impact to women's low economic status.⁸⁰ Chief Mchiwa, a group village headman in Kapondo, Mchinji, remarked that, "Men have the power to control the funds. He can go to the city with money in his pocket, and when he comes home the wife has no say."⁸¹

In the context of debilitating poverty that disproportionately affects women, sex in exchange for food and other material benefits has become part of the local economy, a dangerous form of currency which heightens women's vulnerability to HIV infection.⁸² Rebecca B., a 31-year-old woman living with HIV in Blantyre, noted that poverty leads women to take risks with their health: "Even if a woman knows a man is positive, she will still sleep with him without a condom because she needs money. Men will buy them things and support them."⁸³ During a community meeting with men and women in the lakeshore district of Mangochi, the group highlighted informal sex work as a major cause of the spread of HIV/AIDS: "More women than men have HIV, because they're uneducated," noted one rural man. "They take their small businesses to the lake area, where men pay them for sex. Women don't go to school and don't have small businesses. So a lot of women are selling sex." A woman in the meeting noted that the presence of wealthy foreigners willing to pay for sex in an area where over 75% of the women are unemployed has exacerbated the problem: "Girls go to the lake for *sho-sho* [sex]. They are very poor, they see the foreigners, and they know that they have a lot of money. You can get sex if you have a lot of money and no protection." One man, addressing the entire group noted, "Woman is poor and hasn't got money, so you have to sleep with us...that is why there is HIV everywhere."⁸⁴

b. Violence Against Women

According to a study by Women in Law in Southern Africa (Malawi Chapter) ("WLSA"), half of all Malawian women have experienced some sort of violence from their intimate partners.⁸⁵ Intimate partner violence nurtures a culture of physical and mental subordination of women that weakens their ability to protect themselves from the risk of HIV/AIDS.⁸⁶ The power imbalance that exists in many intimate relationships between men and women in Malawi due to the threat of physical and sexual violence makes it difficult for women to negotiate safer sex practices or confront husbands regarding infidelity.⁸⁷

Margaret M., a widowed mother of five in Salima, feared requesting condom use in her abusive relationship: "I think I got HIV from my husband because he was drinking excessively and had girlfriends. I was afraid I might be exposed to HIV, but I couldn't even think about using a condom. It was hard for me to ask him to do so because he was violent mainly when he was drunk."⁸⁸ Sibongile B. of Nkhata Bay reported a similar experience. Her husband beat her when she refused sex without a condom, even after she discovered her HIV status in 2004.⁸⁹

During community meetings in Chilumba and Nkhata Bay, rural villagers confirmed that insistence on condom use by women often leads to physical violence in the home.⁹⁰ In response to the question whether women can insist on a "no condom, no sex" rule in their homes, one rural woman in Chilumba responded, "You can tell him no sex, but he will tell you 'if you refuse me, I will sack you out.'" A man in Nkhata Bay remarked that such a demand would mean the "husband must beat the woman to capacity." Community members noted that women rarely go to the authorities with grievances regarding domestic violence, instead appealing to maternal relatives or suffering in silence.⁹¹

80 Interview with Chief Kalinde, Group Village Headman of T.A. Mduwa; Chief Maole, Group Village Headman of T.A. Mduwa; Chief Kunungwi, Group Village Headman of T.A. Mduwa; Chief Mchiwa, Group Village Headman of T.A. Kapondo; Chief Chapakama, Group Village Headman of T.A. Kapondo; Chief Chimutu, Group Village Headman of T.A. Kapondo, Mchinji (May 22, 2007).

81 Interview with Chief Mchiwa, *supra* note 80.

82 See Helen Epstein, *The Hidden Cause of AIDS*, N.Y. REV. OF BOOKS, May 9, 2002.

83 Interview with Rebecca B., Blantyre (May 21, 2007).

84 Interview with men and women, Mangochi (May 24, 2007).

85 See Bright Sonani, *Married Women More Vulnerable to HIV/AIDS*, THE NATION (Malawi), Oct. 4, 2006, available at www.nationmalawi.com/articles.asp?articleID=16145.

86 Human Rights Watch (HRW), *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa* 81 (2005) [hereinafter *Policy Paralysis*].

87 See HRW, *Policy Paralysis*, *supra* note 86, at 31; see also Maggie Kathewera-Banda et al., *Sexual Violence and Women's Vulnerability to HIV Transmission in Malawi: A Rights Issue*, 57 INT'L SOC. SCI. J. 649, 656-57 (2005) [hereinafter *A Rights Issue*].

88 Interview with Margaret M., Salima (May 23, 2007).

89 Interview with Sibongile B., Nkhata Bay (May 23, 2007).

90 Interviews with rural men and women, Chilumba (May 22, 2007); Interviews with rural men and women, Nkhata Bay (May 24, 2007).

91 *Id.*

In addition to physical beatings, women are also at risk of rape if they refuse sex with their intimate partners. One study by WLSA indicated that *three-quarters* of all the women surveyed had been forced to have sex by their intimate partners at least once.⁹² Physically forced sex may be accompanied by abrasions, tears and wounds from the violence which increase a woman's physical vulnerability to HIV/AIDS.⁹³ Wittie M., a 40-year-old mother of five from Nkhata Bay, said she was often raped by her husband, who died of AIDS in 2003, and told her, "You must do sex because you are my wife."⁹⁴ Lyness K., also of Nkhata Bay, reported a similar experience: When she refused sex with her husband, who died of AIDS in 2000, he forced her to have sex when she fell asleep or kicked her out of the bedroom if she resisted: "I had no power to say 'no condom, no sex.'"⁹⁵

Forced sex within marriage is often culturally condoned and is not viewed through the prism of rape. During an interview with six traditional leaders in Salima, they all agreed that husbands have the right to physically force their wives to have sex.⁹⁶ "When a woman is refusing to sleep with the man he forces his way into her," remarked Chief Mapiko, a group village headman from Karonga in Salima. "If a woman refuses for three or four days what should we do? It's right because we men are different."⁹⁷

In 2006, Malawi passed the Prevention of Domestic Violence Act, which outlaws violence in the home.⁹⁸ However, women's low legal literacy, the paucity of domestic violence shelters and domestic violence units in police stations, and continued cultural acceptance have left women with few options for legal recourse.⁹⁹ In addition, the new law does not criminalize marital rape. Although marital rape was included in the original bill submitted to the Malawian parliament, legislators were against it and threatened to reject the entire bill if the marital rape clause was included.¹⁰⁰

2. HARMFUL TRADITIONAL PRACTICES

Harmful traditional practices contribute to women's vulnerability to HIV/AIDS in Malawi. The practices fall into two main categories: practices targeted at young women and girls, such as early marriage and initiation rites; and marital practices, such as widow inheritance and widow cleansing.

Fifteen percent of people surveyed by the Malawi Human Rights Commission (MHRC) in 2006 reported the practice of early marriage in their communities.¹⁰¹ Immediate economic family pressures often lead to the exchange of young girls into early marriage to repay family loans.¹⁰² Joyce K. of Salima noted that girls in her village, some as young as twelve, are often forced into early marriage and that traditional leaders refuse to discourage the practice despite their acknowledgment that it contributes to the spread of HIV/AIDS.¹⁰³ Rural men in a village in Salima reported that girls as young as 14 often marry men as old as 40 due to economic pressures placed on families.¹⁰⁴

When young women barely through puberty marry men ten to twenty years older, there is a significant power imbalance between them, rendering women less assertive in dealing with their much older husbands.¹⁰⁵ This affects their ability to negotiate safe sex and to insist on bodily autonomy. Older men are also likely to have had more sexual partners than their younger male counterparts, increasing their risk of exposure to HIV.¹⁰⁶ Early marriage is also physiologically risky as medical studies show that a teenage girl's cervix changes through puberty, rendering her physically more susceptible to contracting the virus.¹⁰⁷ Although in 2006 the Malawian government briefly considered raising the age of consent from fifteen to eighteen, no law has been drafted and child marriages remain legal.¹⁰⁸

Initiation ceremonies and cultural rites for young

92 Brian Ligomeka, *Women Push for Removal of Discriminatory Laws*, RIGHTS-MALAWI (Jul. 7, 2003)(emphasis added).

93 United Nations Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa (UN Task Force), *Facing the Future Together* 32 (2004).

94 Interview with Wittie M., Nkhata Bay (May 23, 2007).

95 Interview with Lyness K., Nkhata Bay (May 23, 2007).

96 Interview with Chief Ntenga, Chief Ntonga, Chief Likongwe, Chief Mapiko, Chief Simaiwa, Group Village Headmen of Karonga, Salima (May 24, 2007).

97 Interview with Chief Mapiko, *supra* note 96.

98 See CEDAW, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women*, para. 6 (Feb. 3, 2006) [hereinafter *Concluding Comments*].

99 See e.g. FAREDA BANDA, *WOMEN, LAW AND HUMAN RIGHTS: AN AFRICAN PERSPECTIVE* 179 (2005); see also Interview with Mildred Sharra, Action Aid, Lilongwe (May 30, 2007).

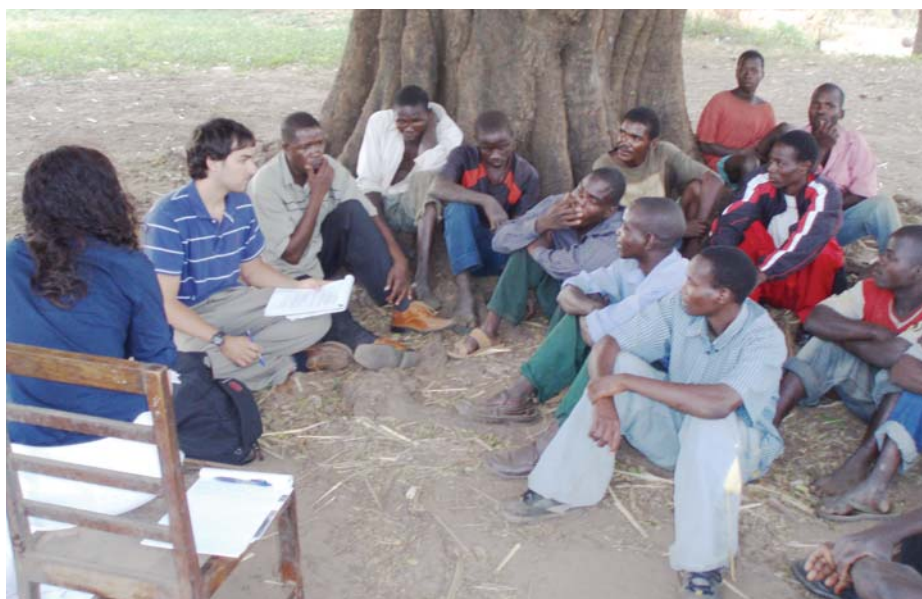
100 Interview with Stella Twea, Gender Specialist, United Nations Population Fund (UNFPA), Lilongwe, (May 29, 2007).

101 Malawi Human Rights Commission, *Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi* 25 (2006), available at <http://humanrightsimpact.org/publications/complete-listing/item/pub/174/> [hereinafter MHRC, *Cultural Practices*].

102 *Id.* See Sharon LaFraniere, *Forced to Marry Before Puberty, African Girls Pay Lasting Price*, N.Y. TIMES, Nov. 27, 2005, at A1. [hereinafter *Forced to Marry*].

103 Interview with Joyce K., Salima (May 23, 2007).

104 Interview with rural men, Salima (May 24, 2007).



Community meeting with a group of men in a rural village in Salima. Many men refuse to accept the reality of their situation: Laston C., a man living with HIV/AIDS from Mangochi, remarked that women are more open and willing to accept the reality of their HIV status, encouraging others to get tested, while men “hide.”

girls and women are practiced in many central and southern Malawian villages.¹⁰⁹ Nearly two-fifths of people interviewed by the Malawi Human Rights Commission reported these practices occur in their communities.¹¹⁰ The use of sex in many of these initiation ceremonies increases the likelihood of HIV/AIDS transmission. One commonly practiced ceremony is “shaking the dust,”¹¹¹ which takes two major forms: one in which young girls are “visited” by older men with whom they are required to have sex,¹¹² and another, referred to as *kusasa fumbi*, which occurs after a weeklong ceremony during which girls are taught how to be women and encouraged to have sex with any boy they can find upon their return to the village.¹¹³

Some traditional leaders in Mchinji have been advocating for the end of such practices because of the spread of HIV/AIDS in their communities. Chief Chapakama of Kapondo in Mchinji maintains that harmful practices such as “shaking the dust” ceremonies have lessened in his area: “If a girl has reached a certain age and has started menstruation the men used to take her to a house and sleep with her to know if she is really grown up. This has stopped... Because of the increase in death rates, we have seen it is important that harmful cultural practices should come to an end for the development of our area. People were attending too many funerals.”¹¹⁴ However, while some traditional leaders have condemned these rituals, the practices remain widespread.¹¹⁵

105 The Alan Guttmacher Institute (AGI), *Risk and Protection: Youth and HIV/AIDS in Sub-Saharan Africa* 9 (2004), available at www.guttmacher.org/pubs/riskandprotection.pdf; Amnesty International, *Women, HIV/AIDS and Human Rights* 7 (2004), available at [web.amnesty.org/library/pdf/ACT770842004ENGLISH/\\$File/ACT7708404.pdf](http://web.amnesty.org/library/pdf/ACT770842004ENGLISH/$File/ACT7708404.pdf).

106 AGI, *Risk and Protection*, *supra* note 105 at 5.

107 AGI, *Risk and Protection*, *supra* note 105, at 9; Amnesty International, *Women, HIV/AIDS and Human Rights*, *supra* note 106, at 7.

108 Avert, *HIV & AIDS in Malawi*, <http://www.avert.org/aids-malawi.htm> (Mar. 27, 2007) (last visited Apr. 7, 2007). Persons aged between fifteen and eighteen may get married with their parents' permission. MALAWI CONST. art. 22.7.

109 Centre for Human Rights and Rehabilitation, *Malawi Human Rights Report 2003-2004*, 32 (2005), available at www.chrr.org.mw/downloads/malawi_human_rights_report_2003_04.pdf [hereinafter CHRR Report].

110 MHRC, *Cultural Practices*, *supra* note 102, at 44.

111 *Id.* at 38.

112 See Julian Siddle, *Cultural Norms Fuel HIV in Malawi*, BBC NEWS ONLINE, Nov. 30, 2004, at <http://news.bbc.co.uk/1/hi/africa/4055527.stm>.

113 MHRC, *Cultural Practices*, *supra* note 102, at 38. There are no clear statistics on initiation rites, because they tend to be categorized together; however, one study estimates that a third of girls go through initiation rights, and a quarter of them when they are under ten years old. See Alistair Munthali et al., *Adolescent Sexual and Reproductive Health in Malawi: Results from the 2004 National Survey of Adolescents* 51, available at www.guttmacher.org/pubs/2006/07/25/or24.pdf.

114 Interview with Chief Chapakama, Group Village Headman of Kapondo, Mchinji (May 22, 2007).

115 CHRR Report, *supra* note 109, at 32.

Widow cleansing is a practice that takes place after the death of a woman's husband, requiring the widow to have sex with one of her deceased husband's relatives or a village-appointed "cleanser" in order to "cleanse" the dead man's spirit from the village.¹¹⁶ While some government officials and traditional leaders have spoken out against the custom, it remains entrenched in many rural areas, with thirteen percent of those surveyed in the MHRC survey reporting its performance.¹¹⁷

Widow inheritance or *chokolo* places new widows at risk of contracting HIV/AIDS and is also common in Malawi. *Chokolo* involves the forcing of a recently widowed woman to marry one of her deceased husband's male relatives.¹¹⁸ Over half of those in the MHRC survey reported it in their communities.¹¹⁹ Originally, widow inheritance was purportedly meant to be a way of providing economic support for a widow who had lost her means of survival through her husband's death.¹²⁰ It is now often a pretext for in-laws to seize the deceased man's property.¹²¹

The delegation interviewed many HIV-positive women who reported that *chokolo* may be on the decline in their villages because of its contribution to the spread of HIV/AIDS. Mary C.'s in-laws in Nkhata Bay accepted her refusal of *chokolo* after her husband's death: "People are refusing *chokolo* more and more and it's accepted," she noted.¹²² Although Lornas K., a 59-year-old mother of eight from Nkhata Bay, fled her village when her husband died in 1994 because she feared being forced into *chokolo*, she reports that there has been a positive change in some communities, with families being urged at funerals to disavow *chokolo*.¹²³ Josephine K. of Chilumba noted that *chokolo* lessened in her village after public meetings in which the chiefs condemned it.¹²⁴ Mercy M. noted that religious education, community workshops and civic education lead by NGOs from Mzuzu has had a positive effect in the

lessening of *chokolo* in her Chilumba village.¹²⁵

Although some communities may be heading in the right direction in terms of the lessening of harmful cultural practices such as *chokolo*, many of the practices continue privately. During a community meeting with rural women in Salima, the women initially claimed that harmful traditional practices had all but disappeared in their village in the past two years. They later admitted that some of these practices still continue, though they are not advertised publicly as in the past when there was widespread community acceptance. One woman argued that the practices will end altogether when there are stiffer punishments for engaging in these practices.¹²⁶

Chief Jeffrey Ndula from Kwambiri in Salima, as well as several other traditional leaders from Kalonga in Salima, asserts that all public and private vestiges of harmful traditional practices have disappeared from their communities.¹²⁷ Gift Rapozo, the district commissioner of Salima, argues that many harmful cultural practices may have simply gone underground: "There may have been some changes in terms of acceptance to undertake these cultural practices, but they haven't disappeared altogether. They are carried out away from prying eyes. The chiefs have information about this since they are the guardians of cultural practices, but they would never say so."¹²⁸

3. COMMERCIAL SEX WORKERS

Commercial sex workers are a high risk group for HIV infection, and yet they are often a neglected group in terms of HIV prevention programs.¹²⁹ Mainstream women's rights groups often neglect issues concerning commercial sex workers, and sex worker collectives are rare in Africa.¹³⁰ Governments have the responsibility to provide HIV-related education and services to commercial sex workers and their clients,¹³¹ although they often fail in this regard. The lack of organization and awareness in this industry

116 See Sharon LaFraniere, AIDS Now Compels Africa to Challenge Widows' "Cleansing," N.Y. TIMES, May 11, 2005, at A1 [hereinafter AIDS Now Compels]; MHRC, *Cultural Practices*, supra note 101, at 63-64 (villager appointed if no relative is willing).

117 See LaFraniere, AIDS Now Compels, supra note 117; see also MHRC, *Cultural Practices*, supra note 102, at 63.

118 MHRC, *Cultural Practices*, supra note 101, at 21.

119 *Id.*

120 See HRW, *Just Die Quietly*, supra note 60, at 34; see also Jeanmarie Fenrich & Tracy E. Higgins, *Promise Unfulfilled: Law, Culture and Women's Inheritance Rights in Ghana*, 25 Fordham Int'l L.J. 259, 279-80 (2001).

121 See e.g. HRW, *Just Die Quietly*, supra note 60, at 34, 38-39.

122 Interview with Mary C., Nkhata Bay (May 23, 2007).

123 Interview with Lornas K., Nkhata Bay (May 23, 2007).

124 Interview with Josephine K., Chilumba (May 21, 2007).

125 Interview with Mercy M., Chilumba (May 21, 2007).

126 Interview with rural women, Salima (May 24, 2002).

127 Interviews with Chief Ntonga, Chief Likongwe, Chief Mapiko, Chief Simaiwa, supra note 97.

128 Interview with Gift Rapozo, District Commissioner of Salima, Salima (May 25, 2007).

129 See generally Helen Epstein, *God and the Fight against AIDS*, April 28, 2005 at vol. 52, no. 7.

130 *Policy Paralysis*, supra note 87 at 55.

has led to a high rate of infection among commercial sex workers in Malawi. As early as 1986, 56% of sex workers in Blantyre tested HIV positive. In 1994, 70% of sex workers in Lilongwe were positive.¹³² Although prostitution is illegal in Malawi, commercial sex workers are found in bars and rest houses, often posing as food handlers and cleaners.¹³³ The bars and rest houses provide the women with rooms at the sites for commercial sexual activity in exchange for serving meals and cleaning.¹³⁴ Their income depends solely on sexual activity with clients at the sites.¹³⁵ Interviews with current and former commercial sex workers in Blantyre and Lilongwe reveal that client pressure, in the form of violence and economic incentives, is the primary reason commercial sex workers engage in unprotected sex, therefore increasing their vulnerability to HIV and other sexually transmitted infections.

Commercial sex workers often succumb to economic pressure within a competitive sex industry in which men pay higher rates for sex without condoms. Mary M., a 32-year-old commercial sex worker in a pub in Blantyre, has been engaged in commercial sex work for the past fifteen years due to poverty and the pressure to provide for her deceased sister's children.¹³⁶ She does not know her HIV status but is certain she is positive after years of unprotected sex with clients who pay higher fees for sex without condoms: "The clients say they'll give me 2000 kwacha (14 USD), but when they get into the room, they offer up to 5000 kwacha (36 USD) if I don't use a condom. It's hard to resist."¹³⁷ T.S., a former sex worker in Lilongwe, who found out she was HIV positive in 2004 and gave up commercial sex work in 2006, admitted that when clients offered her more money she would not use a condom: "With a condom it was 500 kwacha (3.6 USD) and 2000 kwacha (14 USD) without. Why they were so keen on not using condoms I don't know. I just know that many men don't want to use condoms and the men don't think about the possibility of infect-

ing their wives."¹³⁸ Hazel C., a 29-year-old divorced mother of two from Lilongwe, started commercial sex work at the age of 14 and stopped in 2005 after her mother, father, and sister died of AIDS. She did not use condoms unless requested by her clients who offered up to 4000 kwacha (29 USD) for unprotected sex.¹³⁹

Other current and former commercial sex workers reported that they were often the victims of violence if they insisted their clients use condoms: Madalitso M., a 27-year-old HIV-positive widow and mother of two, started sex work after her husband died and she could not support her children. She worked for two years in rest houses and bars and always used condoms even though some men beat her when she insisted.¹⁴⁰ Edina M., a commercial sex worker in Blantyre, who cares for her four children in addition to eight orphans, experiences violence with customers when she demands condom use. Although she said she consistently uses condoms, she recently discovered she was HIV positive.¹⁴¹

Because prostitution is illegal, commercial sex workers fear reporting client abuse to the police: Angelina M., a 16-year-old former sex worker and orphan, slept with an average of three men per night for six nights a week over two years after the death of her parents left her to care for her younger siblings. She reported that she feared going to the police after a client stabbed her.¹⁴² Chitundo M., a 25-year-old former sex worker, had the courage to report a violent incident to the police after she was beaten by a client for refusing to use a condom only to experience indifference and corruption: "I was beaten up and told the police about it. I filed a report but the police didn't do anything. They say things like, 'This is just a prostitute.' A certain policeman asked to sleep with me but I denied him. He threatened to pin a case against me and I had to pay 2000 kwacha (14 USD)."¹⁴³

Increased availability of the female condom, the only woman-initiated method to prevent HIV infec-

131 UNAIDS report, *supra* note 2 at 106.

132 UNAIDS, Joint U.N. Program on HIV/AIDS, *Country Situation Analysis: Malawi*, (2006), available at <http://www.unaids.org/en/Regions/Countries/Countries/malawi.asp> [hereinafter *Malawi Situation Analysis*]

133 R Zachariah, MP Spielmann, AD Harries, W Nkhoma, A Chantulo, and V Arendt, *Sexually transmitted infection and sexual behaviour among commercial sex workers in a rural district of Malawi*, 14 INT'L J OF STD & AIDS 185, 186 (2003).

134 *Id.*

135 *Id.*

136 Interview with Mary M., Blantyre (May 22, 2007).

137 *Id.*

138 Interview with T.S., Lilongwe (May 30, 2007).

139 Interview with Hazel C., Lilongwe (May 30, 2007).

140 Interview with Madalitso M., Lilongwe (May 30, 2007).

141 Interview with Edina M., Blantyre (May 22, 2007).

142 Interview with Angelina M., Lilongwe (May 30, 2007).

143 Interview with Chitundo M., Lilongwe (May 30, 2007).

tion, may provide an important option for high risk women's groups such as commercial sex workers.¹⁴⁴ Stella Twea of the United Nations Population Fund (UNFPA) in Malawi remarked that, "Sex workers have said clearly: 'we believe if we have the female condom, we will have control over our sexuality,'"¹⁴⁵ a sentiment echoed by the commercial sex workers the delegation interviewed. Henzel T., a 30-year-old former sex worker from Lilongwe who was often the victim of abuse at the hands of her clients, believes that female condoms are necessary so that sex workers will be better able to safeguard their health: "So many men hit me because they wanted to fuck me plain...[F]emale condoms are better because sometimes men use plastic condoms and he is not really using a condom...or he puts holes in them."¹⁴⁶ Thaskwani S. has started to teach her friends how to use the female condom: "Women like them—[there's] more control. Sometimes she can use it on herself, and although the man doesn't want to, he has to accept."¹⁴⁷ Hazel C. believes that if there was more civic education about female condoms and if they were more readily available and less expensive both women and men may be more receptive to the idea.¹⁴⁸

4. GIRLS AND YOUNG WOMEN

Age is a significant indicator of a woman's chances of contracting HIV in Malawi. In the 15 to 19-year-old age range, young women account for 75% of HIV/AIDS infections.¹⁴⁹ This staggering statistic is indicative of social norms condoning the early sexual debut of young girls in the form of early marriage and other cultural practices¹⁵⁰ discussed earlier. Young girls also engage in transactional sex as a coping mechanism for dealing with poverty, oftentimes exchanging sex for goods, money, transportation costs, school fees, services, or accommodation.¹⁵¹ Girls are also often subject to sexual harassment and abuse in the school environment, further increasing their vulnerability to HIV/AIDS.¹⁵²

During a group meeting with over 100 students in a secondary school in Monkey Bay, the girls com-

plained of sexual harassment in school, and many of the students acknowledged that "prostitution" is a problem, as girls often exchange sex for school fees and other necessities their parents are unable to provide them.¹⁵³ Mara Kachare, a Partners in Hope peer educator in secondary schools in Lilongwe, witnesses these situations in many of the schools in which she volunteers: "Girls are more likely to get HIV because of poverty and peer pressure. When the girls' parents die or are poor, girls are more likely to engage in prostitution, which is very common. Teachers often have sex with students for money and grades."¹⁵⁴ Carolyn M. of Chilumba admits that her husband, who died of AIDS in 2004, often took advantage of his position as a school teacher to sleep with his young students whom he paid in exchange for sex.¹⁵⁵

Oftentimes girls who face sexual harassment in school feel helpless and do not report the abuse. Miata Coleman, a Peace Corps volunteer focusing on HIV/AIDS prevention in southern Malawi has witnessed this in the schools in which she teaches: "If sexual harassment from teachers happens, who do they report things to? How are they going to pay their school fees? They are not going to tell other people or their peers."¹⁵⁶

5. MALE SEXUALITY AND DENIAL

Many of the delegation's interviews revealed the role that socially accepted notions of masculinity have played in fuelling the AIDS epidemic in Malawi. Men rarely reveal their status to their wives or potential sexual partners and often do not seek HIV testing or treatment.

Many men are in denial about the disease and how it affects their families. Catherine M., a 27-year-old mother of three from Mangochi who has been married for six years discovered she was HIV positive after her last pregnancy. After informing her husband of her status he refused to be tested and still insists that he is not HIV positive.¹⁵⁷ Triness N.'s husband of Nkhata Bay refused to be tested for HIV even though he suspected he was positive, fearing

144 See Backes et al, *supra* note 36 at 21.

145 Interview with Stella Twea, *supra* note 100.

146 Interview with Henzel T., Lilongwe (May 30, 2007).

147 Interview with Thaskwani S., Lilongwe (May 30, 2007).

148 Interview with Hazel C., *supra* note 139.

149 World Health Organization, *Summary Country Profile for HIV/AIDS Treatment Scale-up*, 1 (2005), available at http://www.who.int/hiv/HIVCP_MWI.pdf [hereinafter *WHO Profile*].

150 *AVERT*, *supra* note 108.

151 National AIDS Commission, *HIV/AIDS in Malawi: Estimates of the Prevalence of Infection and the Implications* 17 (2003), available at http://www.policyproject.com/pubs/countryreports/MAL_AIDS.pdf [hereinafter *NAC Report*]; UNICEF *Facing the Future Together*

152 Julian Siddle, *Cultural Norms Fuel HIV in Malawi*, BBC News, Nov. 30, 2004, available at <http://news.bbc.co.uk/2/hi/africa/4055527.stm>.

153 Interview with students, Monkey Bay Secondary School, Monkey Bay (May 25, 2007).

Many of the delegation's interviews revealed the role that socially accepted notions of masculinity have played in fuelling the AIDS epidemic in Malawi. Men rarely reveal their status to their wives or potential sexual partners and often do not seek HIV testing or treatment.

that his wife's family would accuse him of infecting her, and only agreed to be tested after their child died of what may have been AIDS-related causes.¹⁵⁸ Kostas M. of Chilumba has been married to her husband for 21 years. Although he discovered he was HIV positive when he sought treatment for a tuberculosis infection he continues to engage in extramarital affairs and did not reveal his status to his wife until after she discovered she was pregnant.¹⁵⁹

Men's denial means they are less likely to seek testing and treatment and often blame their wives for bringing HIV into the relationship even in situations where the man is known to be engaging in extramarital affairs. Lenia M. of Mchinji often heard rumors of her husband's infidelities, but after they both tested positive he accused her of infecting him and refused to take anti-retroviral medication leading to his death in late 2005.¹⁶⁰ Christina N. of Mchinji reports a similar experience: "When I revealed my status to my husband, he decided to end the marriage and marry another woman. My husband said that I was the one who brought HIV into the house. I wanted to kill myself when my husband denied that he had brought it into the house. He is a womanizer and...was violent with me when I revealed my status. I had to go to the hospital for treatment for the abuse."¹⁶¹

Many men refuse to accept the reality of their situation: Laston C., a man living with HIV/AIDS from Mangochi, remarked that women are more

open and willing to accept the reality of their HIV status, encouraging others to get tested, while men "hide."¹⁶² Many argued that men remain secretive about their status often due to fear that it will decrease their chances of acquiring more sexual partners: Chief Simaiwa, a group village headman from Salima, noted that men in his village are often "shy" about revealing their status because "all women will run away, and he won't marry again."¹⁶³ During a group meeting with rural villagers in Chilumba one man noted, "Men are afraid, it means their women will run from them, but women are not afraid."¹⁶⁴

The socially accepted idea of masculinity as including multiple partnerships and unsafe sex encourages male high risk behavior. Men's reluctance to be tested and to pursue ARV therapy makes them vulnerable to dying of the disease. Indeed, very many of the women interviewed were widows. Men's behavior, in turn, places women at an increased risk of HIV and other sexually transmitted infections. Men must begin to take responsibility for the repercussions of the epidemic on their wives and children, as well as themselves, and programs must work in partnership with men to begin frank discussions about gender relations and HIV/AIDS and how men can become positive role models for change. Gender training community projects that work with men to reinterpret masculinity through discussions on the social pressures that encourage men to take sexual risks could prove useful.¹⁶⁵

154 Interview with Mara Kachare, Peer Educator, Partners in Hope, Lilongwe (May 29, 2007).

155 Interview with Carolyn M. Chilumba (May 21, 2007).

156 Interview with Miata Coleman, Peace Corps Volunteer, Lilongwe (May 28, 2007).

157 Interview with Catherine M., Mangochi (May 23, 2007).

158 Interview with Triness N., Nkhata Bay (May 23, 2007).

159 Interview with Kostas M., Chilumba (May 21, 2007).

160 Interview with Lenia M., Mchinji (May 21, 2007).

161 Interview with Christina N., Mchinji (May 21, 2007).

162 Interview with Laston C., Mangochi (May 23, 2007).

163 Interview with Chief Simaiwa, *supra* note 97.

164 Interview with rural man, Chilumba (May 22, 2007).

165 United Nations Population Fund (UNFPA), *State of World Population 2005* available at <http://www.unfpa.org/swp/2005/english/ch6/>.

II. Stigma and Discrimination Against Women Living with HIV/AIDS in Malawi

In 1996, Jonathan Mann, renowned leader in the health and human rights movement and former head of the World Health Organization's AIDS program, noted that, "In each society, those people who, before HIV/AIDS arrived, were marginalized, stigmatized and discriminated against, became over time those at highest risk of HIV infection."¹⁶⁶ This is true of women in sub-Saharan Africa generally,

and Malawian women specifically, whose low social, cultural, and economic status renders them highly vulnerable to infection. Women's inferior social status also intensifies their susceptibility to HIV/AIDS-related stigma and discrimination. HIV/AIDS-related stigma and discrimination compound pre-existing forms, including that based on gender¹⁶⁷ thereby reinforcing women's economic, cultural and social disadvantages.¹⁶⁸

Although many of the HIV-positive women interviewed acknowledge that HIV-positive men are also victims of stigma and discrimination, some noted that gender inequality makes women particularly susceptible to abuse. Mercy M., a 34-year-old woman from Chilumba, reported that community members regularly mock her when she attends support meetings at the National Association of People Living with HIV/AIDS in Malawi (NAPHAM). Mercy noted that her husband, who died of an AIDS-related illness in 2006, was not a target of abuse and attributes the difference in treatment to gender inequality: "Women are under-weighted; men are over-weighted."¹⁶⁹ Thandi M., a 32-year-old woman from Blantyre, who refuses to reveal her HIV status to her community out of fear of social isolation, observed that HIV-positive women are treated more harshly than HIV-positive men because "women do not have power like men."¹⁷⁰ Jennifer C., a 50-year-old woman from Salima, reasoned that "HIV-positive

women are more violated because they are the less privileged,"¹⁷¹ a statement echoed by many of the women interviewed.

HIV-positive women are also more likely to bear the brunt of HIV/AIDS-related stigma and discrimination because there are simply more women infected.¹⁷² In addition, based on the delegation's interviews, Malawian women may be more likely to go for HIV testing, join AIDS support groups, and access treatment in larger numbers than their male counterparts.¹⁷³ Women may be more willing to acknowledge their status and seek treatment because they are less concerned about loss of sexual partners and more concerned about surviving to care for their children. In any case, the increased visibility of women as the "face" of the epidemic translates into a higher likelihood that community members will be more often aware of the HIV status of women, making women more susceptible to stigma and discrimination.¹⁷⁴ "All the burden of HIV/AIDS, all the blame, is left on women," remarked Daphne Gondwe of the Coalition of Women Living with HIV/AIDS.¹⁷⁵

A. Community-Level Stigma

1. VERBAL ATTACKS

Verbal discrimination against people living with HIV/AIDS takes many forms including insults, taunts, name-calling, gossip and expressions of

166 Jonathan Mann, *Human Rights and AIDS: The Future of the Pandemic*, 30 J. MARSHALL L. REV. 195, 201 (1996).

167 Peter Piot, Executive Director, UNAIDS, Panel on Exploring the Link: HIV/AIDS, Stigma, Discrimination and Racism, for the United Nations High Commissioner for Human Rights (Sept. 5, 2001).

168 RICHARD PARKER ET AL., HIV/AIDS-RELATED STIGMA AND DISCRIMINATION: A CONCEPTUAL FRAMEWORK AND AN AGENDA FOR ACTION 2 (2002).

169 Interview with Mercy M., Chilumba (May 21, 2007).

170 Interview with Thandi M., Blantyre (May 21, 2007).

171 Interview with Jennifer C., Salima (May 23, 2007).

172 Slyvia Chirawu, *Till Death Do Us Part: Marriage, HIV/AIDS and the Law in Zimbabwe*, 13 CARDOZO J.L. & GENDER 23, 29 (2006).

173 See, e.g., Interview with Grace M., Chilumba (May 21, 2007); Interview with Maria C., Chilumba (May 21, 2007); Interview with Annie C., Salima (May 23, 2007); Interview with Miriam S., Salima (May 23, 2007); Interview with Livas K., Nkhata Bay (May 23, 2007); Interviews with rural men and women, Chilumba (May 22, 2007); Interview with men and women, Nkhata Bay (May 24, 2007).

174 Human Rights Watch (HRW), *A Test of Inequality: Discrimination against Women Living with HIV in the Dominican Republic* 13 (2004).

175 Interview with Daphne Gondwe, *supra* note 79.

blame and shame.¹⁷⁶ Gossip and name-calling have particularly harsh consequences for women, who often depend on social networks¹⁷⁷ to gain access to resources like micro-credit loans. WLWHA throughout the country described verbal attacks as the most common symptom of community-level stigma:

Bertha C., a 37-year-old woman from Blantyre, reports that after community members discovered she was attending an HIV/AIDS support group they began to “torture” her and other positive women with the taunt “look at them, they’re positive; they’re going to die.”¹⁷⁸ Jean M., a 21-year-old mother of two from Chilumba, reports that community members deride both her and her younger child, who is also positive, with the insult: “You are dead while you are alive.”¹⁷⁹ Miriam K. from Chilumba has lost four of her children to HIV/AIDS, all of whom were infected at birth. Although Miriam has received steady emotional support from her second husband, who is not HIV positive, she reports that community members shout at her when she attends HIV/AIDS support groups and tell her surviving children that she “is cursed, is a coffin.” Perplexed by the lack of support in her community, Miriam is left only to ask, “How can you help me with shouting?”¹⁸⁰

Esther M., who was fired from her job as a domestic worker after her boss discovered she was HIV positive, notes that community members in her Chilumba village deride PLWHA, often making remarks such as, “They are alive just because of the drugs, but really they are dead.”¹⁸¹ After Chikosa L.’s first husband died of AIDS in 1995 she endured two years of verbal attacks in her Chilumba village before the intensity and consistency of the attacks forced her to flee: “I decided to leave because I was mistreated and teased by people there. I left with just my clothing. The rest of the property was taken by people there. I didn’t want to go back to recover anything because they teased me and I feared going there.”¹⁸²

Overt discrimination in the form of language is

highly stigmatizing and disempowering. Community members often reserve specific disparaging words and phrases exclusively for people living with HIV/AIDS.¹⁸³ As she fetched water at the village bore hole community members in Nazen C.’s Salima village routinely called her “wakachirombo,” a derogative term targeting HIV-positive people, at one point resulting in a physical altercation.¹⁸⁴ Towera Kamwera, a 41-year-old woman from Mzang’unya in Chilumba, who was diagnosed with HIV in 2000 after short and frequent illnesses, is the only woman in her community publicly open with her HIV status. “We are given nicknames,” she said, one of which is translated as “sun-dried fish.”¹⁸⁵ People also often say “they were found with that disease” in Chichewa, exhibiting a refusal to name HIV/AIDS which is also stigmatizing.¹⁸⁶

2. SOCIAL EXCLUSION AND FEAR OF CASUAL TRANSMISSION

Some HIV-positive women also reported social exclusion due to communal fears of casual transmission as a common manifestation of HIV/AIDS-related stigma. The fear of casual transmission of the HIV virus reveals that some level of confusion persists about how the virus is spread.¹⁸⁷ People combine their correct knowledge regarding the sexual transmission of HIV with incorrect knowledge about casual transmission, which results in fear of physical contact with people living with HIV/AIDS and items connected to them.¹⁸⁸

Rose M., a 46-year-old mother of three from Nkhata Bay, learned of her HIV status in 2006. Before her diagnosis, she was afflicted with unexplained rashes, sores, and bouts of malaria, symptoms members of her village interpreted as signs of HIV, prompting the fear of casual transmission: “People will not use a bathroom or a bar of soap if I have used it. Some say, ‘These are dead people.’”¹⁸⁹ Rosemary K., an HIV-positive teacher from Blantyre, has

176 *Disentangling HIV/AIDS Stigma*, *supra* note 15, at 5; Parker et al., *supra* note 168, at 7.

177 *Disentangling HIV/AIDS Stigma*, *supra* note 15, at 38.

178 Interview with Bertha C., Blantyre (May 21, 2007).

179 Interview with Jean M., Chilumba, (May 21, 2007).

180 Interview with Miriam K., Chilumba, (May 21, 2007).

181 Interview with Esther M., Chilumba, (May 21, 2007).

182 Interview with Chikosa L., Chilumba, (May 21, 2007).

183 *Disentangling HIV/AIDS Stigma*, *supra* note 15 at 35.

184 Interview with Nazen C., Salima (May 23, 2007).

185 Interview with Towera Kamwera, Chilumba (May 21, 2007).

186 Interview with Bhatupe Mhango, Representative, UN Plus, Lilongwe (May 28, 2007).

187 Orianne Yin Dutka, *Turning a Weapon into A Shield: Using the Law to Protect People Living with HIV/AIDS in China from Discrimination*, 38 COLUM. HUM. RTS. L. REV. 421, 434 (2007).

188 *Disentangling HIV/AIDS Stigma*, *supra* note 15.

189 Interview with Rose M., Nkhata Bay (May 23, 2007).

only revealed her status to her relatives out of fear that communal misconceptions about HIV transmission will lead to social isolation: “The reaction from outsiders would not be good...They think they can get it from sitting with people or eating their food.”¹⁹⁰ Lina H. notes that during funerals she is not allowed to eat from the same plate as other villagers.¹⁹¹ When Haizo K. of Nkhata Bay attempts to sell tomatoes and fritters in her local market, customers are encouraged not to buy goods from her because of her HIV status.¹⁹² Desdardi Z. from Mchinji tried to start a poultry business as an income generating activity, but after her aunt publicly revealed her status people refused to buy poultry from her fearing that her “chickens were also HIV positive.”¹⁹³

Fear of casual transmission sometimes occurs even in work environments where one would expect correct knowledge of the ways HIV is spread. Mary D. worked with an AIDS organization in Salima, and after she discovered her HIV positive status reports that some of the organization’s staff members refused to use her cups.¹⁹⁴ Rose C., a 47-year-old healthcare worker from Mangochi, has experienced stigma from other healthcare workers: “[T]hose that know I am positive at the hospital where I work used to say ‘do not put me on the roster with her because she’s positive.’”¹⁹⁵

3. AIDS, SEX, MORALITY, AND DEATH

Women living with HIV/AIDS are often stigmatized as sexually immoral and promiscuous due to the sexual nature of transmission.¹⁹⁶ Miriam Kaluwa of the National AIDS Commission notes that in the 1990s it was often preached that HIV-positive people were “adulterers” and “careless” and this perception has been difficult to shake from the collective consciousness.¹⁹⁷ Interviews with traditional leaders and rural villagers exposed the strong and debilitating association between HIV status and perceived immorality:

Group village headman Jeffrey Ndula, a traditional leader in T.A. Kwambiri, Salima, noted that the stigma in his community exists because “people who are infected are seen as reckless, as people who sleep around.”¹⁹⁸ Group village headman Ntonga, a traditional leader in T.A. Kalonga, Salima, echoed this sentiment and argued that people living with HIV/AIDS often hide their status from the community, not out of fear of discrimination, but because HIV/AIDS is a “bad disease.” “It seems as if you are the person who knows how to fuck,” he said bluntly, referring to the common association between HIV/AIDS and promiscuity.¹⁹⁹ A rural woman in Kwambiri insisted that “HIV-positive people stigmatize themselves because they know the way they acquired the virus.”²⁰⁰ Chrissy K., a 23-year-old mother of two from Mchinji, reports that neither she nor any HIV-positive person in her village gets aid from the chief because he blames them for their status: “He says we have the virus because we wanted it.”²⁰¹

During a community meeting with a group of rural women in a village in T.A. Kalonga, Salima, the women associated the spread of HIV/AIDS with promiscuity, reserving the greatest amount of blame for women engaged in informal sex work in their village. “Some women wear short skirts to attract the men in town. The way their bodies look the men can’t resist,” said one woman, adding that “AIDS is spreading much faster because of poverty. It’s hard to get money in Malawi. That’s why the women dress that way—to make business.”²⁰² Other women rejected the idea that poverty forces women to engage in informal sex work, arguing that “[T]he women who wear short skirts! do this because when they discover they are HIV positive, they want to spread the disease and infect more people.”²⁰³ One thing all the women could agree on was that “the women in the short skirts all die.”²⁰⁴ Due to

190 Interview with Rosemary K., Blantyre (May 21, 2007).

191 Interview with Lina H., Chilumba (May 21, 2007).

192 Interview with Haizo K., Nkhata Bay (May 23, 2007).

193 Interview with Desdardi Z., Mchinji (May 21, 2007).

194 Interview with Mary D., Salima (May 23, 2007).

195 Interview with Rose C., Mangochi (May 23, 2007).

196 *Disentangling HIV/AIDS Stigma*, *supra* note 15 at 18.

197 Interview with Miriam Kaluwa, Policy Officer, National AIDS Commission, Lilongwe (June 1, 2007).

198 Interview with Chief Jeffrey Ndula, Group Village Headman of Kwambiri, Salima (May 23, 2007).

199 Chief Ntonga, Group Village Headman of Kalonga, Salima (May 23, 2007).

200 Interview with rural woman, Salima (May 23, 2007).

201 Interview with Chrissy K., Mchinji (May 21, 2007).

202 Interview with rural women, Salima (May 24, 2007).

203 *Id.*

204 *Id.*

Communities condemn people who have AIDS as sinners. People think of it as a result of something you did or shouldn't have done. People say 'see what happens to your friends? Now you better not do the same.'

grinding poverty and the constant flow of outsiders, the practice of sex in exchange for food and other items is rampant in lakeshore districts like Salima. Since so many women engage in informal sex work as a matter of survival, Emma Kaliya of the Malawi Human Rights Resource Center finds the blame attached to this type of activity hypocritical: "During the day it's immoral, but at night they are doing the same. So we need to get past the virus as immoral."²⁰⁵ The stigmatization of HIV-positive people as sexually immoral not only demonizes them, but also feeds into the denial of community members who do not want to believe that they themselves are at risk.

Gift Rapozo, the District Commissioner of Salima and the highest-ranking government official to publicly reveal his HIV positive status, notes that community members often wrongly view HIV/AIDS as a mark of moral failing:

Communities condemn people who have AIDS as sinners. People think of it as a result of something you did or shouldn't have done. People say 'see what happens to your friends? Now you better not do the same.' Even at funerals, they always want to come back to that, as if the person who died of AIDS did something they shouldn't have done. We have to look at other issues and conditions

[related to HIV/AIDS] instead of looking at it as a sin.²⁰⁶

The stigmatizing link between HIV status and immorality intertwines with the powerful fear of death still associated with the disease,²⁰⁷ despite the increasing availability of anti-retroviral life-saving drugs.²⁰⁸ "There is fear because of AIDS—maybe you can die—so you feel shy," noted group village headman Simaiwa, a traditional leader of 18 villages and 289,000 households in Salima.²⁰⁹ The associated link between AIDS, sex, and death creates "a strong belief that HIV is a punishment from God for sexual sins committed by humanity at large, and individuals in particular."²¹⁰ "I feel everyone is HIV positive. I think it is a plague affecting everyone," noted a rural woman in Salima.²¹¹

4. FEAR OF STIGMA AS AN IMPEDIMENT TO STATUS DISCLOSURE

HIV/AIDS-related stigma has created a blanket of silence and secrecy among people living with HIV/AIDS.²¹² Women often decide whether to disclose their HIV status to the community depending on the level of stigma present in the community, often concluding that disclosure will lead to added stigma.²¹³ The fear of stigma has become so great, notes Grace Malera of the Malawi Human Rights

205 Interview with Emma Kaliya, Program Manager, Malawi Human Rights resource Center, Lilongwe (May 29, 2007).

206 Interview with Gift Rapozo, *supra* note 128.

207 See *Disentangling HIV/AIDS Stigma*, *supra* note 15, at 17.

208 There are currently over 100,000 Malawians on anti-retroviral treatment. Interview with Tony Harries, Technical Assistant in HIV Care & Support, Ministry of Health, Lilongwe (May 29, 2007). Many of the HIV-positive women the delegation interviewed expressed frustration at the distances they must travel in order to access ARVs, which are mainly dispensed in district hospitals and not in local health centers. See, e.g., Interview with Miriam S., Salima (May 23, 2007) (stating that "I am on ARVs. I get it from the district hospital monthly. I live 2km away from the hospital...It is very far and thinking of [money for] transport is hard...If I don't sell firewood then I can't afford the transport to the hospital."); Interview with Enita M., Salima (May 23, 2007) ("I have been on ARVs since 2005. I get it from the district hospital...The hospital is 5km away...Sometimes I have to walk and it takes more than two hours to walk there"); Interview with Jennifer C., Salima (May 23, 2007) ("The district hospital is 6km away...If I don't find the kwacha [money for transport] I walk with difficulty and it takes 2½ hours").

209 Interview with Chief Simaiwa, *supra* note 96.

210 See *Disentangling HIV/AIDS Stigma*, *supra* note 15, at 19.

211 Interview with rural woman, Salima (May 24, 2007).

212 See Dutka, *supra* note 187 at 446.

213 See, e.g., *infra* notes 216–220.

Commission that “people would rather suffer in silence than come out in the open.”²¹⁴

Although the delegation did meet with women such as Queen Kaula, a 38-year-old widow from Karonga, who have chosen to reveal their HIV status to their communities (“I want to be as an example,” Queen remarked), verbal attacks, social isolation, the conception of PLWHA as immoral and promiscuous and other forms of community-level stigma, have created an atmosphere in which women living with HIV/AIDS fear disclosing their status to anyone but close relatives and fellow members of HIV/AIDS support groups. Loni S. from Blantyre has only revealed her status to her mother: “I don’t want people to know my status. I hear jokes all the time and I do not want to be denounced...They will say you’re weak and cannot do anything.”²¹⁵ Merezia P., a 55-year-old widow from Blantyre who learned her status in 2006, has only revealed her status to her eldest son out of fear that community members will ridicule her: “In the community, people think that if you have HIV, you’ll die. No one tells anyone they have HIV. Many have it—I know this because physically, you can tell. People will lie and say they have tuberculosis or another disease instead of disclosing.”²¹⁶

Ellen T., a 45-year-old widow and mother of seven from Blantyre, learned of her HIV status in 2004 when doctors diagnosed her youngest child with HIV. Due to fear of isolation and insults from the community, she refused to divulge her status to anyone but her sister and HIV/AIDS support group, although people in the community who suspect her of being HIV positive nonetheless taunt her children with the statement: “Your mother is going to die from AIDS.”²¹⁷ Chiwondi M., a mother of two HIV-positive children in Blantyre, has not told anyone, including family members of her HIV status: “Nobody else knows in my community because they would treat me badly. I have seen this happening to other women. I’m afraid of discrimination in my home, community, and church.”²¹⁸ Hilda K. of Mangochi echoed this fear: “The community does not know because if they knew they will talk bad about me and they will not be my friends anymore. I saw it hap-

pening to others.”²¹⁹

People living with HIV/AIDS also often fear being identified with anything that might reveal their status. At the Lighthouse clinic, Malawi’s premier HIV/AIDS service provider in Lilongwe, which assists over 4000 patients per month, clients who are moderately to severely underweight receive packets of peanut butter from the clinic’s therapeutic feeding center. Fred Chiputula, the clinic coordinator, reports that even the peanut butter packets have become stigmatized: “There is now some stigma associated with the cartons the peanut butter packets come in because it is associated with the ARV [anti-retroviral] center. Some people hide the peanut butter packets in their clothes so that the other villagers won’t see the labels, or they don’t take all of the packets. We can’t dispute that stigma is there.”²²⁰

During a community meeting with a group of rural women in Kudaize Village in Salima, the women affirmed that fear of disclosure due to stigma was not unfounded, although they denied stigma occurred in their village. The women noted that communities often exclude HIV-positive people from social groups.²²¹ Another woman remarked that, “People in the community can access meds, but they hide because they are shy and don’t want people to know because people will say a lot of things. It’s not that all people laugh but people are scared that people will laugh...Some people hang themselves. Not in this village but in other communities, they drown themselves.”²²² During an interview with three HIV-negative women in Mangochi, they confirmed that HIV-positive women in their villages refuse to disclose their status due to well-founded fears that their husbands will divorce them and community members will call them “prostitutes” and shun them.²²³

In early 2007, in a shocking public display of stigma, a prominent chief in Nkhata Bay stated that HIV-positive people should be “marked” with paint on their foreheads so that community members could identify them.²²⁴ Although the majority of the HIV-positive women the delegation interviewed have shied away from publicly declaring their status, communities use many “markers” to identify who is

214 Interview with Grace Malera, Principle Legal Officer, Malawi Human Rights Commission, Lilongwe (May 29, 2007).

215 Interview with Loni S., Blantyre (May 21, 2007).

216 Interview with Merezia P., Blantyre (May 21, 2007).

217 Interview with Ellen T., Blantyre (May 21, 2007).

218 Interview with Chiwondi M., Blantyre (May 21, 2007).

219 Interview with Hilda K., Mangochi (May 23, 2007).

220 Interview with Fred Chiputula, Clinic Coordinator, Lighthouse, Lilongwe (May 28, 2007).

221 Interview with rural men and women, Salima (May 24, 2007).

222 Interview with rural women, Salima (May 24, 2007).



Community celebration involving numerous HIV/AIDS support groups in Mchinji. Based on the delegation's interviews, Malawian women may be more likely to go for HIV testing, join AIDS support groups, and access treatment in larger numbers than their male counterparts.

HIV positive. Rural men and women in Salima admit to using physical markers and symptoms to determine which of their neighbors might be infected. Women in Kudaize Village identified pneumonia, malaria, and shingles as tell-tale signs of HIV,²²⁵ while women in T.A. Kwambiri said they become suspicious when they notice someone becoming very slim and displaying thinner hair, darker skin, redder lips and body sores.²²⁶

Ethel C., a 42-year-old mother of two from Blantyre, was forced to flee her village after community members began to suspect her of being HIV positive when her husband's second wife died of AIDS.²²⁷ After Esther K.'s husband passed away, her neighbors began to suspect she was HIV positive: "People assumed that because of the way he [my husband] suffered that he had AIDS and now 'she has AIDS,

too' they think."²²⁸

Community members also interpret monthly trips to the hospital as well as active membership in HIV/AIDS support groups as additional markers of HIV infection: Rebecca B. from Blantyre, who lost both her husband and newborn child to AIDS in 2000, was "outed" as HIV positive when neighbors spotted her going to the clinic to access her monthly supply of anti-retroviral medication.²²⁹ Memory P., a 27-year-old woman from Blantyre, believes that members of her support group may have revealed her status to the rest of the community. She remarked that since discovering her status, community members chant, "Without ARVs, you are nobody."²³⁰

Fear of HIV/AIDS-related stigma and discrimination discourages people from seeking testing and treatment.²³¹ During a community meeting with rural

223 Interview with women, Mangochi (May 24, 2007).

224 Interview with David Nyarongo, Program Manager, National Association of People Living with HIV/AIDS (NAPHAM), Lilongwe (May 28, 2007).

225 Interviews with rural women in Kudaize Village, Salima (May 24, 2007).

226 Interviews with rural women in T.A. Kwambiri, Salima (May 24, 2007).

227 Interview with Ethel C., Blantyre (May 21, 2007).

228 Interview with Esther K., Blantyre (May 21, 2007).

229 Interview with Rebecca B., Blantyre (May 21, 2007).

230 Interview with Memory P., Blantyre (May 21, 2007).

231 *Disentangling HIV/AIDS Stigma*, *supra* note 15 at 2; UNAIDS report, *supra* note 2 at 8.

men and women in Kaswese Village in Nkhata Bay, villagers noted that community level stigma, especially in the form of verbal attacks on HIV-positive people, has discouraged community members from learning their HIV status. “When a woman with HIV fetches water, the other women move away. There is teasing and stigma. They say, ‘You are dead’ or ‘She has gone to the graveyard.’ Some people are afraid to be tested so they only go to the witchdoctor who will just keep saying ‘1,500 [kwacha] (11 USD),’” noted one woman.²³²

5. FAILURE TO RECOGNIZE STIGMA AND COMMUNITY DENIAL

One of the core challenges in addressing stigma is the lack of recognition on the part of community members regarding how certain characterizations of PLWHA are in fact stigmatizing.²³³ The delegation met with rural men and women who on one hand affirmed the damaging nature of stigma and discrimination while simultaneously and stereotypically characterizing HIV-positive people as weak and useless. For instance, a group of rural women in T.A. Kwambiri, Salima, acknowledged that stigma was harmful, and yet when delegation members asked about the challenges that women living with HIV/AIDS face, the women responded that HIV-positive women “don’t keep up their homes because they are too weak” and “can do lighter work but not heavier work.”²³⁴ The characterization of PLWHA as “weak” is deeply stigmatizing and has shut many HIV-positive women out of social welfare programs that have a labor component, including food-for-work and cash-for-work programs and the acquisition and use of fertilizer subsidies.

Another impediment to addressing stigma is community denial regarding the existence of HIV/AIDS-related stigma and discrimination. During a community meeting in T.A. Kwambiri with a group of thirteen men ranging in ages from 18 to 90, the men all denied that stigma and discrimination exist-

ed in their village and argued that PLWHA refused to reveal their status because of self-inflicted stigma.²³⁵ After the meeting a nineteen-year-old man who had been present at the group session approached delegation members and privately told them that, despite the group’s assertion that stigma is not a reality within the village, he had recently been diagnosed with HIV/AIDS and feared disclosing his status because of stigma: “There are many HIV-positive people in the village, but they don’t talk about it. They fear that people will laugh at them.”²³⁶

During an assembly with over 100 students at a secondary school in Monkey Bay, the delegation asked the students how many knew at least one person who is HIV positive. Only a few students raised their hands. During smaller group interviews, several students noted that the students in the assembly did not want to publicly acknowledge knowing someone with HIV/AIDS.²³⁷

Gift Rapozo, District Commissioner of Salima, believes that community denial surrounding the existence of stigma is a manifestation of denial regarding the far-reaching effects of the epidemic itself: “There is a culture of denial. People are not accepting that we have a problem in our midst. This is why people are denying stigma against HIV-positive people exists. People think by denying [stigma], [AIDS] will disappear. But it’s something that is real. We need to be honest with ourselves.”²³⁸ Denial has not only been relegated to the poor villages of Malawi. There is silence from the middle and upper classes whose ranks have failed to escape the effects of the epidemic. Professionals tend to shun HIV/AIDS support groups,²³⁹ and openness regarding HIV status is often associated with the poor and marginalized.²⁴⁰ Many political figures have also remained silent on the issue. When Commissioner Rapozo first publicly revealed that he was HIV positive in 2006, hoping that his example would inspire other political figures to do the same, he reports that some people, including family members, questioned

232 Interviews with men and women in Kaswese Village, Nkhata Bay (May 24, 2007).

233 *Disentangling HIV/AIDS Stigma*, *supra* note 15 at 21.

234 Interview with rural women, Salima (May 24, 2007).

235 Interview with rural men, Salima (May 24, 2007).

236 Interview with young man, Salima (May 24, 2007).

237 Interviews with students, *supra* note 153.

238 Interview with Gift Rapozo, *supra* note 128.

239 Interview with Daphne Gondwe, *supra* note 79.

240 Interview with David Nyarongo, *supra* note 224.

241 Interview with Gift Rapozo, *supra* note 128.

242 *Id.*

243 Interview with Patrick Kabambe, Principle Secretary for Agriculture and Food Security, Ministry of Agriculture, Lilongwe (May 30, 2007).

why such a senior official would disclose his status.²⁴¹ “If [political leaders] want people to go and test with confidence,” stresses Rapozo, “we must be honest.”²⁴²

B. Discrimination

1. SOCIAL PROTECTION PROGRAMS

HIV/AIDS-related discrimination has resulted in widespread exclusion of HIV-positive women from participation in social protection programs including federal fertilizer subsidy programs, food-for-work and cash-for-work programs.

a. Federal Fertilizer Subsidies

In 2005 the government launched a federal fertilizer subsidy program that distributes fertilizer coupons to small-scale farmers and vulnerable households in order to address the food security crisis triggered by chronic drought.²⁴³ Although Ministry of Agriculture guidelines charge village development committees with the task of distributing fertilizer coupons, in most instances individual village chiefs have distributed the coupons, resulting in corruption, nepotism, and widespread discrimination against people living with HIV/AIDS and other vulnerable groups. HIV-positive women cited systematic denial of access to fertilizer coupons as a common form of HIV/AIDS-related discrimination.

The Ministry of Agriculture acknowledges having received formal complaints of discrimination regarding the fertilizer coupon program from a group of people living with HIV/AIDS in the southern region as well as the organization Physically Impaired People.²⁴⁴ Patrick Kabambe, Principle Secretary of the Ministry of Agriculture, maintains, however, that limited number of fertilizer coupons,²⁴⁵ not discrimination in distribution, is the primary root of the problem: “When you have a limited supply, interested parties will feel left out.”²⁴⁶ Although the ministry did not carry out a deliberate policy of discrimination, and limited supply and corruption have

played a major role in limiting the number of HIV-positive women accessing the coupons,²⁴⁷ it is undeniable that HIV/AIDS-related discrimination has also played a significant role.

The delegation documented numerous accounts of discrimination by traditional leaders against HIV-positive women because of conceptions of PLWHA as weak, useless, and of limited labor capacity. When Lina N., a 52-year-old widow from Chilumba, complained to the chief about her lack of access to fertilizer coupons she was told, “You have nothing to do in this world, just go—die.”²⁴⁸ Katherine K. of Chilumba remarked, “I can’t get a coupon to buy fertilizer or maize. They give to those who are not HIV positive. They say people who are HIV positive are already dead.”²⁴⁹ Kristina M. from Salima was denied a fertilizer coupon in 2006: “The chief said I was not strong enough to cultivate a garden. I never complained to anyone because I was very depressed thinking that nothing would work.”²⁵⁰ Jennifer C. echoed a similar sentiment of frustration and hopelessness: “It is hard to access fertilizer coupons... They tell us since we’re often sick we shouldn’t be given the coupons. I don’t know of any HIV-positive person who has been given a coupon... I never complained about the fertilizer coupons because I don’t know about my rights.”²⁵¹

Groups of people living with HIV/AIDS have formally organized to draw attention to widespread discrimination in the distribution of fertilizer coupons. Dr. Mary Shawa, Principle Secretary for HIV/AIDS and Nutrition in the Office of the President, reports that in February 2007, busloads of over 170 people living with HIV/AIDS journeyed to Lilongwe to present her with formal grievances concerning discrimination in the distribution of fertilizer subsidies. “The chiefs believe they are already dead,” Dr. Shawa noted.²⁵² In 2005, the Central Region Committee of the Coalition of Women Living with HIV/AIDS began to receive reports that women were not receiving coupons because of their HIV

²⁴⁴ *Id.*

²⁴⁵ The program targeted 1.5 million households while ministry studies revealed that over 3 million families were in need. *Id.*

²⁴⁶ *Id.*

²⁴⁷ Interviewees confirmed that chiefs illegally sold fertilizer coupons and often distributed coupons to relatives and friends. See, e.g., Interview with Anne Z., Salima (May 23, 2007) (“In my area, when the chief gets the coupons he gives them at night and says they are finished in the morning. He gives it to relatives as well as friends and some he sells for bribery.”); Interview with Chrissy Y., Mchinji (May 21, 2007) (“The chief... only manages to give coupons to his relatives.”); Interview with Joyce P., Mchinji (May 21, 2007) (“The chief gives coupons to village committee people... They are also given to friends and relatives. There is a lot of corruption”); Interview with rural men, Salima (May 24, 2007).

²⁴⁸ Interview with Lina N., Chilumba (May 21, 2007).

²⁴⁹ Interview with Katherine K., Chilumba (May 21, 2007).

²⁵⁰ Interview with Kristina M., Salima (May 23, 2007).

²⁵¹ Interview with Jennifer C., Salima (May 23, 2007).

²⁵² Interview with Dr. Mary Shawa, Principal Secretary for HIV/AIDS and Nutrition, Office of the President, Lilongwe (May 28, 2007).

status in Mchinji, Nchewu, Dzedza, Salima, and Kasungu: “The chiefs would say, ‘You are already dead people. You are walking skeletons. What do you need?’” noted Victoria Kalumba, central region coordinator.²⁵³ In late 2006, the Central Region Committee organized a group of thirty HIV-positive women from Mchinji to submit a formal complaint to the Mchinji District Commissioner.²⁵⁴ A group of traditional leaders in Mchinji acknowledge that many lower level chiefs who were charged with distributing fertilizer coupons had in fact refused to allow PLWHA to access the coupons during the 2005–2006 season.²⁵⁵ Alice Mtalika, one of the Coalition’s “Mchinji 30,” has been publicly open about her HIV status since being diagnosed in 2004, and notes the cruel hypocrisy of a program designed to aid vulnerable groups denying many of those most in need: “The chiefs say: ‘just get out.’ They say ‘these people are sick—they could die at any time.’ They claim they are giving the aid to poor people. How about me?”²⁵⁶

b. Food-for-Work and Cash-for-Work Public Works Programs

Women living with HIV/AIDS report being denied participation in food-for-work and cash-for-work programs because of the common community perception that HIV positive status renders one incapable of participation in labor activities. “This is the attitude [about HIV- positive people] across the board,” notes Dr. Mary Shawa, who acknowledged receiving reports of discrimination in public works programs against PLWHA. “People believe that if you have HIV you are too weak to work.”²⁵⁷ Food-for-work and cash-for-work programs are projects in which community members are given cash or food-stuffs in exchange for labor on public works endeavors such as the construction, rehabilitation and maintenance of rural roads, afforestation projects and small-scale irrigation projects. The most recognizable of these projects is the Malawi Social Action Fund’s (MASAF) cash-for-work program, a govern-

ment-run program that targets the “able-bodied poor” with a specific focus on vulnerable groups such as orphans, the elderly, and PLWHA.²⁵⁸ Although MASAF dismantled its food-for-work program in 1998, many organizations have continued to run food-for-work programs using MASAF guidelines.²⁵⁹

Several HIV-positive women from T.A. Kwambiri in Salima reported being denied participation in public works projects in 2006 that involved sweeping roads and planting trees.²⁶⁰ “They do not allow us and say that we are already dead because we are HIV positive,” remarked an HIV-positive woman who was denied participation in a public works project by a group of village headman in 2006.²⁶¹ “They say we are not strong enough to work on the roads,” remarked another.²⁶² Many of the women interviewed are currently on anti-retroviral medication and expressed frustration that incorrect assumptions about their health status limits their ability to contribute to community development and gain access to funds: Nazen C. noted, “They were constructing a road at T.A. Kwambiri and I was told that I was not strong enough to work. I felt I was strong enough to work but the chief’s supervisors said that I wasn’t.”²⁶³

HIV-positive women in T.A. Kalonga in Salima report that project supervisors assigned by the chiefs only choose HIV-positive people who manage to hide their status for public works projects.²⁶⁴ Stawa B., a 27-year-old mother of two, was denied participation in a food-for-work project in 2006: “The chief doesn’t defend me and wouldn’t let me be part of the project. I don’t know my human rights. The chief picks supervisors of the project. For the work you get a bag of maize, fertilizer, or rice. The supervisors didn’t let me participate and said if I had a problem I should go and speak to the chief....Only the people with HIV who are not open with their status are allowed to be part of the program.”²⁶⁵ “They do not employ me because of my status,” echoed Floness P. “They call me a ‘sickling’ and ‘AIDS case.’”²⁶⁶

253 Interview with Victoria Kalumba, Central Region Chair, Coalition of Women Living with HIV/AIDS, Mchinji (May 22, 2007).

254 *Id.*

255 Interview with Chiefs, *supra* note 80.

256 Interview with Alice Mtalika, Mchinji (May 21, 2007).

257 Interview with Dr. Mary Shawa, *supra* note 252.

258 See Interview with Booker Matemvu, Head of Development and Communications, Malawi Social Action Fund (MASAF), Lilongwe (May 31, 2007); see also <http://www.masaf.org/index.htm>.

259 Interview with Booker Matemvu, *supra* note 258.

260 Interview with women, Salima (May 24, 2007).

261 Interview with woman, Salima (May 24, 2007).

262 Interview with woman, Salima (May 24, 2007).

263 Interview with Nazen C., Salima (May 24, 2007).

264 Interview with women, Salima (May 24, 2007).

Women living with HIV/AIDS report being denied participation in food-for-work and cash-for-work programs because of the common community perception that HIV positive status renders one incapable of participation in labor activities.

MASAF runs a Community Scorecard program whereby community members can air their frustrations with MASAF projects. Through this mechanism, MASAF has received complaints from vulnerable groups, including orphans, the elderly, and the physically disabled, who believe they have been unfairly locked out of programs originally designed to benefit them.²⁶⁷ Booker Matemvu, MASAF communications coordinator, believes that one of the primary reasons for discrimination is competition among traditional leaders to build the most amount of infrastructure in the least amount of time. In the process, they disallow community members they perceive as weak from participating in public works programs. Matemvu noted that there is often confusion in communities regarding the MASAF cash-for-work programs' primary aim: "It has been a challenge to ensure that people are aware that the asset that results—like a new road—is a secondary outcome and the primary outcome is for vulnerable people to be able to get access to these jobs. The idea behind the public works program isn't just to provide a public asset for the community—it's to provide assistance to vulnerable people."²⁶⁸

2. MICROFINANCE LOANS

Microfinance institutions that provide small business loans to poor women can improve household living standards and mitigate the impact of HIV/AIDS.²⁶⁹

Yet, fear that inclusion of people living with HIV/AIDS in micro-lending circles will lead to higher rates of default and challenge the security of group loans has resulted in HIV/AIDS-related discrimination. The most well-known rural credit scheme in Malawi is the Malawi Rural Development Fund (MARDEF), which is comprised of existing microfinance institutions, and targets the rural poor with a particular emphasis on women, young people, and the disabled as potential beneficiaries. The fund aims to assist rural poor people by providing them with loans to establish small businesses.²⁷⁰ In order to apply for MARDEF loans, community members must form self-selecting groups of no less than ten and no more than twenty members. MARDEF bank officers do not participate in the formation of micro-lending groups.²⁷¹ MARDEF loans are also accompanied by insurance which guarantees that if a group member dies before repayment the remaining group members face no liability.²⁷² Despite this assurance, HIV-positive women report widespread discrimination from community members who refuse to include them in micro-lending circles.

Over 250 HIV-positive women in T.A. Mduwa presented Chief Mduwa of Mchinji with formal complaints that they were unable to access micro-credit loans because of HIV/AIDS-related stigma. The situation has become so serious that Chief Mduwa has taken the issue to the Mchinji District

265 Interview with Stawa B., Salima (May 24, 2007).

266 Interview with Floness P., *supra* note 58.

267 Interview with Booker Matemvu, *supra* note 258.

268 *Id.*

269 Interagency Coalition on AIDS and Development, *HIV/AIDS and Microfinance*, available at http://www.icad-cisd.com/pdf/publications/e_microfinance.pdf.

270 MARDEF was established in 2005. MARDEF selects participating microfinance institutions through a competitive process that takes into account technical and operational capacity and country-wide presence. MARDEF's total loan portfolio size is 5 billion kwacha. The loan interest rate is 15% and the maximum repayment period is 12 months. The default rate is loosely estimated at 20%. Examples of small business the loans have supported include fish, poultry and dairy farming, bee keeping, vegetable growing, fruit juice production, carpentry, and small-scale irrigation farming. See MARDEF Brochure; see also Interview with Robert Nyang'wa, Public Relations Officer, Malawi Rural Development Fund (MARDEF), Lilongwe (May 31, 2007).

271 Interview with Robert Nyang'wa, *supra* note 270.

272 MARDEF insurance does not cover losses if a group member becomes ill and cannot work. *Id.*

Commissioner.²⁷³ Group village headmen in T.A. Mduwa and T.A. Kapondo, Mchinji, echoed Chief Mduwa's concerns and noted that AIDS-related discrimination in access to microfinance is one of the greatest challenges HIV-positive women face.²⁷⁴ Group village headman Chapakama from Kapondo remarked: "This is happening to so many women who are HIV positive because they have revealed their status. This should come to an end and they should all have access to loans. This often happens in my village."²⁷⁵

After Ester Kaunda, a 43-year-old widow from Chilumba, publicly revealed her status and began working as an HIV/AIDS educator, community members refused to include her in micro-lending circles.²⁷⁶ Fales N. from Nkhata Bay has also been locked out of micro-lending groups, noting that "the villagers told me 'because you are sick you cannot repay the loan.'"²⁷⁷ Towera Kamwera of Chilumba reported a similar experience: "Villagers won't allow us loans. They say it's not possible. I've reported this to the chief but he won't help. We don't get the loans because [the villagers say] 'they will leave problems once they die.'"²⁷⁸ Miriam S. of Salima notes, "Most members of groups don't want me to be part of their groups. They say, 'When do you think you're going to repay them? From the grave?'"²⁷⁹

Another common discriminatory occurrence is the initial inclusion of WLWHA in micro-lending circles in order to reach the requisite number of participants followed by the subsequent removal of HIV-positive women once group members have acquired the loan. Nazen C. of Salima was part of a group of 12 that applied for a MARDEF loan, but after the loan was secured, group members voted to omit her name, along with the names of three other women who were suspected of being HIV positive.²⁸⁰ Kristina M. of Salima was part of a lending circle of 15 when her group applied for and received a MARDEF loan in 2005. Later, the group reduced the membership to 13, removing her because she was often

sick.²⁸¹ Annie C., a 42-year-old woman from Salima, related another such experience:

When I was tested I told my whole community. They keep us out of things saying, 'These are already dead women. Why should we involve them in these development activities?' We are denied access to micro loans by other group members. They fear that the HIV-positive people will die and not be able to pay back their loans. A group was formed in the village, and they kicked me out. From their conversations I could tell it was because I was HIV positive. Other group members eventually got the loan. I haven't tried [to join another group] again after this first failure.²⁸²

In the case of the replacement or removal of a group member, MARDEF requires the remaining members to submit a formal application stating the reasons for removal and to include a letter of confirmation from the traditional authority leader.²⁸³ When removals occur, bank officers working for MARDEF and other credit schemes should make every effort to locate and follow-up with the individual removed to ensure that discrimination did not play a part in the removal.

3. PROPERTY-GRABBING

Malawian women rarely enjoy the security that land ownership can provide in lessening the impact of HIV/AIDS. The practice of property grabbing, whereby a widow's property is seized by in-laws and relatives, is widespread in Malawi.²⁸⁴ In 1998, the Malawian Parliament passed a wills and inheritance bill that bolstered widows' rights.²⁸⁵ However, these rights are rarely respected under customary law, which is often the prevailing authority in Malawi, particularly in rural areas.

Women throughout Malawi, regardless of HIV status, are victims of property grabbing.²⁸⁶ The practice

273 Interview with Chief Mduwa, *supra* note 57.

274 Interviews with Chief Maole, Chief Kunungwi, and Chief Chimutu, *supra* note 80.

275 Interview with Chief Chapakama, *supra* note 80.

276 Interview with Esther Kaunda, Chilumba (May 21, 2007).

277 Interview with Fales N., Nkhata Bay, (May 23, 2007).

278 Interview with Tomera Kamwera, Chilumba (May 21, 2007).

279 Interview with Miriam S., Salima (May 21, 2007).

280 Interview with Nazen C., *supra* note 184.

281 Interview with Kristina M., *supra* note 250.

282 Interview with Annie C., Salima (May 21, 2007).

283 Interview with Robert Nyang'wa, *supra* note 270.

284 Emmanuel B.Z. Kondowe & David Mulera, *A Cultural Approach to HIV/AIDS Prevention and Care: Malawi's Experience*, iv, <http://unesdoc.unesco.org/images/0012/001222/122214e.pdf>.

is very widespread and further entrenches women's economic vulnerability.²⁸⁷ As devastating as property grabbing is for all widows, AIDS-related discrimination can aggravate the problem for WLWHA by limiting their ability to secure a remedy or to counter its effects. For example, the delegation interviewed women who believe their HIV status has made it more difficult to reacquire their property. Mary Szulu is a 42-year-old widow and mother of three from Kamwendo in Mchinji District who also cares for six AIDS orphans. In 2004 neighbors stole Mary's family garden after she disclosed her status, arguing that she was too sick to maintain it. She complained to a lower level chief who had witnessed her initial purchase of the plot, and at a small community gathering to discuss the incident, the neighbors acknowledged that they had taken the property because they assumed Mary would die. The village chief granted the land to the neighbors, remarking, in reference to Mary, "This one is going to die." Mary has since filed a claim in magistrate court in Mchinji. Without legal assistance, she doubts she will retrieve her land.²⁸⁸

Chrissie L., also of Mchinji, reported a similar experience. After Chrissie was diagnosed with HIV in 2004, the village chief reallocated part of her farm to other community members. The new owners planted trees to demarcate the boundaries of the land: "Though I was not told openly why my land was given away, I think it is because people think those with HIV are already dead... The chief said we would discuss the matter and that I should go talk to the new owners of the land. When I tried to talk to the new owners, they told me to talk to the chief. I have not pursued the matter further."²⁸⁹ Rene N. complained to a government official after her in-laws stole her property following her husband's death. The government official told her, "You will just die. You should leave this issue."²⁹⁰

Although property grabbing is criminalized, most women do not know they can report it to the authorities.²⁹¹ During a community meeting with

men, women, and village chiefs in Kaswese Village in Nkhata Bay, villagers expressed deep frustration with the high prevalence of property grabbing in their community and the lack of access to justice. One man remarked that women do not report instances of property grabbing to the police because of distrust of the authorities. A woman responded that even women who do go to the police are incorrectly turned away: "The policeman says you are supposed to go to your village headman. This case is not for here [the police]; it's for your headman."²⁹² Community members agreed that assistance in will-writing to safeguard property could possibly make a difference.²⁹³

C. Confronting Stigma and Discrimination: Conclusions and Recommendations

1. COMMUNITY-BASED INTERVENTIONS

Community-based interventions targeting smaller focus groups are needed to address community-level stigma. Workshops and messaging at the national level such as radio appeals and billboard announcements against stigma are valuable but insufficient if they are not accompanied by community-based interventions that tackle the roots of stigma. Donors should provide community-based organizations (CBOs)²⁹⁴ and national NGOs working at the community level with funding to implement programs that deliberately target smaller focus groups which would create safe spaces for individuals to work out misconceptions and discuss fears. The government should encourage the targeting of smaller focus groups in community-based interventions aimed at addressing stigma, providing logistical support to organizations working on the ground.

Well-coordinated and targeted interventions focusing on smaller focus groups at the community-level can facilitate behavior change and confront stigma by: 1) creating greater recognition of the exis-

285 Rebecca Tiessen, *Mainstreaming Gender in HIV/AIDS Programs: Ongoing Challenges and New Opportunities in Malawi*, 7 J. OF INT'L WOMEN'S STUDIES 1, 16 (Nov. 2005).

286 See, e.g., Interview with Jane N., Chilumba (May 21, 2007); Interview with Esther M., Nkhata Bay (May 23, 2007); Interview with men and women, Nkhata Bay (May 24, 2007).

287 See International Center for Research on Women, *To Have and To Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa* (2004).

288 Interview with Mary Szulu, Mchinji (May 21, 2007).

289 Interview with Chrissie L., Mchinji (May 21, 2007).

290 Interview with Rene N., Lilongwe (May 28, 2007).

291 Interview with Pacharo Kayira, Ministry of Justice, Lilongwe (April 23, 2007).

292 Interviews with men and women in Kaswese Village, (May 24, 2007).

293 *Id.*

294 CBOs in Malawi are non-governmental organizations that work at the community-level serving as umbrellas over local support groups that cater to the needs of groups such as orphans and PLWHA. CBOs often work with local government district assemblies to implement their interventions.

tence of HIV/AIDS-related stigma and its many manifestations; 2) dispelling myths about the casual transmission of HIV/AIDS; and 3) encouraging participatory discussions that address the stereotypes and misconceptions that inform beliefs about AIDS, sex, morality, and death.

Community-based interventions should also target traditional leaders whose support and leadership is crucial in efforts to address community-level stigma. Chiefs have an influential role to play in either affirming or challenging stigma. Interventions should target both higher-level chiefs who can play a critical leadership role and lower-level chiefs who have the most direct contact with the people. Traditional leaders' denial of stigma's existence can serve as implicit encouragement of stigma. When delegation members in Salima presented traditional leaders in T.A. Kalonga with the stories of stigma and discrimination arising from their communities, they all declared that HIV-positive women who claimed to be victims of stigma were "total liars" and refused to acknowledge the existence of any level of stigma in their communities.²⁹⁵ "The chiefs are at the forefront of discrimination," noted Miriam S., a 38-year-old HIV-positive woman from T.A. Kalonga. "They need civic education starting from the traditional authority leader all the way down [to the village headmen]."²⁹⁶

The case of Mduwa, a traditional authority area in Mchinji, is a prime example of the way in which pro-active traditional leaders can have a positive effect on reducing stigma within their communities. Chief Mduwa, the highest ranking chief in Mduwa, has waged a campaign against HIV/AIDS-related stigma and discrimination since 2001, working closely with volunteers from the Malawi Red Cross Society and establishing the Chief AIDS Committee to confront and discourage stigma. In 2000, the Malawi Red Cross Society conducted a survey that showed that traditional leaders could play a significant role in spreading HIV prevention, care and support messages. The Chief AIDS Committee speaks publicly and consistently about the importance of HIV testing and against HIV/AIDS-related stigma and discrimination. "I try and live by example," notes Chief Mduwa, "and the community follows my lead. I teach them

about the importance of human rights."²⁹⁷ One of the traditional leaders in the Chief AIDS Committee publicly declared that he was living with the virus in order to encourage others to get tested.²⁹⁸

Group village headmen from T.A. Mduwa and nearby T.A. Kapondo hailed Chief Mduwa as a pioneer and are working in partnership with Chief Mduwa to try and encourage other traditional authority leaders in Mchinji District to follow his example.²⁹⁹ Victoria Kalumba, Mchinji District coordinator of the Coalition of Women Living with HIV/AIDS, receives fewer reports of stigma and discrimination from T.A. Mduwa in comparison with other traditional authority areas in Mchinji District, a reflection of Chief Mduwa's willingness to acknowledge and confront problems that arise.³⁰⁰ Mary Chakonda, a 42-year-old widow from T.A. Mduwa, acknowledged the changes that have taken place in Mduwa, stating that "initially people wouldn't stay close" but now both she and her children are treated well by the community.³⁰¹

2. EFFICIENT TARGETING OF VULNERABLE GROUPS IN FERTILIZER SUBSIDY AND PUBLIC WORKS PROGRAMS

In order to address widespread discrimination in the fertilizer coupon and public works programs, the Ministry of Agriculture, MASAF, and other organizations involved in social protection programs must address the lack of monitoring mechanisms and inefficient targeting procedures that fail to ensure that vulnerable groups like orphans, the elderly, the physically disabled, and people living with HIV/AIDS benefit from these programs. Although targeting to the individual is often hampered by budget constraints and limited manpower, efficient targeting is necessary in programs aimed at assisting vulnerable groups.³⁰²

Traditional leaders often act with impunity, free to discriminate against PLWHA because of lack of accountability and monitoring mechanisms at the community level. This has resulted in vulnerable groups like WLWHA being shut out of programs designed to benefit them. In order to address problems within the fertilizer subsidy program, the Min-

295 Interview with Chiefs, *supra* note 96.

296 Interview with Miriam S., Salima (May 23, 2007).

297 Interview with Chief Mduwa, *supra* note 57.

298 MALAWI: Chiefs lead by example in response to HIV/AIDS, *PlusNews*, Dec. 21, 2006.

299 Interview with Chiefs, *supra* note 80.

istry of Agriculture is developing a scheme whereby community extension workers employed by the ministry will advise village development committees on criteria for targeting vulnerable households.³⁰³ Although the ministry's aim of removing village chiefs from the distribution process is noteworthy, the fact that there is currently only one extension worker per 3000 families will initially limit the effectiveness of the scheme.³⁰⁴

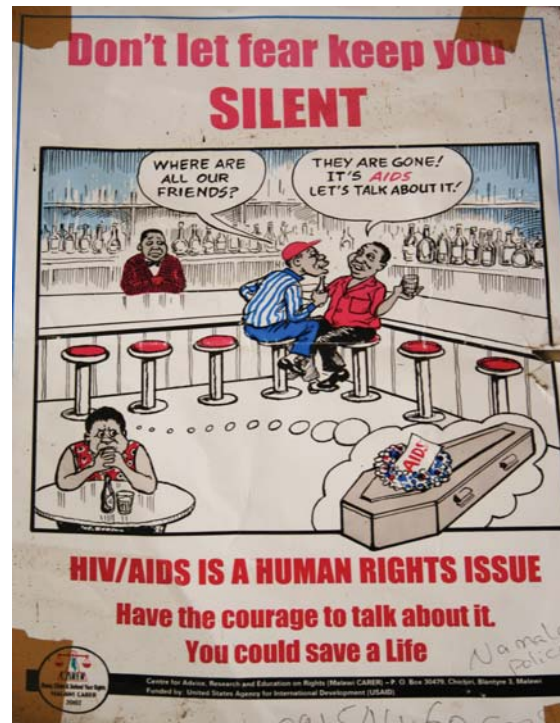
The efficient targeting of vulnerable groups and harsher penalties for those individuals who discriminate against them in social welfare programs will ensure that discrimination does not curb the participation of vulnerable groups in social protection programs.

3. TARGETING HIV-POSITIVE INDIVIDUALS IN MICRO-LENDING

In order to address the discrimination facing HIV-positive women in access to micro-loans, micro-finance institutions should formally incorporate into their projects HIV/AIDS targeting schemes that guarantee funds to people living with HIV/AIDS. Microfinance institutions should improve CBO and NGO access to microfinance projects that directly support people living with HIV/AIDS by encouraging PLWHA to form their own micro-lending circles and to apply for loans directly through their CBOs and NGOs. By applying via their HIV/AIDS support groups, PLWHA can gain access to micro-credit without necessarily declaring their status to their communities. Because so few individuals are publicly open about their HIV status, micro-finance institutions can guarantee they are assisting PLWHA only by working directly with organizations supporting PLWHA.

Micro-finance institutions should also continue to encourage those who are publicly open with their HIV status to form their own micro-lending circles and apply directly to micro-finance institutions for funds without necessarily using a CBO as an intermediary. By incorporating HIV/AIDS support projects into microfinance programs, micro-finance institutions will counter HIV/AIDS-related discrimination and directly address the devastating impact of the AIDS epidemic.

Chief Mduwa has waged a campaign against HIV/AIDS-related discrimination since 2001, working with volunteers from the Malawi Red Cross Society and establishing the Chief AIDS Committee.



A poster in the Police Station in Monkey Bay.

300 Interview with Victoria Kalumba, *supra* note 253.

301 Interview with Mary Chakonda, Mchinji (May 21, 2007).

302 Rights and Democracy and Foodfirst Information and Action Network (FIAN), *The Human Right to Food in Malawi* 48 (2006).

303 Interview with Patrick Kabambe, *supra* note 243; see also Interview with Mary Shawa, *supra* note 252.

304 The ministry's goal is the achievement of a ration of 1:700 which they admit will take years to reach. Interview with Patrick Kabambe, *supra* note 243.

III. Legal Interventions

A. Lack of Access to Justice

When women living with HIV/AIDS experience stigma and face HIV/AIDS-related discrimination in access to land ownership, micro-loans, fertilizer coupons, and participation in public works projects, a constant theme resounds: their lack of access to justice. Interventionist legal services have a significant role to play in addressing the stigma and discrimination HIV-positive women face.

WLWHA consistently complain of ignorance of their rights and lack of access to legal services and recourse to justice: Aida J., a 25-year-old woman from Mchinji, considered taking the village chief to court after he refused to grant her fertilizer coupons because of her HIV status, but eventually retreated due to chronic corruption in the court system.³⁰⁵ When Lestina N.'s deceased husband's relatives expelled her from her property in Chilumba, her appeals to the village chief went unanswered. She shied away from bringing a claim to the police: "It was not a way of our rights, to tell them," she stated.³⁰⁶ Memory K., a 33-year-old primary school teacher from Blantyre, had previously been aware that property grabbing is illegal; yet, when her deceased husband's family took everything "except her children and clothes," all attempts at retrieving her property proved fruitless: her husband's relatives bribed the village chief and the police refused to assist her.³⁰⁷ Rose M., a 32-year-old widow from Chilumba, reported a similar experience:

My husband died before starting ARVs. My children and I were told to leave and chased out of my husband's village after he died. I had to leave all of my property behind except my clothing. I was told to go to the village court before leaving but I didn't go there... My husband's relatives took the property. I have not considered any legal action. The village leaders and courts are not helpful. Now I just want to empower myself so my family can live better.³⁰⁸

Women also rarely report instances of discrimination to traditional leaders in their villages because chiefs are so often at the forefront of discrimination: Kostas M. of Chilumba believes she has been disallowed from participation in the village development committee because of her HIV status: "I cannot complain to the chief about being excluded from community affairs because he is part of it."³⁰⁹ Triness N., of Nkhata Bay, has never complained about her lack of access to fertilizer coupons: "The [village] headman hands out the fertilizer coupons so who is there to complain to?"³¹⁰

Many women express a desire for free legal services to help them fight the stigma and discrimination they face: Esther K. of Chilumba remarked, "I have been taught to be quiet. It would be helpful if someone could come and speak on my behalf."³¹¹ Despite their desire for legal services, women also often view lawyers as inaccessible and profit-driven: "I do not have a way of contacting a legal person," remarked Crystal M. of Blantyre. "Most of the time they want money and how can I pay? I will stay with my problems and not go any place."³¹² Dannick Kathumba of the Lighthouse clinic noted that the perception of legal services as commercially-driven discourages many of their clients from initiating legal services.³¹³

These fears may not be unfounded. During a delegation interview with a private lawyer in Lilongwe he unabashedly stated, "Those who can't pay shouldn't come here [to my office]. Poor people waste my time."³¹⁴ HIV-positive women also believe that stigma itself might limit the number of lawyers willing to take on "AIDS cases." Agnes J. from Mangochi said she has never considered approaching a legal service provider out of fear that they, too, would exhibit discrimination. "Even if you are right," remarked Agnes J., "you are wrong because of status."³¹⁵

B. Linking Health and Legal Services

There is an urgent need for free legal services and advice to women living with HIV/AIDS. Linking health and legal services is an innovative way to

305 Interview with Aida J., Mchinji (May 21, 2007).

306 Interview with Lestina N., Chilumba (May 21, 2007).

307 Interview with Memory K., Blantyre (May 21, 2007).

308 Interview with Rose M., Chilumba (May 21, 2007).

309 Interview with Kostas M., Chilumba (May 21, 2007).

310 Interview with Triness N., Nkhata Bay (May 23, 2007).

311 Interview with Esther K., Chilumba (May 21, 2007).



Staff members outside the Women's Voice paralegal office in Nkhata Bay. Women's Voice was established in 1993 to protect and promote the welfare of women and children through paralegal services, human rights education, home-based care, marriage counseling, and the promotion of policy reform.

address widespread HIV/AIDS-related stigma and discrimination and the lack of access to justice faced by HIV-positive women. This linkage can be realized through the establishment of referral networks in health clinics to legal aid and paralegal service providers and the integration of legal aid and paralegal services into the health setting. By incorporating legal services into their portfolio of services, AIDS service providers will nurture an environment in which "people are less vulnerable to HIV and more likely to enjoy the benefit of prevention, treatment, care, and support services."³¹⁶

1. REFERRAL NETWORKS

AIDS service providers should establish referral networks to legal aid services providers such as the Malawi Law Society, the Women Lawyers Association, the Center for Legal Assistance, and the Malawi

Legal Aid Department and paralegal service providers such as Women's Voice and the Malawi Center for Advice, Research and Education on Rights (CARER). However, referral systems will be insufficient if legal service providers do not familiarize themselves with the issues affecting people living with HIV/AIDS, including HIV/AIDS-related discrimination.³¹⁷ Furthermore, referral systems will also be insufficient if government and donors do not give legal aid and paralegal service providers the financial and technical support required to expand and strengthen their services.

Health clinics should also refer clients experiencing HIV/AIDS-related discrimination to the underutilized Human Rights Commission. The Human Rights Commission has only recently focused on increasing its involvement with HIV/AIDS-related human rights cases. Since 1994, only five HIV/AIDS-related cases

312 Interview with Crystal M., Blantyre (May 21, 2007).

313 Interview with Dannick Kathumba, Deputy Home Based Cared Coordinator, The Lighthouse, Lilongwe (May 28, 2007).

314 Interview with private lawyer, Lilongwe (May 29, 2007).

315 Interview with Agnes J., Mangochi (May 23, 2007).

316 Open Society Institute, *Ensuring Justice for Vulnerable Communities in Kenya: A Review of HIV and AIDS-related Legal Services* 30 (2007) [hereinafter *Ensuring Justice*].

317 *Id.* at 27.

have been filed with the commission; none have included HIV-positive women as complainants.³¹⁸ “People don’t know they can come to the commission with HIV-related abuses, but we know there are many cases,” notes Grace Malera, principle legal officer at the Commission.³¹⁹ The Commission should publicize itself as a possible mechanism for HIV/AIDS complaints and encourage AIDS service providers to refer clients who have experienced discrimination to the commission. Although the Commission is located in the capital, and therefore is out of reach for most rural people, the Commission’s reception to HIV/AIDS-related discrimination cases could raise the issue’s national profile.

2. INTEGRATION OF LEGAL SERVICES WITHIN THE HEALTH SETTING

AIDS service providers should also consider piloting projects that integrate legal services within the health setting. Some organizations in Africa have already implemented similar systems. For example, Comprehensive Community Based Rehabilitation in Tanzania, in conjunction with Tanzanian district health authorities, runs the Holistic HIV/AIDS Related Program (HARP).³²⁰ In addition to providing voluntary counseling and testing (VCT), home-based care, and anti-retroviral treatment, the clinic also provides legal aid services. HARP sees the initial medical consultation as an opportunity to reach out to PLWHA, particularly women.³²¹ Their program includes services that address clients’ potential legal needs including childcare, guardianship, employment disputes, and disposal of property.³²² The piloting of similar programs in Malawi might prove useful in holistically addressing the needs of WLWHA.

Organizations in other parts of the world have also established integrated health and legal services programs. In an attempt to address the increasing number of HIV-positive women in Alameda County, California, U.S.A., the Family Care Network partnered with the HIV Law Project, a public hospital, a

methadone clinic, a provider of at-home nursing care, and a private hospital serving children with HIV/AIDS.³²³ The aim of the project was to offer services to HIV-positive women in a more holistic manner, taking into consideration the specific needs of women.³²⁴ The hospitals began to centralize their system of delivering services by allowing an HIV-positive mother to get check-up when she took her child in for a doctor’s appointment. During this medical visit the mother could also apply for home based care, enter into a clinical trial, and sign up for a “legal check up.”³²⁵ The legal check up is designed to identify immediate needs such as pending eviction or denial of benefits and to have the client consider more long term needs such as child care during hospitalization and drafting a will.³²⁶

Some Malawian AIDS service providers have questioned the efficacy of integration programs. Enous Chang’ana, the medical director of the Lighthouse clinic, expressed reservation about the usefulness of such an endeavor, a sentiment echoed by other Lighthouse staff members: “The integration of services is the talk of the day...The challenge is how do you put this together and with whose agenda? Yes, clients need legal services, but what does it do for our focus? What does it do to our structure? We have concerns about doing too many things...People might come to see Lighthouse as a court rather than a medical center.”³²⁷

AIDS service providers should pilot integration programs to test whether some of the above-mentioned reservations are well-founded and whether the programs could be designed to address these concerns. Based on the experiences of existing integrated programs, it appears that the integrated model provides clients with a single access point for legal and medical care and thus maximizes the efficiency of a single visit. The model also treats legal services more like medical services, acknowledging that direct legal services have emergency and prevention components.

318 All five HIV/AIDS-related complaints were filed between 2003 and 2007 and involved accusations of termination and lack of promotion due to HIV status. The Commission has not yet resolved any of these cases. Interview with Grace Malera, *supra* note 214.

319 Interview with Grace Malera, *supra* note 214.

320 *Holistic HIV/AIDS Related Program (HARP)*, http://www.ccbtrt.or.tz/hiv_aids/aids.htm#Holistic, (last visited Apr. 11, 2007).

321 *Id.*

322 *Id.*

323 See generally, *Family Care Network*, www.familycare.org, (last visited Apr. 10, 2007).

324 Jeffery Selbin and Mark Del Monte, *A Waiting Room of Their Own: The Family Care Network as a Model for Providing Gender-Specific Legal Services to Women with HIV*, *DUKE L.J.*, 104, 123 (2006) [hereinafter, *A Waiting Room*].

325 *Id.* at 124 (explaining that although many women only took advantage of two or three of these services it was a dramatic improvement over the previous decentralized service delivery system).

326 *Id.* at 125.

One major challenge to the establishment of links between health and legal services is the dearth of lawyers in Malawi. There are between 300 and 350 qualified lawyers for a population of 12 million. The vast majority of private lawyers are urban-based and the majority of the population is rural. Many of these lawyers charge fees that most Malawians cannot afford, and a culture of public interest lawyering and pro-bono legal assistance is not well developed in Malawi.

3. THE ROLE OF PARALEGALS

One major challenge to the establishment of links between health and legal services is the dearth of lawyers in Malawi. There are between 300 and 350 qualified lawyers for a population of 12 million.³²⁸ The vast majority of private lawyers are urban-based and the majority of the population is rural. Many of these lawyers charge fees that most Malawians cannot afford,³²⁹ and a culture of public interest lawyering and pro-bono legal assistance is not well developed in Malawi.³³⁰ Legal aid lawyers in Malawi are even scarcer.³³¹ There is a lack of funding for government legal aid services, and the legal aid systems that do exist are severely limited in terms of manpower and funds. Malawian government agencies, including the Malawi Human Rights Commission, have acknowledged that the shortage of lawyers for low-income clients is resulting in a compromised justice system.³³²

In light of the scarcity of lawyers in general and legal aid lawyers in particular, and the continued need for justice services for the poor, the strengthening of paralegal institutions is a necessity. Public

interest paralegals in the developing world can be loosely defined as “lay people with basic training in law and government who assist poor and otherwise disempowered communities to remedy breaches of fundamental rights and freedoms” through methods such as “mediation, investigation, negotiation, advocacy, organizing, and community education.”³³³ In a country in which the majority of the population lives in the rural areas this model is well-suited to reach beyond the urban centers. Community-based paralegals may prove especially useful during mediation efforts with local chiefs because community-based paralegals are familiar with local customary law, and thus equipped to negotiate and advocate for clients in rural settings.³³⁴ Paralegal programs often form loose partnerships with lawyers, referring cases that require litigation and other more formal representation to their legal aid partners.³³⁵

AIDS service providers should consider piloting projects in which paralegals are integrated into the clinical setting. In addition, HIV/AIDS clinics should establish referral networks to paralegal service

327 Interview with Enous Chang'ana, Director, The Lighthouse (May 28, 2007).

328 See Hillery Anderson, *Justice Delayed in Malawi's Criminal Justice System Paralegals vs. Lawyers*, 1 INT'L. J. CRIM. JUST. SCI. 1, 2 (2006); see also Audrey Lewans, *supra* note 77; see also Interview with Marie-Dominique Parent, Regional Director, Penal Reform International (May 29, 2007).

329 Anderson, *Justice Delayed*, *supra* note 328.

330 Interview with Marie-Dominique Parent, *supra* note 328.

331 Anderson, *Justice Delayed*, *supra* note 328, at 3.

332 *Id.*

333 Vivek Maru, *Between Law and Society: Paralegals and the Provision of Justice Services in Sierra Leone and Worldwide*, 31 YALE J. INT'L L. 427, 429 and 469 (2007).

334 Anderson, *Justice Delayed*, *supra* note 328, at 3.

335 Paralegal Advisory Service Institute (PASI) Draft Brochure; Interview with Marie-Dominique Parent, *supra* note 328.

providers. Paralegal service programs, in turn, should consider expanding their services to address the needs of PLWHA. In order for these changes to take place, more support is needed for paralegal programs. There are several successful paralegal programs operating in Malawi, although the number of paralegals is limited and they are not connected to health services. The Malawi Center for Advice, Research and Education on Rights (CARER) has a paralegal program headquartered in Blantyre and operating in 6 districts. Women's Voice was established in 1993 to protect and promote the welfare of women and children through paralegal services, human rights education, home-based care, marriage counseling, and the promotion of policy reform. The Malawi Paralegal Advisory Service (PAS) was established in 2000 and has 38 paralegals throughout the country. The goals of PAS are to train people in criminal law and procedure and to assist criminal defendants and ensure they are not forgotten in the justice system.³³⁶ Donors should provide these existing paralegal programs with further funds to expand their existing programs to address issues related to PLWHA. Financial support, technical capacity building, and training in health and human rights issues will booster the presence and effectiveness of paralegal programs in the country.³³⁷

C. HIV/AIDS Anti-Discrimination Legislation

Despite the existence of widespread HIV/AIDS-related stigma and discrimination, Malawi has yet to pass legislation directly protecting people living with HIV/AIDS.³³⁸ Legislation and the threat of legal sanctions have a role to play in battling the widespread social phenomenon of AIDS-related discrimination that often goes unreported. Carefully crafted legislation attempts to proscribe discriminatory acts and promote the rights of vulnerable groups by imposing rules that aim to engender respect and promote

human rights.³³⁹ The law may also be used as a tool for changing the "underlying values and patterns of social interaction that create vulnerability to the threat of HIV infection."³⁴⁰ Legislation, combined with legal aid services and strong enforcement mechanisms, are necessary ingredients in the campaign to eliminate the stigma that prevents people from seeking testing, counseling, and treatment. By delaying its implementation of HIV/AIDS legislation, Malawi is failing to mitigate the impact of HIV/AIDS on the lives of PLWHA and to reduce the likely infection rates of those most socially and economically susceptible to it.³⁴¹

1. LEGISLATIVE RECOMMENDATIONS

The Malawi Law Commission is currently drafting model HIV/AIDS legislation which will be submitted to the Attorney General in the Ministry of Justice who will then draft a bill for debate by Parliament.³⁴² The anti-discrimination aspects of the bill should reflect the reality on the ground. The legislation should include a preamble that clearly and directly states its anti-discrimination goals, acknowledging current inequalities and the desire to overcome such hurdles. This can be a powerful starting point for any piece of legislation serving to affirm the equality of those living with HIV/AIDS.

In 2006, the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS set out their revised International Guidelines on HIV/AIDS and Human Rights, which had originally been published in 1996 and offered twelve discrete points for governments to consider when crafting legislative and policy responses to HIV/AIDS.³⁴³ In 1999, in support of the original 1996 Guidelines, the United Nations published a Handbook for Legislators on HIV/AIDS, Law and Human Rights, outlining "best legislative and regulatory practices gathered from around the world" for each of the twelve points.³⁴⁴ Both offer helpful roadmaps to crafting HIV/AIDS anti-discrim-

³³⁶ See *id.*

³³⁷ See *Ensuring Justice*, *supra* note 316 at 29.

³³⁸ An HIV/AIDS Bill is currently in the drafting stages. See *infra* note 342.

³³⁹ See Julie Hamblin, United Nations Dev. Programme, The Role of the Law in HIV and AIDS Policy, Issues Paper 11 (1991), available at <http://www.undp.org/hiv/publications/issues/english/issue11e.htm#The%20protective%20role%20of%20law> ("[T]here is...an important conceptual shift between, on the one hand, regarding the role of the law as that of enforcing legal prohibitions and, on the other hand, viewing it as a mechanism for promoting and protecting individual rights.")

³⁴⁰ *Id.* "Where laws uphold certain customs or behaviours that give rise to HIV transmission risks, such as traditional marriage patterns in some cultures, the abolition of these laws can provoke a questioning of the customs and values that underpin them. The active prohibition of certain conduct which may hitherto have been considered acceptable but which places individuals at risk of HIV can also be a powerful force for change. There is, therefore, a need to harness the symbolism of the law in all its manifestations—proscriptive, protective, instrumental, or otherwise—and to use it to promote rather than impede the changes necessary to reduce the spread of HIV." *Id.*

³⁴¹ See *id.* at 24–25.



The Coalition of Women Living with HIV/AIDS Salima Vice-Chairperson Kwangu Makhuwiro and Crowley Scholars during a community meeting with women in a rural village in Salima.

ination legislation:

Guideline 5 addresses anti-discrimination legislation directly, calling on states to implement or enhance laws that are intended to “protect vulnerable groups, people living with HIV, and people with disabilities from discrimination in both the public and private sectors...and provide for speedy and effective administrative and civil remedies.”³⁴⁵ More specifically, such laws should define protected persons as those with “asymptomatic HIV infection, people living with AIDS, and those merely suspected of HIV or AIDS,” and should protect groups who are “made more vulnerable to HIV/AIDS due to the discrimination they face.”³⁴⁶ Anti-discrimination provisions should include a broad range of coverage, including in the areas of “health care, social security, welfare benefits, employment, education, sport, accommodation, clubs, trades unions, qualifying bodies, access to transport, and other services.”³⁴⁷ The proposed legisla-

tion should also prohibit discrimination with regard to access to loans and social services in light of the widespread HIV/AIDS-related discrimination in access to micro-credit, fertilizer coupons, and participation in public works programs.

The provisions should target both direct and indirect discrimination³⁴⁸ and cases that involve multiple discrimination, and include procedures for “independent, speedy, and effective” redress, including fast-tracking for terminally ill complainants, investigatory powers, anonymity for complainants via pseudonyms, representative actions, and actions brought by public interest groups.³⁴⁹ The Handbook for Legislators adds to the U.N. guidelines by raising a number of important points for drafters to consider. Among the most important are lower evidentiary standards of proving discrimination that requires that complainants must prove only a causal connection between their HIV/AIDS status and the conduct

342 Interview with William Msiska, Law Reform Officer, Malawi Law Commission, Lilongwe (May 28, 2007).

343 *International Guidelines*, *supra* note 27.

344 Joint UN Programme on HIV/AIDS (UNAIDS), *Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of Its Devastating Human, Economic and Social Impact 2* (1999) [hereinafter *Handbook*].

345 *International Guidelines*, *supra* note 27, at 31 (setting forth Guideline 5).

346 *Id.*

347 *Id.* at 32.

348 *Id.* “Direct discrimination occurs where a person treats another person less favourably than a third person would have been treated in comparable circumstances, or attributes characteristics which are thought to relate generally or be generally imputed to people of a particular status, i.e. stereotypes. Indirect discrimination occurs where unreasonable conditions or requirements, such as mandatory HIV testing, are applied [with] which a substantially higher proportion of persons of a different status must be able to comply [...] than persons of the same status as the person claiming to have been discriminated against.” *Handbook*, *supra* note 2, at 66.

349 See *International Guidelines*, *supra* note 27, at 32.

in question, rather than having to provide proof of intent to prevail in court.³⁵⁰ For example, the legislation might allow a complainant to establish a prima facie case by proving she was or was perceived to be HIV-positive and was the target of an adverse employment decision. The employer might then bear the burden of proving that he had a legitimate, non-discriminatory basis for the action.

UN Guideline 5 further stresses the need for anti-discrimination laws to reduce HIV-related human rights abuses of women. These laws should ensure women's equality in the realms of property, marital relations, employment, custodial matters, and economic opportunity, and should protect and promote their reproductive rights and include provisions for the criminalization of marital rape.

2. THE LIMITS OF LEGISLATION

a. Awareness-Raising Campaigns and Legal Services

Legislation is important as one facet of addressing HIV/AIDS-related discrimination. However, legislation absent awareness-raising campaigns, legal aid services, and enforcement mechanisms, will be insignificant—a mere exercise for legal elites. NGOs, many of whom have championed the passing of an HIV/AIDS law, fear that legislation divorced from awareness raising campaigns will be meaningless. “Even if the legal framework is there, there is a lack of awareness,” warned Veronica Njikho of the Center for Human Rights and Rehabilitation (CHRR).³⁵¹ Citing the importance of community legal literacy programs, Emma Kaliya of the Malawi Human Rights Resources Centre remarked, “If people don’t accept the law it’s just another document on the shelf of the judiciary.”³⁵² If Parliament passes HIV/AIDS legislation, the government should partner the new legislation with community sensitization workshops as well as use radio programs, billboards, and other communications methods to highlight the legislation.

Awareness-raising campaigns will give people living with HIV/AIDS a sense of the rights to which they are entitled, but individuals without access to paralegal and legal aid services will remain power-

less to enforce these rights.³⁵³ PLWHA need to know that they can rely on advocates who can navigate the court and customary law systems or negotiate and mediate on their behalf.³⁵⁴ The international human rights community has recognized the importance of coupling legislation with effective enforcement mechanisms. The International Guidelines on HIV/AIDS and Human Rights explicitly call on nations to both establish and support organizations that provide free legal services to enforce rights related to PLWHA.³⁵⁵ In addition, the 2001 UN General Assembly’s Declaration of Commitment on HIV/AIDS calls on nations to write legislation aimed at ensuring access to legal protection for PLWHA.³⁵⁶ Five years later the General Assembly, using the same language, again reiterated its commitment to ensuring access to legal protection in the 2006 Political Declaration on HIV/AIDS.³⁵⁷

b. Public Interest Litigation

HIV/AIDS legislation, no matter how progressive or comprehensive, will not be successful without an independent judiciary willing to interpret and enforce its provisions. Public interest litigation regarding the social rights of poor and marginalized groups can be an important method of testing the teeth of legislation, raising awareness on critical issues like HIV/AIDS, and challenging, and thereby encouraging, the government’s commitment to economic and social rights.

Despite Malawi’s adoption of a progressive, pro-poor, pro-social rights Constitution in 1994, there has been a scarcity of jurisprudence affirming economic, social, and cultural rights and very little public interest litigation on behalf of poor and marginalized groups.³⁵⁸ There are perhaps several reasons for the paucity of social rights jurisprudence and limited public interest litigation. Hastings Kamuzu Banda ruled Malawi with an iron fist from 1966 to 1994, repressed NGOs that focused on civil and political rights and allowed organizations that advocated economic, social, and cultural rights to operate with greater freedom. With the fall of the Banda regime and the advent of democracy in 1994, groups cham-

350 See *Handbook*, *supra* note 344, at 66.

351 Interview with Veronica Njikho, Center for Human Rights and Rehabilitation, Lilongwe (May 28, 2007).

352 Interview with Emma Kaliya, *supra* note 205.

353 See *Handbook*, *supra* note 344, at 452.

354 *Id.*

355 *Id.*

356 Declaration of Commitment on HIV/AIDS, available at, <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>, (last visited Apr. 9, 2007).

357 See 2006 Political Declaration on HIV/AIDS, *supra* note 35.

358 See Siri Gloppen and Fidelis Edge Kanyongolo, *Courts and the poor in Malawi: Economic marginalization, vulnerability, and the law*, 5 INT’L J. OF CONST. LAW (2007).

In May 2007, the Center for Legal Assistance, a human rights organization comprised of volunteer lawyers, filed a groundbreaking HIV/AIDS-related test case in the High Court in Lilongwe District, which may prove important in advancing the development of Malawi's social rights jurisprudence.

pioning civil and political rights mushroomed, while social rights organizations have kept a lower profile.³⁵⁹ In addition, the Malawian legal education system does not have a strong emphasis on social equality jurisprudence. The judiciary is thus often comprised of judges who have had little human rights training and are therefore less receptive to pro-poor social rights claims.³⁶⁰ Restrictive judicial interpretations of standing requirements in relation to the enforcement of human rights may also play a role in limiting the number of NGOs willing to engage in public interest litigation on behalf of poor clients.³⁶¹

Despite these hurdles, in May 2007, the Center for Legal Assistance (CLA), a human rights organization comprised of volunteer lawyers, filed a groundbreaking HIV/AIDS-related test case in the High Court in Lilongwe District, which may prove important in advancing the development of Malawi's social rights jurisprudence.³⁶² CLA filed the claim on behalf of two HIV-positive prisoners on anti-retrovirals who are suing the Attorney General and seeking compensation for infringements of their human right to dignity. The prisoners argue that they are subject to inhumane conditions like one meal of beans and porridge per day that has affected their health status as well as poor hygiene conditions and overcrowding.³⁶³ CLA will use sections of the Malawi Constitution as the basis for its case as well as foreign case law and international human rights treaties as per-

suasive authority.³⁶⁴ The Human Rights Commission plans to file an amicus curiae brief in support of the complainants in the case.³⁶⁵

Charles Kasambara, the legal director of the CLA, hopes the test case will raise the profile of HIV/AIDS issues and push the government to strengthen its commitment to economic, social, and cultural rights:

Are ESC [economic, social, and cultural] rights, which are strongly recognized in the constitution, not enforceable in Malawi? That is the crux of the question [of our case]. We are asking that the Prison Commission take affirmative action to address the problems of HIV-positive prisoners. We are trying to make this case a precedent in ESC rights... Shouldn't the second generation of rights be enforced even with our limited resources? Or are we saying that ESC rights are just for decoration?³⁶⁶

Legal organizations can advocate for social rights and raise awareness of marginalized national issues by following CLA's lead and selecting test cases that will advance Malawi's social rights jurisprudence. Donors should strengthen these efforts by supporting organizations that use public interest litigation as a means to draw attention to issues of marginalized groups like women living with HIV/AIDS.

359 See Interview with Charles Kasambara, Executive Director, Center for Legal Assistance, Lilongwe (May 30, 2007); see also Redson Kapindu, Director of Legal Services, Malawi Human Rights Commission (May 29, 2007).

360 See Gloppen and Kanyongolo, *supra* note 358 at 288-289; see also interview with Kapindu, *supra* note 52.

361 See Gloppen and Kanyongolo, *supra* note 358 at 283-285.

362 Interview with Charles Kasambara, *supra* note 359.

363 Deborah Nyangulu, *HIV+ Prisoners Sue AG*, THE DAILY TIMES, May 9, 2007; see also Interview with Charles Kasambara, *supra* note 359.

364 Interview with Charles Kasambara, *supra* note 359.

365 Interview with Redson Kapindu, *supra* note 359.

366 Interview with Charles Kasambara, *supra* note 359.



School children at an HIV/AIDS awareness celebration in Mchinji. Women may be more willing to acknowledge their status and seek treatment because they are less concerned about loss of sexual partners and more concerned about surviving to care for their children.

Conclusion

Throughout the country, the Leitner Center delegation documented widespread discrimination and stigma against women living with HIV/AIDS, whose low social, cultural, and economic status has rendered them the “face” of AIDS in Malawi. Women are disproportionately infected and affected by the epidemic.

Women living with HIV/AIDS throughout the country spoke of a desire to provide for their families and live productive and healthy lives. However, stigma and discrimination impedes these efforts by cutting women off from essential resources and opportunities that can mitigate the effects of HIV/AIDS. In

order to win the prevention and treatment battles in the fight against HIV/AIDS, and ensure that all people living with HIV/AIDS can live productive lives, the Malawian government must make the fight against HIV/AIDS-related stigma and discrimination a central component of its HIV/AIDS policy.

ANNEX I: Mission Itinerary

Malawi Itinerary, May 21–June 1, 2007

TIME INTERVIEW

NORTHERN TEAM ITINERARY,
MAY 21–MAY 24, 2007

MONDAY, MAY 21, 2007 CHILUMBA

9:00 Women Living with HIV/AIDS:

Elizabeth
Rosa M.
Enetie H.
Chikosa L.
Dorah N.
Geogina M.
Edah C.
Elerin M.
Grace M.
Carolyn M.
Lestina N.
Tamala K.
Agnes M.
Emmie F.
Mercy M.
Jean M.
Towera K.
Lina H.
Josephine K.
Maria C.
Esther M.
Mabel M.
Grace J.
Maria M.R. G.
Melas M.
Chikumbu S.
Jeanette M.
Miriam K.
Queen K.
Lonyne N.
Eda H.
Kostas Muhango, N.
Katherine K.
Lina N.
Masiya KM.
Grace M.
Ester K.
Jane N.
Tabu L.
Margaret M.
Interviewee #1
Interviewee #2
Interviewee #3
Interviewee #4
Interviewee #5
Interviewee #6
Interviewee #7
Interviewee #8
Interviewee #9
Interviewee #10

TUESDAY, MAY 22, 2007 CHILUMBA

Mgoyera Village Group Interview
(Men and Women)

Mgoyera Village Group Interview (Women)

Mgoyera Village Group Interview (Men)

Village Nearby Chilumba Group Interview
(Men and Women)

INTERVIEWS OUTSIDE OF CHILUMBA:

Frank Aswile, Teacher

Mrs. Kasweswei, Coalition of
Women Living with HIV/AIDS

WEDNESDAY, MAY 23, 2007 NKHATA BAY

9:00 Women Living with HIV/AIDS:

Tamara B.
Martha C.
Chrisie C.
Rose M.
Maria M.
Rachel K.
Happines S.
Marita B.
Grace K.
Thandi K.
Ellen B.
Maria N.
Veronica K.
Martha L.
Lornas K.
Annee C.
Wittie M.
Livas K.
Estere M.
Mary C.
Jennifer K.
Tiliya C.
Lyness K.
Lornas P.
Fales N.
Tamalize M.
Donnis B.
Esnart M., Translator
Sibongile B.
Fani M.
Triness N.
Selah P.
Elliness C.
Mavuto S.
Haizo K.
Jesse M.
Charity C.
Esther M.
Oliva M.
Lydia L.
Jen N.
Doreen K.
Interviewee #1
Interviewee #2
Interviewee #3
Interviewee #4
Interviewee #5
Interviewee #6
Interviewee #7
Interviewee #8
Interviewee #9
Interviewee #10

THURSDAY, MAY 24, 2007 NKHATA BAY

Kasweswe Village Group Interviews

FRIDAY, MAY 25, 2007 NKHATA BAY

Women's Voice:

Mr. Egson Kubwalo, Project
Coordinator

CENTRAL TEAM ITINERARY,
MAY 21- MAY 24, 2007

MONDAY, MAY 21, 2007 MCHINJI

9:00 Women Living with HIV/AIDS:

Mary S.
Lucy M.
Lenia M.
Mary C.
Elizabeth C.
Joyce P.
Liviness S.
Florence P.
Elube M.
Mercy D.
Hilda P.
Maria C.
Giao Bega D.
Aida J.
Desdardi Z.
Adalesi M.
Elestina M.
Joyce P.
Aida C.
Fanis C.
Belenise L.
Alice M.
Christina N.
Prisca S.
Chrissy Y.
Susan B.
Joyce S.
Alefa C.
Chrissy K.
Effie C.
Aliness N.
Virginia I.
Mary Z.
Elizabeth K.
Katherine K.
Zelifa K.
Chrissie L.
Doris B.
Sophie C.
Telyn K.
Rosemary J.
Masiye L.
Anna K.
Allines M.
Mariam D.
Nasieti W.
Florence Y.

TUESDAY, MAY 22, 2007 MCHINJI

Victoria Kalumba, District
Chairperson, Mchinji and Regional Vice
Chairperson, Central District, Coalition of
Women Living with HIV/AIDS

Meeting with Heads of Villages:

Chief Kalinde, Group Village Headman (Mduwa)

Chief Maole, Group Village Headman (Mduwa)

Chief Kunungwi, Group Village Headman (Mduwa)

Chief Mchiwa, Group Village Headman (Kapondo)

Chief Chapakama, Group Village Headman (Kapondo)

Chief Chimutu, Group Village Headman (Kapondo)

WEDNESDAY, MAY 23, 2007 SALIMA

9:00 Women Living with HIV/AIDS:

Flossie T.
Annie B.
Florence B.
Mercy F.
Dorothy K.
Chrissy M.
Miriam S.
Margaret M.
Emuphy M.
Enita M.
Jennifer C.
Floress P.
Stawa B.
Nazen C.
Kristina M.
Annie C.
Annie Ch.
Florence M.
Annie M.
Loucia S.
Mary D.
Anne Z.
Virginia I.
Monice D.
Mary P.
Christina Z.
Olive P.
Grace C.
Theresa R.
Joyce K.

Ben Tonto, District AIDS Coordinator, Salima

WEDNESDAY, MAY 24, 2007 SALIMA

Women Living with HIV/AIDS in Group Interview

Kudaize Village Group Meeting with Men

Kudaize Village Group Meeting with Women

Kwambiri Village Group Meeting with Women

Kwambiri Village Group Meeting with Men

Meeting with Group Village Headmen in T.A. Kalonga:

Chief Nthenga, Group Village Headman

Chief Ntonga, Group Village Headman

Chief Likongwe, Group Village Headman

Chief Mapiko, Group Village Headman

Chief Simaiwa, Group Village Headman

Chief Jeffrey Ndula, Group Village Headman, Kwambiri

SOUTHERN TEAM ITINERARY,
MAY 21–MAY 25, 2007

MONDAY, MAY 21, 2007 BLANTYRE

9:00 Women Living with HIV/AIDS:

Gracious M.
Memory K.
Bertha C.
Merezia P.
Jane M.
Joyce M.
Merca N.
Joyce K.
Rose M.
Stella G.
Angella B.
Lize H.
Sophie J.
Mary N.
Sunganani J.
Molly M.
Jean C.
Esnat C.
Flora M.
Ester K.
Jen K.
Loni S.
Agnes K.
Crystable M.
Zione S.
Marjory Matthews B.
Maggie
Stiveria Phiri N.
Felia N.
Agnes J.
Angela K.
Ivy W.
Rose
Annie S.
Betha K.
Chimwimwe M.
Juliette D.
Effie M.
Elizabeth
Margaret T.I.
Bertha K.
Thandi M.
Rebecca B.
Charity M.
Agnes K.
Zione F.
Ellen T.
Memory P.
Cecilia M.
Ethel C.
Olivia N.
Amina S.
Teresa G.
Violet N.
Joyce B.
F. M.
Mary L.
Grace C.
Emma M.
Sala M.
Interviewee #1

Rosemary K., Treasurer, Coalition

Mabel K., Office Assistant, Coalition

TUESDAY, MAY 22, 2007 BLANTYRE

Interviews at Blantyre Pub:

Mary M., Commercial Sex Worker

Edina M., Commercial Sex Worker

Flora K., Commercial Sex Worker

Vita N., Commercial Sex Worker

Emily M., Commercial Sex Worker

Tereza N., Commercial Sex Worker

Jos Paans, Director, Stefanos Foundation Orphanage

Alex, Outreach Worker, Stefanos Foundation Orphanage

WEDNESDAY, MAY 23, 2007 MANGOCHI

9:00 Women Living with HIV/AIDS:

Lima D.
Esther J.
Esnati M.
Rose S.
Mabel M.
Zone A.
Jennifer C.
Mary S.
Mariam T.
Agnes A.
Maria P.
Rose C.
Krissy M.
Eliza K.
Anna G.
Eunice P.
Ida M.
Nellie K.
Rose M.
Catherine M.
Eliza N.
Gladys C.
Angelina M.
Hilda K.
Annie M.
Elisa K.
Trifonia N.

RoseMary, Mangochi Coalition Leader

THURSDAY, MAY 24, 2007 MANGOCHI

Interview with Three HIV Negative Women in Mangochi:

Nellie Tchuba
Jessie Namkambe
Christina Kwizombe

Community Meeting in Mangochi (Men and Women)

Edward, Bakery Employee

Unknown, Bakery Manager

Patrick, Bakery Employee

Joseph, Bakery Employee

Bwanari, Bakery Employee and Translator

Gerard, Bakery Employee
Madatlitso G. Samikwa,
 Secretary, Mangochi AIDS Support
 Organization(MAS)

Meeting Men Living with HIV/AIDS:

Laston C.
Kalunga B.

FRIDAY, MAY 25, 2007

Meeting at Mangochi Police Station:

Loexten Kachama, Deputy Commis-
 sioner of Police, Mangochi

Sophie, Commercial Sex Worker

Name Unknown, Head of Monkey
 Bay Police

Kevin, Arrestee

Roderick Ridson, Police Officer

Victim Support Center:

Gift Karoti, Victim Support
 Coordinator

Monkey Bay Secondary School—Q&A With
 Large Group of Students (Over 100)

Secondary School Interviews and
 Assembly: Boys Interview Group

Luke, Student

Benson, Student

Jeffery, Student

Sergeant Spencer Zimba, District
 HIV/AIDS Officer

LILONGWE ITINERARY,
 MAY 28–JUNE 1, 2007

MONDAY, MAY 28, 2007

8:30 **Dr. Perry Jansen**, Partners in Hope

8:30 **Bhatupe Mhango**, UN Plus
 Representative

9:00 **Daphne Gondwe**, President,
 Coalition of Women Living with
 HIV/AIDS

9:00 **Mina Hoseinipour**, University of
 North Carolina PMTCT Project

11:00 **Miata Coleman**, Peace Corps
 Volunteer

11:00 **Veronica Njikho**, Center for Human
 Rights and Rehabilitation

11:00 **Pacharo Kayira**, Senior State
 Advocate, Ministry of Justice

1:30 **Dr. Kristine Torjesen**, Partners in
 Health

1:30 **William Msiska**, Malawi Law
 Commission

2:00 The Lighthouse:

Ann Micheli, Training Advisor

Dennis Ndau, Senior Counselor

Fred Chiputula, Clinic Coordinator

Enous Chang'ana, Director

Dannick Kathumba, Deputy Home
 Based Care Coordinator

3:00 **David Nyarongo**, Program Manager,
 National Association of People
 Living with HIV/AIDS

3:30 **Rene Ngozo**, Senior Women's
 Programme Officer, Ministry of
 Gender

4:00 **Dr. Mary Shawa**, Principal Secretary
 for HIV/AIDS and Nutrition,
 Office of the President

TUESDAY, MAY 29, 2007

9:00 **Marie-Dominique Parent**, Regional
 Director, Penal Reform International

11:00 **Michael Keating**, Resident
 Coordinator, United Nations Malawi
 and Chair, UN Theme Group on
 HIV/AIDS

Audrey Lewans, Program Analyst,
 UNDP

Ulanda Chilezi, HELP Coordinator
 (Helping Employees Living
 Positively), UN System

11:00 Malawi Human Rights Resource
 Centre:

Emma Kaliya, Program Manager

Sindy, Program Assistant

Chimwemwe, Program Assistant

11:00 Partners in Hope:

Mara Kachare, Peer Educator

Male youth volunteer

Male youth volunteer

Ernest Katiyi, Peer Educator

Linda Kalulu, Peer Educator

12:15 Malawi Human Rights Commission:

Redson Kapindu, Director of Legal
 Services

Grace Malera, Principle Legal
 Officer

2 :00 **Bhatupe Mhango**, UN Plus
 Representative

2:00 **Lawrence Khounyoug**, Director,
 Stepping Stone Project, Action Aid

3:00 **Marshall Chilenga**, private lawyer

3:00 **Victor Kantiki**, Director, Youth
 Development and Advancement
 Organisation

4:00 **Tony Harries**, Technical Assistant
 in HIV Care & Support, Ministry of
 Health

WEDNESDAY, MAY 30, 2007

9:30 **Grace Chiudzu**, OB/GYN, Bottom
 Hospital

10:30 **Stella Twea**, Gender Specialist,
 UNFPA

11:00 Action Aid:

Mildred Sharra

Grace Taulo

1:00 Partners in Hope Secondary School
 AIDS Club

Vitu, Peer Educator

1:00 **Dannick Kathumba**, Deputy
 Home Based Care Coordinator,
 The Lighthouse

2:00 **Charles Kasambara**, Executive
 Director, Center for Legal Assistance

3:00 **Hazel**, Former Commercial Sex
 Worker

Madalitso Matchayah, Former
 Commercial Sex Worker

Reuben Daniel Phiri, Field Assistant,
 Youth Development and
 Advancement Organisation

Frank Sangwen, Volunteer, Youth
 Development and Advancement
 Organisation

Henzel Tembo, Former Commercial
 Sex Worker

Martha Chino, Former Commercial
 Sex Worker

Chitundo Mtemwewe, Former
 Commercial Sex Worker

Angelina Maganga, Former
 Commercial Sex Worker

Thaskwani Sibande, Former
 Commercial Sex Worker

4:30 **Patrick Kabambe**, Principle
 Secretary, Ministry of Agriculture

THURSDAY, MAY 31, 2007

9:30 **Booker Matemvu**, Head of
 Development and Communications,
 Malawi Social Action Fund
 (MASAF)

12:15 **Robert Nyang'wa**, Public Relations
 Officer, MARDEF

1:00 **Employee**, Cappucino Cafe

3:00 **Tim Gilbo**, Country Manager,
 World Bank

3:30 **Chris Teleka**, Communications
 Officer, National AIDS Commission

FRIDAY, JUNE 1, 2007

3:00 **Miriam Kaluwa**, Policy Officer,
 National AIDS Commission



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