REPUBLIC OF MALAWI

CALL FOR INPUTS: QUESTIONNAIRE FROM THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE HIGHEST ATTAINALBE STANDARD OF PHYSICAL AND MENTAL HEALTH

1. While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction.

   a. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim?

   Harm reduction practices are currently taking place in hospitals, especially mental health hospitals;

   - **St John of God Hospitaller Services in Lilongwe offers Opioid substitution therapy, Nicotine replacement therapy, alcohol detoxification as well as a residential addiction recovery programme**
     - **Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Gambling Anonymous (GA) groups.**
   - **Kamuzu Central Hospital offers harm reduction services for;**
     - **Tobacco (screening, counselling, education, brief intervention, nicotine replacement therapy)**
     - **Alcohol (screening, counselling, education, brief intervention, detoxification, medication-assisted rehabilitation)**
   - **Zomba Mental Hospital offers harm reduction services for**

- **Alcohol (screening, counselling, education, brief intervention, detoxification)**
- **Private hospitals such as Mwaiwathu Hospital offer harm reduction services for alcohol and tobacco**

b. How successful have they been at achieving that aim? Please provide data, as possible.

- **The hospital-based harm reduction programmes are successful though the replacement therapies are expensive.**

2. How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region?

a. Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices?

- **Criminalization of drug use and drug possession for personal use**
- **Currently, Malawi has a draft policy on drug control in which harm reduction is a priority area**

b. Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.

- **stigma and discrimination towards people who use drugs**
- **violence against people from key populations**
- **inaccessible health services for key populations**

3. How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use?

Malawi still adopts the criminalization approach. The use of drugs is criminalized under the Dangerous Drugs Act.

Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.

4. Beyond reducing the adverse health, social, and legal consequences of drug use,
    a. **what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.**
    - **Antidiscrimination and protective laws to address stigma and discrimination**
    - **Review and revision of laws, policies and practices (including decriminalization of drug use and drug possession for personal use)**
    - **Available, accessible and acceptable health services for key populations**
    - **Enhanced community empowerment**
    - **Addressing violence against people from key populations**
5. What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities?
    - **The services are offered in hospitals only.**

    Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situations of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).
    - **Poor access to health services by key populations, limited and inequitable access to HIV prevention and treatment services.**
6. Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs?

Yes

Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?

Urban based facilities

- **Government hospitals (2),**
  - **Tobacco (screening, counselling, education, brief intervention, nicotine replacement therapy)**
  - **Alcohol (screening, counselling, education, brief intervention, detoxification, medication-assisted rehabilitation)**

- **Christian Hospitals (2)**
  - **Psychosocial intervention**
  - **Needle exchange programme**
  - **Opioid substitution therapy OST**
  - **Residential addiction recovery programme**

Private hospital (1)

7. Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population.

   - **Currently working on minimum service package for people who use drugs. (not yet started the services)**

   What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situations of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).

- **Opioid substitution therapy (OST) is expensive and once people are initiated will require maintenance which the government might not be able to sustain if the foreign assistance pulls out**

8. Are there programmes of research and innovation related to harm reduction from a right-to-health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education programmes, in your community, country, or region? Please provide good practices and examples.

    - **The opioid substitution therapy is done in one institution only which is not a public facility (St John of God Hospitaller Services).**