

The Botswana Review of Ethics, Law and HIV/AIDS

Vol. 3 No. 1 2009

BONELA



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

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FROM THE EDITOR

Welcome to another edition of the Botswana Review of Ethics, Law and HIV/AIDS (BRELA), under a new editor and editorial board. In this 2010 issue, as the HIV and AIDS pandemic enters its fourth decade, we need to reflect on the challenges preventing significant progress in arresting new HIV infections and reducing death caused by AIDS related diseases. For Botswana in particular this year marks the beginning of the countdown towards Botswana's 50th independence anniversary in 2016. The year 2016 is also significant in that, the country has set it as the end date by which it should have made important miles stones in all areas of social life, including health. The national *Vision 2016* committed all resources; state, private, community and individual towards ensuring that "every citizen should have access to good quality housing, and to good quality health services within a reasonable distance". With specific reference to HIV and AIDS, *Vision 2016* pronounced that "The current campaigns for prevention of the spread of the virus must be intensified through all possible media of communication". Prevention is proving to require more than just intensifying media campaigns on prevention.

Male circumcision has emerged as a prevention strategy for HIV and AIDS. The new mantra emerging in the HIV/AIDS prevention and care circles is that male circumcision is essential in preventing the spread of HIV infection. Three randomized controlled trials were undertaken in Kisumu, Kenya, Rakai District, Uganda and Orange Farm, South Africa. From the studies, it is believed that male circumcision reduces the rate of HIV infection by up to 60% for heterosexually acquired HIV infection in men¹. Since the end of 2006, World Health Organization (WHO) had hosted a series of country consultation meetings in different part of the continent including Lesotho, Tanzania, Kenya, Zambia, Swaziland, Congo, Zimbabwe and South Africa. They have also put together a manual for male circumcision under local anaesthesia. In 2007, the guidelines for *Safe, Voluntary, Informed Male Circumcision and Comprehensive HIV Prevention Programming* were launched². Within a short two years, Botswana as an example, is hoping to scale up male circumcision to from around 10% to about 80% by 2012.

1 <http://www.who.int/hiv/pub/malecircumcision/en/>

2 http://data.unaids.org/pub/Manual/2007/070613_humanrightsethicallegalguidance_en.pdf

Their fear is that male circumcision may be misunderstood to be adequate protection against HIV, and this could reverse the gains made through pre-existing strategies. Fresh studies are on-going to establish if circumcision reduces condom use. There are indications that circumcision may enjoy general acceptability, as the initial period was marked by a good turnout of medical facilities of males turning up for clinical circumcision. It is yet too early to say what the effect male circumcision will have on the wider socio-cultural context of Botswana, especially with regards to gender relations.

Other challenges towards the eradication of new HIV infections include the lack of prevention strategies that cater for men having sex with men and women having sex with women. This is because homosexuality is illegal according to the laws of Botswana. Also excluded are commercial sex workers, and prisoners. Treatment is also a big area of concern. BONELA and other stake-holders are making efforts to improve treatment literacy and adherence. Access to ARV therapy for non-citizens also remains a challenge.

Based on qualitative data collected in 2007, the first paper by Carla Giddings is on *“Youth relationships and violence against women (VAW) in Gaborone: implications for HIV and AIDS in urban Botswana”*. True but alarming is the fact that within Botswana, sixty percent of women will experience violence within their lifetime. Particularly insightful is that Giddings places the violence within masculinities in Botswana, a poorly researched area. Because of some milestones that have been made towards women’s empowerment, Giddings identifies two negative outcomes: 1) men’s feelings of disempowerment, and 2) the creation of conflicting expectations in relationships. She argues that both outcomes have the potential to intensify VAW. “Men may violently attempt to regain power in a relationship or may be violent as a reaction to a perceived act of disrespect”.

Still on the question of VAW, Mary O’grady looks at it from how for some women, telling their partners that they are HIV positive has done more harm than good. She presents a very compelling case for non-disclosure in contexts where it may not be safe to do so. In her paper entitled *“The right to know and the right not to tell: the ethics of disclosure of HIV status”*. She unravels the ethical dilemmas that can make ‘disclosure’, the right of another individual to know, to beat odds with another individual’s right to life. This is because, in the context of VAW, women have sometimes become victims of domestic violence when they disclosed their positive HIV status to their male partners. Her argument is that, while practitioners need to observe bioethical principles, they should place the safety of their clients above disclosure.

Findings of a study done by Kakanyo Fani Dintwa reiterates what several studies have shown elsewhere that, there is a positive relationship between the level of basic education and condom use. In *“Education and condom use among the sexually active in Botswana”*, Dintwa’s nationally representative quantitative study shows that, depending on how far people had gone with formal schooling or education, it had a positive relationship with their use of condoms. He does acknowledge other contributing factors such as ideas about masculinity and femininity, patriarchy, gender relations, alcohol and substance abuse as other contributing factors to lower levels of consistent condom use. Other factors include ideas about the permanency of a relationship so that, the married and living together men and women were significantly less likely to always use a condom during sexual intercourse compared to those in short-term relationships.

The paper by Goabaone Stouberg Tsalaiile explores HIV and AIDS among selected retailers and wholesalers in Maun, Botswana. Data was collected in 2006, and revealed that most of the employees were interested in knowing their HIV status and opted for voluntary testing and counselling. It also came out that the majority of retailers and wholesalers in Maun did not have HIV/AIDS workplace policies, though some did express the will to formulate and implement such policies if assisted with human resources and funding. The book reviewed in this volume looks at how increased male involvement in sexual and reproductive health could help in the prevention of violence and HIV and AIDS in Botswana.

Doris Kumbawa, the media advocacy officer at Botswana Network on Ethics, Law and HIV and AIDS (BONELA) which currently hosts BRELA, show cases some of the strides that BONELA is making in the fight against HIV/AIDS and Tuberculosis and the promotion of human rights. *“Towards an ethical and human rights dispensation to HIV in Botswana”*, is an appraisal of work done by the award winning BONELA recently. BONELA has adopted evidence-based advocacy, and has done a number of studies that forms the bases of their interventions. The *Men Who Have Sex with Men (MSM)* Study has brought to an end the denial of the existence of sexual minorities and as such, they can no longer be ignored. BONELA continues, in the absence of legal aid, to fight in court against injustices related to HIV and AIDS. They have won a case for a client wrongfully diagnosed with HIV, and another for publication of otherwise confidential information about the client’s HIV status. They have successfully lobbied the Government of Botswana to give the United Nations High Commission for Refugees (UNHCR) the go ahead to provide HIV positive refugees with antiretroviral treatment. BONELA also continues to produce educational and advocacy material such as *Needs assessment report for the prevention and research*

initiative for sexual minorities (PRISM) program; My pain, my fear, my hope, my dream: chronicles from Dukwi refugee camp; HIV, pregnancy and women's health; and The violations of the rights of lesbians, gay, bisexual and transgender persons in Botswana: A shadow report.

Finally, I and the BRELA team would like to give special thanks to two people that have seen BRELA through its teething stages and who have worked tirelessly to keep it going. They have moved on to take on other equally important responsibilities. They are former Director of BONELA and BRELA's editor-in-chief, Christine Stegling and editor, Shyami Puvimanasinghe. We wish them all the success in their new responsibilities.

Sethunya Tshepho Mosime, editor.

ARTICLES

YOUTH RELATIONSHIPS AND VIOLENCE AGAINST WOMEN (VAW) IN GABORONE: IMPLICATIONS FOR HIV/AIDS IN URBAN BOTSWANA

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In a country where seventy percent of the population is below the age of thirty, youth comprise a significant demographic proportion within Botswana¹. This has particularly meaningful reverberations for HIV/AIDS programs and policies as youth are the most likely to contract HIV/AIDS². Exacerbated levels of violence among urban youth serve as a potential factor in explaining the age discrepancies in infection rates. Given these statistics and trends, a foundational knowledge of youth relationships, violence and possible connections to HIV/AIDS infection rates is imperative for addressing the HIV/AIDS pandemic in Botswana. This paper outlines research conducted on youth relationships³ and violence against women (VAW) in Gaborone in order to provide a greater understanding of youth's vulnerabilities of contracting HIV. Interrelated aspects of youth relationships emergent from the study have potential wider implications for HIV/AIDS infection rates among youth, including young women's financial dependency on men, the incorporation of violence into masculinities and a backlash against gender equality initiatives in the form of VAW. These components of violence may increase the likelihood of contracting HIV/AIDS by hindering access to information and the ability to both make and carry out appropriate decisions.

Methods

The study was based on qualitative data collection methods by means of ten focus groups, eighteen follow-up individual interviews, twelve key informant interviews and a review of relevant documents on VAW in Botswana. From June to August 2007, sixty-one Gaborone youth from senior secondary schools and youth organizations participated in this study. Representatives from the Women's Affairs Department (WAD), Emang Basadi, the Youth Health Organization (YoHO), the National Youth Centre (NYC), Women and Law in Southern Africa (WLSA), Botswana Police Services (BPS) and Kagisano Women's Shelter Project and Drop-in Centre (KWSP) were also interviewed. Reports from BPS, Emang Basadi, KWSP and WAD comprise the foundational sources of statistics on VAW in Botswana.

- 1 C. McIlwaine and K. Datta, Endangered youth? Youth, gender and sexualities in urban Botswana, *Gender, Place and Culture*, Vol. 11, No. 4, 2004, pp. 483-512.
- 2 United Nations Development Group (UNDG), *Millennium Development Goals, Status Report: Achievements, Future Challenges and Choices*, 2004. UNDG estimates that approximately thirty-five percent of the population between the ages of fifteen and forty-nine are HIV-positive.
- 3 Throughout this paper, youth relationships are understood as heterosexual relationships where one partner (or both) is between the ages twelve to twenty-nine years.

Youth Violence in Urban Botswana⁴

Within Botswana, sixty percent of women will experience violence within their lifetime⁵. When examining VAW more closely, trends of age and place emerge in that nationwide reported rates of VAW are consistently highest among youth and within cities. In the capital city of Gaborone there are increases in reports each year on sexual violence against girls, sexual harassment in schools, violence committed by young men and murder/suicides ('passion killings'). The majority of perpetrators of sexual violence are young men and the majority of survivors or victims are women under the age of thirty⁶. The 1999 BPS study found forty-four percent of suspects were under twenty-two years and sixty-six percent were under twenty-eight years⁷. In support of this trend, Mathangwane⁸ discovered that of eighty-five cases of rape, seventy-nine convicts are under the age of thirty. Concurrently, eighty-five percent of female survivors of sexual violence were under the age for thirty⁹. Research by the Women's Affairs Department¹⁰ further suggests that Botswana's urban youth are most likely to perpetuate attitudes that condone or normalize VAW as they expressed the highest levels of acceptance of VAW.

Further associated with age is the increase in 'passion killings'¹¹, the murder of an intimate partner most often followed by the suicide of the perpetrator. Key informants from Emang Basadi, KWSP, WLSA and WAD all expressed concern that passion killings have increased at an alarming rate over the past decade. Overwhelmingly, young men are most commonly the perpetrators of murder/suicides in relationships and young women are most often the victims. Though place is only partially documented, the directors of Emang Basadi and KWSP both suggest that passion killings occur most often within urban centres in Botswana. Both key informants confirm that passion killings are most prominent among youth as well. Potential causes for the escalated

4 The full report is of the study (*Violence against Women in Urban Botswana: A Study of Youth's Ideas on Gender, Relationships and Violence in Gaborone*) is available at BONELA, the University of Botswana, KWSP, Emang Basadi, WLSA, WAD, the Department of Social Services, Ditshwanelo, Women in Action, Botswana Council of Women, Botshabelo or by contacting the author: carla.giddings@gmail.com

5 Women's Affairs Department (WAD). *Report of the Study on the Socio-economic Implications of Violence Against Women in Botswana*, Ministry of Labour and Home Affairs, Gaborone, 1999.

6 Botswana Police Services, Ministry of the State President (BPS), *Report of a Study of Rape in Botswana*, Gaborone Printing Works, Gaborone, 1999.

7 *Ibid.*

8 J.T. Mathangwane, *Rape is a Crime: Taking a Stand Together against Rape and Sexually Related Crimes*. Proceedings of the National Conference on the Findings and Recommendations of the Study of the Incidence and Prevalence of Rape in Botswana. Held on the 5-6 March 2001 at Boipuso Hall, Gaborone.

9 BPS, 1999.

10 WAD, 1999.

11 I will use the term 'passion killing' throughout the paper as this is the language employed in by Botswana Police Services, government, media, NGOs and participants. However, I believe a more appropriate term is 'intimate partner homicide/femicide', as passion killing implies a loss of control over strong emotions as a justification for murder.

violence among urban youth are wide-ranging and beyond the scope of this paper. Instead, this focuses on three vital features of urban youth relationships that may amplify urban youth's risks of contracting HIV/AIDS, beginning with the occurrence of materialistic relationships, women's financial dependence on men and intergenerational sex.

Materialistic Relationships: Young Women's Diminished Power and Sexual Decision-making

Youth relationships in Gaborone are both diverse and complex. This variation is aptly demonstrated through youth's descriptions of expected roles, behaviours and characteristics based on gender. What is perhaps most striking is the clear distinction youth make between gendered expectations in Gaborone in comparison to rural regions. Men in the villages are expected to be leaders, decision-makers, household heads and earn money. Youth's descriptions of rural masculinities align with "strongly patriarchal cultural traditions which have been passed down through the generations"¹². Kidd¹³ suggests that historically "male is synonymous to strength of body and mind regardless of the capacity of the male person" as demonstrated by being in charge of the family and within the customary law system. One seventeen year old female participant summed up the majority of these points when she stated:

the role of a man is to control his family. He's in control of managing his household, you know, disciplining the kids... he's the one who protects the family and he also controls the woman and her activities. If he doesn't want her to do certain things it's like she has no say... he just controls her. And they're also in charge of like their children's needs, they're mostly the ones that are in charge of like school and then all the necessities that a family needs.

A rural woman, alternatively, was described as "a traditional woman and she is well cultured. She has the responsibility of bringing up her family... She is able to clean and provide for her family. And she will be obedient" (eighteen year old female participant). Youth frequently stressed the importance of men bearing the financial responsibilities of the relationships and women's economic dependence. A sixteen year old male supported this point in stating "men are supposed to take care of the family and provide". Within three focus groups, the connections between men's financial support of the family and decision-making at the household level are made explicit through a discussion of *lobola*¹⁴, the term employed for bride price. A twenty-one year old male

12 Mcllwaine and Datta, 2004: 500.

13 P.E. Kidd. 2001. 'Social Perspective', in J.T. Mathangwane, Rape is a Crime: Taking a Stand Together against Rape and Sexually Related Crimes. Pp.43.

14 *Lobola* is the term employed by urban youth to describe bride price paid by a man's family to a woman's family prior to marriage traditionally in the form of livestock (Suggs, 2001). Though the term *lobola* is a Xhosa word, it was the one employed by participants as opposed to the Setswana term *bogadi*.

draws these parallels in stating

You have to pay the *lobola* and you have to be head of the family. Even if the woman is working and earning more money, that *lobola* comes into that. So in the end there would be more money from the man's side.

In contrast, youth convey urban women as financially independent, empowered and striving toward gender equality. Expectations of Gaborone men remain less obvious, with the majority of youth believing that men should remain the primary financial provider. Although youth differentiated urban gender expectations from rural ones, the characteristic of women's financial dependence on men permeated Gaborone youth relationships throughout the focus groups and interviews.

The Principal Gender Officer and Deputy Director of WAD suggests that, despite gender equality initiatives and women's entrance into the labour force, there is the continuation of the "expectation of the society that the man should provide, the woman should be the recipient" throughout Botswana. Accordingly, thirty-five percent of youth participants believe young women living in Gaborone are likely to become involved in financially dependent relationships with men, particularly significantly older men. As discussed by study participants, as well as McIlwaine and Datta¹⁵ work, within urban Botswana there is a high occurrence of young women engaging in sexual relationships for financial gains, referred to as the Triple C: Cash, Cars and Cellphones. As stated by one seventeen year old male participant, "these girls (in Gaborone) only want to be with someone with money". To confirm this point, a seventeen year old female participant explains that

Young women are different [than older women]; they want all kinds of things because they want to show their friends that 'hey, I'm living the good life, the glamorous life that you're not living'. I got a cellphone, a new one, I got a car, he gives me money. So even if they're not attracted to the older man, but just because he has something.

This trend was also discussed by the director of Emang Basadi who believes that "today's youth are very materialistic and go into relationships for material reasons". One such materialistic reason youth discussed was gaining access to bars, clubs or alcohol. Within Gaborone, youth spaces are limited and many are associated with an entrance fee. One seventeen year old male participant summed up concerns of young women's vulnerability in sexual relationships, particularly while under the influence of drugs or alcohol:

[T]here are the temptations of the city. Nowadays we live in a world where teenagers and young women enjoy

15 McIlwaine and Datta, 2004

entertainment: television and going out the clubs. Because when you go out to the clubs you make all these friends. And then your friends might want to get into things like alcohol and drugs, and you can become lost. And then some guy at the club comes up to you and starts talking to you, and the alcohol will tell you ‘yes, this is the one’. And she will go with him, and that’s how teenage pregnancy comes.

As indicated by the quote, the use of alcohol limits youth’s sexual decision-making abilities which can increase the incidence of unanticipated and unprotected sex. Moreover, Gaborone’s bar and late night party scenes are a common space for sexual violence with fifty percent of the rapes that take place between midnight and four in the morning occurring in and around bars¹⁶. According to BPS, “women and girls in bars late at night/early hours are perceived by some men as not respectable and need to be taught a lesson”¹⁷. In line with the increased potential for sexual assault is the augmented risk of HIV-infection.

Young women’s financial dependence on male partners, whether the same age or older, increases their vulnerability to HIV/AIDS. The power dynamic within a materialistic relationship is inequitable in that the financial dependent will have diminished decision-making power. This results in young women’s limited ability to express and enforce their sexual preferences. As a result, young women’s bodily health, bodily integrity and lives are compromised due to increased risks of HIV/AIDS infection. An age difference between partners also exacerbates power inequalities. Young women tend to have less power in sexual relationships within intergenerational affairs due to unbalanced power dynamics¹⁸. Among the age group of fifteen to twenty-four, sixteen percent of men are living with HIV in comparison to twenty-four percent of women¹⁹. Myths advocating the treatment of HIV/AIDS through sexual relations with younger girls have exacerbated this trend, resulting in an increase of intergenerational sexual relationships. HIV/AIDS transmission across generations occurs primarily between men and considerably younger women, with girls under the age of fourteen are twice as likely to have HIV, and girls fifteen to twenty-nine are three times more likely to be infected²⁰. The occurrence of violence can

16 BPS, 1999: 50

17 BPS, 1999: 59

18 Dunkle, K. *et al.*, Gender-based violence, relationship power and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*, vol. 363, no. 9419, 2004, pp. 1415-1421; A.S., Erulkar, The experience of sexual coercion among young people in Kenya, *International Family Planning Perspectives*, vol. 30, no. 4, 2004, pp. 207-213; N. Luke, Age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa, *Studies in Family Planning*, vol. 34, no. 2, 2003, pp. 67-86.

19 United Nations Development Programme (UNDP), *Moving Upstream and Engaging Governments in Strategic Policy Advocacy: The Case of UNDP Botswana’s HIV and AIDS Programme*, 2005.

20 United Nations Development Programme (UNDP). *Botswana Human Development Report: Towards an AIDS-free Generation*, Petadco Printing House, Gaborone, 2000.

also intensify youth's vulnerability to HIV/AIDS infection. As discussed in the following section, young men's violence as a means of maintaining power over a female partner may be taught throughout the gender socialization process, producing grim consequences for youth's HIV-infection risks.

Violent Masculinities: Sexual Violence and Coercion

Within focus groups and interviews, participants indicated that they do not accept violent behaviour within their own lives. However, through the discussions it was ascertained that youth believe men's violence against women continues to be normalized within society. This was demonstrated by one twenty-one year old female participant's comments about young men in Gaborone:

Sometimes there's a group of guys and you can hear them 'I would hit that woman'; these things, they don't matter to them. They think it's okay to hit a woman here in Gaborone. When they shouldn't do that anymore, they should just end the relationship and stuff like that. Nowadays, these guys think, 'ah, it's nothing to hit a woman!'

A seventeen year old male participant confirms this view in sharing his own experiences, "according to my experiences, men tend to be overly controlling. They think a woman is for doing what he says. And they tend to beat up their women". KWSP suggest that the sentiments expressed by these youth are part of a larger trend in which violence is an integral component of masculinity in Botswana: "it is generally believed that one is a real man when one exercises a bit of abuse of some sort to the wife such as beating her, depriving her of some family decision-making and cheating"²¹. It is important to note that the described form of masculinity presents a dominant or hegemonic masculinity and is not the only possibility for being a Motswana man. Hegemonic masculinity is described by Bob Connell as the male identity "that occupies the hegemonic position in a given pattern of gender relations"²². This form of masculinity is most often associated with compulsory heterosexuality, homophobia and misogyny²³. The nature and mechanisms of hegemonic masculinities are best understood as the portrayal of tensions between coercion and compliance, as highlighted in Gramsci's commonly cited definition of hegemony²⁴. Moreover, the values of the dominant social group – in this instance, the dominant male identity – become the 'common sense' belief systems underlying gender relations²⁵. Adoption of a hegemonic form of masculinity is thought to be a common response during times of uncertainty, such as periods of socio-

21 KWSP, *Women's Shelter Report of a Workshop on Domestic Violence Held at Oasis Motel*, 12 August 1999.

22 R.W. Connell, *Masculinities*, University of California Press, Berkeley, 1995: 76.

23 R. Morrell, Of boys and men: masculinity and gender in Southern African studies, *Journal of Southern African Studies*, vol. 24, no. 4, 1998, pp. 605-630.

24 R. Morrell and L. Ouzgane. African masculinities: an introduction. In *African Masculinities: Men in Africa from the Late Nineteenth Century to the Present*, L. Ouzgane and R. Morrell (eds.), Palgrave MacMillan, Hampshire, 2005, pp.1-20.

25 C. Jackson, Men's work, masculinities and gender divisions of labour. *The Journal of Development Studies*, vol. 36, no. 1, 1999, pp. 89-108.

economic change and urbanization²⁶.

As a possible cause of normalized violence, youth point to the gender socialization process and peer pressure. Two focus groups felt that “men bottle up their feelings” (sixteen year old female). Throughout childhood men are conditioned to believe that they should not cry or openly convey their feelings. This may lead to an inability to adequately express their feelings and, as a result, a greater propensity to react through physical violence. This process continues as youth socialize with peers. A twenty-two year old male revealed this point further in commenting:

We fail to change the group dynamics. We fail to influence our friends and say: ‘hey man, that’s not cool’. The next day when he’s harassing a girl and you keep quiet; if you keep quiet he’s gonna think it’s cool.

Peer acceptance of VAW may be the result of, and a perpetuation of, “intergenerational cycling of violence”²⁷. Through the normalization of VAW by parents, peers, media and other social factors, “men learn to use violence and women learn to tolerate it”²⁸.

The normalization of violence among young men has reverberations for HIV/AIDS infection. Given the aforementioned figures on sexual violence, it is clear that rape is most commonly committed by young men and suffered by young women, exacerbating the risks of HIV/AIDS infection. Moreover, sexual coercion through threats of violence diminishes a young woman’s power within the relationship and limits her ability to negotiate sexual decision-making²⁹. If this is normalized during the pivotal stage of adolescence and early adulthood, it is likely that men’s dominance and women’s subservience in sexual decisions will be entrenched within subsequent adult relationships. While violence may occur as an established means of male partners maintaining control over female partners, the study also points to males using violence to regain power in the face of changes or perceived challenges to their dominant position in a relationship.

Backlash Against Gender Equality: a ‘Crisis of Masculinity’ and Unclear Expectations in a Rapidly Changing Environment

Gender equality initiatives question and challenge particular gendered expectations within Botswana. Although youth discussed the importance of women’s empowerment, they also cited two negative outcomes: 1) men’s feelings of disempowerment, and 2) the creation of conflicting expectations in relationships. Both outcomes have the potential to intensify VAW as men

26 H. Moffett, ‘These women, they force us to rape them’: Rape as narrative of social control in post-apartheid South Africa, *Journal of Southern African studies*, vol. 32, no. 1, 2006, pp. 129-144.

27 R. Jewkes, Intimate partner violence: causes and prevention, *The Lancet*, vol. 359, no. 9315, pp. 1423-1429.

28 *Ibid.*, 1426.

29 Erulkar, 2004.

may violently attempt to regain power in a relationship or may be violent as a reaction to a perceived act of disrespect. This increased potential for violence also serves as a risk factor in youth's sexual health.

Men's feeling of disempowerment and resultant violence due to women's improved social status has been frequently labeled a 'crisis of masculinity'. McDowell³⁰, alternatively, contends that the situation is more appropriately conceptualized as a challenge to hegemonic notions of masculinity and male superiority. The notion of a crisis of masculinity has some reverberations in the context of urban Botswana in which women are gaining greater access to employment. Women are more commonly employed within Botswana's cities, as women comprise forty-three percent of the workforce as compared to only twenty-one percent within the rural areas³¹. Within Gaborone's environment of transforming gendered labour relations, urban Botswana youth both challenge and reaffirm gender identities and traits associated with a hegemonic masculinity that values men as the sole breadwinner. Within Gaborone, this was most clearly depicted through young urban women's financial independence and the female participants' performances of assertiveness in focus group discussions. This may illustrate what Kidd³² refers to as women's deviation from "the traditional role of being the gatekeepers of patriarchy; more and more they [Botswana women] no longer promote the values, beliefs and interests of men but rather more and more they are looking out for themselves".

From focus groups and interviews, young women's entrance into the urban labour market was demonstrated to contribute to feelings of disempowerment for men through the loss of their position as the primary breadwinner and hence responsible for decision-making in relationships. As noted by one sixteen year old female participant, "men are insecure because women now have more power". Key informants from WLSA, Emang Basadi, KWSP and WAD all supported the notion that the increasing assertiveness of women may be associated with declining confidence in some men. One all male focus group, alternatively, lamented Gaborone men's decreasing authority at the household level, with one seventeen year old male declaring, "I think men are being oppressed". Men feeling disrespected by a woman's lack of 'obedience' reflects an expectation from the rural gender script that women are to be docile, passive and obedient while resigning decision-making responsibilities to the male in a relationship. Women who align with a gender equality discourse by speaking for themselves, advocating equal treatment and being independent, transgress hegemonic norms which trap women in passivity. In support of this

30 L. McDowell, The trouble with men? Young people, gender transformations and the crisis of masculinity, *International Journal of Urban and Regional Research*, vol. 24, no. 1:2000, pp. 201-209.

31 Central Statistics Office, the Republic of Botswana (CSO). 2006. <http://www.cso.gov.bw/>

32 P.E. Kidd, 2001. 'Social Perspective', in J.T. Mathangwane, *Rape is a Crime: Taking a Stand Together against Rape and Sexually Related Crimes*. Proceedings of the National Conference on the Findings and Recommendations of the Study of the Incidence and Prevalence of Rape in Botswana. Held on the 5-6 March 2001 at Boipuso Hall, Gaborone, pp. 42-53.

trend, within seven of the focus groups participants indicated that urban men are having their ‘rights’ challenged by women’s pursuit of gender equality. Six indicated that men’s roles have become unclear in Gaborone. This is demonstrated through the comment of a nineteen year old female: “they [men] no longer recognize their responsibilities. They don’t know what they have to do anymore. It’s totally forgotten. Now, they think that is just a thing of the past, so it’s forgotten”. These same six focus groups pointed to gender equality initiatives as the underlying impetus for changing gender relations and the modification of masculinities. The changes to masculinities were most clearly expressed through sharing decision-making responsibilities and income generation. These six focus groups, however, focused on men’s feelings of disempowerment as a result of changing gender roles. One nineteen year old female believed that:

We think men and women are like equal to each other. So I feel like men sometimes feel a bit defeated. Because sometimes a woman can earn more salary than a man, so like he might feel like his honour is taken.

Similarly, McIlwaine and Datta’s work demonstrates the views of male focus participants in which they stressed that women’s change in status over the last twenty years had resulted in fewer rights for men³³.

As a negative repercussion of men’s perceived loss of status, focus group members, follow-up interview participants and key informant interviewees consider there to be an increasing incidence of violent behaviour towards women who contest the status of the dominant male identity. As one seventeen year old senior secondary school student stated: “for the man to earn less than the woman’s annual salary would be an embarrassment for the man, to the society; he feels so degraded, in a way...that also could lead to the issues that we have, these issues like passion killing”. This participants’ attribution of passion killings to men’s loss of control over financial resources is indicative of the connections between hegemonic male identities and VAW. The research assistant and Acting National Coordinator of WLSA substantiates this claim in stating: “some men might think they are the breadwinners. When they are not, they might try to physically manifest their presence there because he wouldn’t have the means so he will physically show that he is present”. A nineteen year old male broadens the cause of VAW from contested financial responsibility, more specifically, to the advancement of gender equality more generally:

Many young women right now are concerned with the issue of gender equality. [Laughter] Yeah they want to be equal as men, in the same position with men. So that leads to the development of some violences like women disrespecting their husbands. And that is the answer to many family corruptions, family violence that arises, you see. So that is the cause.

³³ McIlwaine and Datta, 2004.

Concurrently, expectations of youth’s behaviours in relationships are in a constant state of flux within Gaborone. Gender equality has allowed young women to gain access to education, take on new responsibilities and question the status quo. As indicated by one seventeen year old female participant,

Young women now are more independent... In the olden days women have to cook, have to clean the house, look after the children. But these young women, some of us will not do any of that stuff! [laughter] We have our own ideas and our own money so when a man comes you don’t have to do what he says.

Young women’s empowerment is seen as ‘disrespect’ by some of the youth participants. While one eighteen year old male participant suggests “women nowadays don’t respect men”, another eighteen year old male believes this is particularly true among young women: “young women today are more likely to do something disrespectful... Not listening to a man”. Within the study youth discussed what is respectful and disrespectful in relationships, as shown Table 1. The majority of youth felt that respect is exhibited by men and women treating each other equally. However, thirty-two percent of participants thought men demonstrated respect by supporting women financially and nineteen percent thought women should obey men to convey their respect. In terms of disrespect in relationships, youth believe women find cheating and not listening disrespectful behaviour from a man. Youth believe men find it disrespectful when a woman does not listen to his side of the story, does not do as he wishes or cheats. Of greatest significance for this paper is the figure that sixty-three percent of youth indicated that a woman refusing to obey a man can be considered disrespectful. The expectation of women’s obedience contradicts gender equality discourses which advocate for equal power between partners. In this way, certain relationship expectations expressed by youth conflict with one another, resulting in perceived disrespect.

Table 1: Respectful Behaviour in Relationships

Respectful behaviour from women	Respectful behaviour from men
Treating each other equally (31%) Sharing financial responsibilities (31%) Obeying men (19%)	Treating each other equally (68%) Supporting women financially (32%)
Disrespectful behaviour from women	Disrespectful behaviour from men
Not listening (88%) Not doing what he tells her to (63%) Not listening to his side of the story (25%) Cheating (50%)	Cheating (40%) Not listening (40%)

Youth believe that women will have any number of reactions to being disrespected by a man, including: leaving, talking to the man, having no reaction, verbally abusing the man or going to the *kgotla*. Alternatively, all the young people in this study thought that violence was a common reaction for men when disrespected by a woman. The high number of responses indicating violence shows that youth believe violence in relationships occurs frequently, especially when a man feels disrespected by a woman. This is supported by the director of KWSP in her statement that:

younger women are more aware of their rights and question things. And younger men feel like they are losing ground, their masculinity and their identity as men. The more likely women are to talk out and question things, the more likely they are to be abused when they grow up in a community that doesn't allow it.

In this way, young women may represent greater exposure to violence through contradicting and challenging men's dominance in relationships.

The multiplicity of youth responses regarding respect and disrespect in relationships indicates a divergence of expectations within youth relationships. As a repercussion for youth HIV/AIDS infection rates, young women standing up for her rights, asking questions, making her own healthy sexual decisions, may be perceived as 'disrespectful' by her male partner. As indicted by Lary *et al.*'s study of violence and HIV/AIDS among youth in Dar es Salaam, a young woman's ability to establish and express her own beliefs and wants for sexual health does not necessarily ensure she will have the ability to carry out her decisions as it may incite a violent reaction from her male partner³⁴. Lary *et al.* indicate that young men frequently "reported becoming violent when their female partners questioned their fidelity and reported forcing regular partners to have sex when these partners resisted their sexual advances"³⁵. Furthermore, "young men who were violent toward female partners also frequently described forced sex and sexual infidelity in these partnerships"³⁶. While sexual violence considerably increases the risk of HIV infection, the looming threat of violence for perceived 'disrespect' to a male partner by advocating protection, asking about the male partner's sexual health or refusing sex inhibits women's sexual decision-making³⁷.

Youth Violence, Sexual Decision-making and HIV/AIDS

Although this study did not focus explicitly on HIV/AIDS, many of the findings are able to inform the HIV/AIDS situation in Gaborone, Botswana. Despite the many resources available to youth in Gaborone, youth from this study have demonstrated the complexity of relationships within a rapidly changing

34 Lary *et al.*, 2004.

35 *Ibid.*, 200.

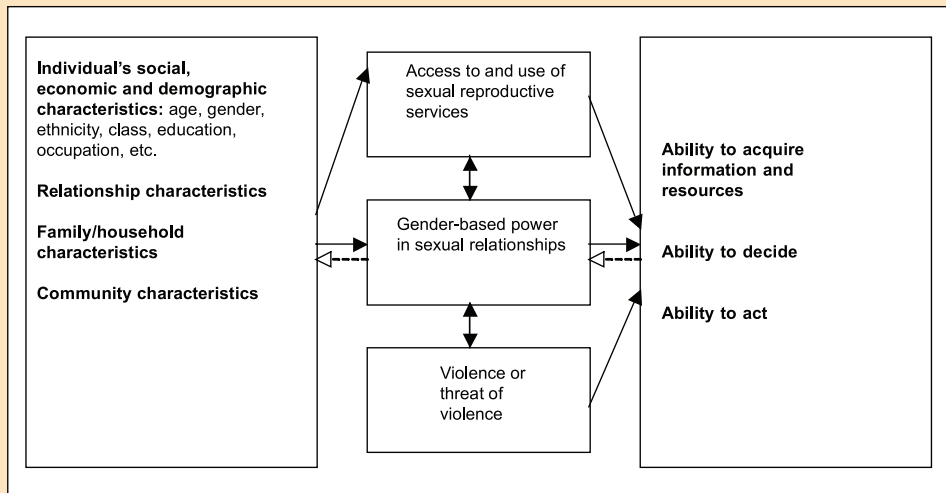
36 *Ibid.*, 200.

37 Luke, 2003.

environment and their considerable vulnerabilities to HIV infection. The forms of violence that surfaced from focus groups and interviews with youth include, though are by no means limited to, financial abuse, sexual violence and threats of violence. As illustrated in Figure 1, all forms of violence, or the existence of a potential for violence, have the potential to negatively affect youth's ability to access information on sexual health and acquire resources, such as protection. Subsequently, youth's ability to make decisions in their own best interest can be severely hampered. Most significantly, violence eliminates the possibility for youth to carry out their own decisions and adequately protect themselves from contracting HIV. The connection between HIV/AIDS and violence is discussed further by the Principal Gender Officer and Deputy Director of WAD who notes that women "don't have the negotiating power when it comes to issues of sexuality. Even if the woman is aware of the husband [or male partner] is not being faithful to her, she's unable to introduce any method of protecting either herself or himself". Consequently, although violence is overwhelmingly committed by males in youth relationships, violence places both parties at risk³⁸.

Figure 1: Violence and Threats of Violence as a Hindrance to Sexual Decision-making

Adapted from Blanc³⁹



The connections between violence and HIV/AIDS are understood as a “twin pandemic” within Botswana and initiatives have been implemented to simultaneously address them. During the second phase of attention to the HIV/

38 It is understood that women's elevated physiological vulnerability to HIV-infection will hold her at greater risk of contracting HIV.

39 A. Blanc, The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. *Studies in Family Planning*, vol. 32, no. 3, 2001, pp. 189-213.

AIDS crisis, the government focused predominantly on increasing awareness of the disease. As women were found to have higher rates of infection, the focus was placed on educating women through the ABC strategy⁴⁰. The ABC program attempted to enforce specific sexual-decision making in the following order: Abstain, Be faithful, Condomize. As this phase occurred during the period of 1989-1997, it is possible to reflect on the implications of this strategy. According the UNAIDS and WHO report (2004: 195), women demonstrate a higher knowledge of HIV/AIDS⁴¹. For instance, eighty-one percent of women know that a healthy looking person can be infected, in comparison to seventy-six percent of men who are aware of this⁴². Similarly, forty percent of women could identify two prevention methods and reject three misconceptions, as opposed to thirty-three percent of men⁴³. Although this phase of prevention policies has been successful in educating women, the burden of ensuring sexual health is placed solely on the shoulders of women. Moreover, women's infection rates continue to surpass those of men, indicating that women are often unable to carry out sexual decisions despite their increased knowledge of HIV/AIDS⁴⁴.

The contemporary strategies outlined by the Government of Botswana seem hopeful as the literature on HIV/AIDS pays particular attention to youth and notes the vulnerabilities of young women in intergenerational sexual relationships⁴⁵. The 2000 Human Development Report subtitle *Towards an AIDS-free Generation*, indicating the government's commitment to addressing HIV/AIDS among youth. At this stage it is difficult to predict the efficacy of new programs as current statistics on HIV/AIDS infection are reflective of the former prevention policies and do not necessarily express the effects of contemporary policies. However, Datta⁴⁶ suggests that these policies continue to address men and women separately, thus overlooking the manner in which gender relations influence individual's control over their sexual destinies. Similarly, in reference to male-focused intervention strategies, Mookodi finds the policies to continue to dichotomize men and women while perpetuating essentialized assumptions about male sexuality in Botswana⁴⁷. Prevention policies must strive to adequately address both gender relations and power dynamics in

40 S. Heald, It's never as easy as ABC: Understandings of AIDS in Botswana, *African Journal of AIDS Research*, vol. 1, 2002., pp. 1-10.

41 UNAIDS and WHO, 2004: 195.

42 *Ibid.*

43 *Ibid.*

44 United Nations Development Programme. 2005. *Botswana Human Development Report: Harnessing Science and Technology for Human Development*. UNDP: Published for the UNDP.

45 United Nations Development Programme (UNDP). 2000. *Botswana Human Development Report: Towards an AIDS-free Generation*. Gaborone: Petadco Printing House.

46 K. Datta, A Coming of Age? Re-conceptualising Gender and Development in Urban Botswana, *Journal of African Studies*, vol. 30, no. 2, 2004, pp. 251-268.

47 G. Mookodi, Understanding male sexuality: the weak link in sexual and reproductive health and HIV interventions in Botswana, *The Botswana Review of Ethics, Law and HIV/AIDS*, vol. 1, no.1, 2007.

youth relationships. Moreover, the complexity, diversity and dynamic nature of youth relationships can be incorporated to strengthen effectiveness of empowering youth to make and implement safer sexual health decisions. As stated by Lary *et al.*, “prevention interventions that fail to take into account the infidelity, violence and forced sex frequently involved in youth’s sexual relationships will have a limited impact”⁴⁸. Accordingly, it is essential that policies continue to stress the connections between violence and HIV/AIDS while creating programs to specifically address the dynamic circumstances of urban youth and youth relationships.

48 Lary *et al.*, 2004: 200. Although infidelity in youth relationships has direct links to HIV/AIDS infection, it was not a significant component of this study and remains an area of needed study.

THE RIGHT TO KNOW AND THE RIGHT NOT TO TELL: THE ETHICS OF DISCLOSURE OF HIV STATUS

By Mary O'Grady

Introduction

One of the most difficult issues patients have to grapple with after testing positive for HIV is whether or not they should disclose their HIV status and, if so, to whom, when, where, and how. The issues surrounding the disclosure of positive HIV status are complex. They are complicated by the stigma toward and discrimination against people living with HIV (PLHIV), which may be growing (Kershaw 2008: 1).

Health care practitioners also have to address the disclosure of the HIV status of their patients who test positive for the virus. They have to deal with issues of confidentiality surrounding information about their patients, whether they test positive or negative for HIV. In some areas, for example in 23 of the 50 states in the United States (USA), notification of the patient's sex partners is mandated by law (Galletly and Pinkerton 2006: 1). In such cases, health care practitioners must decide how such notification can be carried out effectively and without provoking violence or other discriminatory actions against the HIV-positive patient (or themselves) when the patient refuses to disclose to his or her sex partner(s) (Gielen *et al.* 2000: 115-116).

The Influence of Stigma and Discrimination

Stigma toward and discrimination against PLHIV is practically universal (Brown 2007: 1). These ongoing conditions complicate the disclosure of HIV-positive status and the ethical decision-making by everyone surrounding disclosure. Stigmatization towards HIV includes both the internal and external stigmatization many PLHIV feel (Cameron 2005: 53). Justice Edwin Cameron of South Africa's Supreme Court of Appeal, who lives openly with HIV, describes this as: "The disfiguring sense of shame that emanates from the internal world of some with HIV or AIDS...colludes with external stigma, overcoming efforts to deal with the disease rationally, keeping those with AIDS or HIV in involuntarily imposed self-isolation, casting a pall of contamination and silence over the disease" (*ibid.*: 70).

Discrimination against PLHIV is intense in many environments, including those in sub-Saharan Africa. In South Africa, five people, all of them women, have been killed after they disclosed their HIV-positive status or spoke about HIV publicly or interpersonally (Associated Press 1998: 1; Carroll 2003: 1; Human Rights Watch 2007:1). Clearly, disclosure of HIV status can be extremely dangerous. It can result in bodily injury and/or the loss of one's home, one's job, one's children, even one's life.

Examining the ethical underpinnings surrounding the disclosure of HIV status is important as disclosure remains controversial within medical ethics. The goal should be to give appropriate and comprehensive guidance to individuals who must make decisions about disclosing their own HIV status. This paper aims to help foster greater understanding of the hurdles HIV-positive individuals face in their decision-making surrounding disclosure, to help provide some insights to PLHIV and to health care practitioners and ethicists. Ideally, better understanding of the hostile environment in which PLHIV live and the hurdles they face regarding disclosure will help more people, communities, and nations to make more progress toward providing a safer and more secure environment for PLHIV. Changing the hostile environment will, in turn, make disclosure easier. Benefits of HIV disclosure do exist. However, in environments hostile to HIV, which are practically universal, the importance of self-preservation and thus personal protection can be far more important to a PLHIV, especially a woman, than the ethics behind sharing information about her health to potentially protect that of her sex partner.

Initiating condom use or even discussing safe sex practices with a partner, especially in countries where condom use with a regular sex partner is uncommon, can promote distrust rather than security. It is easy to understand that, in environments where sexual inequality, domestic violence, and HIV prevalence rates are high, disclosure of positive HIV status to a sex partner, especially by a woman in sub-Saharan Africa, can be fraught with negative consequences. These consequences can include violence, abandonment, emotional and psychological abuse, as well as murder (Mathews *et al.* 1999: 1128; De Cock *et al.* 2002: 10; Maman *et al.* 2003: 379).

Yet PLHIV can receive treatment for their infection via antiretroviral therapy (ART) only if they are willing to disclose their status to health-care practitioners. These workers are, in many cases, members of the same communities in which the PLHIV live (Norman *et al.* 2005: 10). Thus by disclosing their HIV-positive status to a health care practitioner who lives in their community, PLHIV risk losing confidentiality, privacy, friendships, community support, and sometimes familial support due to the high level of stigma toward and discrimination against them common in communities in Africa. In some health care facilities, privacy and confidentiality are not respected, and unauthorized shared knowledge of the positive HIV status of patients is common (Gielen *et al.* 2000: 113).

The objective of this paper is to review various ethical issues surrounding disclosure of HIV status - mainly for PLHIV and for health care providers. However, it will focus centrally on situations in which HIV-positive disclosure may conflict with self-preservation or future security. Saving one's own life cannot be considered an unethical act by a rational human being. Not only is there a "right to know" in some situations regarding disclosure of HIV status, there also is a right for individuals not to tell in other situations. It is up to each and every individual adult to determine her or his own situation, the

risks entailed, and a rationale for disclosure of HIV status or not (Hayford 2000: 2).

The paper also will summarise the results from multiple studies focusing on HIV disclosure that have been performed in Africa, Asia, Eastern Europe, Western Europe, Latin America and the Caribbean, and the USA. The study results show that disclosure of positive HIV status in hostile environments can have grave consequences for individuals as well as for families. Recognizing the negative conditions existing in such environments toward PLHIV is essential in guiding or determining one's own disclosure decisions in the midst of the current global HIV pandemic. Only through greater insights into the conditions surrounding the complicated decisions about disclosure can public health, development, and policy professionals design individual, community and structural interventions to help facilitate greater openness (Serovich and Mosack 2003: 71).

It was hoped in the 1980s and early 1990s by public health experts that by increasing the rates of disclosure of HIV status, more people would practice prevention behaviours. Therefore, greater disclosure would have an eventual impact in decreasing the spread of HIV. Yet recent studies have found that disclosure rates remain problematic and relatively low because of stigma and discrimination in virtually every community. People living with HIV suffer enormously from the stigmatized lives they have to lead if their HIV status becomes known. This predicament continues to exist in 2008 even in developed countries such as the USA (Moody 2008: 1). It is not unique to resource-limited settings such as sub-Saharan Africa. In considering the balance between public health and individual rights regarding HIV disclosure amidst hostile conditions, reviewing the competing interests becomes a complex exercise even when it involves only two people. Yet the objective for many public health ethicists is to balance the respective interests of PLHIV and their sex partners in such a way that societal health is maximized (Gostin and Hodge 1998: 67). Obviously, this approach to the ethics involved in disclosure determinations is a utilitarian or consequentialist approach.

This paper, however, will present ethical theories and approaches and disclosure study results debating the present societal situation regarding HIV disclosure in many countries from an individual rights-based approach. It will describe the ethical dilemma of trying to determine the appropriate balance of the rights of one individual over another within a largely unequal and unhealthy environment. Such an environment is the existing environment surrounding HIV in sub-Saharan Africa and elsewhere (Farmer 2005: 177). Thus the paper will take an applied ethics approach to disclosure, rather than one based on public health theory or utilitarian ethics. Importantly, this paper also will highlight the fact that only through decreasing stigma and discrimination toward PLHIV will disclosure of positive HIV status become more common. The end result will be progress toward the public health goal of decreasing the spread of HIV infection. Thus by protecting individual

rights, this author believes it is possible to meet a public health objective as well. Focused and pro-active attention to the real environment surrounding HIV and disclosure is urgent. This is especially true in southern Africa where HIV prevalence rates are the highest in the world and continue to grow in some countries (UNAIDS 2007: 12, 16, 18, 20).

The Fundamental Right to Life

The fundamental right all human beings have is the right to life. Brazier and Harris (2003: 172) contend that: "Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate, the right of the individual is paramount." Historically, the right to life, or the right to survive, is partly based on Thomas Hobbes's *Elements of Law*, first published in 1651 (ix). Hobbes wrote, "It is therefore a right of nature: that every man may preserve his own life and limbs, with all the power he hath" (Tuck 1989: 60). According to Hobbes and what is referred to as his general theory of action, in the words of Richard Tuck, "we always act in such a way as to secure what we take to be good for us" (*ibid.*). Acting on behalf of our own self-preservation is, obviously, in our best interest.

Philosopher John Locke's theory of personal identity also serves as an influential foundation for discussions surrounding the importance of personal identity, according to Nicholas Jolley (1999: 101). Locke's *Two Treatises on Government*, published in 1691, 40 years after Hobbes's important work introducing the concept of an individual's rights, stated: "Every one as he is bound to preserve himself, and not to quit his Station willfully; so by the like reason when his own Preservation comes not in competition, ought he, as much as he can, to preserve the rest of Mankind, and may not unless it be to do Justice on an Offender, take away, or impair the life, or what tends to the Preservation of Life, the Liberty, Health, Limb or Goods of another" (Locke: 271). Locke clearly has expanded on the right first identified by Hobbes, that of self preservation. He has added the rights individuals have to liberty, health, bodily protection, and personal property. Locke has laid out the premise that these are fundamental rights each person has, and they should not be taken away from another. Obviously, Locke did not advise taking an altruistic or Christian stance of 'turning the other cheek,' stating that the rights of others are more important than our own. Nor has he stated that the rights of a large group are more important than the rights of one individual, which would be a consequentialist or utilitarian approach to rights. Rather, he pointed out the duty each person has to protect his or her individual rights and the rights of other individuals when they are not in competition with one's own.

The importance of the rights of individuals is also derived from philosopher Immanuel Kant's 'formula of autonomy' described in his volume, *The Moral Law: Groundwork of the Metaphysics of Morals*, published in 1785. Kant defined the principle of autonomy as "every man's freedom of action," because every rational being is "an end in himself" (Paton 1991: 93). In other

words, every rational human being has the inherent right to make decisions for him or herself. Kant wrote that the decisions of individuals deserve ultimate respect, although he also wrote they are subject to the law (*ibid.*). Yet Kant, too, did not write that the happiness of another or others as a group is more important than seeking one's own happiness (Metz 2005: 377). Kant emphasized that furthering one's happiness is a duty, and it has a moral component. He also emphasized the importance of duty over other reasons for making choices. Kant wrote that the choices humans make must be their own individual choices, based on their dignity and their agency as rational human beings. Thus, according to Kant, human beings have the right to make free and informed decisions (Metz 2005: 378). The principle of autonomy, what Kant was espousing, has been a long-held philosophical principle. Autonomy is the right of an individual to make decisions about his or her own person or health and is a central principle in medical ethics.

Integral to Kant's theory is that each rational being is an end in him or herself, rather than the means to an end. This idea is one of the differences between Kant's theory with its extensive focus on the individual and that of the 'Utilitarianism,' promoted by John Stuart Mill—even though Mill believed in individual sovereignty except in cases of preventing harm to others (Vincent 2006: 20). It is important to refine what has been called the "harm principle" of Mill, which focuses on interfering with actions that harm others (Mill 1991: 72). Mill did not state that the harm principle is absolute in and of itself (*ibid.*). The question relevant to disclosure of HIV status regarding the harm principle seems to be whether it might be considered justifiable not to disclose information concerning one's positive status if potentially more harm might come to oneself by doing so than the potential for inflicting harm on another. No studies have shown that disclosing one's positive HIV status to a sex partner automatically results in the other person's taking specific action to protect his or her own health, or investigating his or her own HIV status. Clearly, it is important to be aware of the potential harm to oneself, or to one's patient, that can result from disclosure of an individual's HIV-positive status within a violent relationship, or in an environment fraught with stigma and discrimination against PLHIV.

Mill also recognized the importance of self-protection as a rationale for action (*ibid.*: 30). Yet he also focused on the need to prevent harm of others. Therein Mill's "harm principle" presents a justification for limiting personal autonomy and lays an ethical foundation for the need to maintain public health (Bayer 2003: 133). However, in analyzing what Mill wrote, it seems to most closely relate in the case of HIV infection to someone who would actively try to infect others with the virus. Decisions about the disclosure of one's own HIV status or indeed that of a patient are generally made within more complex circumstances and are less dramatic—and clear cut—than those of someone actively trying to infect others. A PLHIV needs to think about the potential harm disclosing could bring to himself or herself unless a positive outcome is certain. Health care practitioners also need to consider

the potential harm that could come to a patient related to disclosure, which can outweigh the possible benefit of disclosure to a third party. Indeed, according to the Nuffield Council on Bioethics in the United Kingdom, Mill's harm principle doesn't provide "a satisfactory answer to all the questions that arise in the context of public health. Nor does it commit us to the wider theoretical framework in which it was set out, or to claim that harm to third parties is always a sufficient legitimization of coercion" (2007: 16). Thus the Nuffield Council has stated that harm to a third party is a necessary, but not necessarily a sufficient reason for a coercive individual intervention (*ibid.*).

One wonders whether Mill would conclude it is essential for someone to disclose their HIV status to their sex partner if significant harm, even death, might come to them by doing so. This question is central when the person who must make a decision about disclosure is involved in a previously violent relationship. It is also relevant when it is the sex partner who passed on his or her own HIV infection to the person who has to make a decision about disclosure. In both cases, the decision about whether or not to disclose HIV status must be made by individuals who already have been harmed by the very person some feel it is their obligation not to harm. These are complicated situations interpersonally and ethically because they may result in physical harm, potentially physically, and ethically. In environments of secrecy about HIV status, which are common around the world, the sex partner could have passed on his or her HIV infection despite being aware of the potential for onward transmission if unprotected sex (without a condom) was not practiced. Much research has shown that such situations are not unusual (Olley, Seedat, Stein 2004: 1).

Autonomy clearly is the one of the most relevant principles for individuals making disclosure decisions, but it is also of central importance for health care practitioners. For example, 'informed consent' is an ethical requirement for health care practitioners to procure from their patients prior to providing medical treatment to them as competent individuals. Yet the principle underlying informed consent is respect for the individual patient's autonomy. The ethical principle of patient autonomy was elaborated by Beauchamp and Childress when they noted that "principles in ethics are deeply embedded in the concrete world of human social conduct" (1994: 94). According to these authors in the most recent version of their book, *Principles of Biomedical Ethics* (2001: 63), "To respect an autonomous agent is, at a minimum, to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs." Surely, a belief that sharing one's HIV-positive status with a sex partner might put one at risk of bodily harm, potentially losing one's home, or make life in one's home environment emotionally or physically intolerable falls under this realm of respect for personal autonomy. Moreover, Beauchamp and Childress went on to write about autonomy (2001: 64), "As a positive obligation, this principle requires respectful treatment in disclosing information and fostering autonomous decision-making." Thus to try to make a decision for someone who is

competent denies that person respect for his or her own individual autonomy and decision-making.

According to Rachels (2002: 102), fundamental to Utilitarianism, which is based on the amount of happiness for the greatest number of people, is the proposition that “each person’s happiness counts the same.” Yet taking a utilitarian approach in making a decision about HIV disclosure is problematic in situations where the rights of individuals are not equal and may not be equally protected. Such imbalance is common regarding the inferior legal and socioeconomic rights of women in many, if not most, countries. Moreover, how can happiness for the greatest number, which as previously mentioned is fundamental to Utilitarianism, be determined in cases where the ‘happiness’ of one individual is potentially pitted against another in the case of individual HIV disclosure to a sex partner? Again the fundamental question arises: does one have a greater responsibility toward another than one’s duty or responsibility to oneself?

The Universal Declaration of Human Rights (UDHR), adopted on 10 December 1948 by the General Assembly of the United Nations (UN) (2), states: “Everyone has the right to life, liberty and security of person.” The following articles from the UDHR are all relevant to the individual rights that can be jeopardized by disclosure of HIV status. Article 12 states: No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.” Article 12 speaks to at least three examples of the violation of rights many PLHIV must contend with after their HIV status becomes known. The first is violations of their right to privacy. The second is attacks upon their honour and reputation, particularly in the case of, but not limited to, women. The third is protection by the law against such interference or attacks.

Article 16 of the UDHR states: “Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. The family is the natural and fundamental group unit of society and is entitled to protection by society and the state.” This right to marry and found a family is not restricted to those who are not living with an infectious disease. Further, both spouses are entitled to equal rights in marriage, even at its dissolution. This is the case whether or not one has become infected with HIV during the marriage – or knowledge of HIV infection arises during the marriage. Nonetheless, such circumstances have been used as evidence of adultery and therefore grounds for divorce by husbands in some countries, including Kenya and Uganda (Mutungi 2006: 8; Kiapi Matsamura 2004: 1). Article 16 also guarantees protection of families by the State. Thus a husband, according to the UDHR, cannot throw his wife (and their children, if they have any) out of their house after he learns of her HIV infection. This potential personal and familial disaster remains a

relatively common fear of African women after learning of their own HIV infection (Norman *et al.* 2005: 6; Paxton 2002: 561). Abandonment after HIV disclosure is also a common fear of women in the USA (Sowell *et al.* 2003: 3; Kass and Gielen 1998: 96).

Article 23 of the UDHR states: “Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.” (UN 1948: 2-6). This article supports the right of everyone, including PLHIV, to employment. Thus PLHIV should not lose their jobs based on their HIV status. Yet this potential result continues to be a common concern of many PLHIV regarding disclosure decisions, and consequently disclosure to an employer remains risky or even ill-advised in most circumstances (Buckley and Gluckman 2002: 27).

Theories Behind Disclosure

Regarding disclosure of HIV status to sex partners by PLHIV, the simple and basic ethical approach would be that, of course, everyone should disclose their HIV status to their sex partners as soon as they learn they are infected with the virus. Otherwise, they are jeopardising their partner’s health through potential transmission of a life-threatening viral infection to an uninfected person, or re-infecting their partner with, potentially, a different strain of HIV. Such a stance on HIV disclosure was the common moral and legal stance in the 1980s and even the early 1990s when the necessity for disclosure seemed to be considered absolute by many health professionals in developed countries (Marks, Richardson, Maldonado 1991: 1321). Convincing more PLHIV to disclose their status was considered a priority for HIV prevention. Since then, however, recognition has grown of how common the lack of HIV disclosure is to sex partners. Consequently, there is a greater need to understand why such decisions and subsequent actions are so complex. If they were not complex and did not involve risk, there would be no reason not to disclose.

Recently, recognition in the public health community also has grown showing the assumption that a greater degree of disclosure of HIV-positive status by individuals to their sex partners would result in decreased sexual transmission of HIV may be incorrect. In fact, the effectiveness of disclosure of HIV status as an HIV prevention measure is not known (Pinkerton and Galletly 2007: 1). Thus disclosure of HIV-positive status to sex partners may not be an important public health focus for preventing spread of the epidemic. Rather, HIV disclosure seems to be more of an issue relating to the individual’s ‘right to know’ relevant information about the health status and potential infectiousness of a current or potential sex partner. Knowing such information about sex partners can help individuals maintain their own health and potentially prevent their exposure to a chronic, if not deadly, disease. Yet, why should a PLHIV have to disclose his or her status when people with other infectious diseases, such as tuberculosis (TB), which is more infectious than HIV, walk around and cough in the presence of

individuals who might not even be aware of their infection? In fact, many African PLHIV die from TB, as they are up to 50 times more likely to develop TB in their lifetimes than people who are HIV-negative, rather than die from other opportunistic infections to which AIDS can leave them vulnerable by affecting their immune systems (World Health Organization 2005: 1; World Health Organization 2008: 1). In fact, that the criminalization of transmission of HIV alone is unjustifiable when many other communicable diseases can lead to death or serious injury was precisely the legal argument against HIV-related criminalization put forward in the UK in 2000 by Bennett, Draper and Frith (Chalmers 2002: 3). Yet the debate surrounding the potential for criminality regarding HIV transmission, which is legislated in some countries, is receiving increased attention in 2009. For example, five countries in East and southern Africa, including Angola, Kenya, Madagascar, Mozambique and Tanzania, already have legislation criminalising HIV transmission; another four countries, Malawi, Uganda, Lesotho and Comoros, are in varying stages of adopting HIV-specific laws, while a law in Mauritius prevents an HIV-positive foreigner from marrying a citizen of the country (Eba 2009: 1). The related legislation in place does support an individual's right to know the HIV status of a sex partner, but runs into trouble as it is almost impossible to prove legally that viral transmission occurred at a specific time through infection by a specific individual and that it was intentional (*ibid.*: 2).

Consequently, situations related to disclosure of HIV status and any demand related to the 'right to know' face significant ethical and legal hurdles. Among them is the lack of access to full knowledge of one's own health status common to most people around the world and especially so in developing countries (Farmer 2005: 143). Moreover, proving intent to infect remains very difficult. While the right to know remains the ideal, it is mainly hypothetical and largely unenforceable in 2009, at least in relation to HIV.

In fact, most PLHIV do not know that they are infected with the virus. Even in Europe, an estimated 33% of PLHIV are not aware of their infection (Deutsche Welle 2008: 2). A recent survey of 3,500 gay men in five cities in the UK showed most of the men infected with HIV had assumed they were HIV-negative (Medical Research Council 2008: 1). A study of men who have sex with men (MSM) in Washington state, USA, published in 2008, showed that asking a sex partner his HIV status in advance was not a workable approach. More than 30% of the individuals who used this as a protection method subsequently tested HIV-positive (Golden *et al.* 2008: 1). It seems ironic to consider that someone might demand the 'right to know' or calmly ask about someone's HIV status before having sex with the person, but be given the wrong information for the right reason, that is, even when the other person believes s/he is being honest and open about his or her status.

Focusing on Beneficial Disclosure

Both UNAIDS and the World Health Organization (WHO) encourage 'beneficial disclosure' of HIV status. Such disclosure entails voluntariness, respect for the autonomy and dignity of the affected individuals, confidentiality as

appropriate, and “leads to beneficial results for the individual, his/her sexual and drug-injecting partners, and family; leads to greater openness in the community about HIV/AIDS; and meets ethical imperatives so as to maximize good for both the uninfected and the infected” (UNAIDS/WHO 2000: 6). However, based on research conducted from 2007 to 2009 by this author, ‘beneficial disclosure’ defined by UNAIDS/WHO in 2000 remains aspirational, almost universally, except in individual relationships that are unusually personally supportive.

What is needed to foster an environment supportive of beneficial disclosure is more action on the ground by communities and nations to decrease hurdles to HIV openness. The stigma and discrimination faced by PLHIV just about everywhere needs to be greatly decreased and more legislation needs to be put in place (and enforced) to protect individual rights. Unfortunately, some international HIV/AIDS activists believe that the negative attitude towards HIV infection seems to be growing rather than diminishing (Gonsalves 2008: 1).

Making a decision not to disclose, however, is a difficult one. Many people feel the need to reason through an appropriate level of responsibility regarding the practice of justice toward a sex partner. Nonetheless, some research has shown that some people do not feel a sense of justice at all toward their sex partners, including some married women and men toward their spouses even when violence or other subjugation is not a threat (Nsabagasani and Yoder 2007: xv, 37). Some even claim to be protecting their sex partners or spouses by not disclosing, which seems unjustifiable at least in regard to protecting them from possible HIV infection.

Recent innovative programmes focusing on the gap in prevention and care programming for PLHIV i.e. ‘positive prevention’ or ‘positive health, dignity and prevention,’ have identified the need to help PLHIV to understand why they should disclose their status and help them identify appropriate opportunities to do so (Rosenberg, *et al.* 2007: 1-27). However, the reasons for disclosure still should be weighed against any potential harm that may occur before a decision is made.

When men and women in New York City have decided to disclose their HIV status, Klitzman and Bayer found it was done for varying reasons depending upon who was the recipient of the revelation (2003: 233). To sex partners, it was done out of a sense of moral responsibility and concern for a partner’s health. To parents, it was done for support and because of feeling they had a right to know. To friends, it was done for support. Non-disclosure to sex partners was based on the fear of rejection and also a need to maintain secrecy about one’s HIV-positive status. Non-disclosure also was found to be more common for individuals with a greater number of sex partners (Marks *et al.* 1991: 1321; Holt *et al.* 1998:50; Simbayi *et al.* 2007: 2). Some individuals decided not to disclose to family members, particularly parents, out of a sense of shame, or to avoid rejection or dependence. Others wanted

to protect their families from emotional distress (Klitzman and Bayer 2003: 233).

Klitzman and Bayer also found that decisions about disclosure “shifted over time,” based on greater individual understanding of the epidemic, the importance of who the sex partner was, and various other contextual reasons (*ibid.* 235). The length of time since testing HIV-positive also was found to have an impact on disclosure decisions (Crepaz and Marks 2003: 382). When one has been living knowledgeablely with a disease for a long time, it becomes easier to come to terms with it, according to many people. Also, when one is living in an environment where there are some tangible benefits to disclosure, making the decision to disclose is much easier than when the costs seem to outweigh the benefits. It is important to recognize that one person’s decision to disclose in a seemingly supportive relationship or familial circumstance does not necessarily make another’s non-disclosure decision under entirely different circumstances unreasonable or unethical. Disclosure decisions are by their very nature personal ones.

The Overwhelming Impact of Stigma

“AIDS is stigma disgrace discrimination hatred hardship abandonment isolation exclusion prohibition persecution poverty privation” (Cameron 2005: 42). These words were written by Justice Edwin Cameron describing the manifestations of both internal and external stigma toward PLHIV that many, if not all, of them feel or have felt at one point or another after they have tested positive for HIV. These words and feelings highlight the intensity of the societal, interpersonal, and individual response to HIV and AIDS and the very deep negativity accompanying this disease. They connote the enormous difficulty most people face in deciding whether or not to share their HIV status with another person. They also introduce the variety of possible negative reactions that may occur after disclosure.

Stigma toward people living with HIV and AIDS remains pervasive worldwide. According to Valdiserri (2002: 342), in the USA “stigma needs to be recognized as a continuing impediment to HIV prevention and care programs”. While efforts over the last ten years have increased to try to lessen the stigma against HIV and AIDS, the results of a survey conducted in nine countries, encompassing Brazil, China, France, India, Mexico, Russia, South Africa, UK and USA, and released in November 2007, indicated that nearly half the people surveyed said they felt uncomfortable walking next to an HIV-infected person (Brown 2007: 1). This worrisome finding points out that little progress has been made in reducing the level of stigma toward people living with HIV in most countries, including those where ART is widely available. The survey results also emphasize the seriousness of the stigma toward HIV. Many of the respondents felt they wouldn’t want to be seen with a PLHIV.

Fundamental to the decisions around disclosure is that revealing one’s HIV-positive status in a highly stigmatized society could put one’s life at risk.

If disclosed publicly, it most certainly would risk one's liberty, as it would beckon discrimination and freedom of movement. It also could risk one's security of person either from a specific individual, such as one's sex partner, or from members of the community if one's positive status becomes widely known and where HIV is highly stigmatized. This was the case for Gugu Dlamini, a woman who was murdered based on her HIV status in 1998 in KwaMancinza, South Africa (Associated Press 1998: 1).

In South Africa, HIV and AIDS-related stigma continues to be very common, both socially and culturally, according to Kalichman and Simbayi (2003: 442). Edwin Cameron describes it as "stubbornly intransigent" (Cameron 2005: 66). Women living with HIV in South Africa in particular tend to be more stigmatized than men living with the virus, according to Sigxaxhe and Mathews (2000: 1). A higher degree of stigma toward women living with HIV also exists in Zambia, as noted in 2005 by Campbell *et al.* (2). Many authors have noted that women generally tend to be blamed for bringing AIDS into families as they tend to be diagnosed with HIV before their partners, when they are tested for the virus during pregnancy. Stigmatized environments, as noted by Valdiserri (2002: 342), make it extremely difficult for HIV and AIDS prevention and care programmes to operate effectively. Moreover, trying to stop the spread of the epidemic in such an environment, especially in South Africa, a country with the estimated highest number of people living with HIV of any country in the world (according to UNAIDS in 2007 (16)) requires measures well beyond standard infectious disease interventions. Indeed, even sharing one's status with health professionals to access ART in this type of stigmatized environment takes courage. Stigma toward PLHIV does not necessarily stop at the clinic door in health-care settings in Africa (Stegling 2004: 240; Norman *et al.* 2005: 10; UNAIDS 2006: 199; Human Rights Watch 2007: 3).

Black women in South Africa historically are the country's most powerless group (Petros *et al.* 2006: 72). The HIV epidemic is seen by some of them as one more threat to the long-needed elevation of their social status and even to their very survival. In a qualitative research study conducted in Durban, South Africa, all 11 women living with HIV who were interviewed "experienced either physical abuse (hitting, punching, slapping, etc.) and or/psychological abuse (social stigma, name calling, discrimination) related to disclosure of their HIV status" (Finney and Njoko 2000: 1). Further, violence against women in South Africa appears to be so common and was so accepted in 1999 that approximately 44% of men who were interviewed in Cape Town municipalities admitted they abused their female partners (Vetten 2005: 2). Rape Crisis estimates that some 2,800 women are raped each day in South Africa (Hennop 2006: 1). South Africa's Medical Research Council found in a study conducted in 2005 that a woman was killed every six hours by an intimate partner, which is the highest rate ever reported anywhere in the world: 8.8 per 100,000 females older than 14 (Kapp 2006: 719). In such a climate of violence, it is understandable that any South African woman

would think long and hard before providing the type of information to her sex partner, such as disclosure of positive HIV status, which might invite violence.

Little has been accomplished to significantly lessen stigma toward HIV over the last ten years, despite recognition that it is a serious problem in making progress against the epidemic (Sarangi n.d.: 1; Valdiserri 2002: 241-242; Kalichmann and Simbayi 2004: 572; Kalichman *et al.*: 2005: 135; Rennie and Behets 2006: 1; Bartlett 2007: 1; Kershaw 2008: 1). Moreover, testing more people will not necessarily result in increasing prevention behaviours. Indeed, the counselling focus on prevention for those who are potentially HIV-negative, as well as those who test HIV-positive, has been lessened by the major health authorities. The new HIV testing guidelines by the World Health Organization and the U.S. Center for Disease Control and Prevention, called ‘provider-initiated testing and counselling’ by the WHO and under implementation in Botswana, may result in earlier and possibly better treatment for more PLHIV, which would be a very positive outcome (WHO 2007: 34; CDC 2006: 8. Yet the possible prevention outcome from the HIV counseling and testing intervention has been decreased or even minimized over the last two years by these two agencies, which are the most important health agencies in the world. This has occurred despite the HIV prevention outcome on the individual, dyadic (couples), and eventually societal levels being one of the primary reasons for public health support for disclosure of HIV status (Varga *et al.* 2005: 952).

Why Disclosure Remains Difficult

Studies in several countries have found that disclosure of HIV status is one of the most difficult decisions anyone who tests HIV positive has to make, whether or not the individuals live in a country where violence is common (Blais 2006: 37). A study performed by Holt *et al.* (1998: 49) in the UK found that immediately after diagnosis, “individuals were more likely to adopt a policy of non-disclosure and this provided them with an opportunity to come to terms with their diagnosis before having to contend with the reactions of others.”

In many clinics where HIV testing is available in African countries, some individuals only come for a test after they are already gravely ill, according to Chimwaza and Watkins (2004: 799). Even in such cases, however, the home caregiver for the individual, generally a family member and more often than not a woman or girl, frequently is not informed of the person’s real diagnosis while in a hospital or at a clinic testing site because of the stigma attached (*ibid.*). An example cited by Chimwaza and Watkins in their study in rural Malawi shows that many healthcare professionals in Africa are very aware of the extensive stigma toward and discrimination against HIV existing in communities, even in the home setting (*ibid.*).

The Universality of Stigma and Discrimination

Stigma surrounding HIV, however, is not limited to sub-Saharan Africa. In a study in the USA of mostly African-American women living with HIV in the rural South, the “women’s fear that others in their community might learn of their HIV infection was second only to having the disease itself” (Sowell *et al.* 2003: 32). Of the more than 300 women who participated in the study, only 65% had disclosed their status to all their sex partners. Only 3% of them had told all their close friends. Obviously, disclosure of HIV status was a very serious issue to these women (*ibid.* 37). Further, a small group of them had decided not to disclose to anyone, even though by not disclosing to their sex partners they were putting any uninfected partners at risk of HIV infection. Such an action is punishable by imprisonment in the states in which they lived (*ibid.*: 42), yet whether or not each of these women had clearly thought through all the potential consequences of non-disclosure is unknown. That they were afraid of the possible results of disclosure to their sex partners, however, seems palpable.

It is crucial to note, that whether or not women experience physical violence based on disclosure, “notification of a positive HIV test result can profoundly affect a woman’s psychological and physical well-being” (Gielen *et al.* 2000: 111). An HIV-positive test result can cause them to “experience feelings of isolation and shame” (*ibid.*). Such knowledge, even if unshared, will only worsen how a woman feels about herself when she is already in an inferior socio-economic and highly vulnerable position, no matter where she lives.

Men, too, suffer stigma and discrimination after disclosing their HIV status, whether or not many undergo physical violence based on their revelation. Several African-American men who were part of a study conducted by Gaskins in the rural southern USA suffered negative reactions from family members whom they had told of their status (2006: 5). One man’s sister “betrayed him by telling her husband and son” (*ibid.*). Most of the 20 men interviewed for the study wanted to warn other people to be careful about whom they shared their HIV status with and to choose the individuals very carefully. One man advised,
“Pray about it. Think long and hard about who this person is you are going to tell. The last thing, be prepared if the person goes out and tells it. You have to handle it if they do” (*ibid.*: 6).

Many of the respondents who tested positive in a research study conducted in Uganda focusing on HIV voluntary counselling and testing (VCT) and disclosure also were afraid of being talked about in their village (Nsabagasani and Yoder 2006: 35). They expected to experience hostility from any members of their community who learned they were living with HIV (*ibid.*). Yet the men who tested HIV-positive who were not “severely sick” did not tell their wives about their results. They claimed they did so to avoid rumours, blame, and disruption of their familial relationships. Some of them even said that women have “weak hearts” and might collapse after hearing the news. Ironically,

some of these same men disclosed their positive status to others who were not their sex partners, including their parents, siblings, other relatives, and close friends (*ibid.*).

In addition to the concerns PLHIV have about their potential ostracism by their family members, friends, and communities through their disclosure or the shared knowledge of their status without their permission, they concurrently live with other major stressors related to their HIV infection. These include the uncertainties about the disease itself and their own individual rate of disease progression, and consequent anxieties about their future health and their future in general (Holt *et al.* 1998: 49). According to a study by Holt *et al.*, they also worry about how their interpersonal relationships will change based on their disease. Further insecurity, especially about their financial future, also plagues them (*ibid.*).

Examples of Negative Disclosure Responses

Simpson and Forsyth's study of 11 pregnant women in New Haven, Connecticut, USA, who were mandatorily tested for HIV during their pregnancy according to Connecticut state law between 1999 and 2005, produced noteworthy results (2007: 39). When the participants were asked whether their diagnosis had changed their relationship with their spouse, children, or extended families, "some responses were positive and uplifting but the majority of responses were troubled and filled with disappointment and anger" (*ibid.*). At the time of the birth of their babies, 9 of the 11 women were managing on their own with no or minimal support from their spouses or sex partners. The results by Simpson and Forsyth speak for themselves: "Many of the women were victims of verbal and physical

abuse and controlling partners. One woman had been badly beaten and scalded by the father of her baby. Another study subject was later shot dead by the father of her babies. It was not determined what role, if any, the women's HIV infection played in the abandonment and/or abuse" (*ibid.* 38). While the abuse of these women in the USA and even the murder of one of them cannot be attributed directly to disclosure of their HIV status, the study results are chilling.

What is also important to remember, and what does not seem to be adequately addressed in the HIV disclosure guidelines for health care practitioners of several international and national medical bodies, are the results of a study by Zierler *et al.* They also are supported by results from other studies, including one by Vlahov *et al.* (1998: 54). The results state that "Apart from the risk of serious injury, physical assault victimization may have dire consequences for HIV-infected persons. Physical assault may directly affect immune function as well as disrupt other bodily systems" (Zierler *et al.* 2000: 208). Surely, the risk of worsening a patient's physical condition and disease progression needs to be taken into account when health care providers make a decision about partner notification related to HIV infection. Also germane is consideration of the potential emotional deterioration that can follow psychological abuse

by a spouse or sex partner, which also can result in deleterious physical symptoms over time.

To illustrate the impact of psychological abuse, a study by Coker *et al.* in South Carolina, USA, found that psychological “intimate partner violence” (IPV) “was as strongly associated with the majority of adverse health outcomes as was physical IPV” (2000: 1). Among the subsequent physical symptoms resulting from psychological abuse by their partners 13.6% of the 1,152 women in Coker *et al.*’s study had experienced included: disability preventing work, arthritis, chronic pain, migraine and other frequent headaches, stammering, sexually transmitted infections (STIs), chronic pelvic pain, stomach ulcers, spastic colon, and frequent indigestion, diarrhea, or constipation (*ibid.*). None of these women had suffered physical abuse. While most of these physical symptoms can be individually debilitating, it is especially worrisome that some are the same side effects that many people experience at various times while taking ART (Johnson *et al.* 2007: 1). Thus if a woman is already taking ART, from which side effects are common even though it is a life-preserving medication, health care providers considering disclosing the woman’s HIV status to a sex partner must consider the possible concurrent physical after-effects of any psychological abuse she could suffer from her partner.

Worse in some cases is the increased potential that PLHIV aware of their status have for severe depression (Gross 2008: 1). According to Meel based on his forensic pathology work in South Africa with support for his findings from previously published research and other publications, including Beauchamp and Childress (1994: 414), “HIV infection is associated with an increased risk of suicidal behavior” (Meel 2003: 8). Also, “Suicidal acts seem to be more frequent in AIDS patients than in the general population” (*ibid.*). Obviously, health care providers need to take into consideration the potential multifarious effects their disclosure of someone else’s HIV-positive status can have on the individual.

These worrisome findings are a reminder of the basic ethical principle upon which every physician has been trained: “Primum non nocere,” or “First do no harm” (Medical Dictionary 1998: 1). It underscores the fact that in the treatment of a patient, first and foremost the health care practitioner should not make the patient any worse than s/he already is. Consequently, the importance of support for the patient needs to be emphasized, including supportive counselling regarding disclosure. ‘Fully informed’ counselling to PLHIV concerning the disclosure of their status to others, which seems like a logical ethical step in counselling provision and a form of psychosocial treatment for PLHIV, is not widespread (Maman *et al.* 2003: 380). That is, some patients are advised by counsellors, physicians, or nurses to disclose their status to other health professionals; (Sankar and Jones 2005: 2379) some are advised to disclose their status to their sex partners (Gluckman 2002: 27; Olufs 2002: 3); and some are counselled to disclose to their family members, including their children (Murphy *et al.* 2003: 207; Nostlinger *et*

al. 2004: 641). However, during such counselling PLHIV are not necessarily informed about what the negative ramifications of such disclosure can be in individual circumstances. Rather, the emphasis may be put on the benefits of disclosure without delving into discussion of the individual's relationships and any specific circumstances they should consider before disclosing to members of their interpersonal network, including their sex partners.

The trend toward providing good and comprehensive counselling as a key component of HIV testing was reversed by the Center for Disease Control and Prevention (CDC) in the United States in 2006 and the World Health Organization (WHO) in Geneva in 2007 (WHO/UNAIDS 2007: 34; CDC 2006: 8). As these two agencies are the major players in health policy globally, their policies carry a great deal of weight. The HIV testing guidelines were revised by both agencies to result in a greater number of individuals undergoing testing partly though the cessation of counselling before testing as one of the requirements. Yet these international guidelines conflict with the fact that in a highly stigmatized epidemic, more counselling is needed by individuals rather than less (Siyayinqoba – Beat It 2005 (26): 1).

Additional Ethical Principles Relevant to Disclosure

While respect for a patient's autonomy, and indeed respect for one's own freedom to make personal decisions remain central to disclosure, other bioethical principles also are relevant. One of them is privacy. For example, Article 12 of the UDHR supports the fundamental right of each and every person to his or her privacy. This right was not newly formulated in the late 1940s. Focusing on the right to privacy for the *Harvard Law Review* in the USA in 1890, Warren and Brandeis wrote, "In very early times...the "right to life" served only to protect the subject from battery in its various forms;... Gradually the scope of these legal rights broadened; and now the right to life has come to mean the right to enjoy life, --the right to be let alone" (1). Warren and Brandeis's concern was that individual privacy extends across a number of realms: physical and emotional. Further, they wrote that individuals should be protected from having their private information made known to the community (*ibid.*: 9). It might be argued that someone's HIV status is a matter of public health concern to a community. But in considering such an attitude, Warren and Brandeis sagely wrote at the end of their paper on the right to privacy, "Still, the protection of society must come mainly through a recognition of the rights of the individual" (*ibid.*: 11).

Elaborating on the right to privacy, Fried wrote in 1968 that, "...privacy is... the *control* we have over information about ourselves." Also, "The person who enjoys privacy is able to grant or deny access to others." He went on to state that, "Most obviously, privacy in its dimension of control over information is an aspect of personal liberty" (276). In *Privacy: A Moral Analysis*, Fried includes: "The rights of privacy are among those basic entitlements which men must respect in each other; and mutual respect is the minimal precondition for love and friendship (277); "...this most complete form of privacy is perhaps

also the most basic, as it is necessary not only to our freedom to define our relations to others but also to our freedom to define ourselves. To be deprived of this control not only over what we do but over who we are is the ultimate assault on liberty, personality and self-respect (278).”

What is relevant about Fried’s views is that they support an individual’s basic right to privacy, but they also address the need to be able to maintain this right even in one’s most intimate relationships. His views are relevant to disclosure of HIV status and how it falls within the overall parameter of the fundamental right to privacy. That is not to suggest that it is ethical to keep whatever information one has about oneself from others if it will harm them. Rather, one has a right to consider one’s own dignity, self-worth, value to society, and safety in the equation of the need for others to know one’s HIV status and the right not to tell. The circumstances involved in maintaining privacy, whether regarding information about oneself or in actions surrounding revelations of private information, are central to ethical decision-making. Preventing potential harm from occurring to another has to be considered. But it is not more important than considering what harm could come to oneself through the loss of privacy.

Weighing the potential harms involved and to whom they might befall requires extensive knowledge of the environment and the individuals involved. They might include family and community members for whom disclosure of HIV-positive status of a family or community member might be a significant cause for concern. This is the case in African communities where HIV disclosure has ramifications for one’s spouse or partner, one’s children, and one’s extended family in some settings (Kalichman and Simbayi 2004: 578; Varga *et al.* 2005: 956, 959). These considerations are not to be trifled with when one’s life, livelihood, and all social interactions and perhaps the same factors for several others, or possibly many other family members, are at stake.

Yet the weighing of potential outcomes occurs even when there is realization that one’s sex partner has the need to know more than anyone else. In many African countries and in the USA, where ART has been far more readily available since 1996 than in Africa to date, many individuals have decided that it is too risky to share their HIV status with anyone, including their sex partners (Mabunda 2006: 27; Stein *et al.* 1998: 253). These individuals have decided that the cost-benefit ratio most seem to use when making disclosure decisions is against them (Sowell *et al.* 2003: 11; Klitzman and Bayer 2003: 253). Even in the USA where one would think that the availability of ART for more than ten years would have lessened discrimination based on HIV-positive status, evidence exists from various sources about interpersonal violence from sex partners and continuing discrimination in health care situations. The primary care-based study by Zierler *et al.* in 2000 found that 20.5% of HIV-positive women, 11.5% of MSM, and 7.5% of other men had experienced physical harm after their diagnosis (208). Half attributed the violence directly to their HIV status (Mills 2002: 331).

Given the prevalence of violence related to HIV in a number of countries, it seems obvious that maintaining privacy in regard to HIV-positive status would be paramount to most people. One's health status in general should be kept private, and others should honor this principle. Indeed, the WHO has laid out eight regulations regarding privacy of information regarding individuals, including the following: "All information must be kept confidential, even after death. Information can only be disclosed if the patient gives explicit consent, or if the law specifically provides. Consent may be presumed where disclosure is to other health care providers involved in that patient's treatment" (Davies 1996: 31-32). The WHO regulations clearly emphasize the importance of maintaining patient privacy and the confidentiality of all health information. However, in cases where public interest seems to trump private interest based on the danger of death or serious harm, such as through highly infectious epidemic disease, including multi-drug resistant (MDR) and extremely drug-resistant (XDR) TB, disclosure of confidential patient information can be warranted (Brazier and Harris 2003: 175; Gruskin and Loff 2002: 1; Abbo and Volandes 2006: 33). Obviously, though, situations where breaching confidentiality is warranted have to be unusual, and the disease must pose very serious harm to public health and to the public in general.

An English Court of Appeal found in the case of *W v Egdell* concerning a mental health review of a patient in 1988, that "(a) Disclosure should be limited to those regarded as vitally in need of the information...(b) The risk, if the material is not disclosed, must be real rather than fanciful...(c) Rather more specifically this real threat needs to be of physical, as opposed to some other form of, harm" (Harbour 1998: 67; Brazier and Harris 2003: 40). Thus the English Court seemed to say that where a disclosure decision is not clear and a breach is not essential to protect physical health, err on the side of caution.

The World Medical Association (WMA) attempted to strike a balance between patient privacy rights and the rights of their sex and drug-injecting partners in its *Statement on HIV/AIDS and the Medical Profession* policy, released in 2006 (2): "Fear of stigma and discrimination is a driving force behind the spread of HIV/AIDS. The social and economic repercussions of being identified as infected can be devastating and can include violence, rejection by family and community members, loss of housing and loss of employment, to name only a few....Lack of confidence in protection of personal medical information regarding HIV status is a threat to public health globally and a core factor in the continued spread of HIV/AIDS. At the same time, in certain circumstances, the right to privacy must be balanced with the right of partners (sexual and injecting drug) of persons with HIV/AIDS to be informed of their potential infection. Failure to inform partners not only violates their rights but also leads to the same health problems of avoidable transmission and delay in treatment." The WMA's policy advises physicians to counsel their patients to disclose their status to their sex and injecting-drug partners themselves. But in cases where the patients have

refused and physicians know the identity of their partner(s), the physicians should take disclosure action based on their moral and legal obligations. However, the WMA also advises that such action should be taken only after informing the patient, discerning how to protect the patient's identity, and taking "appropriate measures" to ensure the patient's safety especially in the case of a "female patient vulnerable to domestic violence" (2006: 3). The policy further states that physicians must gain understanding of the medical, psychological, social, and ethical considerations involved in partner notification before undertaking it in specific situations. It also declares that national medical associations should work with governments to ensure that physicians who carry out their ethical obligation of patient notification, when necessary, are legally protected (WMA 2006: 3). How to protect the patient's identity in the case of spousal notification seems to present a serious hurdle, however. Also germane is that most developing country legal systems are not equipped to protect physicians from a lawsuit brought against them by the sex partner of one of their patients (Human Rights Watch 2007: 1).

The *Ethical Guidelines for Good Practice with Regard to HIV* published by the Health Professions Council of South Africa (HPCSA) in 2007 are the most explicit and the most sensitive to the reality of positive HIV disclosure in South Africa. They specify that "the primary responsibility of health care practitioners is to their patients" (HPCSA 2007:2). Regarding disclosure, they state, "If the patient refuses consent, the health care practitioner should use his or her discretion when deciding whether or not to divulge the information to the patient's sexual partner, taking into account the possible risk of HIV infection to the sexual partner and the risks to the patient (e.g. through violence) that may follow such disclosure" (*ibid.*: 5). They further state that , "If the health care practitioner *decides* to make the disclosure against the patient's wishes, the practitioner must do so after explaining the situation and taking full responsibility at all times" (*ibid.*). The HPCSA guidelines spell out seven steps the practitioner must take surrounding disclosure. The most relevant are that the health care practitioner must: "After disclosure, follow up with the patient and the patient's partner to see if disclosure has resulted in adverse consequences or violence for the patient, and, if so, intervene to assist the patient appropriately" (*ibid.*). Finally, they state: "Health care practitioners must recognize the major ethical dilemma when confronted with a person who is HIV positive and who refuses, despite counselling, to inform his/her partners" (*ibid.*: 6).

The HPCSA guidelines on HIV disclosure clearly recognise the commonality of violence in South Africa, including as a consequence of HIV disclosure, which is to their credit. Yet by laying all responsibility for the occurrence of violence on the health care practitioner, they make the practitioner professionally responsible for any deleterious result of his or her disclosure to the person's sex partner. Further, the HPCSA makes it the practitioner's responsibility to help the patient in the case of any negative result. What if abandonment of the patient is the result of the practitioner's disclosure to a partner? What

if permanent physical damage to the patient results from violence by the patient's partner after the physician's disclosure, and the patient is no longer able to work? These may seem like extreme consequences resulting from HIV disclosure, but such consequences have occurred in South Africa and in other African countries. It is difficult to imagine any practitioner who would be willing to accept responsibility for a patient's livelihood, shelter, or medical needs resulting from violence following his or her disclosure to the patient's partner.

Importantly, the HPCSA guidelines do not state or imply that the ethical recourse for health practitioners is to inform a patient's sex partner of his or her HIV status if the patient is unwilling to do so. Instead, they state that such disclosure may indeed harm the patient. Further, they do not limit the time period in which resulting harm could occur. As such, they recognize the ethical principle of non-maleficence, without stating or suggesting that practitioner disclosure would be a non-maleficent act. As they are based on the results of the disclosure, rather than the act of disclosing, they take a consequentialist approach to the ethics involved.

In the USA, the legal duties and responsibilities of health care providers regarding disclosure to sex partners if a patient is unwilling to disclose vary from state to state, as previously stated (Nathanson 2002: 1). However, the Association of State and Territorial Health Officials (ASTHO) in the USA does not specifically state in its disclosure guidelines that the ethical and/or legal duty is for a practitioner to disclose a patient's HIV status to the sex partner if the patient is unwilling to do so (*ibid.*). Rather, they recommend that "a health care provider may invoke his or her "privilege to disclose" when that provider knows of an identifiable at-risk partner who has been named by the HIV-infected person" (*ibid.*). Obviously, ASTHO leaves the HIV disclosure decision and action regarding a potentially at-risk third party to the discretion of the health care practitioner. Thus the ASTHO guidelines are cognizant of the ethical quandary such decisions can pose to health care practitioners.

Even if a health care practitioner knows the spouse or sex partner of the patient, exactly what the introduction of the topic of potential infection with a life-threatening disease will do to an intimate relationship cannot be known in advance. Perhaps some believe it can be surmised through extensive knowledge of both individuals involved, as well as in-depth knowledge of their relationship, but how many people, health care practitioners or not, are in a position to make well-informed judgments about the intimate relationships of others and indeed the future outcomes of these relationships? We cannot predict what all the reactions by others will be toward individuals who reveal their HIV status (Sokol 2005:3).

We can, however, provide guidance for making such crucially important decisions - which potentially can change the lives of individuals for the better or, in more extreme situations, even cause their deaths. Indeed,

UNAIDS, WHO, and many government programmes and non-governmental organizations (NGOs) do provide guidance to individuals on how and why they should reveal their HIV status when it will be beneficial, or at least not result in harm to them (UNAIDS 2000: 12; Khomanani n.d.: 2, 4; Department of Social Development n.d.: 10).

However, if such disclosure may result in death; if there is already a history of violence in the relationship; if a woman who has just learned her positive status is totally dependent on her partner to feed herself and her family; if she is pregnant; if the woman's partner is the only sex partner she has ever had and she was infected by him; and if she knows her partner would tell others in the community about her status resulting in ostracism, what should this person do? Should a woman who has just been raped tell the man who has raped her that she is living with HIV and then wait to see if he kills her? This is exactly what happened to Lorna Mlosana, a 21-year-old woman in Khayelitsha, South Africa, on 15 December 2003 when she was raped by two men who then killed after she revealed her HIV-positive status to them (Carroll 2003: 1).

While some of these scenarios might seem overly dramatic, they are real-life situations in the stigmatizing environments where women who test positive for HIV in sub-Saharan Africa live (Colebunders *et al.* 2001: 625; Schuklenk and Kleinsmidt 2007: 1182). Around the world, if women were truly equal with their male sex partners and had various socio-economic options, many might not have become infected with HIV in the first place (Farmer 2005: 166). In the developing world many women are not autonomous. Their level of education does not enable them to make responsible decisions about their reproductive health. They are unaware of the importance of condom use, especially with multiple partners and of the necessity for HIV testing and the concept of the "window period". They do not feel empowered to insist on condom use or to say 'no' to sex because of the potential negative consequences. Even if some are in a position to make these decisions rationally, they do not believe that they have the right to do so, nor the necessary support to engage in lateral thinking and its consequent behaviour.

These issues relate to the essential currency of gender power relations in a very unequal environment more or less worldwide (Farmer 2005: 231). They are relevant to how such relations play out ethically regarding HIV status in a climate of socio-economic disparity and gender violence (Abdool Karim 2005: 258, 275; Varga *et al.* 2005: 959; Orza 2006: 5). Recognition is growing of the developing-country conditions combining the social, cultural, and legal constraints on women that inhibit them from controlling their lives, their basic human rights, and those of their children, which medical anthropologists call "structural violence" (Tuller 2007: 2; Farmer 2005: 230). Yet far too little is being done so far to address and rectify these conditions socially, economically, and legally.

Additional Bioethical Principles to Consider

Also relevant in the argument against disclosure of HIV status by a health care practitioner to a sex partner if it has the potential to do harm to the physician's patient, is that the patient is the physician's primary responsibility, not the patient's sex partner (Levinson *et al.* 1999: 1; Project of the ABIM Foundation *et al.* 2002: 244-245; Friendenberg 2000: 11; Beach *et al.* 2005: 1; HPCSA 2007: 2). This is a key concept related to patient care encompassing a variety of principles. What is most relevant here is the principle of confidentiality on top of primary loyalty to one's patient's needs.

Some aspects of the ethical practice of medicine that Hippocrates held sacred some 2,400 years ago clearly still pertain today. Patient privacy and confidentiality are two of them. Non-maleficence, or the Hippocratic tenet "first do no harm," is a third as already cited (Beauchamp and Childress 1994: 189). Beneficence or what Hippocrates referred to as "benefit of the sick" in the Oath is yet a fourth (trans. Adams 1849: 1). In a discussion of the bioethical principle of beneficence, Kass and Gielen (1998: 92) have defined it as the following: "...beneficence means that persons have the responsibility to do well for others, to prevent harm to others, or, at the very least, to avoid directly harming others. Beneficence also requires the balancing of harms and benefits that might result from a given policy to determine whether or not, on balance, the policy is beneficial." Thus the principle of beneficence also supports the duty to weigh both benefits and harms to individuals before taking any action regarding them.

According to a physician in Botswana who treats many PLHIV, she would not disclose a patient's HIV status to a sex partner. She said she would consider it to be an invasion of the patient's privacy. She further stated that she does not know of any physician in Botswana who would disclose a patient's HIV status to a sex partner for the same reason (Cavric 2008: personal communication). The physician has been treating patients, including PLHIV, in the country's capital for nearly 20 years and she has a wide network of medical colleagues in the country. Further, according to a Physicians for Human Rights report in 2007, nearly one in three men and women in Botswana believed that testing positive for HIV and disclosing their status to their partner would result in the break-up of their marriage or relationship. Surely, the views of these individuals reflect the real environment in Botswana and deserve professional and personal respect.

Beauchamp and Childress's definition of justice in regard to bioethics is "...a group of norms for distributing benefits, risks and costs fairly" (2001: 12). Justice, however, also needs to be considered regarding HIV disclosure in its normal frame of reference. Justice also is "...the constant and perpetual disposition of legal matters or disputes to render every man his due" using the definition in *Black's Law Dictionary* (Gibson 2006: 24). This approach to justice takes into account the need to balance the rights of the health care practitioner's patient and the practitioner's ethical responsibility to the

patient with the rights of the person his or her patient may have infected with HIV, or could infect in the future. It seems that it would be just for a sex partner to learn of his or her possible exposure to HIV infection and take future precautions against it, as well as be tested for HIV and potentially gain access to ART, if needed. This fundamental juxtaposition of rights and the decision about the potential disclosure required currently falls onto the shoulders of the health care practitioner when the patient will not disclose his or her HIV status to the partner. On face value, such a predicament for a physician would be considered an ethical quandary (Bayer and Toomey 1992: 1163).

For health care providers considering disclosure to a patient's sex partner, the determination clearly must be made on an individual basis involving a multiplicity of factors. Indeed, it is not a casual decision. However, the health care provider must also bear in mind that it will be a causal action. It is not neutral. It will have an impact, either for the most part, positive, or for the most part, negative, in the future. In addition to the ethical responsibilities involved in health care practitioners making such determinations, moral and legal responsibilities exist. Weighing their responsibilities and defining the potential impact of their actions need to be addressed very carefully by health care practitioners to ensure a just outcome even when available resources to attend to the consequences might seem unlimited.

One also needs to bear in mind that the resources of many PLHIV are limited as are the number of years they (or anyone) will live. To quote Edwin Cameron (2005:62)., "...millions of South Africans livings with HIV or AIDS...have no jobs, or their jobs would be at risk if they spoke about their HIV. They not only lack community support, but face grave danger if they do so. And, most importantly, they do not have access to proper medical care and treatment. For them, in a still hostile climate, the choices are strictly limited. Their right to invoke confidentiality remains of critical importance to them" Until the hostile climate toward HIV and PLHIV changes in sub-Saharan Africa, it seems unreasonable and unjust to deny these people their right to life by ethically demanding they disclose their HIV status when doing so could put their lives at risk.

The Importance of Social Justice

In environments of significant inequity, social rights and social justice have to be perceived as part of ethical decision making (De Negri Filho 2008: 97). It must be borne in mind that philosophical discussions of ethics and moral principles by contemporary philosophers focus on the moral obligations of individuals when they do not have to sacrifice anything of comparable value to provide support to another individual (Rawls 1999: 385; Singer 1973: 229). This is not the case when one has to decide whether or not to disclose HIV-positive status to a previously violent partner, or to a community member in a largely hostile environment. In such cases, the scales of justice, as well as the principle of respect for autonomy, are clearly weighted toward self-

preservation and protection of the individual rights and dignity of PLHIV.

Where disclosure of HIV-positive status poses no danger or potential loss of future security, the right and ethical choice is disclosure. Clearly, there are benefits to disclosure; most importantly, to be able to access life-saving ART. Yet we cannot expect people to put their own lives at risk in hostile environments simply to help others recognize their own health risks. This is too much to ask of people who have very little, all of which they may lose through such an action.

Differing Responses in Differing Environments

To some PLHIV in developed countries, the negative impacts of disclosure seem less important over time, especially as they become ill and need support and care from others (Klitzman *et al.* 2004: 629). Yet as previously discussed, many Africans do not disclose even when they are on their deathbeds because of the atmosphere of shame and hostility surrounding HIV that continues to be the norm in sub-Saharan Africa. In Botswana, according to Edwin Cameron from what he was told, people do not disclose, "...because they fear they will be identified as having AIDS. So they postpone it for as long as possible. They fall sick first. Even then they delay. They eventually go and stand in the clinic's queues. But mostly they do so only when they are approaching the point of death" (2002: 67).

The continuing stigma and discrimination surrounding this life-threatening disease must be diminished with far greater efforts across society to increase understanding of the need to embrace those who are ill, rather than make them believe they are outcasts (Gluckman 2002: 27; Parsons *et al.* 2004: 459; Kang *et al.* 2005: 145; Serovich *et al.* 2006: 1; Kumar *et al.* 2007: 89). Changing the negative atmosphere surrounding HIV will enable more PLHIV to receive better treatment in general, including life-saving medical treatment. Prevention is a priority and people infected with the virus also need much more psychosocial support and access to social services is not always available in sub-Saharan African countries.

Whether someone lives in an environment of intense stigma toward and discrimination against PLHIV or not, each PLHIV must decide whether to disclose his or her HIV-positive status. Personal ethics are at play as well as each person's interpersonal, familial, and social relationships, and the economic, cultural, political and geographic environment in which they live (Parsons *et al.* 2004: 459; Sullivan 2005: 43). Society has to make the overall environment more receptive to and supportive of disclosure. People living with HIV desperately need conducive conditions to live full, happy, and productive lives in spite of their illness. Until the external environment surrounding HIV changes, there is no reason to expect that the internal environments of those living with HIV intensely felt stigma and discrimination will change in any substantial way.

To this author, the ethics surrounding disclosure of positive HIV status vary depending on an individual's situation within the larger contextual environment. Nonetheless, disclosure of positive HIV status can result in significant benefits. Disclosure of HIV status has the potential to improve personal well-being when assistance, including emotional support, is provided by others (Sullivan 2005: 45). Disclosure to sex partners living with HIV helps them protect themselves from re-infection with HIV or secondary STIs, which will make their own HIV infection status worse (Crepaz and Marks 2003: 379). Disclosing positive HIV status to health providers enables access to HIV treatment, which makes the difference between life and death if a PLHIV requires (Sankar and Jones 2005: 2378). Some health professionals believe that ART can extend the life span of PLHIV perhaps even to normal lengths (Janssen *et al.* 2001: 2-3). Disclosure of positive HIV status to health care practitioners also will help them to provide the best possible care. Even disclosing one's status after one already is seriously ill with AIDS is helpful for partners and family members so that they may protect themselves from infection in personal care situations of late-stage AIDS illness. Children can also be assisted to prepare for a parent's eventual death (Myer *et al.* 2006: 2).

Despite the benefits of disclosure of positive HIV status, it may not be as important a public health intervention toward preventing HIV infection on the population level as many have believed (Marks *et al.* 1991: 1321; Ciccarone *et al.* 2003: 2). Simoni and Pantaleone have shown through their research with PLHIV in the USA that "...although information about a partner's HIV sero-status may play a role in one's choices about safer sex, disclosure alone does not automatically lead to safer sex in the way one might presume" (2004: 117). The same results also were found in a study by Hart *et al.* (2005: 155). What is more important for PLHIV to do ethically than to disclose their status to sex partners is to discuss the absolute need for safer sex, whether and whenever they choose to disclose their status (Crepaz and Marks 2003: 379). Obviously, PLHIV should always use condoms with their sex partners if condoms are accessible (Chalmers 2002: 6). The consistent and proper use of condoms with sex partners who are living with HIV and those who are not is essential. Condom use when one's own HIV status may be in question, or with partners whose status is unknown, also should be the norm.

Continuing gender inequity, especially in sub-Saharan Africa where more women than men are infected with HIV, has to be taken very seriously regarding danger related to the disclosure of positive HIV status (UNAIDS 2007: 8; Schuklenk and Kleinsmidt 2007: 1192). Such gender inequity and its overriding impact on the HIV epidemic, women's vulnerability, and fears related to disclosure are crucial motivations for bolstering the need to further open up the societal and interpersonal dialogue about HIV in general. To start to address this situation, challenging and indeed overcoming the serious stigma and discrimination surrounding the disease remains urgent. While some health professionals working in the field recognize that "we know little

about how to reduce stigma and violence,” we have to start trying to do so much more than we have done to date (Mills 2002: 1).

When the HIV stigma and discrimination paradigm changes, disclosure about positive HIV status will become easier. When the environment becomes less hostile to PLHIV, the ethics behind making disclosure decisions will become more clear to all involved, especially PLHIV. Indeed, when the environment toward PLHIV becomes more open and supportive, more lives will be saved. At that point more PLHIV will go for HIV counselling and testing, more will access ART, and more people living with the virus will be better able to become more productive, live longer, and likely enjoy happier lives. But more lives will not be saved, or the choices become ethically easier to make primarily because of greater openness about disclosure, but about HIV itself.

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LEVEL OF EDUCATION AND CONDOM USE AMONG THE SEXUALLY ACTIVE IN BOTSWANA

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Abstract

This study investigated the relationship between level of education as highest level of schooling acquired, and condom use among sexually active men and women in Botswana. The data used is a nationally representative sample from the Botswana AIDS Impact Survey conducted in 2004. An un-weighted sample of 9065 men and women aged 15-49, who have had sexual intercourse was considered for analysis. Both bivariate and multivariate analyses are used to gain insights into the potential linkages between education and condom use. The bivariate analysis shows that there is a significant relationship between response variables (condom use at first and last sexual encounter, always using a condom) and the main independent variable (level of education). The multivariate analysis shows that, when controls are introduced the statistically significant relationship persisted on the use of condom at first and last sexual encounter as well as always using a condom. The results show that level of education; fully influences the use of condom at first and last sexual encounter, and partly influences consistent condom use. Understanding condom use habits for sexually active women and men allows health workers and policy makers to identify problem areas that need more attention so as to reduce unwanted pregnancies, the rate at which condom use is discontinued and the spread of HIV/AIDS.

Background

According to O'Reilly (2006), condoms have a long history. The first evidence of condom use dates back to around 1000 BC when the ancient Egyptians used a linen sheath for protection against sexually transmitted diseases. In Europe, the syphilis epidemic in the 1500s that spread across the continent gave rise to the first published account of the use of condoms (O'Reilly, 2006). O'Reilly added that later in the 1500s, improvements in the condom were achieved when the linen sheath was sometimes soaked in a chemical solution and then allowed to dry prior to use. These were also the first condoms with spermicides. In the 1800s condom manufacturing was revolutionized by the discovery of rubber vulcanization by the Goodyear and Hancock Company. During the 1900s the quality of condoms improved with innovations in manufacturing technology. The female condom was made available in Europe in 1992 and was approved in 1993 by the United States (US) Food and Drug Administration. In recent years, improved expertise in

condom production has enabled the thickness of the condom to decrease and allowed for variations in size, shape and taste.

Introduction

Condoms are a vital tool in our efforts to prevent HIV infection. They are also essential for the maintenance of other elements of sexual and reproductive health, such as the prevention of unwanted pregnancies and all sexually transmitted diseases. With education, support and consistent supply, people can learn to integrate condom use into their lives. Condoms come in many shapes and sizes, colors and scents for both males and females.

By 2004, access to condoms and HIV/AIDS information had been named “a global health and human rights concern”, by Human Rights Watch. According to Berer (2006), condom use is pleasurable and erotic, and lack of access to condoms infringes on human rights. National governments and international donors have an obligation under international law to provide accurate information on condoms as well as ensuring an adequate supply. However, social and cultural norms make negotiating condom use and safe sex difficult in some societies. Conservative beliefs can stigmatize sex and condom use, making it difficult for people to speak openly and honestly about their desires and realities. Condom use is often undermined by laws and policies that restrict their supply and usage. Misinformation about condom effectiveness, denial of education on sexual risks and criminalization of marginalized groups are among the factors that undermine condom use and give rise to unsafe sexual practices (Berer, 2006).

Despite the effectiveness of condoms in preventing the sexual transmission of HIV and other STDs, they are often not used correctly and consistently. In a study done by Dintwa (2008), about 5.9 percent of the respondents did not always use a condom during sexual intercourse. Barriers to condom use include the perception that they reduce sexual pleasure and affect sexual performance, and misinformation about condom effectiveness.

Education is positively correlated with the use of condoms. That is, the more individuals are educated (being able to utilize and understand information about the dangers of unprotected sex) the more they get to use condoms. But the same (educated) individuals sometimes lack motivation to practice safe sex. Socio-economic and cultural factors influence lack of motivation to practice safe sex. Some religions prohibit the use of condoms like members of the Zion Christian Church in Botswana. This is a commonly known fact in the country.

Socialisation has an influence on the increase of AIDS risk behaviour. Men are the major decision makers in the family. Gender-based imbalance in power found in the economic and social spheres of life is reflected in sexual partnership relations. Women often have less control over the nature and timing of sex and the practice of protective behaviours. A woman's ability

to practice safe sex may be influenced by her ability to communicate openly about sex with her partner, the power dynamic in their relationship, or how much the partner believes in the traditional gender roles [Population Council (undated); Dintwa (2008)].

According to the results of the study conducted by Tlou, Norr, Moeti, Levenger and Gantes in 1992, women in Gaborone have a wide range of experiences and attitudes about condom use. Some have never used condoms; some have negative experiences, while others have used condoms with high rates of success. For women, partner objections and difficulties in negotiating sexual issues with their partners are a major barrier to the initiation of condom use to avoid HIV infection. Many women thought condoms were easier to use with casual partners than with a husband or live-in partner because condom use implies lack of trust between partners. Physical discomforts associated with condom use and concerns about the condom remaining inside the woman also discouraged its use. The reduction of sexually transmitted diseases and protection against pregnancy are the major factors that influence women to use condoms.

In Botswana, the Government response to HIV/AIDS was expanded in the years 1997-2002 in many different directions to include education, prevention and comprehensive care including the provision of antiretroviral treatment (Botswana Government, 2000).

This study differs from previous studies in Botswana as it focuses on the association between education and condom use habits among sexually active Botswana men and women. A Study by Letamo (undated) entitled *Gender Dimensions in Misconceptions about HIV/AIDS Prevention and Transmission in Botswana* revealed that people can be highly educated that is being able to utilize and understand information about the dangers of unprotected sex but still engage in risky sexual behaviour. Researchers are more into the barriers to condom use, but less attention has been paid to the association of education and condom use habits in Botswana. Examples of those researches include: Tlou, Norr, Moeti, Levenger and Gantes (1992) on '*Barriers to condom use for urban Botswana women.*' International conference AIDS; Ntshebe, Pitso, Segobye (2006) on '*the use of culturally themed HIV messages and their implications for future behaviour change communication campaigns: the case of Botswana.*' and Pitso (2002) on '*does alcohol take away condom use? Qualitative evidence from Selebi Phikwe and Mahalapye town districts, Botswana.*' This study therefore intends to consider the link between education and condom use among sexually active Botswana men and women. The study investigates whether:

- The respondent used a condom the first time they had sexual intercourse;
- The respondent used a condom the last time they had sexual intercourse;
- The respondent always used a condom during sexual intercourse.

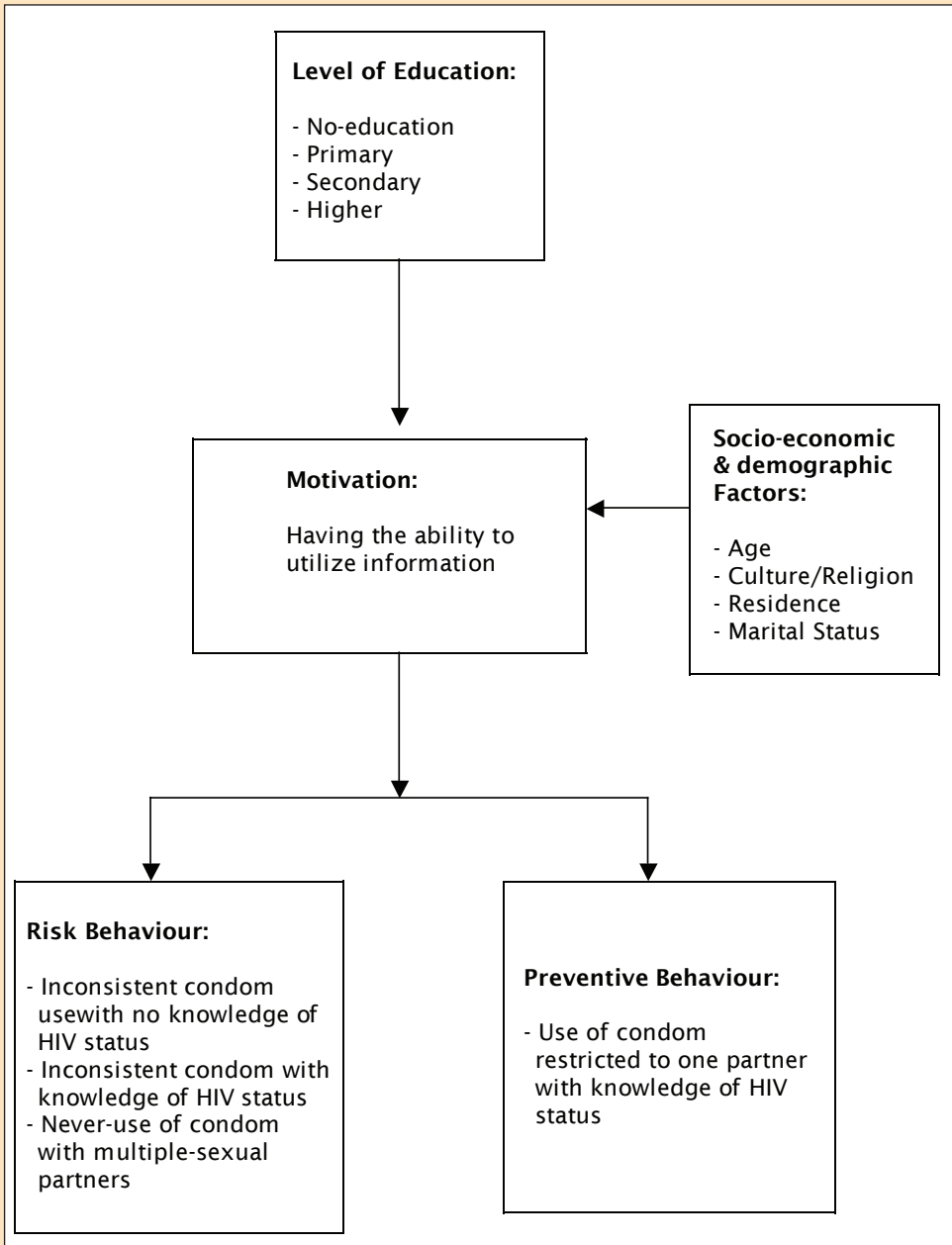
Conceptual Framework

A coherent framework is needed to understand the relationship between education and condom use habits among sexually active Botswana men and women. In this study education means the level of education (no education, primary, secondary and higher level education). It is through education that a lot of people are motivated to utilize and understand information about the dangers of having unprotected sex and the good of having safe sex. Education is provided in different ways and serves different purposes in how a human being should behave. Education about condoms is provided for free in schools (primary and secondary), work places and hospitals and at home through the media. But some people can be motivated to practice behaviors that are acceptable while others can lack motivation. Socio-economic factors like age, culture/religion, residence, marital status can influence the way people behave irrespective of educational level. While educated people who have the ability to utilize and understand information about their sexual and reproductive rights, health facilities and services, are expected to practice safe sex, some do not. Findings from a study by Dintwa (2008) on 'Education and the spread of HIV/AIDS in Botswana' revealed that depending on how far they had gone with formal schooling or education, it has a positive relationship with their use of condoms. Respondent with no formal schooling or education had a lower chance of not always using a condom with their partners during sexual intercourse compared to those with primary education. Use of condoms increased for those with secondary education and still increased further for those with higher education. According to Letamo (undated) some of the educated who engage in risky sexual behaviour believed that information on the prevention and transmission of HIV was not targeted at them.

Although level of schooling has an impact, socialisation also has an influence on AIDS risk behavior. For example, it has been shown that men in Tswana cultures are the key decision makers in the family rather than being equals with women. This is also reflected in sexual relations. As a result women often have less control over the nature and timing of sex and the practice of protective behaviors. A women's ability to practice safe sex (sexual encounter) may be influenced by her ability to communicate openly about sex with her partner, the power dynamics in their relationship, or how much the partner believes in the traditional gender roles (Population Council [undated]; Machaba [2001]; Letamo [undated]). In another study on HIV knowledge, attitudes and behaviours, Physicians for Human Rights found widespread awareness that condoms could prevent the transmission of HIV. However, this knowledge did not translate into behaviour, as 46 percent of sexually active respondents reported unprotected sex over the past year. Over half of the women who had not used a condom in the past year reported that at least one instance of unprotected sex was due to partner refusal to use a condom. One pregnant woman who was HIV positive explained that she had not increased condom use because, "if he refuses, I have no say." (<http://physiciansforhumanrights.org/library/documents/reports/reports/botswana-swaziland-report.pdf>.)

Beliefs about masculinity and femininity often encourage men to have extra-marital affairs, although they do not necessarily use condoms or would use them only when they do not trust the other partner. There are those individuals who are educated (having the ability to utilize and understand information about the dangers of having unprotected sexual intercourse) who engage themselves in preventative behavior, that is, for example, condom use is restricted to one partner. There are those individuals who are not educated and therefore lack the ability to utilize and understand sexual and reproductive information and ending up engaging in risky behavior because they do not know the consequences of such. While education has a positive influence on people's motivation to practice safe sexual encounter, socio-economic factors also impact on their level of motivation.

A Conceptual Framework: The relationship between level of Education and Condom Use



Materials and Methods:

Data

Data for this study was drawn from the Botswana Aids Impact Survey II conducted in 2004. A stratified two-stage probability sample design was used for the selection of the sample. The first stage was the selection of Enumeration Areas (EAs) as Primary Sampling Units (PSUs) selected with probability proportional measures of size (PPS), where measures of size (MOS) were the number of households in the EA as defined by the 2001 Population and Housing Census. In all 460 EAs were selected with probability proportional to size. At the second stage of sampling, the households were systematically selected from a fresh list of occupied households prepared at the beginning of the survey's fieldwork (i.e. listing of households for the selected EAs). Overall 8380 households were drawn systematically (Republic of Botswana, 2004).

The total number of households sampled was 8,275. From the sampled households 7,600 were successfully interviewed yielding a household response rate of 92 percent. The household response was highest (94 percent) in urban villages followed by rural areas at 92 percent. People in cities had the lowest response rate with a response rate of 88 percent (Some of the dwelling units in the rural had no occupants during data collection as respondents had gone to the lands, whereas with the urban areas some of the respondents refused to participate in the survey for reasons known to them). Within the 7,600 completed households 16,992 eligible respondents aged 10-64 years were identified and out of these eligible respondents 15,878 were successfully interviewed yielding an individual response rate of 93 percent (Republic of Botswana, 2004).

The set of questions which are normally asked in the BAIS are based on the UNAIDS Model Questionnaire. Data was believed to be of high quality for a number of reasons. First, the interviewers were thoroughly trained. Second, there was close supervision of the interviewers during the data collection stage. Third, questionnaires were thoroughly edited to check that relevant questions have been answered and coded according to the codes designed for the study. Finally, consistency checks on the data were performed by the Computer Edit Specifications designed by the subject matter specialist (Republic of Botswana, 2004).

Measures

The Botswana AIDS Impact Survey II has several questions (given under response and independent variables below) that were used for addressing the purpose of this study. The reason why the below questions were selected is to identify and document those factors (i.e. behaviour, knowledge, attitudes, cultural) that are associated with the HIV epidemic prevention, infection and impact mitigation amongst the population.

Response Variables:

The following four response variables were used in this study as measures of condom use habits by sexually active Botswana men and women.

Use of condom at first sexual encounter: Respondents were asked if they used a condom the first time they had sexual intercourse with their current partner. This binary variable was coded in such a manner that the response ‘Yes’ equals one and zero otherwise.

Use of condom at last sexual encounter: Respondents were asked if they used a condom the last time they had sexual intercourse with their current sexual partner. The binary variable was coded one for respondents who responded with a ‘Yes’ and zero otherwise.

Always using a condom: Respondents were asked if they always use a condom during sexual intercourse with their current partner. This binary variable was coded in such a manner that the response ‘Yes’ equals one and zero otherwise.

Independent Variable

A question asked on the level of education was the main independent variable. Respondents were asked; “What is the highest level of school you attended: no education, primary, secondary, or higher?”

Control Variables

Control variables used for this study included sex (male and female), age, current marital status, place of residence, religion and the number of sexual partners.

Statistical Methods

Both bivariate and multivariate (logistic regression model) analyses were done. However, the focus was mainly on the logistic regression model rather than chi-square because it allowed the significance of a given predictor to be tested for while controlling for the other predictors in the model. It also provides an interpretable variable linear model for a categorical dependent variable. It should also be noted that although bivariate results were used for investigating the relationship between two variables, they may lead to false conclusions because they do not control for potential confounding variables. That is, we are not sure if the statistical relationship will persist or disappear between two variables when other variables are introduced.

Logistic Regression Model

The question addressed here is whether or not education (level of education) directly influences the use of condoms (condom use habits) in Botswana. If education directly determines the use of condoms, then there should be no change in the parameter estimates (coefficients) of a given explanatory variable even after controls are introduced. Model I presents the results of regressing levels of education on; the use of condoms at first sexual

intercourse; always using a condom; and the use of condoms the last time a respondent exchanged money or gifts for sex. Model II presents the results of regressing the levels of respondents plus the controls of the selected socio-economic and biological variables. A change in the magnitude of co-efficient for experiencing a given response on condom use habits (*Use of condom at first sexual encounter; Use of condom at last sexual encounter; Always using a condom*), would suggest that part of educational level that influence the responses of individuals could be explained by the other factors such as those introduced in Model II.

For the i^{th} individual, this model can be expressed as:

$$\ln \frac{P_i}{(1 - P_i)} = \beta_0 + \sum \beta_{\kappa} \chi_{\kappa i}$$

Where P_i is the probability that the i^{th} individual will use a condom the first time having sexual intercourse with a current partner; use a condom at last sexual encounter; always use a condom for the last sexual encounter in exchange for money/gifts. β_0 is the baseline constant, $\chi_{\kappa i}$ is an array of κ independent variables, and β_{κ} is the corresponding vector of unknown regression co-efficients. The SPSS-PC logistic programme was used for estimating regression coefficients through the maximum likelihood procedure (Hosmer 1989).

For the purpose of this study, the sample was restricted to sexually active men, women and young teenagers aged 15-49 years. The sample size was further focused (filtered) by including individuals who have had sexual intercourse, in order to cater for generalization when it comes to issues of condom use. Only those who completed the questionnaire were used for analysis making a sample size of 9065 respondents.

Sample Characteristics

Table 1 show the socio-demographic characteristics of the sample which do not vary significantly by sex (male and female). Even though there were more females than males, about 21 percent of the males had attained higher education compared to 13.5 percent of females. Regarding the number of sexual partners, about 67.7 percent of males had more than one sexual partner compared to females with 32.3 percent. The implication is that more males are at risk of contracting Sexually Transmitted Infections than females provided there is a high rate of inconsistent condom use. More men do not also have any religion compared to females (See *Table 1*).

Table 1: Socio-demographic characteristics of the sample, Botswana 2004

Characteristics	Sex		Total (n=9065)
	Male (n=3829)	Female (n=5236)	
<u>Education:</u>			
No education	0.6	1.0	0.8
Primary	21.8	26.3	24.4
Secondary	56.6	59.2	58.1
Higher	21.0	13.5	16.7
<u>Age (years):</u>			
<20	6.8	8.7	7.9
20-34	60.8	57.5	58.9
35+	32.4	33.8	33.2
<u>Marital Status:</u>			
Married	17.2	19.0	18.2
Living Together	27.9	28.7	28.4
Not Married	55.0	52.2	53.4
<u>Religion:</u>			
Christian	72.7	86.2	80.5
Muslim	0.9	0.4	0.6
Other religion	8.7	3.4	5.6
No religion	17.8	10.0	13.3
<u>Residence:</u>			
Urban	56.6	50.1	52.9
Rural	43.4	49.9	47.1
<u>Number of sexual partners:</u>			
No partner	50.1	49.9	4.8
One partner	41.4	58.6	87.0
More than one	67.7	32.3	8.2
TOTAL	100.0	100.0	100.0

Limitations of the study

The major limitations of this study were that secondary data was used, thereby limiting the researcher to variables collected by the survey. The second limitation was that the information collected was self reported, which was subject to reporting errors and bias. The third limitation was that the

study was based on cross-sectional data, implying that the direction of casual relationships cannot be determined. The interpretation of results therefore limits it to associations between variables rather than the cause and effect relationship. The last limitation is of the use of UNAIDS model questionnaire from United States of America in the original study (BAIS II) from which the data here was sourced. This therefore limits the researcher to the variables which were initially meant to be used in a developed country instead of variables or questions which were specifically for developing countries like Botswana in particular.

Results

Prevalence of Condom Use

Table 2 presents the percentage distribution by gender of the 9065 respondents who showed/displayed different habits with regard to condom use. Only 68% of the respondents used condoms at first sexual encounter with their partners i.e. almost three out of ten respondents did not use a condom at first sexual encounter. About 64% used a condom at last sexual encounter. About 12.5% of the respondents did not always use a condom during sexual intercourse. Overall, males showed a higher prevalence of condom use than females.

Males and females with no education, primary and secondary education; were less likely to have used a condom at first sexual intercourse with their current partners compared to those with higher level of education (tertiary) (see Model I), and this relationship was significant. When controls for age, marital status, religion and residence were introduced, the statistical significance remained high (see Model II). This finding shows that the use of condoms at first sexual encounter with current partner is a function of education as well as the following socio-economic environments: age, marital status and residence. Respondents (males and females) aged <20 years and between 20-34 years were significantly more likely to have used a condom at first sexual intercourse with their current sexual partners compared to those aged 35 years and over, so were those who resided in urban areas. Firstly the married and the living together were less likely to have used a condom at first sexual intercourse compared to those who were not married. This relationship was statistically significant. Comparison of findings for men and women showed no difference in the use of condoms at first sexual intercourse with current sexual partners. [Factors associated with the use of condoms at first sexual intercourse with a current partner are presented in *Table 3*].

Males and females with no education, primary education and secondary education were less likely to have used a condom at last sexual intercourse with their current partners compared to those with higher level of education (see Model I) and this relationship was significant except for males with secondary level education. When controls for age, marital status, religion and residence were introduced, the statistical significance relationship persisted and even for males at secondary level the statistical significance relationship existed (see Model II). These findings show also that the use of condoms

at last sex with a current partner is a function of education as well as the following socio-economic factors: age, marital status and residence. For example; both men and women aged less than 20 years and those aged between 20-34 years were statistically more likely to have used a condom at last sex compared to those aged 35 years and over. The same applies with those residing in urban areas compared to rural areas. Both men and women who were married had a statistically lesser chance of using a condom at last sex compared to those who were not married. [Factors associated with the use of condom at last sexual intercourse with a current partner are presented in *Table 4*].

Comparison of findings for men and women showed that education, age, marital status and residence were statistically associated with the use of condom at last sex (for both man and women).

The results showed that males with primary education were 0.6 times less likely than those at a higher education level to have always used a condom with their current partners. This relationship was statistically significant at a 5% level. (See Model I). Females with secondary were 1.3 times more likely than those at higher (Tertiary) education to have always used a condom. This relationship was statistically significant at 10% level (see Model I). When controls for age, marital status, religion and residence were introduced, the statistical significance relationship persisted for males at primary level of education but not for females with secondary level education (see Model II). These findings show that always using a condom is not only a function of education except for men at primary level of education. Marital status is not the main predictor for always using a condom for both men and women. The married and living together men and women were significantly less likely to have always used a condom during sexual intercourse compared to those not married. Always using a condom is a function of age for men only. For example, males aged less than 20 years were significantly 7.0 times more likely to always use a condom compared to those aged 35 years and above. [Factors associated with always using a condom with a current partner are presented in *Table 5*].

A comparison of findings for men and women showed that being a man at primary level and aged less than 20 years were the only factors under education and age (under explanatory variables) that were significantly associated with always using a condom. This association did not apply to females. On the other hand, the findings show that being a woman in urban areas was the only factor significant with always using a condom during sexual intercourse with a current sexual partner. Only males with more than one sexual partner were significantly more likely to have always used a condom with their partners compared to those with one partner.

1 Tertiary education was used as a reference category

Discussion

Findings from this study show that the majority of men have used a condom at first and last sexual intercourse with their current sexual partners when compared to a minority of women. Moreover, a high proportion of men always use a condom compared to women. Men are made to believe that they are the major decision makers in the family and women have to take the instructions. During sexual decision making, most of the time women are not consulted. According to Machacha (2001), women often have less control over the nature and timing of sex and the practice of protective sexual behavior. 'A women's ability to practice safe sex may be influenced by her ability to communicate openly with her partner, the power dynamics in the relationship, or how much the partner believes in the traditional gender roles.'

The findings also show that both men and women with no education, primary and secondary education were significantly less likely to have used a condom at first sexual encounter with their current partners compared to those with higher education. It was also revealed that the use of condoms at first sex is a function of education as well as age, marital status and residence. Here, the assumption is that respondents with higher education are more informed about the importance of safe sex that is why they are more likely when compared to others at lower levels of education to have used a condom at first and last sexual encounter, except for women with secondary level of education. This finding might be true because there are females at secondary level who date elderly men who in-turn force young girls into having sexual intercourse with them because they provide for them. Because there is an easy access to health facilities and information in urban areas compared to rural, the findings of this study has shown the following that; 'Urban men and women were significantly more likely to have used a condom at first and last sexual intercourse with their current partners', unless it is difficult to access condoms because their prices are high or there are frequent condom stock-outs.

Young men were significantly seven times more likely to always use a condom with their partners compared to those aged 35 years and above. These individuals have just started being sexually active and they try by all means to do it the right way, they still have motivation to practice safe sex. This result is inconsistent with the findings by Caldwell et al (1989) that the erosion of cultural and social networks has led to the problems of drug abuse and has encouraged risky sexual behaviors among the youth (Caldwell et al 1989: UNAIDS, 2002). Of course drug abuse is associated with risky sexual behaviour among the whole population (the sexually active). This is the case because when people get drunk their reaction time becomes impaired and this has contributed to the non-use of condom in Botswana. According to Pitso (2004), liquor outlets were said to create a 'deregulated' environment, making sexual activity much more spontaneous, and taking precautions easier to advocate than to implement. A younger male discussant in Selebi Phikwe, related his views and experiences;

"I remember the other day at this very bar; I was with a sugar mummy. Wow! She was strikingly beautiful, when we go to her place; she told me that she detested a condom. As we were both tipsy, we had sex without a condom and there seemed to be no problem. To tell you the truth, the following day I was full of remorse, not because I had sex with an elderly lady, but for the fact that a condom had not been used."

The married were significantly less likely to have always used a condom compared to those not married. This result is consistent with the results of the study conducted by Tlou SD, Norr KF, Moeti M, Clevenger T and Gantes R (1992) that, many women thought condoms were easier to use with casual partners than with a husband or live-in boyfriend because condom use implied lack of trust between partners. The problem with the data used is that it did not include a question on the length of the relationship which could have catered for casual relationships and long-time relationships, that's why marital status was used instead.

Both education and alcohol use have an influence on the use of condoms and previous discussions and the findings of this study have proven it. The relationship between educational attainment and alcohol use is 'bidirectional,' for example; alcohol use may hinder educational attainment; whereas education may serve as a protective factor against the development of alcohol-use disorders. A study in the August issue of *Alcoholism: Clinical & Experimental Research*, it was found that educational attainment may also be able to predict drinking outcomes following alcohol treatment. «People have been interested in the association between educational attainment and alcohol disorders because education is a modifiable factor,» said Shelly F. Greenfield, assistant professor of psychiatry at Harvard Medical School, and medical director of the alcohol and drug abuse ambulatory treatment program at McLean Hospital.

A nationally representative youth sexual behaviour study on knowledge, attitudes, practices and behaviours in Botswana, found that one in five males aged 15-24 admitted having been "too drunk to make rational decision (regarding condoms)" the last time they had sexual intercourse (MOH, 2001). Campbell (2003) notes that alcohol was probably the most abused substance in Botswana. He concluded that "alcohol-induced intoxication influences non-use of condoms, and inconsistent condom use by alcohol users which partly explains why incidence of sexually transmitted infections is significantly higher among alcohol users than non-alcohol users."

Conclusions

For condoms to be effective as a prophylactic against HIV infection and other STDs and unwanted pregnancies they have to be used consistently more especially in high risk sexual relations. Although there is evidence of

inconsistent condom use in Botswana, according to this research, the high risk of infection among adults calls for consistent condom use for all those engaged in high risk sexual relationships. Until this goal is reached, there is a need for information campaigns among individuals who need to change their sexual behavior to combat the growth of HIV/AIDS prevalence in Botswana.

The majority of men have significantly used condoms at first and last sexual intercourse with their current partners compared to women. Machacha (2001) supports the fact that women have less control over the nature and timing of sex and the practice of protective sexual behaviour.

The lower the level of education the more are the chances of having not used a condom at first sexual encounter with current partners. Moreover, urban men and women were significantly more likely to have used a condom at first and last sexual intercourse with their current partners. Lastly, the consistency of condom use declines with an age increase and the reason might be because older partners might be willing and ready to have children to enlarge their family sizes.

The afore-mentioned findings have implications for interdisciplinary studies by researchers worldwide. Longitudinal studies are needed to unravel the real causes, consequences and prevention of inconsistent condom use and violation of women's sexual and reproductive health rights. Qualitative studies should be complimented with qualitative research. The combination of these methods might bright to light the understanding of the specific cultural context of and barriers to condom use.

There is need therefore to design and implement specific and culturally sensitive interventions. Advocacy groups should come up with new and comprehensive strategies of combating violation against the rights of women, by empowering women and coming up with laws that deals with marital rape. We conclude by suggesting that efforts at multiple levels such as personal, interpersonal, and cultural regarding safe sex and elimination of the violation of sexual reproductive health rights be intensified.

Acknowledgements

Special thanks are due to my colleagues in the Department of Central Statistics Office who made helpful comments on the paper.

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HIV AND AIDS IN WORKPLACE: A SURVEY OF SELECTED RETAILERS AND WHOLESALERS IN MAUN, BOTSWANA

Goabaone Stouberg Tsalaila

Introduction

HIV and AIDS has had a severe economic impact on many African countries (Bollinger et al, 1999). The Population Council estimated in 2001 that in Sub-Saharan Africa, the epidemic was putting a halt on economic growth by at least 1 to 2 per cent in a year with many countries likely to see their gross national product shrink by a fifth to a quarter by 2020. The private sector growth and enterprise development was also severely affected. The size of the labour force was expected to be 10 to 30 per cent smaller by 2020, as a result of HIV and AIDS and its “erosion of human capital, loss of skilled and experienced workers and reduction in productivity will lead to a mismatch between human resources and labour requirements, with grave consequences for the private sector ... employers” (Population Council 2001: 3).

Botswana’s long term national vision for the year 2016 identified HIV and AIDS as one challenge that needed to be addressed urgently as it was a threat to the health of the nation as well as economic growth. The National Vision 2016 thus urged all business, enterprise and government to set up schemes to educate their employees about the dangers of HIV and to promote safe practices. The workplace has often been identified as one of the areas where it is essential to provide information, in order to prevent the spread of HIV and reduce HIV and AIDS related deaths (Roper 1992:2).

The purpose of this study was to assess the commitment of retail and wholesale sectors in Botswana in coming up with measures for countering the direct effects of HIV and AIDS in the workplace, including welfare of the employees, as well as implementation of suitable programmes and policies. This study has revealed that majority of retailers and wholesalers in the town of Maun in Botswana, did not have HIV and AIDS workplace policies, though some of them expressed the will to formulate and implement them if assisted in human resources and funding. It has also been revealed that most of the employees were interested in knowing their HIV status by opting for voluntary testing and counselling. There was lack of knowledge on general HIV workplace guidelines meant to encourage businesses and firms to establish HIV and AIDS educational, preventative, treatment, care and support programmes. Thus, there is need for the business community to join hands with those that are dealing with HIV AIDS matters, mainly the government, associations, non-governmental organisations, in the bid to reduce effects of the pandemic in the workplace.

Background: The impact of HIV and AIDS on workplaces in Botswana

The Botswana Federation of Trade Unions (BFTU) (1995) explained that HIV and AIDS mostly affected the most productive members of population aged 15-64 years. It also had the effect of reducing productivity. This occurred in two ways; in the long term, it reduced the rate of increase of labour supply and, in the short and medium term, affected the productive capacity of the employing companies by way of loss of trained personnel, increased medical and welfare costs, increased absenteeism, staff turnover and lower staff morale. All these factors combined increase a company's operation costs and drove down corporate profits (in Tirelo 2004).

The NACA quarterly report for January to March 2006 on performance of national programmes noted 104 deaths in the public sector, with Independence Electoral Commission leading the pack at 25 deaths followed by Ministry of Lands and Housing, and that of Finance and Development Planning with 17 and 16 deaths respectively. In the private sector, the University of Botswana, then with a total of 18 full-time academic staff (age-group >40), 33 junior staff (age-group 25-34), had 46 full-time industrial support staff (age group 30-39) dying in the ten year period from 1991 to 2000. Most of these deaths were suspected to be AIDS-related. Because of the age range, the group falls within high HIV and AIDS prevalence age cohorts nationally, hence basis for the conclusion (Chilisa et al 2001).

Efforts by the Botswana Government to combat HIV and AIDS in Botswana

In its response to HIV and AIDS, Botswana has been guided by a number of policies, programmes and strategies including; National AIDS Control Programme; Medium Term Plan 1 and 2 of 1989-1995 and 1997-2002 respectively; HIV and AIDS Sentinel Surveillance Reports (2002, 2003, 2005); The Public Service Code of Conduct on HIV/AIDS in the Workplace of 2001; Botswana National Strategic Framework for HIV/AIDS 2003-2009; Botswana National Policy on HIV/AIDS and Employment of 2005; Botswana Public Service Wellness Policy of 2005; National Policy on Rapid HIV Testing of 2006; Revised National Policy on HIV/AIDS of 2006 (Motshegwa 2003). It also advocates for benefit schemes including; comprehensive insurance, pension and medical aid in the workplace so that those who suffer from AIDS-related illnesses can continue to work productively for as long as possible, and also that families and dependants of employees are adequately and comprehensively catered for. In addition to the national responses, these efforts were supported and complemented by some government ministries and departments who have come up with their individual HIV and AIDS policies and programmes in a move to counter the continued loss of the work force due to AIDS related illnesses.

Efforts by the Private Sector to combat HIV and AIDS in Botswana

The private sector have also made progress against the disease, by implementing policies and programmes which help their workers to access counselling, voluntary testing, and treatment services either externally outsourced, or internally provided (Mochaba 2005). According to the literature available (BOTUSA 2004), it is mostly the Corporate Business Organisations (CBOs), which have HIV AND AIDS workplace policies and programmes in place including for example, Kgalagadi Breweries Limited (KBL), Botswana Training Authority (BOTA), Botswana Meat Commission, Debswana, University of Botswana (UB), etc. For instance, in 1999 Debswana conducted a voluntary anonymous HIV prevalence survey by skill, grade, and age at all of its mines and the results were horrifying. With 75 per cent of the workforce having participated, the survey revealed that 28 per cent of 5 261 employees were infected at every skill and education level. In March 2001, the company approved the provision of ARVs for all employees and their spouses living with HIV AND AIDS for as long as the employee remains employed by the company (Ruggles 2001). “Diamonds remain Botswana’s source of over 75 percent of export income, 50 percent of government revenue, and one-third of GDP despite efforts to diversify the economy through lower tax rates, the elimination of exchange controls, and other foreign investment incentives” (IEF 2006:1). Despite all these, HIV and AIDS threatens the country’s economic future, with estimates indicating that up to one-third of Botswana’s adults are infected

In 2002, the University of Botswana committed both human and financial resources to address this epidemic, through planning, designing, and developing a University of Botswana HIV and AIDS policy which was a collaborative effort of the whole University community, including the HIV and AIDS Committee. The aim of the policy was not only to fight the spread of the disease within the University community, but also contribute to the national effort through education, research, promoting awareness, behaviour change and other innovative initiatives in line with the National Policy on HIV and AIDS (Chilisa et al 2001). This is the kind of move that is expected from each and every company, which cares about the welfare and wellness of its workers.

The greatest challenge to all stakeholders in the fight against HIV and AIDS is to bring about behavioural change in order to bring down the numbers of new infections, and have enough time and funds to manage already existing cases. This can only be achieved if there are suitable and reliable programmes in place for employees to access free available prevention care and support systems (MoH 2005). While strategies to combat HIV and AIDS are improving and recent medical advancements in prevention and care have been significant, there is still a long way to go to suppress further spread of the virus and help those worst affected by the pandemic (UNCERD 2005).

Objectives of the study

- a. To investigate employees' knowledge of their HIV and AIDS status and their awareness of any available programmes by the employees.
- b. To assess if the retail and wholesale sectors currently have any HIV and AIDS and programmes and policies in the workplace; if not, why they do or do not have them; and if they do, the characteristics of programmes they have in place.

Research Methodology

Population and Sampling

The population under study included Managers of the retailers and wholesalers, as well as employees in those sectors. Most of the respondents were aged 15-49 years. A pre-coded questionnaire was used to probe issues of responsibility and response regarding HIV and AIDS in the company to ascertain what has facilitated the company to act, or not to act. The questions asked included: how has your company responded to HIV and AIDS; what has encouraged your company to respond to HIV and AIDS; who takes responsibility, is there budget for HIV and AIDS in the workplace; and lastly, and have you tested for HIV, if yes when, if no why?

Snowball technique was used to trace wholesalers and retailers in Maun. After potential population was identified, managers were approached and requested to participate in the study. Out of twenty six managers approached, only 22 agreed to be interviewed. The interviews involved 22 managers representing 17 retail and 5 wholesale companies in Maun. Twenty-one of the respondents were branch managers whereas only one was a general manager. There was also a short ballot survey on the employees of the retail and wholesale sectors. The aim was to assess employees' knowledge of their HIV status, and go further to establish a baseline data of those who have, and those who have not tested for HIV, and why.

Data collection instruments

Data was collected through the administration of a questionnaire to interviewees (Haralambos and Holborn 1990) to gather data in the study areas. Both open-ended and closed-ended questions were used in the interviews (Bailey 1982). Likert scale was also employed to assess the respondents' attitudes and or feelings on a continuum manner (Brink, 2006). All respondent were asked the same questions under controlled conditions, so as to make comparisons possible, and also to minimise observer biasness (Sayer 1984). Observation method was also employed whereby the researcher objectively observed, classified and measured the variables in the study areas (Haralambos and Holborn 1990).

Data collection and Analysis Techniques

Because the sectors employ quite a manageable number of workers, 186 employees (88 males and 98 females) were assessed using a questionnaire,

which was different from that of managers. Of all the 22 managers, 12 completed the questionnaires on their own whereas the researcher conducted questions on the remaining 10. All the 186 employees completed their own questionnaires, which was short and was both in Setswana and English.

After collection of the data, an analytical system was used. The data was entered into SPSS data files. Frequency tables of distributions, simple descriptive statistics, and cross tabulations were used to describe and summarise the data (Bailey 1982). Different graphic displays were also used to give the data visual appeal.

Maun retail and wholesale sector employees' knowledge of their HIV and AIDS status and awareness of any available HIV and AIDS support programmes.

Demographic information

Out of 186 who participated in the study, at least (52.7%) of them were females and the rest (47.3%) were males. This shows a slightly higher number of females than males. The majority of respondents were in the 19-29 age group, at 66.7 per cent followed by age group 30-39 at 32.8 per cent. This is quite important for the study because nationally HIV and AIDS prevalence rate is very high at 24.1 percent amongst adults aged 15-49 (UNAIDS Report 2006), with the prevalence rate for females at age group 20-24 and 30-34 standing at 26.2 percent and 43.7 percent respectively. For males at similar age groups, the prevalence rates are at 9.1 percent and 36.2 percent respectively (NACA et al 2004). With the majority of workers in this study falling within the mostly affected population nationally, it is possible that some of them may be infected with HIV and AIDS. This could pose a threat to the Maun retail and wholesale sector if the management and staff are not adequately prepared for the situation.

Knowledge of HIV and AIDS status and reasons for not testing or not testing for HIV and AIDS

When asked if they tested for HIV and AIDS, out of 183 employees most of them 69.9 percent, went for voluntary testing and majority of those who tested are females (42.6%) whereas males rate stood at 28.4% and the rest did not test. The age bracket 19-29 years recorded the highest number of testers (47.5%), thus showing progress because other studies including (BAIS II 2004; Sentinel Surveillance 2005) indicated this is age bracket as the "epicentre" of HIV prevalence in the country. Most respondents (33.9%) reported undergoing HIV testing as recent as 2006, followed by 2005 at 20.2 percent and others had started testing as far as 1999. The majority (78.9%) out of the 129 respondents had taken the initiative by themselves to go for HIV voluntary testing. Interestingly, despite the stigma attached to the disease, 91% of those who tested wanted to know their HIV status and considered it very useful. Their reasons for testing and wanting to know their status was so that they could make responsible decisions and to continue working and providing for their families without experiencing effects of HIV and AIDS such as absenteeism

from work due to illnesses associated with HIV and AIDS. This could also result in the loss of jobs. Only 1.5% were motivated or encouraged by HIV and AIDS workplace programmes. This is not surprising given that most businesses did not have HIV and AIDS workplace programmes.

The high rate of testing could be associated with the government's introduction of free antiretroviral drugs in 2002, and the introduction of routine HIV testing in 2005 to make HIV testing become routine like for any other medical condition unless a patient opted out. A study was done in 2005 by Weiser et al. to assess the nation's response to routine testing and the results were highly encouraging. Eleven months into the introduction of routine testing, "most participants (81%) reported being extremely or very much in favour of routine testing. The majority believed that this policy would decrease barriers to testing (89%), HIV-related stigma (60%), and violence toward women (55%), and would increase access to antiretroviral treatment (93%)". The sceptics were much fewer, with 43% worried that routine testing would lead people to avoid going to the doctor for fear of testing.

A study conducted by the National AIDS Coordinating Agency (NACA) in 2006 (Quarterly Report on Performance of National HIV and AIDS Programmes), showed that more females than males tend to volunteer for HIV testing, as also came out from this study. This is a cause of concern because many studies have shown that multiple concurrent sexual partnership are driving the HIV epidemic in eastern and southern Africa (Southern Africa HIV and AIDS Information Dissemination Service, (SAFAIDS), 2008). It makes it important that men should take heed of efforts made by stakeholders in the fight against HIV and AIDS, including Men Sector, to know their HIV status and make the right decisions.

Testing among sexual partners in long term relationships

Married employees reported lower HIV voluntary testing at 8.2% out of 130 who responded. The figures were a bit higher for those who lived together with their partners out of marriage at 16.4%. According to Phorano (et al 2005), cohabiting couples tended to use condoms during the first few months of their cohabitation and discontinue thereafter on account of trust. This could explain the lower rate of HIV testing amongst the "living together" group of employees. This places them at risk of contracting HIV and disruption of employment eventually if preventative measures are not pursued. Concerning married employees; it may be difficult for females to go for voluntary testing because of fear of being labelled promiscuous or unfaithful by their husbands which may result in emotional, and or bodily harm (Susser and Stein 2000).

The common reason that was given by most of the employees who did not go for HIV testing included was that they were not ready (74%). Four percent (4%) mentioned that they did not want to frustrate themselves by knowing the results because it could cause them some emotional stress as far as stigma is concerned. A study done in Botswana in 2004 led by Dr William Wolfe of the

University of California, San Francisco, shows that that stigma was a major issue for couples if they were to test HIV positive and disclose their status. The survey study involving 1,268 adults drawn from five districts in Botswana with the highest HIV prevalence showed that 30% of respondents felt that it could break up their marriages or relationships and 12% said that it could lead to physical abuse by their spouse or partner (Wolfe et al., 2008). The study by Weiser et al. also revealed some concern (14%), that routine testing could increase gender-based violence.

Retailers and wholesalers response to HIV and AIDS in the workplace.

In order to assess the impact of HIV and AIDS on retail and wholesale sectors in Maun in 2006, it was necessary find out if the retail and wholesale sectors had any HIV and AIDS and programmes and policies in the workplace. Also, it was important to find out if they had serious problems of staff absenteeism, which is likely to be a result of poor or absent workplace HIV and AIDS support. Availability of HIV and AIDS policies and programmes

Although 59 % of all 22 respondents admitted being aware of the Botswana Government HIV and AIDS workplace policy guidelines, majority of the retail and wholesale businesses in Maun did not have HIV and AIDS workplace policies. Out of 22 managers, only 7 (31.8%) admitted having HIV and AIDS workplace policies, whereas as many as 15 (68.2%) either did not know or were not sure. This indicated that there were no such policies, otherwise they would know as managers. The earliest of retailers and wholesalers to put in place an HIV and AIDS workplace policy was as early as 1999. By 2002, there were four (4) retailers and wholesalers who had put policies in place. Another three had followed suit by 2006. Six of the seven retailers and wholesalers reported involving or allowed participation of employees in the formulation of policy. All of them (7) admitted that employees were aware of such services because, there are trained HIV and AIDS peer educators; there is often discussion of the disease in weekly / brief / general staff meetings; availability of literature including brochures, newsletters and posters; and DVD and video shows to employees. Some even reported that they have nurses or counsellors specifically engaged to move around their company branches in the country to help workers know and deal with problems associated with HIV and AIDS.

There appeared to be two main reasons for lack of policy formulation. First, managers mentioned that they did not have time, and also that their businesses are small therefore have small labour force. Secondly, some indicated that they never thought there was a problem or need for a policy since the government offered HIV and AIDS programmes and services externally for free, thus employees can voluntarily access them through their choice, and at their own time. Meanwhile, 68% (15) of the respondents held that if assisted they were willing to formulate HIV and AIDS work-related policies covering, transmission and prevention, confidentiality and disclosure, and voluntary

counselling, treatment, care and support. When asked if they had any other types of initiatives in the workplace to support their employees against HIV and AIDS even if they did not have policies per se, most of the managers of retail and wholesale businesses (81.8%) admitted having one or two different programmes. The most common was free access to male condoms for staff. However, 86% did not offer female condoms arguing that they were expensive. They occasionally invited NGOs dealing with HIV and AIDS to come and perform in-house HIV and AIDS activities, most likely Tebelopele Counselling Centre, Botswana Family Welfare Association, and Maun Counselling Centre. They also displayed educational posters modes of infection, prevention, treatment, care and support, fight against stigma, confidentiality, peer education on HIV and AIDS. All respondents (100%) indicated their willingness to allow their members of staff to attend HIV and AIDS-related workshop / seminar / meeting for at least a day, because the move will benefit all the employees in one-way or the other. Most managers gave an indication that when they required more help; they had always relied on the government. Although this is a positive move, some respondents cited stigma associated with HIV and AIDS as a major constraint hence reducing the full utilisation of such services.

Availability of medical aid and healthcare benefits

Although 72.7% of companies indicated that they had medical aid schemes, participation was mostly limited to managers, and highly skilled workers, thus leaving majority of the employees at the mercy of diseases including HIV and AIDS. Overall investment in employee benefits by the retail and wholesalers in Maun varied from company to company. However, only 1 out of 16 companies who responded, offered ARVs in their healthcare menu, showing how reliant companies were on free government HIV and AIDS programmes. Meanwhile, 81.3% of managers of the companies surveyed reported that their medical aid provision was extended beyond workplace, to spouses and children. Although members of the families are not covered for HIV and AIDS treatment (ARVs), at least the healthcare services provided still offer them a chance to improve their quality of life in case of other diseases.

Of the 22 companies that were surveyed, 66.7% of them supported their employees with different sorts of financial packages should they be forced to leave work due to long illness. 52.4% offered early retirement package on medical grounds; 9.5% offered 3-months salary for disability; whereas 4.8% offered half of the salary until the employee can no longer come back to work anymore. It is alarming how 33.3% of the managers reported that they did not have any programme in place to assist employees in that regard.

Rate of absenteeism at work

One of the objectives of the study was to find out if absenteeism was a problem in the retail and wholesale sectors, however, 72.7% of the 22 respondents reported a lower rate of absenteeism, with only 4.6% reporting a higher rate. Major causes of absenteeism cases in the business (68.3%) have been attributed to ill health as opposed to low wages (4.5%), job dissatisfaction (4.5%) and

absconding from work (22.7%). 68.2% did not regard absenteeism from work due to long illness as a major problem, and 90.1% reported replacing less than five employees in the past twelve months. Meanwhile, age group 15-29 has the highest absenteeism rate at 81.8%, and females (59.1%) account for most missed days at work.

Since 68.3% of the respondents reported ill health as major case of absenteeism, it cannot therefore be assumed that HIV and AIDS is the contributory factor since it was not tested in this study. Although most managers expressed their doubts that if an ill employee remains absent for more than three months, they would most definitely suspect HIV and AIDS-related disease, long illness should not always be associated with HIV and AIDS more especially if there is no sufficient evidence proving thus. Besides even that, it is also abuse of that employee's human rights to make unfounded claims. Because most of the workers (79.2%) in the retail and wholesale businesses attained Junior Certificate (junior secondary school level), managers who reported losing or replacing workers regarded such employees as non-critical, because they were unskilled and could be replaced easily and without spending much money. It was only one manager of a wholesale who expressed higher loss because an employee who left work due to long illness (and eventually died), was a qualified "forklift" operator, and it took a long time to train a replacement.

The study showed that only a few businesses in Maun had implemented HIV and AIDS policies and programmes. It was also evident that though most of them had medical aid schemes, the benefits were rarely extended outside workplace (excludes family members), or in some cases it covered only the managers. Member-contribution was made difficult for employees by their low salaries. All these factors had a great impact on productivity, operating costs increase, and profit declines, and lowered staff morale. The only solution is for the business community to be partners with the government in the fight against HIV and AIDS. The retailers and wholesalers needed to recognise that the wellness of their employees should be given priority, so as to prolong the productive life of their workers. They needed to empower them with knowledge on how to remain uninfected or to get treatment. The most effective way is by implementing sound HIV and AIDS policies and programmes, including healthcare systems which are specifically tailored for their businesses.

The survey showed that some of the managers either did not know if they had policies and programmes, or had little knowledge of the available services, the cost (budget) of providing them and where to source them. This may have been caused by the distance between Maun and Gaborone, where most (72.7%) of the respondents have their headquarters located. That is to say, the regional managers could take their own decisions on workplace programmes without the approval of the headquarters. More senior managers, either in Gaborone or outside the country, made the major decisions, for instance 22.7% of businesses reported having their headquarters in South Africa. One other explanation could be that policy and programme planning and development

were done in Gaborone, where there was access to products and services (Botswana Business Coalition on AIDS 2004) and could only reach the regional offices late, if ever.

With respect to awareness of other national structures which are involved in the fight against HIV and AIDS (besides government), the findings show that the respondents were generally aware of the collaborative structure. They were aware of Tebelopele (22.7%), BOFWA (18.2%), Maun Counselling Centre (18.2%), Maun Hospital HIV and AIDS Unit (9.1%). The rest (31.8%) of the 22 respondents were either aware of the existence of such structures but never bothered, or they did not know their roles altogether. It is quite important for managers to know whom they can contact (apart from government structures) in cases of HIV and AIDS related issues. Awareness of structures such as the Ngamiland HIV and AIDS NGO / Private Sector Coalition is crucial because, it is a structure that monitors credibility of structures that offer HIV and AIDS services and checks if the services provided in the region are of good quality and up to the required standard

CONCLUSION

Botswana's HIV and AIDS problem is one of the worst in the world, and all the efforts should be directed towards the possible eradication of the disease. This involves all the stakeholders in the private sector (where businesses fall under), NGOs and the international community to join hands to try and win the fight against HIV and AIDS. The business sector as one of the backbones of the economy in this country, has been severely affected hence, the need for aggressive preventative measures including; education, distribution and free access to condoms, counselling, care and support. The massive loss of employees in any sector of the economy can cause some disturbance in the production and standard of goods, training of new employees, and recruitment of replacements, costs of healthcare and pension funds.

In general, a high number of employees in the retail and wholesale sector did go for HIV voluntary tests, and not only end there, they also wanted to know their status. Most of them were young and sexually active and within the high risk group. This is crucial as a number of studies done in Botswana have shown that most young people engage in risky sexual behaviours including alcohol and substance abuse (causing inability to make prudent decisions), unprotected sex (condoms reduce sexual pleasure), frequent change of partners (for prestige), and sexual activity for financial gain (buy clothes and other utilities) Seloilwe 2005; Pitso 2004.

Retail and wholesale businesses on the other hand needed to improve on the implementation of HIV and AIDS policies and programmes implementation as it remained very low by 2006. Also, it is only through networking that the business community in Maun together with the NGOs dealing with HIV and AIDS, can fight AIDS pandemic through effective and optimal usage and sharing of the resources available, be it technical or logistical support.

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TOWARDS AN ETHICAL AND HUMAN RIGHTS DISPENSATION TO HIV IN BOTSWANA

By Doris Kumbawa

Since its inception in 2002, the Botswana Network on Ethics, Law and HIV and AIDS has grown in leaps and bounds from a one-person entity to an institution boasting more than 28 staff, volunteers and interns. In Botswana, BONELA is a voice to reckon with as witnessed by its award of the 2008 AIDS and Rights Alliance for Southern Africa (ARASA) HIV and Human Rights Award. The award is presented annually in recognition of excellence in the fight against HIV/AIDS and Tuberculosis and the promotion of a human rights based response to the twin epidemics in southern Africa.

The organization has been a constant reminder to the society in Botswana that without human rights as a priority agenda, the mitigation of HIV and AIDS is not effective in line with the national objective of creating a supportive, ethical, legal, and human rights-based environment conforming to international standards for the implementation of the National Response.¹

This was echoed by the international community through the endorsement of a human rights theme for World AIDS Day 2009 with sentiments to the effect that without human rights we cannot achieve universal access to prevention, treatment, care and support. As a human rights organization, BONELA does not take lightly the fact that the third Botswana AIDS Impact Survey (BIAS III) had questions that related to sexual minorities. Although this inclusion was not holistic or adequate, it was a beginning. Further, in the drafting stage of the National Strategic Framework, BONELA was involved as a stakeholder to guide the process and ensure the inclusion of human rights and that the framework responds to key populations that are usually excluded in the national response to HIV and AIDS.

To leverage its position, BONELA strategically embraced evidence-based advocacy through the publishing of the Men Who Have Sex with Men (MSM) Study and a needs assessment. The results of the MSM study were shared at the pre-National AIDS Council (pre-NAC) which basically serves to decide what goes to the NAC. The study was well received by stakeholders and was given a green-light to go to the NAC. However, BONELA was shocked when on the eve of the NAC meeting, it did not appear on the programme that was sent out to stakeholders. The issue was pursued diligently, with a letter being written to the former president of Botswana, Festus Mogae and has not been resolved to date.

¹ National AIDS Coordinating Agency, National Strategic Framework 2003-2009, p. 10

This issue points to the political bottlenecks that BONELA has continued to contend with. It points to an implicit denial and resistance of the existence of sexual minorities which justifies their criminalization. Why should we hear that they exist? After all, if they exist, we can no longer ignore them. The other dimension is the ethical question considering a presentation that did not go to the pre-NAC was allowed to go to the NAC. As a nation, are we willing to be that unscrupulous to ensure that the nation is not informed? Are we more comfortable leading a 'democracy' comprised of uninformed citizenry?

The above incidence is telling of a bigger problem that the nation still has to contend with. Access to information is still greatly limited especially in the absence of a law that guarantees it. In the course of the year, BONELA joined forces with the Botswana chapter of the Media Institute of Southern Africa, other civil society organizations and the local media in forming a coalition on freedom of expression, known as CoFex. The coalition seeks to challenge the Media Practitioner's Act of 2008 which is largely viewed as draconian; sanctions state control of the media; curtails freedom of association by stipulating that every journalist and publication has to register with the state media council and seeks to erode editorial independence. The passing of this act further shrinks democratic space by making the media the domain of a select few with vastly reduced public participation. Needless to say, access to information which is already limited, will be further reduced.

As part of awareness-raising and evidence-based advocacy, BONELA supported the Lesbians, Gays and Bisexuals of Botswana to publish a booklet on personal stories of Lesbians, Gays and Bisexuals (LGB). The booklet will compliment the research by the organisation and points to the need for a more responsive, targeted public sector service provision. BONELA also scored an advocacy victory when the Government of Botswana gave the United Nations High Commission for Refugees the go ahead to provide HIV positive refugees with antiretroviral treatment. BONELA and other stakeholders had made various attempts to convince the government to grant ARVs to refugees and this finally bore fruit although the advocacy continues so that they are not on a parallel programme but on the national ARV programme in line with the rest of southern Africa and according to international best practice. A booklet on the personal stories of refugees and their quest to get access to treatment was published by BONELA as part of this campaign.

The continuing absence of legal aid in Botswana was still apparent in 2009, with 50 perceived unassailable cases being taken up by the organization. Whilst moves have been made by the Attorney General's office to introduce legal aid, it is not clear to what extent the plans had proceeded by the end of the year. To BONELA's credit however, the organization won two major cases in the High Court of Botswana that set new jurisprudence such as the Kgakgamatso Sekgabetlela and Obakeng Madubela cases.

BONELA successfully litigated on behalf of Kgakgamatso Sekgabetlela who

was wrongfully diagnosed with HIV and consequently sued the Government of Botswana for P500 000.00 for negligence, and was awarded P150 000.00 for the pain and suffering as a result. The groundbreaking judgment, which sets a legal precedent in Botswana, the region and on the international arena was handed down on the 29th of October 2009 by Justice Key Dingake at the Lobatse High Court.

In his judgment Justice Dingake acknowledged that Sekgabetlela had been traumatized by the wrong HIV positive result to the extent that she was later diagnosed as suffering from Post Traumatic Stress disorder by a clinical psychologist who gave expert evidence before the Court. He also took into account the fact that Kgakgamatso Sekgabetlela had at one point contemplated suicide due to the inevitable mental anguish that she suffered as a result of the misdiagnosis, her feeling of helplessness and hopelessness, stress exerted by stigma and discrimination from society and the near collapse of her marriage.

Justice Dingake rightly noted that stigma is a compelling factor, hence "... it would be cruel to underestimate the pain and suffering that a person who believes is HIV positive may be subjected to."

Sekgabetlela's case brings to light the fact that the response to HIV and AIDS cannot be won without infusing human rights into public health interventions. It challenges the public health provider to go beyond the call of duty in accommodating individual needs, as a one size fits all will prove too limiting. The State can also providing capacity building and mentoring in bringing awareness of human rights in general and stigma and discrimination in particular, to aid delivery of a holistic package in fighting HIV and AIDS.

This major victory fell hard on the heels of another case that BONELA won in June in which the Lobatse High Court ordered one Sadi Nokane, to pay Obakeng Madubela, who was represented by BONELA Legal Officer Mr. Uyapo Ndadi (now BONELA's Acting Director) to pay P7 000.00 as damages for publication of otherwise confidential information about Madubela's HIV status. The causes of action arose on two separate occasions, the first which took place on the 25 December 2006, and the other in June 2007. On both occasions, the insults which were uttered basically revealed Madubela's HIV status and were done within earshot of several people whom the Madubela had grown up with.

In the first case of its kind before the Botswana High Court, Justice David Newman held that that the publication of the otherwise confidential information about the Plaintiff was done with the intention to cause distress and actually did so. This was in the light of the Plaintiff's testimony that the utterances affected her personal relations, her catering business as well as her political career. Justice Newman pointed out that the Botswana courts 'have long recognized that an action is available against any person who has

committed an intentional wrong causing injury to someone's dignity.'⁷ Another concern for BONELA in 2009 was the constitution of the country, which is antiquated and inadequate as far as human rights are concerned. Whilst the country nobly strove to achieve zero new infections by 2016 in its strategic vision², the bill of rights has left out the fundamental right to health, crucial for the realization of this goal. Threats to stop the provision of ARVs have thus come in the mix, prompting BONELA and other civil society organizations to launch a treatment sustainability campaign that will among other things look into issues of equity, procurement and distribution of drugs in a bid to provide more sustainable solutions that will ensure continued access to ARVs.

As part of commemorating the 2009 World AIDS Day theme: Universal Access and Human Rights, BONELA raised awareness in communities and stakeholders the fact that the rights to health amongst other rights such as the right to education and the right to found a family are not guaranteed in the constitution of Botswana. BONELA also brought to light the fact that stigma and discrimination will continue to fuel the spread of HIV due to the criminalizing nature of the Penal Code on sex workers and Lesbians, Gays, Bisexuals and Trans-gendered individuals as it vastly curtails access to health services be they preventative or therapeutic.

Violence against women, be it personal or structured, has contributed to the spread of HIV by emasculating them of their ability to negotiate for safer sexual encounters. In 2008, the Government of Botswana passed the Domestic Violence Private Member's Bill into an Act to address violence in domestic relations. BONELA took it upon itself to raise awareness on the Act to ensure its utilization as a deterrent to the perpetuation domestic violence. The first training held with magistrates in April 2009, was an eye opener as the magistrates confessed to have no knowledge of the existence of the Act although it was in existence for more than eight months at the time of the training.

Other trainings conducted by the organization have similarly contributed to educating and raising the awareness of the public; service providers and most at risk populations (MARPS) such as sex workers, LGBT and refugees in peer education, human rights, treatment literacy, domestic violence and the law, human rights and HIV and AIDS. The media who have a critical stake in information dissemination, shaping public opinion and influencing legislators who are more often than not, inaccessible have also benefiting from BONELA trainings to aid the quality of reporting around HIV and AIDS and human rights.

Overall, the work that BONELA undertakes is still regarded in Botswana as controversial and is thus fraught with challenges. Building a critical mass of

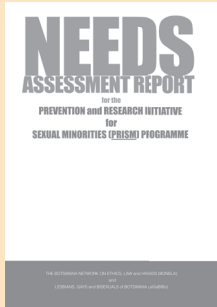
2 National AIDS Coordinating Agency, National HIV/AIDS Strategic Framework 2003-2009, p.9

civil society organizations (CSOs) working on certain advocacy issues is thus difficult considering there is major hesitance by CSOs to issues especially around MARPS. In addition, there is need to strengthen the advocacy skills of CSOs as there is generally a weak advocacy agenda in the country. Other challenges that were brought to the fore include the negative attitude towards people living with HIV and their right to make informed choices and decisions where their sexual reproductive health rights are concerned. The general trend even from government is that they cannot make reasonable and informed decisions and they are blamed for fuelling the pandemic.

With these challenges, BONELA has a long way to go in ensuring that human rights approaches are integrated in the national response to HIV and AIDS and to guarantee universal access to prevention, treatment and care in Botswana.

BONELA PUBLICATIONS

By Doris N. Kumbawa



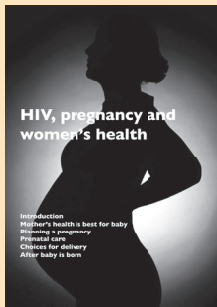
Author: Felistus M. Motimedi
Editors: Dr. Sethunye Mosime
Christine Stegling
Doris N. Kumbawa

The report highlights findings of an assessment conducted to determine access to health services by sexual minorities, namely lesbians; gays; bisexuals and trans-gendered (LGBT) individuals. The study also investigated knowledge, attitudes and behaviours of service providers such as nurses, doctors, traditional healers and social service oriented organizations towards the LGBT community.



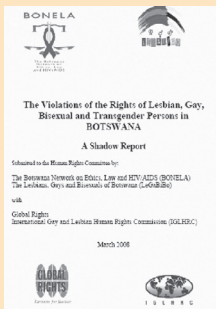
Author: Doris N. Kumbawa
Editors: Dr. Treasa Galvin
Christine Stegling

This booklet is a compilation of personal stories of HIV Positive refugees in Botswana. They are chronicles of their experience with HIV in the absence of life prolonging antiretroviral (ARV) treatment which by that time was not available to them. BONELA produced this booklet as an advocacy tool to lobby the Government of Botswana for their inclusion on the ARV programme.



Author: I-Base
Editors: Nthabiseng Nkwe

This booklet which was also translated into Setswana, the main language in Botswana was adapted by BONELA from I-Base. The content was made relevant to Botswana and outlines options for conception and sexual reproductive health lifestyles for HIV positive women.



Authors: BONELA; Global Rights; IGLHRC & LeGaBiBo

This is a shadow report on the violations of the rights of Lesbian, Gay, Bisexual and Transgender people in Botswana.



Author: BONELA

BONELA continues to reach a wide audience nationally, regionally and internationally through its newsletter – the BONELA Guardian an update of the organisation’s campaigns and other programming activities.

REVIEW OF BOOKS AND ARTICLES

Book Review:

Maundeni, T., Osei-Hwedie, B.Z., Mukamaambo, E., Ntseane, P. G. (eds.) *Male involvement in sexual and reproductive health: prevention of violence and HIV and AIDS in Botswana, Gaborone, Botswana, 2009*, 181 pp.

Sethunya T. Mosime

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Over the last few decades, reproductive health research on women has come to enjoy centre stage vis-à-vis men's health research, as a reaction to concerns about the inequalities in socio-economic and gender status between men and women (Copper, et al, 2004). During this period of addressing gender imbalances in access to health, many studies were done on a range of issues such as the detriment of health sector reforms such as privatization to women's health (Kaufman and Jing, 2001); poverty and access to maternal health care, women and universal access to safe and affordable reproductive-health services. With regards to HIV and AIDS, it was recognized that especially African women faced a disproportionate risk of infection and carried the largest share of the burden of caring for sick or orphaned family members (Magadi, Zulu, and Brockerhoff, 2003; Zelnick and O'Donnell, 2005). Also, women often placed priority on the health of family members above their own (Frasca, 2003).

However, recently there has arisen a sentiment that male involvement in sexual and reproductive is missing. Across the world, scholars are decrying the 'neglect' of men's issues and attitudes towards health care ignored in academic literature (Lichtenstein, 2004). C.A. Varga (2001) of the Women's Health and Action Research Centre (WHARC) labeled boys and men in sub-Saharan Africa, "The Forgotten Fifty Per Cent", in so far as health and sexual reproductive health. It is argued this places them in greater risk of contracting HIV. New research takes the approach that success in women sexual reproductive health requires 'male involvement'.

It is within this context that the book under review, *Male involvement in sexual and reproductive health: prevention of violence and HIV and AIDS in Botswana, Gaborone, Botswana (2009)*, a collection of eleven essays written by more than fifteen Botswana based social researchers emerged. In the introduction, the editors make a very strong claim that "any programme aimed at addressing reproduction and health issues that targets females only is bound to fail" (2009:1).

Written under the auspices of the University of Botswana's Gender Policy and Programme Committee and Friedrich Ebert Stiftung, the objective of the collection of essays is to illustrate in various ways the potential benefits of involving men. This is a multi-disciplinary set of contributions from sixteen researchers based in Botswana, with contributors coming from a

wide range of disciplines including sociology, social work, psychology, nursing, political science, education, mathematics and science, and home economics. The eleven chapters cover diverse perspectives on why men are behind and how they can become more involved in issues of sexual reproductive health. The mutually reinforcing relationship between HIV and AIDS and domestic violence has long been established (Rothenberg and Paskey (1995). Increased male involvement, according to the different authors, could help prevent violence and HIV and AIDS. It makes this book a timely and highly important contribution as Botswana comes closer to 30 years of struggling with HIV and AIDS.

In the first essay, Simon Kang'ethe blames gender-based violence and the fact that women carry the heavier burden of HIV and AIDS on inadequate male involvement in health issues. He thus calls for the positioning of men at the centre of HIV and AIDS campaigns as HIV and AIDS campaigns have been 'gender-skewed' in favour of women. What is not clear is why then the campaigns have at least not resulted in the empowerment of the women even as men could be said to be ignored. It also appears as if, even as government has for nearly a decade now supported Botswana's Men's Sector, this has not been sufficient to 'bring men on board'.

Tapologo Maundeni and Godisang Bridget Mookodi provide a rich account on issues from men's point of view. Men are given a platform to talk about a range of issues such as why they enter into love relationships, on vulnerability, where and how they learn about their sexuality. However, when it comes to the differential accessing of health facilities between men and women, the authors tend to gloss over exactly why it is that women, who are otherwise powerless, have been utilizing sexual reproductive health programmes. For me, the answer lies, not in that facilities are more user-friendly for women as the authors seem to imply, but that women have been unfairly burdened with children's health and family planning.

Kgomotso Gertrude Garegae and Marina Rinas Gobagoba summarize their views this way, "*Disempowerment + blame = zero male involvement in HIV and AIDS issues*". As they see it, women must take part of the blame in why men are reluctant to participate in HIV and AIDS interventions among other things. One example they give is that, in raising children, the boy child is often neglected in terms of helping them acquire the necessary emotional competence to handle emotionally charged situations. In the final analysis, men are not entirely to blame for their lack of involvement (Garegae and Gobagoba, 2009).

Male involvement is also appraised from the point of view of how it would improve the numbers of expectant mothers enrolling for the Prevention of Mother To Child Transmission programme (PMTCT), by Sadasivan Nair and Serai Daniel Rakgoasi. Cultures around domains of each sex and the unwelcoming, women dominated health care system were isolated as some

of the reasons men may have little interest or motivation on sexual and reproductive health issues.

Poloko Nuggert Mmonadibe proposes “couples testing as a tool for promoting male involvement in HIV and AIDS management in Botswana. With HIV discordance among couples being at about 12.5% in Africa. Mmonadibe suggests that NGOs, the private sector and the public service could use existing cultural and traditional structures that celebrate masculinity as a forum to encourage positive behaviours like couples testing.

The position of women in patriarchal cultural settings at a time of HIV and AIDS is explored by Rebecca Nthogo Lekoko. She does not focus on male involvement, but rather on women and how they may be empowered “to be assertive and resist the temptation to engage in unsafe sex”.

Male involvement, it is argued by Diana Letlhogonolo Kgwatalala, could even prevent the escalating numbers of intimate partner femicide in Botswana. She seeks the recognition that “men can also feel powerless”, especially because they are culturally taught to bottle emotions, leading to stress, anger, and ultimately femicide.

Sophie Moagi-Gulubane did a study that established the existence of psychosocial aggression among heterosexual students at the University of Botswana, which is often a precursor to physical violence.

While it is an established fact that mainly due to poverty, some women do sex work to make ends meet; the chapter by Peggy Gabo Ntseane reveals an increase in males as sex workers. Most provide this service to other men. Men having sex with men (MSM) is largely under reported in Botswana, but is potentially explosive as studies have shown that MSM are often also in permanent heterosexual relationships. Elizabeth Poloka Mukamaambo and Venant Rafael Nyonyi Mutabihirwa make a case for gender disaggregated data and also warn of “gender expectations that could impede the involvement of both men and women in reproductive health issues” (2009:162-163).

In the final chapter, Motshedisi Boitumelo Sabone provides concrete examples of the ways in which men and women tended to perpetuate stereotypical gender roles. Even as they sometimes switch roles, the switch would either be temporary or a forced choice. The odd father who carries the heavier burden in childcare vis-a-vis the mother, often does it only if she is incapacitated, but he is still likely to have his daughters doing more housework than the boys.

Conclusion

While the contribution that this book makes has to be applauded, it does not explain how it is that sexual and reproductive health policies, initiatives and programmes in Botswana came to lack male involvement. What is lacking is the conceptualization of male-involvement; is it having the same health-

seeking behaviours between men women? Is it men and women being able to communicate their feelings better, or is it men becoming less violent towards their partners? Also, the conclusion that indeed there is gender-bias in favour of women need a more critical look because, it remains difficult to sustain when at the same time, each of the contributors shows how women in Botswana continue to be abused, to be unable to negotiate safe sex, and to be victims of intimate partner femicide. Women seem not to have in any way been benefitted by the alleged skewed-ness of programmes in their favour. Even as girls are supposed to be better equipped with emotional competence, this does not appear to have given them any edge over men in terms of being able to negotiate safe sex and deal with violent relationships. There is also a danger of being overly deterministic and be heard to be saying that any attempt to empower women will only succeed if men are made to see how such empowerment would be in their best interest. The implication would then be that women's lives are inescapably at the mercy whether or not men are willing to give concessions. Ultimately, it appears that it is local patriarchal forces rather than policy or programme design that is the reason that women continue to be carrying most of the HIV and AIDS burden.

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CALL FOR PAPERS

HIV/AIDS raises many issues because of its complex, all embracing and multi-dimensional nature. It therefore needs 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, including but not limited to Ethics, Philosophy, Law, Medicine, Sociology, Psychology, Anthropology, Development Studies, Gender Studies, Pharmacology, Political Science, Economic Policy, Cultural Studies, African Studies, Social Work and Communication. Contributions from practitioners and activists from all relevant fields are welcome. As an advocacy organisation, BONELA champions human rights for all sections of society and accordingly, *BRELA* is intended to reach as wide an audience as possible. To this end, papers that can be of interest to a diverse audience consisting of many levels of readership are encouraged.

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ISSN 1993-9493