Workshop Report:

"Using complaints to address healthcare violations in Botswana, Malawi and Zambia"

6-7 February 2017

Crossroads Hotel, Lilongwe, Malawi

Contents

Background

The Southern Africa Litigation Centre (SALC) is a regional non-profit organisation that works to advance human rights and protect the rule of law in southern Africa. Research conducted by SALC in 2016 ("Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia") detailed experiences of discrimination in healthcare faced by women living with HIV, lesbian, gay, bisexual and transgender (LGBT) persons, sex workers, and people with disabilities. The research identified a number of processes outside of the courts and available at local levels for healthcare users to seek accountability and redress when experiencing human rights violations and discrimination in healthcare. The research indicated, however, that there is a capacity gap amongst healthcare users, community-based organisations (CBOs) and non-governmental organisations (NGOs) working with human rights, health rights, key populations and vulnerable populations, to make effective and safe use of complaints processes to advance accountability and redress when human rights violations and discrimination occurs in healthcare settings.

With funding from the Africa Regional Grant on HIV, SALC has developed a Guidebook on "Using complaints to address healthcare violations" in an effort to address these capacity gaps. Through the same Grant, SALC hosted workshops in Botswana, Malawi and Zambia on "*Using complaints to address healthcare violations*." A workshop was held in Malawi from 6-7 February 2017 for participants from CBOs and NGOs, and from national human rights institutions and health professionals' regulatory bodies.

Workshop Objectives

The purpose of the workshop was to develop the capacity of in-country CBO and NGO partners to identify and take up cases through complaints processes and to be able to support healthcare users when doing so. The training aimed to expose participants to knowledge and skills to promote and improve the rights of persons living with HIV and persons disproportionately affected by HIV (key populations) and vulnerable groups through the use of these processes. The training further aimed to provide representatives from complaints bodies with exposure to the experiences of key populations and vulnerable groups of discrimination in healthcare and what is needed in order for these groups to access complaints processes safely and effectively.

Outcomes

The ultimate outcome of these workshops will be the increased, safe and effective use of complaint processes to achieve accountability and redress for victims of discrimination and human rights violations in healthcare settings, particularly for key populations and vulnerable groups.

SALC seeks to work with CBO and NGO partners to:

- Build partner capacity through working with partners to identify cases and make complaints.
- Provide appropriate support to complainants.
- Identify strategic interventions to improve the accessibility, effectiveness and sufficiency of complaint processes.

Keynote Address: Justice Zione Ntaba

Justice of the High Court of Malawi, Zione Ntaba, delivered a keynote address to open the workshop. Her address is transcribed in full below.

Health, Dignity and Human Rights: The Malawian Dilemma

"Let me first thank you so much for honouring me by allowing me to give this keynote address at this training. This is very heart-warming because recently I was just dealing with a case which called on me to exercise the very thing which I swore to uphold when I became a Judge: justice and fairness.

I would like at this point want to tell you my personal story which makes believe very much that you cannot do without human rights in the health sector. Before I went to Law School I did two (2) years of training at

Kamuzu College of Nursing. I know what happens in the trenches of our health system. I also worked at the Ministry of Justice and Constitutional Affairs where for a number of years I was the legal advisor to the Nurses and Midwives Council of Malawi and sat on the Disciplinary Committee where I saw first-hand the human rights violations and discriminatory practices. The horror stories of patients have remained with me over the years.

Malawi is a country which is struggling with a lot of issues governance wise but more so economically and this has a major effect on the health system. This effect is not only felt by the users of the system but also those providing services therein. Therefore the theme for this training is very critical in this country - Using Complaints to Address Healthcare Violations in Malawi. I have however decided to focus on human dignity and human rights in the Malawian context in this address as I believe this is what is at the core of using the complaints mechanisms.

Coincidentally, the justice system has over the years in Malawi and other countries have had to deal with health and human rights issues. These issues have helped protect and promote of persons whose health rights have been violated, there continue to be more violations. For instance the famous Indian and South African cases on anti-retro viral medicines which made significant inroads into the fight against HIV/AIDS.

In Malawi, the right to dignity is enshrined in section 19 of the Constitution. Furthermore, section 20 guarantees that all persons should be treated equally and be free from discrimination. Incidentally, a crucial right directly linked to health is the right to privacy under section 21.

However, Malawi does not have the right to health enshrined in its Constitution, it however has the right to development under section 30 which stipulates that all persons and peoples have a right to development right and therefore a right to the enjoyment of economic, social, cultural and political development and women, children and persons with disabilities in particular shall be given special consideration in the application of this right. If a Malawian court was to ever broadly interpret the right to development in line with section 12 and 13 (c) of the Constitution which states that the State will provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care, then health rights could be protected and promoted.

It is therefore imperative that the research conducted by SALC in 2015, under the theme "Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia" is highlighted. The said research identified a number of processes outside of the courts and available at local levels for healthcare users to seek accountability and redress when experiencing human rights violations and discrimination in healthcare. The research indicated, however, that there is a capacity gap amongst community-based organisations and non-governmental organisations working with human rights, health rights, key populations and vulnerable populations, to make effective and safe use of complaints processes to advance accountability and redress when human rights violations and discrimination occurs in healthcare settings.

The key point I want to make is that the health care system in Malawi has throughout the years seen its fair of discriminatory practices and human rights violations. These issues have affected women,

children, persons with disability, sex workers, persons living with HIV/AIDS and vulnerable populations. These violations noted in the research have resulted in refusal to treat, forced testing, verbal or physical abuse to mention a few.

For instance, the case The State v Officer In Charge of Mwanza Police Station and 5 others ex-parte H.B and J.M on behalf of 9others, Miscellaneous Cause No. 10 of 2011 (HC)(PR)(Unrep), a case where eleven (11) women challenged a decision to mandatory test for HIV and the use of these tests as evidence in criminal cases against them. They also challenged the public disclosure of their HIV status in open court. They argued that the above actions violated their constitutional rights. Justice Kamanga ruled that the mandatory HIV testing was unconstitutional as it violated the women's rights to privacy, dignity, equality and freedom from cruel, inhuman and degrading treatment.

Notably, in terms of how the courts dealt with an issue of physical abuse in a case of Paipus Kamwendo v The Republic, Crim. Appeal No. 48 of 2004 (HC)(PR)(Unrep)where the Appellant was at all material times a Medical Officer at Nkando Health Center in Mulanje District of the Republic of Malawi and the complainant was a 15 year old girl who was defiled whilst receiving treatment at the centre. The complainant's story was that on 20th May 2003 she went to Nkando Health Centre to enquire about family planning. At the said Health Centre she met and was attended to by the Appellant. It was her further evidence that upon making the said enquiry she was taken inside an examination room by the Appellant whereupon they had sexual intercourse without her consent. After two days she filed a report with Mulanje police that she had been raped. The police referred her to Mulanje Hospital for an examination. The hospital advised, inter alia, that it was difficult to prove penetration and made a conclusion that the allegation of rape was false. Justice Kapanda in his ruling held that the Appellant had fraudulently obtained consent from the complainant and he had cheated the girl that what they were doing in the examination room was part of family planning. Further that penetration does not always leave bruising as such it did not mean rape did not occur. The court concluded that the appeal failed and the conviction was upheld.

Apart from the ability to take these issues to court, the Malawi health care system has a number of complaints mechanisms like the Ombudsman, Malawi Human Rights Commission, Nurses and Midwives Council, Medical Council, Hospital Administrations, District Health Offices to mention a few.

"Nonetheless it is evident in this country that most patients who have faced discriminatory practices or human rights violations do not report such to the relevant authorities. This therefore hinders the progress which would have been made to reduce these incidences in our health care system."

Similarly, there is a major concern in that these mechanisms are not accessible nor known to health care users more so that they are places for them to lay complaints against service providers' for health violations. Furthermore, there are huge concerns with responsiveness of these health systems complaints mechanisms. By the way, they also do not elicit confidence in patients that they will assist them effectively and efficiently. Notably, the speed at which these complaints mechanisms have handled matters has also eroded the trust in these systems. Lastly, the perceived or real lack of confidentiality for how these complaints mechanisms shall handle discriminatory practices or human rights violations.

"At the core of health violations is the fundamental issue of human dignity that is the freedom from discrimination and the protection from human rights violations."

Therefore to ensure human dignity and human rights, it is my view that such calls for a better augmentation of what the right to health entails in the Malawian context. It is my belief that it does not just like in just the provision of health care services as envisaged under section 13(c) of the Constitution but all the inherent issues relating to such like access to water and sanitation health, healthy occupational and environmental conditions and more importantly access to information, including information about relevant health issues.

Upon reading the concept note for this training I have noted that it is hoped that you as paralegals, community workers, civil society or what I call frontline defenders are equipped with the skills that will allow you to know the complaints mechanisms available at the grassroots, have the skills to identify the discriminatory practices as well as the human rights violations but also provide crucial information to healthcare users on these discriminatory practices and human rights violations and solutions for redress.

Therefore, I implore that as you train on these issues, you bear in mind that the causes of social exclusion continue to plague our society. In Malawi, these are also deeply rooted in culture, attitudes and beliefs which result in groups of people especially marginalized and vulnerable ones are overlooked and unprotected when it comes to health violations. This situation is compounded by the fact that certain groups of people are unprotected by the system because they are politically no go areas so even when their human rights are violated in the health care system, there are tragic results like death of a sex worker because no one wanted to treat her in Malawi. These will continue to go unnoticed if no one brings to light for redress.

It is disheartening that members of the medical profession whose oath of office say first do no harm but they treat human beings in the improbable manners stated in the above research. Humanity demands that we do better, be better and more so aspire for better.

It is my hope that we shall remain vigilant and pay close attention to vulnerable population groups as the essence of human rights promotion and protection is to ensure that these people in need are prioritized. In conclusion I hope that we shall continue to explicitly engage with the underlying concerns of health violations so that complaints are efficiently and effectively dealt with.

When the health care systems become areas of human rights violations and discriminatory practices, then human beings who attend to these systems because of ill health will stop visiting them and thereby end up in tragedy."

"Everyone and I mean everyone deserves to enjoy their rights afforded to them under the Constitution which includes the ability to access health services free from discrimination and protected from violations."

Experiences of discrimination in healthcare

SALC commenced the session with the presentation of the findings of its research report on Accountability and Redress for Discrimination in Healthcare in Botswana, Malawi and Zambia.

The report details anecdotal accounts from people with disabilities, sex workers, women living with HIV, and LGBT persons in the three countries showing serious and varied experiences of discrimination in healthcare in Botswana, Malawi and Zambia, based on a number of grounds. These include health and HIV-status, gender, sexual orientation, disability, socio-economic status, occupation, and rural location.

The conduct described by vulnerable persons through various focus groups across the three countries included:

- Treatment denial.
- Abusive language.

- Failure to properly examine healthcare users before providing treatment.
- Sexual coercion and abuse.
- Physical abuse such as slapping and hitting.
- Failure to observe healthcare users' confidentiality, including health-status confidentiality and confidentiality relating to healthcare users' sexual orientation, gender identity, and occupation.
- Failure to conduct proper informed consent procedures.
- Failure to provide reasonable accommodation for persons with disabilities.
- Denial of access to sexually-transmitted infection (STI) and HIV testing, counselling and treatment, in the absence of (heterosexual) sexual partners.
- Blaming healthcare users for their health status.
- Segregation and the use of identifying practices for people living with HIV.
- Failure to accommodate the particular healthcare and access needs of sex workers, persons with disabilities, gay and transgender persons in particular.

The Centre for Human Rights Education, Advice and Assistance (CHREAA) addressed participants on focus groups with sex workers in Blantyre. CHREAA stressed the migratory or nomadic nature of sex workers' lives as creating particular stresses in accessing healthcare. CHREAA explained how the need for sex workers to protect their confidentiality may drive sex workers to access healthcare in different districts.

The Centre for the Development of People (CEDEP) described focus groups run with LGBT persons in Lilongwe. In addition to the experiences described in the research report, CEDEP noted that LGBT persons struggled with gossiping and verbal abuse by healthcare workers that left healthcare users feeling stigmatised. LGBT persons feared being "outed" by healthcare workers. CEDEP noted in addition that LGBT persons are also often denied the chance to participate in healthcare services unfairly such as in giving blood.

The MANGO Key Populations Network described focus groups with women living with HIV in Chiradzulu and with female sex workers in Mwanza organised through the Coalition of Women Living with HIV/AIDS (COWLHA). It was stressed that women with HIV are denied the right to have a child and often treated by healthcare workers as if they shouldn't be having children. The stigma and discrimination caused as a result of confidentiality breaches by healthcare workers was stressed as creating inhibitions for women to access HIV treatment and prevention services. These experiences leave women feeling depressed and demoralised.

Participants offered further examples of discrimination in healthcare. People with disabilities in Malawi were described as having to access healthcare through separate systems: without mainstreaming services for people with disabilities, people are effectively excluded. This "high level" exclusion leads to what was described as low level exclusion as well in the broader community. Women with disabilities were described as particularly vulnerable to abuses in

healthcare when accessing sexual and reproductive health services.

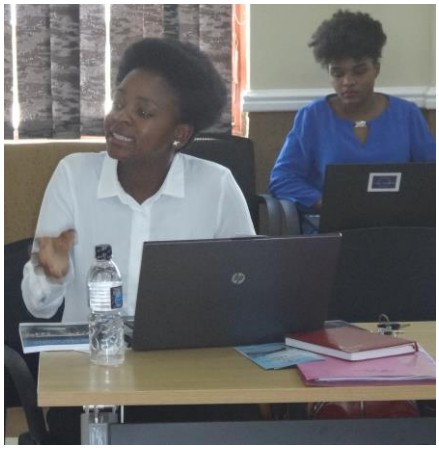
The absence of access to health information was noted as a significant concern for persons with disabilities, particularly for visually- and hearing-impaired persons. One participant stated:

"When information is denied, rights are violated."

Participants further described that persons with mental disabilities experience structural discrimination as mental healthcare is not available at primary healthcare level in health centres but only in Zomba.

Health and human rights

Participants discussed health rights in Malawi law and the duties and ethical obligations of healthcare workers.



It was noted that stigma and discrimination violate human rights and are barriers to effective HIV prevention and treatment. Legal protections and policy commitments in Malawi prohibit discrimination in broad terms and emphasise commitments to equitable access to quality healthcare. It is not a crime to be a sex worker in Malawi and LGBT persons are not criminalised in themselves – even if certain same-sex sexual acts are criminalised. Healthcare workers are ethically and legally bound not to discriminate unfairly against healthcare users and need to respect their inherent human dignity.

Dealing with health rights violations

Participants discussed strategies to deal with human rights violations in healthcare.

There are various options to relate complaints of 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.

The complaints bodies analysed included facility-level or internal complaints processes within the Ministry of Health, the Medical Council of Malawi (MCM), the Nurses and Midwives Council of Malawi (NMCM), the Malawi Human Rights Commission (MHRC), and the Office of the Ombudsman.

Making a complaint

Participants and presenters shared information about best practices in making complaints. The participants worked through the complaint process, including sharing guidance on how to select a complaint process that best serve's the complainant's needs and interests as detailed in the Guidebook.

Supporting vulnerable complainants

Participants discussed the needs of complainants who are vulnerable to abuse and secondary victimisation when complaining and shared strategies on how CBOs and NGO could support complainants.

A number of issues were discussed including the impact of criminal law regimes on the safety and security of sex workers and LGBT persons, the important role of support organisations, the need for healthcare users to understand their rights and the processes to enforce them, and fears of treatment denial, breaches of confidentiality, and social reprisals leading people to fear making complaints.

Participants made a number of useful suggestions on strategies to protect vulnerable complainants and to advance access to justice through these processes. These included:

- Support organisations may work together to access key decision-makers and allies in the system to ensure complaints are advanced.
- Support organisations may consider making complaints together with complainants or on their behalf.
- Anonymous complaints should be considered where there is a risk of reprisals or breaches of confidentiality.

Q&A with Complaints Bodies Representatives

On the second day of the training, UNAIDS assisted in conducting a questions and answers sessions with representatives of the complaints bodies in attendance.

A representative of the Medical Council of Malawi (MCM) stated that when receiving a complaint, they acknowledge receipt of the complaint in writing and conduct an investigation. The composition of the Disciplinary Committee was explained to include a Chairperson, medical doctors as well as representatives of the public.

The MCM representative stated that an analysis of complaints received between 2007 and 2011 revealed that the significant majority of complaints were made by men, by persons in urban areas, and by persons with formal education.

A representative of the National Council of Nurses and Midwives of Malawi (NCNMM) stated that its complaints procedure is governed by the Nurses and Midwives Act. The majority of complaints relate to misconduct or negligence in issues concerning maternal healthcare. The NCNMM representative affirmed that persons accused of misconduct and complainants appear before the Committee to give evidence. These procedures are confidential and lawyers involved are obliged to keep the content of these engagements confidential. Outcomes or verdicts made by the Committee are, however, made public. The NCNMM representative advised that once the Committee makes a decision, it is communicated to the Ministry of Health, which must then take action as an employer. For example, if a nurse or midwife is found to have committed misconduct and is deregistered, this will be communicated to the Ministry that the nurse can no longer be employed as

a registered nurse in a healthcare facility. The length of time it takes to resolve a complaint was explained to depend on the nature of the complaint. When the issue concerns a death of a person, an *ad hoc* committee is appointed to handle the matter.

Both the Medical and Nurses and Midwives Councils advised that they have a hotline that can be called to relate complaints directly.[1]

A Representative of the Office of the Ombudsman explained that the Office has broad investigatory and subpoena powers. She explained that complaints to the Office must be made in writing and that the screening process on receiving complaints includes an assessment of whether the complaint concerns a request for a remedy that the Office of the Ombudsman is empowered to grant. For example, she explained that decisions of the High Court have confirmed that the Office is not empowered to grant individuals compensation or damages. She explained that the Office of the Ombudsman's directives are legally binding but that it lacks an enforcement mechanism like through remedies one obtains in the court. The Office's enforcement mechanism if its directives is through a parliamentary reporting procedure.

The Office of the Ombudsman stated that 108 cases were registered last year, very few of which concerned service delivery complaints. She advised further that the Office aims to resolve complaints within 6 months of receiving them. Finally she affirmed that family members may complain on each other's behalf. In cases that concern issues relating to the conduct of healthcare workers, the representative advised that the Office would likely refer the complainant to the MCM or NCNMM.

A representative of the Malawi Human Rights Commission (MHRC) explained that the MHRC has investigatory powers and can hold public hearings into issues concerning human rights violations. Amongst its powers include the power to order that parties undertake a dispute resolution process, to advise or refer complaints to other bodies or institutions, and can recommend an issue for criminal prosecution. Due to capacity restrictions, the MHRC sometimes refers matters to the Office of the Ombudsman. The MHRC representative stated that the MHRC does not have the monopoly on human rights and that all persons and organisations have a responsibility to protect and promote human rights.

Participants raised a number of concerns and questions relating to the respective processes. Participants were concerned that processes were not practicably accessible for persons in rural areas. While the Office of the Ombudsman made use of structures through the civic education organisation, NICE, available in communities to refer complaints, participants sought mechanisms that were more varied and accessible to persons who may live in rural areas, have minimal access to telecommunications and transport and who may be illiterate.

Participants were particularly concerned with how complaints bodies would respond to immediate needs revealed in crisis situations. Examples included the denial of antiretroviral treatment (ART) or post-exposure prophylaxis following rape, where a health outcomes are too grave and time-sensitive to wait for a complaint to be resolved. Regulatory bodies offered the suggestion that in these cases the immediate complaint should be made at facility level to the person in charge or possibly to the District Health Officer, while participants were unconvinced this would be a reliably sufficient option during crises. The concern was identified as a crucial gap in the functioning of available complaint processes.

[1] An Airtel Toll Free hotline for the MCM has been made available: 59494.

A number of participants engaged the complaints body representatives on how and if they would receive and handle complaints from key populations, particularly men who have sex with men and sex workers. The representative of the MCM stated-

"it is not the role of the [healthcare] practitioner to act as a policeman. It is our mandate to treat all patients."

He stated that medical practitioners are mandated to treat patients irrespective of any status, including sexual orientation. He affirmed a commitment that the MCM would similarly not discriminate against complainants.

Representatives of nurses and midwives similarly affirmed that the role of nurses and midwives is one of care and they should not judge their patients.

The MHRC representative affirmed that LGBT persons are entitled to the rights and dignity enjoyed by all persons on the basis of equality. He noted a capacity gap at the Commission, however, on these issues, and suggested that the establishment of a desk officer dedicated to LGBT issues would be useful.

Participants called on regulatory bodies, the Office of the Ombudsman and the MHRC to take initiative to reach out to key populations and support organisations.

Representatives of regulatory bodies noted that healthcare workers themselves face huge challenges operating in an under-resourced healthcare system in a state of crisis. Healthcare workers may too need protections from abuse and discrimination. It was noted in addition that many complaint bodies were underfunded and therefore limited in their operational capacity. Effective responses to complaints requires these bodies to have meaningful operational resources.

Case study

Mr Godfrey Kammunda, from Ladder for Rural Development, shared a case study with participants regarding the death of a woman in childbirth, ostensibly due to the negligence of healthcare workers on duty in the Mangochi region. He explained efforts that had been taken in cooperation with the family of the deceased to obtain a maternal death audit, all of which had been fruitless. The will of the family, it was explained, was to find out the truth of what happened to the deceased and to seek accountability for those actions. Mr Kammunda noted that in consultations with the broader community, it appeared that there were concerns about inadequate and substandard healthcare services being delivered in the area more broadly and concerns over reprisals or healthcare denial if complaints were made.

Participants offered useful advice and input on the way forward. Some participants stressed the importance of building coalitions with other NGO's and the Malawi Human Rights Commission to

strengthen efforts collectively where smaller organisations might lack capacity or contacts to obtain information. Others noted the perception that it would be unlikely that the documentation sought would be obtained.

Next steps

Participants noted a need to include more stakeholders in engaging on the issues raised, including government bodies such as the Ministry of Health, the Ministry of Justice, the Ministry of Gender, and the Police. More frequent engagements between CSOs, regulatory bodies and human rights institutions were proposed.

Participants noted the value of seeking opportunities to share lessons amongst CBOs and NGOs on advancing access to justice through complaints processes in different countries, for regional sharing of best practices.

A request for further resources was made, including copies of training materials and information to be shared in condensed form through posters and brochures.

Participants noted a need for further training including on the following issues:

- Working with persons with disabilities.
- Collaborating with other organisations in advancing health and rights.
- The experiences of key populations, particularly LGBT persons and sex workers.
- Strategies to protect vulnerable complainants.
- Further information on health rights, law and ethics.
- Working through more practical case studies and drawing out lessons from complaints made.
- Support in capacity-building and civic education of healthcare users more broadly.

Copies of the training materials and research report are available for free download on SALC's website:

Guidebook: Using complaints to address healthcare violations:

http://www.southernafricalitigationcentre.org/2016/12/15/guidebook-using-complaints-to-address-healthcare-violations/

Research Report: Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia:

http://www.southernafricalitigationcentre.org/2016/09/28/research-report-accountability-and-redress-for-discrimination-in-healthcare-in-botswana-malawi-and-zambia/

Hardcopies can be requested at Enquiries@salc.org.za