Assessing the State of Sexual and Reproductive Health Rights Among Women Living with HIV and AIDS in Blantyre and Nkhotakota Districts

Findings from the Baseline Survey on Sexual and Reproductive Health Rights for the We Have Rights Too! Project funded by the Tilitonse Fund

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Acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CBO	Community Based Organizations
CSO	Civil Society Organizations
COWLHA	Coalition of Women Living with HIV and AIDS
GVH	Group Village Headman
HCW	Health Care Worker
PVSU	Police Victim Support Unit
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SG	Support Groups
TA	Traditional Authorities
WLHIV	Women Living with HIV and AIDS
WOFAD	Women for Fair Development
WUSC-Malawi	World University Service of Canada-Malawi

Women from a support group in TA Machinjiri, Blantyre.

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Executive Summary

Numerous international and domestic laws and policies exist to protect individuals from discrimination and violations upon their sexual and reproductive health rights (SRHR). In Malawi, however, WLHIV face immense barriers to asserting their sexual and reproductive health (SRH) needs and aspirations. This baseline report presents findings made from a survey that was conducted to understand the experiences of WLHIV with SRHR violations, stigma and discrimination. In a collaborative effort between the World University Service of Canada-Malawi, the Coalition of Women Living with HIV and AIDS and Women for Fair Development, a total of 665 WLHIV were interviewed in Blantyre and Nkhotakota districts from December 2012 to February 2013. In addition, 29 traditional community leaders, 15 health care workers and 7 police officials were included.

Overall it was found that SRHR violations, stigma and discrimination continue at high levels. The persistent social, economic and political subordination of women in society has severely infringed upon their capacity to assert their basic human rights and in turn, their SRHR. Through the study, it was found that 38.0% of respondents had faced one or more SRHR violations. Violations by health care workers (HCW) were most common and reported by 27.5% of respondents. Respondents reported being denied access to SRH services, refused ARVs and other essential drugs, subjected to verbal abuse and experienced substandard healthcare. Violations inflicted by intimate partners were the second most common issue and reported by 16.7% of respondents. Respondents remain unable to negotiate the terms of sexual relationships and are being denied the right to safe sex and the right to control when and whether to be pregnant. Furthermore, it was revealed that stigma and discrimination remains a major domestic and community issue, as noted by 80.7% of respondents.

Recommendations made at the end of this report highlight the need for a multi-level intervention to address the prevalence of SRHR violations, stigma and discrimination among WLHIV in the districts of Blantyre and Nkhotakota.

1.0. Introduction

1.1. Background

In Malawi, women are disproportionately affected by HIV and AIDS in comparison to men. 10.6% of the population aged 15-49 are HIV positive with a prevalence of 12.9% among women compared to 8.1% for men (Malawi Demographic and Health Survey, 2011). Though HIV prevalence is lower among Malawi's rural populations at 8.9%, HIV and AIDS remains a major public health issue in rural regions given that 85% Malawians reside in the countryside (MDHS, 2011). Furthermore, 10.5% of rural women and 7.1% of rural men are living with HIV and AIDS (MDHS, 2011).

The relationship between the high prevalence of HIV infections among women to the hierarchical relations of power between women and men has been repeatedly demonstrated in the literature (Gupta, 2000; Centre for the Study of Violence and Reconciliation, 2001; Human Rights Watch, 2003; Kistner, 2003; Kathewera-Banda, 2006). Such power disparities largely inhibit a woman's ability to access productive economic and social resources. This, in turn, limits the extent to which a woman is able to negotiate for safer sex, engage in birth control methods, protect herself from unwanted sexual acts, leave abusive relationships, discuss issues of fertility with intimate partners and access SRH services and support. Ultimately, a woman's subordinate position in society facilitates the perpetuation of SRHR violations and high HIV infection rates (Gupta, 2000; Kathewera-Banda et al., 2006, Mwanza, 2012). WLHIV are especially vulnerable as discrimination resulting from their HIV status compounds with pre-existing forms of discrimination associated with gender, class and ethnicity (Mgbako et al., 2007).

Previous studies have found that family, community members and health care providers subject WLHIV to different expectations and pressures surrounding their sexuality and reproductive decisions (Feldman, 2002; Gruskin, 2007). Consequentially, these social expectations and pressures infringe upon a woman's right to make decision surrounding her SRH free from coercion, discrimination or violence.

Various traditional practices that continue in Malawi have also been documented in light of its implications for women's rights. Women being forced into marriage, denied control over their pregnancies and pressured into unwanted sexual interactions all constitutes acts which violate the autonomy with which women are entitled to under international and domestic laws (UNAIDS, 2004; Mgbako et al., 2007).

In accessing health services, research has demonstrated that WLHIV are consistently subject to verbal abuse and substandard health services due to their HIV positive status (Gruskin, 2007). When seeking redress from police or legal institutions, woman are frequently dismissed or inadequately dealt with (Mwanza, 2012). Finally, instances of community, traditional and religious leaders engaging in discriminatory practices against WLHIV have been repeatedly documented and exacerbate the harm already faced by WLHIV (Munthali et al., 2004; Malawi Human Rights Commission, 2006; Mgbako et al., 2007).

These multiple sources of violations against WLHIV persist despite Malawi being a signatory to several international and regional treaties[1] holding broad anti-discriminatory measures designed to protect the rights of all individuals. Under international and domestic laws already in place, Malawi has an obligation to enact domestic laws and policies that protect the SRH needs and aspirations of all women, including HIV positive women. At the international level, Malawi has a commitment to the Universal Declaration of Human Rights, the United Nations Charter, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social, and Cultural Rights, the Convention on the Elimination of all forms of Discrimination against Women, the Beijing Declaration and Platform for Action of Fourth World and Conference on Women and the African Charter on Human and People's Rights. Though these treaties do not explicitly address HIV/AIDS, these instruments with their provisions aimed at eliminating all forms of discrimination, should protect WLHIV from discriminatory acts based on their status. Most recently, Malawi ratified the Maputo Plan of Action (MPoA) developed in 2006 which was created to promote universal access to comprehensive SRH services in Africa

[1] Malawi has ratified the Universal Declaration of Human Rights, the United Nations Charter, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social, and Cultural Rights, the Convention on the Elimination of all forms of Discrimination against Women, and the African Charter on Human and People's Rights.

(African Union Commission, 2006; Kureya & Kureya, 2010). The MPoA resulted from the recognition that the Millennium Development Goals (MDG) would not be achieved if issues specific to SRHR were not addressed (AUC, 2006).

Moreover, Malawi has obligations under domestic law and policies to protect the rights of WLHIV due to anti-discriminatory measures found in The Constitution of the Republic of Malawi and protected rights under the Bill of Rights. Policies aimed at protecting SRHR were furthered when Malawi domesticated the MPoA in 2007 and subsequently developed the National Sexual and Reproductive Health Policy in 2009 and the Prevention of Domestic Violence Act (Ministry of Gender, Child Welfare and Community Services, 2006; Kureya & Kureya, 2010).

However, despite all these laws and policies in place, the current system fails to uphold the SRHR of WLHIV. Recent research conducted in Malawi reveals the persistence of stigma, discrimination and SRHR violations in communities throughout the country (Kathewera-Banda, 2006; Mgbako et al., 2007; MDHS, 2010; Mwanza, 2012). Given the current social, political, economic and cultural environment, findings from the baseline survey show that a woman seeking to protect her SRHR often comes at significant personal costs. In many instances, this entails being "chased" from her marriage, family and community. As a woman, access to productive resources and economic autonomy is already severely limited. WLHIV face an additional level of discrimination due to their status - adding an additional barrier to aspirations of political, economic and social empowerment. These circumstances are coupled with systems of redress that are largely inaccessible and unable to deliver justice. It is in this context that this baseline survey was developed - to begin defining priority areas for interventions that will ensure the protection and promotion of SRHR of WLHIV.

Chrispan from WOFAD conducting a focus group with women from GVH Mwamadi, Blantyre

1.2. We Have Rights Too! Project

The primary objective of the We Have Rights Too! Project aims to protect and promote the SRHR of women and girls living with HIV and AIDS in a total of six Traditional Authorities (TA) within Blantyre and Nkhotakota districts. With two years of funding being provided by the Tilitonse Fund, the project will be implemented as a collaborative effort between the WUSC-Malawi, the COWLHA in Nkhotakota and WOFAD in Blantyre. By 2014, this project aims to promote and protect the SRHR of 2, 500 WLHIV in each district – reaching a total of 5, 000 women by 2014. Achieving this goal will necessitate improving access to and quality of SRH services available to WLHIV. To this end, this project aims to improve access to and quality of SRH services for 5, 000 WLHIV by 2014.

1.3. Objectives of the baseline survey

WUSC-Malawi, COWLHA and WOFAD believe that needs vary from district to district and from community to community. With the focus the We Have Rights Too! Project holds on rural WLHIV in 6 specific TAs in the districts of Blantyre and Nkhotakota, it was critical that accurate

information on SRHR violations in this particular subpopulation were obtained. Research tools for this baseline survey were designed to capture the complex array of factors influencing the experiences of WLHIV with SRHR violations. It was essential that the women themselves were able to voice their needs and begin engagement with this project. The stories, experiences and needs voiced by the women will be used to inform the development and implementation of programs and activities for the We Have Rights Too! Project.

1.4. Defining the Conceptual Framework for Sexual and Reproductive Health Rights

According to the World Health Organization, sexual and reproductive health is "a state of complete physical, mental and social wellbeing in all matters relating to sexuality and the reproductive system" (World Health Organization, 2002). Malawi, as a signatory to international and regional treaties like the Protocol to the African Charter on Human and People's Rights, has an obligation to take all appropriate measures necessary to ensuring that the following rights are upheld for all women, free from discrimination:

- Control over when and whether or not to be pregnant
- Self-protection against STIs, including HIV and AIDS
- Be informed on one's health status and on the health status of one's partner
- SRH education
- Respect for bodily integrity
- Be sexually active or not
- Consensual sexual relations and marriage

Fulfilling these rights includes an obligation on the part of the state to provide adequate, affordable and accessible health services to women, especially in rural areas. Furthermore, it is stipulated that these rights must be exercised free from coercion, discrimination and violence (African Union, 2003). Such measures are necessary for the highest attainable standard of SRH for all.

For the purposes of this baseline report, any act violating any of the above rights and infringing upon the right of a woman to assert her sexual and reproductive integrity and autonomy free from coercion, discrimination and violence will be considered a SRHR violation. Based on this interpretation of SRHR, a violation does not necessarily have to entail physical contact or direct

obstruction of access to SRH services. Any form of manipulation, threat, intimidation, humiliation among women seeking to exercise their SRHR was counted as a SRHR violation. For example, verbal abuse experienced by women seeking SRH services and advice at health facilities falls within the confines of this definition.

2.0. Methods

2.1. Study Sites

The baseline survey was conducted in rural communities in the southern district of Blantyre and the central district of Nkhotakota. Within this, a total of six Traditional Authorities (TA) were included. Study sites were chosen based on previously established relationships between the communities and the implementing organizations, COWLHA and WOFAD. This was done in order to facilitate successful identification and mobilization of eligible respondents. In Blantyre, the survey was conducted in TA Kunthembwe, Machinjiri and Kuntaja (Figure 1). In Nkhotakota, the survey was conducted in TA Kanyenda, Malengachanzi and Mwadzama (Figure 2). Table 1 illustrates the specific wards, within the jurisdiction of a Group Village Headman, that were visited for the baseline survey. According to reports from the District Health Offices, there are a total of 2721 WLHIV residing in the three TA targeted for Blantyre and 11,872 WLHIV in the targeted TA for Nkhotakota. Overall, there are 14, 613 WLHIV residing in the targeted project area.

Table 1: *Study sites included for the baseline survey.*

District	Traditional Authority	GVH
Blantyre	Machinjiri	Mwamadi
		Likomba
		Ntenje
		Magasa
	Kuntaja	Mulima
		Mkata
		Katchakhwala
		Kuntaja
	Kunthembwe	Gwadani
		Stande
		Gimbwa
		Mbvundula
Nkhotakota	Mwadzana	Aron
		Benga
		Chakaka
		Chiwoza
		Jinga
		Mapulanga
		Ngwati
	Kanyenda	Kabvumbula
		Kamkando
		Longwe
		Maluma
		Muijiri
		Mwamudimba
		Sammuel
	Malengachanzi	Gumbi 2
		Kamanga 1
		Kamanga 2
		Kalimanjira
		Makata 2
		Mbaluko
		Mgombe
		Mphangwe
		Mtanga

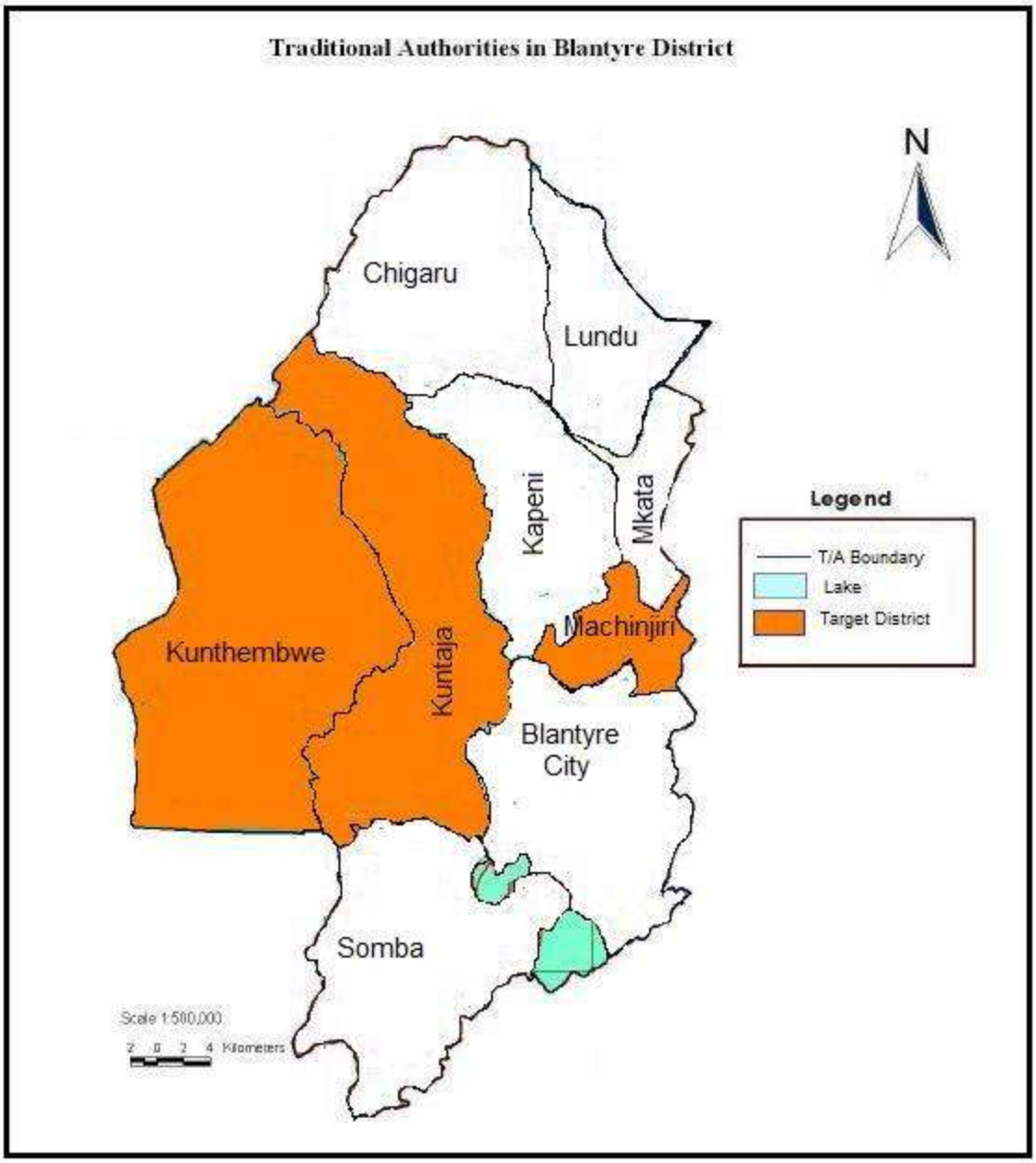


Figure 1: Map of TAs included in Blantyre District for the baseline survey (Map adapted from the Blantyre District Social Economic Profile, 2010).

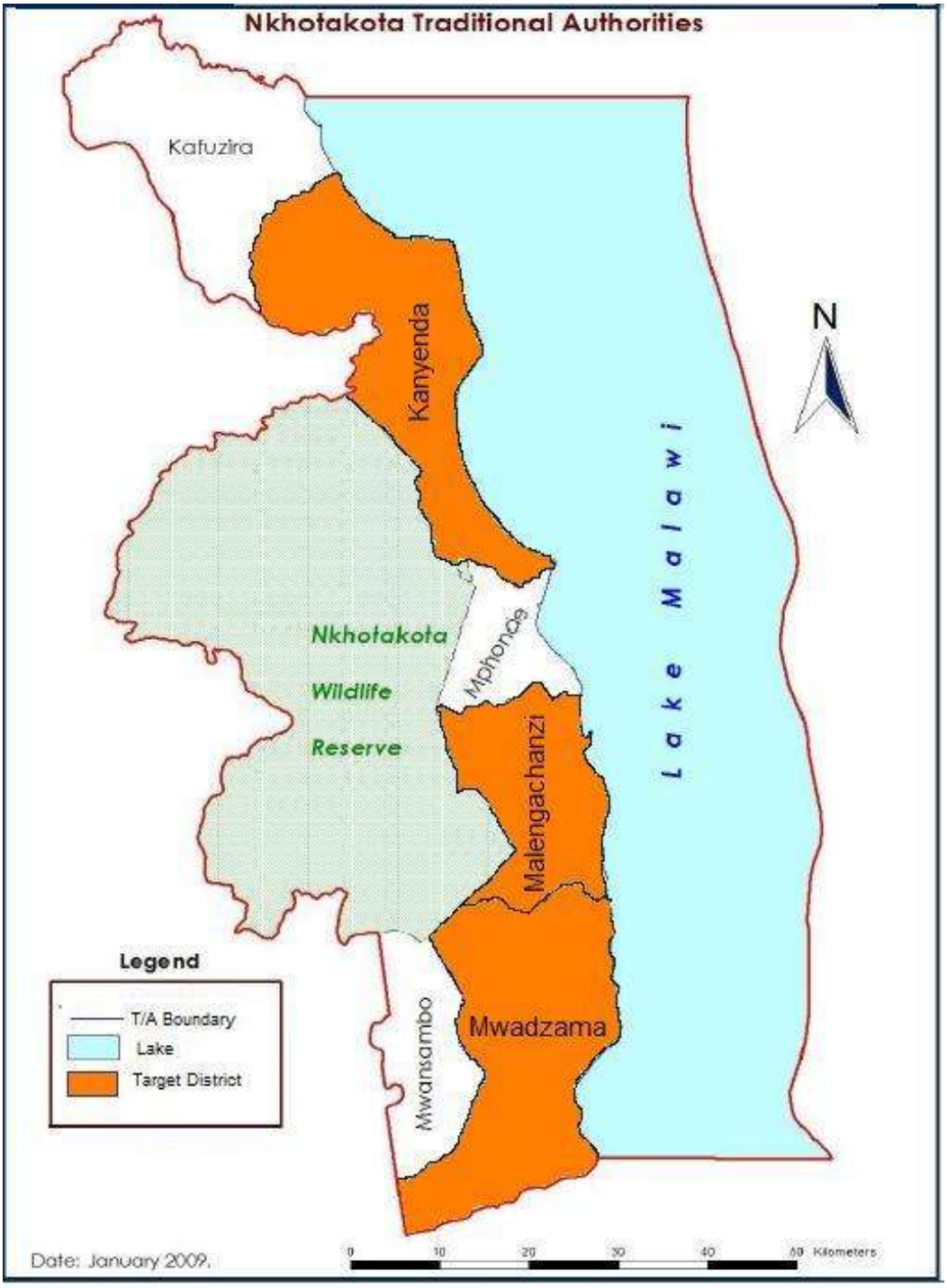


Figure 2: Map of target TAs included in Nkhotakota District for the baseline survey (Map adapted from Nkhotakota District Socioeconomic Profile, 2010).

2.2. Sampling of the population

All WLHIV were considered eligible respondents and were sampled on a voluntary basis. In Blantyre, WLHIV were identified and mobilized with the assistance of leaders from Community Based Organizations (CBO) and Support Groups (SG). A total of 665 WLHIV were identified and included into the baseline study. No one declined participation. 451 WLHIV were incorporated through individual interviews while 214 were engaged through Focus Group Discussions (FGD). Key informant interviews were also administered to traditional leaders, community leaders, health care workers and police. The complete interview list is illustrated below in Table 2. All individual interviews and focus group discussions were conducted from December 2012 to February 2013.

Table 2: Interview list of respondents for the baseline survey.

	Blantyre	Nkhotakota	Total
WLHIV Individual Survey	243	208	451
WLHIV FGD	129	84	214
Traditional and Community Leaders	22	7	29
Health Care Workers	9	6	15
Police	5	2	7
Total	408	307	715

2.3. Baseline Research Tools

2.3.1 Baseline Survey Questionnaire

The survey questionnaires were created following an extensive review of literature on SRHR, SRH, gender based violence (GBV) and discrimination towards WLHIV. This included a review of studies and reports specific to Malawi.

The survey for WLHIV was designed to collect information on the following areas:

1. Respondent's background characteristics.
2. Level of knowledge surrounding SRHR among WLHIV.
3. Incidences of SRHR violations, stigma and discrimination in the home, health centres and community.

4. Perpetrators of SRHR violations, stigma and discrimination towards WLHIV.
5. Persisting cultural and religious practices and beliefs that undermine SRHR.
6. Accessibility, quality and type of SRH services provided to WLHIV.
7. Systems of redress available to WLHIV who have experienced SRHR violations.
8. Quality of service delivery by COWLHA and WOFAD among respondents aware of the organizations' activities.
9. Priority programs and services as identified by WLHIV.

The survey questionnaire was created in English but administered in Chichewa while in the field. A Chichewa version of the survey was later developed to facilitate complete comprehension of survey questions among interviewers. Prior to administering the survey to eligible respondents, the survey was tested among several WLHIV in Chirimba, Blantyre. To develop the final survey tool, issues that surfaced during the survey testing process were discussed among project members and appropriate revisions were subsequently made.

2.3.2. Key Informants

Key informant surveys for traditional and community leaders, health care workers and police were tailored to gather relevant information on their knowledge of and attitudes towards SRHR violations occurring in the communities they serve. Furthermore, survey questions sought to capture the challenges these individuals face in meeting the SRHR needs of WLHIV as well as their recommendations on how to best achieve the objectives of the We Have Rights Too! Project.

2.3.3. Focus Group Discussion (FGD) Guide

The FGD guide consisted of questions adapted from the individual survey questionnaire for WLHIV. The FGD guide was created to facilitate discussion around the women's knowledge surrounding SRHR, key factors infringing upon their ability to assert their SRHR and how the COWLHA and WOFAD should work towards helping them realize their SRHR. The FGD were incorporated into the baseline survey process to generate qualitative data that would enable a richer understanding of the contextual factors driving SRHR violations and allowed for probing and greater insight to various issues that the survey questionnaire may have been unable to capture. Considering resource and time constraints, FGDs allowed for the incorporation of

additional eligible respondents within a reasonable time frame. Respondents included in FGDs were a randomly drawn subsample from the complete list of eligible survey respondents. The surveys and focus groups were conducted in Chichewa and were immediately translated and transcribed into English while on site.

2.4. Data Collection

For each district, a team of 7 interviewers were hired and trained to administer the survey. All interviewers were selected based on their previous experience as enumerators, their commitment to the partner organizations COWLHA and WOFAD and their proficiency in English. A specialist in SRHR monitored the data collection process in both Blantyre and Nkhotakota to ensure consistency between the two study sites and quality of the data collection process. All interviewers were oriented to the objectives of the baseline survey and on the type and quality of responses expected for every component of the survey. Throughout the baseline survey, communication between the SRHR specialist and interviewers were constant to ensure mutual understanding of survey questions and study goals. This was central to ensuring that all interviewers were operating under the same frames of understanding on the issue being studied and to mitigate discrepancies in the quality of data obtained. All completed surveys were reviewed daily to check for the quality of responses and to correct any issues that arose over the course of the baseline.

2.5. Data Analysis

Both quantitative and qualitative data collected through the individual surveys and FGDs were used to further understanding of the magnitude and nature of SRHR violations. Engaging a mixed-methods approach allowed for the qualitative data to provide contextual details needed to form an in-depth understanding of the general patterns observed from quantitative analysis. Microsoft Excel 2010 was employed for statistical data analysis. The focus groups transcripts and all descriptive components of the survey were entered into the qualitative software program Weft QDA to facilitate the analysis of qualitative data. All qualitative data were reviewed several times in order to systematically classify the information into thematic groupings that were subsequently entered as coding into Weft QDA. The quotes derived from qualitative data and presented in this report seek to illustrate some of the common narratives that arose from the

respondents. The original English translations as written by the interviewers were retained. Only grammatical errors were corrected.

3.0. Results

3.1. Study Population

The average age of respondents was 42 years (SD±11) and ranged from 13-83 years. Although a large majority of respondents identified themselves as being literate, 33.5% of respondents were illiterate. In terms of marital status, most respondents from Blantyre were married (59.5%) while in Nkhotakota, women most frequently reported being a widow (37.3%). For both districts, respondents were primarily farmers (59.4%) or farmers simultaneously engaged in business (18.2%). On average, respondents had 4 children. In Nkhotakota, 95.7% of WLHIV were on antiretroviral therapy compared to 87.6% for WLHIV in Blantyre. For Blantyre respondents, the average time required to get to health facility was 2.1 (±1.3) hr using their regular mode of transport (walking or mini-bus). In Nkhotakota, the average time required was reported to be at 1.5(±1.2) hr. Additional aspects of respondent characteristics are summarized in Table 3.

Table 3: *Respondent Characteristics for WLHIV included in the individual surveys.*

	Blantyre (n=242)	Nkhotakota (n=209)	Overall (n=451)
Literacy Level			
Illiterate	29.8% (72)	37.8% (79)	33.5% (151)
Literate in Chichewa	56.2% (136)	47.4% (99)	52.1% (235)
Literate in Chichewa and English	13.6% (33)	13.9% (29)	13.7% (62)
Marital Status			
Married	59.5% (144)	28.7% (60)	45.2% (204)
Widow	32.6% (79)	37.3% (78)	34.8% (157)
Divorced	18.2% (44)	17.2% (36)	17.7% (80)
Single	1.7% (4)	2.9% (6)	2.2% (10)
Occupation			
Housewife	11.6% (28)	5.3% (11)	8.6% (39)
Business	11.2% (27)	7.2% (15)	9.3% (42)
Farmer	59.5% (144)	59.3% (124)	59.4% (268)
Both Farmer and Business	9.9% (24)	27.8% (58)	18.2% (82)
Employed	2.5% (6)	2.4% (5)	2.4% (11)
Other	0.0% (0)	4.3% (9)	2.0% (9)
On ART	87.6% (212)	95.7% (200)	91.4% (412)
Average Number of Children	4	4	4
Average Time to Health Facility (hr)[a]	2.1(±1.3)	1.5(±1.2)	1.8(SD±1.3)

[a] Average time based on respondent's regular means of transport to their most commonly used health facility

3.2. Knowledge of Basic Rights for Women Living with HIV/AIDS

"I know my right to good health but how can I have good health when I don't even have any food." - Woman from Machinjiri, Blantyre (Focus Group Discussion)

Overall, respondents demonstrated an awareness of their rights as WLHIV. When women were asked if they knew about their SRHR, 84.8% of respondents stated they were aware of those rights. On average, respondents from Blantyre knew seven of the nine rights they were examined on. For those from Nkhotakota, the average was only slightly lower at six out of the nine rights. The right of WLHIV to access loans, to education, to be pregnant or not, to human dignity and to subsidized farm inputs were least known by respondents. Table 4 illustrates the proportion of women who exhibited knowledge of various rights they are entitled to.

Analysis of focus group data similarly revealed that there was already widespread knowledge surrounding their rights as WLHIV. Many women articulated that for them, the key issue lay in not being to exercise those rights. Women are aware of their rights to access subsidized farm inputs but are denied access by traditional leaders; women are aware of their right to good health but lack the means to secure nutritious food; women are aware of their right to education but are unable to afford the required school fees; and women are aware of their right to control their fertility but are pressured by their partners to have more children. The following responses by two women during a focus group discussion in Nkhotakota illustrate the challenges they faced when attempting to assert their right to safe sex:

Woman 1: Yes, we know our right to safe sex. But with our husbands, you are not able to deny even if you do not want to. For example, if you are tired or not feeling well, your husband can insist.

Woman 2: Most husbands will insist on not using condoms because you are their wife. Most husbands have gotten used to and desensitized from all the health talks now. They don't care anymore and want plain sex. -Women from Malengachanzi, Nkhotakota (Focus Group Discussion)

Women in Blantyre primarily learnt about their rights through the radio (63.2%) followed by community meetings (57.0%). In Nkhotakota, community meetings were a more popular source of rights based information (69.9%) rather than radio (56.5%). Table 4 summarizes key survey findings from assessing the knowledge of WLHIV surrounding their basic rights.

Table 4: *Knowledge of WLHIV surrounding their rights.*

	Blantyre (n=242)	Nkhotakota (n=209)	Overall (n=451)
Respondents claiming awareness of their rights as WLHIV	87.6% (212)	81.8% (171)	84.8% (383)
Average number of rights known by respondents out of 9	7	6	
Right to Life	80.1% (194)	68.9% (144)	74.9% (338)
Right to Education	72.7% (176)	59.8% (125)	66.7% (301)
Right to Safe Sex	73.6% (178)	70.3% (147)	72.1% (325)
Right to Get Married or Not	76.6% (183)	70.3% (147)	73.2% (330)
Right to be Pregnant or Not	70.2% (170)	63.6% (133)	67.2% (303)
Right to Subsidized Farm Inputs	68.7% (166)	67.8% (142)	68.3% (308)
Right to Access Loans	69.0% (167)	60.3% (126)	64.9% (293)
Right to Human Dignity	70.7% (171)	66.1% (136)	68.1% (307)
Right to Good Health	77.3% (187)	76.1% (157)	76.3% (344)
Knowledge Source			
Radio	63.2% (153)	56.5% (118)	60.1% (271)
Community Meetings	57.0% (138)	69.9% (146)	63.0% (284)
Health Facility	16.6% (40)	8.1% (17)	12.6% (57)
Printed Material	12.4% (30)	8.1% (17)	10.4% (47)
Other[a]	6.8% (14)	4.3% (9)	6.1% (23)

[a] **Includes other trainings, non-governmental organizations and the church**

3.3. Violations of Sexual and Reproductive Health Rights

Overall, 36.4% of respondents in Blantyre and 42.1% in Nkhotakota reported having faced at least one or more SRHR violations. In both districts, respondents most frequently reported incidents of HCW violating their SRHR. In total, 27.5% of respondents had faced at least one SRHR violation by a HCW. Intimate partner violations were the second largest issue in both Blantyre (10.3%) and Nkhotakota (23.9%). Violations resulting from cultural practices were reported by 9.5% of respondents in Blantyre and 4.3% in Nkhotakota. In Blantyre, religious practices resulting in an SRHR violation was reported by only one respondent. In contrast, SRHR violations due to religious leaders and practices appear to be more of an issue where 11 respondents from Nkhotakota faced an SRHR violation due to religious reasons. For both districts, SRHR violations by traditional leaders and police were minimal at 0.4% and were also

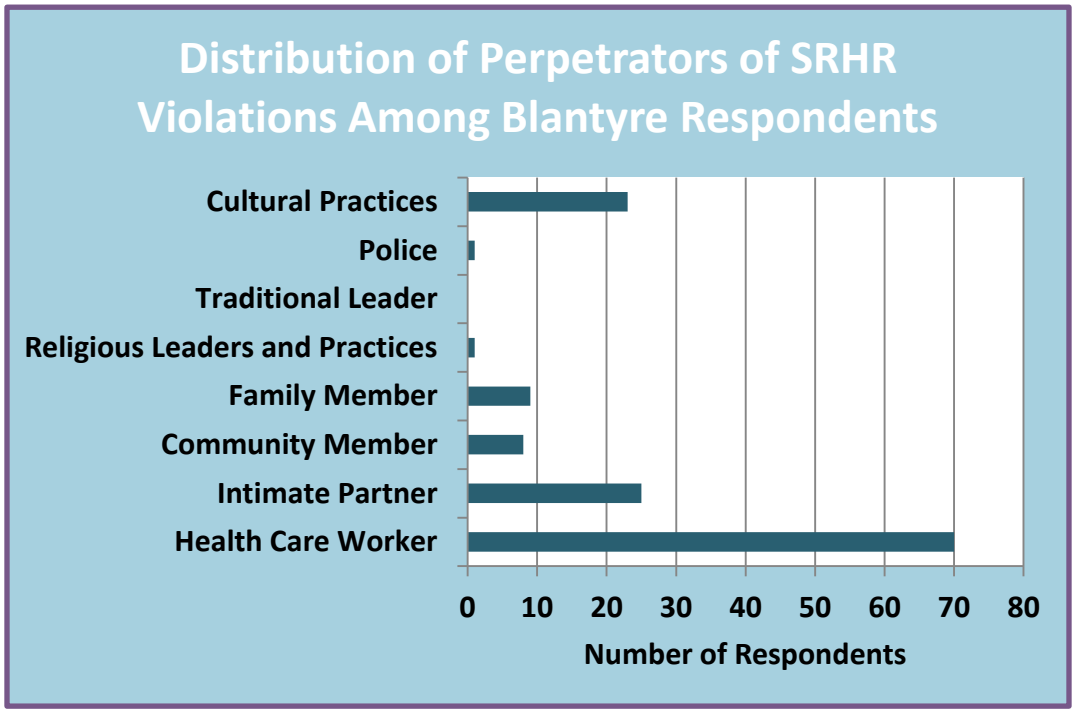
relatively low for family (3.3%) and community (4.2%) members. Figure 3 and Table 5 illustrates the distribution of SRHR violations among respondents.

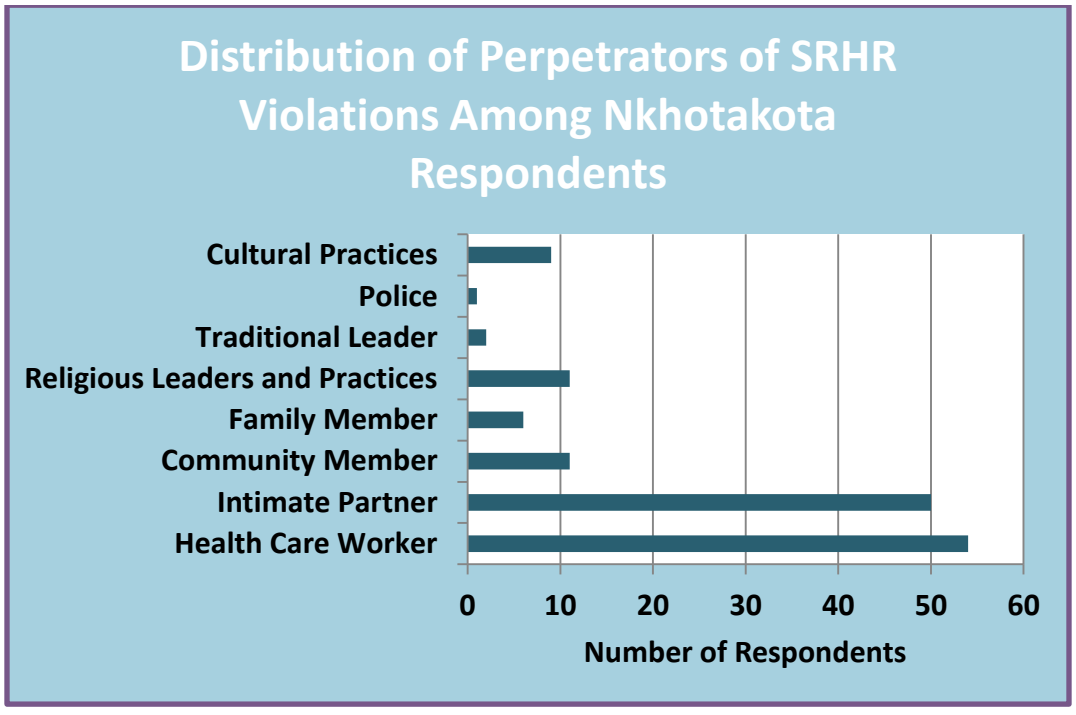
Table 5: *Reported Violations of SRHR Among Respondents*

	Blantyre (n=242)	Nkhotakota (209)	Overall (n=451)
Respondents with ≥1 SRHR Violation	36.4% (88)	42.1% (88)	38.0% (176)
Source of Violation			
Health Care Workers	28.9% (70)	25.8% (54)	27.5% (124)
Intimate Partner	10.3% (25)	23.9% (50)	16.7% (75)
Community Members	3.3% (8)	5.3% (11)	4.2% (19)
Family Members	3.7% (9)	2.9% (6)	3.3% (15)
Religious Leaders and Practices	0.4% (1)	5.3% (11)	2.7% (12)
Traditional Leaders	0.0% (0)	1.0% (2)	0.4% (2)
Police	0.4% (1)	0.5% (1)	0.4% (2)
Cultural Practices	9.5%(23)	4.3% (9)	7.1% (32)
	n=88	n=88	n=176
Sought Redress for SRHR Violation	36.4% (32)	33.0% (29)	34.7% (61)
	n=32	n=29	n=61
Not Satisfied with Redress	96.7% (31)	44.8% (13)	72.1% (44)

A woman from Nkhotakota being interviewed for the baseline.

Figure 3: Distribution of Perpetrators of SRHR Violations among Respondents.





3.3.1. SRHR Violations by Health Care Workers

The nurse left me to deliver on my own because she already discouraged me from falling pregnant. -30 year old woman from Mwadzana, Nkhotakota (Interview Data)

In both districts, HCW contributed to the highest number of SRHR violations reported by respondents. Nearly a third of respondents reported at least one incident in which they faced verbal abuse, received substandard care, were refused medication or denied access to health services. Nurses were the highest perpetrators of violations in Blantyre and were implicated in 44.6% of the reported violations. In Nkhotakota, clinical officers contributed to the most violations faced by respondents at 48.5% of HCW cases. Frequently, respondents recalled how they were 'chased' from the clinic when seeking treatment or medication. In both Blantyre and Nkhotakota, being left unattended or verbally abused in the midst of delivery was reported by 20 women. The following is one example: *At Queen's Hospital, I arrived while I was feeling labour pains and they sent me to a specific nurse who began talking a lot of nonsense. When she read over my medical hi story and found out my status she started shouting "Why are you giving birth if you know your status". She was really undermining me. That nurse was insulting me so much.* -Woman from Machinjiri, Blantyre (Focus Group Discussion)

Though respondents from both districts reported similar concerns, there were some differences in the types of violations that were most commonly experienced. Being denied health services in the ART, Maternity, Family Planning and Antenatal departments were issues most frequently voiced by women in both districts (39.8%). The second most prevalent issue in Blantyre was found to be poor treatment and abusive language by health workers (23.3%). Meanwhile in Nkhotakota, the second most prevalent issue lay in being denied access to medication (15.8%). A common theme arose in which WLHIV, who are generally more prone to opportunistic infections[2], were told that they were 'already dead' as justification for not providing treatment and medication for the illnesses they were facing. Generally, women expressed that even though ARTs were provided free of charge, it was a problem that they were being denied access to other drugs. This included drugs necessary to treat co-infections associated with HIV and drugs like

[2] Opportunistic infections are those associated with severe immunodeficiency. These infections take advantage of the immune deficiencies resulting from the human immunodeficiency virus (WHO, 2012)

birth control. One respondent for Nkhotakota expressed how she was denied birth control pills because the health worker stated that she should not have access to them because of her HIV status.

With regards to where the HCW violations were being committed, it was found that in Nkhotakota 50.0% of reported violations were occurring in ART services. In Blantyre, 47.0% of respondents could not specify in what service delivery sector the violation occurred. Violations in ART services constituted 28.9% of the violations in Blantyre's health facilities. Issues in maternity services constituted 18.1% of health care worker violations in Blantyre and 10.6% in Nkhotakota. A more detailed breakdown of SRHR violations by HCW, service delivery area and the nature of SRHR violations are reported in Table 6.

Table 6: *SRHR Violations by Health Care Workers Reported by Respondents*

	Blantyre n=242	Nkhotakota n=209	Overall n=451
Respondents Reporting ≥1 HCW violations	28.9% (70)	25.8% (54)	27.5% (124)
Total Reported Cases of HCW Violations	83	66	149
% of reported HCW violations enacted by:	n=83	n=66	n=149
Nurses	44.6% (37)	31.8% (21)	38.9% (58)
Clinical Officers	16.9% (14)	48.5% (32)	30.9% (46)
Hospital Attendants	8.4% (7)	3.0% (2)	6.0% (9)
Not Specified	30.1% (25)	16.7% (11)	24.2% (36)
% of reported HCW violations committed in:			
ART	28.9% (24)	50.0% (33)	38.3% (57)
Maternity	18.1% (15)	10.6% (7)	14.8% (22)
Family Planning	3.6% (3)	4.5% (3)	4.0% (6)
Antenatal	2.4% (2)	3.0% (2)	2.7% (4)
Not Specified	47.0% (39)	31.8% (21)	40.3% (60)
Nature of Violation[a]	n=95	n=76	n=171
Denied Services	37.9% (36)	42.1% (32)	39.8% (68)
Denied Medication	14.7% (14)	15.8% (12)	15.2% (26)
Poor Treatment and Abusive Language	23.2% (22)	10.5% (8)	17.5% (30)
Long Waits	17.9% (17)	13.2% (10)	15.8% (27)
Concerns regarding medication side-effects ignored	1.1% (1)	14.5% (11)	7.0% (12)
Other[b]	5.3% (5)	3.9% (3)	4.7% (8)

[a] Note: In several reported cases, a variety of violations occurred. A single case would be classified and counted within several categories of violations. Hence, the change in denominator value used to calculate percentages.
[b] Includes advice denying SRHR, failure to respect privacy and a case of rape by HCW

3.3.2. SRHR Violations by Intimate Partners

"I was beaten by my husband for refusing to have sex" -Woman from Malengachanzi, Nkhotakota (Interview Data)

Violations of SRHR by intimate partners were more frequent in Nkhotakota at 23.9% of respondents compared to 10.3% in Blanytyre. Though there were reported differences in prevalence, the nature of the violations were similar across districts – namely being denied safe sex and forced sex. The nature of the problem was illustrated in this conversation that occurred in TA Machinjiri, Blantyre during a FGD:

Woman 1: For my sexual and reproductive health rights, my husband says that he does not want condoms. He will say that it will not be sweet and be just like paper unless you open it.

Woman 2: Sometimes, with your husbands, you are not able to deny, even if you don't want to. Such as, if you are tired or not feeling well, the husband will insist.

Woman 3: Most husbands will insist on not using condoms, it is their wife.

Woman 4: Most husbands get used to and desensitized from all the health talks all the time. Now, they don't care.

The idea of sex with a condom as not being "sweet", among men, was a view that was found repeatedly in both districts. Other issues raised included women being forced to conceive or denied pregnancy, failure of husband to disclose status or refusal to be tested as well as husbands denying the woman access to treatment, testing and support groups.

3.3.3 SRHR Violations by Community Members

"When someone volunteers to marry me, the church lady members will stop it from happening because of my HIV status." -30 year old woman from Kuntaja, Blantyre (Interview Data)

SRHR violations by community members were experienced by 4.2% respondents. The biggest issue lay in respondents being insulted or laughed at by those in the community surrounding their decisions to get married or to continue bearing children. These acts of humiliation violate the right of women to make decisions on their SRH in a manner that respects their human dignity.

3.3.4 SRHR Violations by Family Members

Similar to issues being faced by respondents due to violations by community members, respondents were being insulted or laughed at by their relatives over their decisions to get married or due to their pregnancy status. Other reported incidents include a case of incest in Nkhotakota where a father forced sex on his own daughter and a case of a woman being beaten by a relative for taking ARVs. This issue of incest was also found in Blantyre during a FGD where a woman stated: *Some men will sleep with their own daughters or step-daughters even if they know they are HIV Positive. They want to go die with their own daughters so they don't have to struggle.* -Woman from Blantyre (Focus Group Discussion)

In six cases, family members denied their daughters the right to marriage: *My parents, when I find a many to marry, they tell the man not to marry me because I am HIV positive. My parents have driven away around ten men I have found to marry me.* -Woman from Blantyre (Focus Group Discussion)

Finally, there were reports of families forcing Kulowa Chokolo and preventing respondent's access to treatment at health facilities.

3.3.5. SRHR Violations by Religious Leaders and Practices

Issues of religious leaders and beliefs promoting the violation of the SRHR of WLHIV was primarily a problem in Nkhotakota and was not expressed as an issue in Blantyre. In Nkhotakota, based on individual and survey data, there were a total of 19 reports where church pastors condemned the use of ARVs, family planning methods and access to tests to determine HIV status: *Some church pastors are preventing us from taking ARVs because it is sinful to God. But it is the pastors, they will say, don't take ARVs, we will pray for you.*

-Woman from TA Kanyenda, Nkhotakota

3.3.6. SRHR Violations Resulting from Cultural Practices

65.5% of all respondents were able to identify cultural beliefs and practices that violated SRHR of WLHIV with 7.1% of respondents actually experiencing an SRHR violation resulting from such practices - 23 cases being from Blantyre and 9 cases being from Nkhotakota. The most

commonly reported violations resulted from the cultural practice of Kulowa Chokolo and Chinamwali. However, there were also reports of Kusasa Fumbi, Kulowa Fisi and Kulowa Thena[3]. It was remarked during a FGD that many of these cultural practices happen in secret and there is conflicting information surrounding the magnitude of the problem in the baseline data. One 32 year old woman from Malenganchai, Nkhotakota stated: *The practice of Kulowa Chokolo violates SRHR but now, the traditional leaders in the area have stopped that practice. There used to be this problem but now it now longer exists*.

However, a 50 year old woman from the exact same TA offered a different view on the same issue: *The cultural practice of inheriting the wife of the deceased husband (Chokolo) is still rampant in this area.*

In Blantyre, the following woman articulated that: *For initiation Kulowa Fisi and Chokolo, this happens in the community. Not frequent but you also cannot predict how often people die. Maybe there is one initiation a year for the young girls. They don't do it often. Some families do, it depends on their cultural background. Only two tribes still do it. It is common for those in the Tombuka and Sena tribes. Civil society they are trying to fight this. Like MANET+, they have done a survey.* -Woman from Blantyre (Focus Group Data)

[3] Definitions of each cultural practice can be found in Appendix I.

Case Study from Blantyre

Age: 37
Marital Status: Divorced
Number of Children: 5
Residence: Kunthembwe, Blantyre

I was forced to get pregnant the time I did not want to because I was weak. My husband's family members were also supporting the idea that my husband should chase me from my home because I was failing to conceive. I finally did get pregnant. That is when community members started talking so much about me, saying that I have had enough children and that I should not have gotten pregnant because of my status.

While I was pregnant, my husband divorced me and married another woman. He forced me to get me pregnant but failed to support me. I did try going to the Ankhosowe (Marriage Counsellor) for redress but he did not help me in the way I needed to be helped. I have 5 children now that I need to support now, on my own.

This case study illustrates how one WLHIV can be subjected to SRHR violations from a range of individuals in her community. Moreover, her experience highlights the different expectations WLHIV are subjected to in making choices over their SRH.

3.4. Summary of Stigma and Discrimination

The previous section presented findings on acts that directly infringed upon a woman's sexual autonomy, right to control her own fertility and access to quality SRH services. The following section highlights cases of stigma and discrimination faced by WLHIV which, in many instances, indirectly affects SRH outcomes. For example, women being denied access to loans, cash-for-work opportunities or fertilizer subsidies due to their status become further disempowered economically. Such situations breed women's economic dependency on men and reduces a woman's capacity to assert her SRHR without having to face severe harm to her economic wellbeing.

Overall, 80.7% of women indicated they had faced at least one, if not more, incidents of stigma and discrimination – with Nkhotakota reporting a greater proportion 88.0% compared to 74.3% in Blantyre. Community members were found to be the greatest source of stigma and discrimination which was experienced by 48.4% of respondents. This was followed by 37.0% of respondents facing stigma and discrimination from family members and 26.4% from traditional

leaders. Cases of stigma and discrimination perpetrated by religious leaders and police were at 2.4% and 0.4% respectively. Among respondents who were stigmatized or discriminated, only 22.5% stated they sought redress. Moreover, among those who sought redress, 47.7% were not satisfied with the assistance they received. . Table 7 details key findings on stigma and discrimination.

Table 7: Cases of Stigma and Discrimination among Respondents.

	Blantyre (n=242)	Nkhotakota (n=209)	Overall (n=451)
Respondents reporting ≥1 cases of stigma, discrimination and/or general rights violation	74.3% (180)	88.0% (184)	80.7% (364)
Community Members	40.5% (98)	59.8% (125)	48.4% (223)
Family Members	38.0% (92)	35.9% (75)	37.0% (167)
Traditional Leaders	22.3% (54)	27.3% (57)	24.6% (111)
Intimate Partner	22.3% (54)	16.3% (34)	19.6% (88)
Religious Leader	1.2% (3)	3.8% (8)	2.4% (11)
Police	0.8% (2)	0.0% (0)	0.4% (2)
Other	1.2% (3)	1.0% (2)	1.1%(5)
	n=180	n=184	n=364
Sought Redress for Case of Stigma and Discrimination	25.6% (46)	18.7% (36)	22.5% (82)
	n=46	n=36	n=82
Not Satisfied with Redress	32.6% (15)	66.7% (24)	47.7% (39)

3.4.1. Stigma and Discrimination from Community Members

48.4% of respondents reported having experienced stigma and discrimination from community members. Public insults and social isolation was found to be the predominant issue. This included being called ‘walking corpses’, ‘already dead’ and being isolated socially from community gatherings and meetings. Results of this study seem to indicate that fear of casual transmission still exists due to reported cases where community members refused to use the same utensils or eat food prepared by a WLHIV. Some of these issues were articulated in the following statement made by a respondent in Nkhotakota: *They say bad words to me and laugh at me because of HIV. Everyone in the family, community and traditional leaders say abusive*

languages and don't consider us to take part in or have access to opportunities that can improve our lives. -Woman from Malengachanzi, Nkhotakota (Interview Data)

Other issues include being excluded from food-for-work and cash-for-work programs, loans, community initiatives and instances of resource redistribution. On being denied access to loans, one woman from Blantyre commented: *I know I have the right to access loans but in most cases, people are scared to give us loans because they fear we will fall sick and the business will fail. Therefore, loan lenders are always thinking that we won't be productive and that our property will just be grabbed once we die. Even if we know our right, we are not encouraged to get loans.* -Woman from Machinjiri, Blantyre (Focus Group Discussion)

We are isolated from community programs as people say we are not capable do development programs as we are expected to die soon. They are not willing to share information on food for work and cash for work programs and they do not share with us welfare program support because of our status. -Woman from Kuntaja, Blantyre (Interview Data)

It was also discovered over the course of the baseline, through focus groups, that the Community Based Organizations themselves were a source of harm to WLHIV:

Woman 1: The CBOs themselves violate our rights. They all know our HIV status. They abuse that knowledge and tell people in the community who is HIV Positive.

Woman 2: It is a problem that HIV Positive and HIV Negative members are mixed at the CBO meetings. This becomes a source of gossip in the community.

Overall, there seems to be a general reluctance among community members to provide social and economic support to WLHIV. Table 8 illustrates the frequency with which key types of discriminatory acts, perpetrated by community members, were reported by respondents.

Table 8: *Frequencies with which certain types of discriminatory acts, committed by community members, were reported by respondents.*

	Blantyre (# of times mentioned)	Nkhotakota (# of times mentioned)
Public Insults and Isolation	48	90
Exclusion from food or cash for work programs, loans and resource redistributions	31	26

Note: Numbers are an integration of data from both individual surveys and FGD.

3.4.2. Stigma and Discrimination from Family Members

Similar to the nature of violations perpetuated by community members, cases of insults and isolation was the most common act of discrimination perpetuated by family members of the respondents: *Relatives talk so much about my HIV. If I am sick, no one will come for me at the hospital. I am all alone and they refuse to come, except for my own mother. They insult and laugh at you. Even my own children were laughing at me.* -Woman from Kanyenda, Nkhotakota (Interview Data)

Family members also generally refuse to support WLHIV in terms of providing food, clothes, school fees for their children or assistance in getting to health facilities. Other issues include property grabbing, being chased from the home and family members publicly disclosing their status. The frequency with which each type of discriminatory act was reported is outlined below in Table 9.

Table 9: *Frequencies with which certain types of discriminatory acts, committed by family members, were reported by respondents.*

	Blantyre (# of times mentioned)	Nkhotakota (# of times mentioned)
Insults and Isolation	65	54
Refusal to provide material support	15	17
Land Grabbing	7	6
Chased from home	4	4
Public disclosure of status	7	0

Note: Numbers are an integration of data from both individual surveys and FGD.

3.4.3. Stigma and Discrimination from Traditional Leaders

Reports of traditional leaders denying WLHIV access to subsidized farm inputs is the most frequent concern voiced by women in this category. This issue was described as follows by a woman from Nkhotakota: *Ever since I was tested positive, the traditional leader has denied me coupons saying, you are a sick person. I listened to this for many years but I recently went to the police. Now I got 2 coupons. But later, the chief came to get the other bag from me saying, where will you ever apply this?* -Woman from Nkhotakota (Focus Group Discussion)

Women surveyed were frequently told "*Ndimalilo oyenda awa sangathe kulima*" meaning 'You are a dead living person that cannot manage to do her farming'. Respondents repeatedly expressed how, when they attempted to register for coupons, they would be told that the distribution of coupons *"does not concern you", "you are not entitled to receive fertilizer coupons"* or *"you are not worthy beneficiaries because of your status."* One woman from Machinjiri, Blantyre expressed how she had to fight for her fertilizer coupons: *The coupons, we are denied them. And if we ask for them, we can't get them in a nice way. We have to fight for it, I mean really fight and threaten to report it.* -Woman from Machinjiri, Blantyre (Focus Group Discussion)

Other issues raised by respondents, in both Blantyre and Nkhotakota, included their exclusion from receiving donations, public work programs or leadership opportunities by the leaders: *He refuses to put me in community program activities to share my ideas and needs with other community members. The District Commissioner had requested a meeting with the chiefs to inform them that, for any welfare program that comes to the community, that we must be the priority to receive the donations. But nothing happened, nothing changed and we are just waiting.* -Woman from Machinjiri, Blantyre (Focus Group Discussion)

The main discriminatory acts committed by traditional leaders are detailed below in Table 10, along with the frequency with which the issue was mentioned in interviews and FGD.

Table 10: *Frequencies with which certain types of discriminatory acts, committed by traditional leaders, were reported by respondents.*

	Blantyre (# times mentioned)	Nkhotakota (# times mentioned)
Denied subsidized farm inputs	34	49
Exclusion from community development work	26	12

Note: Numbers are an integration of data from both individual surveys and FGD.

3.4.4. Stigma and Discrimination by Intimate Partners

Insults and being isolated by intimate partners was the most frequent manifestation of stigma and discrimination faced by respondents. Following this, a recurring theme entailed men abandoning relationships when the woman revealed her positive status. A common reason provided was wanting a 'wife without disease': *Even if your husband is the one that infects you, the husband insults you and says that he wants a wife without the disease. He will leave you alone and marry another wife without HIV.* -Woman from Nkhotakota (Focus Group Discussion)

This issue was also present in the reports provided by women in Blantyre:

He treated me badly and chased me out of the house when he found out my status.

If the man did not fully abandon or divorce the woman, it was reported by several women that the husband would no longer provide monetary support or food. The issue of gender based violence (GBV) was also raised in both districts. Table 11 illustrates the frequencies with which certain acts of discrimination by intimate partners were reported by respondents.

Table 11*: Frequencies with which certain types of discriminatory acts, committed by intimate partners, were reported by respondents.*

	Blantyre (# of times mentioned)	Nkhotakota (# of times mentioned)
Insults and Isolation	23	9
Abandoning wife	13	16
Refusal to provide material support	13	7
GBV	2	3

Note: Numbers are an integration of data from both individual surveys and FGD.

3.5. Systems of Redress in Blantyre and Nkhotakota

"We don't feel that our development is important enough to be reported to other authorities"

-Woman from Kanyenda, Nkhotakota

It was found that 49.2% of women stated they would not know where to go if they faced a SRHR violation. Among those who did face an SRHR violation, only a third of them sought redress. Within this figure, the proportion of individuals seeking redress following a violation by health care workers was even less. Out of the 124 individuals who faced a violation at a health facility, only 7.3% sought redress. For those who faced with stigma and discrimination, less than a quarter sought redress. Key reasons provided by woman included not knowing where to go and fear:

Woman 1: Even though we have experienced violations, we have never gone to anyone. We don't know where to go.

Woman 2: I have never gone anywhere either.

Woman 3: We are aware that maybe we can go to the chief or the police. But if you go, it is of no help. They will tell you that your problem is nonsense.

Woman 4: You have to think of delaying going there. You are scared to go because maybe your marriage will end and you will have nowhere to go after.

-Women from Nkhotakota (Focus Group Discussion)

Additional reasons comprised of not seeing the reason to seek redress because 'they will not be able to help you', that it would be better to 'leave things as they are', 'to trust in God', not realizing one's rights had even been violated or the perception that the violation was not a legitimate problem to bring to authorities. For one respondent from Kunthmebwe, Blantyre "*When my first husband passed away, I was told to sleep with his brother so I did*". When subsequently asked if she sought redress, she replied "*It was my culture. I did not know they were violating my rights*". Another woman in Nkhotakota, who described how a nurse refused to attend to her while she was giving birth to her last born, explained that she did not seek redress because *"I thought it was the way how nurses at the hospital treated patients."*

Another woman demonstrated her sincere belief that the insults were legitimate when asked why she never sought redress: *Because I feel it is not necessary because what they say about me the truth even though it hurts.* -Woman from Kuntaja, Blantyre (Interview Data)

Level of satisfaction expressed by respondents who had sought redress were also extremely low. For those who went for assistance for a SRHR violation, 72.1% claimed they were not satisfied with the response they were met with. In the cases where redress was being sought for an act of discrimination, 47.7% were not satisfied with the redress that was provided. In Blantyre, a woman had the following experience trying to bring her issue to the court: *I reported the issue to the court, to try and sue when my husband sold the property while I was sick in the hospital. The court clerk told me to just go home. He told me to wait, to see if I would live or die because of my status. But he said he could not continue with the case. My husband ran away and the court did nothing to help me. I have all these problems but I do not have anywhere to go to report it.* -Woman from Machinjiri, Blantyre (Focus Group Discussion)

Several leaders interviewed also revealed they were unable to adequately assist community members find redress. In a community in Kunthembwe, where WLHIV were consistently being 'chased' from the hospital when trying to obtain drugs, the Village Headman stated he was unable to support them:

I tried to inform the Group Village Headman about the issue and I spoke with the families but in the end, I could not provide support to such kinds of people due to lack of resources and authorities to reach those issues. I do not have the resources to provide relevant information to such vulnerable people who have had their rights violated by health authorities. -Village Headman from Kunthembwe, Blantyre

The patterns of redress seeking among respondents can be found below in Table 12.

Table 12: *Patterns of Redress Seeking among Respondents*

	Blantyre (n=242)	Nkhotakota (n=209)	Overall (n=451)
Respondents claiming they would not know where to go for redress if faced with an SRHR violation:	48.3% (117)	50.2% (105)	49.2% (222)
Respondents with ≥1 SRHR Violation	(88/242)	(88/209)	(176/451)
% of respondents who faced a SRHR violation and sought redress:	36.4% (32/88)	33.0% (29/88)	34.7% (61/176)
% of respondents who sought redress and were not satisfied with assistance received:	96.7% (31/32)	44.8% (13/29)	72.1% (44/61)
Respondents reporting a personal experience with ≥1 cases of stigma and discrimination:	74.3% (180/242)	88.0% (184/209)	80.7% (364/451)
% of respondents who faced stigma and discrimination and sought redress:	25.6% (46/180)	18.7% (36/184)	22.5% (82/364)
Not Satisfied with Redress	32.6% (15/46)	66.7% (24/36)	47.7% (39/82)
Where women went for redress **(Figures below combine all cases of redress sought following cases of SRHR violation, stigma or discrimination):**[a]			
Chiefs (GVH, VH, T/A)	28.9% (24/83)	24.4% (19/78)	26.7% (43/161)
NGO/CSO	16.9% (14/83)	12.8% (10/78)	14.9% (24/161)
Police Victim Support Unit	12.0% (10/83)	15.4% (12/78)	13.7% (22/161)
Relatives	9.6% (8/83)	14.1% (11/78)	11.8% (19/161)
Hospital/Health Facility	9.6% (8/83)	9.0% (7/78)	9.3% (15/161)
Ankhoswe (Family Marriage Counsellor)	10.8% (9/83)	1.3% (1/78)	6.2% (10/161)
Community Members	3.6% (3/83)	20.5% (16/78)	11.8% (19/161)
Other[b]	8.4% (7/83)	2.6% (2/78)	5.6% (9/161)

Total cases where no redress was sought following a case of SRHR violation, stigma or discrimination:	190	207	397
Key reasons provided for not seeking redress:			
Does not know where to go	37.9% (72/190)	25.6% (53/207)	31.5% (125/397)
Afraid to seek redress	11.6% (22/190)	7.7% (16/207)	9.6% (38/397)
Unsure if violation was severe enough to seek redress	5.8% (11/190)	5.3% (11/207)	5.5% (22/397)
"Should keep things to yourself"	2.6% (5/190)	11.6% (24/207)	7.3% (29/397)
"Trust in God"	1.6% (3/190)	5.3% (11/207)	3.5% (14/397)
No response[c]	40.5% (77/190)	44.4% (92/207)	42.6% (169/397)

[a] Certain respondents sought multiple avenues of redress.

[b] Includes District Commissioner, Church and Court

[c] Many of the woman were reluctant to provide an explanation as to why they did not seek redress and remained silent

3.6. Priorities Identified By Women

In order to further understand the needs and aspirations of WLHIV, the survey consisted of a question asking them what services and programs they would like to see implemented by COWLHA and WOFAD. Table 13 below integrates qualitative data obtained from survey respondents and FGDs to demonstrate the frequencies with which certain demands were mentioned. Responses reveal that women are primarily seeking opportunities that will empower them economically -requesting loans, assistance with business and income generating activities. Women were also requesting trainings, with SRHR trainings being the most requested type of training. Finally the issue of lack of food was found to be a major one and constituted another major demand. Other requests are outlined below in Table 13.

Table 13: *Priorities Identified by Respondents*

	Blantyre	Nkhotakota	Overall
Economic Empowerment	33.3% (173)	37.9% (193)	35.6% (366)
Loans	19.4% (101)	24.6% (125)	22.0% (226)
Business	8.3% (43)	10.0% (51)	9.1% (94)
Income Generating Activities	5.6% (29)	3.3% (17)	4.5% (46)
Trainings	16.0% (83)	16.5% (84)	16.2% (167)
SRHR	5.4% (28)	2.8% (14)	4.1% (42)
Business	2.5% (13)	1.6% (8)	2.0% (21)
Positive Living	1.5% (8)	2.2% (11)	1.8% (19)
Other[a]	2.5% (13)	0.6% (3)	1.6% (16)
Not specified	4.0% (21)	9.4% (48)	6.7% (69)
Food	22.5% (117)	6.3% (32)	14.5% (149)
Farm Inputs	1.2% (6)	14.9% (76)	8.0% (82)
Sensitization Efforts and Awareness Campaigns for Community	2.3% (12)	4.1% (21)	3.2% (33)
Health Services and Medication	2.5% (13)	2.4% (12)	2.4% (25)
Help with school fees for children	2.1% (11)	1.4% (7)	1.7% (18)
Adult Education	2.1% (11)	0.0% (0)	1.1% (11)
Herbal Gardens	2.1% (11)	0.0% (0)	1.1% (11)

Note: Frequencies determined from both FGD Transcripts and qualitative data derived from individual surveys
[a] Other includes trainings on herbal gardens, nutrition, advocacy, home-based care, monitoring and evaluation and HIV/AIDS

Traditional and community leaders interviewed also provided similar responses when expressing the needs of their communities. The need for economic empowerment through income generating activities, business and loans was a theme that resounded throughout. Leaders also highlighted the need for trainings that would help empower WLHIV and community awareness initiatives surrounding SRHR.

4.0. Discussion

4.1. Knowledge of Surrounding SRHR

In both districts, women generally demonstrated an awareness of their rights as WLHIV. Yet, this was commonly followed by remarks on their widespread inability to assert those rights. Based on findings from this baseline survey, it is apparent that the factors driving the persistence of SRHR violations stem from a complex array of issues. An intervention that prioritizes increasing the knowledge of women surrounding SRHR will fail to truly achieve the final objective of ensuring their SRHR are promoted and protected. Hence, it is imperative that any interventions designed and implemented through the We Have Rights Too! Project addresses factors in the current environment that makes WLHIV vulnerable to SRHR violations, stigma and discrimination and their limited access to justice.

4.2. SRHR Violations among WLHIV

4.2.1. Quality of Health Services Provided to WLHIV

Information gathered from this baseline survey further confirmed the persistence of this issue. Among respondents, 27.5% expressed having faced a SRHR violation by HCW. Being denied access to health services was the most frequent violation in both districts and constituted 39.8% of the violations perpetuated by HCW: *At the hospitals, the health workers leave us because they will say "You are back here again? What are you doing back here again with this disease?" They will refuse to attend to you. (All women began murmuring in agreement about this)* – Woman from Nkhotakota (Focus Group Discussion)

In Blantyre, verbal abuse and substandard quality of services was the second most prevalent issue at health facilities. For Nkhotakhota, being denied access to medication constituted the second largest source of SRHR violations where women were being refused access to their ARVs or other essential medicines. All of these issues have implications for a woman's overall health and SRH as the willingness and ability to access services and medication becomes severely reduced.

It has been observed that the choices individuals make relating to their SRH are largely influenced by the perceptions, preferences and values of HCW towards SRH services (Reis et al.,

2005). About 28.6% of respondents in the study by MANET+ were not counselled on available reproductive health options and a further 46.6% were advised not to have children despite the existence of Prevention of Mother to Child HIV Transmission (PMTCT) services in Malawi. This issue was reported among several respondents throughout the baseline survey: *At Queen's hospital, the HCW told me that, the way your health looks, this is to be your last child and shouted at me to not give birth again. She was shouting these things to me and I was unhappy with how she was speaking to me about it.* -Woman from Blantyre (Focus Group Discussion)

International reproductive health guidelines takes the stance that the choice of whether or not to continue with a pregnancy is the decision of the WLHIV following adequate provision of information and counselling (WHO, 2006**).** Yet in Malawi, a recent rapid assessment conducted on SRH found that the availability of PMTCT services is limited, and in many cases not provided, due to shortages in the necessary supplies and commodities (UoM, 2010).

Finally, it was noted 86.5% of respondents reported having received SRHR advice in this baseline. Yet when further probed about the nature of advice received, its contents could not be categorized as rights based advice surrounding SRH. Advice generally did not extend beyond guidance on nutrition, ARV intake and safe sex. Results from the baseline seems to illustrate that training efforts with HCW may prove useful in improving quality of SRH advice and behaviour. It is also apparent that many issues faced by WLHIV stems from time and resource constraints faced by staff at health facilities.

Of the 14 HCW interviewed, 11 stated that their health facilities lacked the resources needed to meet the health needs of WLHIV. Limited drug availability was most frequently quoted as the biggest resource constraint with HCW not being able to provide ARVs, Bactrim, condoms and other essential drugs. This was matched by the lack of nutritious food available to patients. Other constraints faced by HCW included lack of health personnel, equipment needed for treatment, transport, electricity, running water and poor living quarters being provided to HCW. Two HCW also indicated that there was a significant need for private ART rooms to protect the privacy of patients.

Given all of the above issues, it seems that a strategy must be developed that will also address resource constraints that play a role in preventing HCW from providing adequate care and SRH services to WLHIV.

4.2.2. SRHR Violations from Intimate Partners

SRHR violations perpetrated by intimate partners was reported by 10.3% of respondents in Blantyre and 23.9% in Nkhotakota. The predominant issues recounted include forcing sex, refusing to use condoms and forcing a woman to conceive. These reports match conclusions made by previous studies conducted in Malawi that demonstrated a persistence of non-consensual sex, refusal to use condoms, sexual transactions predicated on a women's poverty, pressure to bear additional children and sexual violence (Kathewera-Banda et al., 2006; Mgbako et al., 2007; Mwanza, 2012). Researchers in Malawi have explained this issue through illustrating how the convergence of cultural conceptions of masculinity, women's lack of economic autonomy and subordinate position in society has reduced their negotiating power in intimate partner relationships regarding the terms of sexual relationships and asserting their reproductive right (UNAIDS, 2004; Kathewera-Banda et al., 2006). Women in this baseline consistently expressed that they were subjected to forced sex and forced unprotected sex. Their responses also illustrated their sense of powerlessness: *I found out my status when I was pregnant and my husband accepted it when I told him I was found positive. But he still denies going for testing saying he's okay and doesn't have any problems. At first, he would use condoms but now, he is not willing to use them.* ***I have no choice, he's my husband.***

-Woman from Blantyre (Focus Group Discussion)

In terms of refusal to use condoms, several factors seem to be driving this occurrence. Firstly, condoms themselves seem to have become stigmatized and associated with sexual immorality and prostitution. Secondly, a wife's insistence to use condoms is frequently interpreted as a sign of infidelity or that she suspects her husband of infidelity (Kathewera-Banda et al., 2006; Mgabako et al., 2007). The concept that sex is not as 'sweet' with a condom serves an additional barrier: *The wife might take the initiative of seeking services, get tested for HIV and to get condoms. But the men will stop their wives from doing these things they are supposed to be doing. Men think condoms are not "sweet". (What do you mean by that?). I mean sex is like the*

candy, it must be unwrapped to be tasted properly. -A man living with HIV from Machinjiri, Blantyre

Based on the analysis of our findings, with additional insight from the literature, it is apparent that the power dynamics disadvantaging the negotiating power of women in their relationships and the negative perception of condoms must be targeted.

4.2.3. Harmful cultural and religious practices

Responses from the baseline survey presents contradicting evidence as to whether or not cultural practices still persist within the project's target areas. Based on information presented by the Malawi Human Rights Commission (MHRC), there is considerable evidence that harmful cultural practices still endure in Malawian society. The practice of early marriage was found among 15% of their respondents. 'Widow cleansing', where a widow is required to have sex with her deceased husband's relatives was found to persist at 13% of those surveyed by the MHRC (MHRC, 2006).

The most common cultural practice faced by respondents of the baseline was Kulowa Chokolo which was personally experienced by 7 of the respondents within this baseline. This practice requires that a widow marries a male relative of her deceased husband.

On the whole, 32 respondents from this baseline survey revealed a personal experience with Kulowa Chokolo, Chinamwali, Kusasa Fumbi, Kulowa Fisi or Kulowa Thena[3]. Traditional leaders interviewed also reported encounters with Chokolo.

Another issue, categorized by respondents as a cultural practice which violated their SRHR, were cases of polygyny[3] and extramarital relationships – reported by 23 respondents. An Executive Director of a CBO in TA Kuntaja revealed that polygyny and extramarital relationships were still very common in his community. Researchers have illustrated how the fear of violence and women's economic dependency has left them with little choice other than to accept the extramarital relations of their husbands (Kathewera-Banda et al., 2006; Mgbako et al. 2007)

It is difficult to determine the extent of the problem given that many of these practices now occur privately and respondents may have been reluctant to truthfully share. Despite this limitation, evidence does seem to demonstrate a need to address harmful cultural practices.

Finally, in Nkhotakota, women raised concerns of religious leaders denying the use of ARV, family planning methods and HIV testing. These issues were additionally raised by traditional leaders in Nkhotkota who noted children and women were being prevented from accessing health services and medication due to religious reasons. Interventions in Nkhotakota specifically will need to tackle such problems.

4.3. Stigma and Discrimination

4.3.1. Stigma and Discrimination in the home and community

The study has shown that WLHIV in Malawi are subjected to verbal attacks, social exclusion and discrimination in terms of access to resources such as cash-for-work, food-for-work, piecework and loans – all acts which further infringe upon a women's economic autonomy. There is a definite need for sensitization efforts aimed specifically at community members to begin dealing with their role in excluding WLHIV from social gatherings and economic opportunities in their communities.

A targeted agricultural subsidy program has existed in Malawi since 2005 to provide fertilizers and maize seeds at a reduced price. Vulnerable groups -households impacted by HIV and AIDS, those caring for physically challenged individuals, headed by orphans or females - were defined as the target for this initiative (GoM, 2008). Village Development Committees (VDC) were given the responsibility to distribute fertilizer coupons by the Ministry of Agriculture. Yet, this responsibility has largely been passed on to village chiefs (Chirwa et al., 2011). Subsequently, reports of corruption, nepotism and discrimination against vulnerable groups, including WLHIV, have been widespread (Mgbako et al., 2007).

Information gathered from this baseline reveals the systematic barriers WLHIV face in seeking to obtain subsidized farm inputs they are intended to be beneficiaries of. It has been reasoned

that the issue stems from the vast number of individuals fitting the criteria to receive subsidies significantly outweighs the number of coupons available (Dorward et al., 2010). This view was also noted by Patrick Kabambe, Principle Secretary of the Ministry of Agriculture, *"When you have a limited supply, interested parties will feel left out."* (Mgbako et al., 2007, p.25).

Though this may be the case, Mgbako et al. (2007) found several accounts of traditional leaders explicitly telling women they were being denied coupons due to them being 'weak' and 'useless'. The prevalence of perceptions regarding WLHIV are incapable of engaging in farm work was a common issue faced by respondents interviewed through the course of the baseline. Based on such accounts, it seems that WLHIV are especially vulnerable to being excluded from accessing the subsidized farm inputs they are entitled to. Currently the Women's Legal Resource Centre in Malawi is focusing on campaigning for women's access to subsidized fertilizers in this year's distribution (Nyemba, 2013, p. 25). Collaborating with this organization may prove beneficial in assisting access to fertilizers among WLHIV.

In addition to respondents being faced with extensive levels of SRHR violations, stigma and discrimination, it was widely found that women did not know where to go for redress or feared seeking assistance. Among those who sought redress, a significant proportion were left unsatisfied with the assistance received.

Based on information obtained by interviewing traditional and community leaders, the responses indicate that the allocation of punishment to those who have committed an SRHR violation is limited or non-existent. Twenty-four leaders have had a SRHR violation brought to their attention for assistance. Nineteen of those leaders assisted the individual in seeking redress. However, for the vast majority, redress consisted of the leader counselling the perpetrator or individual who faced the violation. There were only two cases where the leader sought punitive action where in one example; the leader was successful in suspending the duties of health personnel in response to consistent violations against patients. However, several leaders admitted they did not know where to take the matters.

Interviews with individuals from Police Victim Support Units (PVSU) in Blantyre and Nkhotakota also demonstrates severe limitations in their ability to adequately address cases of rape, marriage dissolution, forced unprotected sex and medication being denied to WLHIV. Police expressed that much of the problem is centred on the limited number of PVSU and hence, the current inability of many rural women to access their services. It was also noted that the lack of police trained in counselling, lack of counselling rooms and time constraints faced by police staff all served to inhibit their ability to provide proper redress for those facing SRHR violations.

5.0 Limitations

A total of 665 women were included in the baseline survey. Considering that a total of 5, 000 WLHIV are to be targeted in the 6 TAs, our sample size represents only 13.3% of the WLHIV in the target area. Bias exists in the information collected due to its reliance on voluntary response sampling – where women who took the time to come to meet interviewers may not be representative of the entire population of WLHIV. WLHIV were also mobilized through lists held by Support Groups and Community Based Organizations, biasing the information towards representing WLHIV already accessing some level of support. Consequentially, the generalizability of the baseline findings to all WLHIV in the target areas is limited.

The sensitive and intrusive nature of the topic would have also compromised the validity of data obtained. SRHR violations are personal experiences which respondents may have been unwilling to share truthfully and thoroughly. In addition, the questions were also dependent upon the women's ability to accurately recall upon their past experiences and to understand the questions as posed by the interviewer.

6.0. Recommendations

Based on findings derived from this baseline study, it is apparent that the We Have Rights Too! Project must address issues at multiple levels of society in order to fully support and protect the SRHR of WLHIV.

6.1. Individual Level Trainings and Counselling

Among respondents, the greatest gap in knowledge appear to stem from not knowing the relevant institutions to engage in instances of SRHR violations. In response, trainings and counselling provided through the We Have Rights Too! Project should deliver information on how to access relevant organizations and legal networks in the community. Yet given the weak system of redress that was evidenced, WLHIV should be trained in political advocacy to be able to enact changes in policy and programs available to them at the community and district level. This could potentially be achieved through building the capacity of WLHIV to engage in and initiate public debates, district and community campaigns, meetings and participatory radio campaigns (PRCs).

Though there appears to be widespread knowledge surrounding the rights of WLHIV, further educating the women on their SRHR and relevant laws and policies may assist in strengthening the success of above efforts and their ability to assert their SRHR. Making laws and policies accessible to WLHIV by translating, printing and distributing Chichewa versions will improve their legal literacy and ability to advocate for political change and secure resources for programs that will support the needs of women seeking redress.

As men often are the ones making decisions regarding sexual and reproductive health issues, and most often the perpetrators of sexual and domestic violence among WLHIV, it is essential to include them in order to change behaviour patterns. The project should incorporate couples as SRHR promoter to advocate for SRHR of WLHIV within their families and encourage other couples to do the same. This approach will ensure male involvement in the promotion of SRHR of WLHIV. Trainings and counselling, integrating men through couples and the stepping stones approach, may serve as a start to addressing the power imbalances between genders which enables SRHR violations.

6.2. Community Level Trainings and Advocacy

Identifying and training community SRHR promoters and peer educators represents a start in addressing the complex array of issues driving rights violations at the community level. The project already aims to identify 40 community SRHR promoters and peer educators living with HIV and AIDS and train them as promoters of SRHR within their families and at the community

level. The SRHR promoters should be trained to provide counselling, referrals and follow-ups to WLHIV in the community. In addition, these community SRHR promoters should be intensively trained to advocate for: changes in the health care system to reduce the level of violations WLHIV are facing by HCW; increased legal, economic and social support for WLHIV seeking redress for SRHR violations and effective implementation of anti-discriminatory laws and policies intended to protect their rights. This initiative will require active engagement with traditional leaders, religious leaders and health and government officials. The 40 peer educators are being conferred a significant task and hence, trainings will need to be intensive with constant follow-up over the 2 year span of the We Have Rights Too! Project.

It would also be beneficial to organize a conference at the end of the year for peer educators to come together to share experiences and best practices, to encourage one another and to develop a strategic plan to move forward with their efforts.

The use of participatory radio campaigns will further spread awareness on SRHR and can be used as a tool for political advocacy. Farm Radio Malawi, Nkhotakota Community Radio and Zodiak Broadcasting Stations have demonstrated their commitment to the We Have Rights Too! Project. Ten radiobroadcasters should be trained to promote awareness on the key issues faced by WLHIV as identified in the baseline; acceptance of WLHIV by voicing the need to reduce stigma and discrimination; understanding of SRHR and the laws and policies intended to protect the rights of WLHIV; and to promote an understanding of organizations and referral systems women can access in seeking redress.

6.2.1. Community Level: Addressing Health Service Issues

The project will need to collaborate with key health officials in order to begin addressing issues that were reported by women regarding SRHR violations in health facilities. Initially, meetings should be held with the District Health Officers, District HIV and AIDS Coordinator, Sexual and Reproductive Health Coordinators to begin developing a plan to work with HCW in reducing barriers to access, overcoming resource limitations and knowledge gaps in the delivery of adequate and appropriate SRH advice and services for WLHIV.

6.2.2. Community Level: Addressing access to subsidized farm inputs

The project will need to work with traditional leaders in order to address issues in which WLHIV

are being denied access to subsidized farm inputs, food-for-work, cash-for work and loan programs as well as being subjected to cultural violations. In Nkhotakota, a special effort to collaborate with religious leaders is warranted given the identification of their role in denying women access to ARVs, family planning methods and HIV testing. Sensitization meetings may serve as a starting point to addressing these issues.

6.3. Improving Awareness, Accessibility and Effectiveness of Current Systems for Redress and Support for WLHIV

Several Civil Society Organizations (CSOs) working with people living with HIV and AIDS, gender equality, policy advocacy and legal assistance exist in both Blantyre and Nkhotakota. Yet based on responses provided through the survey, it is clear that WLHIV are either unaware of these institutions or fear seeking redress. Rather than duplicating the activities of organizations already in place, the We Have Rights Too! Project should work with them to strengthen their activities in the project's target areas, build referral networks between the organizations and WLHIV and educate women on how to access these institutions once we have successfully worked to strengthen them. Potential organizations include MANET+, Malawi Health Equity Network, NGO Gender Coordination Network, Women's Legal Resource Centre, the Malawi Law Society, Women Lawyers Association, the Center for Legal Assistance and the Malawi Legal Aid Department and paralegal service providers such as Women's Voice and the Malawi Center for Advice, Research and Education on Rights (CARER).

Through the course of the survey, it was also found that perpetrators of SRHR violations generally did not face punishment for their actions. Hence, the project should also work with the Malawi Police Service and District Courts to determine penalty for perpetrators SRHR violations. Efforts to work with the PVSUs are also necessary in strengthening systems of redress available to WLHIV in target areas.

6.3.1. Linking Health and Legal Services as a Potential Strategy

Due to weak referral systems or lack of awareness on where to go, linking health services to legal aid and paralegal service providers may improve issues of access. In Tanzania, the Centre for Comprehensive Community Based Rehabilitation joined forces with the Tanzanian District Health Authorities to create the Holistic HIV/AIDS Related Program (HARP) which provides

legal aid services in addition to providing voluntary counselling and testing, home-based care and ARV treatment. The HARP program has been successful in targeting the legal needs of WLHIV while simultaneously providing medical care. Previous suggestions have already been made to implement similar initiatives in Malawi (Mgbako et al., 2007).

6.4. Political Change

Recognizing the need to ensure that government moves from words to action in the promotion and protection of the SRHR of WLHIV, the project is calling upon Government to create an enabling environment where the implementation of existing policy commitments is assured. Government should listen to voices of WLHIV and ensure laws and policies that protect rights of WLHIV are enforced through courts, police and traditional systems. For example, government should: ensure that perpetrators of violence against WLHIV are apprehended and punished; prevent healthcare workers in government hospitals from stigmatizing and discriminating against WLHIV; and engage traditional and religious leaders to change or eliminate harmful cultural practices and beliefs. This can be achieved through awareness and advocacy meetings with duty bearers at community, district and national levels.

6.5. SRHR Violations in the Context of Poverty: Need for Economic Empowerment

Results from the baseline clearly indicate that women are demanding means for economic empowerment. Meeting the needs of WLHIV for economic autonomy will be central to truly achieving the project's objectives of protecting and promoting their SRHR. The current state of economic dependency women face exacerbates their vulnerability to violations as they are unable to assert their rights without severe consequences to their economic well-being. Limited access to education and the low economic status of women further reinforces power differentials between gender and serves to sustain women's dependence on men in marriage, families and communities. If women are to be able to assert their SRHR, their economic circumstances must be addressed. It is imperative that the We Have Rights Too! Project begin developing a strategy of economic empowerment for WLHIV in its target areas.

7.0 Conclusion

Currently WLHIV face multiple levels of discrimination as HIV/AIDS-related stigma and discrimination compounds with pre-existing forms, including those based on gender, class and ethnicity (Gupta, 2000). This serves to further perpetuate their socioeconomic disadvantages. It is essential that the We Have Rights Too! Project works towards leading a concerted effort in ensuring WLHIV in the targeted communities will be able to realize their SRH needs and aspirations in a manner that is free from coercion, discrimination and violence. To achieve this goal, this project must commit to tackling the range of factors driving the persistence of SRHR violations and galvanize the political will needed to make certain SRHR of WLHIV becomes a focal concern among community members, traditional and community leaders, health care workers, police and health and government officials.

Annex I: Definitions of cultural practices

Definitions of cultural practices identified through the baseline survey.

Kulowa Kufa/Chokolo	'Wife inheritance' – a woman is 'inherited' and marries a male relative of her deceased husband. This practice is seen by many as a means of offering security to the widow. The family union is seen to increase the ease with which the husband's relatives can support the widow and her children.
Chinamwali (Girl's Initation)	A ceremony that girls undergo during their transition from childhood to adulthood. The practice is intended to counsel girls on a range of social and cultural matters – good manners, respect and other information to prepare them for adult life. Particularly among Yao and Lomwe, it has been documented that sex education during chinamwali encourages premarital sex.
Kusasa Fumbi/Kuchotsa Fumbi	A practice where girls are advised to find a boy to have sex with to preventing 'getting pale' (kutuwa).
Kulowa Fisi	If a woman is not conceiving, relatives will look for another man in the community to sleep with her in order for her to bear children.
Kulowa Nthena	A husband that is providing his wife's family with a lot of support may be rewarded by being given his wife's younger sister for marriage. This practice is a method of showing gratitude for a son-in-law who has been generous in caring for their daughter or to help bear children for the husband if the elder sister is unable to conceive.
Mitala (Polygyny)	Practice where a man marries more than one woman, without the consent of the first wife/wives.

Note: This table only includes information on cultural practices that respondents reported they had faced. This table is not intended to provide a comprehensive list of cultural practices surrounding marriage, rites of passage, pregnancy or death. Definitions are adapted from the report by the Malawi Human Rights Commission, 2006.

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