

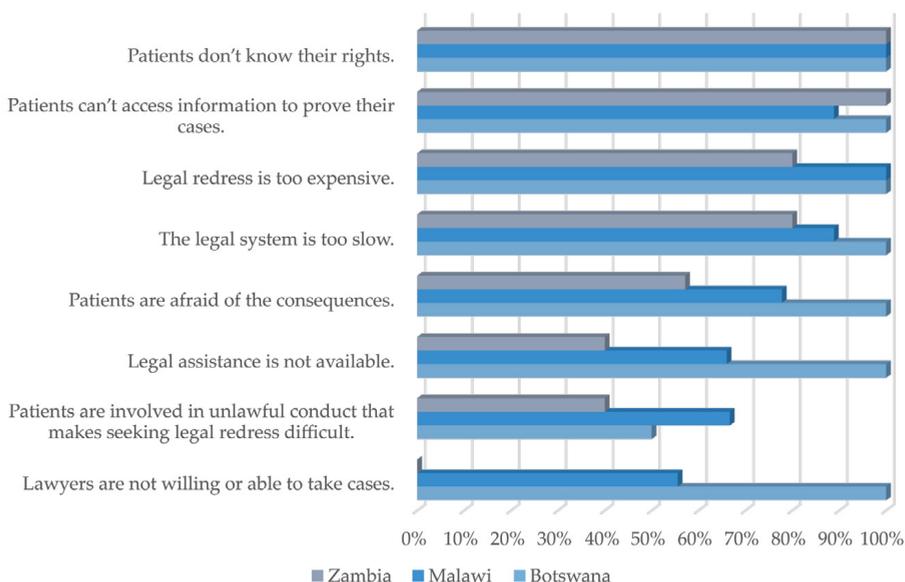
# 5. Mechanisms for accountability and redress

## 5.1 Introduction

*“The courts are only somewhat effective because the cost of litigation is high and accessibility is questionable.” (Complaints mechanisms respondent - Lusaka, Zambia)*

NGO and CBO respondents described several constraints faced by healthcare users in seeking legal redress (involving court processes or the engagement of lawyers) for healthcare users who experience discrimination in healthcare. This includes that healthcare users do not know enough about their rights to be able to enforce them, that they are unable to access information to prove cases in the courts, and that the expense, physical distances, and expertise required to litigate inhibit the use of the courts to access justice. The graph (below) represents the perspectives of NGO and CBO respondents interviewed and who completed questionnaires for the purpose of this report. The graph shows the percentage of respondents who elected particular factors as barriers, in their countries, to healthcare users accessing legal redress.

NGO and CBO perspectives on barriers to legal redress



In this chapter, various complaints mechanisms, as alternative opportunities for accountability and redress, are described and assessed in Botswana, Malawi and Zambia. Considering the disparate informal means in which justice is sought in these contexts, and accepting the limitations faced by many rights-holders in accessing legal redress through the courts, the analysis focuses on complaints processes that relate particularly to the prospect of addressing either healthcare complaints and/or issues of discrimination in healthcare. While efforts have been made to reflect the practices and opportunities for complaint in the three countries, the analysis does not purport to be comprehensive. The focus is therefore on facility-level complaints processes in healthcare facilities, health professions and nursing councils, and also national human rights institutions. The procedures for complaint through these mechanisms are described and analysed in the light of the principles developed in chapter 3 on the features of complaints mechanisms most capable of fulfilling the right to redress for human rights violations.

Desktop research was conducted on the complaints mechanisms detailed below. In addition, key informant interviews were conducted with health professions councils, nursing councils, and national human rights institutions, where available. Due to limitations in this research, it was not possible to interview representatives of the ministries of health in the three countries in order to gather more detailed information on facility-level complaints procedures. However, where respondents did have experiences of making complaints, focus groups, NGO and CBO respondents related experiences almost exclusively of using facility-level processes. In some instances, the complaints mechanisms themselves cited these processes as the preferred route for complaint.

The information on internal or facility-level complaints procedures is that which was obtainable through desktop research and the experiences of focus-group, NGO and CBO respondents. It is noted that researchers for this report were unable to access information on any formalised procedures detailing the facility-level processes in the jurisdictions described.

## 5.2 Botswana

### Introduction

In Botswana, focus-group participants and NGO/CBO participants were unaware of professional complaints mechanisms. Disability rights organisations and persons with disabilities noted the Office of People with Disability as a possible avenue for complaints. Most respondents, however, understood their options as either laying facility-level complaints or seeking redress through the courts, a process most deemed to be inaccessible and unaffordable. It is noted that in Botswana there is no national human rights institution available to receive complaints relating to human rights abuses.

### Facility-level complaints procedures

Amongst focus-group respondents in Botswana, none related engaging formal complaints processes. If any efforts to seek accountability or redress were sought, this was through directly confronting the healthcare workers or, rarely, by escalating a complaint to a superior within the health facility.

NGO and CBO respondents gave examples only of facility-level complaints options or litigation in the courts. The process was described as follows:

*"[Healthcare users can] complain to the person overseeing the clinical facility. This is usually the matron or senior nurse. One can complain to nurses, doctors and/or midwives. If it fails, the case goes to the District Health Team (DHT) and the person heading the DHT will handle the matter for them. Some members also go to the Headmen or village Kgosi/Chief or the Village Development Committee (VDC). We have seen in some cases where people go to the Ministry of Health or to NGO's that deal with health matters". (NGO respondent – Gaborone, Botswana)*

Information distributed by the Ministry of Health envisions a ten-step procedure for escalating complaints regarding services in health facilities. The healthcare user is advised to report complaints through the following steps:

- Step 1: Supervisor in charge
- Step 2: Public Relations Officer or call Hospital toll free number
- Step 3: Matron
- Step 4: Hospital Manager/Chief Admin Officer
- Step 5: Hospital Superintendent/Chief Admin Officer
- Step 6: [Ministry of Health] Headquarters Toll free number 0800 600 740
- Step 7: Director of relevant Department
- Step 8: Permanent Secretary/DPS
- Step 9: Minister/Assistant Minister
- Step 10: Office of the President.

Facility-level complaints were described by NGO and CBO respondents as "seldom effective":

*"All these structures mentioned are not formal complaint mechanisms that are formally acknowledged but these are structures that individual communities have identified that works for them. There are no formal legal mechanisms." (NGO respondent – Gaborone, Botswana)*

*"Once a complaint is lodged it is not dealt with. The process takes a very long time to deliver results and involves lots of bureaucracy. The mechanisms are such that it would not be easy for non-medical practitioners or individuals to be able to effectively engage with the processes." (NGO respondent – Gaborone, Botswana)*

Staff from professional bodies' complaints mechanisms in Botswana who were interviewed for this research indicated that clearly written complaints procedures *should* be available at all health facilities. The Public Relations Department of the Ministry of Health was indicated to be responsible for receiving complaints, although this could not be verified as being an established practice. Health professions bodies in Botswana described these processes as the primary system for healthcare user complaints but indicated that the process was "seldom effective."

It is noted, in addition, that bodies such as the Health Inspectorate and the Clinical Practice Committee carry out health-facility audits. The Council for Health Service Accreditation of Southern Africa (COHSASA) works with the Health Inspectorate, accrediting facilities in terms of the quality of health-service provision and practice. The role of COHSASA is understood by health professions bodies as instructive in ensuring standards of practice. In addition, the District Health Management Team is responsible for monitoring and evaluation of healthcare facilities' performance. The Health Inspectorate also has a role to play in monitoring the performance of the health sector and in ensuring adherence to norms and standards. It is unclear to what extent these bodies would receive healthcare users' complaints in their processes.

### ASSESSMENT

- ✘ These facility-level processes have low levels of **effectiveness** due to several factors, including the lack of clarity and guarantees in process. The efficiency, transparency and independence of the process is unstable and without guarantees.
- ✔ Facility-level processes perform better on **availability**, being accessible outside of urban centres and not necessarily requiring financial expenditure.
- ✘ While it does appear in practice that complaints can be made on behalf of others, it is unclear whether there are any confidentiality guarantees or opportunities for anonymous complaints.
- ✔ From a **sufficiency** perspective, facility-level processes appear to be well-positioned to sanction wrongdoers and to enforce those decisions and they may have the power to influence policy changes. Theoretically, since these processes constitute administrative decision, they are appealable to the courts.

## Botswana Health Professions Council

The Botswana Health Professions Council (BHPC) was established in terms of the Botswana Health Professions Act.<sup>221</sup> It is an independent regulatory body whose objectives include to promote the “highest standards in the practice of healthcare, and to safeguard and promote the welfare and interests of the Botswana public in relation to healthcare.”<sup>222</sup> In fulfilling these objectives the BHPC's duties and functions include the registration of health practitioners, monitoring standards of care and medical ethics and investigating professional misconduct and public complaints.<sup>223</sup> The BHPC is responsible for the registration of several health professionals, including medical doctors, dentists and pharmacists but not nurses and midwives.<sup>224</sup>

<sup>221</sup> 2001, Chapter 61:02.

<sup>222</sup> Section 4(1) of the Botswana Health Professions Act.

<sup>223</sup> Section 4(2) of the Botswana Health Professions Act.

<sup>224</sup> The BHPC registers the following professions: medical, dental, pharmacy, radiographers, physiotherapists, occupational therapists, opticians, optometrists, biomedical engineers, clinical psychologists, environmental health officers, laboratory scientists, speech therapists, audiologists, dieticians, paramedics, laboratory technicians, dental therapists, clinical officers, chiropodists, homeopaths, naturopaths and acupuncturists.



**Complaints** and allegations can be filed against professionals registered with the BHPC.<sup>225</sup> The BHPC's Disciplinary Committee is empowered to enquire into any complaint, charge or allegation of improper conduct of a professional nature against a healthcare professional. In addition, the BHPC Code of Conduct states that disciplinary proceedings must be taken against a practitioner if there is a contravention of the Act, the Code of Ethical Professional Conduct or a conviction for any criminal offence.

In an interview with a representative of the BHPC, the respondent described the purpose of its complaints system as: ensuring adherence to ethical standards; providing opportunities for professional misconduct and public complaints to be lodged; and protecting the rights of healthcare users. However, when asked to describe how a healthcare user should make a complaint after experiencing discrimination, the BHPC respondent did not refer to its own complaints system but to the internal processes of individual health facilities. It described these processes as "seldom effective".

The BHPC respondent stated that any person who feels they have not been treated fairly by a medical practitioner or healthcare facility can register a written complaint with the BHPC. The Botswana Health Professions Council (Professional Conduct) Regulations (Professional Conduct Regulations) state that persons who make complaints of "improper or disgraceful conduct" are required to make a written statement that sets out in precise terms the specific conduct of the practitioner.<sup>226</sup> In addition, the complainant must be willing to bring evidence of the complaint if they are requested to do so. The complaint is received by the BHPC's Executive Committee and the relevant healthcare professional is informed of the complaint. The Executive Committee determines the seriousness of the complaint. If it is considered "trivial" it is dismissed. If it is considered to be "serious", it may order that an investigation be undertaken.



**Investigations** are conducted by the BHPC Disciplinary Committee, whose investigations may include an examination of the healthcare user's medical records. The Disciplinary Committee prepares a report which is received and deliberated on by the Executive Committee. The accused practitioner is at this stage requested to provide a written statement. The Executive Committee will refer the complaint for an inquiry at the Disciplinary Committee if it considers there to be *prima facie* evidence of improper or disgraceful conduct.



**The inquiry** process before the Disciplinary Committee is detailed in the Professional Conduct Regulations as similar to a trial process before a criminal court.<sup>227</sup> The accused practitioner is asked to plead. Evidence is led by the virtual complainant and witnesses are called and may be subpoenaed to give evidence. The facts must be proved beyond a reasonable doubt for an accused practitioner to be found guilty of misconduct.<sup>228</sup>

<sup>225</sup> Available at: <http://hcp.moh.gov.bw/hprs/BHPCComplaints.aspx>.

<sup>226</sup> Regulation 33.

<sup>227</sup> Regulation 36.

<sup>228</sup> Regulation 36(1)(q).

The BHPC states that healthcare users have a right to appear before the Disciplinary Committee and make representations if they wish. Complainants are also entitled to information on the status of their complaint throughout the investigation process.<sup>229</sup> It is noted that the Regulations allow for an order to be made to protect the identity of witnesses from public disclosure but not from the accused practitioner.<sup>230</sup> In addition, statements may be made by complainants and witnesses who are not present in person at the inquiry in the form of affidavits. However, the accused practitioner may object to the use of the affidavits as evidence if they are unable to cross-examine the witness.<sup>231</sup>



**The penalties** the Disciplinary Committee are entitled to impose if a complaint is proved are set out in the Botswana Health Professions Act: the Committee may impose a penalty as it considers appropriate.<sup>232</sup> The Act provides for the Council's power to caution and reprimand the health professional, to suspend them from the profession, to impose conditions on their practice, or to cancel their registration as a healthcare professional. There is no specific provision for ordering compensation or an apology to the complainant or victims of misconduct. Practitioners can appeal decisions of the Council to the High Court in terms of the Act.<sup>233</sup>



The average time taken to process a complaint was stated to vary depending on the complexity of the case and whether the healthcare user concerned was deceased or alive. The BHPC respondent indicated that very few complaints were received, that funding for the BHPC complaints system was inadequate, and that the human resource capacity to handle the few complaints they received was inadequate for it to be effective and impactful. While diverse public relations and media engagements were described as efforts to raise public awareness of its complaints system, the respondent considered that healthcare users were often unlikely to complain, describing them as not being vocal about their rights and unlikely to question professional misconduct.

The Disciplinary Committee is appointed from members of the BHPC<sup>234</sup>. It comprises the following members: the Director of Health Services, the Dean of the Faculty of Medicine at the University of Botswana, fourteen healthcare practitioners elected from members of the profession, and one member of the public not associated with the medical profession who is appointed by the Minister.<sup>235</sup> A member of the Disciplinary Committee or BHPC may ask to be excused from an inquiry if the person cannot give the accused practitioner a fair hearing.<sup>236</sup>

<sup>229</sup> The Botswana Health Professions Act provides for the right of an accused practitioner to make representations and to have legal representation before the Disciplinary Committee but does not create a similar right for complainants.

<sup>230</sup> See regulation 44.

<sup>231</sup> See regulation 36(1)(n).

<sup>232</sup> Section 14(1).

<sup>233</sup> Section 15. The Act does not specifically provide for an appeal by a complainant or aggrieved party. It is likely, however, that a party with sufficient interest in the decision (other than the accused), could take the decision on review to the High Court.

<sup>234</sup> See section 7 of the Botswana Health Professions Act.

<sup>235</sup> See section 3(1) of the Botswana Health Professions Act.

<sup>236</sup> Regulation 34(2) of the Professional Conduct Regulations.

The BHPC respondent stated that its Public Relations programme is considered an intervention to combat stigma and discrimination in healthcare in its emphasis on healthcare users' rights. In addition, the BHPC stated that it provides orientation, or induction and capacity-building training to medical professionals on a regular basis in which issues of stigma and discrimination and healthcare users' rights are addressed. The BHPC nevertheless acknowledged that further training of healthcare workers on issues of stigma and discrimination and rights-based healthcare is a continuous need.

### ASSESSMENT

- ✓ The BHPC is relatively **effective** because it ensures complainants the opportunity to make representations and because it has legislated guarantees for the independence of decision-makers.
- ✗ The **availability** of the complaints process is compromised by the limited manner in which complaints can be submitted. In addition, the requirement that complainants must be prepared to present evidence and that they can be subpoenaed are aspects that may compromise safety for vulnerable complainants.
- ✗ While rules and procedures are clear in legal terms, NGO and CBO respondents and focus-group participants showed little to no awareness of the processes.
- ✓ Finally, the **sufficiency** of the process is strong in terms of the capacity to apply sanctions against healthcare workers.
- ✗ However, the scope of redress is limited, and the prospect for the complainant to contest a decision, is likely limited to judicial review.

## Nursing and Midwifery Council of Botswana

The Nursing and Midwifery Council of Botswana (NMCB) was established in terms of the Nurses and Midwives Act.<sup>237</sup> The NMCB has powers, amongst others, to manage the registration of nurses and midwives in Botswana;<sup>238</sup> to deal with breaches of discipline or professional ethics;<sup>239</sup> and to establish and promote a code of ethical conduct for nurses and midwives.<sup>240</sup>

<sup>237</sup> Act 1 of 1995, Chapter 61:02, section 3.

<sup>238</sup> Section 7(2)(f) of the Nurses and Midwives Act.

<sup>239</sup> Section 7(2)(g) of the Nurses and Midwives Act.

<sup>240</sup> As above, section 7(2)(l).



The NMCB has a **complaints procedure**, which a respondent from the Council indicated was to ensure that nurses and midwifery practitioners embrace the highest standards of service for the protection of the public and healthcare users utilising healthcare services. Anyone can make a complaint to the NMCB about a registered nurse or midwife, including fellow registrants, colleagues in the healthcare system, healthcare users, families, the police and employers.<sup>241</sup> The NMCB respondent interviewed stated that the Council also makes use of whistle-blowers at strategic points in the health sector who assist in relating issues of concern. In addition, the respondent stated that the NMCB has a public member on its Board (selected by the Ministry of Health to represent public interests) who is also able to receive and lodge complaints from the public. Further to this, facilities are required to make reports to reflect the complaints made by the public on the conduct of healthcare workers and service provision at facility-level. The respondent stated that health facilities do not as a matter of course deliver these reports. Lastly, in a number of cases, the NMCB is alerted to professional misconduct in facilities by the media and launches an investigation on its own accord.

Complaints must be in the form of a written statement relating to a disciplinary matter of a nurse or midwife and must be lodged with the NMCB.<sup>242</sup> The NMCB has the power to make interim orders to protect the physical or mental health of any person during the conduct of an investigation into misconduct.<sup>243</sup>



Following the receipt of a complaint, the Disciplinary Officer assesses whether there is a need for an **investigation** team selected from the NMCB board.<sup>244</sup> The Investigation Team has broad powers to inspect premises and documents and to compel the production of evidence.<sup>245</sup> The Team prepares a report and recommends to the Disciplinary Committee how the complaint should be dealt with. The Disciplinary Committee can charge a nurse or midwife with misconduct following the receipt of the Investigation Team's report.<sup>246</sup> The Disciplinary Committee comprises five members of the NMCB, whose members include the President of the Nurses Association of Botswana, a member of health services appointed by the Minister, a member of the public appointed by the Minister, thirteen registered nurses elected by other registered nurses, and three enrolled nurses elected by their peers.<sup>247</sup>



Following the Committee's receipt of the accused nurse or midwife's plea on the charge, a **Disciplinary Hearing** is convened to try the accused party.<sup>248</sup> These proceedings are closed to the public.<sup>249</sup> Accused nurses and midwives have a right to be heard before the Committee, to legal representation, and to call and

<sup>241</sup> Regulation 5(1) of the Disciplinary Regulations. The complaints procedure is listed on the Ministry of Health website (<http://hcp.moh.gov.bw/hprs/NMCBComplaints.aspx>). However, there were no active links on the site to the complaint forms at the time of writing.

<sup>242</sup> Regulation 5(2) of the Disciplinary Regulations.

<sup>243</sup> As above, regulation 9.

<sup>244</sup> Regulation 7(3).

<sup>245</sup> Regulation 8.

<sup>246</sup> Regulation 10.

<sup>247</sup> Section 3(1) of the Nurses and Midwives Act.

<sup>248</sup> Regulation 13 of the Disciplinary Regulations.

<sup>249</sup> As above, regulation 13(3).

cross-examine witnesses.<sup>250</sup> The Committee has the power to summon witnesses before it.<sup>251</sup> The NMCB respondent stated that healthcare users have a right of appearance as a chief witness if they wish and are entitled to information relating to the status of their complaint.



Following a guilty finding, the Committee is empowered to impose the following **punishments**: reprimand; a fine not exceeding BP1,000; recommending suspension to the NMCB for a maximum of three months; or recommending to the NMCB that the nurse or midwife be removed from the register.<sup>252</sup> Nurses and midwives subjected to disciplinary proceedings are entitled to reasons from the Committee for reaching its decision<sup>253</sup> and can appeal the Committee's decision to the NMCB, and may further appeal the NMBC's decision to the Minister. If still aggrieved, the nurse or midwife can appeal further to the High Court.<sup>254</sup> The NMCB respondent described the responsibility of enforcement as resting with the Ministry of Health.



The time it takes for the assessment and determination of a complaint differs but was described by the NMCB respondent as representing a grey area in the delivery of its mandate. The NMBC respondent described several challenges facing its processes at the time of writing, to which the role of the Ministry of Health was indicated as the source of the challenges. Many cases were said to have been waiting to be tried and to be at risk of expiring. The cause of the delays was apparently that since December 2015 the NMCB did not have a Board, the renewal of which rests with the Ministry of Health. Without the Board in place, many cases are left pending. The NMCB respondent indicated distress at these delays, stating that "justice delayed is justice denied" in the absence of an effective governance structure at the NMBC. The respondent could not indicate the number of complaints received annually. The NMCB respondent described its own process as "seldom effective":

*"We, as a Council, attend to all the cases reported to us but facilities show a tendency to sweep issues under the carpet. However, as the Council, we make all efforts to follow the due processes for [the] issue to be investigated and if in our view there is a case to answer, we take it through due process up to the hearing stage." (NMCB respondent – Gaborone, Botswana)*

In order to inform the public of its mandate, the NMCB respondent indicated that it conducts awareness-raising activities and capacity strengthening programmes including instructing health facilities on laws, policies and regulations that regulate professional conduct.

<sup>250</sup> As above, regulation 13(6).

<sup>251</sup> As above, regulation 14. Regulation 15 makes disobedience of a summons an offence which is subject to a fine.

<sup>252</sup> As above, regulation 22.

<sup>253</sup> As above, regulations 13(7) and 22(2).

<sup>254</sup> As above, regulation 24.

## ASSESSMENT

- ✘ The NMCB rates low on **sufficiency**. While empowered to impose sanctions on respondent nurses or midwives, it has difficulty with enforcement and has no powers to order redress for complainants or meaningfully motivate structural changes.
- ✓ In terms of **effectiveness**, the NMCB can be considered to be in policy terms independent and provides opportunities for complainants to be heard.
- ✘ It is unclear however whether complainants have a right to access reasons for the disciplinary decisions made.
- ✘ The **availability** of the complaints process rates low from physical accessibility criteria and in the diversity of entry points. The process for lodging a complaint is relatively obtainable but NGO, CBO, and focus-group respondents were unaware of the processes.
- ✓ The **safety** of the complaints process is mixed. While third parties appear to be able to complain on behalf of others and the power of the NMCB to make interim orders to protect complainants are positive protections for vulnerable complainants, the NMCB's subpoena powers may inhibit vulnerable litigants from complaining if concerned about social or legal exposure following a complaint.

## Office of People with Disability

The Office of People with Disability (Disability Office) falls under the Office of the State President and works to coordinate the implementation of disability policy in Botswana through developing strategies and programmes to empower people with disabilities. It envisions a “barrier-free society for people with disabilities by 2016”. The Disability Office plays a coordinating role between government departments and ministries and persons with disabilities.



The Disability Office receives **complaints** from the public relating to persons with disabilities. The respondent from the Disability Office interviewed for this research stated that any person who has a complaint relating to disability can file a complaint in writing in either Setswana or English. Complainants can attend in person to make their complaints. In rural areas, the complaints can be made with the district Disability Committee. Social workers can assist in putting the complaint into writing and in directing it to the relevant department. Healthcare-related complaints would go to the District Health Office for investigation and redress. In urban areas, the complaints go directly to the Disability Office.



Details of the complaint are recorded and would be forwarded to the Ministry of Health for further investigation. The respondent stated that complainants can make follow ups, but there are no guarantees they will receive information on the status of the complaint. The respondent noted no restrictions on who could bring complaints to the Disability Office's attention, nor any restrictions on anonymity or parties making complaints on behalf of others.



The respondent stated that the objective of the procedure is not necessarily to punish an offender but to ensure the behaviour is not repeated, to right the wrong incurred and to ensure that persons with disabilities are treated with dignity and

respect. The purpose is to address discriminatory practices in the public service and to combat future incidences while collecting and collating data on human rights issues affecting persons with disabilities. The Disability Office does not have any particular powers to order redress nor to enforce change: its powers are those incidental to the Office of the State President.



The Disability Office respondent described that the procedure is fairly new and that it is working towards formalising protections for persons with disabilities in laws and policies. No information on the annual number of complaints received was available.

### ASSESSMENT

- ✓ The Office of People with Disability rates high on **availability**, offering diverse entry points, options for assistance of complainants and referrals, and having no requirement for complainants to expose their identities.
- ✗ The clarity of rules and procedures, however, is low considering that the complaints process has not yet been formalised.
- ✓ The Disability Office's **sufficiency** is good in terms of the breadth of interventions it can pursue when handling a complaint, including in motivating structural change and engaging other government agencies.
- ✗ The Disability Office, however, has no enforcement powers and is limited in the absence of a strong legislative and policy framework for persons with disabilities in Botswana.
- ✗ The Disability Office ranks lowest on **effectiveness** in that its transparency, independence and efficiency is either unclear or not yet prescribed. However, it does appear that the Disability Office in principle would wish for complainants and rights bodies to make representations and to engage in its decision-making process when considering a complaint.

## The Office of the Ombudsman

In Botswana, the Ombudsman is appointed by the President in consultation with the leader of the opposition party in Parliament, in terms of the Ombudsman Act 5 of 1995. The Ombudsman's mandate is to investigate complaints of maladministration against public institutions. The Ombudsman's functions are narrowly focussed on administrative action.<sup>255</sup>

Complaints relating to healthcare may feasibly fall within the Ombudsman's mandate to the extent that an administrative decision made by a healthcare institution or healthcare provider indicates behaviour such as bias, neglect, arbitrariness, or incompetence. Under the Ombudsman Act, the following complaints way not be investigated, among others:

- issues relating to private, non-governmental institutions or persons;
- any case before a court or any other tribunal;

<sup>255</sup> See section 3(1) of the Ombudsman Act.

- actions taken under order of the Botswana Police Force or Defence Force; and
- a case that concerns the investigation of a crime.<sup>256</sup>

From public information distributed by the Office of the Ombudsman, it also appears that its mandate is understood as excluded if the complaint deals with any case that has a remedy before a court of law. The Ombudsman further requires a complainant to exhaust all internal review mechanisms first, before approaching the Ombudsman.



Any member of the public or a group of people can **complain** to the Ombudsman. The Act requires complaints to be submitted to the Ombudsman in writing.<sup>257</sup> However, because the Ombudsman has the power to consider an issue on his own motion,<sup>258</sup> it is conceivable that an investigation could be prompted by informal, anonymous, or third-party complaints, should the Ombudsman elect to exercise this power.



Once the Ombudsman has determined that the complaint falls within the Office's jurisdiction and that it warrants **investigation**, broad powers exist for the Ombudsman to investigate the issue in an appropriate manner.<sup>259</sup> There are no costs associated for complainants and it is not necessary to be represented by a lawyer during these proceedings. The Ombudsman may agree to the presence of a lawyer, however, if a person is giving evidence as a witness. Complainants are entitled to information on the status and outcome of their complaint



Following an investigation, the Ombudsman may make **recommendations** to the relevant public official or body. This may include recommendations to re-examine a decision or policy, to offer an apology, or to compensate someone for financial loss. However, these recommendations are not enforceable. If the recommendations are not complied with, the only recourse available is for the Ombudsman to present a special report to the National Assembly detailing the issue for further action.<sup>260</sup> The Ombudsman's findings may be published in the Annual Report.



The Ombudsman Act creates offences relating to interference in the execution of its mandate,<sup>261</sup> which may be understood to include criminal prosecution of persons who victimise complainants.

---

<sup>256</sup> As above, at section 4.

<sup>257</sup> Section 5(1).

<sup>258</sup> Ombudsman Act, at section 3(1)(c).

<sup>259</sup> As above, at section 6(2).

<sup>260</sup> As above, at section 8(2).

<sup>261</sup> As above, at section 14.

## ASSESSMENT

- ✘ The Office of the Ombudsman has a narrow mandate and functions as a “last resort” for the investigation of maladministration. For this reason, its complaints procedure would have low **availability** and **effectiveness** for the particular needs of healthcare complaints who experience discrimination, and whose complaints are unlikely to meet the strict confines of the Ombudsman’s jurisdiction.
- ✓ The guarantee for **safety** from secondary victimisation for complainants through the creation of a criminal offence under the Act, may, however, support the safety of this process for vulnerable complainants.
- ✘ In terms of **sufficiency**, while the Ombudsman may make a broad array of recommendations to provide for accountability and redress, that these recommendations are unenforceable may undermine its utility as a prospect for meaningful accountability and redress for individual complaints.
- ✓ In the context of complaints relating to healthcare discrimination, the Ombudsman may be strategically useful to deal with systemic accountability issues where the function of the complaint is aimed primarily at bringing transparency to an issue where the Ombudsman’s investigatory powers can be most usefully employed.

## 5.3 Malawi

### Introduction

In Malawi, neither service providers nor vulnerable healthcare users are aware of complaint mechanisms to report an experience of healthcare discrimination.<sup>262</sup> It is rare for healthcare users to complain to health facilities.<sup>263</sup> In the present research, none of the focus group or NGO and CBO respondents related making any complaints but through a multitude of bodies internal to the health systems and at facility level. Access to redress and accountability in healthcare in Malawi appears therefore to be most accessible through networks and diverse entry points with little clarity or predictability in process or outcome.

### Health system and facility-level complaints

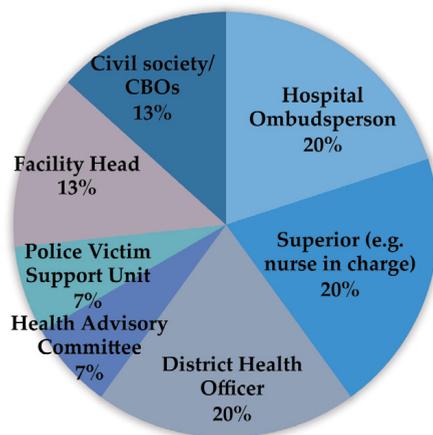
When asked how healthcare users should complain if experiencing discrimination in healthcare, NGO and CBO respondents gave different answers, suggesting low levels of uniformity or varied understandings of processes in place. Respondents variously suggested that complaints should be made through a hospital ombudsperson at each health facility, the healthcare worker’s superior (nurse or medical officer in charge), the District Health Officer or District Health Team, Health

<sup>262</sup> IJ Anderson “Sex workers’ access to health care in Lilongwe, Malawi” *Masters Thesis at Simon Fraser University* (2011), available at: <http://summit.sfu.ca/item/11649>, 45.

<sup>263</sup> Norwegian Agency for Development Cooperation (NORAD) *Local Perceptions, Participation and Accountability in Malawi’s Health Sector* (2013), available at: [http://www.opml.co.uk/sites/default/files/Norad%20-%20Local%20Perceptions,%20Participation%20and%20Accountability%20in%20Malawi’s%20Health%20Sector\\_0.pdf](http://www.opml.co.uk/sites/default/files/Norad%20-%20Local%20Perceptions,%20Participation%20and%20Accountability%20in%20Malawi’s%20Health%20Sector_0.pdf), 74 (hereinafter referred to as the NORAD Report).

Advisory Committees, the Police Victim Support Unit, the facility Head, or simply to NGOs, CBOs and support groups. These processes were predominantly described as inconsistently effective, somewhat effective, or never effective.

### Where should a patient complain? NGO and CBO perspectives



The respondent interviewed from the Nurses and Midwives Council of Malawi (NMCM) stated that healthcare users experiencing discrimination should complain to the hospital ombudsperson or the management of the particular facility. In some cases, one could complain to the Hospital Advisory Committee. These complaints procedures were described as “inconsistently effective”.

The respondent from the National Organisation of Nurses and Midwives of Malawi (NONM) similarly described that if healthcare users experience stigma or discrimination in healthcare settings, they should directly approach the facility head. The respondent described health facilities as usually having their own mechanisms, such as reporting to the management at the ward, reporting at the department level or directly to the hospital directors. The respondent indicated these processes to be “somewhat effective” depending on who handles the case and the gravity of the consequences.

A 2013 study by the Norwegian Agency for Development and Cooperation (NORAD)<sup>264</sup> identified routes through which public concerns on services could be voiced. This included:

- Direct supervisors including facility in-charge, District Health Officers and District Management Teams.
- Health Care Advisory Committees.
- Village Health Committees.

<sup>264</sup> NORAD Report, note 232 above.

- District Health Ombudsmen.
- Civil society organisations.
- Traditional leaders.

**District Health Officers** are responsible for managing primary and secondary health facilities and are often located in the district hospital.<sup>265</sup> The NORAD study, referred to above, indicated that complainants to these structures were seldom informed of the process or status of their complaint and meaningful redress was not often achieved.<sup>266</sup>

The Malawi Health Sector Strategic Plan 2011-2016 establishes **Health Centre Advisory Committees (HCAC)** at each Health Centre. The HCACs comprise health workers and community members. NGO respondents described the HCACs as working to ensure transparency and accountability on health facilities' performance and to mobilise communities' participation in accountability efforts. NGO respondents stated that the HCACs have not been particularly effective in this role due to a lack of funding and the ignorance of members of their functions:<sup>267</sup>

*"We do not know ... the [HCAC] that you are talking about. If they are there, then they do not work to protect our interests. When we complain to the hospital administrators, they do not help us adequately because in all honesty, how do you expect hospital administrators to punish their colleagues who have wronged us? Of course they will always defend each other." (Sex worker respondent – Mwanza, Malawi)*

NGO respondents recognised, however, the potential for the HCACs to be used to ensure accountability for healthcare discrimination even if not offering the possibility for redress for complainants. Respondents recognised instances where HCACs were visible and effective in the communities and where cases had been taken up by the HCACs to pursue disciplinary actions against healthcare workers.

The Health Sector Strategic Plan also establishes **Village Health Committees (VHCs)** which aim to promote health services and preventative interventions such as improving sanitation and hygiene at community level. The Plan further envisages VHCs as facilitating community involvement in planning and monitoring health services. VHCs can channel healthcare complaints. However, the 2013 NORAD study showed that the VHCs were the least functional of the accountability structures examined within the health system and many were inactive.<sup>268</sup>

**Ombudspersons** at hospital or district level are understood to have been put in place following the development of District Service Charters. These ombudspersons are seemingly able to receive and determine complaints from the public and healthcare workers. It is unclear what decision-making powers, processes and referral systems are in place for complaints processing or to what extent there is uniformity in processes. The 2013 NORAD study found that district health

<sup>265</sup> As above, 18.

<sup>266</sup> As above, 77.

<sup>267</sup> See also, NORAD Report, as above, 67, where research indicates that HCAC and VHS members indicate frustrations with not being orientated in their roles.

<sup>268</sup> As above, 80.

ombudspersons had been appointed in most but not all districts but they received little or no guidance or training on their functions and dealt with “extremely small numbers of complaints”.<sup>269</sup> Key informants interviewed for the present research noted that guidelines and terms of reference for ombudspersons were still in development.

All police stations in Malawi should provide victim support services. **Victim Support Units** are a component of the Community Policing Services Branch and their key functions are: counselling, first aid, advice, referral, interviewing of complainants in cases of sexual abuse, rape, defilement, indecent assault and other offences that require privacy and confidentiality; dealing with cases of domestic violence; helping victimised children; and conducting general sensitisation on human rights and policing.<sup>270</sup> According to the Victim Support Unit guidelines, forms of gender-based violence include: physical abuse; psychological or emotional abuse; sexual abuse (rape, defilement, indecent assault, procuring); cultural abuse (any harmful act/practice that causes suffering on the part of the victim and results in, among other things, physical, sexual, psychological harm and economic deprivation); social abuse; economic abuse; and financial abuse.

## ASSESSMENT

- ✓ Subject to limitations in available information, these processes rate well on **availability** criteria as multiple means of entry ensure physical accessibility and options for supported complaint-lodging that may enable precautions for vulnerable complainants.
- ✗ Due to the absence of any identifiable reporting chain or process for any of these systems, the clarity of rules and procedures are low.
- ✗ These processes rate relatively low on **sufficiency** – particularly because, in the absence of a formalised process and decision-making criteria, the enforceability, arbitrariness and absence of viable prospects for appeal or review by complainants compromises the process.
- ✓ However, the process rates higher in terms of the scope of redress available, in that it is possible for individualised sanctions and redress to be offered as well as for information feedback for policy reform.
- ✗ It is not apparent however that there are systems in place to ensure structured information feedback from complaints into the healthcare system.
- ✗ These complaints processes are low on **effectiveness** as there are no guarantees of complainants being given an opportunity to be heard by decision-makers, and the transparency, efficiency and independence is dependent on the individual decision-makers and is not formalised with any guarantees in place.

<sup>269</sup> As above, 73.

<sup>270</sup> Malawi Police Service & Malawi Human Rights Resource Centre *Guidelines for the Support and Care of Victims of Gender Based Violence, HIV and AIDS related abuses, and other Human Rights Violations.*

## Medical Council of Malawi (MCM)

The Medical Council of Malawi (MCM) is established by the Medical Practitioners and Dentists Act.<sup>271</sup> The MCM's aims include the promotion and improvement of the health of the population of Malawi and the exercise of disciplinary control over the professional conduct of practitioners registered under the Act.<sup>272</sup> The Malawi Health Sector Strategic Plan describes the objects of the MCM to include setting and maintaining standards of healthcare in relation to the qualifications and credentials of healthcare personnel including their behaviour and conduct towards healthcare users and clients.



The MCM respondent interviewed for this research stated that individuals can **complain** about medical practitioners' conduct to the MCM either in writing, or by phone, or by coming in person to meet the Registrar.<sup>273</sup> The respondent described the purpose of its complaints procedure as to help discipline professionals and to ensure abidance to medical ethics.



Upon receiving a complaint, the Registrar creates a confidential case file. The Registrar, Assistant-Registrar and investigators assess the complaint. Following an investigation into a complaint or allegation against a practitioner, the MCM may refer the allegation to the Disciplinary Committee for an inquiry, may dismiss the allegation, or may "take such action as it deems fit".<sup>274</sup>



**Inquiries** into professional misconduct and incompetence are dealt with by the Disciplinary Committee.<sup>275</sup> The Disciplinary Committee comprises the Chairman of the Council, two to four other practitioners appointed by the Chairman, and two other members who may or may not be members of the MCM.<sup>276</sup>

The Disciplinary Committee is empowered under the Act to regulate its own procedure.<sup>277</sup> It is obliged to afford an accused practitioner an opportunity to be heard and the accused is entitled to the assistance of legal counsel.<sup>278</sup> The MCM Chairman or Registrar can summon witnesses and compel the production of documentary evidence.<sup>279</sup> The MCM respondent stated that complainants have a right to appear before the Registrar and are usually contacted to hear their side of the story. The respondent considered that complainants are entitled to information on the status of their complaints. The Disciplinary Committee, after its inquiry, reports its findings to the MCM and makes recommendations.<sup>280</sup>

<sup>271</sup> Act 17 of 1987.

<sup>272</sup> See: section 10(a) and (c) of the Medical Practitioners and Dentists Act.

<sup>273</sup> Section 55 of the Medical Practitioners and Dentists Act empowers the MCM to make regulations to regulate the procedure for lodging complaints. At the time of writing, no regulations had been promulgated.

<sup>274</sup> As above, section 50(2).

<sup>275</sup> As above, section 47(1).

<sup>276</sup> As above, see section 46(1).

<sup>277</sup> As above, section 46(7).

<sup>278</sup> As above, section 47(2).

<sup>279</sup> As above, section 48(1). Refusal to abide by a summons is an offence punishable by a fine or six months' imprisonment, under section 48(4).

<sup>280</sup> As above, section 51(1).



The **discipline** of the practitioner is decided upon by the MCM after considering the Disciplinary Committee's findings and recommendations.<sup>281</sup> The MCM may dismiss the allegation and if the allegations are considered frivolous or vexatious, the complainant can be ordered to pay the costs of the inquiry.<sup>282</sup> The MCM is empowered upon a guilty finding to deregister practitioners and to order them to cover the costs of the inquiry.<sup>283</sup> In the alternative, the MCM may order the practitioner's suspension, impose conditions on their practice, order a penalty to be paid, or censure or caution the practitioner.<sup>284</sup> The Registrar is obliged to publish in the Government Gazette the names of any persons who have been deregistered or suspended from practice.<sup>285</sup>

The Act provides that "any person who is aggrieved" by the MCM or Disciplinary Committee's decisions may appeal the decision to the High Court within three months.<sup>286</sup> The breadth of the provision includes the option of appeal by the complainant.



In terms of section 50 of the Medical Practitioners and Dentists Act, if any allegation is brought to the notice of the Council that might be the subject of an inquiry by the Disciplinary Committee, the MCM is empowered to call for information and refer the issue for further disciplinary inquiry. This process indicates that third party and anonymous complaints to the MCM are possible and may be acted upon. It is noted, however, that under section 47 of the Act, an accused medical practitioner has the right to be heard in disciplinary proceedings, which may include the possibility of cross-examining a complainant. This may limit the potential for anonymous complainants to successfully use the MCM process.



The MCM respondent interviewed for the report indicated that it receives over twenty complaints per year. Reports in early 2015 stated that the MCM receives on average of ten complaints per month relating to negligence and incompetence of its members.<sup>287</sup>

The MCM respondent described its own complaints procedure as "very effective" and that complaints are assessed and determined "immediately". On the other hand, a media report describes the MCM's monitoring system as "porous" with inadequate adherence to ethical standards and supervision.<sup>288</sup> In the same report, the MCM's Registrar stated that in early 2015, the Council was yet to deal with 30% of the 120 cases registered in 2014, indicating a much slower process than accounted for.

When asked if the MCM has any programmes to combat stigma and discrimination, the MCM respondent indicated that the MCM "reminded professionals about the evils of stigma and discrimination." The MCM respondent, while acknowledging

<sup>281</sup> As above, section 51(2).

<sup>282</sup> As above, section 51(2)(c).

<sup>283</sup> As above, section 51(2)(ii).

<sup>284</sup> As above, section 51(2)(b).

<sup>285</sup> As above, section 53.

<sup>286</sup> See section 52(1), as above.

<sup>287</sup> A Kasakura "Complaints Choke Medical Council" *Times Malawi* (28 February 2015), available at: <http://timesmediamw.com/complaints-choke-medical-council/>.

<sup>288</sup> As above.

that a lack of information on its mandate is a principal barrier to healthcare users making complaints, stated that it engages multiple media forums (radio, television and press releases) to inform healthcare users and healthcare providers of their complaints service.

### ASSESSMENT

- ✘ In terms of **sufficiency**, the MCM process does not provide for systemic input or complainant redress – it has power only to discipline its members.
- ✔ The MCM process does, however, provide for a right of appeal of its decisions by complainants.
- ✔ The **availability** of the process is strengthened by the MCM's stated commitment to receive complaints in a variety of forms and to accommodate anonymous and third-party complaints.
- ✘ However, there are low levels of awareness of the process by NGO, CBO and focus-group respondents and it is unclear what protections could be afforded to vulnerable complainants.
- ✔ The **effectiveness** of the process is strengthened by the right of complainants to make representations before decision-makers and to access information on the status of the complaint.
- ✔ The constitution of decision-making bodies is also likely to ensure a measure of independence.
- ✘ Public reports suggest that **efficiency** of the system may be constrained.

## Nurses and Midwives Council of Malawi (NMCM)

The Nurses and Midwives Council of Malawi (NMCM) is established in terms of the Nurses and Midwives Act.<sup>289</sup> It is the sole regulatory body for nursing and midwifery education, training practice and professional conduct. Its functions include exercising disciplinary control over the professional conduct of registered nurses and midwives.<sup>290</sup>



A patient, client, professional colleague, or any other person who has a substantial interest in the practice and conduct of a registered nurse or midwife may lodge a **complaint** with the Investigations Committee of the NMCM.<sup>291</sup> The complaint must be in writing and must state in clear terms the specific acts or omissions that are being reported.<sup>292</sup> The NMCM respondent interviewed for this research stated that individuals can complain to secretaries or nursing officers at health facilities, who may in turn file the complaints at the Director's Office where the complaint is registered.

<sup>289</sup> 16 of 1995.

<sup>290</sup> Section 11(c) of the Nurses and Midwives Act.

<sup>291</sup> As above, section 52(1).

<sup>292</sup> As above, section 52(2).

It is possible to make **anonymous and third-party** complaints to the NMCM. However, the NMCM does not encourage anonymous complaints in order to ensure that investigations can be easily conducted.

---



The Director and nursing officer conduct an initial assessment of the complaint which is then referred to the **Investigations Committee**. The Committee regulates its own procedure and has the power to investigate any matter referred to it by the NMCM.<sup>293</sup> If after conducting a preliminary investigation, the Investigations Committee determines that the exercise of disciplinary control is necessary, it will refer the complaint to the Disciplinary Committee.<sup>294</sup>

---



The **Disciplinary Committee** will then conduct an inquiry into the allegation referred to it. Nurses and midwives who are the subject of an investigation before the Disciplinary Committee have a right of appearance and may be legally represented in those proceedings.<sup>295</sup> During its inquiry process, the Disciplinary Committee is empowered to summon witnesses and procure any record, book, document or thing.<sup>296</sup> Parties to the procedure may also call expert witnesses.<sup>297</sup> All witnesses may be cross-examined by a respondent or their legal representative.<sup>298</sup> The NMCM respondent stated that complainants have a right of appearance during the complaints procedure and that feedback on the process is given to the complainant. While the structure of the Disciplinary Committee procedure is much like that of a trial, it is not bound by strict rules of evidence and practice: its inquiry may be conducted in an informal manner.<sup>299</sup>

---



Following its inquiry, the Disciplinary Committee reports its findings and recommendations to the NMCM. If the NMCM agrees that the relevant nurse or midwife has committed misconduct or is incompetent, it has several **disciplinary powers** at its disposal. This includes the nurse or midwife's removal from the Register, their suspension, the payment of a penalty or expenses relating to the inquiry, or imposing conditions on their practice.<sup>300</sup>

Any person who is aggrieved by the findings of the Disciplinary Committee or the decision of the NMCM, may **appeal** to the High Court within three months.<sup>301</sup>

---



The NMCM respondent stated that complaints take three to six months to process, depending on financial resources. The NMCM respondent interviewed for this report indicated it receives 20-30 complaints per year. Healthcare users and healthcare workers are informed of the procedure through meetings and radio programmes.

---

<sup>293</sup> As above, section 50-51.

<sup>294</sup> As above, section 55.

<sup>295</sup> As above, section 58(2).

<sup>296</sup> As above, section 59.

<sup>297</sup> Rule 15 of the Nurses and Midwives (Disciplinary Inquiry) Rules GN 11/2003.

<sup>298</sup> As above, rule 10(1).

<sup>299</sup> As above, rule 14.

<sup>300</sup> Nurses and Midwives Act, section 62.

<sup>301</sup> As above, section 63.

### ASSESSMENT

- ✓ The **availability** of the NMCM complaints process is strengthened by the possibility of relating complaints through secretaries and nursing officers at facility-level.
- ✗ The requirement that complaints be in writing, however, may be restrictive for some complainants.
- ✓ Even though anonymous and third-party complaints are discouraged, the possibility for their inclusion enhances the safety of the NMCM process for vulnerable healthcare users.
- ✗ Vulnerable complainants might, however, be wary of the safety consequences of being summoned to give evidence and cross-examined during the investigation process.
- ✓ The **efficiency** of the procedure is strengthened by there being legislated structures in place to in theory secure independence of the investigation and decision-making processes.
- ✗ The **sufficiency** of the NMCM process is limited by its strictly disciplinary powers against its members.
- ✓ A broad prospect of appeal to a court of law does, however, enhance sufficiency potential.

## Malawi Human Rights Commission

The Malawi Human Rights Commission (MHRC) is an independent body established in terms of the Constitution.<sup>302</sup> It is vested with the responsibility to protect against and investigate violations of rights in the Constitution and other law.<sup>303</sup> In fulfilling its mandate, the MHRC has powers to investigate issues and make recommendations on its own accord or on application of individuals or classes of people.<sup>304</sup> Complaints are sometimes related to the Commission through public inquiries.



According to the Commission's website,<sup>305</sup> **complaints** can be submitted by writing letters or filling out a complaint form, or calling or visiting the Commission's offices in Blantyre or Lilongwe. Written complaints must include the name, contact details and address of both the complainant and the respondent, and also details of the complaint and all relevant documents. Commission officers may assist complainants who are unable to read or write. In addition, complaints may be brought by representatives, third parties, NGOs, and other legal persons.<sup>306</sup>

<sup>302</sup> See: sections 129-131 of the 1994 Constitution of Malawi.

<sup>303</sup> As above, section 129.

<sup>304</sup> As above, section 130.

<sup>305</sup> Available at: <http://www.hrcmalawi.org/complaints.html>.

<sup>306</sup> Section 16(2) of the Human Rights Commission Act 27 of 1998.

Complaints may relate to any violation of a person's rights under the Constitution or other law. However, the Commission will not consider cases pending before the courts or other decision-making bodies, or issues that are frivolous or vexatious.



It is understood that generally after a complaint has been submitted the Commission proceeds to categorise it and assign officers to be in charge of it. An **inquiry plan** is then completed by the assigned officer who can proceed to consider the complaint. An investigation of the facts and merits of the case is conducted and further evidence acquired. The Commission has significant investigatory powers, including to search and also seizure powers (under a warrant)<sup>307</sup> and can subpoena witnesses.



The Commission is empowered to determine its own procedure for the conduct of hearings on matters brought to its attention.<sup>308</sup>



In terms of section 22 of the Human Rights Commission Act, following hearing a complaint or based on any investigation, the Commission has several **remedies** at its disposal. These include seeking amicable settlement, transmitting the complaint to any competent authority, compelling mediation, making recommendations to the competent authority proposing reform, and referring a matter for prosecution.<sup>309</sup> The Commission is also empowered to litigate in the public interest, affording the Commission broad standing in the context of otherwise narrow limits in legal standing for court cases to be brought in the public interest.



The Human Rights Commission Act requires the MHRC to promote a complainant's access to remedies, and to provide assistance to complainants and information on the status of a complaint and parties' rights.<sup>310</sup>

The Commission states that it treats all matters "in a confidential way". It is unclear to what extent complainants are entitled to anonymity or if they may seek that their identities are protected from respondents.

Commissioners and staff are guaranteed independence and organs of government are required to assist and cooperate with the MHRC as may be reasonably required.<sup>311</sup>



Respondents from the MHRC interviewed for this report estimated that about 300-500 individual cases are dealt with per year. However, respondents believed that the number of complaints was insignificant in relation to the extent of human rights violations. This they stated was due to accessibility constraints. Accessibility challenges were identified as knowledge deficits, geographic limitation, and restrictions on the Commission's outreach work in outlying areas due to financial constraints. The respondents explained the Commission's focus as being largely

---

<sup>307</sup> See, as above, sections 19 and 20.

<sup>308</sup> As above, section 17.

<sup>309</sup> See, as above, section 22.

<sup>310</sup> As above, section 22.

<sup>311</sup> As above, section 34.

demand-driven and was interested in understanding factors that might constrain complainants to report healthcare-related violations. The respondents stated that the MHRC does not receive many complaints relating to healthcare discrimination, a phenomenon respondents described as due to low levels of service delivery making it difficult for healthcare users to complain as they would inevitably need to return to the same parties and facilities for healthcare.

The MHRC respondents related frustrations for the Commission in fulfilling its mandate due to human resource and financial constraints. Considering the breadth of its human rights mandate and the limited resources available, respondents considered that perhaps the most strategic use of the MHRC's mandate would be to focus on *systemic* issues and to pursue *structural* interventions to lessen occurrences of symptomatic individual cases, as opposed to focussing on individual issues.

### ASSESSMENT

- ✓ The MHRC rates high on **availability**, showing strong indications of physical and financial accessibility through offering diverse complaints lodging options even if having limitations in its physical localities.
- ✓ The legal obligations on the MHRC to ensure **accessibility** of its system and to support complainants, ensures diverse entry points for complaints in addition to offering flexibility in ensuring the safety of complainants.
- ✓ In terms of **effectiveness**, three aspects are positive attributes for the MHRC: its institutional independence; that complainants enjoy the rights to making representations and to information; and that the MHRC processes relatively high volumes of complaints.
- ✗ However, its **efficiency** is constrained by severe funding shortfalls.
- ✗ With respect to **sufficiency**, while it does not appear that the Commission can impose binding sanctions on respondents or redress for complainants.
- ✓ However, its processes may be useful for creating opportunities for systemic input and policy change and for broad-based public interest issues to be raised through the MHRC, including through its broad standing to litigate.

## Office of the Ombudsman

The Office of the Ombudsman is a constitutional body tasked with investigating and litigating on government abuses or legal violations on behalf of individuals who lack other means of redress. The respondent from the Office interviewed in this report described its function as assisting individuals who cannot use the courts.



In terms of sections 15(2) and 46(2)(b) of the Constitution, persons or groups who believe that their constitutional rights have been violated or threatened may approach the Ombudsman for assistance or relief. The respondent from the Office interviewed for this report understood the Ombudsman's powers as extending to ensuring that no discrimination is faced in public-health institutions. The Ombudsman's powers are limited, however, to the investigation of public facilities. The conduct of private facilities would be excluded.

**Complaints** can be sent to the Office of the Ombudsman directly or to its regional officers in Lilongwe, Balaka, Mzuzu or Blantyre. Complaints can be made in writing or orally at one of these offices. Legal officers assess and screen complaints.

---



The respondent from the Office indicated that the initial assessment process usually takes about ten days. Healthcare users can make submissions to legal officers and may appear before the Ombudsman if mediation or public enquiries are pursued on the issue. Complainants are entitled to information on the status of their complaints.

---



Following an investigation of the complaint, the Ombudsman has the power to recommend an action to the respondent. However the recommendations of the Ombudsman are not binding. This is acknowledged by the respondents from the Office interviewed in this report as being a major barrier to the effectiveness of the Office. Its own procedure was described as "somewhat effective" for this reason.

---



The length of time taken to determine the complaint is stated to vary according to the complexity of the case and the evidence presented.

Per annum, the Office of the Ombudsman receives about 105 complaints.

Healthcare users and healthcare workers are made aware of the complaints procedure through civic education, workshops, and "Ombudsman days".

### ASSESSMENT

- ✘ The **availability** of the Office of the Ombudsman appears to be limited for persons living in rural areas.
- ✓ However, the use of regional offices and options for either oral or written complaints supports **accessibility**.
- ✓ The complaint turnaround indicates a relatively **efficient** process and there appears to be flexibility in how investigations are conducted to ensure complainant safety and input in the process. This flexibility may make the process difficult to predict for complainants but highlights the potential for the process to be **effective**.
- ✘ The **sufficiency** of the Office of the Ombudsman in fulfilling the right to redress is significantly undermined by the non-binding nature of its recommendations.

## 5.4 Zambia

### Introduction

Studies in Zambia have shown that accountability, equity and responsiveness at the primary level of healthcare is essential to achieving population health outcomes.<sup>312</sup> The same study found that there were comparatively few mechanisms for enforcement, and healthcare facilities at primary healthcare level, in particular, were marked by permissive work norms and a culture of impunity.<sup>313</sup> Internal or facility-level complaints mechanisms are identified in the present report as being largely informal but tending to be the preferred or only-known method of complaint amongst NGO/CBO and focus-group respondents.

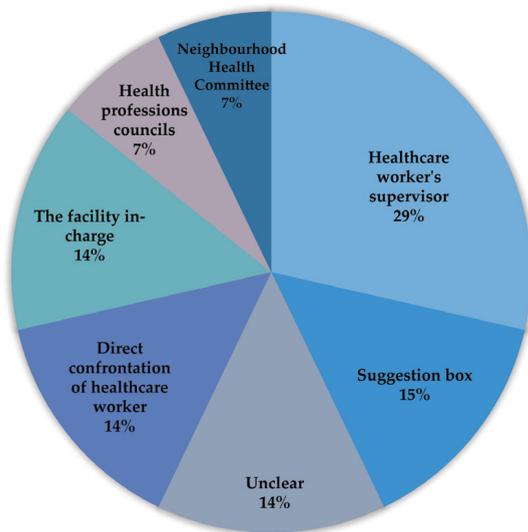
### Facility-level complaints

NGO and CBO respondents interviewed for this report in Zambia in all cases thought healthcare users should lodge complaints at health-facility level. The manner of complaint varied from use of suggestion boxes, to complaining to the healthcare worker's supervisor or the facility in-charge. Some considered that there were no complaints mechanisms available. A small proportion referred to engaging Neighbourhood Health Committees and others to a process of escalation of complaints eventually to health professions councils and courts but that initial complaints must occur at facility-level. Where respondents could identify a manner of complaint, these were universally described as "inconsistently effective".

<sup>312</sup> SM Topp et al. "Understanding the Dynamic Interactions Driving Zambian Health Centre Performance: a Case-based Health Systems Analysis" (2014) *Health Policy and Planning*, available at: <http://heapol.oxfordjournals.org/content/early/2014/05/14/heapol.czu029.full.pdf+html>.

<sup>313</sup> As above, 12.

### Where Should a Patient Complain? NGO and CBO Perspectives



**Neighbourhood Health Committees** comprise volunteer representative members of the community in which the health facility is located. These Committees were established under the National Health Services Act 22 of 1995, later repealed by the Health Services Act 17 of 2005. The committees therefore operate without a formal legal mandate but, where they exist, they operate to link the health facility to the community in its catchment area.

**Health Centre Committees** were not noted by respondents as being an avenue for complaint but may be a useful channel. Like the Neighbourhood Health Committees, Health Centre Committees were established by the 1995 National Health Services Act and were subsequently repealed under the 2005 Health Services Act. They nevertheless continue to function and operate as a high-level link between the community and the health centre. These Committees are only located at health centres and comprise the person in-charge of the health centre, volunteer representatives of the Neighbourhood Health Committee, an Environmental Health Technician, and a Maternal and Child Health Coordinator.

The respondent interviewed from the Health Professions Council of Zambia (HPCZ) stated that the appropriate response for a healthcare user complaint was to relate the concern to the **head of the facility**. The respondent nevertheless stated that there were different mechanisms at each institute. The respondent from the General Council of Nurses of Zambia (GNCZ) stated similarly that management at facility level should receive healthcare user complaints. The GNCZ respondent's view was that only if management failed to address the complaint should it be approached.

Researchers were in addition able to establish a formalised complaints procedure at the **University Teaching Hospital** in Lusaka, which is Zambia's largest hospital. Anyone who is dissatisfied with the

delivery and quality of healthcare services can complain. In a pamphlet detailing the procedures, healthcare users are advised to lodge complaints, either verbally or in writing, through:

- The sister-in-charge;
- Block nursing officers;
- Heads of departments;
- Customer Relations Offices;
- The Public Relations office;
- The Chief nursing officer;
- The Deputy managing director;
- The Managing director;
- Suggestion boxes;
- By telephone;
- By email; or
- Via the University's website.

The department management committee is nominated to handle the complaints. Healthcare users are advised that they can expect three possible outcomes:

*“Apology.*

*Explanation of what went wrong.*

*Hope that staff will recognise their short-comings.”*

### ASSESSMENT

- ✘ Researchers had difficulty obtaining sufficient information on internal or facility-level complaints processes. This dearth of information is itself an indication of low **availability** of the processes.
- ✔ Like other facility-level processes, however, these systems should have good **availability** in having the potential to be accessible to health users because they function at the point of care.
- ✘ **Safety** concerns for complainants, particularly for those who would need to return for care are, however, noted.
- ✘ In the absence of any indication of a formalised or structured complaints-management process, it appears that the facility-level processes in Zambia have low levels of **effectiveness**, being entirely reliant on the individual receiving the complaint to ensure effectiveness.
- ✔ There should be potential in the **sufficiency** of the process to determine and enforce varied redress and accountability. However, there is no indication that complaints made through these channels would necessarily result in sufficient outcomes for complainants.

## Health Professions Council of Zambia (HPCZ)

The Health Professions Council of Zambia (HPCZ) is a regulatory body established under the Health Professions Act.<sup>314</sup> The HPCZ is responsible, amongst others, for the registration and regulation of the professional conduct of registered health practitioners except for nurses and midwives.<sup>315</sup> The Council is empowered to investigate allegations of professional misconduct and can impose sanctions against practitioners if necessary.<sup>316</sup> The HPCZ respondent interviewed for this report described the purpose of the HPCZ's complaints process as being to regulate health practitioners.



Members of the public can lodge **complaints** for professional misconduct against HPCZ-registered practitioners with the Disciplinary Committee through the Registrar of the HPCZ. Complaints must be in writing. Complainants may refer any contravention of the Code of Ethics or any provision of the Health Professions Act.<sup>317</sup> The HPCZ respondent understood this to include cases relating to stigma and discrimination in healthcare, while noting that it had not ever dealt with any cases of discrimination in healthcare.

The HPCZ does not ordinarily receive anonymous complaints, in keeping with its policy of transparency. The HPCZ respondent stated, however, that in exceptional cases, and where it is in the best interests and safety of the healthcare user, an anonymous complaint may be received.



The HPCZ respondent explained that the Registrar and Legal Officer conduct an initial **assessment** of the complaint. This includes addressing correspondence to the institution in question to request a reply on the allegations and for the healthcare user's medical records. The medical practitioner is asked to explain their conduct. The Executive Committee determines whether an inquiry shall proceed on a complaint

The **Investigations Committee** meets every quarter to discuss cases and decides to either close the case or refer it to the Disciplinary Committee for determination of the allegations.



The **Disciplinary Committee** is established by the HPCZ and comprises a chairperson and vice-chairperson who are legal practitioners qualified to hold high judicial office, the chairperson of the HPCZ, a peer of the health practitioner accused of misconduct, and a lay member of the HPCZ.<sup>318</sup> The HPCZ respondent stated that the Committee meets twice every quarter due to the backlog of cases on file.

A Disciplinary Committee's **hearing** is deemed to be a judicial proceeding.<sup>319</sup> The respondent stated that complainants have a right to appear before the

---

<sup>314</sup> 24 of 2009. See Part II, Section 3.

<sup>315</sup> Section 4 of the Health Professions Act.

<sup>316</sup> As above, section 4(1)(h).

<sup>317</sup> A guideline to the complaints procedure is available at: [http://hpcz.org.zm/download/?file=1442646766aints\\_Submission\\_Procedure.pdf](http://hpcz.org.zm/download/?file=1442646766aints_Submission_Procedure.pdf).

<sup>318</sup> Section 63 of the Health Professions Act.

<sup>319</sup> As above, section 66(4).

Disciplinary Committee during a hearing of a case and are entitled to information on the status of their case. All parties are entitled to legal representation at the Disciplinary Committee proceedings.<sup>320</sup> However, all proceedings are closed to the public.<sup>321</sup> During the hearing, the Disciplinary Committee may hear and receive evidence and has the power to summon witnesses and to compel the production of evidence.<sup>322</sup>



The standard of proof required to find a practitioner guilty is not specified in the Act. On a guilty finding by the Committee, several **sanctions** may be imposed.<sup>323</sup> This includes cancelling the healthcare worker's license to practice, imposing conditions on the person's practice, censuring or cautioning the practitioner, imposing a fine payable to the Council, ordering payment of the costs of the hearing or of parties to the hearing, and ordering the payment of restitution to an affected party or complainant.<sup>324</sup> The Committee is obliged to give a reasoned judgment of its decision and all parties and affected persons must be given a copy of the judgment.<sup>325</sup> The Disciplinary Committee may publicise the facts relating to a practitioner found guilty of misconduct but is not obliged to do so.<sup>326</sup> Factual findings of the Committee are not appealable;<sup>327</sup> however, any person aggrieved by the Committee's decision (including a complainant) may appeal its decision to the High Court within 30 days.<sup>328</sup>



The HPCZ respondent stated that complainant confidentiality is protected in line with patient confidentiality rights. Some facts around a complaint may be published with the Committee's decision, however, the names of patients are concealed.



The HPCZ respondent estimated that complaints take on average six months to process and that the HPCZ receives 30 cases of professional misconduct per year.

The HPCZ has a Public Relations Unit that uses multiple channels to inform the public of its work, including print, radio and television media, and events at agricultural trade shows and traditional ceremonies.

<sup>320</sup> As above, section 65(5).

<sup>321</sup> As above, section 65(3).

<sup>322</sup> As above, section 66. Failure to abide by a summons is an offence in terms of section 66(2), and is punishable by a fine.

<sup>323</sup> As above, section 66(5).

<sup>324</sup> As above, section 66(5).

<sup>325</sup> As above, section 65(6).

<sup>326</sup> As above, section 64(2).

<sup>327</sup> As above, section 66(6).

<sup>328</sup> As above, section 68(1),

## ASSESSMENT

- ✘ The HPCZ disciplinary process is relatively formalised, which may limit the **effectiveness** and availability of the process for healthcare users who lack legal support in pursuing a complaint against a health professional. The limited recognition of anonymous complaints may also be difficult for vulnerable complainants.
- ✓ However, the HPCZ's stated commitment to preserving patients' confidentiality is an important safety guarantee for vulnerable complainants.
- ✘ The **sufficiency** of the process is limited by the narrow focus of its remedial powers in disciplining health professionals and in the apparent absence of a system for capturing information on the content of complaints to feedback into the health system or professional training.
- ✓ That decisions of the HPCZ are appealable by any aggrieved person, and the formality of the process may, however, stand as guarantees for the independence and transparency of the process, at least in principle.

## General Nursing Council of Zambia (GNCZ)

The General Nursing Council of Zambia (GNCZ) is a statutory body that was established in terms of the 1970 Nurses and Midwives Act,<sup>329</sup> which has since been repealed. The Nurses and Midwives Rules,<sup>330</sup> promulgated in terms of the 1997 Nurses and Midwives Act,<sup>331</sup> detail disciplinary procedures that can be taken against nurses and midwives registered with the GNCZ. The GNCZ respondent interviewed for this report understood this process as being aimed at healthcare users who had failed to obtain relief at the hospital or clinic facility level and defined the purpose of the process as regulating nurses and midwives, and protecting the public from malpractice.



Any person who is aggrieved by the conduct of a registered nurse or midwife can make a **complaint** in writing to the GNCZ or in person as a "walk-in client". The GNCZ also accepts anonymous complaints. An inspector is positioned to investigate anonymous complaints. The GNCZ also follows up on allegations against nurses and midwives' professional conduct in the media.



The GNCZ respondent explained that, on receiving a complaint, the Monitoring and Evaluation Officer and the Standards and Compliance Officer **assess** the complaint. The Registrar then prepares a statement on the complaint received. These are then presented to the Professional Conduct Committee comprising a legal officer from the Ministry of Justice, the Board President of the GNCZ and five other board members appointed by the Ministry of Health. The Committee meets every quarter. The Committee compiles a report on each complaint which is sent to the full Council, which also meets once a quarter.

The Nurses and Midwives Board is established in terms of the Nurses and Midwives Act.<sup>332</sup> It is the body that decides whether disciplinary proceedings should be

<sup>329</sup> 55 of 1970.

<sup>330</sup> 1981.

<sup>331</sup> 31 of 1997, Chapter 14:05.

<sup>332</sup> As above, section 3.

pursued against a nurse or midwife. The Board is constituted by the Chief Medical Officer, the Matron of the Public Hospital and three other members appointed by the Minister of Health.<sup>333</sup> If a decision is made to hold an enquiry or to dismiss a complaint, the complainant and respondent must both be notified.<sup>334</sup>



In a disciplinary **enquiry**, an accused nurse or midwife is entitled to legal representation.<sup>335</sup> Accused persons are entitled to make presentations to the Board, to present evidence, to call witnesses and to cross-examine them.<sup>336</sup> The Board is also empowered to call and question witnesses.<sup>337</sup> During this process, the Zambia Union of Nurses Organisation may participate in the interests of its members.

The GNCZ respondent stated that complainants do not have a right of appearance or a right to make representations before the Committee. A complainant is, however, entitled to information on the status of their complaint, in the respondent's view.



If the Board is satisfied that the "evidence is insufficient", charges can be dismissed. If the Board finds the nurse or midwife guilty of professional misconduct it is empowered to impose sanctions. Outcomes of the complaints procedure can include the issuing of a warning to the nurse or midwife, temporary or permanent removal<sup>338</sup> from the register or suspension.



The GNCZ perceives its own complaints system as being very effective. The respondent estimated that it receives twelve complaints per year, each which takes on average of 3 to 13 months to determine.

The public are made aware of the GNCZ's complaints mandate through public relations activities that include distributing brochures, agricultural shows and the use of its website.<sup>339</sup>

<sup>333</sup> As above, section 3(1).

<sup>334</sup> Rule 31(6) of the Nurses and Midwives Rules.

<sup>335</sup> As above, rule 31(7).

<sup>336</sup> As above, rule 31.

<sup>337</sup> As above, rule 31.

<sup>338</sup> In terms of section 13 of the Nurses and Midwives Act, the Nurses and Midwives Board can remove a nurse or midwife from the register or roll, if they are shown to be incompetent or negligent, incapable of discharging their duties, convicted of any felony, misdemeanor, or other serious offence, or are of "bad character". Persons removed from the register or roll may appeal their removal to the Appeals Tribunal. Removal from the register or roll results in a prohibition against practice as a nurse or midwife.

<sup>339</sup> General Nursing Council of Zambia website (2016), available at: <http://www.gnc.org.zm/>.

## ASSESSMENT

- ✘ The GNCZ process does not have structured means in place to ensure the system's **availability** to diverse users and particularly to ensure the safety of vulnerable complainants.
- ✓ The GNCZ's willingness to accept anonymous complaints does, however, offer **safety** prospects for vulnerable complainants.
- ✘ The low number of complaints received per annum signals inaccessibility of the systems and low **efficiency** prospects.
- ✘ Efficiency is further limited by the absence of a complainant's right of appearance or a right to make representations before the Committee
- ✓ A measure of **effectiveness** is, however, provided in the relatively formalised guarantees for independence and transparency in the complaints process.
- ✘ **Sufficiency** is limited by the GNCZ's mandate to regulate professional conduct.
- ✘ That the GNCZ respondent perceived the GNCZ process as secondary to failure at facility-level processes is perhaps a worrying indication of the extent to which the GNCZ perceives the importance of its mandate in regulating the professional standards and conduct of nurses and midwives in Zambia.

## Human Rights Commission (HRCZ)

The Human Rights Commission of Zambia (HRCZ) was established subsequent to amendments to the Zambian Constitution in 1996. Its mandate under the 2016 Constitution of Zambia (Amendment) Act is to “ensure that the Bill of Rights is upheld and protected”.<sup>340</sup> To this end, the 2016 amendments to the Constitution empower the HRCZ to investigate and report on the observance of rights and to “take necessary steps to secure appropriate redress where rights and freedoms are violated”.<sup>341</sup> Further to this, section 241(d) of the 2016 constitutional amendments states that the Commission “shall take measures to ensure that State institutions and other persons comply with its decisions”. The HRCZ respondent interviewed for this report stated that the purpose of the Commission's complaints system was to provide redress for victims of human rights violations.



The respondent explained that **complaints** could be made by any person to the Commission by phone, in writing by email or letter, or in person at any of their offices. Because complaints must be in writing, if a complainant relates a complaint telephonically or in person, staff at the Commission are required to assist those who cannot write. The HRCZ is in the process of developing an electronic filing system for complaints, noting that members of the public sometimes make use of social media such as Facebook to note complaints to the HRCZ.

<sup>340</sup> Section 230(2).

<sup>341</sup> Section 230(3)(a) and (b).



The HRCZ does accept anonymous complaints of a general nature, where it is possible to independently investigate the complaint. For investigations that require investigations into a particular set of facts, a complainant would need to be identified in order to be interviewed.



Lawyers in the Commission's legal department **assess** complaints. Complainants have a right to appear before the Commission, to make representations, and are also entitled to receive information on the status of their complaints.



The HRCZ respondent indicated that complaints take on average 60 days to assess and determine. The determination of a complaint can result in a **recommendation** made by the Commission to the relevant public institution. The case can further be referred to the Legal Aid Board for litigation. The HRCZ respondent indicates the system as "somewhat effective" on the basis that its recommendations can be accepted or rejected by the respondents to a complaint. However, under the 2016 constitutional amendments noted above, new opportunities have been created for the Commission to improve its effectiveness under provisions that appear to create enforcement powers for the Commission.



The HRCZ respondent stated that the Commission receives on average 700 cases per year, dealing with human rights generally.

The HRCZ respondent noted that the Commission is accessible and affordable for complainants. In order to make the public aware of its activities, the Commission conducts general sensitisation programmes on equality and fundamental rights but does not have any specific programmes on discrimination in healthcare.

A Zambian transgender focus-group respondent noted distrust, however, of the Commission's capacity to deal with discrimination-related complaints for transgendered persons, indicating a need for the HRCZ to make its stance on LGBT issues clear:

*"I am sceptical about the Human Rights Commission. The Human Rights Commission does not carry out their own research on the stigma and discrimination we experience. They have not engaged the transgender community. I would like to see them take a lead so we can trust their complaints mechanism." (Transgender respondent – Lusaka, Zambia)*

In response to an enquiry regarding these concerns, a respondent from the HRCZ stated that the Commission would not turn away a complainant simply because they were a member of the LGBT community but thus far they have not been formally approached with a complaint based on discrimination against members of the LGBT community.

## ASSESSMENT

- ✓ The HRCZ is open to receiving information and complaints through varied media and appears to be committed to expanding its accessibility and **availability**.
- ✗ The availability of the HRCZ is in practice constrained for certain vulnerable persons to the extent that there is a sense of distrust. The HRCZ need to show a willingness to embrace the particular **safety** needs and interests of key populations such as LGBT persons.
- ✓ The HRCZ is in structure independent but **effectiveness** appears to be limited by funding restrictions.
- ✓ The HRCZ receives the highest volume of complaints in comparison with all the other complaints bodies interviewed for this report across the three countries.
- ✓ The **sufficiency** of the HRCZ has great potential under the constitutional amendments. The extent to which it exercises and enjoys compliance with these expanded powers remains to be seen.

## 5.5 Conclusion

A variety of options exist for persons in the three countries analysed to relate complaints on stigma and discrimination in healthcare outside of the formal court process. However, these processes provide for varying levels of availability, effectiveness and sufficiency in holding healthcare workers and systems to account and in providing healthcare users with the right to redress.

### Internal and facility-level processes

- All three countries have some version of facility-level or health system complaints procedures and, usually, a number of avenues for relating a complaint can be pursued internally. These were the processes most frequently referred to by all research participants when asked how a healthcare user should make a complaint.
- These processes generally have higher levels of availability, being closer to communities with no formal complaints-lodging process. They also have the potential to be sufficient forms of redress in that they offer the prospect of system-level information feedback and policy input, of individual disciplinary action against offenders as employees, and of direct redress to victims.
- This potential is undermined by the absence of predictable processes for complaints management in all three countries, which makes these processes unreliable for complainants.
- Where examples have been related of successful outcomes following complaints being laid through these processes, this has usually been through the vigorous support of NGOs or

## Health professions and nursing councils

- Health professions and nursing councils exist in all three countries and have, in most instances, some level of formalised process through which complaints can be handled.
- These systems focus exclusively on the management of their respective professions and so offer a narrow range of redress in the professional discipline of a particular healthcare worker. While most of these bodies have mandates that would include some level of systemic input and, in the least, systemic input through the management of professional training, there have not been any indications that these bodies capture data from complaints or provide health-systems-information-feedback from the complaints received.
- The councils interviewed generally handle very few complaints per annum and appeared in some examples to lack a willingness to engage with concepts of discrimination in the context of professional misconduct.
- While comparatively lower on availability and sufficiency, these complaints processes do appear to have better efficiency prospects in the existence of more formalised processes that typically allow for complainant input. Efficiency is however compromised by the lack of clarity on the standard of proof required for a complaint to succeed against a healthcare worker. In the BHPC the standard is specified as requiring proof beyond reasonable doubt to succeed with a claim against a healthcare professional. This high standard of proof required, particularly when healthcare users may struggle to access evidence of abuses and where no more reconciliatory processes are offered within the complaint system, may in effect exclude healthcare users from being able to use the process effectively.

## National human rights institutions and ombudspersons

- Human rights commissions exist in Malawi and Zambia. In Malawi, it would also be possible to relate a complaint to the Office of the Ombudsman. Botswana has no national human rights institution but the Office of the Ombudsman may deal with healthcare discrimination complaints to the extent that they meet its narrow mandate.
- These systems tend to have better availability than health professions and nursing councils in terms of being more flexible to the ways in which information reaches the bodies and in which complaints can be made and determined.
- Because these bodies are not prosecutorial in nature, the manner in which they engage with complainants can vary, potentially allowing for better accommodation of security concerns for vulnerable complainants.
- Having high levels of institutional independence, these complaints processes have the potential to be effective options for lodging discrimination complaints in healthcare.
- These bodies are limited, however, from a sufficiency perspective and are likely best placed to deal with issues concerning more systemic and policy-based complaints than with individual grievances. With the exception of the Zambian Human Rights Commission's expanded powers under the 2016 constitutional amendments, these bodies lack enforcement powers to sanction offenders or to deliver direct redress to victims.

- However, the litigation-powers of the commissions in Malawi and Zambia may prove a useful resource for NGOs and CBOs to work with the commissions to pursue individual remedies in the public interest, particularly for vulnerable persons.

## Specialised bodies

- Only one specialised body was examined in this report – the Office of People with Disability in Botswana.
- To the extent that specialised bodies are financially sustainable to run, they may offer prospects for ensuring more tailored access to accountability and redress for vulnerable persons, depending on the nature of their powers and the process.

While having some potential to be used by healthcare users to lodge complaints on healthcare discrimination, these processes all require significant investment and improved procedural clarity and consistency to be able to ensure that States are complying with their obligations to fulfil the right to redress for victims of discrimination. As will be illustrated in chapter 6, greater sensitivity to the needs of key populations and vulnerable populations needs to be guaranteed within these systems to ensure that the processes in themselves are not discriminatory by excluding certain persons from meaningful, safe and effective access.