

# The Botswana Review of Ethics, Law and HIV/AIDS

Vol. 1 No. 1 2007

**BONELA**



**The Botswana  
Network on  
Ethics, Law  
and HIV/AIDS**

## **The Botswana Review of Ethics, Law and HIV/AIDS**

The *Botswana Review of Ethics, Law and HIV/AIDS* is a periodical published by the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) based in Gaborone, Botswana. BONELA is a prominent non-governmental organisation in the country, dedicated to creating an enabling and just environment for people infected and affected by HIV/AIDS through the integration of ethical, legal, and human rights dimensions into the national response to HIV/AIDS. BONELA is involved in research, training, advocacy, legal assistance and public education. The *Botswana Review of Ethics, Law and HIV/AIDS* is a peer-reviewed journal intended to create a participatory forum for critical and analytical discussion of a broad range of multi-sectoral issues and debates surrounding HIV and AIDS.

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## EDITORIAL

It is in a spirit of openness, co-operation and hope that the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) lays the foundation to this inaugural volume of the *Botswana Review of Ethics, Law and HIV/AIDS*. Based in Gaborone, Botswana, BONELA has since its inception, been a prominent non-governmental organization in the country, dedicated to creating an enabling and just environment for people infected and affected by HIV/AIDS through the integration of ethical, legal, and human rights dimensions into the national response to HIV/AIDS. BONELA works with communities, NGOs, community-based organizations, support groups of people living with HIV/AIDS, the private sector, development partners and the government. Consisting of an evolving network of several individual and organizational members, its activities include education, training and awareness raising, a media campaign, advocacy for change to law and policy, legal assistance and research and publications.

The cyclical relationship between HIV/AIDS and human rights is such that just as people with HIV/AIDS experience abuse of rights, vulnerability to the epidemic thrives on violations of rights. It has long been internationally recognized and confirmed that human rights protection and promotion are central to the response to HIV/AIDS, and universal access goals will not be achieved in the absence of human rights based approaches, in which they must be anchored. Such approaches will in effect help to resolve ethical dilemmas and realize the mutually reinforcing objectives of public health and human rights, towards human dignity and social justice.

The publication of this *Review* marks another milestone in the firm resolve of BONELA, to provide a transparent, constructive and participatory forum for discussion and dialogue on the multitude of multi-sectoral issues, debates and approaches to HIV/AIDS, in its mission to create an enabling environment. With this in mind, the editors of the *Botswana Review of Ethics, Law and HIV/AIDS* welcome, invite and look forward to contributions on a wide variety of relevant issues, from a broad diversity of disciplinary backgrounds, from Botswana and beyond.

The Editorial Committee would like to take this opportunity to thank Babafemi Odunsi whose determination to set up a literary forum for ideas led to the creation of the *Botswana Review of Ethics, Law and HIV/AIDS*. He had worked with BONELA for ten months, sharing his knowledge and experience. We welcome him onto the Editorial Advisory Board and wish him the very best in Nigeria where he has returned to resume teaching at the Obafemi Awolowo University and to complete his doctoral studies.

# ARTICLES





# WOMEN LIVING WITH HIV/AIDS AND THEIR REPRODUCTIVE RIGHTS: A HUMAN RIGHTS POSITION

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Women living with HIV face tremendous challenges coming from all angles when it comes to their reproductive health rights. To start with, they are not exempt from the socio-cultural pressures on women to have children, and many experience difficulty negotiating safer sex practices with their partners for the purposes of safeguarding and managing their sexual and reproductive health. But beyond these challenges that they share with other women, they are also inundated with a barrage of discriminatory and unsupportive statements from political leaders and public health structures that leave them with few alternatives. Unfortunately, the growing discourse in Botswana, largely articulated through the media, has narrowly focused on a debate as to whether or not women living with HIV have a right to have children, and have held women living with HIV solely responsible. Critical to but missing from this discourse has been the holistic consideration of reproductive health rights, the acknowledgement of this issue as one affecting, and thus needing, the involvement of both the sexes. An implication of this has been that the issue, having been crudely simplified, ignores the sheer complexity of the factors involved. As such, this article aims to expand the scope of the current discourse in an attempt to sensitize all actors involved to the enormity of the situation, and to suggest solutions.

In early 2006, the Honourable Member of Parliament for Palapye, Boyce Sebetela, commented to the press that women living with HIV are to blame for the spread of HIV to their partners. Viewed as inappropriate, the comment was responded to by concerned groups such as the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) as well as Bomme Isago which is a network of women living with HIV. They argued that the comment was misleading in

that it appeared to blame HIV-infected women for the spread of the virus. In light of existing evidence and acceptance that gender imbalances fuel the epidemic, the comment appeared to be unreasonable and unfounded. Further still, spoken by an influential member of society, the comment perpetuated and legitimized discriminatory tendencies towards people living with HIV in general, and placing blame on women with HIV in particular.

At the Botswana World AIDS Day 2006 commemoration in Tsabong, the Minister of Health gave a speech attended by the media, in which she made three comments that were, in the opinion of many, vague and inappropriate. Firstly, she stated that it is the government's position that every woman has a right to sexual and reproductive health. Secondly, she stated that it was *also* the government's position that nobody has the right to knowingly transmit HIV or knowingly expose another person (partner, spouse or child) to possible HIV infection. Finally, she said that women living with HIV were a 'challenge' to the zero transmission goals of Vision 2016, a national instrument that articulates the state's general goals, including health and HIV. The first two statements, read separately, do not cause concern. The third does.

The third comment raises concerns because it suggests that women are to blame for the spread of HIV (thus being a 'challenge' to the goal of zero transmission, as also stated by Sebetela). This further justifies discrimination against women living with HIV because it objectifies them by not calling the problems that they face challenges, but instead, characterising the women themselves as challenges.

The second comment is a chimera: the source of its power has been partly in its subtle delivery, making it a harder issue to uproot and address. This statement undermines the integrity of the inclusive nature of the concept of rights. The message created a subtle subtext suggesting that demands for the right to reproductive health do not take into consideration the apparent responsibilities to those affected, such as the unborn child and sexual partner. This

comment undermines the equal value and role of responsibilities inherent in the rights concept. If the intention was to clarify that rights include responsibilities, it could have been better achieved by just saying so: that having a reproductive health right does not mean that one has a right to wilfully transmit HIV. Stated as it was, its ambiguity left open space for such interpretations that are clearly erroneous and unfairly accusatory.

It was also one of the first times that the concept of 'wilful transmission' was used in relation to HIV in the media, and in doing so, the Minister's speech initiated what will no doubt be an emerging issue in Botswana in the near future. There is already a regional and international debate about whether the criminal law concept of wilful transmission can be applied to HIV. There are several arguments against its usage as an HIV-transmission prevention method. Gender activists have said that it is particularly unfair on women living with HIV. Since it is known that women tend to know of their status before men, opponents to the application of wilful transmission to HIV argue that such a law ironically imposes a negative implication on a woman who tests early by placing the onus on her to tell her partner about her status in order to avoid criminal charges. In light of pervasive gender based violence, consideration should be given to whether it is fair to ask a woman to risk her life in order to avoid such charges.

Not to belabor the point but to show that the statements of the two MPs above are not isolated incidents, an article from the local media will be quoted. Sensationalized with the title, 'AIDS patients on a killing spree', the Francistown District AIDS Coordinator was quoted with the comment, "(...) when some of the people who are on ARV therapy recover, they go back to their old wild sexual ways deliberately forgetting that they are HIV positive and infecting others."<sup>1</sup> The Coordinator cited women who fall pregnant whilst knowing their HIV status as examples of such persons.

The comments made by the officials mentioned reveals that discussions on medical health issues by political authorities

<sup>1</sup> 'AIDS patients on a killing spree', *Echo*, 7 December 2006.

have their limitations. As influential leaders and in their official capacities, they have a responsibility to convey accurate medical information and give a balanced viewpoint. The common assumption that women living with HIV have control over their reproductive health rights can spiral into a dangerous situation. It begins when the social and political accusations against women who are blamed for transmitting HIV to their 'unknowing' partners and unborn children ignore and undermine the socio-cultural and institutional vulnerabilities which have been accepted nationally as the real 'drivers' of the epidemic. This leads to interventions that pull at the wrong root problems and disempowering them, while simultaneously failing to provide mitigating interventions to these vulnerabilities.

BONELA has attempted a rights-based approach to this issue. Its guiding principle is the assumption that all rights are, at best, inalienable and must be upheld to the greatest extent. It then considers the limitations posed on the practice of rights with regard to the extent to which it threatens the rights of others. These limitations are not moralistic, but are based upon a normative ethical position, the needs of a particular community and, in this case, the availability of bio-medical resources. The questions posed are thus, 'what is the normative understanding of this right?' A second question could be, 'how do medical technologies (treatment etc.) in the area of HIV provide opportunities for the practice of reproductive health rights, and what are their limitations?' Finally, 'what does a particular group of rights-bearers want?'

"Normatively speaking, women should enjoy complete autonomy when it comes to making reproductive health choices irrespective of their HIV status."<sup>2</sup> Underpinning this is the right to make an informed choice: to choose whether or not to have children, when to have them and under what circumstances to have them.

From a purely normative rights-based perspective, informed by the pro-choice movement of the U.S., a woman, regardless of the risks involved, has sovereign authority over her reproductive health

<sup>2</sup> R. Cook, *Reproductive Health and Human Rights*, Clarendon Press, New York, 2003.

rights. Until a child is actually born and gains legal personality, he/she is considered legally to be an entity of, and controlled by the mother. As such, a quick answer to this question would simply be that women have a choice to be pregnant regardless of their HIV status. From a public health perspective, the goal is to prevent any further infections and protect the common good. In this context, rather than providing for a legitimate balancing of rights, there is a tendency to prioritise public health objectives with little regard for implications on the integrity of the rights of those involved. It has been at this point of collision between human rights interests and public health interests that a rights-based approach has emerged. Guided by the Syracuse principles that suggest an approach for legitimizing limitations of health-related rights, BONELA's human rights practitioners have sought to find ways to negotiate both interests by taking into consideration the undeniable risk of transmission and gravity of harm potentially affecting the child born without medical intervention, on the one hand, and the inalienable rights of the mother on the other hand.

Botswana has the opportunity, made possible by available bio-medical resources, to enable women living with HIV to continue practicing their sexual and reproductive health rights. Many people in the HIV/AIDS field are familiar with the debate about whether it is ethically sound to provide routine HIV testing where there is a shortage of, or no anti-retroviral treatment available. It is in a similar vein that the reproductive health rights issue can be discussed in terms of availability of medical resources. Botswana was one of the first states in Africa for HIV service 'roll-outs' by the public health system: roll-out of its Prevention of Mother-To-Child-Transmission (PMTCT) programme began in April 1999 to all public health facilities country-wide. In 2002 the anti-retroviral therapy (ART) programme (Masa) started and it apparently stands at a current coverage of about 80%,<sup>3</sup> and in 2004, the state rolled out routine HIV testing. These statistics give a strong foundation for the enablement of affected rights.

<sup>3</sup> This figure has been under scrutiny by BONELA and has only been used for the purpose of demonstrating the apparent capacity of the Government of Botswana to provide for greater sexual health service support.

The PMTCT programme in Botswana has been able to reduce the risk of transmission to about 6-7% nationally. Without intervention, about 40% of children born to HIV positive mothers will contract HIV during pregnancy, labor, delivery or breastfeeding.<sup>4</sup> This figure should be considered against the much lower figure of less than 1 % quoted for countries without resource constraints, including the availability of optional caesarean section delivery services and readily available HAART for all pregnant women.<sup>5</sup> Botswana is considered to still suffer resource constraints and these higher figures have been attributed in part to the fact that only pregnant women with CD4 counts of below 200 are being treated with HAART through the ART programme, whereas women with a CD4 count above 200 are enrolled on the PMTCT programme with a much less effective regimen.<sup>6</sup> The consideration to be made is an ethical one, that is, whether 6-7% is a figure that the Botswana government and its citizens feel is a low enough risk factor legitimizing chosen pregnancies by women living with HIV.

Yet, it appears that the state discourages women living with HIV from actively making use of these programmes to enable informed reproductive choices. While not explicitly stated, the Botswana PMTCT Guidelines of 2005 suggest that the PMTCT programme in Botswana was not designed to enable HIV-positive women to safely have children by choice. In fact, it appears that PMTCT was designed as an intervention only for women who did not know of their status before falling pregnant. The 2005 PMTCT Guidelines state under the heading, 'Prevention of pregnancies among HIV-positive Women' that, "[a]lthough it is every woman's or couple's right to have children, health workers should discuss issues surrounding pregnancy including the risk of MTCT of HIV and treatment options to prevent MTCT. Discussions can also include the option of adoption as another alternative to having a child."<sup>7</sup> The above statement suggests that while recognition is made of the right a woman and her partner have to bear children, people

<sup>4</sup> National Guidelines, *Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS*, Republic of Botswana Ministry of Health, BOTUSA Project, 2005, p. 9.

<sup>5</sup> <http://www.aidsmap.com/en/news/3453A0BF-AD96-443B-858D-E17411103126.asp?type=preview>. Accessed August 2006.

<sup>6</sup> S. Spring, *Current Treatment Regimes for PMTCT- Internationally and Locally, A Medical Backgrounder*, Botswana Network on Ethics, Law and HIV/AIDS documentation. Finalised August 2006.

<sup>7</sup> *Supra* n. 4.

who are HIV positive should be discouraged from doing so, given the risks involved.

The apparent reluctance to state clearly the position of the Botswana government, as reflected in the Minister's speech on World AIDS Day 2006, coupled with the vague objectives set out in the PMTCT Guidelines, do not comply with the advised approaches to PMTCT articulated by the World Health Organisation. In a 2002 report entitled 'Strategic Approaches to the Prevention of HIV Infection in Infants', the World Health Organisation stated that necessary elements of a comprehensive PMTCT strategy are, "services to HIV-infected women that support their reproductive choices" which, "(...) include reproductive health counseling and related services that enable them to make informed choices about childbearing in the context of HIV and to carry them through".<sup>8</sup> Thus, health care workers are obliged to provide the necessary information with which women can make informed choices.

Women living with HIV are often denied access to family planning services including family planning counseling and the advice and provision of oral and other contraception. One woman quipped, "when I was told that I was HIV positive, they did not tell me that I would also lose my right to access family planning services".<sup>9</sup> It is unclear why this is happening, since dual contraceptive methods combining condom use and an additional method are known to be most effective in preventing pregnancy as well as sexually transmitted infections.

The other possible factor affecting the discrepancy between the national and international risk rates is the extent of support given to women by reproductive health services. From early 2005, the Botswana Network on Ethics, Law and HIV/AIDS has conducted ongoing community dialogues with women living with HIV to explore their sexual and reproductive health realities, challenges and rights-based needs. The discussions with the participants indicate that in at least some of the public health facilities, some women felt ignored and discriminated against when they attended ante-natal PMTCT

<sup>8</sup> Available on: <http://www.who.int/hiv/pub/mtct/en/StrategicApproachesE.pdf>

<sup>9</sup> Female participant at Gaborone Fact Finding Mission, Maharaja Conference, 28 February 2006.

a second time. They felt that they were treated differently from when they were in their first pregnancies. It was suggested that when dealing with an HIV-positive woman who knows her status and who falls pregnant more than once, the health care workers in charge would ask her why she was falling pregnant, in a tone suggesting that this was wrong. They said that the questioning by the health care workers did not appear to be motivated by an intent to help, but rather, by a stigmatizing view that women living with HIV were not meant to deliberately fall pregnant.

Yet, beyond PMTCT and other HIV-specific services, there are indications that there is more ground to cover in order to close the gap to providing comprehensive generalized reproductive health services to women in Botswana.

Botswana public health procedures limit the availability of emergency contraception to situations of rape and defilement. It is not available in cases of marital or spousal rape, accidental condom bursts and an array of other circumstances. Many of the women in the community dialogues felt that they would like to have access to state supported abortions, which are currently illegal. The state has a responsibility not only to refrain from infringing on these reproductive rights by denying women the right to choose to abort, but also not to respond with a hands-off approach by not actively institutionalizing and enforcing the necessary public health procedures and legislation.

Communities and familial structures are also in need of interventions to cultivate a respect for human rights and personal dignity. As was mentioned earlier, BONELA has been guided by discussions with groups of women living with HIV to better understand their realities. These deliberations have been both insightful and full of promise. Firstly, BONELA holds that, as a principle, any discourse around rights requires participation and insight by the rights-bearers themselves, giving validation and legitimacy to the advocacy work that BONELA engages in. Secondly, the organisation felt it was imperative to ensure that a realistic and accurate representation of



issues from the community was provided to guide and strengthen effective interventions and responses.

One of the most illuminating and popular discussions was about the circumstances under which pregnancies had occurred by women who felt that they had not fallen pregnant out of choice. Several of the women experienced a dilemma around safeguarding the confidentiality of their HIV-status when they felt pressured to explain why they were reluctant to have children. They discussed how a woman who does not have a child becomes suspect to inquisitive family, friends and neighbors who speculate, in the form of gossip, about her HIV-status. Sexual violence may erupt when her partner, in fear that his status is also being speculated upon, forces unprotected sex on her in an attempt to impregnate her and hopefully divert the community's attention away from them both.

Even in situations where women are co-conspirators with their male partners, together creating false pretences, sadly their attempts may not always result in the desired effect. Illness or death of mother and/or child is possible if the mother did not take up the necessary precautions, such as treatment of mother to child transmission of HIV. In fact, fear of exposure of HIV status was one of the reasons given by women who had not enrolled on PMTCT. The preservation of confidentiality at the root of this situation could unravel since, in Botswana, death is a loss expected to be shared in the community. Clearly, this account indicates that interventions have to involve the larger community, including male partners. It is also an indication that the interplay between reproductive health rights and other rights such as the right to confidentiality has to be drawn upon to develop inclusive and holistic approaches.

These challenges mentioned above are snapshots of what is clearly a daunting challenge, not only for the people experiencing them, but also for human rights and public health professionals. On the one hand, public health specialists ask the question, 'in what ways can we control the spread of the epidemic?' On the other, human rights activists ask the question, 'in what ways can people continue

to live fulfilling lives?’ The enablement of a conducive environment for people to practice their reproductive health rights is made possible by a partnership of resources and ideas from both public health and rights based proponents. In simplistic terms, this is achieved by combining medical advances in HIV treatment, care and prevention- the area of expertise of public health specialists- with the efforts of rights-based civil society groups to bring about changes to social attitudes towards and legal protections for people with HIV through community mobilization,

The Botswana Network on Ethics, Law and HIV/AIDS has been a leading organization that articulates a rights-based approach to HIV in Botswana, but evidently, it is a task that requires a true multidimensional and multi-sectoral approach. Such an approach requires commitment and an ability to give fair consideration to all the emerging and inextricably linked rights and responsibilities, cultural sensitivities and public health concerns. Perhaps the elementary consideration of rights by those involved in this discourse may have inadvertently contributed to the misdirected and exclusive blame being placed on women living with HIV. It is time now to systematically use dialogue to provide clear evidence and clear justifications for positions taken by all concerned.

# UNDERSTANDING MALE SEXUALITY: THE WEAK LINK IN SEXUAL AND REPRODUCTIVE HEALTH AND HIV INTERVENTIONS IN BOTSWANA

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The title of the article covering the first male-focused workshop on the Prevention of Mother to Child Transmission (PMTCT) reads: 'Men Lack Knowledge on Sexual Issues'.<sup>1</sup> The article attributes men's low uptake of PMTCT programme services to their lack of involvement in issues of sexual and reproductive health (SRH). The title of the article denotes the complexity of confronting male sexualities in the wake of the HIV pandemic in Botswana.

This article identifies challenges and opportunities relating to male involvement in sexual and reproductive health in Botswana. The lack of male participation in reproductive health has adverse implications for arresting the spread of HIV, treating those who are infected, and assisting others who are affected. Two challenges are, *inter alia*: the marginalisation of males in the maternal child health and family planning programmes in Botswana, as well as the limitations of efforts to engage males in current reproductive health programmes. In the face of these challenges, however, there are efforts in policy and programme arenas, including civil society activism, which can be enhanced by holistic discourses and research on male sexualities and male sexual behaviour in Botswana.

## **Of Missing Males and Female-Oriented Family-Health Interventions**

Public reproductive health interventions have been predominantly female-oriented under the rubric of the Maternal Child Health and Family Planning (MCH/FP) programme. Whilst female-focused health programmes can be lauded as a means of improving the

<sup>1</sup> *Botswana Daily News*, 22 June 2005.

status of women's health, the maternal child/family care approach is based on the 'mother-child nexus'<sup>2</sup> approach to family welfare in general, and family health in particular. Family health education and care continues to be the domain of women in Botswana, who also constitute the majority of Family Welfare Educators (FWEs). Women are also the main recipients of health education through the MCH/FP programmes administered through community clinics. In the past, males have not been directly targeted for family reproductive health interventions, or played any significant role in the implementation of government reproductive health initiatives.

I have argued elsewhere that the focus on females is also couched in *gender* discourses that continue to focus almost exclusively on women.<sup>3</sup> We speak of *gender* – ideally referring to women *and* men/ females *and* males, but we have not made the paradigm leap to incorporate males and masculinities in our *gender* discourses, including policy interventions. The emergence of the Gender and Development (GAD) paradigm in the 1990s seemed to offer a more balanced approach from the female-focused (regarded by some critics as isolationist) Women in Development (WID) approach by introducing the notion of 'gender relations' as an ideological and analytical premise. The notion is interpreted thus by the National Gender Programme of Botswana:<sup>4</sup>

The WID approach failed to look at relations between women and men and how those relations of dependency and subordination limit women's opportunities to get full value out of the development process (...) It did not address or challenge power relations. Gender and Development moves away from the narrow focus on women and instead focuses on the roles of women and men, and their relationship[s], and how these relations affect women and men and the development process. Men are given roles that give them more power and allow them to control and dominate women

<sup>2</sup> S. Mvududu and P. McFadden, *Reconceptualising the Family in a Changing Southern African Environment*, Women and Law in Southern Africa, Harare, 2001.

<sup>3</sup> See G. Mookodi and D. Fuh 'Finding the Missing Male in Gender Discourses in Botswana', *Pula: Botswana Journal of African Studies*, Vol. 18, No. 1, 2004, pp. 31-42.

<sup>4</sup> The National Gender Programme of Botswana indicates the key considerations in the shift from the WID to the GAD paradigm in six critical areas: Poverty, Power and Decision Making, Education and Training, Health, The Girl Child, and Violence Against Women.

(...) The GAD approach questions these relations and analyses how they restrict women's access to opportunities and benefits.<sup>5</sup>

It is evident that this interpretation of 'gender relations' practically translates to *women in relation to men* as the overriding focus.<sup>6</sup> References to 'men's power' are in direct juxtaposition to 'female lack of power' reflecting what Arnfred refers to as the dichotomised notions of 'universal patriarchy' and 'universal female subordination'.<sup>7</sup> The international debates regarding gender and development reflect concerns by feminists that involving males in gender projects could derail the objective of female empowerment and the achievement of gender equality due to their relative positions of power. Furthermore, the dichotomisations tend to polarise policy and programme interventions. A growing number of advocates for male-inclusive gender discourses and interventions,<sup>8</sup> point to the necessity of understanding the positionalities of males within the context of patriarchy and social life. What is particularly relevant with respect to the promotion of public health and curbing the transmission of HIV is establishing links between gender and sexuality. Sexuality relates to the expression of intimacy, including the physiological, psychological, socio-cultural aspects of sexual identity and behaviours.

## Sexual and Reproductive Health and Male Inclusion

The drive to focus on reproductive health was spearheaded by the International Conference on Population and Development (ICPD) Programme of Action (Cairo, 1994), which underscored the centrality of reproductive health to human development. The ICPD Programme of Action also pointed to the importance of addressing male sexual and reproductive health. Based on recommendations from a workshop on sexual and reproductive

<sup>5</sup> Women's Affairs Department, *Advocacy and Social Mobilisation Strategy for the National Gender Programme, Republic of Botswana*, Ministry of Labour and Home Affairs, Gaborone, 1999.

<sup>6</sup> A. Cornwall, 'Missing Men? Reflections on Men, Masculinities and Gender in GAD', *Institute of Development Studies Bulletin*, Vol. 31, No. 2, 2000, pp. 18-24.

<sup>7</sup> S. Arnfred (ed.), 'Rethinking Sexualities in Africa: An Introduction' in *Re-thinking Sexualities in Africa*, Nordiska Afrikainstitutet, Upsalla, 2004, pp. 7 - 29.

<sup>8</sup> R. Morell (ed.), *Changing Men in Southern Africa*, Zed Books, London, 2001; 'It Takes 2: Partnering With Men in Sexual and Reproductive Health. A Programme Advisory Note', UNFPA, New York, 2004; R.W. Connell, 'Growing Up Masculine: Rethinking the Significance of Adolescence in the Making of Masculinities', *Irish Journal of Sociology*, Vol. 14, No. 2, 2005, pp. 11-28.

health in 1998, the Ministry of Health in Botswana has embarked on a process of developing a national sexual and reproductive health programme – which effectively meant a re-orientation of the MCH/FP programme.<sup>9</sup>

The government of Botswana's National Sexual and Reproductive Health Programme<sup>10</sup> (NSRHP) signifies a potentially momentous re-orientation of health care policy and programme delivery on the part of the government of Botswana. One of the goals of the NSRHP is to 'promote gender equity and equality' by the year 2011. The goal aims at increasing male involvement and participation in sexual and reproductive health by 50%. This is based on the need to broaden the conceptualisation of gender to include males.

The NSRHP blames the male-breadwinner/female-homemaker-caregiver dichotomy for focusing on women while excluding men, and points to the need to foster male responsibility in sexual and reproductive health activities. Suggested areas include improving communication between spouses, male support for women's reproductive rights, partnering with males to address socio-cultural factors that affect reproductive rights, and changing male sexual behaviour to prevent the spread of STIs – particularly HIV. This list is not exhaustive.<sup>11</sup> The NSRHP points to the need for a multi-sectoral approach (as emphasised by the ICPD). The NSRHP implementation plan points to the role of political leaders, civil society, District Health Teams and relevant ministries in realising the goal of male involvement.

### **Male-Focused Interventions: Opportunities and Challenges**

A comprehensive evaluation of male-focused interventions is beyond the scope of this article. Here I highlight a few observations relating to male involvement in reproductive health and HIV prevention in Botswana. The Men, Sex and AIDS program was set up in the AIDS/STD Unit after the pilot research study on male sexuality<sup>12</sup> emphasised the importance of incorporating the social construction

<sup>9</sup> Republic of Botswana, Ministry of Finance and Development Planning and United Nations Population Fund, *International Conference on Population and Development Country Report 2003*, Gaborone, 2003.

<sup>10</sup> Republic of Botswana, Ministry of Health, *National Sexual and Reproductive Health Programme Framework*, Government Printer, Gaborone, 2002.

<sup>11</sup> *Ibid.*, pp. 44-48.

<sup>12</sup> Republic of Botswana, Ministry of Health, *Men Sex and AIDS: Addressing Male Sexuality. A Pilot Study*, AIDS/STD Unit, Gaborone, 1998.

of masculinity in HIV prevention strategies. The study engaged men in discussions focusing on a range of sexuality issues including masturbation, unprotected sex, commercial sex, homosexuality, as well as the link between alcohol use and sexuality. The pilot was to be replicated in various towns and villages in Botswana. The replication process was to be institutionalised through the Men, Sex and AIDS (MSA) programme which was based in the Botswana National Youth Council. Over time, MSA has concentrated on taking the mainstream AIDS-prevention programme to males in Botswana. This included peer counsellor training aimed at encouraging males to: abstain from sexual intercourse, practice monogamy, use condoms and secure access to appropriate treatment. This programme did not result in the integration of male sexuality into programmes as was recommended by the pilot study. The MSA programme was discontinued in 2006. The reasons for the discontinuation of the programme are not known.

Currently male-involvement activities in the Ministry of Health are centred in the Community Health Services Department (CHSD) under a rubric of the project entitled: 'Strengthening Institutions and Programs for Enhancing Male Involvement in Sexual Reproductive Health and HIV/AIDS' under the current government of Botswana and UNFPA Program of Assistance (2003 – 2007). The project aims at increasing male participation in sexual reproductive and health matters in order to reduce the transmission of HIV and STIs, as well as addressing gender-based violence. This component was to design an appropriate male-targeted SRH programme. The workshop that was mentioned in the beginning of this article was organised by the CHSD in collaboration with the Family Health Division's PMTCT division. One of the efforts to increase male participation in PMTCT is a publicity campaign that includes billboards and media-based messages. One of the billboards is pictured below:



Source: Nata Village Blog <http://natavillage.typepad.com/> [accessed on 30.1.2007]

The billboard points to the need for self-reflection among heterosexual males – partners, husbands and fathers. What, however, does the concept of ‘real man’ connote? Who is a ‘real man’? The complexity of conceptualising ‘male’ and male sexuality within the context of HIV prevention was reflected in the following comment in a local newspaper in a satirical column (ironically) titled ‘Below the Belt’. The comment is titled ‘I am a real man’:

The Ministry of Health has launched a ‘real man’ (*ke monna tota*) campaign that holds up testing for AIDS as a measure of proving that you are a real man. The supposition would seem to suggest that the entire experiences of real men revolve around sex when everybody knows that the ‘manly’ experience involves much more than that (...) the campaign underlies the unfortunate myth that has been successfully sponsored by a mostly female AIDS elite. The myth that they peddle is that men are responsible for the spread of the AIDS virus (...) the ‘real man’ campaign is a misguided indictment on men and could have an adverse effect on how men respond to the scourge (...).<sup>13</sup>

This comment alludes to two issues that I have raised in this intervention. Firstly, the author alludes to the inherent dichotomisation of women and men in HIV prevention. Secondly, the author points to the problem of making assumptions about male identities and male sexuality. These issues can be addressed by developing masculinity paradigms that are appropriate to Botswana. Much of the international literature on masculinities<sup>14</sup> seeks to break down generalised, dominant, and often hegemonic, depictions of masculinity. Some males may be powerful, while others may be powerless – depending on factors such as economic status, ethnicity, and sexual orientation. Research on masculinities in Botswana should, as Sillberschmidt, Ratele<sup>15</sup> and others state, include investigations of the interplay between social structure (culture, economy, religion, etc.) and individual agency – how

<sup>13</sup> *Sunday Standard*, 18 – 24 February 2007, p. 6.

<sup>14</sup> R.W. Connell, *Masculinities*, Polity Press, Cambridge, England, 1995. Kimmel (ed.) *Changing Men: New Directions in Research on Men and Masculinity in Boston*, Sage, Newbury Park, 1987. R. Morell (ed.), *op. cit.* n. 8.

<sup>15</sup> See M. Sillberschmidt, ‘Male Sexuality in the Context of Socio-Economic Change in Rural and Urban East Africa’, *Sexuality in Africa Magazine*, Vol. 2, No. 1, 2005, pp. 5–8. K. Ratele, ‘Versions of Masculinity’, *Sexuality in Africa Magazine*, Vol. 2, No. 1, 2005, pp. 3–4. Both of these scholars have conducted qualitative studies on male sexuality in the context of socio-economic change in African societies.



individual males negotiate their lived realities – in this case sexual identities and sexual behaviour over time in Botswana.

HIV/AIDS is a crisis in Botswana. I acknowledge that dealing with the crisis is not simple. What I am suggesting here is the need to engage males and masculinities through research that will also inform policy and program interventions on sexual and reproductive health and HIV prevention.



# SOCIO-ECONOMIC RIGHTS: THE MISSING LINK IN FIGHTING THE HIV/AIDS PANDEMIC

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Critical to the success of any social intervention is a thorough grasp of the context in which it is being implemented, based on the recognition that numerous contextual factors can affect the success of an otherwise inspired intervention. When considering HIV/AIDS in the Sub-Saharan context, the impact of socio-economic factors on prevention, care and mitigation efforts cannot be overstated. This paper examines the relationship between a few of these factors – namely poverty, nutrition, education and access to treatment – and the HIV/AIDS pandemic; with specific reference to the International Covenant on Economic, Social and Cultural Rights. The undeniable links between this so-called ‘second generation’ of human rights and HIV/AIDS would indicate that, until measures are taken to ensure these rights as a critical basis for intervention efforts, progress against this pandemic will be greatly limited.

## **HIV/AIDS: An Unprecedented Crisis**

In 1981, when the world was for the first time introduced to a deadly virus known as the Human Immunodeficiency Virus (HIV), it was not possible to foresee the far-reaching devastation that would be inflicted by this disease, or to anticipate the extent to which it would alter the course of history.

Over 25 years and 25 million deaths<sup>1</sup> later, it is tristic to say that HIV/AIDS is one of the most pressing crises facing humankind today. The unique complexity of this pandemic has propelled it out of control – whilst simultaneously hampering efforts to stem it. Far from being simply a bio-medical issue, as was originally perceived, HIV/AIDS is a political, social, economic and undoubtedly, a human rights issue.

<sup>1</sup> UNAIDS, *Report on the Global AIDS Epidemic*, Geneva, May 2006.

Vast quantities of resources have been invested in efforts to address various aspects of this multi-dimensional crisis, but despite the apparent success of numerous prevention programs and significant scientific advances in the efficacy and accessibility of Anti-Retroviral Therapy (ART), the battle is far from won. With prevalence statistics showing a consistently increasing trend almost everywhere, or, even if not increasing, remaining unacceptably high, there is clearly a need to rethink our approach.

## Learning from History – The Value of Lateral Thinking

The UNAIDS publication *AIDS in Africa: Three Scenarios to 2025*<sup>2</sup>, a collection of diverse perspectives provided by people working on various aspects of the HIV/AIDS response in Africa, describes three possible scenarios for the future of our continent with respect to this pandemic. Taking into account both national and international responses, it was developed to serve as a decision-making aid, by drawing on the experiences that we have had and analyzing their implications for the future. While we may not have known in 1981 where the HIV/AIDS pandemic would lead, *AIDS in Africa* asserts that “if, by 2025, millions of African people are still becoming infected with HIV each year (...)it will not be because there was no choice (...) [or] because there is no understanding of the consequences of the decisions and actions being taken now (...)It will be because the lessons of the first 20 years of the pandemic were not learnt, or were not applied effectively. It will be because, collectively, there was insufficient political will to change behavior (at all levels, from the institution, to the community, to the individual) and halt the forces driving the AIDS epidemic in Africa”.<sup>3</sup>

Of the three possibilities depicted in this thought-provoking publication, the most effective and sustainable benefit is to be found in the scenario ‘Times of Transition: Africa Overcomes’. What sets this scenario apart is that HIV/AIDS is tackled in the context of a broader approach to development; that it catalyzes the mobilization of national and international civil society to respond to the numerous other socio-economic problems facing

<sup>2</sup> UNAIDS, *AIDS in Africa: Three Scenarios to 2005*, Geneva, January 2005.

<sup>3</sup> *Ibid.*, p. 14.

Sub-Saharan Africa: problems that create an environment that not only exacerbates the spread and impact of HIV/AIDS, but also diminishes our capacity to fight back.<sup>4</sup>

## Economic, Social and Cultural Rights

It is based on this understanding that the campaign for Economic, Social and Cultural Rights (ESCR) takes on even greater importance. While civil and political rights, the so-called 'first generation' of human rights, receive much attention from governments and humanitarian organizations; ESCR, on the other hand, are too often viewed as idealistic propositions that are of secondary concern and lesser importance in the broader human rights campaign.

To espouse this school of thought, however, would be to overlook one of the underpinning principles of the Universal Declaration of Human Rights – namely, that *all* human rights are universal, indivisible, interdependent and interrelated.<sup>5</sup> Hence the absence of ESCR in any given context would impede the promotion of civil and political rights, and these two 'generations' of human rights can therefore not be considered separately from each other. Furthermore, as stated by the UN committee on ESCR, "The right to live a dignified life can never be attained unless all basic necessities of life – work, food, housing, health care, education and culture – are adequately and equitably available to everyone".<sup>6</sup>

This perspective takes on even more significance in an era where HIV/AIDS threatens to derail many sectors of society. While numerous programmes and initiatives exist in response to the pandemic, many of these function in isolation and lack the deeper and broader development perspectives needed to achieve optimal outcomes. The implications of this include: duplication of effort; failure to achieve the desired output due to the hindrance posed by unfavorable socio-economic contexts; or negation of some efforts where parallel efforts advocate opposite approaches to certain aspects of HIV/AIDS (for example, organizations promoting condom use are in direct opposition to religious and/or quasi-

<sup>4</sup> *Ibid.*, p. 20.

<sup>5</sup> Part 1, para. 5, Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights, Vienna, 25 June 1993.

<sup>6</sup> Fact Sheet No.16 (Rev.1), The Committee on Economic, Social and Cultural Rights, United Nations, Geneva, 1991.

moral institutions that advocate against condom use in preference of sexual abstinence until marriage).

But now more than ever, there needs to be coherent, unified action to combat HIV/AIDS. The action – or inaction – taken now will have ramifications for generations to come; and while it may not be possible to find a point of convergence at which all HIV/AIDS campaigns can meet and move forward together – and perhaps one should not try to find such a point, for the multi-dimensional nature of this pandemic requires a multi-dimensional approach – we can and must find a common denominator. This common denominator can be found in the campaign for socio-economic rights.

In the face of increasing poverty, hunger, illiteracy and ill health, the International Covenant on Economic, Social and Cultural Rights (ICESCR) was opened for signature in 1966. It is an international legal instrument that, when ratified by a state, imparts upon it a series of legal obligations to uphold the rights and provisions established in the covenant and to ensure that national laws are compatible with this. Such states then become accountable to the international community and to their own citizens, in terms of the obligations that they have accepted.

The ICESCR contains some of the most significant international legal provisions relating to working conditions, to social protection, to an adequate standard of living, to physical and mental health, to education and to enjoyment of the benefits of cultural freedom and scientific progress. It contains such fundamental rights as the right to social security, the right to adequate nutrition and the right to treatment of diseases. As such, it requires a significant and sustained level of commitment and investment of resources from covenant parties. Governments are expected to respect, protect, promote and fulfill the rights in the covenant – particularly through the adoption of legislative measures – in order to achieve progressively the full realization of these rights to the maximum of their available resources.<sup>7</sup>

<sup>7</sup> Article 2, International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by General Assembly 2200A (XXI) of 16 December 1966.

In April 2006 the ICESCR had 153 parties and 66 signatories – of which only 41 parties and 6 signatories are from Sub-Saharan Africa – which remains the hardest hit region with regards to HIV/AIDS.<sup>8</sup> The juxtaposition of these two facts is no mere chance.

## Breaking Vicious Cycles: The Argument for Investment in ESCR

One of the main reasons cited for the reluctance of states to sign the ICESCR is the vast amount of resources and infrastructure that would be necessary for its implementation. This is not to say that no socio-economic assistance is provided to the populations of countries whose governments have not signed the ICESCR – Botswana, for example, has policies that provide citizens with various forms of social security, ranging from free healthcare to food baskets for the destitute. Nonetheless, only a few constitutions in the region recognize access to such services as a constitutional right, preferring their provision to remain the prerogative of the ruling governments. Many would argue that the ICESCR is simply not a realistic model for developing countries.

What, however, are the implications of failing to recognize the rights contained therein – particularly with respect to HIV/AIDS?

One of the possibilities discussed in *AIDS in Africa: Three Scenarios to 2025* is that of 'Traps and Legacies'. In this scenario, HIV prevalence and the impacts of the pandemic continue to increase over the next 20 years, devastating the African continent. The root cause of this scenario is that "AIDS does catalyze people and institutions into a response, but they cannot make sufficient headway with depleted capacities and infrastructure (...) continuing underdevelopment undermines the ability of many countries to get ahead of the regime. The scenario shows (...) wasted resources (...) [and] how, despite good intentions, the epidemic will simply continue against many countries and populations in the continent as HIV is seen in isolation from its root economic, social and political context".<sup>9</sup>

<sup>8</sup> Office of the United Nations High Commissioner for Human Rights – Weblink: <http://www.ohchr.org/english/countries/ratification/3.htm> Accessed 23 April 2006.

<sup>9</sup> *Op. cit.* n. 2, p. 19.

In other words, the campaign against HIV/AIDS will not provide any lasting solutions as long as the pandemic is not addressed in its broader development context, as long as its root and aggravating factors are not dealt with – as long as we remain in the vicious cycles that tend to characterize HIV/AIDS initiatives in the absence of ESCR fulfillment. Resources invested in – otherwise viable – campaigning strategies will fall into the gaps created by the lack of fulfillment of these vital human rights, and the vicious cycles will continue *ad infinitum* until civil societies and governments take concrete steps to bridge said gaps, some of which will be expanded on below.

**The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international cooperation based on free consent.**

ICESCR, article 11, paragraph 1<sup>10</sup>

Perhaps the most prominent and widely recognized of the above mentioned ‘vicious cycles’ is that based on the interaction between HIV/AIDS and poverty. Poverty exacerbates the spread of HIV/AIDS, for example through the reduced capacity of women to negotiate for safe sex where they are economically dependant on their partners. HIV/AIDS, in turn, exacerbates poverty through killing “the most productive (...) members of society, increasing household dependency ratios, [and] reducing household productivity”<sup>11</sup> – thus undermining efforts to mitigate the impact of the pandemic.

Care, the third pillar of the conventional HIV/AIDS response, is also hindered in the context of poverty, which diminishes the capacity of communities to support people living with HIV/AIDS (PLWHAs). Furthermore, should the financial burden of care and support prove to be overwhelming, this in turn may contribute to the stigmatization of HIV – where PLWHAs are viewed as being an unbearable drain on

<sup>10</sup> *Op. cit.* n. 8.

<sup>11</sup> S. Gillespie and S. Kadiyala, *Rethinking Food Aid to Fight AIDS*. Food Consumption and Nutrition Division Discussion Paper No. 159. International Food Policy Institute, Washington D.C., 2003.



the already meager resources of impoverished communities.

Money may be the root of all evil, but poverty gives rise to numerous other evils as well. In fact, all of the socio-economic issues discussed in this paper can be linked back to poverty – for example, food insecurity.

Article 11, paragraph 2 of the ICESCR recognizes the fundamental right of everyone to be free from hunger, and obliges States Parties to take steps to “improve methods of production, conservation and distribution of food (...) by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources”.<sup>12</sup> This paragraph also notes the problems that exist in the food-import and food-export industry (such as the controversial issue of ‘food dumping’ and agricultural subsidies in developed countries).

The right to food, although regarded as a social/economic right, is inherently tied to the right to life. It is also inextricably linked to the campaign against HIV/AIDS, where:

- i) The agricultural sector has been shown to be affected disproportionately by the HIV pandemic – as its relatively small size in comparison to other sectors means that it is less able to absorb, and hence be less resilient to, the destabilizing impact of the pandemic – leading to increased food insecurity (The New Variant Famine Hypothesis). In fact, HIV/AIDS has been said to be one of the most fundamental underlying causes of the Southern African food crisis;<sup>13</sup>
- ii) PLWHAs have increased nutritional needs that are essential to compensate for their immunocompromised state; and in a continent where food insecurity is already rampant, this factor can act as a disincentive for potential caregivers of PLWHAs by contributing to the financial burden of support as discussed earlier;
- iii) People suffering from malnutrition are more susceptible to HIV and are also more likely to develop full-blown AIDS;

<sup>12</sup> *Op. cit.* n. 8.

<sup>13</sup> A. De Waal and J. Tumushabe, *HIV/AIDS and Food Security in Africa*, 2003.

- iv) Recipients of ART have specific nutritional needs that, if not met, can compromise the efficacy of the treatment. This is a particularly important point, as millions of dollars that are invested in ART roll-out programmes could potentially go to waste where those receiving this treatment lack consistent access to adequate nutrition and clean water.

To a world quaking at the unprecedented threat presented by HIV/AIDS, the advent of ART was a double-edged sword. While bringing hope, it also brought new problems and tensions – namely, the battles around access to treatment, which have seen treatment activists, pharmaceutical companies and governments pitted against each other in the complex controversy surrounding patent law and the right of people to have access to life-saving ART.

The ICESCR is clear on each of these issues, but ambiguous in their relation to each other. While Articles 12 and 15(1)(b) recognize, respectively, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and to the enjoyment of the benefits of scientific progress and its applications; Article 15(1)(c) also recognizes the right of people (or, for the purpose of this discussion, pharmaceutical companies) – to “benefit from the material interests resulting from any scientific production (...) of which he is the author”.<sup>14</sup> This right, often invoked by pharmaceutical companies in battles to strengthen their drug patents, presents an apparent dilemma, where their right to material benefit is seemingly in contravention of PLWHAs’ right of access to life-saving drugs.

There has to be some compromise; but to reach this requires willingness and commitment on behalf of all players involved to engage in constructive discourse and find a common meeting-ground. Of course, this is much easier said than done; particularly when governments are not bound by this covenant and can thus opt to neglect their role in these vital negotiations on behalf of their populations living with HIV.

<sup>14</sup> *Op.cit.* n. 8.

Another significant socio-economic dimension of HIV/AIDS is that of education – which is recognized in Article 13 of the ICESCR as a fundamental right of all persons – and its importance cannot be overstated. Ignorance is not only a major factor in high-risk behavior, but also fuels maladaptive responses to the disease – such as stigmatization, the use of dubious ‘remedies’ and lack of adherence to ARV treatment regimens.<sup>15</sup> Lack of education also restricts people’s capacity to take ownership of, and maintain, intervention efforts in their communities – thus undermining the sustainability of these efforts.

The breadth and depth of the ESCR-HIV/AIDS interaction is, of course, far more complex than can be discussed in a brief paper of this kind. These few examples, however, show categorically that as long as HIV/AIDS interventions fail to address the socio-economic context in which they take place, they are building on a flimsy foundation that is bound to crumble.

### **From Rhetoric to Reality: The Feasibility of ESCR in Sub-Saharan Africa**

Finally, we consider the inevitable question: while the ideals presented in the ICESCR may be agreeable in rhetoric, are they a realistic goal for many Sub-Saharan African countries that are already facing so many other resource-draining problems and lack the infrastructure to develop social security systems? But to ask this question on the one hand, while attempting to confront HIV/AIDS on the other, is to put the cart before the horse. If one is serious about winning the battle against this pandemic, one must also be serious about addressing the factors that fuel it.

The Limburg Principles on the Implementation of the ICESCR<sup>16</sup> make it clear that progressive realization of these rights should not be taken to mean that countries should progress to a certain economic level first, whereafter they can consider fulfilling ESCR; but rather that governments, regardless of their level of wealth

<sup>15</sup> For more information on HIV/AIDS and Education see ‘HIV/AIDS Impact on Education Clearing House’: [http://hivaidsclearinghouse.unesco.org/ev\\_en.php](http://hivaidsclearinghouse.unesco.org/ev_en.php).

<sup>16</sup> The Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights, UN doc. E/CN.4/1987/17, Annex; and *Human Rights Quarterly*, Vol. 9 (1987), pp. 122–135.

or development, should begin working towards the realization of the ICESCR as an integral part of their approach to development, and should consider themselves obliged to ensure minimum subsistence rights for everyone.

As mentioned earlier, several countries already have policies in place to drive the fulfillment of these rights – such as the right to health and education. However, there seems to be a decided reluctance amongst governments to embed these rights in their constitutional frameworks – a binding move that would consolidate them and make them a mandatory consideration in government planning and expenditure. Policies can be changed with much more ease than can constitutions, and by relegating the principles of socio-economic rights from the constitutional to the policy level, governments thus allow themselves ‘wiggle room’ – the option to decrease or cease their commitment to the provision of social services, should this become desirable for political or other reasons.

To change this status quo would certainly require tough choices to be made; priorities to be adjusted and new development paradigms to be established. While the scope of this paper has no room to set forth the logistics for such strategies, it is worthwhile remembering that while we speculate on the transition of ESCR from rhetoric to reality, HIV/AIDS remains a stark reality, and the hope of overcoming it fades further and further into the rhetorical realm.

## **Conclusion**

As this paper has shown, there is an urgent need for intensified activism around increasing the prominence of social and economic rights in the HIV/AIDS response. The passing of time, with the increasingly devastating toll of this pandemic, make it patently clear that we need new approaches, new solutions. Numerous intervention efforts fail to produce the desired results because we are stuck in vicious cycles that impede our progress and, while

further draining our resources, fail to provide lasting solutions.

The realization of the ICESCR, far from being merely an idealistic goal for policy change, presents a real and concrete way to break these cycles and begin to make truly meaningful progress against HIV/AIDS. If we have learnt anything from the past two decades, we should know that a short- and narrow-sighted approach to combating this pandemic will lead us nowhere. The question is not, 'can we afford to?' The question is, 'can we afford *not* to?'

Certainly, we cannot afford to sit back and wait for future generations to answer this question with retrospective clarity, for by then it will be too late.



# A NEED TO RE-EXAMINE THE VOICE OF THE PEOPLE? REFLECTIONS ON THE INTERPLAY OF HOMOPHOBIA AND THE HIV/AIDS PANDEMIC IN BOTSWANA

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## Introduction

We are final not because we are infallible, rather we are infallible because we are final. Justices of this court are human beings, capable of erring. It will certainly be short-sighted arrogance not to accept this obvious truth. It is also true that this court can do inestimable good through its wise decisions. Similarly the court can do incalculable harm through its mistakes (...) This court has the power to over-rule itself (and has done so in the past) for it gladly accepts that it is far better to admit an error than to persevere in error (...).<sup>1</sup>

With the above statement, the Nigerian Supreme Court, the country's highest and court of last instance, inferably highlights a crucial point. This point is that official stands, decisions or views on issues in some situations, may have been based on wrong grounds, or can be defective in some other respects. From another perspective, the statement highlights that official positions on any issue should not be immutable; periodic reviews of such positions are necessary to determine whether they are still relevant or appropriate in the context of new developments.

As the directing mind or *alter ego* of the State, the government of a country takes decisions on behalf of and for the citizens of the country. In democratic systems, where the people elect the government, the people vicariously speak through their elected government. Generally, a government in a democratic setting

<sup>1</sup> *Adegoke Motors Ltd v Adesanya* (1989) 3NWLR per Oputa J.S.C., pp. 274-275.

consists of three arms: the Legislature,<sup>2</sup> the Executive<sup>3</sup> and the Judiciary.<sup>4</sup> The executive applies or executes the law while the judicial arm interprets the law where necessary.<sup>5</sup> The three arms interact and coordinate the affairs of government. They also act as checks on the excesses of one another.<sup>6</sup>

Generally, the position of the government, and by the same token, that of a country can be deciphered from the stand of any of these three arms of government. For example, the laws made by the legislature would be a reflection of the position of that country on the subject matter of that law. Similarly, the pronouncements of the judiciary can also be an indication of the position of the government and the country. Set against this background, this paper examines the legal position on homosexuality in Botswana, as reflected in the provisions of the Penal Code and case law based on a judgment of the Court of Appeal in the case of *Kanane v The State*.<sup>7</sup> The paper argues that the legal position on homosexuality deserves a review in light of the troubling HIV/AIDS pandemic in the country. This paper proceeds in the following section with an examination of the legal position on homosexuality.

## The Law and Homosexuality in Botswana

Botswana is a democratic country, with the three arms of government interacting and coordinating as described above.<sup>8</sup> The country's judiciary consists of a hierarchy of courts, with the Court of Appeal as the highest and the court of last instance.<sup>9</sup> Generally, in adjudicating and interpreting the scope of laws, the

<sup>2</sup> Depending on the system of government in a country the Legislature can, for example, be referred to as the National Parliament (as in Botswana), the Senate and House of Representatives (as in the United States of America) or the House of Lords and House of Commons (as in Britain).

<sup>3</sup> The Executive refers to the Head of Government which may be the President, Prime Minister or even the King (as in the case of Swaziland), together with Ministers overseeing various aspects of state affairs and other state officials that are not part of the other arms of government.

<sup>4</sup> The Judiciary refers to the courts of a country collectively.

<sup>5</sup> See D.D. Ntanda Nsereko, *Constitutional Law in Botswana*, Pula Press, Gaborone, 2001, pp. 63-67.

<sup>6</sup> *Ibid.*, p. 63. See also C.M. Fombad, 'The Separation of Powers and Constitutionalism in Africa: The Case of Botswana', *Boston College Third World Law Journal*, Vol. XXV, No. 2, 2005, p. 301.

<sup>7</sup> [2003] (2) BLR 67 (CA).

<sup>8</sup> D.D. Ntanda Nsereko *supra* n. 5, p. 63; C.M. Fombad *supra* n. 6, pp. 301-303.

<sup>9</sup> Section 99, Constitution of Botswana (hereinafter 'the Constitution'); D.D. Ntanda Nsereko *supra* n. 5, p. 193.



judiciary stands as overseer and determiner of the validity of the conducts and acts of the other arms of government as well as its citizens. Thus, the judiciary can declare an action or position taken by the executive arm invalid. A recent example of this is the widely reported case in which the High Court, a component of the Botswana Judiciary declared the executive action of relocating the Basarwa people of the Central Kalahari Game Reserve (CKGR) to be invalid.<sup>10</sup> Similarly, the judiciary can also declare a law made by the legislature invalid, based on inconsistency with the Constitution. An example is afforded by the widely known case of *Attorney General v Unity Dow*,<sup>11</sup> in which the Botswana Court of Appeal invalidated some provisions of the Citizenship Act<sup>12</sup> for being inconsistent with provisions of the Constitution. Based on this role of the court, the pronouncements and declarations of the judicial arm would seem to be a very significant, if not the best, indicator of a country's position on any issue.

In the case of *Kanane v The State*,<sup>13</sup> the Botswana Court of Appeal upheld section 164 of the Penal Code,<sup>14</sup> as amended, relating to sodomy and 'unnatural sex' as constitutional and held that provisions of the section were not in violation of the rights of homosexuals to non-discrimination. The court rejected the submission by the appellant that the provisions were invalid based on constitutional inconsistency. Rationalising its position, the court maintained, *inter alia* that:

- a. There was no evidence that the approach and attitude of society in Botswana to the question of homosexuality and to homosexual practices by gay men and women required a decriminalization of those practices, even to the extent of consensual acts by adult males in private. The trend was not to move towards the liberalization of sexual conduct by regarding homosexual practices as acceptable conduct but showed a hardening of a contrary attitude.<sup>15</sup>

<sup>10</sup> See e.g., Editorial, 'CKGR judgment vindicates judicial independence', *Mmegi*, Vol. 19, No. 1, 15 December 2006.

<sup>11</sup> [1992] Botswana Law Reports (B.L.R.) 119.

<sup>12</sup> Cap. 01:1, *The Laws of Botswana*, Revised Edition of 2002. The sections of the Act mainly affected are sections 4 and 5.

<sup>13</sup> *Supra* n. 7.

<sup>14</sup> Penal Code, Cap. 08:01, *The Laws of Botswana*, Revised Edition of 2002.

<sup>15</sup> *Supra* n. 7, p. 80 (paras. A-D).

- b. The time had not yet arrived to decriminalize homosexual practices even between consenting adult males in private. Gay men and women did not represent a group or class which at this stage had been shown to require protection under the Constitution.<sup>16</sup>

From the holding of the court as set out above, it is inferable that the Court of Appeal conveys a position that, in general, the people of Botswana disapprove of homosexuality and they have not shown any inclination to change their attitudes. In line with the earlier analysis that the government of a democratic country amplifies the voice of the people, *Kanane v The State*, in simple terms, would qualify as an authoritative indication that the citizens of Botswana are homophobic. Because this position comes from the judiciary, the ultimate determinant of validity amongst the three arms of government, it would seem to have greater credence. For clarity, it is pertinent to analyse the background facts that led to the court's position.

The appellant, Mr Kanane, an adult male, was charged with committing indecent acts with another male contrary to section 167 of the Penal Code and with committing an unnatural offence contrary to section 164(c) of the same Code. The Penal Code came in to force in 1964 prior to Botswana's independence in 1966. In the original form, sections 164 and 167 respectively read thus:

- S. 164:- Any person who-
- (a) has carnal knowledge of any person against the order of nature;
  - (b) has carnal knowledge of an animal; or
  - (c) permits a *male person*<sup>17</sup> to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.
- S. 167:- Any *male person*<sup>18</sup> who, whether in public or private, commits any act of gross indecency with another male person, or

<sup>16</sup> *Supra* n. 7 p. 80 (para. H), 81 (para. A).

<sup>17</sup> Emphasis added.

<sup>18</sup> Emphasis added.

procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of an offence.

In 1998, the National Parliament of an independent Botswana amended the provisions of sections 164(c) and 167. Following the 1998 amendment sections 164 and 167 respectively now read:

S. 164:- Any person who-

- (a) has carnal knowledge of any person against the order of nature;
- (b) has carnal knowledge of an animal; or
- (c) permits *any other person*<sup>19</sup> to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.

S. 167:- *Any person*<sup>20</sup> who, whether in public or private, commits any act of gross indecency with another person, or procures another person to commit any act of gross indecency with him or her, or attempts to procure the commission of any such act by any person with himself or herself or with another person, whether in public or private, is guilty of an offence.

As noted, the core of the amendment of sections 164 and 167 of the Penal Code in 1998 was that 'male person' was replaced with 'any other person' in section 164 (c) and with 'any person' in section 167. In broadening the scope of these provisions, the

<sup>19</sup> Emphasis added.

<sup>20</sup> Emphasis added.

legislature tangentially neutralised constitutional challenges of gender discrimination against the provisions.<sup>21</sup>

The appellant pleaded not guilty, contending that the relevant sections of the Penal Code were invalid based on inconsistency with the Constitution of Botswana. One basis of the argument was that sections 164 and 167 of the Penal Code discriminated against male persons on the ground of gender and offended against their rights of freedom of conscience, expression, privacy, assembly and association entrenched in section 3 of the Constitution. Another basis was that the sections hindered male persons in their enjoyment of their right to assemble freely and associate with other persons as contained in sections 13 and 15 of the Constitution, and the sections are thus discriminatory. Moreover, the acts for which the appellant was charged had taken place in private between two consenting male adults.

Identifying the main issue for determination, the Court of Appeal noted thus:

Whether homosexual acts between two consenting male persons carried out in private should be decriminalised in Botswana is the essence of the issue that has arisen for determination by this court.<sup>22</sup>

<sup>21</sup> A constitutional challenge of gender discrimination was actually raised against section 164 (c) of the Penal Code in the case of *Kanane v The State* when the case was presented before the High Court. The High Court applied the law as it was when papers were filed against Mr Kanane, thus the law prior to the Constitutional amendment. For the subsequent Court of Appeal judgement, see generally, *Kanane v The State supra* n. 7, pp. 72- 73, particularly p. 72, paras. B-C per Tebbut J.: "As stated above, the appellant's contention is that ss. 164 and 167 violate the Constitution as they hinder his right of association with other males or are *discriminatory against males, including him, on the basis of their gender*". Emphasis added.

The Court of Appeal seemed to note that such a challenge to section 164 (c) may have been germane prior to the 1998 amendment. However, the present provision as it stands seems to have rendered such challenge nugatory: "It will be recalled that s. 164(c) in its pre-amendment form read thus: 'Any person who -(c) permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of an offence (...)' It becomes readily apparent from the amendment that the legislature widened the scope of s 164(c) by changing the person who the offender permits to have carnal knowledge of him or her from a 'male person' to 'any person' i.e. both male and female". Per Tebbut J., p. 73 paras. F-H.

<sup>22</sup> *Ibid.*, p. 69, para. B.

After reviewing the facts and legal arguments the court gave its decision as earlier stated.<sup>23</sup> Seeming to expatiate on the rationale of the court's position, Justice Tebutt, who delivered the lead judgment, observed:

The question, however, remains whether the time has arrived when society in Botswana requires that Botswana should follow those other countries where decriminalisation of homosexual practices has occurred (...) No evidence was put before the court *a quo nor* that public opinion in Botswana has so changed and developed that society in this country demands such decriminalisation (...) As I have stated, there is no evidence that the approach and attitude of society in Botswana to the question of homosexuality and to homosexual practices by gay men and women requires a decriminalisation of those practices, even to the extent of consensual acts by adult males in private. In my view, the indications are to the contrary (...) the time has not yet arrived to decriminalise homosexual practices even between consenting adult males in private.<sup>24</sup>

An important inference from the declaration of the Botswana Court of Appeal above is that the legal position on homosexuality purports to echo the voices of the people. Considering this, it is necessary to examine whether the position on homophobia ascribed to the people by the Court of Appeal in the case of *Kanane v The State*, is *actually* the position of the people, or simply that of the legislature and judiciary acting on their own accord. This task is undertaken in the following section.

### Homophobia in Botswana: the Voice of the People?

In modern liberal democratic settings, the elected legislatures normally decide which kinds of conduct to criminalise.<sup>25</sup> In reaching such a decision "parliament must inevitably take a moral position in tune with what it perceives to be the public mood".<sup>26</sup> The Court of Appeal's decision in the case of *Kanane v The State*

<sup>23</sup> See notes 15 and 16 above.

<sup>24</sup> *Ibid.*, p. 78 (paras. G-H), p. 80 (paras. A & H).

<sup>25</sup> *Patrick Reyes v The Queen* [2002] 2 W LR 1034 (PC), *Moatshe and Ors v The State* (Crim. App. 26/01), CA, unreported.

<sup>26</sup> *Kanane v The State supra* n. 7, p. 9 (para. H).

rested primarily on the provisions of sections 164 and 167 of the Penal Code promulgated by legislators democratically elected by citizens of Botswana, and thus constitutionally empowered to act on behalf of the people.

Logically, with Botswana being a liberal democratic society, the people, through their elected legislators, had expressed their disapproval of homosexuality through the strengthening of sections 164 and 167 by the amendment of the Penal Code in 1998. The absence of any manifest protestation against the amendment by the populace evidently is additional indication that legislators indeed amplified the voices of the people. Subject to compliance with a minimum standard of human decency and respect of basic rights, the right to self-determination entitles Botswana to formulate their acceptable social, cultural or other norms and to reflect this in their laws, as in the case of the criminal law on sodomy. Based on this analysis, one can hardly question the correctness of the position of Botswana on the criminalisation of sodomy or homosexual practices. In light of this sequence, it seems unnecessary to scrutinize the basis of homophobia in Botswana.

Notwithstanding the foregoing, it is still pertinent to verify whether the views on homosexuality as vicariously ascribed to the people of Botswana represent *truly* the collective or majority voice of the people; or whether it is the dominant and suppressing voice of a minority, or perhaps, echoes of colonial voices from the past, which the people are subconsciously induced to re-echo.<sup>27</sup> The verification further seems necessary because in some countries, particularly in

<sup>27</sup> One criticism that may be laid against Botswana's Penal Code is that, having been made under colonial rule, it was imposed by colonial masters without the input of the people. It may thus not qualify as a law made by Botswana through their democratically elected representatives. Whatever may be the merit of such an argument, it cannot apply to the provisions of sections 164 and 167 based on the amendment by a democratically elected legislature of an independent Botswana in 1998. As the Court of Appeal noted, "[W]hile the Penal Code in its original form might be criticised as having been taken holus bolus from some other legislation, prior to Independence, thereby including, as it does, matters such as piracy by forcibly boarding a ship, which is unlikely to occur in a landlocked country like Botswana, and that therefore the legislature of the day never gave particular attention to s 164 and s 167, the same cannot be said today. The legislature, in passing the 1998 Amendment Act, clearly considered its provisions and, as with the effect of the rest of the act, broadened them"-*Kanane v The State*, p. 80 (paras. B-D).

the Southern African region, there are situations in which political leaders evidently influence public opinion on homosexuality with their undisguised anti-homosexuality pronouncements.<sup>28</sup> Moreover, because the criminal laws also frown upon homosexual practices in these countries, the comments of these leaders tend to have legitimacy as ‘protectors of public morals’. By virtue of their positions, the views of these leaders are perfunctorily echoed and re-echoed by followers and government officials.<sup>29</sup> Ultimately, the domineering voices of the leaders can take on the appearance of the ‘voice of the people’. As one source notes,

One leader discovered a potential target and a vituperative language that struck a responsive chord among his people. Others followed suit. They have echoed and reinforced one another across borders and over time-scapegoating one group of people for their countries’ difficulties, and explicitly excluding “homosexuals” from constitutional protections granted to their other citizens.<sup>30</sup>

Generally, the Botswana scenario seems to be of a different pattern from the countries in which the overbearing views of political leaders tend to cloud the debates on homosexuality. There are generally no provocative anti-homosexuality sentiments from the government. Rather, there are reports, for example, of the President preaching tolerance for homosexuals.<sup>31</sup> With regards to society’s views on homosexuality, there is no clear indication what societal attitudes towards homosexuality are, and the Court in the *Kanane* case has not made any effort to establish what this is.

One pertinent question in the homosexuality debates is whether

<sup>28</sup> See generally, Human Rights Watch and The International Gay and Lesbian Human Rights Commission, *More Than A Name: State-Sponsored Homophobia and Its Consequences in Southern Africa*, Human Rights Watch, New York, 2003, pp. 1-3; R. Morgan and S. Wieringa, *Tommy Boys, Lesbian Men and Ancestral Wives, Female Same-Sex Practices in Africa*, Jacana Media (Pty) Ltd., Johannesburg, 2005, p. 17.

<sup>29</sup> Human Rights Watch and The International Gay and Lesbian Human Rights Commission, *Ibid.*, p. 2.

<sup>30</sup> *Ibid.*

<sup>31</sup> See e.g., Mask Admin, ‘Botswana President: ‘Don’t be judgmental on homosexuals’ online at <http://www.mask.org.za/article.php?cat=&id=105>. Accessed on 09/06/2006.

anti-homosexuality criminal laws and the positions of political leaders influence the anti-homosexuality attitudes of the people, or whether it is the other way round. Put differently, would people still generally be intolerant of homosexuality if the laws were changed, or political leaders showed a tolerant attitude towards homosexuality. Whatever the case, in situations where the overbearing voices of leaders collaborate with anti-homosexuality criminal laws to influence, or perhaps emasculate, public opinion, it would be difficult to determine the *real* voices and positions of the citizens on homosexuality, or the desirability of the anti-homosexuality laws.

### Effect of Homophobia on HIV/AIDS Control in Botswana

A major consequence of the legally endorsed homophobia in Botswana is that it hinders the government from giving all-embracing or effective preventive measures to some population groups who are particularly vulnerable to HIV/AIDS, such as prisoners. In the specific context of prisoners, the legal and social disapproval of homosexuality has been the basis for the inability of the government to provide condoms in prisons. Research has shown that sex occurs in Botswana prisons.<sup>32</sup> However, sex in prisons is, largely, man-to-man anal sex, which constitutes the criminal act of sodomy punishable under the Penal Code.<sup>33</sup> This incapacitates the government from providing condoms to prisoners because doing so would essentially amount to indirectly condoning, abetting or encouraging the criminal act of sodomy.<sup>34</sup>

Because of the interrelation between the prison population and the outside community, the withholding of condoms in prison constitutes a gap in HIV/AIDS control, not only in prisons, but also

<sup>32</sup> See generally, K. Masetlhe, *HIV/AIDS Prevention in Botswana Prisons: What Could Be Done? The Prisoners' Perspectives and Policy Recommendations*, Department of Social Psychology, London School of Economics, London, 2002.

<sup>33</sup> *Supra* n. 14. See also *supra* n. 32, pp. 22-24.

<sup>34</sup> For further reading on the interplay between anti-sodomy laws and the non-provision of condoms in Botswana prisons, see e.g. S.B. Odunsi, 'Policies and practices aimed at withholding or denying access to HIV related prevention or treatment to people living with HIV/AIDS, particularly on the basis of sexual and social behaviour that is deemed to be 'immoral' or questionable by health care practitioners, including failure of governments to distribute condoms in prisons' - a paper presented at the HIV/AIDS and Human Rights in Southern Africa Regional Workshop held on 3 July 2006 at the Centre for Human Rights, University of Pretoria, South Africa. See also K. Masetlhe *supra* n. 32, p. 17.



in the country at large. The United Nations Commission on Human Rights alludes to this with the following words:

There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. *Protection of prisoners is protection of our communities.*<sup>35</sup>

It is trite to say that the HIV/AIDS crisis in Botswana is of serious concern.<sup>36</sup> Thus, a country with such disturbing levels of HIV/AIDS prevalence cannot afford to leave any gap that can vitiate efforts to control the disease. Along this line, it becomes imperative for the legislative and judicial organs to re-examine the necessity of maintaining anti-homosexuality legal regimes that facilitate a gap in the efforts to control HIV/AIDS in Botswana. In line with the views of the Nigerian Supreme Court,<sup>37</sup> these organs need to appreciate that although their positions are legally unchallengeable, it does not necessarily connote that their positions are flawless. However, as the case of *Kanane v The State* indicated, the prevailing position on homosexuality in Botswana exists because that is the perceived collective wish of the people. It is thus also necessary that the citizens too should re-examine the 'instructions' given to their legislative agents on the issue of homophobia. In this context, as a starting point, the legislative organ needs to reappraise the mindset of the people to determine whether it remains as it was when the anti-homosexuality legal regimes were established. Issues for determination in the reappraisal can be phrased as below:

- a. Granted that, at the time the legislature and judiciary decided the legal position on homosexuality, the people of Botswana indeed frowned upon homosexuality, *is* their position the same now as it *was* then?
- b. Considering the impact of homophobia on HIV/AIDS control, due

<sup>35</sup> United Nations Commission on Human Rights, Fifty-Second Session, Item 8 of the Agenda, HIV/AIDS in Prisons Statement by the Joint United Nations Programme on HIV/AIDS, UNAIDS, April 1996. Emphasis added.

<sup>36</sup> See e.g., Republic of Botswana, *Botswana National Strategic Framework for HIV/AIDS 2003-2009*, Pyramid Publishing, Gaborone, 2003, p. 1.

<sup>37</sup> *Supra* n. 1 and accompanying text.

to depriving condoms to prisoners who are particularly prone to HIV infection, would the people still prefer that the inhibitive laws that sustain homophobia be maintained? Put differently, between the supposedly two 'evils' of homosexuality and an unchecked spreading of HIV/AIDS, which one would the people prefer to accommodate?<sup>38</sup>

## Conclusion

Based on the issues raised above, it is necessary for the Botswana legislature and judiciary to determine whether the prevailing legal positions on homosexuality *vis-à-vis* the HIV/AIDS crisis, are in tune with reality or in the best interests of Botswana. It is true that the positions may have been appropriate and wise when they were taken originally. However, the need to effectively control the HIV/AIDS crisis dictates that critical measures should be taken to curtail the spread of the disease. The Botswana National AIDS Coordinating Agency (NACA) appreciated this by declaring,

Botswana is at a critical crossroad. To halt and eventually reverse the destructive tide of the [HIV/AIDS] epidemic requires a more dynamic, determined and radical response. To do anything less may well spell disaster.<sup>39</sup>

The 'radical response' should include removing the legal and social barriers of homophobia and all other barriers that militate against an effective control of HIV/AIDS in any way. This requires that the society should develop tolerance, if not total acceptance, of people who manifest different sexual inclinations, particularly homosexuality.

<sup>38</sup> In relation to the criminalization of homosexuality, see M.M. Chilisa, 'Two Steps Back for Human Rights: A Critique of the *Kanane Case*' in this volume.

<sup>39</sup> *Supra* n. 36, p. 11.

## TWO STEPS BACK FOR HUMAN RIGHTS: A CRITIQUE OF THE *KANANE* CASE

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Lesbians, gays, bisexuals, transgendered and intersexed (LGBTI) people in Botswana are a voiceless, invisible, vulnerable minority. Their silence and invisibility is not the result of shame as many conservatives may believe. It is rather the result of attempting to avoid societal prejudices and stigma, which are reinforced and perpetuated by the criminalization of homosexual activity. This criminalization has ensured that LGBTI will forever remain marginalised in our society<sup>1</sup>.

Their status as a minority means that LGBTI are unable to wield political power to influence and lobby for legislation to protect them against discrimination and other forms of prejudice. Like minorities in most constitutional democracies, they are predominantly reliant on the Courts for protection of their rights. In general in a constitutional democracy, the Courts are intended to protect minorities through the enforcement of a Bill of Rights, which inevitably contains provisions to guarantee all citizens the right to equality and the freedom from discrimination. This is because the courts in a constitutional democracy are the guardians of constitutional rights and through the exercise of their powers of judicial review are able to protect citizens from the trampling of their constitutional rights by other branches of Government. The courts are clothed with judicial independence to ensure that they vigorously protect constitutional rights without fear or favour and without regard to popular subjective views on the issues before them.

In the landmark case of *Utjiwa Kanane v The State*<sup>2</sup> the Botswana Court of Appeal was presented with a novel opportunity to spell out what protections—if any—the Constitution confers upon LGBTI.

<sup>1</sup> Their status as a minority and how this hinders their visibility as a group and ability to wield political power was eloquently dealt with by Justice Ackerman in the South African case of *National Coalition of Gays and Lesbians Equality and Another v Minister of Home Affairs and Ors* 2000(2) South Africa (SA) 1 (CC).

<sup>2</sup> 2003 (2) Botswana Law Review (BLR) 67 (CA).

The matter came before a full bench of the appellate court that comprised of five judges: the Honourable Judge President Tebutt, Justice Nganunu; and Justices of Appeals: Grosskopff, Korsah and Kirby. Rather than protecting the minority in Botswana, the manner in which they approached the matter showed little sympathy for the plight of LGBTI.

The Court of Appeal was asked to consider constitutional issues related to the following facts of the case: sometime in 1995, police broke into the house of Mr. Robert Norrie and found him in a compromising position with Mr. Utjiwa Kanane. Norrie was subsequently charged with and pleaded guilty to engaging in unnatural sexual acts contrary to section 164 of the Penal Code.

Mr. Kanane was also charged with the same offence, however he contested the charge on the basis that the provision violated various freedoms that the Constitution conferred upon him: namely, the right to non-discrimination (section 15 of the Constitution), the right to privacy (section 9) and the right to freedom of association (section 13). The constitutional challenge originally came before the High Court and was adjudicated upon by Justice Mwikasu, a staunch conservative orthodox Christian. In dismissing Kanane's arguments the High Court relied heavily on religious doctrine, asserting that homosexual practices were unknown to Africans until they had been brought to Africa by Westerners. Judge Mwikasu reasoned that liberal sexual attitudes had brought about 'evils' like HIV/AIDS and teenage pregnancy. Homosexuality, in his view, was a practice brought on Africans by liberal Westerners that would also bring about similar evils.

Naturally dissatisfied with the High Court judgment, Kanane appealed to the Court of Appeal. There, he persisted with the same constitutional arguments that he had advanced in the lower court. The Court, in a dry judgment that showed little enthusiasm for human rights, took the view that the time had not yet come in Botswana for the decriminalisation of homosexuality. The Court ruled that no evidence had been placed before it indicating a

change in the negative attitude of Botswana towards homosexuality, nor was there evidence that the majority of Botswana felt this minority was, at this point in time, sizable enough to be worthy of constitutional protection. The Court went on to hold that Kanane had not been able to establish that laws prohibiting homosexuality infringed on the freedom of association because LGBTI are free to associate within the confines of the law.

The Court, it seems, viewed the matter purely through the binoculars of an outsider passing judgment on homosexual conduct. It selectively framed the issue for consideration within the question of whether or not 'Botswana' were ready for the decriminalization of homosexuality. This was an extremely narrow approach to a matter that touched on the most fundamental human rights. It is, in fact, commonplace in law that constitutional rights are to be allowed as wide as possible an interpretation.<sup>3</sup>

Indeed, the first issue with which the court ought to have concerned itself with was whether the law had any business in seeking to regulate sexual activity conducted between two consenting adults, which takes place in private and does not result in harm to any of the parties involved—whether homosexual or heterosexual. This ought to have been the starting point, especially in light of the fact that section 9 of the Constitution of Botswana entrenches the right to privacy. In *Diau v Botswana Building Society*<sup>4</sup> Justice Dingake described the right to privacy as the right to be left alone. In the South African case of *National Coalition of Gays and Lesbians Equality and Another*,<sup>5</sup> Ackerman J. described this right as recognizing that all individuals have a right to a sphere of private intimacy, which allows people to establish relationships with each other without interference from the community. In the private domain, he continued, it is not the State's business to dictate with whom individuals are intimate.

In the *Kanane* case, the Court of Appeal does not seem to have dealt at all with whether laws prohibiting homosexual conduct infringe on the constitutional right to privacy. It is startling that

<sup>3</sup> See *Unity Dow v Attorney General* 1992 BLR 119 (CA).

<sup>4</sup> 2003 (2) BLR 409, p. 431.

<sup>5</sup> 1999 (1) SA 6 (CC), p. 30.

any Court asked to address the constitutionality of criminalising sexual conduct that takes place in private would fail to deal with the impact that such a prohibition would have on an individual's right to privacy. The test of whether a law violates a constitutional right is two-fold. Firstly, does the act in question limit the enjoyment of a constitutional right? Secondly, is the limitation reasonably justifiable in a democratic society?

On the first point, the intrusion of the State into an individual's private sphere undoubtedly amounts to an infringement on the right to privacy. This applies to any law that penalizes sexual conduct carried out in private—at the very least, this limits an individual's enjoyment of a constitutional right to privacy.

This, therefore, leaves the only issue to be decided as whether the prohibition of the conduct is reasonably justifiable in a democratic society. Not every prohibition is unjustifiable. For example, virtually all democratic societies, without exception, penalize intergenerational sex, intra-familial and cross-species sex regardless of whether it takes place in private or in public. Although never applied by the Court of Appeal in *Kanane*, a three-fold test is used to determine whether or not infringements are reasonably justifiable in a democratic society. If it does not meet any one of the criteria, then it should be struck down as unconstitutional:

1. the legislative objective which the limitation is designed to promote is important enough to warrant overriding a fundamental right;
2. the measures designed to meet the legislative objective are rationally connected to it and are not arbitrary, unfair or based on irrational considerations; and,
3. the means used to infringe upon the right or freedom are no more than is necessary to accomplish the objective.<sup>6</sup>

Penalizing homosexual conduct does not seem to advance any legislative objective. The Court in *Kanane* failed to state what legislative objective was advanced by the criminalization of

<sup>6</sup> See *Chavanduka & Anor. v Minister of Home Affairs, Zimbabwe & Anor.* 2000 (4) (ZS); p. 15-16.

homosexuality—because it does not advance any. Homosexual conduct does not result in any harm so long as it takes place between two consenting adults. This is in contrast to the prohibition of cross-species sex; in that case, there is harm because the non-human species lacks the capacity to consent to the act and, therefore, the Legislature is entitled to legislate against it. With respect to prohibiting homosexuality, there is no reason apart from the fact that it is different from what is practiced by the majority. As a result, the penalization of homosexuality cannot be said to be reasonably justifiable in a democratic society. Had the Court of Appeal properly addressed the weighty constitutional issues placed before it, it would have arguably found as a matter of both fact and law that no justification existed for criminalizing homosexual conduct and that this criminalization infringes on the right to privacy.

The *Kanane* case was not just about the enforcement of privacy rights. At the heart of Kanane's challenge to the law prohibiting homosexual conduct was that criminalizing anal sexual intercourse unfairly discriminates against gay persons—even if this type of sexual intercourse is criminalized between men as well as between men and women. This is because a common means available to the gay community to express themselves sexually is by engaging in such acts of sexual intercourse.

The Court took a peculiar approach to the question of whether the prohibition unfairly discriminates against gays and lesbians as a minority. The Court reasoned that because the negative attitudes of Botswana towards homosexual activity have not softened, the non-heterosexual community did not at this present time constitute a minority worthy of constitutional protection against discrimination.<sup>7</sup> The Court rather disappointingly at page 80 of the judgement found that the legislature had in 1998 extended the prohibition of 'unnatural sexual acts' to cover acts as between women and as between men and women, out of concern about the incidence of AIDS: "This court can take judicial locus of the incidence of AIDS both worldwide and in Botswana, and in my

<sup>7</sup> However, the Court has not explained in its judgment the basis on which they decided societal attitude towards homosexuality. For further insight on this issue, see: B. Odunsi, 'A Need to Re-examine the Voice of the People? Reflections on the Interplay of Homophobia and the HIV/AIDS Pandemic in Botswana' in this volume.

opinion the legislature in enacting the provisions it did was reflecting a public concern”.

Section 15(3) of the Constitution prohibits discrimination on various grounds—but does not include sex or sexual orientation. The Court of Appeal in *Unity Dow v Attorney General*<sup>8</sup> reasoned that the list of grounds in section 15(3) upon which discrimination is prohibited was not exhaustive and furthermore prohibited any discrimination that was unfair and irrational. The late Ammisah J.P. who joined the majority in the *Dow* case stated:

I am fortified in this view by the fact that other classes or groups with respect to which discrimination would be unjust and inhuman and which, therefore, should have been included in the definition were not. A typical example is the disabled. Discrimination wholly or mainly attributable to them as a group as such would, in my view, offend as much against section 15 as discrimination against any group or class. Discrimination based wholly or mainly on language or geographical divisions within Botswana would similarly be offensive, although not mentioned. Arguably religion is different from creed, but although creed is mentioned, religion is not. Incidentally, it should also be noticed, that although the definition mentions “race” and “tribe”, it does not mention “community”, yet the limitation placed on section 15 (1) by section 15 (4) refers to “a particular race, community or tribe.” All these lead me to the conclusion that the words included in the definition are more by way of example than as an exclusive itemisation. The main thrust of that definition in section 15 (3) is that discrimination means affording different treatment to different persons wholly or mainly attributable to their respective characteristic groups.<sup>9</sup>

Departing from the test as set out in the *Dow* case about whether an Act of Parliament offends section 15(3), the Court in *Kanane* seems to have come up with another test that gives an extremely narrow meaning and renders meaningless the right to non-discrimination. The *Dow* case maintains that all discrimination that is irrational is unlawful. The test for unfairness is whether a rational basis exists for distinguishing between two classes of persons and whether such a

<sup>8</sup> *Supra* n. 2.

<sup>9</sup> *Ibid.*, p. 147.



distinction is reasonably justifiable in a democratic society. In the *Kanane* case, the Court determined whether a minority is worthy of constitutional protection based on the attitudes of the majority of Batswana towards a minority group and on the size of the minority. That is an extremely unsound test for deciding whether a minority qualifies for constitutional protection.

Discrimination is often the result of ignorance, stereotyping and certain irrational prejudices held by the majority about a minority. It is not judicious for a Court to turn away a minority population that has sought its protection on the basis that the majority does not believe in their cause. In so doing, the Court is tolerating and perpetuating discrimination along with irrational stereotypes about the minority held by the majority. This is alarming because the Courts are not majoritarian institutions; rather, they are entrusted with protecting constitutional liberties because they are intended to be impartial and beyond majoritarian politics.

When presented with the opportunity to do so, the Court of Appeal failed to uphold Kanane's appeal and, thus, dismally failed to protect minority rights. Instead, it reaffirmed unjustifiable societal prejudices and stereotypes against the LGBTI community. The Court failed to realize that equality does not require the homogenization of human conduct but requires respect for and acceptance of difference.

The conservative segment of society may be entitled to *feel* that homosexuality is morally wrong and disgusting and may be entitled to *express* those views in the exercise of their constitutional right to freedom of speech and conscience. However, their feelings, expression and prejudices should not be legislated for at the expense of other individuals' rights to privacy and equality. The Court seemed to have missed this point in failing to strike down the prohibition against homosexual conduct and justifying such failure on the basis that the majority of Batswana support such a prohibition.

Consistent with its approach that displayed little enthusiasm for human rights, the Court of Appeal concluded that the prohibition of anal sexual intercourse did not hinder Kanane's freedom of association because he was still free to associate within the confines of the law. It was not a very novel answer to a very weighty constitutional argument that deserved thorough consideration. It is akin to a situation in which Parliament passes a law banning all opposition political parties, only to have the Court respond to a challenge to the ban by saying, "You can join the ruling party or form other non-political associations that are not prohibited". Had the Court considered whether it was reasonably justifiable that the criminalization of homosexual conduct violated constitutional rights, then the judgment may have had more substance to it.

The *Kanane* case, thus, represents a major setback in terms of the development of Botswana's human rights jurisprudence. The Court's reasoning or lack thereof seems to suggest that the Court is prepared to engage in *ad hoc* decision making rather than develop concrete principles of judicial precedence that will guide them in dealing with like cases in the future. It is fervently hoped that the Court of Appeal will once more be presented with an opportunity to reconsider its reasoning in the *Kanane* case. It is not so much the outcome but the reasoning behind it that has caused anxiety in the minds of those who are passionate about human rights and the law. It seems there was no justifiable reason at all to continue criminalizing homosexual conduct. Rather, it was perpetuated based on perceptions of the majority's attitude towards a minority, even despite numerous constitutionally enshrined protections. If similar reasoning were to be followed for other minority groups seeking protection, then it would spell doom for the right to equality as envisaged and guaranteed by the Constitution.

# UGANDA'S POLITICAL RESPONSE: SUCCESS OR VIOLATION OF RIGHTS?

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Uganda is a special case in the history of the HIV/AIDS pandemic, not only because it was the first African country to acknowledge that HIV was a serious public health threat, but because its early prevention strategies led to a significant decrease in HIV prevalence and incidence from the 1980s and into the 1990s. More so for the latter reason, Uganda has been hailed by international donors, activists, politicians and health experts as an exemplary country which has effectively taken action to inhibit the spread of the epidemic. Also, Uganda is a unique case in the East African region, as surrounding countries such as Tanzania and Kenya have not witnessed similar declines in the same decade (from 1989 to 1999). However, wide skepticism remains about the reality of trends in HIV/AIDS and whether HIV incidence rates have decreased over the last decade. An even more controversial debate has centred around which particular strategies and programs can be attributed with catalyzing the turn around in the spread of the virus. Nevertheless, Uganda's reversed trends have made it a highlight of foreign aid for donors who were starved for a success story in the midst of continuous economic development crises of the late 1980s. The influence of foreign donors was tremendous as it not only played a large role in supporting HIV prevention strategies, but also in changing national attitudes regarding basic rights to sexual and reproductive health (SRH) information. With the ebb and flow of donor funding and shifts in the nature of the funding, primarily from the US, there was a simultaneous change in access to indispensable SRH information that could make or break one's life.

## Apparent Turn-Around of the Epidemic

Since the first discovery of HIV/AIDS in Uganda in 1982, the government has taken action by setting up sentinel surveillance

sites throughout the country in antenatal clinics (ANCs). Pregnant women were anonymously tested and HIV has been regularly monitored from 1992 to 1998. In 2000, it was clear that HIV prevalence rates had substantially declined, most notably in the village of Mbarara, which experienced a huge decline from 30% to 10% during the course of the decade.<sup>1</sup> Such a decline in prevalence rate among antenatal clinics was unheard of at the time, leading other countries who faced the HIV/AIDS challenge to look to Uganda as a model and attempt to replicate the strategies used to achieve the same results.

## Uganda's Response

Uganda's political response to HIV occurred in 1986, very early in comparison to others. The AIDS Control Programme, established by President Museveni, started the surveillance of HIV prevalence in ANCs, ensured safe blood supply, and provided extensive information on AIDS and control of sexually transmitted diseases (STDs).<sup>2</sup> Social marketing of subsidized condoms was also very effective in encouraging safe sex, thereby lowering the risk of contracting HIV. Additionally, in the early 1990s, the Ugandan government set up the Uganda AIDS Commission (UAC), which was intended to be a multi-sector response to the epidemic because it brought in members from other ministries such as the Agricultural, Internal Affairs and Justice Departments.<sup>3</sup> In its programming, the UAC invited stakeholders from the government and non-government sectors for advice. It substantially attempted to avoid duplication of efforts by collaboration with existing non-governmental organizations (NGOs) who were already facilitating HIV prevention programs. The government continues to identify the needs of HIV infected and affected populations, including recently, the need to improve capacity building and in-depth surveillance mechanisms.<sup>4</sup>

The political commitment of the government in response to HIV/AIDS has been exemplary as the government pursued the inclusive strategy of working with community based organizations (CBOs)

<sup>1</sup> J. Parkhurst, 'The Crisis of AIDS and the Politics of Response: the Case of Uganda', *International Relations*, Vol. 15, 2001, pp. 69-87.

<sup>2</sup> *Ibid.*, p. 73.

<sup>3</sup> <http://www.avert.org/aidsuganda.htm>

<sup>4</sup> *Op. cit.* n. 1, p. 74.

and non-profit organisations, as well as international donor organizations. This has minimized sectarianism and divisions between different groups which pursue different HIV prevention strategies. Given the degree of sensitivity around changes in sexual behavior, there are a multitude of strategies for addressing sexual behavior change to inhibit HIV. The fact that the government, from an early stage, has encouraged the proliferation of different approaches to HIV for targeted populations was a very positive response because it did not control or limit innovative methods. This is otherwise referred to as the 'open approach'. The government recognized that non-state actors such as NGOs and community-based organizations facilitate public service provision in ways that the government could not, and allowed them to do so without imposing any stringent limitations or oppression. This open approach helped minimize stigma and discrimination and encouraged people to freely discuss otherwise taboo topics.<sup>5</sup>

### Success and Misinterpretation

While the above is cited as particularly exemplary of a government's response to the HIV epidemic, it is important to comprehend the basis for claims regarding Uganda as the model success story. Much of Uganda's success is attributed to only a few areas, with surveillance in antenatal clinics in urban areas. In fact, the 30 to 10% decline in antenatal clinics in the village of Mbarara has been cited in many official documents and reports as the decline in prevalence in all of Uganda. This is a misused statistic and such antenatal clinic results are not representative of the entire country, especially when 87% of the population lives in rural areas.<sup>6</sup> Different perspectives on the causality of the HIV decline complicate this analysis. In the communities surveyed between 1989 and 1999 by the AIDS Control Programme, changes in migration and the nature of these communities contributed to the decline in HIV prevalence.<sup>7</sup> It is hard to understand if HIV prevalence declines because of mortality rates or because of lower incidence. Also, since HIV causes decreased fertility in women, those women who experience miscarriages and those who live with HIV for a long time

<sup>5</sup> *Ibid.*, p. 79.

<sup>6</sup> J. Parkhurst, 'HIV Prevention Policy in Sub-Saharan Africa: The Ugandan Experience', D.Phil. Thesis, Oxford University, 2002, Chapter 4.

<sup>7</sup> M. Mbulaiteye *et al.*, 'Declining HIV-1 Incidence and Associated Prevalence in a Rural Population in South-West Uganda: A Cohort Study', *The Lancet*, 360, 6 July 2002.

but do not get pregnant are not accounted for in the surveillance set up. As stated by UNAIDS,

[T]his shift in bias could in part explain observed reductions in HIV prevalence in Uganda. Not only is there a bias with surveying pregnant women in antenatal clinics, but HIV prevalence among pregnant women is not an accurate indicator of progress in the decline of HIV in the country. Instead, incidence rates, new infections over a set period of time, should be used to understand changes in the spread of HIV. These are difficult to measure because monitoring must be done over a specific group of people for a long period of time. Since measuring prevalence (total number of people with HIV) is a lot easier, prevalence rates are used to reflect HIV in the country. Use of prevalence instead of incidence rates adds to the false impression that the spread of HIV is declining. Unfortunately, statistics based on the above mentioned data analysis have been created into 'myths' – used to describe an overall improving situation in the entire country.<sup>8</sup>

This was a significant contributor to Uganda's image as a success story. Nevertheless, all cohort studies point to a reversed trend in both prevalence and incidence of HIV relative to surrounding countries. For this reason, there is much the world can learn from Uganda's response to HIV.

### **Implications of Misinterpretation, Foreign Influence and Denial of Rights**

Precisely because a large part of HIV prevention was spearheaded by community based organizations and NGOs – actors who are not, by law, accountable to the people - the development of HIV policies in the 1990s shed new light on people's human rights. The desire to push forward culture specific HIV policies was mitigated by the continuous need to appease international donors. Most NGOs rely on private and international funders who consistently seek such success stories as Uganda, which was not only progressive in its approach to HIV but also in poverty alleviation and macroeconomic

<sup>8</sup> *Op. cit.* n. 1.

stabilization. Misinterpretation of epidemiological data, as discussed above, as well as other biases which contributed to Uganda's image as a remarkable example of inhibiting HIV, framed Uganda as a goldmine for international donors. As it attracted more donors, Uganda also attracted increasing infringements on the freedom to exercise multi-faceted approaches against HIV.

The US has been a particularly significant donor to Uganda, but in the early 21st century US foreign aid was heavily influenced by evangelical Christians and conservatives in the Bush administration who had very specific views on sexual and reproductive health. Namely, the Bush administration cut off funding for family planning projects which included abortion, and geared support to programs which advocated for abstinence-only education as an HIV prevention method. As a result, Human Rights Watch has accused the US government of violating the rights of young people to information about sexuality, condoms and other methods of live-saving contraception.<sup>9</sup> NGOs and CBOs in Uganda have always competed for international funding. But recently, the born-again Christian movement coupled with strong conservative sentiments from donors in the United States have gradually shifted most funding to those NGOs that advocate a specific, limited agenda on sexual health and HIV/AIDS prevention, an agenda that is in line with faith-based concepts.

Since 1995, HIV prevention has been predominantly manifested in abstinence-only education, and to this day the 'C' (condom use) and the 'B' (be faithful) in the world-wide known ABC approach that Uganda has taken has been marginalized in the overbearing emphasis on the 'A' (abstinence) from born-again Christians. The born-again Christian movement is supported both financially and spiritually by evangelical Christians in other parts of the world and most dominantly, in the United States. The implications of this current influence from faith-based groups on the Ugandan people's culture, behavior, traditions and society, have been central to a wave of neglect of basic human rights. Not only has the religious movement challenged basic rights to information for

<sup>9</sup> H. Epstein, 'God and the Fight Against AIDS', *New York Review of Books*, 28 April 2005.

one's own well being, but it has completely failed to acknowledge the vulnerabilities of women and their right to understand how to protect themselves from sexual abuse. In Uganda's case, as with many developing countries that rely on foreign funding, a trade off occurred between effective preventive methods that substantially contributed to the observed decline in HIV and obtaining funds from international donors. The basic human right to health information was also traded off in this regard.

Since the born-again Christian movement became widespread, it has condemned any messages that advocate condom-use. Uganda has ratified the International Covenant on Civil and Political Rights in 1966, which claims that 'all people have the right to seek, receive and impart information of all kinds, including information about their health'.<sup>10</sup> The Committee on the Rights of the Child, which is responsible for ensuring the implementation of the Convention of the Rights of the Child (which Uganda ratified) also states, "effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information and that is consistent with their obligations to ensure the right to life, survival and development of the child".<sup>11</sup> Even though numerous studies have been done to show the ineffectiveness of the abstinence-only strategy, religious backing manifested in financial support from the international community outweighed the detrimental implications of an abstinence-only approach. The burning of condoms by respected religious leaders and the acknowledgement by high ranking officials such as President Museveni's wife about the fact that abstinence-only education was the key to Uganda's success, deny people their right to important information.<sup>12</sup> These rights have been forgone for misinterpreted science and ignorance about preventative methods. Instead of facts based on real scientific evidence, young people are taught to be faithful to their sexual partners through a belief in God. This is clearly exemplified by Epstein's discussion with a young girl from the Girls of Glory of Virginity Movement (GGVM), a group funded by Mrs. Museveni: when asked how they know their husbands will

<sup>10</sup> 'The Less They Know, the Better: Abstinence-Only Programs in Uganda', Human Rights Watch, 2005.

<sup>11</sup> *Ibid.*

<sup>12</sup> *Op. cit.* n. 9.



be faithful, the girl replied that she will pray for him.<sup>13</sup>

This denial of information also neglects the cultural, political and economic context that makes women particularly vulnerable to infection. Abstinence is impossible for women who face sexual violence and abuse due to warfare, as is the case in the northern regions of Uganda, where, incidentally, there has been minimal research on HIV surveillance.<sup>14</sup> As for being faithful, many men are susceptible to involvement with sex workers if they partake in occupations such as long-haul truck driving, which requires them to be away from their families for extended periods of time. For the girls, sex work is often the only means of survival rather than a voluntary occupation. While a wife might be faithful to her husband and think that she is not at risk as a result, it is hard to guarantee that the latter will be. Moreover, while virginity in Uganda is traditionally valued and advocated to be preserved, faithfulness among men never was. Polygamy, in both its formal and informal forms, has been practiced in Uganda for centuries, with government officials and the president themselves being participants. It is thus that 'abstinence [and being faithful] seems at odds with this culture'.<sup>15</sup>

In Uganda, as the condom promotion that was widespread in the late 1980s and early 1990s was swept under the rug, so was the Zero-Grazing campaign, once used as a local strategy to promote monogamy among men. The campaign encouraged men to stay faithful to their wives and not engage in irregular sexual activity. Coupled with condom promotion, this campaign was considered very effective in lowering the proportion of men with non-regular partners in the late 1980s. According to an interview with David Apuuli from the Uganda AIDS Commission, Zero-Grazing openly recognized the prevalence of polygamy and promiscuous behavior and that this would not be acceptable in the current political and religious environment.<sup>16</sup> The money coming from American evangelical missionaries has revolutionized the country's approach to HIV prevention. In 2004, condom billboards, once extremely effective, were replaced with abstinence only messages by cardinals

<sup>13</sup> *Ibid.*

<sup>14</sup> T. Coates, 'Science vs. Assumption in Public Health Policy: Abstinence is Not the Answer', *San Francisco Chronicle*, 25 May 2004.

<sup>15</sup> *Op. cit.* n. 9.

<sup>16</sup> *Ibid.*

and bishops and all condoms are subject to quality control tests even though the required equipment is unaffordable.<sup>17</sup> Culturally-sensitive approaches and scientific reality were replaced with religious ideology.

It is no myth that Uganda has experienced a reversal trend with the HIV epidemic and the response of the government and non-state actors has been overwhelmingly conducive to such a reversal. However, misrepresentation of statistics that provides inaccurate frames of understanding, confusion about incidence and prevalence and premature assumptions about the cause of decline lead to misinterpretation about the nature of success.<sup>18</sup> Changes in development assistance in the early 1990s and into the early 21st century have transformed any hopes for further declines while taking away human rights. It is still unclear as to which prevention strategies turned the epidemic around in the 1990s; it is most likely a combination of government, NGO and faith-based community involvement but there is no doubt that condom promotion via effective condom social marketing campaigns have led to low HIV incidence rates.<sup>19</sup> Cultural and political contexts make it impossible to rely on abstinence and be faithful messages and neglect the existing disempowerment of women. Individuals exposed to abstinence-only education are not being given the full range of tools that they need to take care of themselves and in this way, are denied of essential sexual and reproductive health information.<sup>20</sup> As political environments dictate science and manipulate evidence, thousands of lives are placed in danger of misinformation, disease and ultimately, death.

<sup>17</sup> *Ibid.*

<sup>18</sup> *Op. cit.* n. 6.

<sup>19</sup> *Op. cit.* n. 9.

<sup>20</sup> *Op. cit.* n. 14.

# LEST WE DO NOT SEE THE WOOD FOR THE TREES: HUMAN RIGHTS AND ROUTINE HIV TESTING

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The currents of global and local trends in HIV/AIDS prevention and treatment bear witness to concerted efforts towards the goals of universal access including testing, normalizing, facilitating and scaling up diagnosis, treatment and care. In social reality, HIV/AIDS has virtually, from its inception, been universally unique in its attraction of stigma, trauma and discrimination, and in Africa, stigma has been identified as *the* key challenge to prevention and care efforts.<sup>1</sup> The debilitating and destructive effects of stigma and human rights violations need to be recognised, and efforts need to be made to prevent, reduce and eliminate them through multi-sectoral approaches, especially in resource-limited settings in the developing world.

In 2002 Botswana, which had the world's highest prevalence rate of HIV/AIDS, introduced free antiretroviral treatment (ART) to all citizens in need of it. To increase the use of free ART and Prevention of Mother to Child Transmission (PMTCT) programs, the country changed its testing processes from patient-initiated 'opt-in' Voluntary Counseling and Testing (VCT), to provider-initiated 'opt-out' Routine HIV Testing (RHT) in 2004. In RHT, patients in a clinical setting are informed that they will be tested for HIV in the absence of express refusal. The cyclical relationship between HIV/AIDS and human rights is such that, just as people with HIV/AIDS experience abuse of rights including stigma, vulnerability to the epidemic thrives on violations of rights. Since stigma continues to stop people from testing, testing mechanisms while undoubtedly essential, need to integrate protection from stigma and discrimination, rather than do away with legal and policy-based checks and balances. Routine Testing, in principle, integrates human rights. The challenge lies in ensuring this integration in practice.

<sup>1</sup> Statement from the First Regional Conference on Community Home Based Care, 5 - 8 March 2001, Gaborone, Botswana, cited in S. Gruskin, M. Maluwa, 'Human Rights and HIV/AIDS', in M. Essex *et al.*(eds.), *AIDS in Africa*, Kluwer Academic/ Plenum Publishers, New York, 2002, at pp. 648, 653.

This paper endeavours to underline the significance of the Human Rights Dimension in responding to HIV/AIDS using the particular example of the Routine HIV Testing policy and its implementation in Botswana and beyond; and to argue that the integration of essential qualitative factors would help to realize the winds of change in RHT and in HIV/AIDS as a whole. Qualitative research on the practice, process and quality of RHT would study *inter alia* whether and to what extent guidelines on RHT are followed, and whether and to what extent human rights concerns are integrated in their implementation; relevant medical and ethical standards; the degree to which pre- and post-test counseling is offered; the adequacy of volition and information; and the fulfillment of the requisites of informed consent and confidentiality.

### Public Health, Human Rights, HIV/AIDS and Routine Testing

The importance of bringing HIV/AIDS policies and programs in line with human rights law is generally acknowledged. The course of the AIDS epidemic has shown that public health efforts to prevent and control the spread of HIV/AIDS are more likely to succeed when policies and programs promote and protect human rights (...) Information, education, and advocacy in the context of a human rights framework continue to provide an opportunity to ensure that public health efforts will positively impact the response to the HIV/AIDS epidemic (...).<sup>2</sup>

The issue of RHT lies at the cross-roads of public health efforts to prevent HIV/AIDS and human rights goals to protect human dignity. It has long been internationally recognized and confirmed that human rights protection and promotion are central to the response to HIV/AIDS,<sup>3</sup> and universal access goals will not be achieved in the absence of human rights based approaches<sup>4</sup>

<sup>2</sup> Gruskin, Maluwa, *ibid.*, pp. 651, 653.

<sup>3</sup> M. Robinson, Foreword, International Guidelines on HIV/AIDS and Human Rights, Office of the United Nations High Commissioner for Human Rights (OHCHR)/Joint United Nations Program on HIV/AIDS (UNAIDS), Geneva, 1998; L. Arbour, P. Piot, Foreword, International Guidelines on HIV/AIDS and Human Rights (Consolidated Version), OHCHR/UNAIDS, Geneva, 2006. Also see UNAIDS, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, Geneva, 1999.

<sup>4</sup> For more on a rights - based approach to health, see World Health Organization (WHO), *25 Questions & Answers on Health and Human Rights*, Health & Human Rights Publication Series, Issue No. 1, Geneva, July 2002.

in which they “must be anchored”.<sup>5</sup> Although law and human rights should be a core element in the global HIV/AIDS struggle,<sup>6</sup> they often constitute the missing link. Such approaches will in effect help to resolve ethical dilemmas and realize the mutually reinforcing objectives of public health and human rights, towards human dignity and social justice. In applying a holistic approach, the integration of ethical, legal, and other interventions can help reconcile apparently conflicting interests, and compliment rather than contradict public health objectives.

## Routine Testing - Ethics, Law, Principle and Policy

Routine HIV Testing raises numerous ethical, moral, legal and other issues which attract a range of values, standards and rules at different levels and in diverse aspects. The concept of ‘ethics’ denotes moral principles that control or influence a person’s behaviour; a system of moral principles or rules of behaviour; and also the branch of philosophy that deals with moral principles.<sup>7</sup> RHT has attracted much debate, and there are writers who support it from an ethical, moral and philosophical basis.<sup>8</sup>

Before the introduction of RHT in Botswana, stigma and discrimination, including fear of test results, were some of the reasons that kept Botswana away from Voluntary Counseling and

<sup>5</sup> UNAIDS Global Reference Group on HIV/AIDS and Human Rights, UNAIDS/WHO Policy Statement on HIV Testing, Geneva, June 2004. WHO and UNAIDS have recently developed draft guidance on provider - initiated testing and counseling in health facilities, to improve HIV related diagnosis, treatment and care and to expand the availability and uptake of HIV testing and counseling in clinical settings. When finalized, the guidance is intended to expand on the 2004 Statement.

<sup>6</sup> Open Society Institute, *Human Rights and HIV/AIDS: Now More than Ever, 10 Reasons Why Human Rights Should Occupy the Center of the Global AIDS Struggle*, OSI, USA, 2006.

<sup>7</sup> *Oxford Advanced Learner’s Dictionary*, Oxford University Press, Oxford, 2000. Further, ‘ethical’ means connected with beliefs and principles about what is right and wrong; morally correct/acceptable.

<sup>8</sup> See for instance, T. Metz, ‘The Ethics of Routine HIV Testing: A Respect-Based Analysis’, *South African Journal of Human Rights*, No. 21, 2005, p. 370. In the scientific sphere, K. De Cock *et al.* in an often cited article, ‘Shadow on the Continent: Public Health and HIV/AIDS in Africa in the 21<sup>st</sup> Century’, *Lancet*, 360:70, 2002 called for RHT which need not necessarily require consent or counseling, basing their argument against AIDS exceptionalism, and in favour of emergency health measures.

Testing.<sup>9</sup> With recent changes in international policy in relation to HIV testing, one of the key justifications for the introduction of RHT in Botswana was the removal of stigma and avoidance of 'AIDS exceptionalism', so that HIV is treated like any other disease. The Human Rights Dimension is intrinsic to the principle and practice of RHT. The UNAIDS/WHO Policy Statement on HIV Testing<sup>10</sup> requires the integration of the 3 Cs of Consent, Counseling and Confidentiality in testing procedures. The purpose of integrating ethical and legal values into the RHT process, as evidenced by their integration in the Ministry of Health Guidelines on the RHT process for healthcare-workers in Botswana,<sup>11</sup> primarily through the 3 Cs, was to preserve non-negotiable human rights principles in HIV/AIDS as in the treatment of all other diseases, in accordance with general WHO standards and/or professional standards on ethics and/or human rights principles to be utilized or adhered to in medicine in general. The Principles of Medical Ethics of the American Medical Association, for instance, are well known standards of conduct which define the essentials of honourable behaviour for physicians.<sup>12</sup>

Basic human rights are non-violable because they are inherent in all human persons; they are based on the obligations undertaken by governments in international and regional law and policy; and they are enshrined in national Constitutions. Under the United Nations Charter, respect for human rights and dignity are a general obligation of all member states, which need to adhere to the Universal Declaration of Human Rights. Further, all states are obligated to operationalize and internalize their obligations under several international treaties - to not violate, to respect,

<sup>9</sup> UNICEF, UNAIDS, WHO, UNFPA, Report from the African Regional Meeting on Pilot Projects for the Prevention of Mother to Child Transmission of HIV, Gaborone, Botswana, March 2000, cited in Gruskin, Maluwa, *op. cit.* n. 1, pp. 648, 653.

<sup>10</sup> *Op. cit.* n. 5. As pointed out by S. Rennie, F. Behets, 'Desperately Seeking Targets: The Ethics of Routine HIV Testing in Low - Income Countries', *Bulletin of the WHO*, 84:1, 2006, p. 52 at 53, the UNAIDS/WHO policy clearly states under the section entitled 'Ensuring a Rights Based Approach' that the uses of RHT are only ethically legitimate under certain conditions. Ongoing review relating to provider-initiated testing and counseling in health facilities with a view to elaboration of the UNAIDS/WHO Statement of 2004 will hopefully lead to overall improvement of the processes.

<sup>11</sup> Republic of Botswana, Ministry of Health, *Routine HIV Testing Patient Centred Care Model*, 29 February 2004.

<sup>12</sup> <http://www.ama-assn.org/ama/pub/category/2512.html>

protect, and fulfill all relevant rights, and overall, to ensure conditions enabling all persons to realize or progressively realize their rights to the fullest, even if resources are required. In the case of Botswana, treaty commitments include: the African Charter on Human and Peoples' Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

At the policy level, the Millennium Development Goals are intended to steer global development and integrate several objectives which include combating HIV/AIDS,<sup>13</sup> eradicating extreme poverty, promoting gender equality, improving maternal health and reducing child mortality.<sup>14</sup> From 1987, the WHO Global Programme on AIDS made human rights an integral part of its global AIDS strategy and set guidelines on several issues, including HIV testing. This is also consistent with WHO's holistic definition of health as including complete physical, mental and social well-being rejecting the compartmentalization of these dimensions. Human rights provisions are included in many regional AIDS programmes. African states in the Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa,<sup>15</sup> and Southern African Development Community (SADC) states in the Maseru Declaration of SADC Heads of State on HIV/AIDS,<sup>16</sup> committed themselves to the integration of human rights in HIV/AIDS. Since 1997, several of the international human rights treaty-monitoring bodies have discussed HIV/AIDS in the context of human rights with many African governments, and a primary focus has been on the need to use a human rights framework to develop and enact strategies for HIV prevention, care, and impact mitigation, allowing *inter alia*, for providing information and education.<sup>17</sup>

<sup>13</sup> [www.undp.org/mdg/goal6.pdf](http://www.undp.org/mdg/goal6.pdf)

<sup>14</sup> For a discussion of HIV/AIDS in relation to the MDGs, see Stephen Lewis, *Race Against Time*, House of Anansi Press, Toronto, 2005.

<sup>15</sup> Organisation of African Unity and African Development Forum, Abuja, 27 April 2001.

<sup>16</sup> SADC Heads of State and Governments, Summit on HIV/AIDS, Maseru, Kingdom of Lesotho, 4 July 2003.

<sup>17</sup> Gruskin, Maluwa, *op. cit.* n. 1, pp. 646, 647.

The Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) 2001 states that the realization of human rights and fundamental freedoms for all is essential in reducing vulnerability to HIV/AIDS.<sup>18</sup> The International Guidelines on HIV/AIDS and Human Rights 1998 (as amended in 2002 and consolidated in 2006)<sup>19</sup> lay down essential human rights in the context of the epidemic, including: non - discrimination in any form, as equality and non-discrimination are basic tenets of human rights theory and practice; privacy; liberty and security of person; education; work; freedom of expression and information, assembly and association; right to the highest attainable standard of physical and mental health; adequate standard of living and freedom from cruel, inhuman and degrading treatment and punishment. The most basic rights in the RHT context involve security of the person, individual sovereignty and autonomy, health, privacy and information. The UN Guidelines require domestic implementation of treaties, and provision of non-discrimination laws.

On the national level in Botswana, Vision 2016<sup>20</sup> outlines the Nation's Vision for herself of becoming an Educated and Informed, Innovative, Compassionate, Just and Caring, Safe and Secure, Open, Democratic and Accountable, Moral and Tolerant Nation and sets a context for the direction of law and policy making, implementation and interpretation. The Constitution of Botswana enshrines several rights and freedoms, including: life, personal liberty, privacy, protection from discrimination and inhuman treatment, freedoms of conscience, expression including information and communication,<sup>21</sup> association and movement. The Constitution, as the basic law of the land, needs to inform the making, implementation and interpretation of all laws and policies.

<sup>18</sup> UNGASS Declaration of Commitment 2001, para. 98.

<sup>19</sup> *Op. cit.* n. 3.

<sup>20</sup> 2016 will mark 50 years of independence for Botswana, which became free from Britain in 1966.

<sup>21</sup> Article 12 (1) reads: "Except with his own consent, no person shall be hindered in the enjoyment of his freedom of expression, that is to say, freedom to hold opinions without interference, freedom to receive ideas and information without interference, freedom to communicate ideas and information without interference (whether the communication be to the public generally or to any person or class of persons) and freedom from interference with his correspondence".



The Botswana National Policy on HIV/AIDS 1998 recognizes the need for respect of human rights, privacy and self-determination; expressly provides for counseling, consent and confidentiality<sup>22</sup> and envisages non-discrimination in relation to HIV/AIDS. The Ministry of Health Guidelines for RHT,<sup>23</sup> in principle, incorporates the requirement of the 3 Cs in the process to be adopted by healthcare workers. Provision of a 'Strengthened Legal and Ethical Environment' constitutes the fifth goal under Botswana's National Strategic Framework for HIV/AIDS.<sup>24</sup> Towards this goal, the Framework provides for: creation of a supportive human rights-based environment conforming to international standards for the implementation of the National Response; integration of multi-sectoral strategies and identification of gaps in sectoral responses; information, education and communication; non-discrimination; care and support of vulnerable groups; and review and reform of laws and policies in keeping with human rights approaches. The Botswana HIV/AIDS and Human Rights Charter<sup>25</sup> calls on all Botswana, the government, the business sector, non-governmental organizations, religious organizations, faith-based organizations, traditional healers and trade unions to share the responsibility of challenging HIV/AIDS in Botswana.

### **Counseling, Consent, Confidentiality: Routine Testing Practice and Reality**

There appears to be a gap between the international, regional and national commitments, and their legal, policy and practical implementation so that in reality, many of the issues remain unresolved.<sup>26</sup> Denial, shame, stigma, fear, rejection, ostracism, marginalization, discrimination, criminalization and human rights abuses in relation to HIV/AIDS are still a stark reality in many communities. They prevent people from wanting to know their HIV status, and can thus be an obstacle to effective and optimal

<sup>22</sup> Republic of Botswana, Ministry of Health, Botswana National Policy on HIV/AIDS, 1998, para. 1.7 and para. 6 on ethical and legal aspects. The ongoing process of updating will, it is hoped, clarify human rights concerns around RHT in the National Policy of 2005.

<sup>23</sup> *Op. cit.* n. 11.

<sup>24</sup> 2003 - 2009, currently in mid - term review process.

<sup>25</sup> Ditshwanelo - The Botswana Centre for Human Rights and The Botswana Red Cross Society. Adopted in Kasane, 15 September 1995; revised in Gaborone, 13 September 2002.

<sup>26</sup> Gruskin, Maluwa., *op. cit.* n. 1, p. 648.

prevention, care, support and treatment. Discrimination against people living with HIV/AIDS is counter-productive to public health efforts, and it is well recognized that lack of respect for human rights at personal and societal levels is closely linked to individual and collective risk of infection, and to a lack of access to care and support after infection.<sup>27</sup> In an approach which integrates human rights and public health, the benefits of testing need to be weighed against the adverse consequences to the person being tested and to his/her family. In order to have maximum benefits, the policy of RHT needs to be analyzed in relation to its effectiveness, including cost-effectiveness, and should include the indicators of stigma, abandonment, violence and other possible adverse outcomes of disclosure of HIV status. Several important issues need to be considered here - the issue of HIV testing, that of confidentiality and that of disclosure of test results.

The societal context is a primary consideration in any discussion on testing, especially as most people using public health facilities, particularly in the developing world, are disadvantaged in terms of economics, class and level of literacy or education.<sup>28</sup> In the broader context of sustainable, social and human development, the notion of equity, increasingly important in human rights discourse, necessitates that in the interests of fairness, vulnerable or disadvantaged groups deserve focused attention. Hitherto, Botswana has no legislation protecting the rights of persons infected with HIV specifically or outlawing discrimination against them, and her legislative framework as a whole is not particularly enabling for those living with the virus. It has been commented that “[u]nfortunately, legislation designed to combat the spread of the virus has not kept pace with other anti- HIV/AIDS policies”.<sup>29</sup> Privacy is limited, for instance through policies of shared confidentiality and partner notification. Unfair dismissal, refusal of employment, unfair treatment at the workplace and other violations of basic human rights have not, up to now, attracted legal protection.

<sup>27</sup> *Ibid.*, p. 641.

<sup>28</sup> For an analysis of health, human rights, poverty and power, see P. Farmer, *Pathologies of Power: Health, Human Rights and the New War on the Poor*, University of California Press, Berkeley, 2003.

<sup>29</sup> C.M. Fombad, ‘Children and Informed Consent to HIV/AIDS Testing and Treatment in Botswana’, *University of Botswana Law Journal*, December 2005, p. 33.

Gender inequality is integral to the social fabric of most societies, especially in the developing world, and Botswana is no exception. RHT can thus function unfairly given the vulnerability of women, especially as they visit health facilities more often, due to pregnancy and child-bearing. Women are more accessible to the health system, and thus are subject to testing for HIV more often than men. Linked to these factors, there is a tendency towards feminization of the epidemic, and unfortunately, also the blaming of women. Women have difficulties when they are not psychologically ready to test, receive or accept a positive diagnosis, but may not be empowered to opt out or refuse people in positions of power whether they be healthcare workers, husbands or partners. In Botswana, RHT now involves rapid testing, but there is evidence that suggests that formerly when Elisa tests were used, women frequently failed to return for test results.<sup>30</sup> Difficulties in accepting realities, including ARV treatment, will impact on adherence to treatment. The psychosocial and emotional support needed by a woman (and her partner and family) who tests positive and gives birth, will have an effect on her return for testing of her new born child, as well as her adherence to formula feeding.<sup>31</sup> These are issues of life, health and death for infected children. The violence and abuse faced by some women who are HIV positive, together with the absence of legal protection specifically for cases of violence against women and marital rape, can further exacerbate the situation. A recent study on RHT in Botswana, while recognizing several merits in the process as a means for prevention and treatment of HIV/AIDS and reducing related stigma, highlights the need for the implementation of measures to ensure true informed consent and human rights safeguards, including protection from HIV-related discrimination, protection of women against partner violence related to testing, and also protection of confidentiality.<sup>32</sup>

<sup>30</sup> K. Seipone *et al.*, 'Introduction of Routine HIV Testing in Prenatal Care', *CDC (Centers for Disease Control) MMWR Weekly*, 53(46), 26 November 2004, pp.1083-1086, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5346a2.htm>

<sup>31</sup> G. Sedio, 'Expanding HIV Testing: The Point of View of Women Living with HIV', Sessions on HIV Testing in the Era of Treatment Scale Up, XVI International AIDS Conference (AIDS 2006), Toronto, Canada, 14 August 2006.

<sup>32</sup> S.D. Weiser *et al.*, 'Routine HIV Testing in Botswana: A Population - Based Study on Attitudes, Practices, and Human Rights Concerns', 3 (7):e 261, *PLoS Med*, 2006, p. 17, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030261>.

The degree to which a routine offer of an HIV test in health facilities to pregnant women allows for pre-test counseling and informed, voluntary and specific consent is not clear. In practice, it is unclear to what extent people understand that they have the facility to opt out, especially given the power imbalances of health-care users *vis-à-vis* health-care providers, the scarcity of healthcare resources and conventional attitudes of fear, awe, respect and deference, especially among less educated and disadvantaged communities, towards health care professionals. The WHO/UNAIDS policy distinguishes routine offer of an HIV test from routine HIV testing. There exists a danger that informed consent<sup>33</sup> can in practice be replaced by implied consent, thereby moving from routine offer to routine imposition.

Research studies and anecdotal evidence suggest that many healthcare professionals who carry out HIV tests or provide medication to people suffering from AIDS do not specifically obtain the informed consent of such persons or consider that such consent is nothing more than a ritual. There thus appears to be insufficient appreciation of the role and importance of informed consent and the implications of the failure to obtain such informed consent. The new policy of routine testing for the HIV virus using rapid testing technology, and the ambivalence on the right of informed consent, may exacerbate the uncertainty over the nature and role of informed consent.<sup>34</sup>

The adequacy of pre-test counseling gives rise to questions, since in practice, group counseling and simplified counseling measures have at times been adopted due to resource and time constraints. A recent study clearly illustrates the need for exploration of how the 3 Cs are implemented in RHT, given the many dimensions that need considerable improvement, particularly with regard to confidentiality:<sup>35</sup> "[t]here are however, currently no data available

<sup>33</sup> The imperative need for informed consent in practice has been well spelt out in South Africa: W.A. Joubert, *The Law of South Africa*, Vol. 3, p. 883; O. Dingake, *HIV/AIDS and the Law, A Guide to Our Rights and Obligations*, 1999, p. 11; *C. v. Minister of Correctional Services* [1999] (4) SA 292 (T); *Ex Parte Dixie* [1950] (4) South African Law Reports (SALR) 748, all cited by B. Mguni, in 'HIV Testing from a Government Lawyer's Perspective, Routine or Compulsory Testing in Botswana?' Seminar Report, Gaborone, 13 September 2003.

<sup>34</sup> Fombad, *op. cit.* n. 29, p. 33.

<sup>35</sup> USAID, BONELA, POLICY, *Healthcare Staff Knowledge and Attitudes toward Confidentiality of HIV Test Results in Botswana*, USAID, BONELA, POLICY, USA/Botswana, 2006, p. 6.

in Botswana to evaluate how well staff has been trained to offer RHT, the manner in which HIV testing is offered, nor the acceptance rates among patients in various clinical settings, other than PMTCT sites, for routine HIV testing".<sup>36</sup> There appears, therefore, to be a grey area between the principle and practice of RHT, and this needs to be addressed in an objective and balanced manner to ensure optimum outcomes which can protect and promote public health and the basic rights of all - both the infected or affected, and the uninfected or unaffected, and both the rights of the individual and the rights of society at large.

### Qualitative Research: Key Basis for Success of Routine Testing

Botswana is a pioneer or perhaps the flagship in the introduction of RHT, and its experience is being watched by the rest of the world. Although operational, there is no clear written policy on *how* RHT should be carried out in this country, making international and comparative law and policy a significant factor for consideration. Recently in the USA, the Centers for Disease Control have introduced a policy of RHT,<sup>37</sup> and the most contentious debates around this policy are on issues of individual rights. Most countries in the SADC region have some form of RHT in operation, usually as part of the PMTCT programme. With the exception of Malawi, however, there is no clear policy in place on how it should be carried out. With regard to pre-test counseling and informed consent in the context of testing practice in the region, the policies of Lesotho and Malawi, and to a greater degree Zimbabwe and South Africa, incorporate human rights concerns and the 3 Cs to a considerable level. Confidentiality is integrated into the policies of most countries (most notably South Africa). In Botswana confidentiality has been identified as an area to be addressed and improved on, particularly in the context of RHT, "along the continuum of counseling, testing, care, and treatment".<sup>38</sup>

The lack of clarity in practical implementation, together with the absence of a clear domestic policy, makes research, in particular

<sup>36</sup> *Ibid.*, see especially pp. 16-18.

<sup>37</sup> In September 2006 a new Centres for Disease Control policy recommended making HIV tests part of routine medical care for all persons between 13 and 65 years of age: [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=18DR=39969](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=18DR=39969)

<sup>38</sup> USAID, BONELA, POLICY, *op. cit.* n. 35, p. 16.

qualitative research on the practice of RHT, a key to the development of a policy. Quantitative approaches can only reveal testing uptake, and are thus inadequate on their own in appreciating the multiple dimensions of RHT and the many complexities that surround issues of human rights in the HIV/AIDS context, as well as HIV/AIDS in the human rights context. These include stigma, especially in resource-limited settings,<sup>39</sup> and other numerous social dynamics involved.<sup>40</sup> Increase in testing does not have significant implications unless related to its actual impact on the decline of the epidemic. There is a dearth of qualitative data to evaluate how RHT is offered or carried out. The inextricable inter-linkage of the relevant issues clearly illustrates that the public health concerns clearly have human rights implications, and conversely, that human rights concerns have public health implications. As one account expresses it, many major unanswered questions remain. They include:

To what extent do people still experience counseling and testing as voluntary, and how will a shift away from 'voluntariness' affect responses to the messages? Are more marginalized populations particularly vulnerable to human rights abuses if testing becomes routinised? Where does routine voluntary testing turn into compulsory testing? How do expanded testing programmes provide the right degree of information to people during the testing process when resources are so stretched?<sup>41</sup>

<sup>39</sup> Rennie, Behets, *op. cit.* n. 10, p. 54 state: "Qualitative and quantitative social research are needed to shed light on issues surrounding the voluntariness associated with routine testing practices in the field, a task hampered by lingering uncertainties about the meaning of the term and its measurability (...) Until there is a greater body of evidence and conceptual clarity, it would be premature to assume that "voluntariness is at the heart" of routine HIV- testing practices being implemented in resource - poor settings".

<sup>40</sup> J. Csete, R. Elliott, 'Scaling Up HIV Testing: Human Rights and Hidden Costs', *Canadian HIV/AIDS Policy & Law Review*, Vol. 11, No. 1, April 2006, p. 1. At p. 6 it is stated: "More research is urgently needed to investigate whether the absence of informed consent and counseling affects people's experiences of abuse or other negative outcomes as a result of testing HIV - positive"; at p. 8 it is clearly expressed that HIV testing without requisite counseling and consent cannot be justified under the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights (UN Doc. E/CN.4/1984/4 91984) which justify the limitation of human rights in certain conditions; and at p. 9, it is concluded that scale up of HIV testing is essential, but in a manner which minimizes harm and maximizes benefits.

<sup>41</sup> 'Routine or Opt - Out Counseling and Testing: Findings from the 2006 PEPFAR (President's Emergency Plan For AIDS Relief) Meeting', reported by K. Alcorn, T. Smart, *HIV & AIDS Treatment and Practice* No. 71, 27 July 2006, p. 8, <http://hivinsite.ucsf.edu/InSite?page=pa-hatip-71>

The objectives of testing are important – in relation to whether knowing one's status necessarily means positive behaviour change, seeking care, treatment, protection and support. People should be involved in making decisions that affect their lives, including their health care, and should have an enabling environment which protects and promotes human rights for carving out their own destiny and for a turn around of the epidemic in Botswana.<sup>42</sup> Ethical considerations need to take into account human rights norms and standards, not only in substance but also in relation to the processes of ethical discourse and reasoning.<sup>43</sup>

The lack of a clear law or policy on the process of RHT and the vacuum between principle and practice make a study of implementation of RHT singularly significant.<sup>44</sup> There is a need for further research in this sphere, both for the purposes of the development of a policy and for the improvement of the practice.

The human rights dimension that lies at the heart of the issues raised in this paper should be integral in research relating to RHT which is multi-dimensional, because behind every number, beyond all data, and besides all statistics in research, there is a human being or a section of humanity facing the reality that HIV/AIDS affects each and every aspect of human existence. Many are the difficulties, complexities and obscurities which flow from this multidisciplinary terrain, where the vistas of science, medicine and public health need to be reconciled with those of ethics, law and human rights. Optimization of testing is beyond doubt essential in the quest for universal access, and thus wholly supported by

<sup>42</sup> C. Stegling, 'Routine Testing - The Botswana Experience - One Point of View', Sessions on HIV Testing in the Era of Treatment Scale Up, *op. cit.* n. 31. M. Heywood in 'Human Rights and HIV/AIDS in the Context of 3 by 5: Time for New Directions?' *Canadian HIV/AIDS Policy and Law Review*, 2004: 9 (2):1, 7-13, has argued in favour of real knowledge through counseling, which can guide and direct behaviour change.

<sup>43</sup> WHO, *op. cit.* n. 4, p. 22.

<sup>44</sup> The importance of human rights related research, monitoring and safeguards in RHT has been repeatedly stressed: Botswana Health Minister Hon. Sheila Tlou, in addressing the Sessions on HIV Testing in the Era of Treatment Scale Up, *op. cit.* n. 31, stated that the *caveat* in relation to the practice of RHT was the need for aggressive training of healthcare workers on policy, human rights and public education, which are the cornerstones to success.

human rights approaches. However, testing has to take place within an enabling environment, which makes it only natural to posit Routine HIV Testing and indeed HIV/AIDS as a whole within the broader picture of the Human, and especially the Human Rights Dimension.....Lest We Do Not See the Wood for the Trees.



## REVIEWS OF BOOKS AND ARTICLES



## REVIEWS OF BOOKS AND ARTICLES

**Fanny CHABROL**

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Botswana's experience in fighting the HIV/AIDS pandemic is the subject of very close international attention. Moreover, researchers who are willing to undertake studies in Botswana are able to do it due to various cooperation arrangements and partnerships built in recent years. Scientific international reviews and other publications often reflect this trend. Recently, the results of two studies conducted in Botswana have been published in a review available on the Internet (Plos Medicine).

WEISER SD, HEISLER M, LEITER K, PERCY-DE-KORTE F, TLOUS, *et al.* (2006) Routine HIV Testing in Botswana: a population-based study on attitudes, practices, and human-rights concerns. *PLoS Med* 3(7), pp. 1013-1022. <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030261>

Studies dealing with the implementation of routine testing are of significant interest at a time when routine testing is being debated worldwide. The United States took the lead in these debates a few years ago with new recommendations made by the Centers for Disease Control and Prevention (CDC) in favour of a routine offer of HIV testing. The World Health Organisation (WHO) and the Joint United Nations Programme for HIV/AIDS (UNAIDS) have also changed their testing recommendations (UNAIDS/WHO Policy Statement on HIV Testing, Geneva) in June 2004.<sup>1</sup> This has represented an important shift in the public health approach to HIV and explains why Botswana's experience is widely regarded as a case study that might highlight this change and its effects.

The implementation of the routine testing policy in Botswana is the core of a study conducted by a team of nine researchers, most of them from hospitals or institutions in the United States (Physicians

<sup>1</sup> Documents available online: <http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf>. A draft guidance is currently being developed by WHO and UNAIDS to expand the 2004 Statement.

for Human Rights, University of San Francisco, University of Michigan School of Medicine, University of Minnesota among other academic institutions in the United States), and on the Botswana side, with the participation of Sheila Tlou (Department of Nursing, University of Botswana) prior to her new position as Minister of Health. This article was published in July 2006 but the study was carried out in November and December 2004, only 11 months after the implementation of the routine testing policy in Botswana. The decision to make HIV testing routine in all health facilities in Botswana was motivated by the acknowledgment that testing is the entry point for accessing prevention, support and treatment (including free anti-retroviral therapy that was progressively made available from 2002).

The justification for this study is to understand the slow uptake of enrolment in HIV treatment – which is thought to be due to under utilization of HIV testing – and the perceptions on numerous questions related to testing for HIV. Participants were asked about their knowledge of HIV testing, their attitudes to HIV testing, HIV related stigma, beliefs about gender roles and discrimination and measures of health care access and utilization. People had to respond regarding their past experiences with testing and the perceived barriers and facilitators to testing. For example, participants had to answer if they agreed with the following propositions: “*Do you believe that Routine Testing (RT) helps people to get access to ART?*”; “ (... ) *that RT makes it easier (or harder) for people to get tested?*”; “ (... ) *that RT results in less discrimination (bad treatment) of HIV-positive people?*”; “ (... ) *that RT testing leads to less (or more) violence against women?*”, “ (... ) *that RT will cause people to avoid seeing a doctor or nurse for fear of being tested?*”; “ (... ) *that RT makes it harder for people to get tested?*”. The entire study is built on quantitative methods, with pre-defined questionnaires such as these.

The study confirms that free access to treatment for HIV/AIDS is an essential part and a *sine qua non* condition for routine HIV testing. Indeed, the relation between testing and access to treatment is

fundamental: the study found that the most commonly cited factors (for 67% of the participants) that would facilitate testing included the knowledge that they could get treatment for HIV/AIDS (p. 1018). More generally, and regarding the outcome of the study, the authors conclude that there is *"widespread support for this policy in a population-based survey, with 81% of participants reporting that they were either extremely or very much in favour of routine testing"* (p. 1013). However, this does not reflect some important limitations, for example that 68% felt that they could not refuse the HIV test whether or not they had made the initial decision to test: *"approximately two-thirds of participants who were tested either by routine testing or VCT felt that they could not refuse the HIV test, suggesting that the voluntary nature of both routine testing and VCT is not fully understood"* (p. 1019). This is precisely one of the most debated points when discussing how routine testing is being carried out because it is extremely difficult to appreciate the thin line between an offer of an HIV test or a routine HIV test as part of other routine blood tests that are made without prior consent from the patient. The authors acknowledge some confusion surrounding the details of the implementation of this policy, including the extent to which routine testing should be provided as 'opt-out' or as 'routine-offer': *"Detailed guidelines for the implementation of routine testing were not introduced until February 2004, and the training of healthcare practitioners and the development of training materials were still ongoing in early 2005"* (p. 1019).

When expressing their views on testing, 43% of the participants believed that routine testing would lead to avoidance of visits to the doctor for fear of being tested. That could be one of the worst counterproductive effects of a policy which is clearly aimed at facilitating access to treatment for those affected by HIV and AIDS.

Given the subject of the study, human rights aspects could have had a greater emphasis in this paper. It nonetheless opens up the scope and points to the need for further research in this area,

especially in relation to the way that consent for an HIV test is obtained, how pre- and post-counselling are provided and whether, or to what extent, confidentiality is guaranteed. It is particularly important to document these factors, when considering that the WHO and UNAIDS recommendations require the integration of the '3 Cs' in HIV/AIDS testing: Consent, Counselling and Confidentiality. However, any information of that kind might only come through qualitative studies, especially with a systematic observation of how the routine testing is being offered and what counselling is given. Also in-depth interviews could bring about more accurate information on patients' experiences and feelings with regards to routine HIV testing.<sup>2</sup>

Finally, the authors also recognize that given the scope of this study, the results cannot be generalized to the entire country; neither can they be transposed to other African countries.

WEISER SD, LEITER K, HEISLER M, McFARLAND W, PERCY-DE-KORTE F, TLOU S, *et al.* (2006) A population-based study on alcohol and high-risk sexual behaviours in Botswana. *PLoS Med* 3(10).

<http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030392>

Interestingly, a few months later, in October 2006, another study carried out in Botswana was released by the same editor and almost the same authors. It deals with the relation between alcohol consumption and risky sexual behaviours in Botswana. The methods and sample for the studies are very similar: 1268 adults selected in the five districts in Botswana with the highest prevalence rates (Gaborone, Kweneng East, Francistown, Serowe/Palapye and Tutume). The study has also been carried out according to the same schedule, in November and December 2004, and it is therefore possible that the same persons were asked to participate in two different studies at the same time. However, this study has a completely different objective which is to look at the impact of alcohol consumption on the probability of engaging in risky-sexual behaviours.

<sup>2</sup> See Shyami Puvimanasinghe's article in this volume.

Consistent with previous studies elsewhere in Africa, the authors report a high prevalence of heavy alcohol drinking in Botswana and demonstrate a strong link between alcohol drinking and risky sexual practices. This article also highlights the clear correlation between risky sex and practices of intergenerational sex or sex in exchange for money especially for women, and their inability to negotiate the use of a condom in those circumstances. It is unfortunate that this study relies only on statistically analysed answers from closed questionnaires. Indeed, the outcomes show the correlations between the following variables: the participants' social, economic and health status, their drinking personality (for example 'heavy drinker': someone who is drinking more than 14 drinks a week for a woman and 21 drinks a week for a man), their history of '*having multiple sexual partners over the past 12 months*' and experience of '*engaging in sex exchange*'. However, quantitative tools are often inappropriate to provide a rich insight into some crucial questions. It would have been more stimulating to understand the socio-economic roots that led to such a high rate of alcohol drinking in Botswana. This social issue is strongly raised by individuals, members of civil society, community and political leaders in Botswana but very few studies have been done to help them solve the problem.<sup>3</sup> A qualitative study would adequately inform policy makers in their aim to regulate alcohol consumption. By understanding the factors that lead to alcohol drinking, they might be able to better address this issue. That might in turn benefit the overall HIV/AIDS prevention efforts in Botswana.

<sup>3</sup> For an exception see for example D. Suggs, 'Mosadi tshwene. The Construction of Gender and the Consumption of Alcohol in Botswana', *American Ethnologist*, Vol. 23, No. 3, 1996, pp. 597-610 and 'These Young Chaps Think They Are Just Men, Too: Redistributing Masculinity in Kgatleng Bars', *Social Science and Medicine*, Vol. 53, 2001, pp. 241-250.





## RECENT DEVELOPMENTS AND EVENTS



## RECENT DEVELOPMENTS AND EVENTS

### A NOTE ON TWO RECENT EVENTS IN BONELA

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This paper presents a commentary of two events that the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) hosted recently. The first part highlights the key issues that were raised at BONELA's Annual General Meeting under the theme 'Advocacy through Networking'. The second component focuses on the Legal Fraternity Seminar, and presentations made by prominent legal icons at this event will be analysed. Their arguments will be summarized briefly. BONELA's position will be discussed thereafter.

#### Annual General Meeting

BONELA appreciates that changes in the structural impediments to social justice and fundamental freedoms cannot be realised in isolation. Advocacy as an intervention model needs effective networking. In the context of AIDS and human rights where no single dominant reason or cause can be cited as an explanation for any violation of human rights, a multi-pronged strategy is necessary. The Chairperson of BONELA was quoted as saying "people living with HIV/AIDS face double jeopardy. They are faced with a host of health problems, extreme prejudice and stigmatization from their employers and other members of society and now the law fails them",<sup>1</sup> emphasizing the urgency and relevancy of networking in dealing with human rights and HIV/AIDS. Networking is necessary for advocacy in the context of HIV/AIDS because HIV is a cross cutting issue with different dimensions that are intricately intertwined, hence the need for partnerships for effective human rights advocacy.

<sup>1</sup> D. Boko quoted in the AGM and Legal Fraternity Seminar Minutes (hereafter, 'Seminar Minutes, 2006'), BONELA, 2006.

BONELA therefore envisions strengthening the existing partnerships and reaching out to other organizations, communities and diverse stakeholders to build more coalitions to enable effective resource mobilization and bargaining power to influence decision makers on pertinent issues regarding human rights and HIV. Reaching out to other organizations interested in making human rights a reality does not only reflect BONELA's commitment to creating an enabling and conducive environment for people living with HIV/AIDS to reach high levels of human contentment and dignity, but also appreciates that the complexity and social dynamics involved in HIV and human rights need to be addressed using an integrated approach.<sup>2</sup>

An integrated approach in strategic and tactical analysis of power relations in society is ideal. Therefore, through networking, social ills such as discrimination which have been associated with the escalation and pervasive violation of the rights of vulnerable groups may be addressed from multiple angles. 'Vulnerable groups' denotes segments of society that are at risk of subjection to injustices such as sexual assault, inordinate stigmatization of HIV positive women and systemic bottlenecks that hinder their access to testing and treatment. All of these structural inadequacies and injustices (economic, social, cultural and political) indicate the vulnerability of women and children, necessitating a multi-sectoral approach to level the social inequality pyramid between genders.<sup>3</sup> This was well captured in BONELA Director Christine Stegling's response to a certain legislator who was reported to have said, "any literate who contracts HIV now, gets it by choice", to which Stegling asserted clearly that "in Botswana, marginalized groups are largely excluded from national HIV-prevention efforts".<sup>4</sup>

Networking broadly across all levels of society -that is, at community, district and national levels- is furthermore ideal for reducing the possibility of re-inventing the wheel in terms of identifying issues for advocacy, planning for action, implementation and monitoring and evaluation. It also indicates the openness of BONELA and its acknowledgement that people are different and have different

<sup>2</sup> M.B. Awuah, 'Stigmatisation Causes Litigation', *BONELA Guardian*, Vol. 1, Issue 3, 2004.

<sup>3</sup> M. Bokole, 'Workshop for Policy Makers Centres on HIV/AIDS, Law and Human Rights', *BONELA Guardian*, Vol. 2, Issue 3, 2005.

<sup>4</sup> C. Stegling, 'MP Dead Wrong', *Echo*, 19 October 2006.

experiences – therefore social change consciousness is not only ascribable to professionals or intellectuals, but must take into account the views of so-called ordinary people, who know best what is ideal for themselves. They live in the context; they experience and deal with stigma and discrimination almost daily. It is imperative, therefore, to borrow extensively from the experiences of people living with HIV/AIDS so that we can best represent their wishes and understand their strengths and limitations.<sup>5</sup>

Through networking, people living with HIV/AIDS may also benefit broadly in terms of developing self advocacy fostered by self awareness, acceptance, conflict management, development of coping capacity and motivation, the feeling that they have rights and the belief that they can exercise those rights. For instance it was made clear that “a woman’s right to bear children should not be violated because she tests positive. Instead, Botswana should (...) assist women’s access to information and services to allow them to make informed and healthy choices for themselves and their children”.<sup>6</sup>

If Vision 2016 (Botswana’s national vision which outlines what ought to be achieved by the nation in general by 2016) is to be realized, advocacy through networking becomes a necessity. It does not only mean working with allies and dismissing opponents. Strategic networking entails an appreciative enquiry principle. This principle takes into consideration opposing views and arguments, assesses all that constitutes them and incorporates measures to ensure that even though these views may not be ideal for the preferred course of action, a mutually fulfilling position should still be sought.

In this sense, community empowerment can thus be realized, so that people can advocate for themselves. As BONELA’s Director aptly observed, “It is only when we assist people in becoming agents of their own destiny in an environment that protects and respects their human rights that we will make a real change to the HIV epidemic”.<sup>7</sup> Advocacy will then transcend beyond the

<sup>5</sup> W. Chirambo, ‘Turning Up the Volume on HIV/AIDS and the Deaf’, *BONELA Guardian*, Vol. 2, Issue 3, 2005.

<sup>6</sup> C. Stegling, ‘Human Rights Training Manual, A First for Botswana’. *BONELA Guardian*, Vol. 3, Issue 1, 2006.

<sup>7</sup> C. Stegling quoted in the Seminar Minutes, 2006.

organizational structures of BONELA, to incorporate community activism, and thus become a sustainable and local initiative for the attainment of freedom of expression, self reliance and social justice within a democratic environment. Communities and support groups for people living with HIV/AIDS will develop and strengthen their social networks, social capital and active participation in the championing of human rights in the context of HIV/AIDS.

## Legal Fraternity Seminar

In referring to the cyclical relationship between HIV and Human Rights, Justice Albie Sachs firmly argued that it is imperative for the legal profession to make a decision on the role of and importance of law in protecting the philosophy of human rights. Even though professionally it is inappropriate for a judge to take part in marches and take a seat on the court bench, that does not imply that judges cannot help in the struggle towards full realization of human rights. Judges can be part of the campaign on appropriate legislative review in different capacities.

Justice Sachs pledged to help BONELA develop a manual that will assist Civil Society Organizations in their participation in legal issues pertaining to human rights and gender training of judges, without undermining the independence of the judiciary. He cited a few South African cases that involved the violation of human rights, where the shortcomings of law in safeguarding human rights allowed for such violations to take place. He shared a personal experience, revealing how deeply moved he was by his ability to have a positive impact on this: "I cried to feel that I am a judge in a court with the possibility to intervene to contribute something to protect fundamental human rights, not the way we were with racial discrimination but against the new forms of discrimination. As a member of the Constitutional Court of South Africa, I was in a position to protect human rights".<sup>8</sup>

Attorney, and Chairperson of the BONELA board Duma Boko, strongly argued that people are not resistant to following the course

<sup>8</sup> A. Sachs quoted in the Seminar Minutes, 2006.

of action needed to protect human rights and alleviate the adverse effects of HIV/AIDS. Boko observed that “HIV is a social problem where HIV related stigma gives rise to the social legitimization of discriminatory behaviours towards anybody perceived to be or known to be HIV positive and by proxy, their circle of family and friends”.<sup>9</sup> Therefore, he emphasized that the law should be called upon to protect human rights in this regard. He envisages an effervescent legal profession that champions human rights. Boko reiterated that the world will only make meaningful strides in the fight against HIV if human rights are protected.

It is apparent from the arguments made above that the legal system has an ethical duty to protect and promote the full realization of human rights in the context of HIV/AIDS. Irrespective of personal ideology and predisposition to human rights and HIV debates, there was general acknowledgement that the values of justice and freedom as enshrined in Vision 2016 cannot possibly be attained if human rights are not respected in every dimension of society.

To this end, BONELA endeavours to influence transformative legal changes that are cognizant of the loopholes in the law as it relates to the recognition, acceptance and enforcement of human rights in the context of HIV.<sup>10</sup> Taking into consideration the unknown cases of human rights violations that may be attributed to the absence of law protecting these rights, BONELA is committed to ensuring that at least through community education, research and community mobilization, legislative reforms will be acceded to, eventuating in an equitable democratic society.<sup>11</sup>

Stigma and discrimination were depicted in the different cases that were cited by the practitioners and were seen as a threat to effective intervention in the fight against HIV. Although a piece of legislation may not resolve all ethical issues evolving around the interaction between HIV and human rights in the workplace, at

<sup>9</sup> D. Boko quoted in the Seminar Minutes, 2006.

<sup>10</sup> O.K. Dingake *et al.*, *Justice, Reason and Hope in the HIV Epidemic in Botswana*, BONELA, 2002.

<sup>11</sup> M.B. Awuah, ‘Stigmatisation Causes Litigation’, *BONELA Guardian*, Vol. 1, Issue 3, 2004.

<sup>12</sup> C. Lee, ‘Botswana Demands HIV Employment Law’, *BONELA Guardian*, Vol. 3, Issue 4, 2006.

least no effective advocacy can be fruitful without such legislative change.<sup>12</sup> It was asserted that “the status of most issues that existed in 2003 has not changed while new challenges continue to emerge all of which need the participation and support of the legal fraternity”.<sup>13</sup>

BONELA vows not to let human dignity be eroded under the illusion that civic and political rights are secured in the relatively stable political environment of Botswana. While in principle the political environment may be stable, underlying this stability are the disheartening violations of human rights where HIV/AIDS is concerned, such as unfair dismissal from work and systemic arrangements that ensure employer safety over the employee. Stegling expressed her hope that “the Legal Fraternity Event may encourage lawyers to get back on board and address issues such as confidentiality and informed consent, health rights and rights of those infected and affected in the workplace”.<sup>14</sup> To this end, BONELA resolutely petitions the government to enact an HIV employment law with a sense of urgency to protect the rights of people infected and affected by HIV/AIDS in the workplace.<sup>15</sup>

In line with Vision 2016 BONELA endeavours to network with other Human Rights Organizations to advocate for the social visibility of the rights of people living with HIV/AIDS. BONELA’s activities are aimed at the aversion of inequalities and injustices, by persuading policy makers to reflect on the existing policy and institutional social inequalities that hinder the full realization of all human rights.

<sup>13</sup> C. Stegling quoted in the Seminar Minutes, 2006.

<sup>14</sup> C. Stegling quoted in the Seminar Minutes, 2006.

<sup>15</sup> C. Stegling, ‘Now More Than Ever: Human Rights at the World AIDS Conference’, *BONELA Guardian*, Vol. 3, Issue 3, 2006.



# CONDOMS IN PRISONS? A SEMINAR ON THE PRISON POPULATION AND HIV/AIDS CONTROL IN BOTSWANA

MAHARAJA CONFERENCE CENTRE, 20 FEBRUARY 2007

## Hitomi KUWABARA

Botswana Network on Ethics, Law and HIV/AIDS, Gaborone, Botswana.

Whether infected or affected by HIV/AIDS, the pandemic has become a constant presence in the political, social and economic consciousnesses of all Batswana. It has, however, been recognized that certain groups in society are more vulnerable than others. This may be due to their age and dependency on others, in the case of children; or the inequitable social structures that hinder their ability to negotiate the use of condoms, in the case of women.

Prisoners are another such group. Studies conducted elsewhere in the world show that the number of prisoners who are HIV positive is disproportionately higher than the rest of the population. The facts already known about the HIV/AIDS crisis in this country suggests that the situation in Botswana's prisons is dire. Botswana's HIV prevalence rate is one of the highest in the world. There is overcrowding in her prisons and the homosexual act is criminalized and socially stigmatized. Violence and sexual abuse are inevitable in prison environments. All these factors demonstrated an urgent need for this seminar. A diverse group of stakeholders including: members of Parliament, prison officials, NGOs, the media, academia and the legal profession were invited by the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) to discuss issues concerning the prison population and HIV/AIDS, in particular, whether condoms should be provided in prisons.

This issue is controversial in Botswana because section 164 of the Penal Code criminalises 'carnal knowledge of any person against the order of nature', which has been defined as including the penetration of the anus. It has therefore been argued that providing

condoms in prisons will be tantamount to encouraging or condoning the homosexual act, and thus, criminal conduct. However, the arguments for condoms pointed out that men in prisons are having sex with men, regardless of its criminality, whether this was due to rape, abuse, 'trade offs' or for other reasons. Prisoners need condoms because they are engaging in risky activities and therefore, need protection. After the period incarceration, prisoners are released back into the wider community, and if infected, can further transmit the virus- thus illustrating the relevance of this issue with regards to national HIV/AIDS prevention campaigns.

The key issue was the application of human rights concepts to prisons and prisoners. Christine Stegling, the Director of BONELA, argued that prisoners were dependent on the State during their incarceration since they were unable to affect their own circumstances. She raised the argument that the State owed a greater obligation to prisoners precisely because of this dependency. Chibuya Dabutha from Women Against Rape was one of the few participants who had been able to witness at first hand the conditions in prisons. She talked about the violence amongst prisoners, between prisoners and guards, and the problem of coerced and unsafe penetrative sex. She stated that the prisoners she spoke to wanted condoms and confirmed that sodomy was taking place.

This account raised questions amongst participants about the need for evidence and statistics. The lack of research conducted in Botswana prisons was a concern because we are currently extrapolating from studies done in other countries. The lack of knowledge about such an urgent issue indicates that the sensitive nature of topics raised, such as men who have sex with men, is hindering the protection of prisoners as a particularly vulnerable group with respect to HIV/AIDS.

However, these topics need to be dealt with and questions must be asked. Modise Maphanyane from the Media Institute of Southern Africa (MISA) took this as the theme for his presentation. He highlighted the discrepancy present between public health and

prisoners' health, and the fact that prisoners continue to be a part of our society despite living behind bars. Dr. Treasa Galvin from the Department of Sociology at the University of Botswana, elaborated further on this. She studied international instruments such as the WHO *Guidelines on HIV Infection and AIDS in Prisons* to illustrate what the Government ought to be achieving with regards to prisoners' health. She identified the underlying philosophy behind these international guidelines as: recognizing the connections between prisoners and the wider community; seeing prisoners as part of the public health system and the discrediting of national strategies against HIV/AIDS when vulnerable groups such as prisoners are neglected.

Mboki Chilisa, an attorney of the High Court of Botswana, spoke on the case of *Kanane v. The State*, where it was argued that section 164 (which prohibits the homosexual act) is an infringement of the right to privacy, dignity and non-discrimination. He argued that there was no longer any basis for penalizing homosexuality, based on the fact that sex is no longer considered to be purely for procreation purposes, and urged for a campaign to decriminalize it. This was followed by a presentation by Babafemi Odunsi, Research Intern at BONELA through the Centre for the Study of AIDS, who presented an 'alternative solution'. He gave the example of Iran, a state that is often perceived as very conservative, but which has allowed for the provision of clean needles although drug use is still illegal. This shows that the Iranian government has faced reality, acknowledged the problem and acted to safeguard the health of its citizens. In response to a potential argument that the provision of condoms would amount to aiding and abetting a crime, Mr. Odunsi explained that both a criminal act and a mental intent are necessary for the commission of an offence. Therefore, by providing condoms to prisoners, the Government would not be committing a crime since their intention is to prevent the transmission of HIV/AIDS, which does not constitute criminal intent.

Richard Matlhare from the National Aids Coordinating Agency (NACA) set out his position as that of the Government's, since

NACA is an organisation under the office of the President. He stated that a legislative review of all laws and policies with regard to HIV/AIDS utilizing a human rights approach, commissioned by the National AIDS Council Sector on Ethics, Law and Human Rights (the Sector), will drive NACA's position on this issue and accepted that they had the initiative as government to make Vision 2016 a reality.

Throughout the seminar, the presentations were interspersed with interesting discussions. Paula Akugizibwe, a BONELA volunteer, pointed out that we could not juxtapose the two issues of providing condoms and criminalising homosexuality because although sodomy is illegal, it is still happening in prisons and we need to respond to this reality. Also, men who have sex with men outside of prisons can get access to condoms. This illustrated a key distinction: the difference between homosexuality; and men who have sex with men. As Dr Galvin pointed out later in the discussion, the majority of the prison population may be heterosexual but can still engage in sexual acts with males. This is because much of the sexual behaviour in prisons around the world is coercive, for example, rape and 'trade offs'- the exchange of material and social benefits or protection in return for sex.

Remarks were put forward by Shirley Owageng from the Department of Prisons to explain her Department's policy. She stated that the health education received by prisoners was the same as that provided to other members of society. Prisoners were told about condoms as a preventative measure, but the only difference was that condoms were not provided. The Department's position on condoms in prisons was that, as long as the homosexual act was illegal, they could not, as a government department, provide condoms.

There was further discussion on whether it was preferable to approach this from a purely legal angle, or to go direct to prisons. Changing the law on homosexuality is necessary in order to lift the legal and social stigma off the issue, but it will take time. Although

the legislative review commissioned by the Sector deals with this, there is no guarantee that the law will change, or that it will do so in the near future. Ms. Stegling gave the example of the Sector's recommendation to lower the age of consent for testing from 21 to 16. This occurred three years ago, and still the change has not been effected. The fact that condoms are a life saving measure in the face of the 'national emergency' caused by HIV/AIDS, means that urgent action is necessary. Yorokee Kapimbua, the Research Officer at BONELA, said this succinctly. He agreed with the need for research and legislative review, but he asked, what do we do in the meantime? Prisoners will continue to get infected and die.

Some questioned the efficacy of the measure since many men in Botswana are said to refuse to wear condoms. Would providing them in prisons be enough to change their minds, asked Lieutenant Colonel Phetogo. MP Nonofu Molefhi advocated a law requiring compulsory testing of prisoners upon entry into prisons, although this was strongly opposed by others because of the human rights violations this would entail. Ms. Owageng even suggested that if condoms were provided, homosexual prisoners would be lucky because they would be able to have sex in prison while heterosexual prisoners would not. Such comments illustrate the sensitive nature of the issue and the many misconceptions and prejudices surrounding it.

Despite the difficulties of discussing an issue that deals with many moral, legal and social dimensions, this seminar was able to bring together people of diverging opinions to exchange ideas. It was followed on the subsequent day by a debate at the University of Botswana on prisoners' rights, also organised by BONELA. There was a great deal of media interest on this topic. Two radio call-in shows were conducted and there was wide coverage of the seminar in the national press.



## CALL FOR PAPERS

HIV/AIDS raises many ethical and legal issues because of its complex, all embracing and multi-dimensional nature. It therefore has to be understood in relation to numerous scientific, social, legal, political, economic, cultural and other parameters. The *Botswana Review of Ethics, Law and HIV/AIDS* welcomes contributions on a wide variety of relevant issues from a broad range of disciplinary backgrounds.

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Every contribution sent for publication in the *Botswana Review of Ethics, Law and HIV/AIDS* will be reviewed by a peer review committee of at least two anonymous reviewers.

### Form and Length:

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- Reviews of Books and Articles should be up to 2,500 words.

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All manuscripts should be submitted in their final form and should conform to the following guidelines:

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- Contributions should include the name(s), professional details (including affiliation) and contact information of the author(s).
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