

# Promoting the Right to Healthcare Services for HIV-positive Persons with Disabilities in Malawi: Incorporating Disability into HIV Programming

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## Abstract

African countries at the epicentre of the HIV/AIDS pandemic have been working hard to confront the scourge. Malawi is one of the continent's most affected countries and has been attempting to remedy the situation by providing healthcare services, promoting sexual and reproductive rights, and putting in place numerous HIV-programming initiatives such as HIV education, prevention, care and treatment. However, persons with disabilities have not been included in this initiative in spite of their vulnerability to the disease and their high rates of exposure to HIV risk factors. Their exclusion from HIV/AIDS programming is a product of the incorrect perception that they are asexual or are not vulnerable to the illness. As a result, the mainstreaming of people with a disability into HIV/AIDS programming has not been taking place. Such mainstreaming should take the form of the reasonable accommodation and adoption of universal design measures which ensure that persons with disabilities enjoy the right to health on an equal basis with others. This article seeks to close this gap in Malawi by calling for the inclusion of disability in HIV programming. To this end, and on the basis of desktop research, it examines the laws and policies that assess the extent to which persons with disabilities are able to participate in the response to HIV. It also considers whether they have access to HIV services that are both customised to their diverse needs and equal to the services available to others in society. The author finds that the failure to mainstream disability into HIV programming is a serious problem that will hinder the fight against the pandemic in Malawi.

**Keywords:** HIV programming; disability rights; right to health; Malawi; non-discrimination; persons with disabilities; HIV programme



## Introduction

The early discussions on HIV and disability considered whether HIV could be regarded as equivalent to a disability. The discussions aimed to protect HIV-positive persons under legislation aimed at preventing discrimination against persons with a disability in order to guarantee their full inclusion in society and to secure their socio-economic rights (UNAIDS 1996). This would protect their right to equality with other members of society who do enjoy these rights. In the 1998 case of *Bragdon v Abbott*<sup>1</sup> the United States Supreme Court ruled that HIV is indeed a disability. In deciding that a woman living with HIV was entitled to protection under the Americans with Disabilities Act (1990), the court was unequivocal in its position. At the time, unlike today, the question was not one of knowing whether persons with disabilities were vulnerable to HIV infection and whether they had access to HIV-related services (Gerntholtz, Grant and Hanass-Hancock 2010, 9).

The question of vulnerability to HIV of persons with disabilities and their accessibility to HIV-related services is an important one because ignorance of these issues in the fight against the pandemic is detrimental to the prevention and eradication of the disease (Touko et al 2010). In addition to the vulnerability of persons with disabilities and their exclusion from HIV policies, it is also important to note that HIV-positive persons are likely to develop a disability – hence the need to have inclusive responses to dealing with HIV. These questions are particularly relevant in Malawian society, which not only has one of the highest HIV prevalence rates in the world – with 980 000 HIV-positive people, including 350 000 undiagnosed (estimated at 11% of the adult population) and 27 000 HIV-related deaths annually<sup>2</sup> – but it also has approximately 498 122 persons with disabilities, amounting to a disability prevalence of 3,8% (Chilemba 2014, 207).

Malawi has various laws and policies related to HIV and disability in place and it has recently adopted a Disability Act (2012). Yet, in the area of systematic, large-scale research, the impact of HIV/AIDS on persons with disabilities has been widely ignored (UNAIDS Report 2010). The problem lies in the fact that the government and policy-makers have rarely considered the needs of persons with disabilities when formulating HIV/AIDS policies.

This article seeks to investigate the legal protection which is necessary to ensure that persons with disabilities who live with HIV/AIDS are treated as equals in Malawian society. The author argues that HIV-positive persons with disabilities are discriminated

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<sup>1</sup> *Bragdon v Abbott* 524 US 624 (1998); see also *X v Commonwealth* (1999) 167 ALR 529, where the High Court of Australia was of the view that the dismissal of an employee on the ground of his HIV status is forbidden by the Disability Discrimination Act; for more see K Barrett-Grant et al (ed) *HIV and the Law: A Resource Manual* (3rd ed). AIDS Law Project (Johannesburg 2003), 68, 69 and 73.

<sup>2</sup> Malawi Country Operational Plan. 2017. “Strategic direction summary”. Available at <<https://www.pepfar.gov/documents/organization/272017.pdf>> (accessed 16 May 2019).

against regarding access to healthcare services and calls for the mainstreaming of disability into HIV programming. The article emphasises the need to include persons with disabilities in HIV prevention, management and treatment in order to ensure that they have access to HIV services which are both adapted to their various needs and equal to the services available to other members of society. Relying on the desktop research, the article examines the relevant laws and policies in order to assess, first, the extent to which persons with disabilities participate in the HIV programming and, secondly, whether they have access to HIV services which are both customised to their diverse needs and equal to the services available to others in society. Ultimately, the article seeks to apply

a disability lens to HIV/AIDS policies and programmes to assess the current level of activity and investment, and to identify next steps to improve inclusion of [people with disabilities (PWDs)] in HIV/AIDS programming and policies (Minister of Health – Health Canada 2009, 7).

This study was conducted in the light of the social and human rights models of disability which deal with the environmental or societal barriers to the enjoyment of human rights (Mizrachi 2014; Oliver 2013, 1024). These models are different from the medical model, which describes disability as an illness or an impairment located in the body of the person (Burgstahler and Doe 2014).

First, the article examines HIV/AIDS and disability in order to reveal whether HIV/AIDS is indeed a disability; secondly, the vulnerability of persons with disabilities to HIV/AIDS is explored; thirdly, it examines the incorporation of disability into HIV programming in Malawi. This third section analyses Malawi's commitment to international and regional instruments aiming to ensure universal access to healthcare and HIV-related services. More importantly, it considers how these instruments are incorporated into national policies on HIV and disabilities and how they are implemented. This section contends that much more needs to be done to mainstream disability into HIV programming. Accordingly, the fourth part of the article suggests a framework for incorporating disability into national strategies more satisfactorily in order to combat HIV/AIDS. The final part of the article provides concluding remarks which summarise the discussion and call on all African countries to mainstream disability into HIV programming as this will be an important step towards combating a pandemic that kills millions of people on the continent (UNAIDS Report 2010, 20).

This article relies strongly on a situational analysis which reveals that in Malawi the prevalence of HIV is high and that the state makes every possible effort to deal with the illness. Nonetheless, persons with disabilities affected by the disease are generally not included or mainstreamed in the processes adopted to find remedies to the pandemic.

## **HIV/AIDS and Disability**

This section explores whether HIV is a disability. Under the first article of the Convention on the Rights of Persons with Disabilities (CRPD), “disability” is defined in the following way:

persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

This definition does not include those who carry the HIV/AIDS virus. Elliot et al write (2009): “The Disability Convention addresses many of the issues faced by people living with HIV (PLHIV) but does not explicitly include HIV or AIDS within its open-ended definition of ‘disability’.”

None the less, states are compelled to

provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other people, including in the area of sexual and reproductive health and population-based programmes (Article 25, CRPD).

This is to say that when a person with a disability is infected with HIV/AIDS, they should enjoy the same services as other HIV/AIDS patients. According to this perspective, it is important to recognise that HIV/AIDS can weaken the patients and cause a disability, and that such patients who suffer from “disability-related HIV” (Elliot et al 2009) should enjoy protection under the CRPD. The UN Office of the High Commissioner for Human Rights, WHO and UNAIDS (2009, 1) explains the position as follows:

States are required to recognize that where persons living with HIV (asymptomatic or symptomatic) have impairments which, in interaction with the environment, results in stigma, discrimination or other barriers to their participation, they can fall under the protection of the Convention.

In this context, the impairment and barriers as well the stigma are defining factors for the protection of the persons with a disability. In this context, Article 26 of the CRPD comes into play. It obliges states to

take appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.

At issue here is the intersection of HIV and disabilities. In dealing with this question, on the one hand, some countries incorporate the protection of persons living with HIV under national disability legislation based on the stigma and marginalisation faced by both persons living with HIV and those with disabilities. In this context, “anti-discrimination laws can be used to challenge HIV-based discrimination as a form of discrimination based on disability”, to use the words of Elliott et al (2009). This approach was sustained by UNAIDS (1996), which explains its position as follows:

The so-called disabling feature either does not disable at all, but is perceived as disabling; or it may disable somewhat, but could be addressed with reasonable accommodation. The main thing is that there is no justification for differential treatment. The disabilities consequences of asymptomatic HIV is that often people living with HIV, as well as those suspected of being HIV positive, are very often discriminated against because they are wrongly perceived as being unable to perform; they are wrongly perceived as being a threat to public health; or they are perceived as being, or indeed are, a member of some group already suffering discrimination. Thus, if they are not actually disabled by HIV-related conditions, they are often disabled by the discriminatory treatment they receive because of their HIV status. The result is that they are denied the possibility of being productive, self-reliant, full and equal members of society ... Thus, the clinical, social and cultural elements of HIV/AIDS, including the impairment which can result from it and the ignorance, discrimination and stigma which surround it, confirm that it is appropriate to consider HIV/AIDS as a disability for purposes of protection against discrimination.

In the same breath, UNAIDS (1996) was also adamant in pointing out that the assimilation of HIV/AIDS with disability is unavoidable. Echoing UNAIDS, Elliot et al (2009) write:

in order to fully protect the people who face discrimination because of actual or perceived notions regarding their abilities due to their health status, definitions of disability should move beyond functional limitations to cover medical conditions, such as HIV/AIDS.

In compliance with the *Handbook for Parliamentarians on HIV*, updated in 2007 by Inter-Parliamentary Union, UNAIDS and the UNDP (2007), countries that assimilate HIV/AIDS with disabilities adopt anti-discrimination legislation that prohibits discrimination based on disability broadly defined to include HIV/AIDS. Countries that subscribe to this approach include Australia, Canada, Ireland, New Zealand, the United Kingdom and the United States, for example. In these countries, anti-discrimination laws forbidding discrimination on the ground of disability include asymptomatic HIV infection “within the ambit of the term ‘disability’, either by explicit statutory language or as a result of statutory interpretation by courts and tribunals” (Elliot et al 2009). It could be argued that in such a context the medical model of disability applies (Chappell, Goodley and Lawthom 2001). Accordingly, disability is an illness or an impairment

located in the person who needs to be assisted by a medical doctor, who should provide a cure to deal with the functional limitation (Burgstahler and Doe 2014). The impairment is both a problem that needs to be “solved” and a “personal tragedy” (Burton, Sayrafi and Abu Srour 2013).

On the other hand, other countries have adopted either anti-discrimination laws that discernibly deal with discrimination on the basis of HIV status or other laws related to disability-based discrimination (UN Office the Commissioner of Human Rights et al, 2009). In such cases the discrimination based on HIV/AIDS is not necessarily associated with the prohibition of discrimination based on disability. It could be argued that, in this group of countries, HIV/AIDS anti-discrimination legislation has nothing to do with discrimination legislation that targets disability. A comprehensive example of such legislation comes from South Africa, where the *White Paper on an Integrated National Disability Strategy* (1997) reads:

People who are HIV positive suffer from social discrimination similar to that experienced by people with disabilities. This does not, however, imply that they are necessarily disabled. For the purpose of the Integrated National Disability Strategy therefore, they are not included in the definition of disability, except where symptoms, such as prolonged fatigue, interfere with their normal functioning.

Similarly, the Employment Equity Act in South Africa (1998) prohibits “unfair discrimination” in employment on numerous grounds, including both “disability” and “HIV status” as different grounds on which discrimination in employment often takes place (Elliot et al 2009). Mauritius has followed the South African approach in explicitly acknowledging that HIV and AIDS are not disabilities.<sup>3</sup> None the less, under this law a patient who is infected with HIV/AIDS might, in the right conditions, be permitted to acquire a disability pension benefit (Eliot et al 2009). In this context, the social model of disabilities applies. It entails shifting the focus from the impairment to that of the disabling barriers within society (Mizrachi 2014; Oliver 2013, 1024). In this vein, disability is not present in the body of the person but is caused by an environment which is not conducive to the enjoyment of human rights. The social model defines disability as “externally imposed limitations and disadvantages” (Nario-Redmond et al 2013, 469). This extends to the human rights model echoed by the CRPD, which emphasises the need to protect the right of persons with disabilities to enjoy the same dignity as other human beings.

It is within this understanding that this article calls for disability to be mainstreamed into HIV programming. Among other measures, this entails relying on reasonable accommodation, which is defined as

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<sup>3</sup> The Republic of Mauritius, HIV and AIDS Bill 2006, art 3(1).

necessary and appropriate modification and adjustments, as well as assistive devices and technology, not imposing a situation, where needed in a particular case, to ensure persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms (*White Paper on the Rights of Persons with Disabilities* 2015, 12).

Ultimately, the social model of disability is an equaliser for attempting to ensure that persons with disabilities enjoy, on an equal basis with others, all human rights and fundamental freedoms and, specifically, the right to health and sexual and reproductive health at the centre of this article. For this to happen, reasonable accommodation measures would have to include:

assistive devices, assistive technology, personal assistance, adaptations of the built environment, signage, captioning, text available in audio, loop systems, FM systems, alerting/alarm systems for evacuation procedures, dedicated SMS lines to all emergency service call centres, adaptation of (for example) work arrangements and the implementation of flexibility within the workplace to accommodate persons with disabilities (*White Paper on the Rights of Persons with Disabilities* 2015, 60).

The social or human rights models of disability also imply reliance on universal design, which is understood to be “the design of products, environments, programmes and services to be usable by all persons to the greatest extent possible without the need for adaptation or specialised design” (*White Paper on the Rights of Persons with Disabilities* 2015, 15). In this way, universal design seeks to ensure “the ability of users to have equal opportunity and access to services, products, systems and environments; regardless of their social and/or economic” (*White Paper on the Rights of Persons with Disabilities* 2015, 15). According to this design, persons with disabilities will also be included in HIV education, campaigns, counselling and treatment as well as other related programmes.

## **Vulnerability of Persons with Disabilities to HIV/AIDS**

HIV/AIDS is the most serious global epidemic. Sub-Saharan Africa is having to deal with the majority of victims (Swart et al 2006, 108). According to Swart et al (2006, 108), “more people die of AIDS-related illness in sub-Saharan Africa than of any cause.” Yet, very little has been done to assess the impact of HIV/AIDS on persons with disabilities (Groce et al 2008, 4). Consequently, persons with disabilities are constantly at risk of becoming HIV-positive, and once they contract the disease, they are much less likely to obtain assistance or services (McElliot 2003). In some quarters it is believed that persons with disabilities are asexual and therefore do not require sexual education (Groce et al 2008, 4), although in reality they are sexually active and may have unprotected sex (Baines et al 2018, 1). In eSwatini, for instance, a deaf man was refused an HIV test at his local clinic, because the clinic staff claimed that deaf people are not vulnerable to the disease. This even though the man had had five sexual partners in a

year and was very concerned about his HIV status (Sweeney 2004, 24). The belief that persons with disabilities are asexual is widespread. In a workshop, a woman with a disability commented:

Using us and infecting us with AIDS, many people think a disabled person is safe from HIV/AIDS, maybe if she is just forced and raped. That shows how some people talk. So it's very easy for a disabled person to get HIV in that way (Yousafzai and Edwards 2004, 46–47).

Furthermore, persons with disabilities encounter physical barriers to accessing HIV-related services dealing with prevention, testing, counselling and other needs (Groce 2004), largely because these services are often located far away from the beneficiaries in urban areas. As stated by the woman with a disability above, persons with disabilities, specifically women and children, are highly at risk of sexual violence, which exposes them to a higher risk of contracting HIV (UNFPA 2018). In Africa, the vulnerability of women with disabilities to sexual violence, rape and HIV is aggravated by a well-known myth that sex with a disabled person will cure AIDS – presumably an even more twisted version of the so-called “virgin cure” that is based on the common misconception that persons with disabilities are not sexually active and therefore have to be virgins (Kamga 2011). A woman with disabilities testifies in these words: “One time I went to workshop, someone had AIDS, the man was sick and when he went for the witchcraft, he was advised to rape a disabled girl, the disabled girl was raped” (Yousafzai and Edwards 2004, 46–47). In addition, rapists target women with disabilities as they are more vulnerable, being unable to run away if they are physically impaired, scream if hearing impaired and unable to speak, and unable to identify the rapist later if they are visually impaired (Kamga 2011).

Malawian persons with disabilities are no exception to the bleak picture of vulnerability described above. The Government of Malawi expressly recognises that the sexuality of its citizens with disabilities

is rarely appreciated and therefore infrequently discussed [as] disabled persons are presumed not to have sexual desire, which may yet be another reason why information about HIV and AIDS does not reach these groups.<sup>4</sup>

Moreover, research conducted by the Southern Africa Federation of the Disabled (SAFOD) shows that in Malawi, besides “the virgin cure” belief associated to HIV/AIDS and the sexuality of persons with disabilities discussed earlier (SAFOD 2008, 12), there is a belief that having sex with persons with disabilities is a traditional medicine which increases wealth (SAFOD 2008, 8). These beliefs increase the vulnerability of persons with disabilities to rape and HIV, hence the correctness of the

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<sup>4</sup> Malawian National Policy on Equalisation of Opportunities for Persons with Disabilities (2005) 5.



observation that Malawian persons with disabilities are “particularly affected by and vulnerable to HIV and AIDS”.<sup>5</sup>

In addition, the vulnerability of persons with disabilities is exacerbated by poverty. Groce correctly observes:

The roughly 600 million individuals who live with a disability are among the poorest, least educated, and most marginalised of all the world’s peoples. They are at serious risk of HIV/AIDS and attention needs to be focused on them (Groce 2003, 1402).

There have been reports that, as a consequence of poverty, women with disabilities have sexual relations with any man who may assist them merely with food (SAFOD 2008, 13). This was explained by a woman with disabilities in Uganda in these words:

you might get a bad friend who may advise you that if you know you don’t have money, you can go and love the other boy so that he can give you money and if you follow that bad advice, you can easily be attacked by AIDS (Yousafzai and Edwards 2004, 46–47).

Besides the risk of becoming promiscuous because of poverty, penury can also hinder the ability of persons with disabilities to reach the HIV-testing centres merely because they lack the necessary bus fares. Unaffordability is responsible for similar circumstances elsewhere: in Kenya, there were reports of deaf people refusing to go to the medical centres because they could not afford the services of an interpreter (Ombara 2004). Hanass-Hancock (2009, 7) summarises the vulnerability of persons with disabilities to HIV as follows:

Persons with disabilities are more likely to believe in wrong modes of transmission; are less likely to receive information and resources to ensure “safer sex” because common prevention programmes do not include disability-specific approaches; are more likely to be excluded from or deprived of education, particularly sex education; are at increased risk of violence and rape and are also without legal protection; are, as children, particularly vulnerable because parents (in particular, fathers) might desert children; have less access to testing and treatment because transport and medication might be unaffordable, clinics might not be accessible, voluntary counselling and testing might not be disability specific, or counselling may violate basic requirements of confidentiality; are marginalized, and the double stigma of disability plus HIV/AIDS might make it difficult to disclose HIV status, particularly in the case of women who depend on their families, friends, boyfriends or husbands.

The vulnerability of persons with disabilities to HIV cannot be over-emphasised. This is recognised by the Malawian government, which, as the primary entity responsible for

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<sup>5</sup> Malawian National Policy on Equalisation of Opportunities for Persons with Disabilities, 5.

ensuring that human rights are upheld in the country, must take action to resolve the issue. Such action is the focus of the next section.

## **Incorporation of Disability into HIV Programming in Malawi**

This section examines Malawi's commitment to international and African regional laws pertaining to the inclusion of persons with disabilities in HIV programming, and focuses on their implementation through national policies on HIV and disability.

### **Malawi's Commitment to International Law**

At the international level, the Universal Declaration on Human Rights (UDHR),<sup>6</sup> the International Covenant on Economic Social and Cultural Rights (ICESCR),<sup>7</sup> the UN Convention on the Rights of the Child (CRC),<sup>8</sup> the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities<sup>9</sup> and the UN Convention on the Rights of Persons with Disabilities (CRPD)<sup>10</sup> provide for the right to health of all, including persons with disabilities. It is worth noting that Malawi is a signatory to all of these instruments.<sup>11</sup> The UDHR provides for the right to health for "everyone" and, more importantly, the right to medical care "... in the event of disability" (Article 25).

Although the ICESCR does not expressly mention persons with disabilities, they are protected by Article 2(2), according to which "the right to health should be exercised without discrimination of any kind" based on numerous grounds and "other status" such as disabilities. The General Comment No 5 (para 5) of the Committee on Economic Social and Cultural Rights clearly prohibits discrimination based on "other status", which can include discrimination based on disability. In the same perspective, the committee explains that "disability-based discrimination" includes any distinction based on disability or the denial of reasonable accommodation of a disability which restricts a person's ability to enjoy the benefit of their socio-economic rights (General Comment No 5, para 5). Moreover, General Comment No 14 explains the right to the highest attainable standards of health as provided by Article 12 of the ICESCR. In doing so, it clearly specifies that the availability of and the accessibility to (including non-

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<sup>6</sup> UDHR adopted by the UN General Assembly, on 10 December 1948.

<sup>7</sup> Adopted by the UN General Assembly Resolution 2200A (XXI) of 16 December 1966, came into force entry into force 3 January 1976.

<sup>8</sup> Adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989; entered into force on 2 September 1990.

<sup>9</sup> Adopted in 1993.

<sup>10</sup> Adopted by the General Assembly in December 2006, was opened for signature in March 2007 and came into force on 3 May 2008.

<sup>11</sup> Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted in 1979 and ratified by Malawi on 12 March 1987; CRC that Malawi ratified on 2/01/1991, ICCPR on 22/12 1993, ICCPR Optional Protocol on 11 June 1996; ICESCR on 22 December 1993.

discrimination, physical accessibility, affordability and information accessibility) the right to health and healthcare are applicable to persons with disabilities living with HIV (Elliot et al 2009). The CRC (Article 2) forbids discrimination on a range of grounds, including “disability”, and highlights that a

mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community (Article 23).

However, although international law protects the right to health of persons with disabilities, this protection is incidental because these persons are generally protected under general provisions prohibiting discrimination. They are protected under the prohibition of discrimination measures based on “other status”. Stein and Lord aptly note that

[t]he principal difficulty with this approach is that existing human rights obligations are not tailored to address the specific barriers faced by persons with disabilities in the realisation of their human rights (Stein and Lord 2009, 19).

In the same vein, Kayess and French argue that incorporating the rights of persons with disabilities in a universal provision will not enhance “the recognition and respect” of the rights of the beneficiaries because:

[t]o a significant extent, the traditional human rights paradigm is based on an “able-bodied” norm [and that] [i]n most cases it is not self-evident how traditional human rights are to be interpreted and applied in a manner that will penetrate to the specific human rights violations to which persons with disability are subject (Kayess and French 2008, 3). In fact, international instruments present a catalogue of formal equality between able-bodied people and persons with disabilities without any real attempt to ensure substantive equality that can be obtained through the prescription of specific measures to accommodate persons with disabilities in all aspects of society in general and to ensure their right to health in particular. Even the CRPD, the main international treaty on the rights of persons with disabilities, does not refer expressly to HIV/AIDS. This omission is harmful to mainstreaming disability into HIV programming.

Nevertheless, as correctly observed by Gerntholtz et al,

key concepts within the CRPD are relevant to the protection of people with disabilities from HIV, as well as to the protection of the rights of people living with HIV who experience disablement (Gerntholtz et al 2010, 9).

For instance, concepts such as “universal design” (CRPD, Article 2) and “reasonable accommodation” (CRPD, Article 2) are vital to ensuring that persons with disabilities

who are HIV-positive are provided with the same rights to health and HIV-related treatment, products and services as other members of society. This is clearly highlighted by Article 25(a) of the CRPD, which calls on state parties to:

Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes (Peak 2009, 2).

It could therefore be argued that international law provides a good framework for protecting the right to health of persons with disabilities. The efficient implementation of this law at the domestic level would lead to mainstreaming disability into HIV programming.

More importantly, though, Malawi subscribes to the dualist approach to international law. According to this approach, an international treaty can be cited in a domestic court only after its domestication by an Act of Parliament (s 211(1) of the Constitution); moreover, the Constitution (s 11(2)(c)) empowers judges to consider public norms of international law and foreign case law when interpreting the Constitution. This provision is important as it can be used to ensure that the right to health of all, including persons with disabilities, is enforced in the country through a consideration of international law by the courts. In *Thandiwe Okeke v The Minister of Home Affairs* (2001) the High Court held:

Apart from general law and constitutional provision emphasizing the right ... there are international instruments setting standards and aspirations which our legal system must aim to achieve. These obligations require our legal system to adopt systems of laws that accord citizens these rights and reduce the likelihood of undermining these rights. These instruments require authorities of member countries not to undermine these standards and principles in decisions affecting citizens.<sup>12</sup>

This was reiterated by the Malawian Supreme Court of Appeal in the MSCA Adoption Appeal No 28 of 2009.<sup>13</sup> This suggests that Malawian judges have the tools to protect disability rights. This means that even when national law is unclear on a question, the judiciary can rely on international law to interpret the local law to the benefit of persons with disabilities so as to ensure their full inclusion in society.

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<sup>12</sup> *Thandiwe Okeke v The Minister of Home Affairs* (Misc Civ Appl No 73 of 1977) decided on 8 July 2001 in the High Court of Malawi, as quoted in AIDS and Human Rights Research Unit *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law* PULP (2007) 88.

<sup>13</sup> Judgment Number 1 [2009] MWSC 1.

## Malawi's Commitment to African Regional Laws

As far as the African human rights system standards addressing HIV and disability are concerned, they are incorporated in the African Charter on Human and Peoples' Rights (ACHPR),<sup>14</sup> the Protocol to the African Charter on the Rights of Women in Africa (African Women's Protocol),<sup>15</sup> the African Charter on the Rights and Welfare of the Child (African Children's Charter),<sup>16</sup> the African Youth Charter,<sup>17</sup> the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa<sup>18</sup> and other non-binding continental undertakings.

The ACHPR protects persons with disabilities living with HIV through its general non-discrimination provision,<sup>19</sup> which was given effect by the African Commission in *Purohit & Others v The Gambia* (2003).<sup>20</sup> There, though non-expressly mentioned in the ACHPR, the commission affirmed disability to be a prohibited ground of discrimination. In addition, the ACHPR (Article 18(4)) protects persons with disabilities in providing that “[t]he aged and the disabled shall also have the right to special measures of protection in keeping with their physical and moral needs”, even though it is incorrect to combine the aged and the disabled as these are two different groups with different interests. According to this provision, persons with disabilities should be afforded a special measure of protection in the provision of healthcare, including HIV/AIDS-related services.

Moreover, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa African Women's Protocol (Maputo Protocol) also deals with HIV issues related to women with disabilities. The Maputo Protocol calls upon states parties to

take appropriate and effective measures to: enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public (Article 4(2a)).

In addition, under “Health and Reproductive Rights” (Article 14), among other things, states are obliged to ensure that “the right to health of women, including sexual and reproductive health is respected and promoted” (Article 14(1)):

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<sup>14</sup> Article 2; Malawi ratified this instrument on 17 November 1989.

<sup>15</sup> Adopted in 2003, entered into force in 2005, ratified by Malawi on 20 May 2005.

<sup>16</sup> Adopted in 1990, entered into force in 1999, ratified by Malawi on 16 September 1999.

<sup>17</sup> Adopted in 2006, entered into force 2009.

<sup>18</sup> Adopted on 18 January 2018.

<sup>19</sup> Article 2.

<sup>20</sup> (2003) AHRLR 96 (ACHPR 2003).

the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices (Article 14*d* and *e*).

More importantly, there are “Special Protection of Women with Disabilities” which entail the adoption of “specific measures commensurate with women with disabilities’ physical, economic and social needs ...” (Article 23(*a*)) and shield them from violence especially “sexual abuse, discrimination based on disability and the right to be treated with dignity” (Article 23(*b*)). Adopting “specific measures commensurate with women with disabilities” and shielding them from sexual violence will definitely lead to their inclusion into HIV programming.

Furthermore, the African Children’s Charter uses its non-discrimination provision (Article 3) to protect “every child”, including HIV-positive children with disabilities, from discrimination. In addition, the specific protection afforded to children with a disability (Article 13) is also valid for HIV-positive children with disabilities, and this too should be mainstreamed into HIV programming.

Following the trend set by the instruments discussed above, the African Youth Charter protects youths with a disability in a general non-discrimination provision which forbids discrimination on the ground of “race, sex ... and other status” (Article 2). To its credit and in compliance with international and regional laws, through one of its courts in the case of *The Republic v Evance Edison* (2014),<sup>21</sup> Malawi convicted Mr Edison for sexually abusing a girl with a disability and sentenced him to 14 years’ imprisonment. While this decision was in line with international and regional laws prohibiting discrimination on the ground of disabilities, it also complied with Article 41 of the Malawian Constitution, which reads as follows:

1. Every person shall have a right to recognition as a person before the law.
2. Every person shall have access to any court of law or any other tribunal with jurisdiction for final settlement of legal issues.
3. Every person shall have the right to an effective remedy by a court of law or tribunal for acts violating the rights and freedoms granted to him by this Constitution or any other law.

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<sup>21</sup> As quoted from The Republic of Malawi Combined Initial and Second Periodic Reports submitted by Malawi under article 35 of the Convention on the Rights of Persons with Disabilities to the Committee on the Rights of Persons with Disabilities, CRPD/C/MWI/1-2 of 8 March 2019.

In other words, the court clearly underlined the right to equality before the law, the right to access to court and the right to effective remedies to be enjoyed by all, including persons with disabilities.

Besides the binding instruments mentioned above, HIV and disability is also covered under non-binding undertakings such as the 1999–2009 African Decade for Disabled Persons extended until 2020; the 2007 Africa Campaign on Disability and HIV/AIDS, which aims for the incorporation of disability rights within HIV policies and programmes on the continent and the 2008 Kampala Declaration on HIV, which also aims to integrate disability into all aspects of national responses to HIV. While these instruments are non-binding at the regional level, they inform legislation and policies in Malawi and should be implemented.

Overall, notwithstanding that international and African regional laws do not expressly address the right to health of persons with disabilities, they do provide a framework which can ensure that persons with disabilities benefit from the same services available to able-bodied persons. A good translation of non-discrimination provisions and a satisfactory application of equality provisions strengthened with express provisions to accommodate persons with disabilities in national policies will make an enormous difference to protecting the rights of such persons in general and their right to be included into HIV programming in particular. As noted at the beginning of this section, Malawi subscribes to international and regional laws related to the right to health of persons with disabilities. What follows investigates the extent to which disability is mainstreamed into HIV policies in Malawi.

## **Malawian Legislation, Policies and Programmes on HIV and Disability**

The National AIDS Commission (NAC), which is the main coordinating institution of the HIV response in Malawi, was set up in 2001 under the office of the President and the Cabinet (AIDS and Human Rights Research Unit 2007, 90). Its mandate is to

facilitate policy development, guide the National HIV/AIDS Strategic Framework, facilitate policy and strategic planning in sectors and locally, built partnership among stakeholders, mobilise resources, monitor and evaluates and identify HIV research priority (AIDS and Human Rights Research Unit 2007, 90).

The NAC has spearheaded the adoption of various pieces of legislation and policies that address HIV. Nevertheless, as will be shown below, these national initiatives do not include persons with disabilities.

## National Legislation, Policies and Programmes on HIV

Malawi has undertaken various policy initiatives to tackle HIV/AIDS. However, as will be shown below, the trend has been that disability is not integrated into these policies. Persons with disabilities are protected by the Malawi Constitution that expressly recognises disability rights (Chapter 3, para *g*) and also uses the general prohibition of discrimination to protect PWDs (Chapter 4, s 20). More importantly, the state commits itself to “support the disabled through – greater access to public places; fair opportunities in employment; and the fullest possible participation in all spheres of Malawian society” (Chapter 3 para *g*(i), (ii) and (iii)).

None the less, policies aimed at inclusion do not incorporate disability into health and HIV issues, for two reasons: the first is that the prohibition of discrimination on the ground of disability provides formal equality and not substantive equality, as no measures are prescribed to accommodate persons with disabilities in society. In this context, equality simply becomes “a vacuous slogan and one that attracts derision and skepticism rather than serious attention”, to use Gwena’s (2011, 303) words. Secondly, when the state commits itself to supporting persons with disabilities, the commitment is incorporated in the non-justiciable fundamental principles of national policies. In other words, the provision is non-binding on the state. The same approach is used by the state in its provision on the right to health (Chapter 3, para *c*), which could have been a bridge with which to mainstream disability into health in general and into HIV programming in particular. Nevertheless, hope lies in section 30 of the Constitution, which reads:

All persons and peoples have a right to development and therefore to the enjoyment of economic, social, cultural and political development and women, children and the *disabled in particular* shall be given special consideration in the application of this right (Article 30(1); emphasis added).

This provision should be understood in connection with its second paragraph, which compels the state to

take all necessary measures for the realization of the right to development. Such measures shall include, amongst other things, equality of opportunity for all in their access to basic resources, education, *health services*, food, shelter, employment and infrastructure (Article 30(2); emphasis added).

This provision should be commended for the special emphasis it places on the “disabled” as well for prescribing access for all “to basic resources, education, *health services*, food, shelter, employment and infrastructure” in the context of the right to development. Not only are all basic necessities needed to mainstream disability into HIV programming included in this provision; access to health services and, consequently, HIV-related services are expressly provided for. Yet, as will be shown in



the analysis of policies below, Article 30 of the Constitution has yet to be given effect so as to benefit persons with disabilities.

In fact, key national HIV/AIDS policies such as Malawi's National Response to HIV/AIDS for 2000–2004 (2000), which aimed to combat HIV/AIDS with renewed hope and vigor in the New Millennium, the 2003 HIV/AIDS Policy and the Strategic Framework of Action for the Transport Sector in Malawi are strangely silent on mainstreaming disability. Even though the 2003–2006 Strategy for the Health Sector Response to HIV/AIDS in Malawi acknowledges that “people with disabilities are more vulnerable to the risks of HIV infection”,<sup>22</sup> it does not prescribe any specific measure to integrate disability into HIV programming. When these policies list HIV/AIDS implementing agencies that comprise religious, youth, gender and non-governmental organisations (NGOs), no explicit reference is made to disabled people organisations (DPOs).<sup>23</sup>

Indeed, it could even be argued that Malawi excludes persons with disabilities from its HIV-related services because of the constant neglect of persons with disabilities in its HIV policy framework. For instance, the 2000–2004 Malawi National HIV/AIDS Strategy Framework that aimed, among other things, to develop the economic skills of men, boys, girls and women<sup>24</sup> is silent on persons with disabilities. Similarly, the 2005–2009 National HIV/AIDS Action Framework (NAF), in attending to the prevalence and incidence of HIV in the country (para 1.4.2), does not include persons with disabilities. In the same vein, the analysis of the impacts of HIV also ignores persons with disabilities. This same approach is mirrored in the Ministry of Health's Prevention of Mother to Child Transmission of HIV (Ministry of Health 2008), the Treatment of AIDS Guidelines for the use of Antiretroviral Therapy in Malawi (Ministry of Health 2008), and the 2010–2012 Malawi HIV & AIDS Extended National Action. It is disquieting to note that none of these policies includes the needs of those who are blind, unable to hear, unable to walk or who have other disabilities. Even though it was reported that the National AIDS Commission, as the HIV and AIDS national funding agency, has funded some DPOs to run HIV and AIDS programmes (Malawi Sate Report 2016, para 165), the impact of this assistance has been minimal.

So far, education had been identified as one of the most efficient measures for preventing HIV (World UNAIDS 2002), and has been correctly labelled as a “social vaccine” for HIV (Coombe and Kelly 2001). But a large group of vulnerable persons – persons with disabilities – in Malawi are simply deprived of this “vaccine” against HIV: they have little or no access to HIV education, prevention services and treatment

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<sup>22</sup> The 2003–2006 Strategy for the Health Sector Response to HIV/AIDS in Malawi, 23.

<sup>23</sup> The Malawi National HIV/AIDS Strategy Framework 2000–2004.

<sup>24</sup> See component 3 of the Strategy Framework on “Socio Economic Status and HIV”.

because information is not available in appropriate formats for them. During the SAFOD (2008, 11), research in Malawi alluded to earlier, a woman with disability said:

In most cases we, as disabled women, find it difficult to access awareness talks on planning methods because we are sidelined in society. When it comes to door to door campaigns, if they see that in this house there is a disabled woman, they just pass by and go to an able-bodied woman because they have nothing to do with PWD and yet we also need such services. It is therefore, very difficult for PWD to access such information.

From the same perspective, in its report to the UN Committee on the Right of Persons with Disabilities, the Malawi government (2016, para 166) writes:

They [persons with disabilities] do not access health services at the same rate as others because of their disabilities. For instance, there is lack of health specialist medical personnel who are able to understand health problems as communicated by persons with disabilities especially those with hearing, speech, visual and intellectual impairments. The situation is worse in rural areas where rehabilitation services are inadequate. Further, there are no accessible beds in the labour wards for women with physical disabilities.

Still in Malawi, the lack of education of persons with disabilities on HIV was noted during a discussion at Montfort School for the Blind, where false perceptions of how the disease can be contracted were voiced. A blind student said “the virus can be contracted through sharing a cup of water with the infected person’s spit”. Another student disagreed and argued that “the virus could only be transmitted if one bathed a patient without gloves on when he/she has cuts or bruises in the hands and not through sharing a cup of water” (SAFOD 2008, 2). This led Munthali (2011, 13–14) to argue that the failure to provide adequate information on HIV to persons with disabilities will hinder the ability of Malawi to deal with the pandemic. It is, however, important to note that the neglect of persons with disabilities in HIV-related matters is not unique to Malawi. In eSwatini, persons with disabilities were of the view that HIV could be contracted from “toilets, inhaling in dirty places, kissing (and) sharing bowls and utensils”. More disturbing is the fact that in a research study involving 36 persons with disabilities, only three believed that HIV testing was important to find out one’s HIV status (Sweeney 2004, 23).

The neglect of persons with disabilities is also a reality in south-east Kenya, where a deaf woman seeking contraception at the clinic was given condoms but no instructions on how to use them, and none of the condoms’ wrapping contained information on how to use them. As a result, the woman swallowed several condoms and had to be brought back to the same clinic suffering from stomach ache (Sweeney 2004, 22). This led to the following explanation from Gitonga Kiraithe, who works for the Blind & Low Vision Network in Kenya:

The majority of our members know very little about the modes of transmission and the various facts related to this disease. Many have not touched a condom. A few have confessed to having sex indiscriminately and using no precautionary measures. We have not yet come across any member who has visited the VCT centre. Many blind persons complained of it as not being “blind-friendly”. The personnel at these centres are not trained in the skills required to handle (blind people). They have been accused of asking offending questions and wonder loudly whether blind persons can engage in sexual intercourse ... The sighted members of society have always thought that blind persons do not engage in sexual activities (Sweeney 2004, 24).

This shocking observation shows graphically how persons with disabilities are excluded from national policies on HIV/AIDS. In this regard, persons with disabilities who are unable to communicate without a sign-language interpreter are of the view that there is no privacy at such testing centres and consequently stay away from those that may be too far for those who cannot walk to them and those who cannot afford transport. These centres are also too far for those who have to use wheelchairs with no one to push them, and too far for a blind person who lacks information in Braille and who has no trustworthy guide (SAFOD 2008, 13).

As mentioned earlier, the exclusion of persons with disabilities from HIV programming is widespread in Malawi as well as in other African countries. Not surprisingly, the statistics collected during a review of the National Strategic Plans (NSP) on HIV and AIDS NSPs of the 18 focus countries of eastern and southern Africa (ESA) indicated that persons with disabilities are still excluded. The report exposes five important points:

- First, all of the countries have multi-sectoral institutions that conduct the national response to HIV, but only three countries (Rwanda, Seychelles and South Africa) particularly include persons with disabilities on their coordinating structures. Most of these countries therefore violate the right to participation of persons with disabilities on issues affecting their lives; the vital principle of “nothing about us without us” is therefore violated.
- Secondly, although most countries identify and target key populations at higher risk of HIV exposure in their national response to HIV, fewer than half of the countries surveyed classify persons with disabilities as a key population.
- Thirdly, all the countries have strategies to protect and promote human rights in the context of HIV within their NSPs; however, only three countries (Lesotho, South Africa and eSwatini) explicitly incorporate protection for the rights of persons with disabilities.
- Fourthly, only 50 per cent of the countries make available HIV-related prevention services for persons with disabilities, and even fewer countries provide for treatment, care and impact mitigation services.

- Finally, although all the countries provide for HIV programmes to be monitored and evaluated, only three countries (the Democratic Republic of Congo (DRC), Namibia and eSwatini) refer particularly to the collection of data on disability and HIV (Gernholtz et al 2010, 11).

These statistics clearly demonstrate that several African countries' responses to HIV do not include persons with disabilities – who are not considered as a group at risk. Consequently, they do not receive prevention services and very few countries in the group surveyed provide treatment, nor do they even attempt to collect data on disability and HIV. In short, HIV-positive persons with disabilities are simply excluded from HIV policies and outreach (Kamga 2013, 21). McElligott correctly points out that

[m]ajor gaps in national HIV/AIDS prevention campaigns and treatment programs have made disabled people more vulnerable to HIV infection than their non-disabled counterparts (McElligott 2003).

In Malawi, the blatant neglect of the right to health of persons with disabilities happens in violation of the 2003 National HIV/AIDS Policy: a call for renewed action in which the government explicitly commits itself to

ensure that HIV-related prevention information, education, treatment, care and support strategies are tailor-made for and accessible to people with disabilities; ensure that all decision-making fora and structures provide for the full and active participation of people with disabilities; and to ensure that all responses to HIV/AIDS consider the implications for people with disabilities and plan for more effective responses based on models of national and international best practice.<sup>25</sup>

Unfortunately, this call was ignored, because in 2016 a country report also claimed that the HIV and AIDS Policy of 2005

does not recognize disability as a cross-cutting issue and its importance cannot be over-emphasised for purposes of interventions and programming in HIV and AIDS (Government of Malawi 2016, para 48).

Before focusing on what must be done to mainstream disability into HIV programming in Malawi, it is important to investigate whether specific disability policies in Malawi provide solutions for HIV-positive persons with disabilities.

### **Specific Disability Laws and HIV**

Specific disability laws and policies include:

- the Constitution (which provides for the right to equality);

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<sup>25</sup> See para 5.11.1 "Policy Statement".

- the 1971 Handicapped Persons Act;
- the 2005 National Policy on Equalisation of Opportunities for Persons with Disabilities, and
- the 2012 Disability Act.

The Handicapped Persons Act of 1971 basically sets up the Malawi Council for the Handicapped, which oversees the promotion of the welfare of persons with disabilities. According to this Act, the Council of the Handicapped informs the minister on issues pertaining to persons with disabilities and takes care of training centres and rehabilitation and welfare services for persons with disabilities. Even though it could be argued that rehabilitation centres are able to provide HIV/AIDS-related services to persons with disabilities, the Handicapped Persons Act is completely silent on the matter of HIV.

However, the National Policy on Equalisation of Opportunities for Persons with Disabilities (2005, 14) was the first specific instrument to attempt to put persons with disabilities at the same level with other Malawians. The aim of this policy is to

integrate fully persons with disabilities in all aspects of life thereby equalizes their opportunities in order to enhance their dignity and well-being so that they have essentials of life.

In addressing the plight of HIV-positive persons with disabilities, the policy includes HIV/AIDS in its priorities (Priority area 3) with the objectives to “[p]romote access to HIV/AIDS information and health care by persons with disabilities” and “empower persons with disabilities to develop and maintain safer sexual and reproductive health practices”. In order to realise these objectives, the strategies employed revolve around:

- increasing consciousness on HIV/AIDS among all persons with disabilities;
- involving DPOs in publicising information about HIV/AIDS to persons with disabilities;
- encouraging these persons to go for voluntary counselling and testing.

It is also necessary to support relevant projects or programmes that include orphans with disabilities, promote discussion and openness about sex and sexuality among persons with disabilities, and encourage safe sex and reproductive health practices among persons with disabilities (National Policy on Equalisation 2005, 24).

But although the government should be commended for enacting this National Policy on Equalisation of Opportunities for Persons with Disabilities, it is worth noting that the obvious exclusion of persons with disabilities from HIV programming described earlier occurred while the policy was in force. This shows that its implementation was

questionable, hence the government went back to the drawing board and adopted the “Disability Act [to] ensure the protection of the rights of the disabled”.

The 2012 Disability Act provides a comprehensive coverage of disability rights. It calls upon the government to adopt policies and legislation on the equalisation of opportunities to “promote and protect the rights of persons with disabilities; and fully include them in all aspects of life, to enhance their dignity and well-being”.<sup>26</sup> It prohibits discrimination on the ground of disability in all areas of life and ensures that a person who contravenes the law is fine or imprisoned. Furthermore, a Disability Trust Fund is set up to support the implementation of disability programmes and services.<sup>27</sup> Regarding health services, the government is compelled to

provide appropriate health services to persons with disabilities, including prevention, early identification, intervention and other services designed to minimize and prevent the occurrence of more disabilities.<sup>28</sup>

This initiative covers those who are HIV-positive; more importantly, by seeking to minimise and prevent the cause of disability, HIV should be included as it weakens the body and may therefore cause disability.

The Disability Act also attempts to mainstream disability into HIV programming by calling upon the state to

provide persons with disabilities the same range, quality and standard of free or affordable health care services as provided to other persons, including sexual and reproductive health services and population based public health programmes (s 6(2)(c)).

Furthermore, the government must “develop national guidelines, minimum norms and standards for the provision of assistive devices and personal assistants to persons with disabilities” (s 6(2)(f)). This provision should lead to the provision of Braille and other assistive devices commensurate with people’s disabilities to enable them to take part in HIV campaigns, education, screening, treatment, prevention and other strategies or methods to tackle the disease.

Although this provision clearly addresses the right to health of persons with disabilities, it would have been better also specifically to mention HIV/AIDS, which was a key priority in the National Policy on Equalisation of Opportunities for Persons with Disabilities. Nevertheless, it is hoped that, in adopting policies and passing legislation on the equalisation of opportunities for persons with disabilities as prescribed by the

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<sup>26</sup> Part II “Adoption of policies and legislation”, paras *a* and *b*.

<sup>27</sup> Part V “Disability Trust Fund”, ss 28 and 29.

<sup>28</sup> Part IV “Rights of persons with disabilities”, s 6(1).

Act,<sup>29</sup> the government will specifically focus on mainstreaming disability into HIV programming through guidelines, directives or guiding principles. In doing so, the following strategy could be considered.

## **Suggested Framework for mainstreaming Disability into HIV Programming**

Numerous approaches could be adopted to mainstream disability into HIV programming, so the suggestions made here are not exhaustive. It is, however, important always to ensure that HIV-positive persons with disabilities:

- are reached by HIV messages;
- access HIV-prevention educational materials and condoms;
- access HIV/AIDS-related services, and
- access AIDS-related medicines, care and social support schemes (Groce et al 2008).

Incorporating the human rights and needs of persons with disabilities into national HIV strategic plans and policies and raising awareness about the link between HIV and disability should be the *motto* of the government. To ensure that HIV messages are accessible to persons with disabilities, it is important to start by giving AIDS educators, outreach workers, and clinical and social service staff the capability to deal with disabilities and the challenges encountered by persons with disabilities. In addition, persons with disabilities should be trained to be AIDS educators or outreach workers, and to ensure and maintain the visibility of persons with disabilities (eg a wheelchair-user) in HIV/AIDS announcements, posters and other forms of public notice.

A promising practice worthy of emulation came from Kenya, where a clear link between disability and HIV was established by the Kenyan National AIDS Control Council, which funded HIV/AIDS-related activities. Furthermore, Miss Disability Kenya, Susan Mwikali, together with the president's wife, featured in a commercial on HIV/AIDS using sign language, targeting deaf people (Ombara 2004). Even though this advertisement did not reach most of its target groups as television stations charged a lot of money to air the announcement, such initiatives, coupled with more resources to ensure the dissemination of the advertisement, would have a positive impact. Not only would it reduce or eradicate the stigma attached to disability; it would also show that persons with disabilities are sexual beings just like every other member of society (Sweeney 2004). Indeed, it would "be an effective awareness-raising campaign" on disability rights (Sweeney 2004, 35).

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<sup>29</sup> Part II, s 3(1).

Similarly, persons with disabilities should be included on a research team designing, implementing and analysing the research related to HIV and disability (OHCHR, WHO and UNAIDS 2009, 5 and 7). In this vein, it will be necessary to disseminate HIV/AIDS information in various formats such as Braille, on television with sign-language interpreters, or in the form of compact discs (CDs) and other accessible means. This would build the confidence of persons with disabilities to approach HIV/AIDS centres and institutions. In fact, it is necessary to research and develop well-designed HIV-related health goods, services (testing and counselling), equipment and facilities in order to ensure that they meet the specific needs of persons with disabilities. Furthermore, the accessibility of HIV/AIDS centres should be ensured, where assistance is tailored to the nature of the disabilities. For instance, a blind person should not only be told about a condom, but should be allowed to touch and understand what a condom is, how to use one, and where to obtain them.

Understandably, this will not be an easy task, because, in the first instance, there are several forms of disability which are anchored in culture and context (Lawson 2001) and therefore very difficult to define and deal with. The other hurdle is that most persons with disabilities are uneducated and may struggle to understand the messages. However, working in partnership with various DPOs would mitigate the challenges and enhance the prospects of better incorporation of disability into HIV programming. Peake (2009, 2) is of the view that a sustained dialogue between disability and HIV/AIDS networks on mechanisms for the exchange of research and good practices will make a significant difference in the lives of HIV-positive persons with disabilities.

The other challenge to mainstreaming disability into HIV programming revolves around funding, because training AIDS workers on disability, obtaining assistive devices, employing sign-language interpreters, ensuring the accessibility of buildings and transport and providing sex education to persons with disabilities can be expensive. However, persons with disabilities are not second-class citizens and should be accommodated in society, which means that they should be given the same opportunities as able-bodied individuals. Suitable budgetary provision should therefore be made for the protection of disability rights. In this regard, Malawi should be commended for establishing a Disability Trust Fund for persons with disabilities in order to support the implementation of disability programmes and services.<sup>30</sup> Nevertheless, it is important to note that for this fund to improve the lives of HIV-positive persons with disabilities, HIV/AIDS outreach endeavours incorporating persons with disabilities must be permanent, not be a “one time or isolated effort” (Groce et al 2008, 14), but one incorporated into sustainable HIV programming.

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<sup>30</sup> Malawi Disability Act, Part V ‘Disability Trust Fund’, ss 28 and 29.



Furthermore, persons with disabilities will be protected from HIV only if they are included as participants and subjects in monitoring and evaluation schemes related HIV. This means that persons with disabilities must take part in the research and should also be included in the key populations at risk who are the subject of the research. Besides government initiatives, NGOs in general and DPOs in particular should be at the forefront of plans for the inclusion of disability into HIV programming. They should campaign, design projects on the issue and work in cooperation with the government to ensure that persons with disabilities are not forgotten when HIV policies are enacted and implemented.

A positive example of this worth mentioning came from the African Union of the Blind (AFUB), a pan-African NGO that led an Africa-wide initiative for HIV/AIDS education for blind people which normally works to prevent disabilities (Sweeney 2004, 30). A second example came from the Kenya Union for the Blind (KUB). It ran a one-year HIV/AIDS-awareness programme in Nairobi Province. Also, the Kenya Programmes of Disabled Persons (KPDP) based in Nairobi campaigned for access for persons with disabilities to quality healthcare and ran HIV/AIDS programmes for this group (KDP, 2003). The involvement of more of these DPOs would surely boost the initiative to incorporate disability into HIV programming.

## **Conclusion**

This article set out to investigate the extent to which disability is incorporated into HIV programming in Malawi. In responding to this investigation, the article engaged with the debate on HIV/AIDS and disability to show that while some countries assimilate HIV/AIDS with disability, others do not, instead provide separate discrimination legislation to address both issues. It demonstrated that persons with disabilities in general and those in Malawi in particular are very vulnerable to HIV/AIDS. Notwithstanding Malawian compliance with international and regional human rights standards for the protection of the right to health of all, including persons with disabilities, very little has been done at the national level to ensure that these individuals benefit from HIV/AIDS-related services and treatment. Although the adoption of the 2012 Disability Act brought some hope to persons with disabilities who have HIV/AIDS, measures adopted to give effect to this Act must expressly establish a link between HIV and disability. These measures must prescribe persons with disabilities' involvement in all campaigns, training, research and other activities related to HIV. Moreover, the human rights and needs of persons with disabilities must be fully integrated into national HIV strategic plans and policies and accounted for in budgetary provisions. In addition to the government's action, DPOs should be actively involved in ensuring that no stone is left unturned in striving towards the successful incorporation of disability into HIV programming. Given that HIV is the greatest pandemic in Africa, the measures recommended here should not be applicable to Malawi alone. They should

be extended to the entire continent, which has a high number of persons with disabilities who need to be protected from HIV, especially if the fight against the virus is to be won.

## References

- Acknowledgement: I am grateful to the National Research Foundation of South Africa, which provided funding to conduct the research for this article. Grant/Award Number: 109395.
- AIDS and Human Rights Research Unit. 2007. *Human Rights Protected? Nine Southern African Country Reports on HIV, AIDS and the Law*. Pretoria: PULP.
- AIDS Law Project and the AIDS Legal Network (eds). 2001. *HIV and the Law: A Resource Manual* (2nd ed). Johannesburg: AIDS Law Project.
- Baines, S, Emerson, Robertson, J and Hatton, C. 2018. “Sexual Activity and Sexual Health among Young Adults with and without Mild/Moderate Intellectual Disability”. *BMC Public Health* 18(667): 1–12. Available at <<https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-018-5572-9>>. <https://doi.org/10.1186/s12889-018-5572-9>
- Barrett-Grant, K, AIDS Law Project (University of the Witwatersrand), Aids Legal Network (South Africa) and AIDS Legal Network. 2003. *HIV and the Law: A Resource Manual* (3rd ed). Johannesburg: Wits University Press.
- Burgstahler, S and Doe, T. 2014. “Disability-related Simulations: If, When, and How to use Them in Professional Development”. *Review of Disability Studies: An International Journal* 1(2): 4–17.
- Burton, G, Sayrafi, I and Abu Srour, S. 2013. “Inclusion or Transformation? An Early Assessment of an Empowerment Project for Disabled People in Occupied Palestine”. *Disability & Society* 28(6): 812–825. <https://doi.org/10.1080/09687599.2013.802223>
- Chappell, AL, Goodley, D and Lawthom, R. 2001. “Making Connections: The Relevance of the Social Model of Disability for People with Learning Difficulties”. *British Journal of Learning Disabilities* 29(2): 45–50. <https://doi.org/10.1046/j.1468-3156.2001.00084.x>
- Chilemba, EMC. 2014. “Malawi”. *African Disability Rights Yearbook* 2: 207–226.
- Coombe, C and Kelly, M. 2001. “Trends/Cases: Education as a Vehicle for Combating HIV/AIDS” *Prospects* XXXI 3: 493–445. <https://doi.org/10.1007/BF03220082>
- Elliott, R, Utyasheva, L and Zack, E. 2009. “HIV, Disability and Discrimination: Making the Links in International and Domestic Human Rights Law”. *Journal of the International AIDS Society*. Available at <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2788342/>> (accessed 10 July 2019). <https://doi.org/10.1186/1758-2652-2-4>

- Gerntholtz, L, Grant, K and Hanass-Hancock, J. 2010. “Disability Rights and HIV/AIDS in Eastern and Southern Africa: A Review of International, Regional and National Commitments on Disability Rights in the Context of HIV/AIDS in Eastern and Southern Africa”. Available at <<https://www.k4health.org/sites/default/files/disability-rights-and-hiv-aids-in-eastern-and-southern-africa.pdf>> (accessed 16 May 2019).
- Government of Canada. Minister of Health. 2009. HIV/AIDS and Disability: Final Report of the 4th International Policy Dialogue. Available at <[http://data.unaids.org/pub/report/2009/20091111\\_hiv\\_and\\_disability\\_en.pdf](http://data.unaids.org/pub/report/2009/20091111_hiv_and_disability_en.pdf)> (accessed 13 July 2019).
- Government of Malawi. 2005. Malawi National HIV/AIDS Strategy Framework 2000–2004. Available at <[http://data.unaids.org/topics/nsp-library/nsp-africa/nsp\\_malawi\\_2000-2004\\_en.pdf](http://data.unaids.org/topics/nsp-library/nsp-africa/nsp_malawi_2000-2004_en.pdf)> (accessed 13 July 2019).
- Government of Malawi. 2007. The 2003–2006 Strategy for the Health Sector Response to HIV/AIDS in Malawi.
- Government of Malawi. Ministry of Health. 2008. *The Ministry of Health Prevention of Mother to Child Transmission of HIV: A Five-year Scale-up Plan 2008–2013* (3rd ed). Lilongwe: Ministry of Health.
- Government of South Africa. Ministry in the Office of the Deputy President. 1997. *White Paper on an Integrated National Disability Strategy*. Pretoria: Office of the Deputy President of South Africa.
- Government of South Africa. 2015. *White Paper on the Rights of Persons with Disabilities*. Available at <[https://www.ru.ac.za/media/rhodesuniversity/content/equityinstitutionalculture/document/White\\_Paper\\_on\\_the\\_Rights\\_of\\_Persons\\_with\\_Disabilities.pdf](https://www.ru.ac.za/media/rhodesuniversity/content/equityinstitutionalculture/document/White_Paper_on_the_Rights_of_Persons_with_Disabilities.pdf)> (accessed 14 July 2019).
- Groce, N. 2003. “HIV/AIDS and People with Disability”. *The Lancet* 361: 1401–1402. [https://doi.org/10.1016/S0140-6736\(03\)13146-7](https://doi.org/10.1016/S0140-6736(03)13146-7)
- Groce, N. 2004. *HIV/AIDS & Disability: Capturing Hidden Voices. Global Survey* Washington, DC: The World Bank. Available at <<http://siteresources.worldbank.org/DISABILITY/Resources/Health-and-Wellness/HIVAIDS.pdf>> (accessed 13 July 2019).
- Groce, N, Trasi, R and Yousafzai, AK. 2008. “Guidelines for Inclusion of Individuals with Disability in HIV/AIDS Outreach Efforts”. Washington, DC: World Bank. Available at <<http://www.nac.org.zm/sites/default/files/publications/HIV%20Guidelines%20on%20Disability.pdf>> (accessed 13 July 2019).

- Hanass-Hancock, J. 2009. "Disability and HIV/AIDS: A Systematic Review of Literature on Africa". *Journal of the International AIDS Society*. Available at <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2788347/pdf/1758-2652-12-34.pdf>>. <https://doi.org/10.1186/1758-2652-12-34>
- Inter-Parliamentary Union, UNAIDS and UNDP. 2007. *Taking Action against HIV: A Handbook for Parliamentarians*, No 15/2007. Available at <<file:///C:/Users/dkamgsa/Downloads/aids07-e.pdf>> (accessed 14 July 2019).
- Kamga, SD. 2011. "The Rights of Women with Disabilities in Africa: Does the Protocol on the Rights of Women in Africa offer Any Hope?" Barbara Faye Waxman Fiduccia Papers on Women and Girls with Disabilities. Available at <[http://www.centerwomenpolicy.org/programs/waxmanfiduccia/BFWFP\\_TheRightsofWomenWithDisabilitiesinAfrica\\_DoesTheProtocolonTheRightsofWomeninAfrica.pdf](http://www.centerwomenpolicy.org/programs/waxmanfiduccia/BFWFP_TheRightsofWomenWithDisabilitiesinAfrica_DoesTheProtocolonTheRightsofWomeninAfrica.pdf)> (accessed 16 May 2019).
- Kamga, SD. 2013. "A Call for a Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa". *African Journal of International and Comparative Law* 21(2): 219–249. <https://doi.org/10.3366/ajicl.2013.0060>
- Kayess, R and French, P. 2008. "Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities". *Human Rights Law Review* 8(1): 1–34. <https://doi.org/10.1093/hrlr/ngm044>
- Kenya Programmes of Disabled Persons (KPDP). 2003. 'KPDP: The Voice of Persons with Disabilities in Kenya'. Available at <[www.kpdp.kabissa.org/objectives.htm](http://www.kpdp.kabissa.org/objectives.htm)> (accessed 28 May 2019).
- Lawson, J. 2001. "Disability as a Cultural Identity". *International Studies in Sociology of Education* 11(3): 203–222. <https://doi.org/10.1080/09620210100200076>
- Malawi Combined Initial and Second Periodic Reports submitted by Malawi under article 35 of the Convention on the Rights of Persons with Disabilities to the Committee on the Rights of Persons with Disabilities, CRPD/C/MWI/1-2 of 8 March 2019.
- Malawi Country Operational Plan. 2017. *Strategic direction summary*. Available at <<https://www.pepfar.gov/documents/organization/272017.pdf>> (accessed 16 May 2019).
- Malawian National Policy on Equalisation of Opportunities for Persons with Disabilities. 2006. Available at <<http://www.malawi.gov.mw/images/Publications/policy/Malawi%20National%20Policy%20on%20Equalisation%20of%20Opportunities%20for%20Persons%20with%20Disabilities.pdf>> (accessed 13 July 2019).
- McElligott, M. 2003. "Disabled people at significantly increased risk of HIV infection". Available at <<http://allafrica.com/stories/200312020521.html>> (accessed 13 July 2019).

- Mizrachi, N. 2014. "Translating Disability in a Muslim Community: A Case of Modular Translation". *Culture, Medicine and Psychiatry* 38(2): 133–159. <https://doi.org/10.1007/s11013-013-9350-y>
- Munthali, AC. 2011. "A situation analysis of persons with disabilities in Malawi". Available at <<file:///C:/Users/dkamgsa/Downloads/situation-analysis-of-pwds-in-malawi-final-report.pdf>> (accessed 28 May 2019).
- Nario-Redmond, M, Noel, JG and Fern, E. 2013. "Redefining Disability, re-imagining the Self: Disability Identification predicts Self-esteem and Strategic Responses to Stigma". *Self and Identity* 12(5): 468–488. <https://doi.org/10.1080/15298868.2012.681118>
- OHCHR, WHO and UNAIDS. nd. Policy Brief "Disability and HIV Policy". Available at <[https://www.who.int/disabilities/jc1632\\_policy\\_brief\\_disability\\_en.pdf](https://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf)> (accessed 10 July 2019).
- Oliver, M. 2013. "The social model of disability: Thirty years on". *Disability & Society* 28(7): 1024–1026. <https://doi.org/10.1080/09687599.2013.818773>
- Ombara, O. 2004. "Beauty breaking the silence on HIV". *Daily Nation*. Available at <<https://allafrica.com/stories/200401140005.html>> (accessed 28 May 2019).
- Peake, S. 2009. "Meeting Report of the International Policy Dialogue on HIV/AIDS and Disability". *Journal of the International AIDS Society* 12: 27. Available at <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2788340/pdf/1758-2652-12-27.pdf>> (accessed 13 July 2019). <https://doi.org/10.1186/1758-2652-12-27>
- Southern African Federation of the Disabled (SAFOD). 2008. "The Call on HIV/AIDS and Reproductive Health Care amongst Disabled People". Available at <<https://assets.publishing.service.gov.uk/media/57a08bc4ed915d3cfd000f18/HIVandAIDS.pdf>> (accessed 16 May, 2019).
- Stein, M and Lord, J. 2009. "Future Prospects for the United Nations Convention on the Rights of Persons with Disabilities". Available at <[http://www.law.wisc.edu/m/zdq3n/2-20-09\\_stein-lord\\_future\\_prospects\\_for\\_un\\_on\\_disability\\_rights.pdf](http://www.law.wisc.edu/m/zdq3n/2-20-09_stein-lord_future_prospects_for_un_on_disability_rights.pdf)> (accessed 16 May 2019). <https://doi.org/10.1163/ej.9789004169715.i-320.14>
- Swart, L, Schneider, M and Rohleder P. 2006. "HIV/AIDS and Disability: New Challenges". In L Watermeyer, T Swart, M Schneider and M Priestley (eds) *Disability and Social Change: A South African Agenda*. Pretoria: HSRC, 108.
- Sweeney, J. 2004. "Double Exposure: Disability and HIV/AIDS in Sub-Saharan Africa". Available at <<https://asksource.info/ar/node/62986>>.

Touko, A, Mboua, CP, Tohmuntain, PM and Perrot, AB. 2010. “Sexual Vulnerability and HIV Seroprevalence among the Deaf and Hearing Impaired in Cameroon”. *Journal of the International AIDS Society* 13(5): 1–8. <https://doi.org/10.1186/1758-2652-13-5>

UNAIDS. Report on the Global AIDS Epidemic. 2010. Available at <[https://www.unaids.org/globalreport/Global\\_report.htm](https://www.unaids.org/globalreport/Global_report.htm)> (accessed 10 July 2019).

UNFPA. 2018. ‘Five Things You didn’t know about Disability and Sexual Violence.’ Available at <<https://www.unfpa.org/news/five-things-you-didnt-know-about-disability-and-sexual-violence>> (accessed 6 July 2019).

Yousafzai, A and Edwards, C. 2004. *Double Burden: A Situation Analysis of HIV/AIDS and Young People with Disabilities in Rwanda and Uganda*. London: Centre for International Child Health, Institute of Child Health, University College London, 46–47.

## Cases

Adoption Appeal No 28 of 2009 Judgment Number 1 [2009] MWSC.

*Bragdon v Abbott* 524 US 624 (1998).

*Purohit & Others v The Gambia* AHRLR 96 (ACHPR 2003).

*Thandiwe Okeke v The Minister of Home Affairs* (Misc Civ Appl No 73 of 1977).

*The Republic v Evance Edison* Criminal Case of 2014.

*X v Commonwealth* (1999) 167 ALR 529.

## Legislation and Conventions

African Charter on Human and Peoples’ Rights adopted in 1981 and entered into force in 1985.

African Charter on the Rights and Welfare of the Child Adopted in 1990, entered into force in 1999, adopted in 2006, entered into force 2009.

Constitution of the Republic of Malawi, 1998.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted in 1979.

Convention on the Rights of the Child, Adopted and opened for signature, ratification and accession by General Assembly Resolution, 44/25 of 20 November 1989 entry into force 2 September 1990.

Employment Equity Act 5 of 1998 (South Africa).

HIV and AIDS Act 31 of 2006 (Republic of Mauritius).

International Covenant on Civil and Political Rights adopted by the UN General Assembly Resolution 2200A (XXI) of 16 December 1966, came into force entry into force 3 January 1976.

International Covenant on Economic Social and Cultural Rights adopted by the UN General Assembly Resolution 2200A (XXI) of 16 December 1966, came into force entry into force 3 January 1976.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, adopted on 18 January 2018.

Protocol to the African Charter on the Rights of Women in Africa Adopted in 2003, entered into force in 2005, ratified by Malawi on 20 May 2005.

United Nations Commission on Human Rights: Sub-Commission on Prevention of Discrimination and Protection of Minorities. 1996. 'HIV/AIDS and Disability' Statement by the UNAIDS. 48 Session, August 1996 (on file with author).

United Nations Convention on the Rights of Persons with Disabilities, adopted by the General Assembly in December 2006, and came into force on 3 May 2008.

United Nations Standard Rules on the Equalization of Opportunities for persons with Disabilities adopted in 1993.

Universal Declaration on Human Rights adopted by the UN General Assembly, on 10 December 1948.