CONSULTANCY SERVICES FOR REVIEW OF LAWS AND POLICIES RELATING TO HIV/AIDS

FINAL REPORT SUBMITTED TO:

NAC SECTOR ON ETHICS, LAW AND HUMAN RIGHTS

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PRESENTATION

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. We are now happy to present the Final Report in respect of the consultancy to review laws and policies relating to HIV/AIDS in Botswana.

This Report is the fourth and final deliverable for the consultancy we were engaged to undertake. It contains an extensive review of laws, policies, circulars and practices with a bearing on HIV/AIDS in Botswana. It covers a review of national, regional and international legal and policy documents. It also contains our recommendations on the extent to which Botswana’s approach to HIV/AIDS is in compliance with human rights provision of the constitution and the country’s obligations under international human rights instruments.

As we were required by the terms of reference, our recommendations took into account of the outcome of the literature review, stakeholders’ consultations and the findings of the field work (interviews with key informants). The findings of the fieldwork are attached hereto as annex 1. The Discussion Paper which formed the basis for the stakeholders' workshop that took place on 28 September 2005 is attached as Annex 2.
The Terms of Reference also required us to prepare a draft for drafting instructions to the Attorney General in the event we recommend legislative amendments. The study proposes a number of amendments to some Acts of Parliament to ensure conformity with a human rights approach and a new legislation that would make the National Aids Coordinating Agency (NACA) a statutory body. The ‘draft’ drafting instructions in respect of proposed amendments to existing laws and or for new legislation is included as appendices to the Report.

In the cause of our work we also reviewed existing policies and practices. Some of those policies require amendments to align them to a rights based approach to HIV/AIDS. In some critical areas there are no policies at all. We have accordingly included, also as an appendix, a list of proposed amendments to existing and or proposals for the promulgation of new policies especially in those areas where we felt that it would be inappropriate to propose legislative intervention, in the absence of a detailed policy guideline.

We felt that it would be problematic to make any specific proposal amendments for the amendment of the Children’s Act. This is because proposals for amendments of the said Act to align it to a human rights approach are at an advanced stage. We were advised that a draft is already at the Cabinet level. We have nevertheless discussed general areas for possible reform in the body of the Report.

MOLATLHEGI & ASSOCATES

NOVEMBER 2005, GABORONE
OBJECTIVES OF THE CONSULTANCY

Under the Scope of Work (Section 2), the tender document specifies three main objectives for the consultancy:

- Review of all laws, regulations or policies providing/or having a bearing on HIV/AIDS.
- Analysis of Botswana laws, regulations and policies constitutionality and their compatibility with international human rights instrument to which Botswana is a signatory.
- Review of different options of dealing with HIV/AIDS and human rights and propose the appropriate legislative and institutional approach that would be underpinned by a human rights perspective.
- Prepare draft instructions to the Attorney –General to prepare legislation to give effect to the consultant’s recommendations where appropriate.
Chapter 1: Fundamental Principles, Issues and Documents

Findings

1.1 The Human Rights Approach to HIV/AIDS prevention, care, treatment and management is generally accepted as the right approach because:

(a) The protection of human rights is the right thing to do independent of public health, social and economic benefits that accrue therefrom. That is, being universal and intrinsic to the , human rights must in general be protected regardless of the perceived costs of doing so.

(b) The human rights approach is in line with Botswana’s political system founded on general and fundamental democratic principles.

(c) Promoting human rights (through prohibiting non-discrimination, for example) helps ensure a more effective HIV prevention programs

(d) Marginalization intensifies the risk of HIV infection;

(e) Botswana can respond effectively to HIV/AIDS by respecting the basic right of people to participate in decisions, which affect them.

(f) There is no contradiction between the protection of human rights and public health objectives.

1.2 Currently there is no coherent approach towards the integration of human rights into Botswana’s response to HIV/AIDS pandemic. However, the human rights approach appears generally to have been accepted (as reflected, for example, in the National HIV/AIDS Policy and Botswana National Strategic Framework for HIV/AIDS (in particular Goal 5 thereof commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’), and
The constitution of Botswana is generally protective of fundamental human rights. However, it fails in some crucial instances to protect the rights of People Living with HIV/AIDS (PLWHA) fundamentally because it does not guarantee and protect social and economic rights.

The Constitution of Botswana is in general consistent with Botswana’s international human rights obligations. It is nevertheless lacking in critical areas relating to the guaranteeing of social rights such as the right to health, treatment of foreign nationals (in respect of which the country fails to comply with its international obligations assumed through international agreements such as the African Charter on Human and Peoples’ Rights).

There is insufficient legal protection for marginalized and vulnerable groups such as children, women, and homosexuals, which may further expose these groups to infection and aggravate the effect of the epidemic on them.

Customary law, traditional and cultural practices do not always sit easily with a human rights approach. However this does not necessarily translates into the need for legislative intervention.

The Constitution of Botswana has provisions that empower Parliament to legislate for the duty to accommodate. However, there is currently no legislation that expressly creates a duty to accommodate in respect of PLWHA and or generally.

The Industrial Court has introduced the principle of the duty to accommodate into Botswana labour law through its decisions.

Recommendations in Respect of Chapter 1
Recommendation 1a: - Constitutional Limitations

i. A constitutional review process should be initiated, the outcome of which would be the incorporation of social and economic rights, such as the right to health and the right to work, in the Constitution, and an express prohibition of discrimination on the basis of status, sexual orientation, health and or nationality.

ii. Given the difficulty of amending the constitution, amendments of existing laws and or on enactment of new laws on a sector-by-sector basis to give effect to the above objectives is the most practical way to proceed. In any case even if the constitution could be amended it would still be necessary to legislate on a sector by sector basis.

Recommendation 1b - Children:

i. A National Policy on Children and HIV/AIDS should be promulgated as a prelude to possible amendments to the Children’s Act. Such an amendment (to the Children’s Act) should specifically address issues of sexual abuse of children, child trafficking, strengthening of children’s right to sexual reproductive information and other children’s specific human rights such as the right to child friendly sexual reproductive health services.

Recommendation 1c – Customary Law and Human Rights Approach

I. Government should consider establishing a law reform commission, preferably as a statutory body I, to spearhead law reform in generally and to perform an educational role on the effect of the dual legal system on personal rights including options for opting out of the Customary Law and other areas where being subjected to common law, statutory and or customary law may yield different results.

ii. We are not recommending any legislation on customary and human rights since the current legislation if understood by the subjects could sufficiently address
issues surrounding HIV/AIDS.

**Recommendation 1d – Principle of Accommodation:**

There should be sectoral legislation, in particular in the employment law setting, to give effect to the accommodation principle. Such a legislative intervention should be worded in general so as to ensure that it does not unintentionally encourage stigmatisation.
Chapter Two: HIV/AIDS and Employment

Findings

2.1 There is no specific provision on any employment related legislation on HIV/AIDS.

2.2 A number of policy documents including the National Policy on HIV/AIDS address aspect of HIV/AIDS at work.

2.3 Pre-employment HIV testing takes place in the private sector. As regards the public service, only expatriates are required to undergo pre-employment HIV testing.

2.4 The practice of subjecting non-citizens to pre-employment HIV testing by the Botswana Government is clearly contrary to the National HIV/AIDS Policy and international human rights norms which Botswana has undertaken to observe.

2.5 General pre-employment testing offends the constitution of Botswana and international human rights instruments, which Botswana has ratified.

2.6 Some employers require employees to undergo HIV testing before they could be sent for further training on the employers’ account.

2.7 The common law imposes a general duty of care on employers in relation to their employees, which may address some aspects of HIV/AIDS such as prevention of infection etc.

2.8 There is no legislation that regulates issues of informed consent and or confidentiality in relation to HIV/AIDS infected and or affected employees and that outlaws sexual harassment in the private sector.

2.9 There are provisions in some employment related statutes, which may facilitate and or encourage discrimination against workers infected and or affected by
2.10 The Industrial Court has incorporated the principle of accommodation into Botswana labour law.

2.11 The Draft Botswana National Policy on HIV/AIDS and the World of Work reflects a human rights based approach to HIV/AIDS at the workplace and is in line with international best practice.

**Recommendations in Respect of Chapter 2**

**Recommendation 2(a)- Employment testing**

There should be statutory intervention (by amending the Employment Act) so as to prohibit HIV testing for pre-employment purposes subject to permissible exceptions. Such an intervention should be intended to:

- Create certainty and clarity on the legality or otherwise of HIV testing as a specific form of discrimination in the employment relationship.
- Prohibit testing where it constitutes unfair discrimination.
- Protect job applicants and existing employees in order to enable the fair allocation of employee benefits.
- Give the responsibility of determining whether employment HIV testing is permissible in given job categories to an independent third party (e.g. the Commissioner of Labour and or the Industrial Court) with clearly defined factors to take into account, so as to ensure that the concerns of employers are as well addressed.
- Ensure that the prohibition of HIV testing in the workplace is not absolute but allows for exceptions to testing where testing is allowed under legislation and in certain
circumstances where it is deemed to be fair and justifiable provided prior set conditions are met.

- The burden to show that HIV testing under specific circumstances is fair and therefore justifiable and necessary should rest upon the employer.

**Recommendation 2(b)- General Discrimination at the Workplace**

i. The Employment Act, Public Service Act, Workers Compensation Act and other employment related legislation should be amended to provide for a general non-discrimination and non victimisation right on the basis of an employee or potential employees’ HIV status.

ii. The provision in the Public Service Act banning sexual harassment at work should be transposed into the Employment Act to protect private sector workers from sexual harassment as well.

**Recommendation 2(c) - Confidentiality and Informed Consent**

There should be a statutory obligation on employers to respect workers rights in relation to confidentiality of health-related information in their possession and only disclose same pursuant to the employee’s informed consent. A consideration should be given to protect confidentiality in the dispute settlement process.

**Recommendation 2(d) – Termination and duty to accommodate**

i. The commendable approach by the Industrial Court of incorporating the accommodation principle into Botswana labour law should be given statutory backing.

ii. Unlawful termination of an employee on the basis of his/her HIV status should be one of the factors entitling the employee to the remedy of reinstatement.

**Recommendation 2(e) Care, Support & Prevention of HIV at the Workplace.**
i. As part of health and safety at work obligations, employers should be required to ensure that necessary steps are taken to prevent and control HIV infections at the workplace.

**Recommendation 2(f) – Content of Collective Labour Agreements**

Among the statutory grounds (in Trade Unions and Employer’s Organisations Act) on which the Commissioner of Labour may decline to register a collective labour agreement must be added provisions that are directly and or indirectly discriminatory on the basis, inter alia, of gender, health (including HIV) status and or any provision which is prejudicial to vulnerable and marginalized groups.

**Recommendation 2(g) – Draft Botswana National Policy on HIV/AIDS and the World of Work**

The Draft Botswana National Policy on HIV/AIDS and the World of Work should be finalised as soon as possible, preferable before the proposed amendments to the labour legislation in this Report.

**Recommendation (2h) National Industrial Relations Code of Practice**

The code should be amended to reflect the national approach to HIV/AIDS as reflected in the Botswana National Strategic Framework for HIV/AIDS, the National HIV/AIDS Policy, Draft Botswana National Policy on HIV/AIDS and the World of Work and other current developments, which took place since the Code was adopted.

3. **Chapter Three: HIV/AIDS and Public Health**

**Main Findings**

3.1 The pursuant of human rights and public health objectives can be made complimentary to each other.

3.2 A human rights based approach to HIV/AIDS is more likely to be effective than an approach based on coercion, discrimination, stigmatisation etc.
3.3 The requirements of confidentiality and informed consent are generally complied with within the public health facilities. However, since the introduction of routine testing, it appears that patients seeking assistance in Government health services are not given sufficient information to understand that they can opt out of routine testing.

3.4 There are no special arrangements to ensure confidentiality in relation to the disabled such as the hearing impaired.

3.5 There is uncertainty in terms of the scope of confidentiality and shared confidentiality and notification of partners generally.

3.6 Compulsory testing is allowed by law only in the event of sentencing of convicted rapists and other sexual offenders.

3.7 There is legal uncertainty as regards the stage at which one can be said to have the capacity to give informed consent for purposes of testing for HIV/AIDS.

3.8 HIV/AIDS is currently legally not a notifiable disease.

3.9 There is no express statutory right to health in Botswana.

3.10 The Government of Botswana provides citizens with free access to ARVs but non-citizens are not entitled to same.

3.11 Regulation in all aspects of HIV/AIDS, including testing and access to treatment is effected mainly through Presidential and other executive directives, circulars, guidelines and instructions. However the High Court held that executive directives are of doubtful legality.
3.12 Botswana has not yet taken advantage offered by the Doha Ministerial Declaration to investigate alternative access to cheaper generic drugs for HIV/AIDS and other essential drugs such as those for the treatment of malaria.

3.13 The regulatory framework for medical/clinical and or vaccine trials in Botswana is very rudimentary and needs to be amended to sufficiently protect the rights of the subjects of trials.

**Recommendations in respect of chapter 3**

**Recommendation 3(a)- Informed Consent and Routine Testing**

An extensive public education directed at informing the public about the benefits of testing and the fact that individuals seeking medical services in Government health facilities have the right to opt out of routine testing should be embarked upon.

**Recommendation 3(b) – Informed Consent- Age of Consent.**

The capacity to give informed consent for purposes of testing for HIV should be based on a combination of age (16), the fact of sexual activity and or the reason for wanting to undergo the testing. That is, any person aged 16 and above should be presumed to have the capacity to give consent for HIV testing and sexual reproductive health services. However, if a person under 16 is shown to be sexually active then, such a person should be presumed to have the capacity to give informed consent for purposes of HIV testing and obtaining of sexual reproductive services such as condoms. Any person who does not meet the above criteria, but has sufficient reason for wanting to undergo the test unassisted by the parent and or guardian (such as a child who is being sexual abused by a guardian) should also be allowed to avail himself/herself to the reproductive health facilities.

**Recommendation 3(c)- Regulating Confidentiality**
There is need to provide in clear administrative (not legislative) guidelines in respect of different types of HIV testing, confidentiality, informed consent and circumstances under which the rules of confidentiality may be waived. We note in this regard that the proposed amendments to the National Policy on HIV/AIDS have detailed proposals on this point. This, however, does not do away with the need to have clear guidelines applicable to public and private facilities providing testing services.

**Recommendation 3(d)- HIV and Notification**

The Minister should exercise her powers in terms of the Public Health Act to make HIV a notifiable disease and or provide the legal basis for data collection in respect of the disease and the handling and distribution of information about HIV/AIDS patients generally.

**Recommendation 3 (e) – The Right to access to health facilities**

I. The practice of denying non-citizens access to ARV drugs while the same is offered to citizens should be reviewed as it is in violation of Botswana’s international human rights obligations in particular, the African Charter on Human and Peoples’ Rights which prohibits discrimination on the basis of nationality.

ii. In the event that it is desired to maintain the practice of denying non-citizens access to free state supplied ARVs, it should then be based on a statutory basis (since it is a derogation from the constitutional principle of non-discrimination), rather than a Presidential Directive, and should have clearly spelt out flexible exceptions to take account of the fact that citizens do have intimate relationships with non-citizens and a recognition that an inflexible application of the law in this regard may seriously undermine public health objectives of managing the pandemic.

iii. To ensure equitable access to medical services, there should be a statutory obligation on medical aid schemes to generally provide services on a non-discriminatory basis.
**Recommendation 3(f)**

Government should undertake a dedicated study to find out the opportunities (if any) offered by the Doha Declaration in the area of access to essential medicines for HIV/AIDS and other conditions such as malaria.

**Recommendation 3(h)**

An update of legislation and/or statutory regulation on the conduct of medical and clinical trials in general and HIV preventive vaccine trials should be effected to address in detail the human rights of the subject of the trials.

**Chapter Four: HIV/AIDS, Criminal Law and Rehabilitation**

**Main Findings**

4.1 Intentional transmission of infection has been criminalized through general criminal law rather than an HIV specific legislation. This is consistent with a human rights approach.

4.2 There are no HIV/AIDS specific offences.

4.3 The Penal Code assigns different punishment (enhanced) for convicted rapists and those convicted of defilement.

4.4 There is uncertainty as to whether marital rape exists or not

4.5 Acts considered to be against the order of nature have been criminalized. This has been interpreted by the courts to include homosexuality and sodomy.

However, this approach compromises efficient public health approaches to dealing with HIV/AIDS.
4.6 Living on the proceeds of sex work and or operating brothels is a criminal
offence.

4.7 The Prisons Act does not have an express provision on any aspects of
HIV/AIDS.

4.8 The distribution of condoms in prisons is prohibited as a policy measure.

4.9 There is no provision for conjugal visits for prisoners regardless of the nature of
offences they have been convicted of.

**Recommendations in Respect of Chapter 4**

**Recommendation 4(a) – Homosexuality, sodomy and HIV/AIDS**

i. The Penal Code should be amended to indicate, for the avoidance of
doubt, that the so-called ‘acts against the order of nature’ do not include
sexual preferences and sexual orientation (for example, homosexuality)
provided such conduct takes place in private and between consenting
adults.

ii. An educational programme targeted at providing information and
education on prevention, care and treatment of HIV/AIDS related
conditions to the marginalized such as homosexuals and or sex workers
should be put in place.

**Recommendation (4) c) – Marital Rape and Reproductive Rights**

A ‘for the avoidance of doubt’ amendment must be made to the Penal Code
creating the offence of marital rape and generally protecting the autonomy of
women over sexual activity and or reproduction sphere.
Recommendation 4 (c) – Sex Work

Sex work and related services should be de-criminalized and regulated with a view to providing safe working environment for the workers and their clients and improved access to sexual health information and other services.

Recommendation 4(d) – Distribution of Condoms in Prisons

Condoms and other HIV prevention products should be distributed in prisons.

Chapter 5- HIV/AIDS and Insurance and Finance Services

Findings

5.1 Insurance companies generally require applicants for life-cover to take pre-life cover HIV test where the insured amount is in excess of P100,000.00

5.2 Insurance service providers are under a statutory obligation to provide services for life in respect of applicants whose lives insured have an equal expectation on a non-discriminatory basis.

5.3 The non-discrimination obligation referred to in 5.2 above does not apply in certain circumstances including where the amount insured is in excess of P100,000.00

5.4 There is no express obligation on financial service providers to provide service on non-discriminatory basis

Recommendations in respect of Chapter 5

Recommendation (5a) – Non-discrimination

There should, as a general rule, be a statutory obligation on insurance and financial service providers to provide services on a non-discriminatory basis. The
exceptions to this rule must be in accordance with prior set conditions, approved by the relevant sector regulator.

Chapter 6: Education and Training

Findings

6.1 There is no legislation dealing with HIV/AIDS in the education setting

6.2 Applicants to education and training institutions in Botswana are not required, as a condition for admission, to take HIV test.

6.3 Some big employers, notably, Debswana, condition further training by its employees at the expense of the company on the outcome of an HIV test.

6.4 The school heads have the power to remove from school medically unfit pupils and can order the pupils to be medically examined without consent of parents and or guardians.

Recommendations in respect of chapter 6

Recommendation (6a)- Access

i. There should be statutory obligation on education and training institutions to provide access on a non-discriminatory basis.

ii. Scholarships and bursaries should be granted on a non-discriminatory basis by all public bodies including private companies in which the Botswana Government has substantial financial, and other interests. Any exceptions to this rule should be based on the need to ensure the health of the applicant.

iii. The Education Act should be amended to align the powers of the school-heads with the human rights approach.
Chapter 7: Sports

Findings

7.1 There is no legislation addressing issues of HIV/AIDS in Sports. Even the Botswana National Sports Council Act is silent on issues of HIV/AIDS and sports.

7.2 There is risk, albeit small, of HIV transmission in sports in particular contact sports such as rugby and boxing.

Recommendations in respect to Chapter 7

Recommendation (7)

1. In order to secure the safety of sportspersons and the human rights of PLWHA, a detailed Policy on HIV/AIDS and sports should be developed following consultations with relevant stakeholders.

iii. Legislation should await the promulgation of the policy.

iv. Should it be felt necessary to legislate before policy formulation, we recommend that a general provision be inserted in the Botswana National Sports Council Act that expressly obligates the Sports Council to ensure the health and safety of all the players in different sports codes and promote equitable and non-discriminatory access to sports facilities. This flexible approach would ensure that the special concerns of different sports codes are taken into account.

Chapter 8: Institutional Issues

Findings

8.1 The political leadership over the fight against HIV/AIDS lies with the National AIDS Council chaired by His Excellency, the President.
8.2 The national body for coordinating national efforts in the sphere of HIV/AIDS is the National Aids Coordinating Agency (NACA), which falls under the Office of the President.

8.3 Given the nature of HIV/AIDS issue, a multiplicity of Government ministries and departments are, rightly, involved including the Ministry of Health and Ministry of Local Government.

8.4 In cases of disputes HIV/AIDS related issues are settled through the court system.

8.5 There are a number of non-governmental organisations involved in the promotion and protection of human rights of PLWHA.

Recommendations in relation to chapter 8

Recommendation 8(a)

i. Current policy, service provision and coordinating institutions should be left as they are.

ii. The location of NACA within the Office of the President should be retained and there is currently no sufficient case for making NACA a Parastatal.

iii. The powers and functions of NACA should be given statutory basis to ensure certainty, accountability and consistency in service delivery.

iv. NACA, as part of realising GOAL 5 of Botswana Strategic Framework for HIV/AIDS, of creating a supportive ethical, legal and human rights based environment, should spearhead and coordinate the proposed legislative review.

Recommendation 8(b)
I. Consideration should be given to the possible establishment of a human rights commission to investigate alleged violations of human rights generally including HIV/AIDS related cases.

ii. Civil organisations working in the area of human rights in general and in the area of HIV/AIDS should continue to be provided with necessary financial assistance targeted towards promotion and protection (including through litigation) of the rights of PLWHA by Government. In addition Government should consider providing incentives such as tax incentives and breaks to private sector entities that assist and or contribute to non-governmental organisations working for the protection of the human rights of PLWHA.

Chapter 9 – Comparative

Findings
9.1 There is no universal legislative approach to the HIV/AIDS issue.

9.2 There are a number of possible approaches including; an omnibus legislative approach with one HIV statute, a sectoral-based approach and the South African Model (strong constitutional foundation backed by sectoral legislative interventions).

Recommendations in respect of chapter 9
A sectoral legislative approach, which is in line with Botswana’s legal tradition and practice, should be adopted.
CHAPTER 1: FUNDAMENTAL RIGHTS, ISSUES AND DOCUMENTS

1.1 Introduction

The analytical framework for this study is given in the invitation to tender as a human rights approach. In this chapter we provide an overview of this approach in the context of HIV/AIDS. It is critical to do this because the human rights perspective will guide us in the execution of our mandate. Our review and analysis of laws, regulations, circulars, practices and policies in the selected areas will be undertaken within the context of a human rights perspective. This approach seeks to ensure that in dealing with HIV/AIDS in any area (e.g., employment, public health, criminal law, financial and insurance), civil, political, cultural, social and economic rights of those infected and or affected by the disease are respected, promoted and effectively enforced in cases of breach.

Some of the issues that we will enquire into, as we required by the study’s terms of reference to do, when analysing the human rights approach to the HIV/AIDS issue within the Botswana context, would include a consideration of the extent to which Botswana’s approach complies with human rights provisions of the Constitution of Botswana and Botswana’s international obligations in the sphere of human rights.

1.2 Fundamental Rights

A human rights approach to an analysis of laws, policies and directives with a bearing on HIV/AIDS in Botswana necessarily means that we must from the onset understand the meaning of human rights in general, and then isolate those rights which are relevant to the HIV/AIDS issue. We shall then give an over view of relevant fundamental documents. These are those documents that deal with basic elements of human rights. Their analysis, would therefore, assist us in establishing the extent to which Botswana’s approach to HIV/AIDS is in compliance with fundamental human rights provisions of the Constitution of Botswana and international human rights norms. These documents are applicable across all sectors.
Dingake (2000) has usefully identified four characteristics of human rights. These are: a) Human Rights are rights that accrue to people by virtue of their being human; b) Human Rights apply equal to all people regardless of their status; c) Human Rights address the relationship between an individual and Government. That is, every individual has a claim against his/her Government arising as a matter of right and not as a result of privilege or favour; and d) Some human rights are not easily amenable to restrictions such as the right to life.

We should point out from the onset that human rights are not absolute. In certain circumstances, human rights may be restricted to protect public and or national interests. Given the importance of human rights, restricting them is permissible only if two critical conditions are met. First, the restrictions must be prescribed by law. Second, the restrictions must be such that they could be justifiably in a democratic society. The first requirement means that the restrictions should not be arbitrary. The second means that whatever restrictions are imposed, such restrictions should be proportional to the objectives sought to be achieved. That is, they must be the least restrictive measure available and must be such that they will achieve the objectives sought (the 'Proportionality test').

The following are human rights that are relevant in the context of HIV/AIDS:

1.2.1 The Right to Non-Discrimination

The right to non-discrimination is one of the fundamental human rights recognised by all enlightened legal systems and major international instruments on human rights. It means that all persons are entitled to equality before and equal protection of the law. Guarantees of equality before the law and equal protection of the law is critical in preventing Government and other relevant entities from arbitrarily making distinctions among classes of persons in promulgating and making laws and regulations.

In the context of HIV/AIDS, the right to non-discrimination means that a person living with HIV/AIDS should not be subjected to less favourable treatment on account of
her/his HIV status. As the South Law Commission on the Aspects of the Law Relating to HIV/AIDS found, in practice it has been shown that;

“non-discrimination is not only a human rights imperative but also a technically sound strategy for ensuring that persons with HIV are not driven underground, where they are inaccessible to education programmes and unavailable as credible bearers of AIDS prevention messages for their peers. The effect of discrimination is also to alienate. People living with HIV are often members of already stigmatised groups who experience discrimination and who may suffer lower self-esteem and reduced motivation to make sustained and responsible behaviour change. Fear of discrimination is a significant impediment to persons coming forward for counselling, testing, support and treatment. Therefore, upholding human rights principles assists public health efforts to protect the health of the whole community in promoting the individual behaviour change necessary for a reduction in infection rates”

The right to non-discrimination is recognised by domestic, regional and international human rights and policy instruments.

**Domestic Instruments**

*The Constitution of Botswana:*

Before a detailed analysis of the relevant provisions of the Constitution of Botswana, we must first note say something about our constitutional system itself. Botswana’s constitution guarantees to every person fundamental human rights and freedoms irrespective of sex, political opinion, creed or political opinion or place of origin.¹These rights are the rights to liberty, life, conscious, freedom of expression, assemble, movement, privacy of the home and other property and protection against the deprivation of property without compensation.

¹ Chapter 1 constitution of Botswana. Section 3 –16
The constitution places much emphasis on civil and political rights. These rights are entrenched in order to make it difficult for politicians to interfere with them. The Constitution is the supreme law of the law and all laws derive their validity therefrom. The rights referred to above are normally classified as the first generations human rights.

The second and the third generation of rights pertain to socio-economic and the right to development. The socio-economic rights aims at ensuring that all human beings have access to the resources, opportunities and services needed for an adequate standard of living. Government would thus be expected to provide or deliver social services to the people. Socio-economic rights cannot be enjoyed and realized if government does not take steps to improve the lives of its people. Some scholars argue that these rights do not learnt themselves to ease enforceability because they are dependant on stages of development a country reaches at any given time. It is important, however, to note that all human rights are equally important and dependant and supports one another. They cannot be divided or separated or treated as existing independently from one another. A violation of one right often result in a violation of another, for example without access to socio-economic rights people living with HIV/AIDS will not be able to participate equally in the political, economic and social life of their country.

Guaranteeing social and economic rights in the constitution would place a duty on the state to ensure socio-economic rights by making laws as well as developing and carrying out policies and programmes to ensure that people enjoy socio-economic services. Realistically the Botswana Government cannot immediately give everyone socio-economic rights because it does not have sufficient resources to do so. Nevertheless the state must take steps to improve access to socio-economic rights over a period of time for all Batswana.

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2 United nations General Assembly Resolution 22.130 of 1997
In the *Government of South African and Others vs. Grootboom and others* 2000 constitutional court said that socio-economic rights are important because they make it possible for people to enjoy all other rights listed in the bill of rights, for example without food, clothing or shelter people cannot enjoy rights such as the right to dignity, freedom and equality. In a related case of Soobramaney vs. Ministry of Health Kwazula Natal 1997, Mr Soobramaney suffered from kidney diseases, which required regular treatment. He could not afford a private hospital and the government hospital could only admit a limited number of patients to its treatment programmes because of scarce resources. Unfortunately he did not meet the conditions set by the hospital for an admission to this programme. Mr Soobramaney asked the constitutional court for an order forcing the state to treat him. He based this on his right to emergency medical treatment and the right to life. The Court said that on-going dialysis could not be defined as emergency treatment and that the case should be decided on the basis of the right to access to health care services. The Court decided that state does not have to provide free health care to everyone, the hospital or clinical as a limited budget. It is therefore allowed to make decisions about the type of treatment it will give and who will receive that treatment as long as the decision of the hospital or clinic is reasonable. The Court could not interfere with the budgetary and policy decision made by the state in that case.

As regards civil and political rights, we have already noted that the Constitution of Botswana is extensive in its scope. It guarantees equality before the law and equal protection of the law. It also prohibits discrimination based on race, tribe, and place of origin, political opinion, colour or creed (section 15). The constitutional prohibition against discrimination does not mention gender, medical condition and or health status. This does not mean that discrimination on the basis of these grounds is permissible. Any irrational discrimination based on gender and or health status would be unconstitutional. It is now an established principle of Botswana law that the Constitution should be interpreted liberally so as to give effect to its intended purposes. There is absolutely no doubt that the purpose of section 15 is to outlaw discrimination of whatever nature unless such discrimination can be justified in a democratic society.
Our opinion is that, for the avoidance of doubt, consideration should be given to amending the constitution to expressly include prohibition of discrimination based on gender, health, status and or other ground that cannot be justified in a democratic society. If it is felt that amending the Constitution would be difficult, we would suggest that the approach be adopted in the reform of specific sectoral laws.

As it would appear from Annex 1 to this Report the majority of informants support the constitutionalisation of social and economic rights.

The Long Term Vision for Botswana: Towards Prosperity for All (Vision 2016 Document) – The Vision Document does not have any express provision on non-discrimination on the basis of one’s health. It nevertheless aspires to ensure that by 2016 conditions would have been created to enable those infected with HIV to live long and productive life. Vision 2016 document does not have legal force. It is inspirational in form and content and therefore cannot be enforced.

The Botswana National Policy on HIV/AIDS (National Policy on HIV/AIDS): The National Policy on HIV/AIDS incorporates the right to non-discrimination. It expressly provides that the principles it contains are intended to give effect to the “Forty-First World Health Assembly WHA42.24 (“Avoidance of discrimination in relation to HIV-infected people and people with AIDS.”) (p.11).

Botswana National Strategic Framework for HIV/AIDS: This document contains Botswana’s comprehensive strategy for responding to the HIV epidemic. It clearly spells out targets, goals and objectives. The National Strategic Framework Goal 5 expressly incorporates a human rights approach in the national response to the epidemic. In this way, it recognises and incorporates the right to non-discrimination. This being a policy document, it is also not binding in law.

Regional Documents

The African Charter on Human and People’s Rights (The “Charter”)
The Charter provides an African framework on which state parties (of which Botswana is one) can build an ethical response to the problem of HIV/AIDS (African Network, p.86). On the issue of discrimination, the Charter is much broader than the Constitution of Botswana. It prohibits discrimination based on race, ethnic group, sex, colour, language, religion, political or any other opinion, national or social origin, birth or other status [Art. 2]. Thus, unlike the Constitution of Botswana, the Charter expressly prohibits gender and any status based discrimination. In this way, one’s medical and or health status including HIV status is not a permissible ground for discrimination. In addition, national origin is not a permissible basis for discrimination.

The right to non-discrimination and the protection thereof is accorded to individuals regardless of their citizenship under the Charter. The Constitution of Botswana, on the other hand, allows discrimination in so far as it is visited on individuals who are not citizens of Botswana [section 15(4)]. In fact, currently the Government requires pre-employment HIV testing for non-citizens while the same is not required of citizens. This is not a strange position to Botswana. In the absence of treaty obligations, countries obligations' for providing social, economic and other amenities and facilities is to its citizens.

The Charter, just like the Constitution of Botswana, enjoins member states to ensure that every individual is entitled to equality before the law and equal protection of the law (Article 2).

To the extent that the Constitution of Botswana permits discrimination against non-citizens, it falls short of Botswana’s human rights obligations under the Charter. It is also arguable that the absence of an express provision prohibiting discrimination on the basis of one’s health status offends the Charter. We would recommend an attempt be made to align the Constitution of Botswana with the Charter.

The view of majority of informants is that the primary responsibility for every Government is to its citizens and therefore there is nothing wrong in discriminating against foreign nationals in such areas as in the provision of HIV/AIDS and mitigation
drugs (see Annex 1). While prima facie this is so, there are two fundamental problems with this view. First, the Government of Botswana has voluntarily assumed international obligations under the African Charter not to discriminate on the basis of status and or place of origin and or nationality, which it must be held to. Secondly, discriminatory practices raise fundamental public health problems in the area of access to treatment in view of the fact that there are no legal restrictions as nationality of sexual partners of citizens of Botswana. Most informants felt that the exclusion of foreigners from such service as free state supplied ARVs should have in-built exceptions.

The SADC Treaty
The SADC Treaty enjoins Member States to respect the right to non-discrimination. Article 6(2) thereof provides that Member States shall not discriminate against a person on the grounds, inter alia, of gender, race, ethnic origin, ill-health and disability. Thus Botswana’s approach as contained in the Constitution also falls short of its obligations under the SADC treaty.

The SADC Declaration on HIV/AIDS
The Declaration commits Members States to the upholding of human rights and fundamental freedoms of all including the prevention of stigma and discrimination against People Living with HIV/AIDS (PLWHA) (paragraph (b) of the Preamble). However, the Declaration is merely an expression of intent without creating international obligations.

International Instruments
A range of international instruments, including the Universal Declaration on Human Rights, the International Covenant on Civil and Political Rights (ICCPR), the International Convention on the Elimination of all forms of Racial Discrimination, the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) the Convention of the Rights of the Child (CRC), the United Nations General Assembly

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1 The Court of Appeal in Attorney General vs Unity Dow [1992] BLR 119 at 172 inter alia state thus “…the courts must interpret domestic statutory laws in a way as is compatible with the State’s responsibility not to be in breach of
special session on HIV/AIDS Declaration of Commitment on HIV/AIDS, and the Millennium Development Goals all prohibit discrimination against PLWHA. Several International Labour Organisation conventions and recommendations call for steps to be taken against work-related discrimination.

The U.N. Guidelines on HIV/AIDS and Human Rights published in 1998 by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, provide critical guidance in interpreting international instruments relating to HIV/AIDS. As regards the right to non-discrimination, the Guidelines emphasise the need to come up with and strengthen anti-discrimination legislation and other protective laws that protect, inter alia, PLWHA from discrimination in both public and private sphere (Guideline 5).

The interpretation of the ICCPR is, in this regard very instructive. Article 26 of the ICCPR provides that, “the law shall prohibit any discrimination and guarantee equal and effective protection against discrimination on any ground such as colour, sex, national or social origin...birth or other status.” State Parties are also prohibited from discriminating in securing the fundamental rights and liberties guaranteed in the ICCPR (article 2). The Human Rights Committee, the body charged with monitoring compliance with the ICCPR interprets article 26 to prohibit discrimination based on sexual orientation. It determined in a 1994 case that Australian legislation banning sexual contact between consenting adult men was a violation of Australia’s obligations as a party to the ICCPR.

There is now a consensus that international human rights instruments prohibit discrimination on the basis of status. There is also consensus that the term ‘other status’ used in the general non-discrimination clauses of international and regional instruments should be interpreted to include health status such as HIV/AIDS (UNAIDS, Protocol for the identification of discrimination against people living with HIV, p.5).
1.2.2 The Right to Health and Medical Services

All individuals are, under international human rights law, entitled to the right to enjoy the highest attainable standard of physical and mental health. This right comprises, *inter alia;* the prevention, treatment and control of epidemic diseases and the creation of conditions which would ensure access to medical services, and medical attention in the event of sickness. The right to health implies that the state has an obligation to provide health facilities to its citizens. The actual realisation of the right to health depends on measures that are taken to prevent infection, to ensure greater access to medical services and curative drugs and general care for the sick. Whether the right to health exist in Botswana is a moot point, as it shall more fully emerge in the discussion of relevant documents below.

National documents

The Constitution of Botswana does not have an express provision that guarantees the right to health. However, section 4 thereof guarantees the right to life. The Public Health Act [Cap: 63:01] does not also expressly provide for the right to health.

The absence of an express provision on the right to health does not necessarily mean that such a right is not recognised by Botswana law. It is arguable, for example, that section 4 of the Constitution of Botswana guaranteeing the right to life is capable of being interpreted to include the right to health.

At an international level, the Human Rights Committee, has observed in relation to Article 6 of the International Covenant on Civil and Political Rights that:

“The expression the ‘inherent right to life’ cannot properly be understood in a restrictive manner and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for State parties to take all possible measures to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemic”

Nations and the [African Union],”
The right to health can safely be considered a subset of the right to life, which is universally accepted as a human right.

The Public Health Act while not expressly creating the right to health places an obligation on the Ministry responsible for health to carry out activities that could contribute to the realisation of the right to health. Under Section 3, the relevant Ministry is under an obligation, *inter alia*, to promote the personal and environmental health within Botswana; to prevent or control communicable diseases; and to prepare and publish reports and statistics or other information related to public health.

Both the National Health Policy and the Botswana National Policy on HIV/AIDS do not expressly recognise the right to health as a human right. This is not surprising given the constitutional silence on the subject.

The Vision 2016 Documents for its part envisages a comprehensive multi-sectoral programme on sexual and reproductive health, incorporating HIV/AIDS prevention (p. 52)

**Regional Instruments**

The SADC Declaration on HIV/AIDS and the SADC Charter on Fundamental Social Rights all incorporate the right to health. The Declaration on HIV/AIDS commits Member States to the upholding of human rights by, *inter alia*, ensuring the right to access to health services (paragraph b of the preamble, paragraphs 1 and 2). The Charter expressly provides for the right to health (Article 12). These documents, not being protocols are, however, not legally binding on Member states. They are nevertheless strongly persuasive.

**The African Charter on Human and People’s Rights**

The Charter guarantees the right to health. It entitles individuals to the right to ‘enjoy the best attainable state of physical and mental health (article 16 (1)). The Charter creates a specific obligation on State Parties to ‘take the necessary measures to protect
the health of their people and ensure that they receive medical attention when they are sick” (article 16(2)).

International Instruments
Major human rights instruments guarantee the right to health. These include the International Covenant on Economic, Social and Cultural Rights ("ICESCR", article 12); the Convention on the Rights of the Child ("CRC", article 24); and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, article 12).

The Committee on Economic, Social and Cultural Rights responsible for the monitoring of the implementation and respect of the rights created by the ICESCR, has interpreted the “right to prevention, treatment and control of diseases” in article 12 of the ICESCR imposes an obligation on State Parties to take positive steps for the prevention, treatment and control of epidemic, occupational and other diseases,” including the “establishment of prevention and education programmes for behaviour-related health concerns such as sexual transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health.” The Committee takes the view that the right to health include the right to information and education on health issues. That is, the right to seek, receive and impart information on health issues. The Committee, recognising the importance of access to information in health matters, has advised state parties from censoring, withholding or intentionally misrepresenting health-related information, including sexual education information.

The CRC for its part specifically requires State Parties to ensure that all segments of society have access to education and are supported in the use of basic knowledge of child health (article 24). Similarly the U.N. Guidelines on HIV/AIDS and Human Rights recommend that states should ensure that children and adolescents have adequate access to confidential sexual and reproductive health services including HIV/AIDS information, testing, and counselling and prevention measures such as condoms (Para. 38(h)).
Notwithstanding our view that the Constitution should be interpreted as recognising the right to health, our preliminary position is that it is necessary, given the critical importance of this right and to ensure that Botswana fully complies with its international human rights obligations in so far as the right to health is concerned, to give statutory and or express constitutional recognition to the right to health by amending the Public Health Act to provide for the same.

1.2.3 The Right to Information
In the context of HIV/AIDS, the right to information places an obligation on the state to ensure that citizens have access to information on the epidemic that would empower them to take necessary prevention measures. Prevention requires effective information about safe sex and sexual relationships in general. That is, the right to information in relation to HIV/AIDS gives concrete expression to the public health view that providing accurate information about the transmission of HIV and the means of protection against infection is an essential and effective part of addressing the pandemic.

Domestic Documents
Constitution of Botswana: The Constitution does not have an express provision on the right to information. It does, however, under section 12-guarantee freedom of expression. This includes freedom to receive or give out information or ideas. The guarantee of free speech includes the right to receive information as well as to speak out. In the context of HIV/AIDS, this would include the right to receive information concerning prevention, care and treatment.

The Public Health Act: This Act puts an obligation on the Ministry responsible for health to, *inter alia*, promote or carry out research and investigations in connection with prevention and treatment of human diseases and to prepare and publish reports and statistics or other information relative to public health. These are positive provisions, which if complied with could immensely contribute to the fight against the HIV/AIDS pandemic through the provision of information.
The National Policy on HIV/AIDS does not have a provision recognising the right to information. It nevertheless recognises the critical importance of information in so far as the control of the spread of HIV infections is concerned. In particular, the Policy recognises the importance of information, education and communication in the fight against the spread of HIV infection.

The Vision 2016 Document also has general provisions aspiring to ensure that Botswana enjoys a free flow of information (p.20). It recognises that the spread of the HIV/AIDS pandemic could be reduced through provision of information and education (p.52).

Regional Documents
The SADC Treaty does not guarantee the right to information in relation to individuals. It nevertheless lists as one of the objectives of SADC, the combating of HIV/AIDS and or other communicable diseases (article 5(I)). Within this objective, it is arguable that Member States are under an obligation to ensure that individuals have access to appropriate health information on how to prevent the spread of HIV infection.

The African Charter on Human and People’s Rights provides that ‘every individual shall have the right to receive information’ (article 9). Thus State Parties, in the case of HIV/AIDS are obliged to ensure that individuals have appropriate and relevant information.

International Documents
Both the ICCPR and the CRC have provisions mandating state parties to ensure that every person has the right to ‘seek, receive and impart information of all kinds’ (ICCPR, article 19 and CRC, article 13). The Committee on Economic, Social and Cultural Rights has stated that access to information is essential to the securing of the right to the highest attainable standards of health.iii The U.N. Guidelines on HIV/AIDS and Human Rights emphasize the need for states to take affirmative action to provide adequate, accessible and effective HIV-related prevention and care education, information and services (paragraph 38(b)).
The U.N. Declaration of Commitment on HIV/AIDS also offers a guide in terms of the critical importance of the right to information in relation to HIV/AIDS. It, in particular, calls on countries to ensure that HIV prevention programmes, including information, education and communication, are available (paragraphs 52 and 58). The United Nations Millennium Declaration also affirms the right of the public to receive information (paragraph 25).

Most informants, while accepting and recognising that the right to information is a critical element of the right to health and that in the fight against the spread of HIV/AIDS, information is and should be considered a critical core element, were nevertheless ambivalent as regards the actual practice of the right to sexual information/education in relation to children. Our opinion is that Botswana obligated by the Convention on the Rights of the Child to impart health including reproductive health. There is, therefore, a need first to incorporate this international obligation into national legislation and then take the necessary policy measures to ensure that children and parents have access to health related information. We suggest the amendment of the Public Health Act and the Children’s Act to give meaning to the right to health in relation to children.

1.2.4 The Right to Privacy:

The right to privacy is closely related to the right to personal dignity. It is a recognition that an individual is entitled to some form of autonomy which should not be invaded unless justifiable under some pre-defined public interest. Privacy issues arise in at least three settings;

- Territorial Privacy- the claim to solitude within a circumscribed physical domain;
- Personal privacy – in particular protection against physical assault including HIV testing without consent;
- Information Privacy – including notions of personal information as ‘property’ and consequently claims to limiting access and distribution; and
• Communication and surveillance privacy – this refers to electronic surveillance as opposed to epidemiological surveillance [Africa Network, p120].

In the context of HIV/AIDS, the right to privacy is often realised by insisting on the respect for the confidentiality rule and voluntary testing (people should in general only be tested if they have given free and informed consent).

**Botswana Documents**

The Constitution of Botswana guarantees the right to privacy. Section 9 (1) thereof provides that ‘except with his own consent, no person shall be subjected to the search of his person or his property or the entry by others on his premises’. As already pointed out, in the context of HIV/AIDS this constitutional right is best expressed by the rules of confidentiality and informed consent.

The constitutional guarantee of the right to privacy is strengthened by the constitutional right against inhuman and degrading treatment (section 7(1)) and the right to liberty (section 3). The prohibition against inhuman and degrading treatment and the right to liberty recognise and seek to protect the autonomy of the person. The Industrial Court has held in this regard, that HIV testing without one’s consent amounts to an unauthorised search under section 9(1) and thereby unconstitutional. This decision was not appealed. It, therefore, remains unclear whether the Court of Appeal would have come to the same conclusion.

The National Policy on HIV/AIDS acknowledges the need to take cognisance of and respect for ‘human rights, privacy and self-determination of persons living with HIV/AIDS in line with the country’s constitution’ (paragraph 1.7). The draft amendment to the National Policy on HIV/AIDS also accepts this fundamental point.

**Regional Documents**

The SADC Treaty does not have any provision on the right to privacy. The Africa Charter on Human and Peoples’ Rights does not also have an express provision on the right to privacy. It nevertheless has provisions guaranteeing individuals the right to
personal integrity and prohibition against inhuman or degrading treatment (articles 4) and 5 respectively).

**International Documents**

The right to privacy is widely recognised in international instruments. The ICCPR, the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights all proclaim the right to protection of the law and from arbitrary interference with a person’s privacy.

In 1988, the Human Rights Committee issued an explanatory note on the obligation incurred by state parties under article 17 of ICCPR guaranteeing the right to privacy. It explained the content of the state parties’ obligations thus:

- State parties are under a duty themselves, not to engage in interferences inconsistent with article 17 and to provide legislative framework prohibiting such acts by natural or legal persons.
- The gathering and holding of personal information on computers, databanks and other devices, whether by public authorities or private individuals or bodies must be regulated by law.

In so commenting, the Committee collapsed to a large extent the private/public divide in so far as the obligation to ensure the protection and respect for individual rights is concerned. We shall return to the issue of whether private entities are bound by human rights instruments later.

### 1.2.5 Vulnerable and Marginalized Groups

It is given that the impact of HIV/AIDS affects different sections of society differently. Certain sections of society are more vulnerable to HIV infection or are more affected than other members. Stigmatisation, victimization and discrimination against vulnerable sections of society are a major contributory factor to the spread of the HIV infection. Those discriminated against would be less likely to take advantage of
preventative measures and or treatment of the disease. Vulnerable groups in relation to HIV/AIDS include women (gender issues), children and gays and lesbians.

The relationship between the protection of human rights and the reduction of vulnerability (and therefore levels of AIDS discrimination) was recognized specifically in the U.N Declaration of Commitment on HIV/AIDS’ chapter on HIV/AIDS and human rights. The preamble reads:

Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives and [begets] effective response.

Paragraph 58 of the chapter binds heads of states and government to:

...Enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.

1.2.6 Gender Equality

Women generally carry a heavier economic and social burden of the impact of HIV/AIDS than their male counterparts. Due to historical and cultural factors, women are generally the caregivers for the sick and those orphaned by the epidemic. At the same time, women living with HIV/AIDS more often than not suffer two types of discrimination. Discrimination based on their gender and as PLWHA. Thus the issue deserves special attention. Gender inequality no doubt aids the spread of HIV/AIDS. It reduces women’s control over their lives and increases their vulnerability to HIV infection [UNDP Bots Report, p.14]. Thus systematic gender inequality is a major factor in the spread of HIV/AIDS.
The right to Gender equality means that all forms of discrimination based on gender should be prohibited. In the context of HIV/AIDS, it means ensuring access to health care, equality before the law and the modification of cultural and traditional practices that disadvantage women. It also means that concrete measures should be taken to ensure the respect for women’s autonomy in issues such as control of their sexuality and sexual activity. Allocation of sufficient resources to uniquely women health problems such as those related to childbirth, is one way of promoting and ensuring equality in health issues.

Gender discrimination is often a matter of deeply rooted traditions, customs and social norms, which may not necessarily be addressed by law. These would better be addressed by education and information promoting gender equality. Accordingly sensitising all sections of society, in particular the media, is crucial if gender equality is to be realised. This does not mean that the law cannot make a contribution in terms of promoting gender equality.

*Majority of informants were united in advising against legislative ban on some traditional and or cultural practices that may be deemed to aid the spread of the epidemic. The general view seems to be that customary law (which we discuss below), tradition and culture, would, if appropriate information is disseminated evolve to address issues of prevention and mitigation of the impact of HIV/AIDS]*.

**National Documents**

*Constitution*

We have already observed that section 15 of the constitution dealing with non-discrimination does not include gender and sex discrimination. We have also noted that Botswana courts have long held that gender and sex based discrimination is not permissible. There is no piece of legislation that makes any distinction between men and women in terms of access to health facilities. Notwithstanding the constitutional provisions guaranteeing gender equality, there are other laws such as customary law, which may compromise gender equality.
The National Policy on HIV/AIDS is surprisingly silent on matters of HIV/AIDS and Gender. However, the draft amended Policy addresses the issue of Gender and HIV/AIDS in line with international human rights requirement. The Vision 2016 Document recognises that 'women of child bearing age bear the highest risk of contracting the HIV virus, and women of all ages bear the heaviest burden of caring for AIDS sufferers and their dependants.' (p.53). The vulnerability of women to infection is also recognised in the Botswana National Strategic Framework for HIV/AIDS.

**Regional Documents**

*SADC Treaty*

The treaty binds member states to the observance of the right to non-discrimination, *inter alia*, on the basis of gender. More specifically member states are bound to mainstream gender in the process of building SADC (article 5(k)).

*The African Charter on Human and Peoples’ Rights*

We have already noted that the Charter guarantees the right to non-discrimination. Thus it prohibits discrimination based on gender.

*International Instruments*

All international documents dealing with non-discrimination, discussed earlier are applicable here.

**1.2.7 Children**

Reports show that an increasing number of children are being infected with HIV throughout the world particularly in developing countries. Infected children are of course subject to the general problems facing PLWHA such as stigmatisation and discrimination. Children though face additional problems that are unique to them as
children. This includes loss of lack of support and life and health supporting services and facilities.

**National Documents**

The Constitution of Botswana does not say anything about children’s rights in general and health rights in particular. The Constitution’s Bill of rights that guarantees human rights as already discussed is however of general application and thus protects, albeit in general terms, children’s human rights.

Botswana has children specific legislation, the Children’s Act. The Children’s Act is mainly concerned with children in need of care and juvenile offenders (Dingake 2000). It does not have a specific provision on HIV/AIDS. At the core of the Act is the “Best Interest of the Child” principle. The principle requires that when dealing with children all parties concerned should be guided by what is in the best interest of the child. The Children’s Act has provisions that confer specific ‘rights’ on children. These follow hereunder.

*Protection from Sexual Abuse*: It is an offence for any parent, guardian and or any person to cause the child to be abducted, seduced and or put into prostitution (Section 12). This provision is of particular relevance to HIV/AIDS situation in the sense that it seeks to prevent sexual abuse of children, which can facilitate transmission of infection. In so far as matters of health are concerned, the Commissioner of Children’s Welfare has the right to order that a child be provided with medical services. The child is also given the right to be supported by their families. The Act, however, does not have provisions on some critical rights of children such as the right to child friendly sexual reproductive information and health information generally.

*Our recommendation is that the Children’s Act needs an urgent review in particular to incorporate the right to reproductive health information in respect of children. Some work is underway, the purpose of which is to mainstream a human rights perspective into the Children’s Act and align it with the Convention on the Right of the Child. We were informed that the proposed draft amendment to the Children’s Act is already with*
Cabinet. We are accordingly constrained to make detailed and or specific proposal as regards the Children’s Act. Suffice is to say that as part of realising the right to life for children, infected or affected (for example as orphans), consideration should be given to statutorily creating and defining the right to health as it relates to children, the right to reproductive health and facilities, the right to children friendly health services, the right to be protected from trafficking and the duty on the state to provide for orphans. We would also highly record the promulgation of a national policy on Children and HIV/AIDS to provide a guide in terms of address children specific HIV/AIDS related problems.

At a policy level, the National Policy on HIV/AIDS is silent on the issue of children’s rights and HIV/AIDS. The proposed amendments to the National HIV/AIDS Policy address the situation of children and HIV/AIDS.

Regional Documents
SADC Treaty and the African Charter on Human Rights do not have specific provisions applicable to children. The African Charter on the welfare of the Rights and Welfare of the Child, which Botswana has ratified addresses issues of child rights in line with the CRC.

International Documents
The U.N. Guidelines on HIV/AIDS and Human Rights recommend that states should ‘ensure that children and adolescents have adequate access to confidential sexual and reproductive health services including HIV/AIDS information, counselling, testing and prevention measures such as condoms.’ (Paragraph 38(h)). It also encourages states to enact non-discrimination legislation that would ‘reduce human rights violations against children in the context of HIV/AIDS and to ‘provide for children’s access to HIV-related information, education and means of prevention inside and outside the school’ (paragraph 30(g)).

The Convention on the Rights of the Child also guarantees children the right to ‘seek, receive and impart information of all kinds’ (article 13). The CRC specifically requires state parties to ‘ensure that all segments of society of society, in particular parents and
children, are informed, have access to education and are supported in the use of basic knowledge of child health’ (article 24(2)(e)). There is no formal way and structured approach sex education for children in Botswana

Our recommendation is that a separate policy dealing with the rights of children infected and or affected by HIV/AIDS must be developed. In addition we suggest that the outcome of the study on the mainstreaming human rights approach to children law in the country must be given legislative effect by amending the Children’s Act. This would go a long way in addressing human rights issues of HIV/AIDS in relation to children such as the right to information. We have already noted that most key informants are very ambivalent in terms of the right to sexual and or reproductive information as regards children.

1.2.8 Gays and Lesbians

Amongst the marginalized groups in Botswana are gays and lesbians. As it would appear from discussion of HIV/AIDS and Criminal Law, in Botswana same sex relationships have been held to be ‘against the order of nature’ and, therefore, a criminal offence. This does not only raise the question of discrimination in general, but also issues of enjoyment of other rights such as the right to health by gays and lesbians. Once their conduct is criminalized, it would be difficult to convince them to avail themselves to public health services and facilities. International human rights law accordingly prohibits the criminalization of consensual sexual relationship between adults, directly and or indirectly.

National Documents

The constitution of Botswana does not have an express provision on sexual orientation. It is, however, our argument that the non-discrimination provisions of the Constitution serves to prohibit discrimination on the basis of sexual orientation. However, the High Court has upheld the constitutionality of legislation outlawing same sex relationships. We discuss this issue in detail under the specific discussion on HIV/AIDS and Criminal Law in chapter 4. No policy document addresses this issue.
Regional Documents

Both the SADC Treaty and African Charter on Human Rights do not have express provisions on sexual orientation. However, it is our view that the guarantee against non-discrimination in both documents serve to protect gays and lesbians against discrimination.

International Documents

As noted under the general discussion of the right to non-discrimination, the Human Rights Committee, the body charged with monitoring compliance with the ICCPR interprets article 26 to prohibit discrimination based on sexual orientation. It determined in a 1994 case that Australia’s legislation banning sexual contact between consenting adult men was a violation of Australia’s obligations as a party to the ICCPR.

The U.N. Guidelines on HIV/AIDS call on state to ‘ensure the implementation of specially designed and targeted HIV prevention and care programmes for those who have less access to mainstream programmes, including men who have sex with men.

As we argue in detail in chapter 4, we strongly recommend that the laws that seek to classify same sex relationships as being against the order of nature and therefore illegal be repealed. At a policy we are of the view that targeted preventative and educational programmes for sex workers, men having sex with men be introduced along as part of the efforts to discourage discrimination against the marginalized groups and as a way of preventing the spread of the pandemic.
1.2.9 Fundamental Issues
The issues we discuss hereunder are issues of general application across all the specific sectors we deal with in the study. These are the issues that must be tackled if Botswana is to effectively mainstream human rights into its approach to dealing with HIV/AIDS.

1.2.10 Interaction between Human Rights and Public Health Objectives- Conflict or Co-existence?
The question posed here is crucial and needs to be answered in clear terms. Effective cooperation of human rights and public health practitioners and activists, in the fight against HIV/AIDS pandemic is very much dependent upon the answer to this question.

There are two schools of thought on the efficacy of mainstreaming human rights in the fight against HIV/AIDS. One school of thought holds that human rights based approaches to HIV prevention and control is self-defeating in that it reduces the role of public health. It is posited that public health on its own offers a more applied, practical and effective framework. The respect for human rights, it is argued, is more often than not inconsistent with public health objective of disease prevention and control.

The other school of thought holds that public health strategies and human rights protections are mutual reinforcing. It argues that safeguarding of human rights is an essential part of responding effectively to HIV/AIDS pandemic at individual, national and global level. HIV/AIDS strikes hardest where individual rights are not protected.

Admittedly, as the South African Commission on Aspects of the Law Relating to HIV/AIDS noted, the role of law in the field of HIV/AIDS is undoubtedly complex. In its approach to HIV/AIDS, the law has to protect two conflicting interests: It must recognize the right of the public to be protected against disease. It must also recognize the right of the individual not to be unfairly restricted because he or she is infected or perceived to be infected with HIV. Consequently, the law must make some compromise, which while protecting the public health of the community, also protects the individual so that the individual will feel free to come forward for available treatment.
compromise reached? The answer, we suggest, lies in accepting that the goal should be to link health and human rights to contribute to advancing human well being beyond what could be achieved through an isolated health-or human rights-based approaches.

In attempting to mainstream human rights into HIV/AIDS prevention and control, attention must be paid to the fact that public health and human rights have traditionally rarely been linked in an explicit manner. In seeking to fulfil its core functions and responsibilities (collection of data on important health problems in a population, developing policies to prevent and control priority health problems, and assuring services capable of realising policy goals) public health may unavoidably impact upon human rights. In the past, restrictions on human rights were often simply justified on the basis that they were necessary to protect public health. Indeed, public health has a long tradition, anchored in the history of infectious disease control, of limiting the "rights of the few" for the "good of the many.". Thus public health approaches in combating diseases have historically been based upon erecting barriers between the healthy and the infected. This has resulted in coercive measures being used against individuals in an effort to limit the impact of an epidemic. Thus clear reasons have to be advanced for the view that human rights and public health objectives are consistent with each other.

It is our view that the mainstreaming of human rights into approaches to HIV/IDS prevention and control is necessary on account of one or all the following;

- Health policies and programmes will be more effective when they incorporate human rights perspectives and objectives. A human rights-based prevention approach takes into cognisance the societal vulnerability to HIV/AIDS. It identifies, highlights and contextualises vulnerability in different forms providing a framework for addressing HIV/AIDS in a comprehensive manner. For example, failure to deal with stigma and discrimination may fuel the impact of the epidemic on those who are living with HIV/AIDS or people who are more vulnerable to infection when their economic, societal or cultural rights are not respected.
- Where civil and political rights are not respected, civil society finds it difficult or impossible to respond effectively to the epidemic.
Vulnerability to HIV is reduced to the extent that when human rights (including the right to non-discrimination) of PLWHA are respected, society will freely take advantage of preventive and treatment services.

Health based information can add a powerful dimension to larger discussions about the need to improve respect for human rights in general which in itself is in society’s interest.

Health based information can also be used to enhance the realisation of other human rights such as the right to health.

Discrimination on the basis of HIV status can lead to general discrimination in society in other areas unrelated to HIV/AIDS. In any case, studies undertaken indicate that HIV prevention and care programmes that were based on coercive measures resulted in reduced public participation and an increased alienation of those at risk of infection.

Since most HIV infections are spread through voluntary activities, both infected and uninfected individuals are themselves in the best position to slow the spread of the disease. If confidentiality, informed consent and non-discrimination are not guaranteed, individuals will not come forward for early counselling, testing and treatment. Instead they will remain outside of the public health services thus posing a greater risk to the community at large.

Finally, it has been said that the best approach to convince people to change their behaviour requires cooperation - not coercion.

Human Rights approach achievements
If any empirical evidence for the need to integrate respect for human rights into approaches for the prevention and control of HIV/AIDS so far is needed, UNAIDS has summarised such achievements thus:

Enhancing of public outcomes: Protecting a person’s right, particularly a PLWHA- to achieve the highest attainable standard of physical and mental health has brought about increased confidence in health systems. In return, this has led more people to seek and receive relevant information on HIV prevention, counselling and care.
• Ensuring a participatory process linking patients and care providers, has improved the relevance and acceptability of public health strategies.

• Fostering non-discriminatory programmes that include marginalized groups more vulnerable to HIV infection.

• Scaling up the AIDS response through empowering people to claim their rights to gain access to HIV prevention and care services. A number of countries including Botswana, Brazil, Mexico and Panama, have entrenched this by providing free access to treatment and other related health services for many people living with HIV.

• Enhancing the capacity of states through people seeking redress for the negative consequences of health policies. Legal action based on human rights has been a vehicle to enforce people's right to gain access to health care, including antiretroviral treatment. For example in South Africa, Treatment Action Campaign won a court case that required Government to supply the antiretroviral drug, Nevirapine to HIV-positive pregnant women in public facilities, within a phased roll-out of a comprehensive national programme to prevent mother-to-child HIV transmission.

It also seems to us that those who oppose the human rights approach to HIV/AIDS prevention and control on the ground that such an approach may unduly restrain public health strategies in dealing with the pandemic forget that human rights, including those applicable in relation to HIV/AIDS are not absolute. According to Mann & Tarantola (1996) public health is recognized as one of the legitimate grounds for restricting human rights only if they are provided for and carried out “(I) in accordance with the law; (ii) in the interest of a legitimate objective of the general interest; (iii) strictly in a democratic society to achieve such a goal; (iv) imposed without a less intrusively means being available to reach the same goal; (v) not imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner”. (328).
Accordingly, only those public health measures which are just focusing on curbing the spread of the scourge but not recognizing the abovementioned criteria would be regarded as violating human rights.

1.2.11 Are human Rights Applicable to Private entities and/or Individuals

Historically fundamental human rights were founded on the need to protect individuals from state tyranny. That is, the duty to ensure the observance of the fundamental human rights was understood to be on the state and its organs. Accordingly the relationship between individuals including between natural and corporate entities was considered a contractual matter. Thus the so-called public-private divide played a major role in the understanding of the scope of human rights.

With the passage of time, it became clear that private entities and individuals were also implicated in human rights issues. Some regional (within the European Union, for example) and international instruments started putting obligations that sought to protect individual human rights from whatever the source of infringement. We have already noted the views of the Human Rights Committee on obligations incurred by state parties under article 17 of ICCPR guaranteeing the right to privacy. It explained that State parties are under a duty themselves, not to engage in interferences inconsistent with article 17 and to provide for legislative framework prohibiting such acts by natural or legal persons. Thus increasingly, at international level, there is recognition that the promotion and protection of human rights cannot only be effectively secured by the states' non-interference with human rights. It also needs positive action on the part of the state to ensure that all persons, legal and or natural, respect same. Accordingly there now exists in a number of countries including Europe and Africa (for example South Africa) countries with human rights statutes binding on the state as well as private entities).

New approaches to human rights recognises that in the current world dominated by private multinational corporations, some of which are more economically powerful than the state, it is necessary to bridge the public-private divide when it comes to the protection of human rights. In the case of HIV/AIDS, it is critical to apply the obligations
to respect individual rights on individuals since the pervasive discrimination and stigma that PLWHA are subjected to is usually at the instance of private parties.

In Botswana the Industrial Court has adopted the view that the Bill of Rights applies to private individuals as it does to public bodies. This, the Court reasoning is line with the accepted rule of constitutional interpretation that provides for a liberal and purposive interpretation.

Our view is that an attempt should be made to ensure that in general all sectors operate in accordance with constitutional guarantees of fundamental human rights and whatever human rights based legislation on HIV/AIDS we may recommend, should be applicable to public and private entities.

1.2.12 The Binding Effect of International Human Rights Instruments

One of the issues of general application relates to the status of international legal instruments’ effect on Botswana. Botswana has not ratified all the treaties and conventions discussed herein. The fundamental issue is what conditions precedent is necessary for an international treaty to be binding on Botswana. The general principles distilled from the decisions of Botswana Courts are as follows:

- Treaties concluded and ratified by Botswana are binding on her at an international plane.\(^6\)

- International treaties concluded and or ratified by Botswana do not create rights and obligation enforceable by domestic courts unless incorporated into national law by legislation. That is, in general individuals can only rely on a treaty for a remedy if such a treaty has been incorporated into Botswana law through national legislation.

- Botswana’s courts in the interpretation of domestic legislation shall do so in a way that to the extent possible is consistent with the country’s

\(^6\) Nsereko, p.43
international treaty obligations even where the country has not incorporated the concerned treaty into national law.\textsuperscript{7}

We have already discussed under specific rights, a number of international resolutions, recommendations, guidelines and codes of practice. What is the legal status of these instruments? While these instruments on their own may not be binding in the legal sense, they provide a critical tool for the understanding of the content and scope of specific rights. In some cases, the international recommendations and or resolutions are a restatement of customary international law norms. Throughout this project, we consider the resolutions, recommendations, codes of practice and guidelines as a guide to understanding of the content and scope of particular rights rather as binding instruments unless otherwise stated.

1.2.13 The Relationship between customary law and Human Rights

Introduction

Any law reform project in Botswana must take account of the fact that Botswana is a dual legal system (the common law exists side by side with customary law). In practice, the majority of Batswana are subject to customary law. Customary law courts administer about 80\% of cases in the country excluding those resolved by mechanisms not formally recognised under the Customary Courts Act.\textsuperscript{8}

While customary law is said to reflect customs, culture and the way of life of particular tribes, it is also true that it may contain and or tolerate practices, which are antithetical to human rights including the rights of PLWHA. These include such practices as domination of women by men, inheritance principles that favour male children etc.

In general, it is accepted that both codified forms of law and unwritten customs or customary laws can play an important role in curbing or exacerbating the AIDS epidemic. Certain customary practices and beliefs can contribute to the spread of HIV/AIDS. These include customs and cultural institutions like polygamy, customs aimed at procreation, ritual circumcision and skin-piercing procedures, and culturally

\textsuperscript{7} Attorney-General vs Unity Dow
related attitudes and beliefs in which patriarchy plays a dominant role. Numerous customary laws and practices make women particularly vulnerable to human rights violations and therefore also to HIV infection. These include:

- Non-recognition of marital rape;
- Tribal courts treating adultery as a female crime only and/or assigning greater penalties to the woman for adultery; and
- Mandatory wife inheritance by a brother if the woman’s spouse dies.

The Position of Customary Law in Botswana

From a legal point of view, customary law is inferior and subject to other sources of law in the country. The definition of customary law includes only those “rules of law which by custom are applicable to any particular tribe or tribal community in Botswana”, but exclude those rules, which are inconsistent with provision of any enactment. Similarly customary rules that are “contrary to morality, humanity and natural justice are excluded from qualifying as customary law. The Chieftainship Act for its part provides that customary law must not be “injurious to the welfare of members or repugnant to the constitution and or any other enactment.” The general presumption in Botswana as regards the applicable law is that the common law is applicable unless the relevant personal law, agreement, or intention suggests the application of customary law.

The above means, in relations to a rights based approach to HIV/AIDS pandemic that:

- Any customary rule that infringes or is repugnant to any of the constitutionally protected human rights of PLWHA would be invalid to the extent of the inconsistency.
- Any customary law rule, which is inconsistent with any written law, would be invalid to the extent of the inconsistency.
One can opt out of the common law by operation of personal law, agreement and conduct. This is the most problematic area in that it can easily be used to escape the obligations relating to the protection of the rights of PLWHA. Personal law include law of inheritance, marriage etc. Thus personal law in our view is very critical to ensuring the rights of PLWHA.

It would appear that in order to accord the majority of Batswana, the benefits of a rights based approach to HIV/AIDS, law reform must be accompanied by information and education to members of the public in terms of legal options available to them. Consideration should be given to ensuring that possibilities of escaping from statutory provisions and the common law in personal matters such as inheritance are limited. Personal law can be a source of inequality, which may aid the spread of HIV infection. We have noted the general rejection by most informants of any attempt to change by law, customary, cultural and traditional practices deemed to be aiding the spread of HIV/AIDS. We believe that the current legislative provision that subjects customary law to the constitutional, statutory and common law would sufficiently address most of the concerns if public education on the legal options available to citizens is given due consideration.

1.2.14 The duty to accommodate
This is an obligation on those dealing with the weak, those who are different and in the context of this project, the infected, to take practical measures to accommodate the special needs of the concerned weak, different and or infected/affected. The duty to accommodate is a critical element of human right law. It is based on the understanding that in every society there are either weak people and or those who are different from the mainstream whose rights also needs to be respected by taking reasonable measures.

The purpose of accommodation can be said to prevent the dictatorship of the majority. It would mean, for example, in the context of an HIV infected employee, that the employer should, before terminating the employee on the ground of ill-health, try to find alternative measures to ensure continued employment either by redeployment of the
concerned employee or reducing his/her working hours to take account of his/her peculiar situation.

Section 15(4) of the Constitution of Botswana, in our view, leaves room for parliament to enact laws that would authorise differential treatment as part of accommodating a certain class of persons. It, inter alia, provides that the prohibition of discrimination shall not apply in cases where persons mentioned in sub (3) [defining discrimination] ‘may be accorded any privilege or advantage, which having regard to its nature and to special circumstances pertaining to those persons or persons of any other such description, is reasonably justifiable in a democratic society.’

There is currently no legislation that creates a general duty to accommodate. As it shall emerge in the next chapter, the Industrial Court has incorporated the principle of the duty to accommodate into Botswana’s labour law through its decisions. We have taken the view in the discussions of sectoral areas that the duty to accommodate should be given a statutory basis.

In the next chapters, we discuss in detail selected areas, chosen on the basis of the terms of reference and discussions with client in the context of a human rights approach.
Chapter Two: HIV/AIDS AND EMPLOYMENT

2.1 Introductions
The issue of HIV/AIDS and employment is one of the critical questions facing any human rights based approach. Every country’s economic prosperity or otherwise is, *inter alia*, determined by the way in which it regulates productive relations. In addition, employment relationships are often the basis for existence for a lot of people including PLWHA. In this regard, the U.N. Declaration of Commitment on HIV/AIDS identifies workplace as an area of special concern. Paragraph 69 of the chapter on alleviating social and economic impact commits heads of states and governments to:

> …Develop a national legal and policy framework that protects, in the workplace, the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking into account established international guidelines on HIV/AIDS in the workplace.

There is no law in the country with a specific provision on HIV/AIDS in the employment setting. However, the Constitution of Botswana, labour legislation and other pieces of legislation not specifically on employment contain provisions, which are relevant to the question of HIV/AIDS at the work place.

The absence of legislation has resulted in a lot of uncertainty in the law. Faced with the absence of legislation, the Industrial Court, which is a court of law and equity has had to rely on the Constitution, the common law, general provisions of the employment legislation and international guidelines to protect the rights of HIV/AIDS positive workers.

Our analysis, in this chapter addresses general key problem areas as regards HIV/AIDS and employment. These include the following:
Pre- and post – employment mandatory testing of workers.
Confidentiality and informed consent of workers
Protection of vulnerable groups at the workplace
Discrimination and victimisation of HIV infected workers
Lack of job security / employment protection of HIV infected workers
Care and support of HIV infected workers
Gender inequality
Prevention of HIV/AIDS at the workplace
Balancing workers’ rights and businesses imperatives

Other than the above purely human rights concerns, HIV/AIDS is a critical issue of concern in the area of employment for many different reasons. These include the following:

- Low productivity on account of increased absenteeism due to HIV related illness and death;
- Loss of valuable skills as more workers leave their jobs due to ill health
- Low productivity resulting in low profitability

Worsening of inequalities, such as gender inequality in society. The poor suffers disproportionately, especially women who end up having to carry the burden of work as well as caring for the terminally ill, the aged and the orphaned children.

All the above could directly undermine the fundamental rights of workers. This possibility bolsters the case for a human rights approach in dealing with HIV/AIDS at the workplace. As the deepening of economic integration and interdependency of economies of the world increases, countries tend to compete for foreign direct investment through policy reform in line with the perceived needs of capital. Consequently, the likelihood of labour policy and labour law being deployed to increase countries’ competitiveness for attracting FDI by lowering down of protective labour standards becomes real. Accordingly, democracies such as Botswana should in coming up with a human rights approach to the HIV/AIDS scourge include employment setting as an integral element of that approach.
In addressing the issue of HIV/AIDS at the workplace, we took account of the fact that discrimination, victimisation and other violations that HIV/AIDS infected and affected workers suffer, is not only perpetuated by employers. In some cases, fellow employees and workers’ organisations can put pressure on employers to dismiss workers suspected to be living with HIV/AIDS on the believe that such infected workers pose risk to others.

2.2 HIV Testing

In discussing legal reform on the subject of HIV/AIDS in employment setting in generally, and testing in particular, it is important to take into account fears and or perceived fears of employers and employees. Only when one understands this can one come up with a balanced reform agenda.

Employers generally advance three reasons to justify workplace testing, viz; (a) workplace testing is necessary for the protection of existing employees from infection, (b) HIV/AIDS infected workers generally contribute to low productivity in the workplace since HIV/AIDS affect performance and (c) workplace testing is necessary to protect employment benefits schemes such as pension funds, medical aid, training etc.

The above concerns while understandable are not backed by sufficient evidence. Medical and scientific evidence suggest that the risk of workplace transmission is very small even for health workers. The South African Appellate Division of the Supreme Court found, for example, that “not a single case of occupationally transmitted HIV has been confirmed in South Africa.” Similarly that country’s Medical and Dental Council 1993 guidelines took the view that pre-clinical testing in an attempt to protect health workers from HIV is misguided and unethical. This is not to say that there is no risk for health workers in certain sectors. We are only suggesting, as the South African Court in the abovementioned case did, that workers whose work is such that it creates necessary conditions for transmission of HIV infection could be empowered to take necessary preventative measures.
The perceived negative effect of HIV infected workers on productivity also ignores medical and scientific advances made in managing the epidemic generally. With the advance of antiretroviral drugs (ARVs) and other improved health practices capacity for productive employment after infection should not be a major problem.

There is no doubt that HIV/AIDS has the potential to cause a massive negative impact in the economy in general. There is, however, no evidence that employment testing will reduce the economic impact and or the rate of infection of workers. One possible way out of this potential dilemma is to come up with arrangements under which cost sharing by Government, employers and workers is adopted as away to protect the sustainability of benefits such as pension funds and medical aid schemes.

### 2.2.1 Pre-Employment Testing

Pre-employment testing is common in Botswana. The Botswana Government, for example, makes a distinction between citizens and non-citizens. Citizens are not required to undergo HIV test as a condition for employment in the public service. Non-citizens are, however, required to undergo HIV test as a condition for employment. Foreigners who are already in employment are required to take HIV-testing as a condition for contract renewal. Those foreigners and or expatriates who are found to be HIV positive are not employed and or do not have their contract renewed.

In the private sector (including parastatals and other statutory organisations) pre- and post employment testing, where it is being required is independent of nationality of applicants for jobs. Some employers require HIV testing as a pre-condition for future training. This includes one of the major employers, Debswana. During our interviews with key informants we found out that employers generally consider future training as an investment. They accordingly consider HIV/AIDS positive workers as a high-risk investment.

Pre-employment testing is not prohibited by legislation. In fact, section 46 of the Employment Act, provides for pre-employment medical examination for every person who enters into a contract of employment under which such person will be required to
work outside Botswana and those entering into contracts of employment specified by the Minister as requiring pre-employment medical examination.

From a legal point of view, the question of pre-employment testing is complicated by the fact that the law does not generally regulate access to employment. That is, employers retain the common law right to decide whom to hire. Strange as it may seem, the House of Lords’ statement in Allen v Flood to the effect that “an employer may refuse to employ [an individual] for the most mistaken, capricious, malicious or morally reprehensible motives that can be conceived, but that individual has no right of application against him” is generally applicable particularly in relation to private sector employers in the country. The Court of Appeal has expressly endorsed this view in stating that in the absence of legislation, employers have the right to make their decisions regarding recruitment and requirements for same.

The absence of legal regulation of recruitment also means that the law does not concern itself with the type and content of recruitment instruments. This is a serious lacuna given that recruitment instruments such as recruitment forms and questions as regards lifestyle and HIV/AIDS status during interviews can be used to find the status of an individual and thus potentially be a basis for the denial of employment.

At a policy level, The Botswana National Policy on HIV/AIDS, inter alia, provides that pre-employment HIV testing is unnecessary and should be discouraged. We have already noted that the Policy has no legal basis and therefore can only have a moral and not legal authority.

2.2.2 Post-Employment Testing
Post employment testing is also not subject to detailed regulation. There is no provision in the Employment Act that expressly or impliedly deal with post employment testing. Thus post-employment testing is left mostly to the common law and contractual arrangement between employers and employees. That is, a unilateral demand by the employer for the employee to undergo post-employment HIV test amount to a breach of contract.
In practice, post-employment testing is usually carried out where an employee's work is such that he/she is required to undergo annual or periodic medical check up. This usually arises either from the terms of the contract and or from the requirement of some specific legislation. The most common example is employees in sectors subject to the Public Health Act such as those working in food outlets. The Public Health Act requires such employees to undergo annual medical examinations as a condition for them to continue working as food handlers. It does not also say what should happen in the event the employee is found to be unwell.

Some employers (for example Debswana) require HIV testing as a pre-condition for future training. This is post-employment in the sense that the person would be an employee when considered for future training. We have already noted that some employers consider future training as an investment and accordingly consider HIV/AIDS positive workers as a high-risk investment. It could also be that some employers need to know the status of employees they are sending for long term training as to be able to take necessary precautions for the sake of the employee such as making arrangements to ensure that they are accompanied by their families and or to send them to nearby places or countries with appropriate facilities. As earlier pointed out, unless there is a clear contractual provision requiring an employee to undergo post-employment testing, a unilateral requirement to undergo post employment HIV-testing would amount to a breach of contract.

The majority of informants, including non-governmental and Governmental organisations working in the area of HIV/AIDS and PLWHAs are opposed to pre-employment HIV testing, but feel that there should be no general ban on pre-employment HIV-testing. The informants in general suggested that whether pre-employment testing is allowed or not should depend on a number of factors including the type of work, the purpose of testing etc.

The feeling is that testing is one of the most effective way of tackling stigmatisation and discrimination and should, therefore, be encouraged rather than discouraged. The
compromise view seemed to be that employers must be discouraged from forcing potential employees to disclose the result of the pre-employment testing. That is, from the point of view of most key informants, which position we align ourselves with; the law’s concern should be to;

(a) encourage testing both as a way of ensuring early disease management and interventions and or treatment of the disease and tackling stigmatisation

(b) less regulation on whether employers require pre-employment testing or not,

(c) Where pre-employment testing is carried out, then the outcome of the test should not on its own be used to deny applicants employment and

(d) applicants should be given the choice, of disclosing their HIV-status to potential employers where they were required to undergo pre-employment testing.

(e) Where employers require pre-employment HIV-testing, and a potential employee do test and disclose his/her HIV-positive status to the employer, than the employer should be under a legal obligation to accommodate such an applicant.

Our review is that:

There should be statutory intervention (by amending the Employment Act for example) so as to prohibit HIV testing for pre-employment purposes subject to permissible exceptions. Such an intervention should be intended to:

- create certainty and clarity on the legality or otherwise of HIV testing as a specific form of discrimination in the employment relationship.
prohibit testing where it constitutes unfair discrimination

protect job applicants and existing employees in order to enable the fair allocation of employee benefits.

Give the responsibility of determining whether employment HIV testing is permissible in given job categories to an independent third party (e.g. the Commissioner of Labour and or the Industrial Court) with clearly defined factors to take into account, so as to ensure that the concerns of employers are as well addressed.

Ensure that the prohibition on HIV testing in the workplace is not absolute but allow for exceptions to testing where testing is allowed under legislation and in certain circumstances where it is deemed to be fair and justifiable provided prior set conditions are met.

The burden to show that HIV testing under specific circumstances is fair and therefore justifiable and necessary should rest upon the employer.

2.3 Discrimination against HIV affected and/ or infected Workers

Once in employment, there are other fundamental human rights issues that arise in addition to issues of testing. Possible discriminatory practices abound in the workplace. These include, but are not limited to, denial of promotion, exclusion from some benefits that are meant for all employees on the basis of HIV status. How is this situation dealt with in the employment context in Botswana?

There is no law in the country with a specific provision on discrimination on the basis of HIV/AIDS status. However, there are provisions in employment related legislation that create conditions that may facilitate discrimination on the basis of one’s health status. Notwithstanding the absence of anti-discrimination legislation, there appears to be some clarity in the policy front. The National HIV/AIDS Policy has elaborate provisions
intended to protect workers from discrimination on the basis of their HIV/Status including discrimination perpetuated by other employees.

One serious lacuna in the law is the issue of discrimination, including stigmatisation and victimization, visited on HIV/AIDS infected workers by fellow employees and workers’ organisations. It is critical that the law specifically addresses this issue and provide appropriate remedies. Where discrimination is at the instance of workers’ organisation, the remedy could be sought against the employer for allowing or creating conditions conducive to discriminatory practices. However, in the event of individual workers discriminating against another employee on the basis of his/her HIV status, then the action could be against the guilty employee alone and or jointly with the employer.

2.4 Confidentiality and informed consent of workers

We have given general definition of confidentiality in chapter 3 of this study. The law is implicated at a number of stages in respect of collection, storage and dissemination of HIV/AIDS-related personal information. There is no legislation that expressly deals with confidentiality of information relating to health status of workers.

Some Acts, such as the Public Service Act, which we review in detail below, have provisions bearing on non-disclosure of information obtained in the course of employment generally. In particular, the Act prohibits disclosure of and publication of information obtained in the course of employment, thus protecting confidentiality and the right to privacy. This Act is, however, limited by the fact that it protects only those employees who are covered by that Act. That is, the Civil Service employees.

At a policy level, the National Policy on HIV/AIDS provides that workers have no obligation to disclose their HIV status to their employers. It also creates a duty of confidentiality on those who have information about the HIV status of others including employers.
2.5 Termination of Employment on account of HIV Status

As in other areas of employment, there is no specific provision in any statute that deals with dismissal from employment on the basis of one’s HIV status. There are, however, provisions dealings with termination of employment generally and retirement on conditions of health. These are mainly contained in the Public Service Act and the Workers’ Compensation Act. Some of the statutes, as we show below in the specific analysis of legislation, permit ‘termination’ and or retirement’ on the basis of ill health. That is, once the conditions precedent for dismissal on the grounds of ill-health generally is satisfied, then an employee suffering from poor health including, those infected by HIV/AIDS may be lawfully terminated.

While there is no specific provision regulating employee dismissal on the basis of HIV status, the Industrial Court has held that dismissal of an employee on the basis of HIV status alone, that is, with no evidence that the HIV status affects the employee’s ability to perform his duties, amounts to unfair dismissal. That is, dismissal on account of HIV/Status, where such dismissal is contrary to the provisions of the law and common law, could entitle the dismissed worker to remedies for unfair dismissal.

As we discussed in chapter 1, the duty to accommodate is one critical element of protection of the rights of the vulnerable such as PLWHAs. In this regard, we note that there is no express obligation on the part of employers to make necessary provisions for accommodating their workers infected by HIV/AIDS. Such a provision would clearly spell out employer obligations such as the duty to transfer such employees to departments under which they can be productive notwithstanding their poor health status. While this may seem to be an onerous obligation on employers, the reality is that with the advances in medical field, HIV/AIDS infected are generally healthy enough to lead productive life. In any case, .

Our view is that a general approach creating a duty to accommodate in dealing with ill employees (including those infected and or affected by HIV/AIDS) should be adopted.
2.6 Care and support of HIV infected workers, Prevention of HIV/AIDS at the workplace and Vulnerable Groups

If one takes the view, as we do, that the right to health is a human right, then there must be obligations on someone to ensure the satisfaction of that right. In the context of the workplace, this means that in general there must be an obligation on the employers (be they private and or public) to ensure that the human rights of workers leaving with HIV/AIDS are respected.

In the current regulatory framework, there is no express provision in the law that provides for an obligation on any body to take care of and provide support to HIV infected workers. However, a review of employment legislation shows that there is a general legal obligation on employers to ensure safety of their workers. In particular, employers are required to ensure at all times the ‘care and welfare’ of workers. The Commissioner of Labour is given a statutory obligation to ensure that safe working conditions are adhered to. An analysis of the Employment Act and the Workers Compensation Act in particular shows that employers are under an obligation to create safe working conditions. These provisions as we illustrate below, in our view would require employers to take positive steps in the campaign for the prevention of HIV/AIDS.

The provisions of the law in relation to safe working environment, in our view, places a positive obligation on employers to ensure that discrimination and victimisation of workers living with HIV/AIDS do not take place at the workplace. This means that employers are by law required to ensure protection of vulnerable groups such as women and children. In respect to women, the duty to ensure safe working environment would cover the duty to prevent sexual harassment and remove environment conducive to sexual related offices such as rape. As regards children, the employer is under an obligation to ensure compliance with law regulating the employment of children.10 In some specific instances employers are required to ensure that sick workers have access to medical attention.

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10 Employment Act
The National HIV/AIDS Policy also places an express obligation on employers to ensure that infected workers are not discriminated against and or subjected to stigmatisation by colleagues, supervisors and the trade unions. As part of this obligation, the Policy provides, *inter alia*, that workers are entitled to receive information and educational programmes on HIV/AIDS at the workplace.

Even if our view that the current regulatory framework provides a legal basis for the duty to provide care to HIV infected workers is erroneous, it is our argument that the common law provides an obligation on employers to take care of workers within their premises. This would ensure an obligation to protect workers from harassment and discrimination on the basis of their health status.

*Notwithstanding our view that the current framework and the common law can protect the rights of HIV/AIDS infected workers, we suggest that a statutory approach be taken for clarity. The common law leaves a lot of discretion to court. The remedies under the common are also limited by the requirement to prove damages. This, may be difficult in some cases involving alleged failure to exercise the appropriate duty of care on the part of employers. We accordingly would suggest a statutory obligation, perhaps as part of health and safety at work, on employers to ensure that HIV/AIDS infected and or affected workers are not discriminated against and or victimised. As a policy, employers should be encouraged to join the war against the epidemic by providing necessary sexual reproduction health information.*

### 2.7 An Overview of Employment-Related Documents

**Domestic Documents**

*The Constitution of Botswana:*

We have already noted that the Constitution of Botswana does not have an express provision banning discrimination on the basis of HIV/AIDS and or health status. We discussed in detail the issue of binding effect of the Constitution on private entities in chapter 1. *We recommend the amendment of the constitution to insert a provision prohibiting discrimination on the basis of health; and a general anti-discrimination legislation outlawing discrimination on the basis of health status.*
Employment Act

Scope

The Employment Act is Botswana’s main employment law regulating conditions of service for workers employed outside the public service. As already pointed out, the Act has no provisions specifically dealing with any aspects of HIV/AIDS. However, there are some provisions, which are relevant to certain aspects of the handling of HIV/AIDS issues at the workplace.

HIV Testing for Employment Purposes

The Act, in particular section 46, provides for pre-employment medical examination for every person who is employed in relation to contracts of employment falling under Part IV. Part IV deals with special contracts in respect of recruitment. Recruitment contracts for purposes of the Act fall under two categories being those in relation to work outside Botswana and those prescribed by the Minister.

The fundamental problem, with section 46, from a human rights perspective is that it is too general. It does not, for example provide, the purpose of pre-employment medical examination or even the medical conditions to be examined for. Thus, this provision can be used by employers to carry out pre-employment HIV testing as part of pre-medical examination.

Section 32 of the Act, dealing with the duty of employers to repatriate employees, entitles the employer to refuse to employ a person solely on the basis of the outcome of the medical examination carried out under section 46. Consequently, the Act does not exclude pre-employment testing for HIV.

Our view is that the Employment Act should be amended to state that pre-employment medical examination should be general, intended only to ascertain the person’s ability to perform the work he/she is being considered for. The proposed amendment should expressly provide that such a general medical examination should
exclude HIV-testing, unless the concerned job applicant opts to undergo HIV testing as part of the general pre-employment medical examination.

Post-employment testing: The Act does not have any provision for post and periodic medical examination. These are dealt with by specific legislation such as the Public Health Act.

Discrimination Against HIV/AIDS Infected Workers.
We have already pointed out that there is no express provision in the Employment Act prohibiting discrimination at the workplace on the basis of HIV and or health status. We also noted, in the preceding section, that section 46 of the Employment Act has the potential to encourage and facilitate discrimination against HIV/AIDS infected job seekers.

Care and support of HIV infected workers, Prevention of HIV/AIDS at the workplace and Vulnerable Groups
While there is no express provision dealing with the duty to provide support to HIV infected workers on the part of the employer, the Act has provisions that provide a general duty of care. These provisions can be invoked in certain limited cases to protect the human rights of workers infected with HIV/AIDS.

Part XIV of the Act dealing with Labour Health Areas has detailed provisions requiring the employer to provide medical facilities to employees working in areas declared to be labour areas by the Minister. Employers are required, at their own expense, to provide medicine and medical treatment to workers and their families residing and working in a labour health area. It is arguable that these would cover HIV infected workers and their families. However, the Employment (Labour Health Areas) Regulations exempt the employer from the obligation to provide medicine and medical facilities for contagious and venereal diseases. It is impossible to find the rationale for this provision. Suffice is too say that this provision sits uneasily with anti-discrimination provisions of the Constitution of Botswana. It is nevertheless clear that these
Regulations would exempt the employer from an obligation to provide drugs to HIV infected workers in labour health areas.

In terms of section 35, an employer is under a positive duty to provide reasonable medical facilities to workers and their family members who the employer has agreed may accompany them (workers), where such workers are required to work in areas in Botswana where medical facilities are not readily available. We believe that an HIV/AIDS infected worker, where such worker is required to work in specified areas, should be entitled to demand to be provided with ARVs under this section, since ARVs would, in our view qualify as reasonable medical facilities for a person living with HIV/AIDS. However, it could be argued that the test of what is reasonable medical facility should be an objective one and not judged in the context of HIV infected worker or his/her family members. If this logic is followed, then it may be difficult to say provision of HIV mitigation drugs is reasonable.

Section 35 can also be a basis for compromising human rights of HIV infected worker and his/her family. It requires in particular that family members may accompany the worker only with the permission of the employer. Employers, may, in order to avoid providing medical facilities, refuse permission for family members to accompany the worker where some members of the family are infected. There is no provision in the Employment Act dealing with protection of employees from being harassed and subjected to stigmatisation in the workplace.

Notwithstanding the limitations in the law discussed above, our preliminary research has shown that some employers are coming up with innovative ways of availing HIV mitigating drugs to their employees even where such workers are employed in areas where there are state provide medical facilities.

It is our considered opinion that there is a need to review the provisions of the Employment Act relating to provision of medical facilities by employers to address the human rights aspects of the HIV/AIDS epidemic.
Termination of Employment on account of HIV Status

The Act does not deal with termination of employment on the basis of ill health. The Workers Compensation Act deals this with.

One of the most important way to ensure respect for human rights, as discussed in chapter 1 is the duty to accommodate. Within the employment relationship, in particular, in relation to dismissal on poor health including HIV related illness, the Industrial Court has adopted an equity driven accommodation principle, which requires that before the employer dismisses an employee on the basis of ill health such an employer should have complied with the following:

- the employer is obliged to ascertain whether the employee is capable of performing the work for which he was employed;
- if the employee is unable to perform the work, the extent to which he is unable to perform his duties should be ascertained;
- the employer is thereafter obliged to ascertain whether the employee’s duties can be adapted;
- If the employee cannot be placed in his former position, the employer must ascertain whether alternative work, at a reduced salary if necessary can be found.

Only when the above conditions have been met, would the dismissal on the ground of poor/ill health be justified. The accommodation principle as articulated by the Industrial Court is based on equity rather than a rule of law.

In terms of the Employment Act, employment can lawfully be terminated on notice and or summarily. There are extensive provisions regulating the giving of notice. In generally once the statutory procedure for notice has been complied with, then employers retain the right to dismiss employees. However, if the giving of notice for dismissal is motivated by an extraneous conditions such as the HIV status of an employee, then such a dismissal may be found to be unfair notwithstanding compliance
with the statutory notice period. Summary dismissal is permitted where the employee is guilty of serious misconduct.

Section 26(2) provides circumstances under which the employee may terminate employment without notice. That is, constructive summary dismissal. These include where the employee is badly treated by his employer and or employer’s representative and the employee and or his/her dependants are threatened by violence and or disease such as the employee did not undertake to accept by virtue of his/her contract of employment. We submit that the first circumstance would entitle an employee who is subjected to discrimination and or victimisation by the employer to resign without notice and then claim damages for unfair dismissal.

In respect of the second scenario, that is, existence of threat of violence or disease, the provision could be invoked by other employees who are not HIV positive in the event the employer does not take necessary precautions to ensure that the workplace is such that it is not conducive to transmission of HIV/AIDS either through sexual abuse of other employees and or in any other way.

Remedies for breach are an important consideration. So what can an employee who has been unfairly dismissed on the basis of her/his HIV status claim? The issue is dealt with by the Trade Disputes Act, which provides for the remedy of reinstatement in exceptional circumstances or a maximum of six months pay. In our view, the remedies are very insufficient. A person dismissed from employment on account of her/his HIV status is unlikely to find another employment especially when the matter reached court. In view of the fact that the issue of HIV interrogates society’s commitment to fundamental human rights, it is critical that this is reflected by the penalties visited on those who violate the human rights of those infected or affected by HIV/AIDS.

Consideration should be given to incorporating the duty to accommodate as described herein in a statute to ensure consistency and general application of the principle. We also feel that a special remedy for discrimination motivated dismissal on the basis on ill health in general and or HIV status in particular, should be legislated for.
Workers’ Compensation Act

Scope of the Act

The Workers Compensation Act provides for the compensation of workers for injuries sustained in the course of employment and or death resulting from such injuries or occupational diseases. It has extensive provisions some of which are applicable to dealing with HIV/AIDS related issues. Workers who suffer from occupational accidents and or diseases are entitled to compensation in terms of the Act.

The Second Schedule of the Act provides a list of occupational diseases. The Schedule includes conditions relevant to the HIV/AIDS epidemic. It deals with such conditions as skin disease caused by physical, chemical or biological agents, infectious or parasitic diseases contracted in an occupation where there is a particular risk of contamination and all work involving health or laboratory work and any other work with a particular risk of contamination.

While the Act does not expressly provide for protection of workers who contract HIV/AIDS in the course of their employment, it is nevertheless clear that such workers would be entitled to compensation in terms of the Act (section 27). Employers are also under an obligation in terms of section 28 to defray medical expenses incurred by the worker in the treatment of occupational disease and or injury. We suggest that this section would cover expenses for ARVs where HIV virus was contracted in the course of employment.

The Act does not expressly deal with situations where a worker contracts HIV/AIDS due to that workers’ particular vulnerability. In particular, it does not deal with situations where an employee is exposed by the nature of his/her work to non-consensual sexual activity. Could this perhaps be covered by section 41? This section retains the common law right of workers to sue employers for damages for injury and or death due to the employers’ negligence. While this is welcome, it still leaves workers to uncertainties of the common law.
Part III of the Act provides for the administration of the Act. It requires that occupational accidents and diseases be reported to the Commissioner of Workers' Compensation. Failure to so report is a criminal offence. Workers on their part are obliged to submit to a medical examination by the practitioner offered by and at the instance of the employer. Compensation is then dependent upon the worker undergoing such medical examination.

While the requirement for medical examination is a reasonable measure to ensure that workers are only compensated for occupational accidents and diseases, it raises serious questions in relation to confidentiality and privacy of the worker who suffers an occupational injury and or disease. How can this be reconciled with the fundamental right of the individual to privacy, which include the right to refuse to be medically examined? Secondly there is no provision regulating the handling of the outcome of the medical examination. Who is entitled to receive such information? Can the employer insist on being given such information on the ground that he is paying for the examination? How can the worker be sure that the test is restricted to the occupational accident and or disease?

*It is our opinion that consideration should be given to addressing HIV/AIDS related infections at work expressly in the Act. This seems to us to be the best way to deal with a number of human rights issues such as the right to privacy and treatment issues.*

**Employment of Non-Citizens Act**

**Scope**

This Act provides for the regulation of the employment of and other engagement in occupation for reward or profit by non-citizens of Botswana. The Act prohibits non-citizens from engaging in employment in Botswana unless they either have a work permit and or an exemption certificate.

Applications for work permits (including variations, renewals etc) are considered by the relevant Regional Immigration Board under Section 8 of the Immigration Act. In making its determination the Board is entitled to call for and obtain such additional information.
as it thinks necessary and or expedient to have. This is a very wide discretionary power that would entitle the Board to seek information on the health (including HIV) status of the applicant. As already pointed out, in practice only Government has a formal requirement for pre-employment HIV testing for non-citizens. Other than the provision on work permits, there is no other provision with a bearing on HIV status of non-citizens seeking employment in Botswana.

Public Service Act

Scope
This Act regulates working conditions for public service workers excluding daily rated workers who are subject to the Employment Act. It gives the Permanent Secretary to the President, the power to make rules governing conditions of services in the public service.

Access to Employment
In so far as the appointment of persons into the Public Service is concerned, the Act does not list one’s health status in general or HIV status in particular as a requirement. That is, the Act is silent on the issue of pre-employment HIV testing. The practice of pre-employment HIV testing of non-citizens by Government has no basis in the Public Service Act. It is founded on a Government practice.

Termination
Section 16 of the Act provides for the retirement of public officers on medical grounds. In particular, if the Permanent Secretary is of the view that an officer is incapable of performing his/her duties on account of infirmity of mind and or body, such a Permanent Secretary may direct that the concerned officer be subjected to medical examination to ascertain his state of health. Public Officer may also request to be so examined.

The issue for purposes of this project is whether the medical examination referred to in the preceding paragraph could include HIV test, and if so what would happen were the officer to be found to be positive. If this could be so, it would put the right to privacy of
the employee at risk. It is however arguable in our view that given advances in medical science, the mere fact of being found to be HIV positive should not qualify to justify retirement from the public service on medical grounds.

**Consideration should be given to a statutory protection of the content of the medical report while addressing the concerns of the employer (productivity concerns). This could be achieved for instance by creating a very strict condition of need to know basis. This concept is already recognised by the National Policy on HIV/AIDS. We are also of the view that given the stigma attached to HIV infection, it is necessary to indicate that the medical examination should not include HIV testing unless the public servant so opts.**

**Confidentiality and Privacy**

Sections 21 and 38 of the Act address some aspects of confidentiality and privacy rights of public officers. Section 21 prohibits the use and publication of information acquired by virtue of employment for private use, while section 38 provides a penalty for such disclosure. These provisions would go a long way in protecting information on health (including HIV) status of public officers.

The fundamental weakness of section 21 is that it prohibits the disclosure of information in so far as such disclosure is for private use. Thus within the public service itself, a wide gate for abuse is left uncontrolled. **Our opinion is that consideration should be given to statutory protection of the health and HIV/AIDS related information of public service officers in line with general confidentiality rules.**

**Protection of Vulnerable Group**

A progressive provision in the Act introduced through an amendment in 2000 classifies sexual harassment as misconduct justifying dismissal from the Public Service. Sexual harassment in turn is rightly defined in wide terms to include any verbally or sexual advance, derogatory and or discriminatory sexual statement that causes the recipient discomfort, or humiliation and or creates a threatening or intimidating work environment. While this provision would also protect HIV positive workers from sexual harassment,
it falls far short of protecting them from discrimination based on their HIV status. There is also no similar provision in the Employment Act, thus private sector employees are not statutorily protected from sexual harassment in the workplace.

Unified Local Government Service Act
This Act provides for the creation of the Unified Local Government Service, which is the sole employer of certain local Government employees. It also does not have any express provision on HIV/AIDS. The only provision that impliedly relates to HIV/AIDS is section 16, which provides for the retirement of local government workers on medical grounds. The wording of this section is similar to the Public Service Act and accordingly it has the same shortcomings.

Trade Dispute Act
The Trade Dispute Act provides for the settlement of employment related disputes. It covers the creation of disputes settlement institutions and the procedures and processes of invoking those dispute settlement institutions.

One of the critical concerns in employment setting, as we have already pointed out, is the issue of confidentiality and privacy of workers infected with HIV/AIDS. In disputes settlement, the question is whether there are statutory provisions to ensure that a worker who is HIV positive and desires to use the settlement process can opt to have his health status not disclosed even in those cases where the basis of his case is that he/she was treated unfairly on the basis of his/her HIV status.

The Trade Dispute Act contemplates two-pronged process of dispute settlement, being mediation/arbitration (by the Commissioner of Labour and his appointees) and adjudication by the Industrial Court. The issue of confidentiality and privacy arises at each of the two stages.

In so far as mediation is concerned, section 8(8) provides that any statement made during mediation shall be confidential and without prejudice unless the party making the statement states otherwise. This provision is welcome. It, however does not deal
sufficiently with confidentiality issues. First, it does not state whether any of the parties can insist that the mediation hearings be in camera. Second, it gives the right of confidentiality to the person making the statement. From the point of view of complainant worker who does not want his/her HIV status made public, the critical issue is whether the mediator and or the employer would not disclose his/her status to third parties without his/her knowledge. Third, there is no penalty for breach of the aforesaid provision.

As regards hearings in the Industrial Court, section 22 allows the Court, on the application of any party to the proceedings, on good cause, to exclude members of the public from the proceedings and or part thereof. Thus it is arguable that HIV/AIDS infected workers could use this section to exclude members of the public from hearings where the case is based on the HIV status of the worker. It should be noted though that this section does not entitle the potential complainant to demand that the Court documentation relating to his HIV status be treated confidentially and perhaps be disclosed on a need to know basis within the Court’s staff.

Section 23 dealing with publication of evidence downplays the importance of section 22. It prohibits, the publication of any information and evidence disclosed during the course of the proceedings before court by any organisation representing employers or employees or any individual business whether carried out by an individual person, firm or a company. The objective of this section is certainly to protect commercial sensitive information. In so doing, it does not prohibit the disclosure of information disclosed by an employee.

Another provision relevant to this study is section 24 dealing with remedies for wrongful termination of employment. It empowers the Court to order that a wrongfully terminated worker be compensated. It can also under specified circumstances order compulsory reinstatement. Sub-section 2(a) in particular, provides that the Court could consider compulsory reinstatement as a remedy for wrongful dismissal where the termination was found to be unlawful, or motivated by trade union activity, trade union membership,
the lodging of a complaint or grievance, or religious, tribal or political affiliation. It is clear that this provision is intended to deal with dismissal motivated by discrimination.

We are of the opinion that the remedy for restatement should be available in cases of unlawful dismissal on the basis of one’s health/HIV status.

Section 38 of the Act dealing with the registration of Collective Labour Agreements empowers the Commissioner of Labour to withhold registration, where he/she is of the opinion that any term of the Collective Labour Agreement lodged with him is contrary to any provision of the Act or any other written law.

In the absence of a general anti-discrimination legislation and in view of the wording of section 24 discussed above, it would be advisable to consider empowering the Commissioner to withhold registration if, inter alia, the lodged agreement discriminates against some workers on the basis of their health/HIV status and or gender.

Trade Unions and Employers Organisations Act
This Act provides for regulation of trade unions and employers organisations including their registration, rights and obligations.

Prior to the Act’s amendment in 2004 (through Trade Unions and Employers’ Organisation (Amendment), 2004 [Act No. 16 of 2004], the Act had detailed provisions relating to the content of trade unions’ constitutions and rights and obligation of union members and officials. The amendments, which are mostly welcome, give trade unions greater autonomy in terms of how they are organised and run. While autonomy of trade unions is a welcome development, it should be kept in mind that trade unions’ operational rules, including their constitutions and contents of collective labour agreements, can perpetuate discriminatory practices such as gender inequalities and less favourable treatment of union members on the basis of HIV status.

We recommend that the law expressly prohibit potentially discriminatory practices that may be perpetrated by trade unions against their members and or by trade unions and
employers’ organisations by concluding collective labour agreements that are prejudicial to vulnerable workers either on the basis of gender and or health/HIV status.

Factories Act
This Act has been enacted to provide “for the regulation of the conditions of employment in factories and other places as regards the safety, health and welfare of persons employed therein and for the safety and inspection of certain plant and machinery” and related matters”. The Act is, therefore, relevant to the discussion of HIV/AIDS at the workplace.

Part VI dealing with welfare, and Part VII with health, safety and welfare are of particular relevance to this project. Part VI places an obligation on the employer to ensure that factory workers have access to adequate supply of water, washing facilities, accommodation for clothing and First Aid facilities. Part VII regulates handling of dust, taking of meals in dangerous place and obligates the employer to provide protective clothing for factory workers. Section 55 falling under Part VII empowers the Minister to make regulations, *inter alia*, prohibiting the employment of, or modifying or limiting the hours of employment for certain class of employees in connection with any manufacture, machinery, plant, equipment, appliance, process or description of a manual labour. *This provision while prima facie harmless, creates a potential for discriminatory practices in the sense that it does not give any guidance and circumstances under which the Minister may limit the employment of certain categories of people.*

Section 57 provides for the notification of industrial diseases. Such diseases are listed under the Sixth Schedule and as expected exclude HIV/AIDS. Once again it is not clear what information the reporting person must include in his/or report about the injured or dead worker. *That is, there is no guarantee of privacy and confidentiality in the manner in which the information about the employee is handled within the firm and Government officials.*

Botswana Defence Force Act

*Pre-employment Testing*
The Act does not authorize or provide for compulsory pre-employment HIV testing. However, recruits are subject to general medical examination that is undertaken by all new employees of the Government of the Republic of Botswana. There is of course a possibility, not just in relation to the army, but any other department of Government, that general medical examination may be used to test potential employees for HIV/AIDS without their consent.

Periodic HIV Testing – The Act does not expressly provide for periodic HIV testing for soldiers. However, the Regulations gives the Commander the power at any time to order that an officer should present himself for medical examination at the expense of Government by a medical officer, medical practitioner or medical board. This regulation is too wide and open to abuse. Like many other provisions relating to medical examinations, there are no stated precautions to ensure confidentiality including who is entitled to receive the information on the outcome of the medical examination.

Termination
Section 23 empowers the Commander to discharge a soldier from the army at any time upon such grounds as may be prescribed. The Regulations in turn provides for the retirement of an officer if he is found by the Medical Board to be mentally or physically unfit for further service. There is no express provision that list HIV status as possible grounds for dismissal. It is however clear that where one’s HIV status negatively affects, one’s physical fitness for further service one may be terminated. Like other employment statutes, there is no obligation on the army to accommodate soldiers of poor health either due to HIV infection or any other condition.

Police Act
As per its preamble, this Act, *inter alia*, provides for the ‘enrolment, discipline, control and administration’ of the Botswana Police Service. It also does not have an express provision on HIV/AIDS.

*Pre-employment Testing*
Just like the Botswana Defence Force Act, the Police Act does not authorize or provide for compulsory pre-employment HIV testing. However, recruits are subject to general medical examination that is undertaken by all new employees of the Government of the Republic of Botswana. Accordingly same issues as for the army arise here as well.

**Periodic HIV Testing** – The Act does not expressly provide for periodic HIV testing for officers. However, just like the BDF Act, the Regulations give the Commissioner the power, at any time, to order that an officer should present himself for medical examination at the expense of Government by a medical officer, medical practitioner or medical board. Similar issues arise as well.

**Termination**
Section 15 empowers the Commissioner to discharge an officer from the police service if such an officer is found by the Medical Board to be mentally or physically unfit for further service. There is no express provision that lists HIV status as possible grounds for dismissal. It is however clear that where one’s HIV status negatively affects, one’s physical fitness for further service one may be terminated. Like provisions in other employment statutes, there is no obligation on the army to accommodate soldiers of poor health either to HIV or any other condition. We will seek to find out whether in practice there the police service does accommodate on the basis of poor health.

**Public Health Act**
The Act does not in its main body have a specific provision on HIV/AIDS at the workplace. However, the Public Health Regulations made pursuant thereto have provisions conditioning access to and continued employment on one’s health status. Regulation 27(1) in particular prohibits the employment of persons infected or suspected to be infected with a communicable disease in a concern handling, storing, processing or manufacturing of food or a catering service. Communicable disease is defined as ‘any disease which can be communicated directly or indirectly by any person suffering therefrom to any other person.” This is a very wide definition, which may include HIV infection. The operational effect of this provision is to legitimise discrimination on the basis of one’s health status. It is of great concern that while it
could be argued that the intention was to control infections from food handlers to diners, the wording of the regulation is of a general application.

Regulation 27(3) provides for pre-employment testing for food handlers and periodic annual medical examination for all food handlers who are in employment. A number of issues arise from this regulation. *There is no indication of the type of diseases that the worker will be tested for nor is there a provision on how the results of the medical examination would be handled. Thus this regulation potentially violates confidentiality and privacy rights of workers as regards their health status.*

**Botswana National Policy on HIV/AIDS**

The relevant provisions of the Botswana National Policy on HIV/AIDS to employment setting are paragraphs 6.2 to 6.4. On HIV testing paragraph 6.2 provides that pre-employment HIV testing as an assessment for fitness is unnecessary and should not be carried out. It also discourages HIV testing as part of periodic medical examination of employees. On confidentiality, the Policy, *inter alia*, provides that employees should not be put under an obligation to disclose their HIV status to their employers.

Paragraph 6.4 has detailed provisions on HIV/AIDS and employment. This paragraph incorporates most accepted general principles intended to protect the human rights of workers infected with HIV/AIDS such as the principle of non-discrimination, access to relevant information etc.

The National Policy on HIV/AIDS is currently under review. We were supplied with a copy of an undated draft marked as Draft Version 04. In the area of employment, the Draft proposes only one major change. This is in the area of HIV testing. While the existing Policy has extensive provisions for HIV testing covering pre-employment, periodic testing, advancement in employment and termination, the Draft offers a limited protection. It only provides that ‘HIV testing or the results thereof will not be used as a prerequisite for employment.’ Thus, it addresses only the issue of access to employment. If the final policy adopts this approach, this would be a very serious setback to efforts to mainstream human rights in the battle against HIV/AIDS.
The National AIDS Policy does not have any legal binding force. Employers can, and
indeed do ignore its provisions. Even the Government of Botswana has acted against
the Policy’s provisions by requiring expatriates to undergo pre-employment HIV testing.

The Long Term Vision for Botswana (Vision 2016)

This document as pointed out elsewhere in this Report, is a compilation of Botswana’s
aspirations. It has no legal force. It is nevertheless an important document. In respect
of HIV/AIDS and employment, the Vision 2016 Document, aspires for a situation where
HIV/AIDS infected workers will have access to information, support and treatment at
their places of work. It also calls for research into the virus with a view to finding a cure.

Draft Botswana National Policy on HIV/AIDS and the World of Work

At the time of writing this Report there were ongoing discussions to develop
employment sector specific HIV/AIDS policy. We secured a draft of the proposed
policy. The proposed policy is comprehensive in its address of issues of HIV/AIDS and
employment. The draft policy is founded upon the following key principles;

- Recognition of HIV/AIDS as Workplace Problem
- Continuation of Employment: (HIV/AIDS should be treated like any other disease
  or condition and should not on its own be a condition for employment
  termination).
- HIV Testing (should be voluntary and one’s HIV status must not be a prerequisite
  for employment)
- Confidentiality and Disclosure
- Promotion of a safe and health environment
- Non-Discrimination
- Gender Equality and Empowerment
- Prevention of HIV/AIDS at the Workplace
- Social Dialogue
- Treatment, Care and Support
If the Draft were adopted as a Policy, it would go a long way in mainstreaming human rights into Botswana’s approach to HIV/AIDS at the workplace. A number of issues that are not addressed in the current legislative framework such as employers’ obligations to ensure access to comprehensive cost-effective and affordable care and specific obligation to prevent HIV/AIDS transmission at the workplace are dealt with in detail in the proposed employment sector policy. This is a welcome innovation. However, the policy has one fundamental weakness, it does not prohibit pre-employment testing in relation to foreign nationals. We have already indicated this is non-justifiable discrimination.

**National Industrial Relations Code of Practice**

The Code provides practical guidance on the day-to-day implementation of fair labour practices and the promotion of good industrial and human relations at the workplace. As paragraph 8 of the Code points out, the Code does not have any legal force on any of the parties to an employment relationship save that the Industrial Court may in determining cases take the provisions of the Code into account in appropriate cases.

The Code has very little to say on HIV/AIDS in general, let alone on human rights aspects of dealing with the epidemic. Paragraph 44, entitled “AIDS at the workplace” only recognises the potential danger of the spread of HIV as well as other infectious diseases and calls upon employers to conform to the provisions of the National Policy on AIDS and Employment, which at the time of writing this Report was still in a draft form.

**The Public Service Code of Conduct on HIV/AIDS in the Workplace**

The Public Service Code on HIV/AIDS is a comprehensive guide that covers all officers in the public service. Based on the existing National Policy on HIV/AIDS, but more precise and direct, it covers issues of prevention, care, confidentiality and non-discrimination at all levels of employment or potential employment relationship. Unlike the National Policy, the Code is taken as an integral part of the conditions of service and thereby binding on Government (clause11).
On job access, the Code does not expressly discourage pre-employment testing. It reaffirms the practice that requires all applicants for employment in the Public Service to undergo medical examination. A general principle that comes out of the Code is the one that says HIV/AIDS shall be treated like any other illness for job classification purposes. It also provides that being infected with HIV/AIDS should not be a reason for denying citizens employment and creates a duty to accommodate on the employer. The detailed provisions under the job access paragraph explaining how to treat an applicant who is HIV positive, is a clear indication that the Code is not intended to discourage pre-employment HIV testing.

The Code creates a very strict rule of confidentiality than the National Policy on HIV/AIDS. It does not, for example, provide for shared confidentiality. HIV testing is not a condition precedent for further training. The Code also protects officers from victimisation by other officers on account of their HIV status. The Code provides an obligation on Government to provide protective clothing to employers in ‘special occupational setting such as health workers. The Code also provides for the provision of occupational benefits on a non-discriminatory basis.

While the Code is a very progressive document, it only applies to officers in the public service and would do no little to PLWHA in the private sector. However most of the principles contained therein can be useful as a guide in other sectors.

Regional and International Instruments
The most important regional document that deals with HIV/AIDS and Employment is the Southern African Development Community (SADC) Code on HIV/AIDS and Employment. The Code by its own declaration is based on fundamental principles of human rights and patients rights (paragraph 2) of WHO/ILO standards and Guidelines. SADC member states, of which Botswana is one, are expected to harmonise their approach to the standards set by the Code.
In terms of its scope, the SADC Code covers all employees and prospective employees (That is, it addresses access to employment and treatment within employment). It applies to all forms of employment, formal and informal.

The Code attempts to ensure that the following aspects of employment are underpinned by a respect for human rights; job access, job security, occupational benefits, education and awareness, prevention programmes, managing illness, protection against victimisation, grievance handling and information handling. The manner in which the Code addresses each of these is basically to adopt the ILO approach as contained in its Code of Practice on HIV/AIDS and the World of Work discussed below.

The International Labour Organisation Conventions, Guidelines and Codes of Practice.

The ILO Convention (Employment and Occupation) No. III of 1958, which Botswana has ratified, prohibits discrimination at the workplace. The Convention defines discrimination to include exclusion or preference made on the basis of race, colour, sex, and religion, political, origin, which has the effect of nullifying equality of opportunity or treatment in employment or occupation. While this Convention was passed long before the HIV/AIDS problem started, the definition of discrimination is wide enough to include discrimination based on one’s health/HIV status in employment setting.

The guiding principle in relation to identifying discriminatory practices is whether the exclusion is such that it nullifies the right to equality in employment. The Industrial Court has adopted the test for discrimination as contained in this convention. Accordingly to the extent that Botswana law allows and or does not prohibit pre-employment HIV testing means that Botswana’s law in this regard falls short of compliance with the obligations the country has undertaken pursuant to Convention 158.

The Occupational Safety Health Services Convention No. 155 (1985) and the corresponding recommendation No.166 of the same year incorporate the principle of accommodation which content we described in detail in chapter 1. As already noted, accommodation is a basic element of non-discrimination. Failure to accommodate
where this could reasonably be done, can therefore amount to discriminatory practices. In essence this Convention would require that where an HIV infected worker presents health risks, which other workers and the employer can reasonable avoid, then the obligation is on others to take the necessary precautions rather than sacrifice the right of the worker infected with HIV/AIDS.

*While the Industrial Court has incorporated the principle of accommodation by interpretation into our law, the absence of a statutory obligation in employment related legislation sits uneasily with Botswana’s constitution and international Conventions under discussion. It is also clear that for Botswana to be said to be in compliance with anti-discrimination Conventions it would be necessary to amend the various pieces of legislation to incorporate the duty to accommodate.*

**ILO/WHO Statement from the Consultation on AIDS and the Workplace (1988).**

This statement, jointly issued by the ILO and WHO, is a very important document in terms of best practice when it comes to dealing with HIV/AIDS at the workplace. In summary the statement establishes the following principles:

- HIV/AIDS should not be a cause for termination of employment
- Workers infected with HIV/AIDS should be allowed to work for as long as they are medically fit for available appropriate work.
- Workers infected or perceived to be infected by HIV/AIDS must be protected against stigmatisation and discrimination by their colleagues and employers.

The statement signed by both the ILO and WHO is without legal force *per se*. However, just like international guidelines and Codes of practice, it provides a very strong reference point as to what is international best practice and the content of specific rights created by legally binding treaties and or conventions. The statement in particular gives greater content to the principle of non-discrimination in the context of employment. It provides, *inter alia*, that HIV infected workers should be allowed to work for as long as they are medically fit to do so for available appropriate work (the obligation to
accommodate), persons infected and or affected should be protected from stigmatisation and or discrimination by their co-workers and employers.

The ILO Code of Practice on HIV/AIDS and the World of Work

This ILO Code is perhaps the most definitive international statement on the way to mainstream human rights to the issues of HIV/AIDS at the workplace. It distils relevant ILO Conventions, Recommendations and Codes of Practices into one document that is intended to apply to all workers (including applicants for work) in the public or private sectors and to cover all aspects of work, formal and informal. The application to informal work is important in countries such as Botswana where informal work dominates the labour market.

The Code is founded on the same principles as the draft Botswana National Policy on HIV/AIDS and the World of Work. This is not surprising in that the Botswana Draft itself is based on the Code almost word by word. Its guiding principles are:

- Recognition of HIV/AIDS as Workplace Problem
- Continuation of Employment: (HIV/AIDS should be treated like any other disease or condition and should not on its own be a condition for employment termination.
- HIV Testing (should be voluntary and one’s HIV status must not be a prerequisite for employment)
- Confidentiality and Disclosure
- Promotion of a safe and health environment
- Non-Discrimination
- Gender Equality and Employment
- Prevention of HIV/AIDS at the Workplace
- Social Dialogue
- Treatment, Care and Support
Chapter 3: HIV/AIDS and Public Health

3.1 Introduction

The field of public health aims at “preventing disease, prolonging life and promoting physical health and efficacy through environment, organized community efforts for sanitation of the environment, the control of community infections, the education of the individuals in principles of personal hygiene, [and] the organization of medical and nursing service for the early diagnosis and preventive treatment of disease” (Modeste 1996:95). That is, the objectives of public health are: (I) to protect the general population through prevention and control of the disease and (ii) to protect the individual through early detection and adequate medical treatment. Therefore the role of public health is to identify risks or harms and intervenes to ameliorate them. This is achieved through health policies which are meant to influence actions, behaviour and decisions. Health polices can be in forms of public health law such as Acts; rules and regulations; judicial decisions; operational decisions, and macro policies.

In the process of implementing health polices and addressing different health problems, including HIV/AIDS, there are ethical public health issues that arise. Common ethical public health issues are testing, informed consent, notification, non-discrimination, confidentiality, principle of autonomy, right to access, right to health, and right to privacy. Efforts to address public health issues or to take appropriate public health interventions should take ethical and human rights issues into consideration.

Ethics in public health focus on the ethical dimensions of professionalism and the moral trust that society bestows on public health professionals to act for the common welfare (Callahan.2000). “Ethics aims at discovering whether a conduct is good or bad or right or wrong. Ethics includes values or standards designed to shed light on the relative rightness or wrongness of actions based on moral principles, professionally endorsed and practiced.” (Modeste 1996:35)

In chapter 1 we made a case for the public health and human rights interface in dealing with HIV/AIDS. We argued that a human rights-based approach takes into cognisance
the societal vulnerability to HIV/AIDS. It identifies, highlights and contextualizes vulnerability in different forms, thus providing a framework for addressing HIV/AIDS in a comprehensive manner. Failure to deal with stigma and discrimination may, for example, fuel the impact of the epidemic on those who are living with HIV/AIDS. People are more vulnerable to infection when their economic, societal or cultural rights are not respected.

3.2 HIV/AIDS Testing
Testing is essential to provide information that can give demographical understanding of the epidemic and guide targets for prevention, impact mitigation, care and support interventions. It can be done for two purposes being (I) screening for public health surveillance and (ii) testing for case finding.

Screening for public health surveillance is done to give the country information on presence and spread of HIV in a population. The systematic collection of data on the prevalence of HIV infections or AIDS and on its trends in a population is the basic tool for public health surveillance. This type of data does not require the identity of a person to be revealed. Epidemiological surveillance can be carried out with no serious implication for human rights as it does not need to disclose who is infected but states how many are infected. Public health surveillance is necessary for the prevention and control of the disease.

Testing for case finding is whereby individuals who are infected are identified. Case finding, therefore, has serious human rights implications including the need to protect people protected from HIV/AIDS stigmatisation and discrimination.

There are different types of testing. These are: Voluntary Testing; Routine Testing; Mandatory Testing; and Compulsory Testing. HIV test must be preceded by counselling and then followed by post-test counselling. Pre- and post-testing counselling enhances understanding of the test; what it entails, the purpose, the pros and cons of testing. It is crucial that it be done to assist individuals to be able to accept the test results. From a human rights perspective, counselling is crucial in ensuring that individuals exercise
informed choice, which is an integral aspect of human dignity and autonomy. *There is, however, no legislation mandating pre and post counselling.*

**Voluntary Testing**

Voluntary testing aims at allowing the person to freely exercise their right to decide whether or not they wish to have a test without any form of coercion. The person may have reasons for wanting to know their status, and therefore voluntarily decides to test for HIV. Voluntary testing has been practiced in Botswana since the start of the epidemic. It was used for pregnant women, out-and-in patients or individuals who wanted to know their HIV status. Voluntary testing is consistent with human rights based approach since it is based on free will and autonomy of the individual who opts to test.

**Routine Testing**

Routine HIV test is offered like any other test to individuals seeking medical services. Botswana has adopted the “Opt-Out Policy” where HIV testing is made routine for the general public in government health facilities. The “opt-out policy” makes HIV a routine test. Accordingly anyone who seeks health care services is offered the test together with others. However, if one chooses to opt-out or decline to take the test they are not forced.

The previous policy of “Opt-In Policy” was the first to be introduced where individuals had to volunteer or choose to be do HIV test. After the realization and commitment to intensify HIV prevention, impact mitigation and support & care, en routine HIV testing was introduced in 2004. In some countries routine testing is done in people who are considered to be at high risk for HIV infection. e.g. commercial sex workers. Which ever form routine HIV testing takes, the question is whether it compromises human rights and respect for personal dignity.

Routine HIV testing raises serious human rights questions such as the extent to which people could be said to freely consent to being tested. *In our view what is crucial is to strike the right balance between Government public health objectives of controlling the epidemic by encouraging testing and human rights imperatives of respecting the rights of the individual. We are of the view that an extensive public education directed at*
informing the public about the benefits of testing and the fact that individuals seeking medical services in Government health facilities have the right to opt out of routine testing.

Mandatory Testing

Mandatory testing is where an individual or the blood product is required to be tested before they could be allowed to enrol or participate in a process of any kind or the products could be used. Mandatory testing, as we saw in the employment chapter is currently done for expatriates seeking employment in the public service. We have referred to the fact that some employers, notably Debswana, insist on HIV testing before sending employees for further training. The Student Placement of the Ministry of Education also does mandatory testing on students going to study in foreign countries only if it is a requirement for that particular country. It is also mandatory to test donated blood and blood products before it could be utilised.

The mandatory HIV testing of individuals raises human rights concerns. Conditioning of access to services and facilities on HIV testing is a clear contravention of the right to privacy and guarantees of personal dignity. It is also against the right to non-discrimination in the sense that people would be denied access on the basis of their HIV status. Most fundamentally, mandatory testing fails the proportionality test in that there are other ways and means of achieving the objectives sought. PLWHA can, and do very productive life capable of working and undertaking training.

However, mandatory testing for blood donation in our view seems to meet the requirements of the proportionality test justifying the qualification and or restriction of human rights. The need to secure safe blood for national system far outweighs benefits of privacy concerns and there is no other viable way of securing safe blood other than pre-testing. In any case no one is under an obligation to donate blood. Those who do not want their blood to be tested can opt not to donate blood. We also learnt that in practice blood donors are not given the results of the test unless they so request.

Compulsory testing
Compulsory testing involves forcing some one to undergo medical test of any kind. The motive behind compulsory testing is to employ some control or restrictions either being work related or mobility within or outside the country’s boundaries. Compulsory testing compromises someone’s privacy thus violating his or her human rights. Compulsory testing is based on prejudice, which blames certain groups for being responsible for spreading the disease.

As discussed in detail in chapter 4, compulsory testing is practised when it comes to sentencing of convicts for the offence of rape. Human rights implications arising out of this practice are canvassed in the said chapter. Suffices to say here that the constitutionality of legislation providing for compulsory testing for purposes of sentencing rape convicts has been upheld by the Court of Appeal.

3.3 Informed Consent

One of the fundamental requirements in public health is that patients should be given an opportunity to give consent to be treated and or tested for diseases. This applies to HIV testing. The requirement of informed consent is consistent with a human rights approach in the sense that it gives primacy to individual autonomy. It ensures that one freely decides what should happen to one’s body or health in accordance with one’s values and priorities in line with the need to respect personal dignity and the right to privacy. The need for informed consent means that health workers or researchers should obtain the patient’s or subject’s agreement before any medical test or procedures or treatment is conducted on them.

In giving informed consent the patient or subject should be made to; understand what the test, procedure or treatment involves, its purpose and how the findings will be used, be aware of alternatives available and that he/she could refuse the test without negative outcome. In the South Africa case of C v Minister of Correctional Services, Kirk-Cohen J laid out parameters under which an HIV test could be performed. He held that, generally, informed consent was a prerequisite for testing a person for HIV. An individual, could consent to an HIV test only if he or she understood the object and purpose of the test, understood what a positive result could entail, had time and place
to reflect on the information received concerning the test, and had the free occasion to refuse to submit to the test.

Currently it is a requirement in Botswana that informed consent should be sought for HIV test. That is, to say even though HIV test is routine, those who opt-out or refuse to undergo an HIV test are not supposed to be subjected to any negative outcomes.

Botswana law is not clear as to when a person can be said to have the capacity to give informed consent. There are various pieces of legislation providing for different ages for qualification for certain things. In terms of the Botswana Defence Force Act only 18 years old and above can join the army. The same threshold applies to joining the Police Service. People can be admitted to midwifery and nursing only when they are 17 years and 6 months. For adoption purposes a child is person under 19 years and a child of 10 years or more must consent to be adopted. The interpretation Act makes the age of majority 21 years.

The above notwithstanding, in the area of reproductive health, the applicable guidelines (Policy Guidelines and Service Standards on Sexual and Reproductive Health) seem to suggest that any person, regardless of age, who seeks reproductive health services should be provided with the service. This would mean that any sexually active person, regardless of the age would be entitled to consent to taking HIV test.

A study commissioned by the National AIDS Council on consent recommended that for purposes of HIV testing and consenting to receiving reproductive health services, the age of consent be set at 16 without the need to be assisted by parents and or guardians. We were advised, but could not find a copy of the instrument, that the directive to give effect to this recommendation has already been issued.

The age at which one is entitled to consent for HIV/AIDS is not just a legal issue. It is a public health issue as well. Since testing is one way through which the pandemic can be controlled, there should be no uncertainty as regards the conditions to be met for
one to have the capacity to give consent for testing unassisted by parents and or guardians.

Interviews with key informants yielded divergent views with some suggesting that the age of consent for purposes of testing for HIV be set at 16 while others felt that the test should be that of whether one is sexual active or not.

*It is our opinion that the capacity for giving informed consent for purposes of testing for HIV should be based on a combination of age (16), the fact of sexual activity, and the reasons for wanting to have the testing and or whether the person seeking to undergo the testing has the capacity to understand the consequences for such tests.*. That is, any person aged 16 and above should be presumed to have the capacity to give consent for HIV testing and sexual reproductive health services. However, if a person under 16 is shown to be sexually active then, such a person should be presumed to have the capacity to give informed consent for purposes of HIV testing and obtaining of sexual reproductive services such as condoms. In addition any person at any age should be allowed to give consent for testing if the circumstance he/she is in warrants it. The health worker should be given the discretion to determine whether a person requesting HIV testing meets the above factors.

3.4 **Confidentiality**

Confidentiality is essential in the management of findings revealed by HIV testing. Strict confidentiality in reporting, testing, record-keeping and research procedure is required to protect the privacy of those who opt to test and are not willing to publicly declare their HIV status. That is, the confidentiality rule serves to give meaning to the right of privacy. As Harms AJA stated in relation to the preservation of confidentiality in the South African case of *Jansen van Vuuren v Kruger* at 850B-D:

*The reason for the rule is twofold: On the one hand it protects the privacy of the patient. On the other it performs a public interest function. This was recognised in X v Y and Others [1988] 2 All ER 648 (QB) at 653a-b*
where Rose J said: 'In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients "will not come forward if doctors are going to squeal on them". Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care ...'

In the United States the Supreme Court captioned the rationale for confidentiality in respect of HIV status in Doe v The City of New York Commission on Human Rights, thus:

*Individuals who are infected with the HIV virus clearly possess a constitutional right to privacy regarding their condition. In Whalen v Roe [1977] the Supreme Court recognized that there exists in the United States Constitution a right to privacy protecting "the individual interest in avoiding disclosure of personal matters." . . . There is, therefore, a recognized constitutional right to privacy in personal information. ...*

*Extension of the right to confidentiality to personal medical information recognizes that there are few matters that are quite as personal as the status of one's health, and few matters the dissemination of which one would prefer to maintain greater control over. Clearly, an individual's choice to inform others that she has contracted what is at this point invariably and sadly a fatal, incurable disease is one that she should normally be allowed to make for herself.

*This would be true for any serious medical condition, but is especially true with regard to those infected with HIV or living with AIDS, considering the unfortunately unfeeling attitude among many in this society toward those*
coping with the disease. An individual revealing that she is HIV seropositive potentially exposes herself not to understanding or compassion but to discrimination and intolerance, further necessitating the extension of the right to confidentiality over such information. We therefore hold that Doe possesses a constitutional right to confidentiality under Whalen in his HIV status.

The Medical Council (Professional Conduct) (Amendment) Regulations make provision for the notion of “shared confidentiality” in which medical practitioners can disclose a patient’s HIV status to caregivers or to family members without the patient’s consent and without ensuring that these third parties will not disclose to others. It is doubtful from a legal point of view whether spouses and partners who are not necessarily caregivers are entitled to information on the status of their spouse and or partner on the basis of shared confidentiality as contained in the Botswana Medical Council (Professional Conduct) Regulations.

In addition the ambiguity about who is entitled to receive and under what conditions information about patient’s status, there are no clearly defined statutory penalties for breach of confidentiality and or rules relating to informed consent before testing for HIV. This is not surprising given that the confidentiality rule in the health services is more an ethnical rather than legal issue. In fact, all the informants felt that there should be no legislation for confidentiality and that it should be left as an ethical issue.

We appreciate the difficult of legislating on such an issue as confidentiality. First caregivers are not necessarily trained health professionals. They include caregivers under the home-base care, programme, relatives and other volunteers. Legislation may deter these volunteers and thus transfer an unduly heavy burden to the state. Second, the issues of confidentiality especially in relation to partners, spouses or sexual contacts raises fundamental personal, cultural and social issues that the law may not satisfactorily deal with. However, the uncertainty on notification generally and notification to spouses and or partners deserves immediate administrative and policy clarification.
Our view is that there is need to provide in clear administrative (not legislative) guidelines in respect of different types of HIV testing, confidentiality, informed consent and circumstances under which the rules of confidentiality may be waived. We note in this regard that the proposed amendments to the National Policy on HIV/AIDS has detailed proposals on this point.

3.5 Reporting
Reporting refers to passing on information on HIV or AIDS to the health authorities. The health care worker has a responsibility to investigate and report cases. The information concerned is mainly statistical, among others stating numbers of new cases.

The public health objectives for reporting include among others: (i) to alert the responsible health officials to the presence of the person(s) who is/are or likely to be infected. (ii) to allow responsible health authorities to ensure that such persons are properly counselled as to the significance of their laboratory test results and what they need to do to care for themselves and prevent further exposure to other strains and transmission. (iii) to allow responsible health officials to monitor the occurrence and spread of infection.

In Botswana health care workers at hospitals and clinics are required to report new case to the Public Health Specialist in the District Health Team (DHT). The Public Health Specialist in-turn reports to AIDS/STD Unit of the Ministry of Health. The private practitioners are also required to report to the DHT they fall under. The reporting forms or procedures in place protect the confidentiality of HIV/AIDS patients.

In addition, it is the health care workers’ responsibility to counsel and inform the patient if one is HIV positive or negative. Counselling should be done pre and post test to prepare the person for accepting the outcome of test, understand the need and how one should care for themselves to avoid infection or transmission to others. The counselling may include family members or sexual partners to advice on lifestyle that will minimize
the risk of infection to others and also offer to remain in contact for the family and patient for any help to guidance they may need.

The duty to notify is only applicable in respect of diseases classified as notifiable by the Public Health Act. Currently in Botswana HIV/AIDS is not legally a notifiable disease. However by practice directives health care workers at hospitals and clinics are required to notify new case to the Public Health Specialist in the District Health Team (DHT). The Public Health Specialist in-turn does notification to AIDS/STD Unit of the Ministry of Health. The private practitioners are also required to report to the DHT they fall under.

*We suggest that the Minister should exercise her in terms of the Public Health Act to make HIV a notifiable disease or provide a legal basis for collection of data on HIV/AIDS. This would help give legal validity to the public health objectives for notification spelt out above. From a human rights perspective, it is imperative that the handling and distribution of information about HIV/AIDS patients is based on a clear legal basis.*

### 3.6 The Right to Health

The right to health stands out as the most pertinent issue that closely interrogates the interaction of public health and human rights objectives. We noted in chapter 1 that there is no provision in the constitution and or any other law guaranteeing the right to health. We also pointed out that in our opinion the right to health is an integral component of the right to life guaranteed by the Constitution of Botswana. From our discussion of the right to health, it emerged that this right implies positive obligation on states to ensure access to health facilities, prevention and care of the sick and the provision of health related information. In this section of the report we provide an overview of the extent to which Botswana’s approach to HIV/AIDS complies with the critical elements of the right to health.

*Access to medicine and health facilities* – The Government has a comprehensive and integrated programme designed to ensure the availability of anti-retroviral drugs to the largest number of people. ARVs are provided to qualifying citizens free of charge.
Free distribution of ARVs does not, however, apply to non-citizens and refugees staying outside the Dukwi Refugee Camp (per Presidential Directive CAB.13©/2002).

Our preliminary view is that the practice of denying non-citizens access to free drugs while the same is offered to citizens is certainly in violation of Botswana’s international human rights obligations in particular, the African Charter on Human and Peoples’ Rights which prohibit discrimination on the basis of nationality. In addition, it is our view that to the extent that the practice is based on a directive, its legal validity may be in doubt. While the Constitution of Botswana permits the possibility of discrimination based on nationality, it is doubtful whether the derogation can be effected through a directive. Our opinion is that section the Constitution of Botswana permits the derogation from the non-discrimination principle in respect of foreigners where such derogation is made pursuant to an Act of Parliament. In any case the High Court has expressed discomfort as regards the legality of Presidential Directives in general. It held in the case of *Patrick David Murima & Matse Rankonyane Vs Kweneng Land Board (Misca No. 4/2001)* that Presidential Directives issued in the absence of a state of emergency duly declared in terms of the constitution are of no legal force at all. The Court emphasised in that case that neither the President nor cabinet may rule by decree. This particular judgement in fact throws the legality of the core of the HIV/AIDS regulatory framework in doubt since regulation in this area, as we have already seen is mainly done through directives.

The practice of reserving ARVs for Botswana citizens also raises serious public health questions. What would happen if a couple is infected and one of them is not a citizen? Would one of them (the citizen) receive treatment while the other does not? If this were so, there would be a serious risk of couples sharing ARVs meant for one person which would result in non-compliance with one’s recommended dosage.

*All informants felt that Botswana’s obligation is first and foremost to its citizens. Accordingly the general view is that the policy position Government has undertaken is acceptable. Our opinion based on our understanding of Botswana’ obligations under the African Charter on Human and Peoples’ Rights is that the practice is contrary to*
Botswana’s international obligations. If the Government has intentionally taken this policy position of making a distinction between citizens and non-citizens for purposes of access to ARVs, appropriate steps must taken to put the practice on sound legal grounds by legislating for it.

In general we are of the view that Botswana has taken sufficient steps to ensure that its citizens have access to all the necessary HIV/AIDS related information, care, prevention and treatment that contributes to the realisation of the right to health.

In the long term, however, there is an issue of whether the provision of free patented HIV/AIDS drugs is sustainable. It is critical to answer this question, since once one begins an ARV treatment one has to be on treatment for one’s entire life. Our view is that the answer to this question lies outside the human rights based approach. It is in the sphere of economic planning and international trade regimes. We brought this to the attention of the Reference Committee, which, decided we should nevertheless deal with the issue within the context of the Doha Declaration only in general terms.

3.7 The Right to Health and Trade - Doha WTO Ministerial Declaration on TRIPS and Public Health - An Opportunity or Mirage?

The World Trade Organisation (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) is the most comprehensive international agreement on intellectual property issues. In summary, TRIPS deals with three fundamental issues; a) It establishes minimum standards for the protection of copyright and related rights b) provide for enforcement of intellectual property rights by incorporating commitments regarding domestic procedures and remedies for enforcement for intellectual property rights and; c) provides a binding and enforceable dispute settlement mechanism to resolve dispute involving WTO members.

Intellectual property protection standards set by TRIPS necessarily had serious implications as regards access to drugs and medicines. TRIPS meant that developing countries would no longer have access to cheap drugs as patents lead to higher prices. Consequently TRIPS triggered outrage from developing countries and human rights
activists for its perceived failure to address public health interest as regards access to essential drugs such as HIV/AIDS and malaria drugs.

Growing international condemnation of TRIPS for having led to excessive prices in respect of patented medicines, resulted in the Doha Declaration through which WTO members declared that members have a “right to protect public health, to promote access to medicine for all” and “to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.” The main objective of the Doha Declaration is to ensure that TRIPS supports rather undermine public health. It affirms the primacy of public health over intellectual property rights by providing that TRIPS Agreement does not and should not prevent Governments from taking measures to protect public health.

If properly implemented the Doha Declaration would give developing countries greater leverage to make use of the public health safeguards in TRIPS to increase access to cheap and affordable drugs. However the final responsibility for creating a legislative framework for taking advantage of the opening to affordable drugs including HIV/AIDS drugs lies with individual member states, which must include same in their domestic laws.

Our opinion, based solely on the interpretation of the TRIPS Agreement and the Doha Declaration, is that Botswana can take advantage of the dispensation afforded by Doha by developing capacity in the pharmaceuticals, in particular, the capacity to develop and acquire cheaper and yet effective HIV/AIDS drugs. We are not in position to say why Botswana has not taken advantage of the opportunity presented by the Declaration, opting instead to use expensive drugs which puts the long term sustainability of its HIV/AIDS drugs programme in doubt.

We suggest that Government should consider undertaking a dedicated study to find out the opportunities offered by the DOHA Declaration in the area of access to essential medicines for HIV/AIDS and other conditions such as malaria.
3.8 The Right to Health, Clinical Trials and the Right to Privacy and Personal Dignity

The WHO consultation meeting of 1989 stated very clearly that “AIDS vaccine trials should adhere to three basic ethical principles of biomedical research in humans: beneficence, justice, and autonomy” (Fuenzalida-Puelma, H., Parada, A M L & Serrano LaVertu. 1992. 164). The beneficence principle seeks to ensure that trials should do no harm, maximize individual benefits and minimize individual risks. Justice principles require or emphasize equitable sharing of risks and benefits include the good expected from the research while the autonomy principle is concerned with ethical aspects of the exercise as it requires informed consent.

There is currently no cure and or vaccine for HIV/AIDS. There is accordingly increasing scientific and medical research on the medical aspects of HIV/AIDS. In this section we provide a review of the regulatory framework for the conducting of medical trials in Botswana. This is critical given that medical research and or clinical trials the extent that they may involve human subjects have the potential to invade the right to privacy, personal autonomy and personal dignity of the participants in the trials. Clinical trials are imperative as they are meant to find out whether a medication is safe to use and effective against medical condition being researched.

The regulatory framework for the conduct of clinical trials in Botswana is rudimentary. Reference to clinical trials is only found in Regulation 18 of the Drugs and Related Substance Act. In terms of Regulation 18, the Director of Health Services is empowered to issue permits for carrying out clinical trials involving humans. The Director can issue such permits subject to such conditions as he/she may determine. The director is required, for the ‘protection of the general public against any risk or adverse effects from the clinical trial of any drug’ to monitor the trials from the beginning to the end.

12 CAP: 63:04
We were advised that the Ministry of Health is in the process of developing guidelines on clinical trials which are expected to address ethical and human rights issues. Currently the trials, in addition to Regulation 18, are carried in accordance with “Health Research Guidelines” and the “Guide – Consent Form.”

**Health Research Guidelines**

The document has been produced with the intention to guide Institutional Review Board on how to review and approved research proposals. A special emphasis is given on scientific and ethical implications. The protection of the participant confidentiality is also given vigorous and thorough examination that goes beyond to consider storage of biological specimens and future intentions of using the latter. There is no particular reference to HIV/AIDS research proposals.

**Guide – Consent Form**

The document aims at protecting the subject. It requires the researcher to explain what the research is all about, its purpose, what are expectations from both the researcher and the participants. It requires the researcher to explain how the producers for anonymity and confidentiality are going to be executed. However, the document does not have any specific clause either on HIV/AIDS studies nor anything on clinical trials.

**International Approach**

The most authoritative guide on the conduct of vaccine trials at the international level is the *UNAIDS Guidance Document on Ethical considerations in HIV Preventive Vaccine Research*. The Document provides for 18 Guidance Points. These are:

- **Guidance Point 1: HIV Vaccine Development**: calls for the development of sufficient capacity and incentives to foster the early and ethical development of effective vaccines.
- **Guidance Point 2: Vaccine Availability**: Any preventive vaccine demonstrated to be safe and effective, as well as knowledge and benefits resulting from HIV vaccine research, should be available as soon as possible to all participants in
the trials in which it was tested, as well as to other populations at high risk of HIV infection.

- **Guidance Point 3: Capacity Building:** Strategies should be implemented to develop capacity in host countries and communities to enable them to practise meaningful self-determination in vaccine development and ensure scientific and ethical conduct of vaccine development.

- **Guidance Point 4 – Research Protocols and Study Populations:** Research protocols should be scientifically appropriate and the desired outcome of the proposed research should potentially benefit the population from which the research participants are drawn.

- **Guidance Point 5 – Community Participation:** Representatives of affected communities should be involved in an early and sustained manner in the design, development, implementation, and distribution of results of HIV vaccine research.

- **Guidance Point 6- Scientific and Ethnical Review:** HIV preventive vaccine trials should only be carried out in countries and communities that have capacity to conduct appropriate independent and competent scientific and ethical review.

- **Guidance Point 7- Vulnerable Populations:** Where relevant the research protocol should describe the social contexts of a proposed research population that create conditions for possible exploitation or increased vulnerability among potential research participants, as well as the steps that will taken to overcome these and protect the dignity, safety and welfare of the participants.

- **Guidance Point 8- Clinical Trial Phases:** The choice of study population for the trial phase must be justified in advance in scientific and ethnical terms in all cases regardless of the study population.

- **Guidance Point 9- Potential harms:** The nature, magnitude, and probability of all potential harms resulting from participation in an HIV preventive vaccine trial should be specified in the research protocol as fully as can be reasonably done.

- **Guidance Point 10- Benefits:** The research protocol should outline the benefits that persons participating in HIV preventive vaccine trials should experience as a result of their participation. Care should be taken so that these are not presented in a way that unduly influences freedom of choice in participation.
• **Guidance Point 11 – Control Group**: As long as there is no known HIV preventive vaccine, a placebo control arm should be considered acceptable in a phase III HIV preventive vaccine trial.

• **Guidance Point 12- Informed Consent**: Independent and informed consent based on complete, accurate, appropriately conveyed and understood information should be obtained from each individual while being screened for eligibility for participation in an HIV preventive vaccine trial, and before s/he is actually enrolled in the trial.

• **Guidance Point 13- Informed Consent special measures**: Special measures should be taken to protect persons who are, or may be, limited in their ability to provide informed consent.

• **Guidance Point 14- Risk- reduction interventions**: Appropriate risk-reduction counselling and access to prevention methods should be provided to participants in the trial.

• **Guidance Point 15- Monitoring Informed consent and Interventions**: A plan for monitoring the initial and continued adequacy of the informed consent process and risk-reduction interventions should be agreed upon before the trial commences.

• **Guidance Point 16- Care and Treatment**: Care and treatment for HIV/AIDS and its associated complications should be provided to participants.

• **Guidance 17- Women**: Women should be included in the clinical trials to verify safety, immunogenicity, and efficacy from their standpoint as future recipients of HIV preventive vaccine

• **Guidance Point 18- Children**: Children should be included in the clinical trials to verify safety, immunogenicity, and efficacy from their standpoint as future recipients of HIV preventive vaccine

The guidelines are clearly inspired by a human rights approach. They seek in particular to ensure and protect the right to health, privacy, autonomy and dignity of participants in HIV preventive vaccine trials. In our view the guidelines have drawn a delicate but right
balance between public interest in securing the vaccine and protection of human rights of participants.

Our opinion is that there is urgent need for a dedicated legislation and/or regulations to regulate the conduct of clinical trials in general including HIV preventive vaccine trials in particular. Given the sensitive of the subject, we suggest that a separate comparative study be undertaken before the legislation is drafted/regulations are drafted to ensure that whatever regulatory framework is adopted is in line with international best practice.
A number of issues arise in dealing with HIV/AIDS in criminal and prison systems. These include the following:

- The extent to which Botswana’s criminal law outlawing sex acts considered to be against the “order of nature” complies with the Constitution of Botswana human rights provisions and international human rights instruments and how that impacts on the human rights of HIV patients.
- Protection of fundamental rights of sex workers and children including protection from trafficking
- Specific offences as against general offences for intentional transmission of HIV
- The extent to which Botswana’s approach provides for equality of access to HIV-related prevention and care services
- The extent to which prisoners are protected against violation of personal dignity through involuntary acts such as rape.
- The extent to which Botswana’s approach provide for non-discriminatory access to facilities and privileges for HIV positive prisoners.

4.1 HIV/AIDS AND CRIMINAL LAW

Immediately following the identification of the Human Immuno Deficiency Virus almost all countries and peoples went into a frenzy and fear. A label of the condition as one of homosexual and drug users was propagated. However, many states especially in Africa are yet to promulgate the statutory provision that address the HIV/AIDS situation.

Suitable and specifically tailored statutes are yet to emerge in most countries. Prior existing public health law and criminal statutes have been mobilized in an ad hoc and sectarian basis to regulate HIV/AIDS issues in many countries. Public Health law on its own, as we argued in detail in chapter one, is ill suited to tackle many human rights issues brought about by HIV/AIDS. Botswana’s Public Health Act, for example, permits isolation of a person infected by communicable disease. While this may be reasonable
in relation to other infections, it is generally not suitable for dealing with PLWHA given the nature of HIV/AIDS condition.

In Hong Kong, the disability discrimination ordinance was promulgated in 1995 through the efforts of the Hong Kong Aids Foundation. The ordinance allows the discrimination of a person with disability if the discriminatory act is reasonably necessary to protect public health but makes the section inapplicable in HIV/AIDS cases.

In all these instances there have been serious debates on the suitability of criminal law to play a part in combating HIV/AIDS. Shekters, who support the use of Criminal Law in the fight against HIV/AIDS says that “it is difficult to argue against the preposition that one who maliciously and intentionally and with full knowledge of his/her seropositive status attempts to transmit the virus through the act of either sexual intercourse or the fearing of contaminated and drug paraphernalia merits criminal prosecution.” Intentional infliction of physical injury or disease is something that must be accepted as being universally abhorrent. This writer sees merit in the argument that despite the potential availability of alternative remedies under public health legislation, Criminal Law in those specific instances has a definite role to play”.

Those who oppose the use of Criminal Law in curbing the spread of HIV/AIDS argue that the approach is overly retributionist. If criminal sanctions are to be used to punish conduct that is merely negligent, as opposed to conduct intended to cause harm or actual foreseen by the accused as carrying an unjustifiable risk of harm then;

a) It is preferable that actual harm flowing from the negligence should be the pre condition of punishment;

b) If an objective standard of assessing negligence is applied, it should at least be personalized by considering the accused circumstances including any factors relevant to his/her capacity to both appreciating the risk of harm and respond to it.
Even if all the above are in place, particular care must still be taken to ensure that punishment is tailored to conduct, and not to social prejudices about the guilt of certain communities and/or individuals affected and or infected by HIV/AIDS. To this end, the anti-retributionist argue that criminalization has hindered previous efforts at dealing with epidemics particularly those involving sexual activity and activities such as drug use or prostitution.

The debate has been going and is still on, in relation to issues of the mental state of the accused person for purposes of criminal liability. Those who favour public health initiatives as a way of handling the epidemic like the HIV/AIDS argue that criminal law frustrates public health initiative aimed at controlling HIV/AIDS namely that (a) testing for HIV is desirable from a public health perspective because it is the starting point for treatment and health promotion purposes. (b) That if knowledge of HIV positive diagnosis entails potential criminal liability, it would discourage HIV testing.

In addition, threat of potential exposure to criminal liability in matters of public health may not only deter people from testing, but also frustrate efforts at providing education about HIV/AIDS and modes of transmission and protection. This can also hinder non-cohesive interventions such as counselling and other support services. Criminal law leads to stigmatisation and discrimination against all those who are HIV positive and those associated with the infection.

**Botswana Legislation**

Botswana like many other countries has as at to date not enacted any specific legislation addressing the issue of HIV/AIDS. However, ad hoc and piecemeal amendments have been made on certain Acts of parliament in an effort to address the issue of HIV/AIDS particularly from the criminal law perspective.

Sections 141 to 174 of the Penal Code [Cap 08:01] deals with offences, which are classified as offences against morality. Of significance in relation to the aforesaid list of offences i.e. Section 141 to 171 is in Section 141, which defines the offence of rape, and Section 147, which deals with defilement of persons under the age of 16 years. In
relation to cases of rape, and cases of defilement, the amendment introduced in 1998 by Act number 5 of 1998, section 4 thereof in relation to the punishment for rape and section 8 in relation to defilement of persons under the age of 16 have made it mandatory in either of two circumstances that “any person convicted under sub-section 1 shall be required to undergo a Human Immune System Virus test before he/she is sentenced by the Court.” In terms of Subsection 4, “any person who is convicted under subsection 1 or subsection 2 and who test for the Human Immuno System Virus under subsection 3 is positive shall be sentenced to a minimum term of 15 years imprisonment or to a maximum term of life imprisonment with corporal punishment where it is proved that;

a) such person was unaware of being Human Immuno System Virus positive; or
to a minimum term of 20 years imprisonment or to a maximum term of life imprisonment when it is proved that on a balance of probabilities such person was aware of being Human Immuno System Virus positive”.

The Penal Code (Amendment Act) thus assigns different punishments for convicted rapists with HIV than for rapist who tests HIV-negative. A person found guilty of rape will only be tested for HIV after conviction by a court. When the results of the HIV test are received, the rapist could be sentenced in the following ways:

- test HIV-negative: the minimum sentence is 10 years, but could be higher if serious violence was committed during the rape;
- test HIV-positive without prior knowledge and diagnosis: if the rapist did not know his HIV status at the time of the rape, the minimum sentence is 15 years; or
- tests HIV-positive with prior knowledge and diagnosis: if the rapist knew he was HIV-positive at the time of the rape, the minimum sentence is 20 years.

The enhanced punishment not only applies to the rape convict, but also to a convict of defilement in terms of section 147 of the Penal Code. The testing as is done in terms of the Penal Code is compulsory.
The two provisions particularly the one dealing with rape has been put to test in a number of Court of Appeal judgment, namely Dijaje Makutu vs. The State Criminal Appeal No. 81/99 and in Ontshabetse Lesong vs. The State Criminal Appeal No. 23/2000 where the Honourable Justice Amissah as he then was said as follows in relation to the above provisions;

“finally I wish to remark that the possibility exist in this case as always it will that the accused got his HIV status if he has it from his victim, the law does not say that he should be punished for that. He would however be punished if he was HIV positive though unaware of it when he committed the offence. This is what I understand the law to be saying. Therefore in the view that I have taken unless a Court is satisfied that the convicted person was HIV positive though unaware of it at the time of committing the offence it has no right to punish him under subsection 3 (a) of section 147 of the Penal Code”.

The Penal Code makes it a criminal offence for any persons to commit an act deemed to be “against the order of nature”. The High Court has recently interpreted “acts against the order of nature” to include any act that involves anal or oral sex. i.e. homosexuality is an offence against the order of nature and that the aforesaid section 164 and 165 of the Penal Code are constitutional. In the result people who practice homosexuality have to live what in other jurisdictions is referred to as double life, to hide it, making it difficult to have access to educational facilities on protected sex and knowledge about HIV mitigation drugs and services

The Penal Code clearly marginalizes gay men and lesbians. It also severely limits access to information on safer same-sex sexual practices. It is appropriate at this juncture to quote the observation of the Human Rights Committee in Toonan vs. Australia:

“the criminalization of homosexual practices cannot be considered a reasonable means or a proportionate method to archive the aim of preventing the spread of
HIV/AIDS … by driving underground many of the people at risk of infection…[it] would appear to run counter to the implementation to the effective programmes in respect of the HIV/AIDS prevention”.

There is no domestic-violence legislation in Botswana currently. The law does not expressly provide for marital rape.

PROSTITUTION
In terms of Section 155, 156 and 157 of the Penal Code, a person who knowingly lives wholly or in part on the proceeds of prostitution is guilty of an offence and is liable to punishment in terms of the code. In terms of Section 58 any persons who keep brothel or a landlord in respect of any premises used, as a brothel is guilty of an offence and is liable for punishment in terms of the Penal Code. Brothels are where most sex workers would be found.

In terms of the Penal Code those who are engaged in activities listed in the preceding paragraph have to hide for fear of being prosecuted. By treating sex work as a personal service industry, which is, neither condemned nor condoned could assist from a public health point of view and human rights in addressing the issue of HIV/AIDS. Criminal prosecution against sex workers may be motivated as much by homophobia or disapproval of prostitution rather than any empirical evidence that sex workers represent a reservoir of infection or factor of transmission and that sex workers (of any sex) are generally at higher risk of infection from their customers than vice versa.

Awareness of risks of unprotected sex may be higher among sex workers whose work carries the great hazard of infection associated with a larger number of less well-known clients who are unlikely to disclose their own HIV or STD infection before purchasing sexual services. Sex workers have considerable incentives to ensure their own safety. As a result, it is suggested that many of these communities are more likely to assume some degree of personal responsibility for their health and less likely to assign all blame for contracting HIV/AIDS to their sexual partners if no precautions were taken during sex.
To this end it is proposed that although prostitution, sex work and the use of brothels may not be encouraged and they should not be discouraged in such away that those engaged in the service will shy away from protecting themselves or seeking the necessary help if such a need arise. They should not be treated as outcasts. Given that most of sex workers are likely to be women, outlawing prostitution is likely to expose them to more gender violence such as rape.

**Intentional Transmission of Infection**

Some commentators argue that it is not necessary to have specific legislation dealing with HIV/AIDS and that the existing legislation sufficiently deals matters set out above. Section 209 of the Penal Code, for example, criminalises causing death. It provides, inter alia, thus “causing death is defined to include any act or omission that hastened the death of a person suffering under any diseases or injury which apart from such act or omission would have caused death.” In terms of section 227 any person who does any grievous harm to any person is guilty of an offence and is liable to imprisonment for life and the grievous harm may be by way of corrosive fluids or any destructive or explosive substance in any place”.

Section 184 of the Penal Code also creates an offence that could capture HIV transmission. It provides as follows;

“Any person who unlawfully or negligently does any action and which he knows or has reason to believe to be likely to spread the infection of any disease dangerous to life is guilty of any offence”.

In several cases HIV positive accused have not only been charged with but also convicted of attempted murder or serious assault charges in respect of conduct that carried no or negligible risk of transmission of infections. An Indian HIV positive gay man was convicted for three counts of attempted murder for spraying blood from his slashed wrist at emergency personnel responding to his suicide attempt.
In Albaman, an HIV positive prisoner was convicted of attempted murder after biting a correctional officer on the arm during the scaffold. In appeal his conviction was over turned, as it was not proven that he intended to cause serious injury in biting the officer or that the bite was capable of resulting in such injury. In another case in the United States, a sex worker who had tested HIV positive was charged with attempted manslaughter for engaging in unprotected sex with two different men without disclosing her serostatus. In California, a gay man was charged with attempted murder and assault with intent to commit bodily harm for biting two policemen during an altercation at a gay pride rally.

All the above go to demonstrate that there is no need to create HIV specific offences as general criminal law is capable of addressing perceived dangers caused by HIV/AIDS in a manner consistent with human rights and the need to protect the general public.

4.2 Prisons/rehabilitation/correctional services

The issue concerning the human rights of prisoners is always controversial. Should a prisoner be entitled to his fundamental human rights? There are those who argue that being sentenced to a prison term is intended to ensure that one does not enjoy the benefits of everyday life including human rights. Others argue that one’s rights should be limited to the extent necessary for one to serve one’s term. It is argued, for example, that being sentenced to a prison term is not the same as being sentenced to death, which means that while the prisoner who foregoes his freedom of movement, he/she would be still entitled to the right to life. We align ourselves with this view.

In the past prisoners were regarded as slaves of the state and therefore prisons were said to be place for punishment for the slaves of the state. Prisoners were regarded as having lost their civil liberties to the state consequently having no rights to enforce. This is no longer the case. Prisoners are still entitled, albeit in a limited way, to their fundamental human rights. All prisoners are entitled to the fundamental human rights, and in respect to HIV/AIDS, the right to health, the right to health related information, including information about prevention of HIV infection and the right to prevention of HIV facilities.
The Prisons Act [Cap 21:03] makes no reference specifically to HIV/AIDS but deals substantively with administrative security and disciplinary issues. However, the regulations thereof make a specific reference to examination of prisoners and recommendations for release in case of contagious diseases, which may include HIV/AIDS.

MEDICAL TREATMENT
The Botswana Prisons Act, in particular section 56(2) provides as follows;

“The Medical Officer shall be responsible for the health of prisoners in prison and shall cause all prisoners to be medical examined at such times as shall be prescribed”.

At section 57 the Act provides;
“A Medical Officer may, whether or not a prisoner consents thereto, take or cause to be taken or direct to be taken such action (including the possible feeding, inoculation, vaccination and any other treatment of the prisoner whether of the like nature or otherwise) as he consider necessary to safeguard or restore the health of the prisoner or prevent the stretch of the diseases.”

Subsection 2
“All actions of a Medical Officer in exercise of the powers conferred by this section and all actions of a Prison Officer, Medical orderly or other person acting under any other accordance with the directions or instructions of a Medical Officer given under this section shall be deemed to be lawful”.

What is clear from the foregoing provisions is that under certain circumstances medical test of prisoners can be carried out with such force as is reasonably necessary. The Act further exempts all officers acting pursuant to the instructions of the Medical Officer from any liability in respect of any damages caused in consequence thereof. The provisions are sufficiently broad to cover cases of compulsory HIV testing.
NUTRITION
The Botswana Prisons Act, Regulation 34 provides;

“Every prisoner shall be entitled to a sufficient quantity of plain wholesome food in accordance with the scale set out in part one of the said schedule…”

The result in restricting access to adequate nutrition has an impact on health concerns of all kinds. In particular prisoners living with HIV/AIDS are affected because proper nutrition and vitamins are crucial for management of HIV/AIDS infections (United Press International 1993). The Prisons Act does not have any specific provision of variation of diet as planned for in the schedule to ensure optimum nutritional health or make provision for prisoner with special dietary needs, like HIV/AIDS. No provision is made even for special diet.

TRANSMITTION OF HIV/AIDS IN PRISONS
The prisons authorities have a common law duty of care to prisoners. Damages may be claimed against such authority if evidence of recklessness and/or negligence is proved. Thus at common law the prison authorities are under a duty to ensure that prisoners are protected from HIV infection in prison. This would include the duty to ensure that prisoners have sufficient information about HIV/AIDS and access to prevention facilities.

The Act does specifically deal with issues of information dissemination on HIV/AIDS, condom distribution and/or access to ARVs. However, the Botswana Prison Service HIV/AIDS and Health Care Delivery Policies have detailed provision the gist of which is to ensure that prisoners have the necessary HIV/AIDS related information, discrimination is prohibited, no isolation of prisoners and generally discourage stigmatisation of HIV/AIDS. An otherwise progressive Policy is nevertheless compromised by the fact that it prohibits the distribution of condoms to inmates.

Married prisoners, even if they are not convicted of sex related offences, are not entitled to conjugal rights. Given the escalating rate of infection, allowing conjugal visits could
potentially reduce the infection. In any case by denying conjugal visits, prisoners’ partners are being punished although they would not have been convicted.

**TESTS**

The Prisons Policies on HIV/AIDS are modelled on the National HIV/AIDS Policy. Informed consent of the prisoner must be obtained before making the test as was established in the Minister of Correctional Services 1996 (4) SA 292.

**THE SPREAD OF HIV/AIDS AND OTHER CONTAGIOUS DISEASES (EARLY RELEASE)**

Currently in terms of Section 78 of the Prisons Act, a prisoner may be released early for health reasons.

*We are of the view that the policy position relating to non-distribution of condoms in prisons should be revoked. Its existence unduly exposes Government to potential litigation by those who may contract any deadly disease including HIV/AIDS due to the non-availability of condoms in prisons.*

*We would also suggest that the debate be initiated to discuss the possibility of granting prisoners convicted on non-sexual offences the right to conjugal visits. Given the fact this would have implications for prison facilities, this should be considered a long-term option.*
CHAPTER 5: HIV/AIDS AND INSURANCE AND FINANCIAL SECTORS

5.1 Introduction
In this chapter we review the current legal, regulatory environment for the financial and insurance sectors. The purpose is to isolate problem areas, if any, from a human rights perspective in relation to the provision of services by these sectors to HIV/AIDS infected and or affected consumers.

5.2 Insurance Sector
The fundamental issue, in so far as PLWHAs are concerned is that of access to insurance services and facilities on a non-discriminatory basis. The non-discriminatory principle requires that PLHWAs should have access to the insurance services on a non-discriminatory basis. As it would more fully appear from the discussion of applicable legislation, the Insurance Industry Act, provides, subject to a host of exceptions, for the duty on insurers to provide service on non-discriminatory basis.

In many jurisdictions, insurance companies require applicants for long term insurance cover to undergo HIV test and or medical condition generally including HIV status. In the event the applicant is HIV positive, his/her application is either rejected or higher premiums are sought. Our findings indicate that insurance companies in Botswana have also followed the international trend. They require applicant seeking life cover beyond a given threshold (by law more than P100,000.00 and above) to undergo HIV testing. However, perhaps due the increasing advocacy for the rights of PLWHAs, some companies (for example Metropolitan Botswana) now, do not reject HIV/AIDS positive applicants outright, but instead are attempting to come up with special products for PLWHA.

There are business considerations that may have led insurance companies to adopt their current position. These include

- The fear that HIV positive insured will die prematurely.
- The risk of ensuring PLHWA is high.
Some re-insurers insist on HIV tests.

Insurance industry is generally of the view that demanding pre-insurance HIV testing is not discriminatory. In their view, they only offer justifiable differential treatment to ensure sustainability of the industry. That is, to ban pre-insurance HIV test would be to substantially impede the industry’s ability to assess risk and thereby undercut the industry’s financial stability and compromise its ability to settle future claims. Some commentators have also argued that to ignore HIV status in life insurance in particular would be to grant PLWHA favoured treatment in that other health conditions would continue to be a basis for denial for cover and differential rates.

The above are said to justify either the insistence on HIV testing as precondition for cover or result given a different products and or the inclusion of clauses excluding liability in the event the insured dies of HIV/AIDS. It seems to us that the view that PLHWA die prematurely is not generally true given the advances in medical science in particular the availability of drugs such as ARVs.

As it has been pointed out elsewhere, the critical question is whether the above practices by insurance companies constitute discrimination as defined in the Constitution of Botswana? It is our considered opinion that the above practices are indeed discriminatory within the meaning of the constitution of Botswana.

5.3 Financial Services Sector

A similar issue that of access to financial services and facilities such as loans on non-discriminatory basis obtains here. In terms of opening and operating accounts, there is no evidence of discriminatory practices. However, unlike in the insurance industry, there is no law providing for non-discriminatory access to service in general and or in relation to HIV/AIDS in particular.

The approach of insurance companies to PLHWA in terms of setting a threshold when it comes to the granting of loans beyond which the applicant would be required to undergo HIV testing as a condition of obtaining the facility has, in a way been imposed
on financial institutions such as banks. In general banks would insist, as a condition of granting a loan beyond a given threshold that the applicant take loan protection insurance cover. What happens is that the applicant would then go to an insurance company, which if the amount falls within the bracket that the company requires HIV testing, would ask the applicant to undergo the test. In simple terms, if the applicant is positive and the insurance company refuses cover, then the bank would also not grant the loan.

In view of the importance of insurance and financial services in the fight against poverty and their being conditions precedent to the realisation of other human rights, consideration should be given to amending applicable legislation and policy documents as discussed below to create an express the right to access to financial and insurance services on a non-discriminatory basis.

5.4 Review of Applicable Legislation

Insurance Industry Act
This Act regulates the provision of insurance services in the country. Accordingly it is predominately concerned with regulating the actual conduct of the business rather than dealing with access and related issues. However, some sections are of potential application to the issue of HIV/AIDS although they do not specifically refer to it.

The most pertinent section is 96. This section creates a binding non-discrimination obligation on the insurers for life. That is, insurers are bound in general to accord similar treatment to similar situated applicant for life cover. Subsection 1 thereof provides thus:

‘An insurer shall not make or permit to be made any discrimination in respect of the rate of premiums charged or the bonuses granted between life policies which are of the same kind and under which the persons whose lives are insured have an equal expectation of life.’
While the statutory provision for non-discrimination is welcome, subsection 2 of the same section authorises exemptions with potential negative consequences for PLWHA. It provides, *inter alia*, that the non-discrimination obligation does not apply to reinsurance contracts, insurances for large sums in excess of P100,000.00 and granting of preferential rates for the lives of employees of one employer or a combination of employers or members of employees families. In practice, insurance companies insist on HIV test for all sums in excess of P100,000.00. The practice we have seen is discriminatory and arguably unconstitutional. Allowing insurers to give differential rates to different employers is also problematic. There are certain occupations, in respect of which there is a perceived a high risk for contacting the HIV/AIDS infection. The exemption would allow insurers to discriminate against these occupations.

Section 23 of the Act dealing with reinsurance and retention, *inter alia*, empowers the Registrar of Insurance to prohibit the insurer from transacting any individual policy or all insurance of a class where in his/her opinion the arrangement of reinsurance in respect of the insured interest would not be favourable to the economy or the insurance industry or the public interest or where he/she is of the opinion that the gross or net retention limits are too low or too high. This provision would be especially problematic in the event the reinsurer demands very high premiums from the insurance companies in the country in respect for policies covering PLWHA, which in turn would put the industry at risk. This would on the face of it justify the intervention of the Registrar in the manner above. The way out of this potential problem may be to involve the Government in terms of taking some burden off the insurance companies. Encouraging insurance companies to provide cover for PLWHA would go a long in mitigating the economic impact of HIV/AIDS on their families.

**Bank of Botswana Act**

This Act provides for the establishment of the Bank of Botswana, its constitution, and objectives and powers and matters incidental thereto. The objectives of the Bank are stated as being the promotion and maintenance of monetary stability, fostering of monetary, credit and financial conditions conducive to the orderly, balanced and
sustainable economic development of Botswana and finally to assist in the attainment of national economic development goals (section 4).

There is no express provision on access to financial services by individuals. This is not surprising given that the Bank of Botswana Act is mainly concerned with corporate governance issues, powers of the Bank and the Bank’s relationship with third parties.

Banking Act
This Act provides for the licensing, control and regulation of banks and matters incidental thereto. The provision of banking services is reserved for entities and persons licensed by the Central Bank (sections 3 and 6).

Section 9 empowers the Central Bank in the granting of the Bank licence to impose such conditions as it deems appropriate. While the Act does not provide for non-discriminatory access to financial services, the Central Bank, may in the issuance of licences require that licensee provide access on a non-discriminatory services. *For purposes of ensuring the realisation of the non-discrimination principle, consideration should be given to providing for non-discriminatory access to financial services in the Act.*

Section 43 of the Act providing for confidentiality of information is of particular relevance to this project. It prohibits, officers, employees and agents of any licensed Bank, who by virtue of their professional relationship with the Bank has access to the records of the Bank, during and after their relationship with the Bank, to directly or indirectly disclose any information he may acquire in the course of his duties concerning any customer’s deposits, borrowings or transactions, or other personal, financial or business affairs, without the written and freely given permission of the customer concerned. This is a very strict duty of confidentiality, which could ensure the confidentiality of PLWHA personal and health information.

**Botswana Savings Bank Act**
The Act’s preamble says that the Act is intended to provide for the establishment of the Botswana Savings Bank for purposes of providing financial and banking services for the peoples of Botswana. Section 3 thereof lists, as some of the Bank’s objectives, the promotion of ‘saving habit among the peoples of Botswana’ and provision of banking and financial services to rural and urban population in Botswana. This, in our view suggests an obligation on the Bank to ensure access on non-discriminatory basis including non-discrimination against PLWHA. However, there is no substantive provision in the Act providing for non-discriminatory access to financial and banking services.

**Hypothecation Act**

The Act provides for securing of loans, advances and debts by hypothec granted over movables. It does not have any provisions intended to ensure that authorised creditors do not discriminate on the basis of health/HIV status as regards to access to and qualification for hypothecation.

**Hire Purchase Act**

The Act provides for the regulation of hire-purchase agreements and instalments sales. Like the Hypothecation, it does not provide for the right to non-discriminatory basis.

**Constitution of Botswana**

The Constitution of Botswana has no express provision on individuals and or group or class of individuals’ access to insurance and financial services. However, the applicability of the constitution provisions against discrimination may apply as discussed in chapter one.

**Vision 2016 Document**

The Vision does not have an express provision on access to insurance and financial services on non-discriminatory. Its clauses dealing with HIV/AIDS are of a general nature. However its pillars suggest an approach that would ensure equitable and non-discriminatory access to these services.
The National AIDS Policy and the draft amendment to same have no provision on access to insurance and financial services and possibilities of denial of such services to PLHWA. This is a serious omission that deserves a possibly amendment of the policy document given the importance of insurance and financial services to economic well being of any person.

We would suggest that an amended be effected to the Bank of Botswana and the Insurance industry Act mandating the Bank and the Registrar to ensure that access to insurance and financial services is on a non-discriminatory basis. Similarly the National HIV/AIDS Policy should be amended to deal with discrimination in the financial and insurance sectors.
6.1 Introduction

There is no legislation specifically dealing with HIV/AIDS in the education and training setting in the country. The absence of legislation dealing with HIV/AIDS and education and training means that in practice there is no consistency of practice. The result is that PLHWA are treated differently in different scenarios, which is hardly a satisfactory situation. In so far as admission to learning institutions is concerned, the door is left wide open for discriminatory practice such as denial of admission and or dismissal from educational institutions on account of one’s HIV status.

It appears that in general applicants to Government and private education and training institutions in Botswana are not required to undergo HIV test as a condition for admission and or continued stay in training institutions. This does not mean that issues of the respect for the human rights for PLWHA do not arise. Given that there are no clear and consistent guidelines to tackle issues of discrimination, stigmatisation, privacy and victimisation of teachers and students on account of HIV status, there is need to address the issue.

The absence of legislation on HIV/AIDS and educational setting has in a way made it possible for some big employers to require potential students and trainees to undergo HIV testing as a condition for sponsorship. In addition, potential Government sponsored students are required to undergo HIV test in cases where such students study outside Botswana and the country of study require such test as a condition for entry.
6.2 Review of Documents

Education Act
This Act provides for the proper development of education and matters incidental thereto. The Act does not confer the right to education. In so far as this study is concerned, there is no provision dealing with HIV/AIDS situations. However there are provisions of general application that can affect PLWHAs.

Section 19 empowers the Permanent Secretary in the ministry responsible for education, with the approval of the Minister, to make regulations for the health and safety in school premises. While this section does not specifically lists conditions that the Permanent Secretary has to take into account, it is clear that it has the potential to be used to ensure care and safety of teachers and students living with HIV/AIDS.

Of particular concern, however, is Part IX of the Education (Government and Aided Secondary Schools) Regulations made pursuant to the Act dealing with ‘Safeguards for the Health of Pupils’. These regulations empower the headmaster, inter alia, to remove a pupil from school if it appears to her/him that the concerned pupil is medically unfit and the parents and or guardian fails to produce a certificate of fitness, to withdraw from school a pupil suffering from infectious and or contagious disease and at his/her discretion to order that a pupil should be medically examined by a Government Medical Officer who would submit the medical report to the headmaster in confidence (Reg. 44).

The regulation referred to in the above paragraph is a potential minefield in so far as the human rights of pupils in general and in particular those living with HIV/AIDS are concerned. First, it is strange, that the head teacher is given the power without the intervention of health officials to determine the nature of a disease and expel pupils on his own determination. Second, the generality of the regulation is a potential danger to pupils living with HIV/AIDS. There is no guidance in terms of which ‘infectious diseases’ may entitle the headmaster to dismiss the pupil. HIV/AIDS, while qualifying to be classified as an infectious disease, is and should be treated differently from diseases such as smallpox etc. Lastly, it is a serious intrusion into the privacy of a pupil to allow
the headmaster to order that such a pupil be subjected to medical examination without the pupil and or its parent/guardian’s consent. This particular provision sits uneasily with the constitutional protection to the right to privacy.

It should be noted that the regulations under discussion apply to Government and Government Aided Schools. Thus, even if there were positive provisions, such would not apply to private schools.

Tertiary Education Act
This Act establishes the Tertiary Education Council (the Council). There are only two provisions that have potential application to the issue under discussion. The Council is, inter alia, empowered to formulate policy on tertiary education and advise the Government accordingly. In this way, the Council can play a pivotal role to ensure that a human rights approach to HIV/AIDS is mainstreamed into tertiary education policy. Section 23, for its part, gives the Minister the power to prescribe regulations on the recommendation of the Council for institutional standards to govern the performance, operations and general conduct of all tertiary institutions authorised to operate under the Act. Given that the Act applies to Government and private institutions, this provision can have greater impact were the Minister to be minded to mainstream HIV/AIDS issues into his approach.

University of Botswana Act
As Botswana has only one-university questions of access thereto are critical. Given this fact one would have thought that issues of admission and or access would have been addressed in the statute. Unfortunately the University Act, which establishes the university does not say anything about access and or admission. For our purposes, it is important to note that the University of Botswana has a very progressive HIV/AIDS Policy.

Botswana College of Distance and Open Learning Act
As per its preamble the Act provides for the establishment of the Botswana College of Distance and Open Learning. Only section 5 of the Act is of potential application to
HIV/AIDS and human rights. This section provides, *inter alia*, that the College shall, as one of its functions, advise the Minister on the requirements for admission to the college. Through such advice the College can ensure that a human rights approach to HIV/AIDS is entrenched in the college's admission requirement. For our part we would prefer a specific provision ensuring the integration of the principle of non-discrimination on the basis of one's health status.

**Nurses and Midwives Act**
This Act, *inter alia*, provides for the training and examinations for nurses and midwives. In terms of the section 7 the Nursing and Midwifery Council established under the Act has the power to set admission and examination standards for the training of nurses and midwives. It does not establish conditions for admission. This is covered under the General Nurses (Training, Examinations and Student Registration) Rules made pursuant to the Act. Rule 3(b) in particular provides that no person shall be admitted to the nursing college or training school unless he/she can produce a certificate of good health. ‘Good health’ is not defined. *Our opinion is that ‘good health’ should be defined such that it does not create conditions for discrimination against applicants living with HIV/AIDS.*

**Botswana Training Authority Act**
This Act provides for integration and promotion of vocational training in the country. It establishes the Botswana Training Authority (section 3). Only section 17 dealing with functions, powers and duties of the authority appears to be relevant to this study. It provides, *inter alia*, that the Authority ‘shall promote access to training opportunities on an equitable basis.’ This provision can be relied upon to ensure that health status is not used as basis for discrimination when it comes to access. *We are, however, of the view that the best approach is to be specific and outlaw health/HIV/AIDS related discrimination.*

**Vision 2016**
One of the objectives of Vision 2016 is to build ‘an educated, informed Nation.’ While the Vision advocates for universal and compulsory education with special measures to
mainstream gender equality there is no express provision prohibiting denial of access to educational opportunities on the basis of one’s health. However, taken as a whole the Vision’s certainly intended to ensure that by 2016 discrimination on whatever ground would not be allowed.

**Botswana National Policy on HIV/AIDS**

The draft new National HIV Policy provides that discrimination in any form violates fundamental human rights of the individual. This would cover discrimination in education setting.

**Revised National Education Policy**

This Policy is silent on issues of HIV/AIDS. *This is a serious omission and our view is that the Policy should be reviewed to include issue of HIV/AIDS including instruction in relation to sex education.*
Chapter 7: HIV/AIDS and Sports

7.1 Introduction

Within sport, in particular contact and physical sport such as boxing, wrestling and martial arts, there is risk of injury and subsequent bleeding. There is, therefore, a possibility albeit small of HIV infection during participation in physical activities. Scientifically there appear to be a very small risk of HIV transmission during participation in a majority of sports code.

The fact that the risk of contacting HIV infection through participation in sports is low does not make the issue irrelevant. In so far as a human rights approach is concerned, the issue is whether HIV testing should be made a pre-condition for participating in contact and physical sports. In addition, should PLWHA be allowed to take part in contact sports?

The difficulty in providing answers to the above questions lies in trying to balance the rights of a person infected with HIV to leisure (which is an aspects of the right to health) against the right to health of other players, not to be infected. The fact that the risk of infection is extremely low means that there is very little guidance on the subject. In general the right to non-discrimination should be applicable in the sports sector as well. This would mean that the limitation of the right of sportsperson living with HIV would be subject to the proportionality test like any other right.

There have been suggestions in some quarters that compulsory HIV testing should be undertaken in relation to certain sports code. However, the general acceptable practice is that based on current medical and scientific evidence compulsory HIV testing is neither desirable nor prudent. In addition to creating numerous ethical dilemmas, such an approach would be unproportional to the risk sought to be averted (risk of infection), give that it could have legal implications that could wreck the livelihood of sportspersons, sports clubs, federations and related organisations and institutions. It is
our view that voluntary testing must be encouraged and general information about the risk of infection through participation in sports is undertaken.

7.2 The Current Situation in Botswana

There is no law in Botswana with a provision with a bearing on sports, HIV/AIDS and the human rights of sportspersons. Even the Botswana National Sports Council Act has no provision with a bearing on HIV/AIDS. The National Policy on HIV/AIDS and its proposed amendments are silent on HIV/AIDS and sport.

It is our position that in order to secure the safety of sportspersons and the human rights of PLWHA, it is critical that a detailed Policy on HIV/AIDS and sports be developed. The fact that the risk of transmission through sports is extremely low should not be reason for inaction. PLHWA continue to suffer stigma and discrimination not on the basis of scientific and or medical information, but mainly on the grounds of prejudice and unfounded perceptions. From a legal perspective we would suggest that any legislation await the outcome the promulgation of the policy. Should it be felt necessary to legislate, we would suggest that a general provision be inserted in the Botswana National Sports Council Act that expressly obligates the Sports Council to ensure the health and safety of all the players in different sports codes. This in our view is a flexible approach that ensures that the special concerns of different sports codes are taken into account.
CHAPTER 8: INSTITUTIONAL ISSUES

8.1 Introduction
Human rights in general, and those dealing with an issue with far reaching personal and societal consequences as HIV/AIDS would be meaningless unless they are accompanied by an effective institutional set up. Compliance with any standard is not only dependent upon the provision of necessary incentives (including penalties), but also on the existence of accessible and efficient institutions to ensure enforcement. In the case of HIV/AIDS, institutional issues are crucial at different stages including prevention (including through ensuring access to health-related information), treatment and care and enforcement of human rights in the event of breach.

The main issue for this study is whether the existing institutions for dealing with all aspects of HIV/AIDS would be suitable and appropriate under a human rights based approach to the HIV/AIDS. Do we need new institutions to reflect the shift to a rights based approach? Or can the existing institutions be reformed to reposition them such that they can effectively deal with HIV/AIDS within a rights based perspective? We give an overview of the existing institutions below.

8.2 Governmental Institutions
A variety of Government related institutions currently deal with the HIV/AIDS issue. These include Political Institutions, Government Ministries and Departments with general competency and jurisdiction over health issues.

8.3 Political Leadership
The political leadership over HIV/AIDS falls under the National AIDS Council (NAC). NAC, chaired by His Excellency the President is the highest national coordinating body to advise Government on HIV/AIDS matters. NAC is the ultimate authority within the National Response to HIV/AIDS. It has the power to issue binding decisions as regards the overall strategic direction and priorities for the nation as well as extending the required endorsement of national programmes and other national new initiatives.
8.4 *Ministerial Institutions*

In so far as Government Ministries are concerned, the Ministry responsible for health is responsible for overall national policy development on HIV/AIDS. This does not mean that other Government ministries play no role in the battle against HIV/AIDS. Botswana’s National Strategic Framework for HIV/AIDS details the specific roles of all Government departments, local authorities and other stakeholders. The ministry of health also has statutory obligations pursuant to the Public Health Act, inter alia;

- To prevent and control communicable diseases;
- To promote or carry out researches and investigations in connection with the prevention and treatment of human diseases; and
- To prepare and publish reports and statistics and other information relative to public health.

Thus the ministry of health, in relation to HIV/AIDS, is, in addition to policy formulation charged with duty to ensure prevention, treatment and ensuring access to HIV related information. In so far as information is concerned, the ministry plans and implements awareness campaigns about HIV/AIDS, ensures availability of drugs and other services such as condoms to eligible citizens. The Ministry is of course responsible for administering the Public Health Act. Specific key responsibilities of the Ministry of Health include; implementation of health sector based interventions regarding the prevention of sexual, blood borne and vertical transmission of HIV; implementation and management of Anti-retroviral Therapy and the Prevention of Mother to Child Transmission, HIV surveillance and epidemiological research, HIV/AIDS reporting. The Ministry of Health also provide health-specific technical support to other Ministries and stakeholders.

The other important body is the National Aids Coordinating Agency (NACA), which is a department in the office of the President. According to Botswana National Strategic Framework for HIV/AIDS, one of NACA’s key roles is to manage and coordinate the policy environment as it relates to HIV/AIDS. NACA is also charged with harmonising the planning and implementation of all ministries, sectors, districts, civil society
organisations, private sector and other relevant stakeholders programmes on HIV/AIDS. NACA is also the implementing institutions for the National HIV/AIDS Policy.

8.5 The Courts System
There is no statutory organisation charged specifically with the obligation to promote and protect the human rights of PLWHAs. As the comparative chapter shows in countries such as Tanzania and Ghana, statutory organisations have been created to discharge functions akin to what NACA does in Botswana.

The only institution that has been created to protect individuals from bureaucratic power, the Ombudsman, does not have an express mandate to deal with HIV/AIDS issues. In any case, the Ombudsman’s jurisdiction is limited to overseeing Government misadministration. It is not a human rights body and it is conceptually unsuited for the role of protecting human rights.

The only avenue for redress for a person, whose human rights have been violated on account of his/her HIV status are courts and other sector specific institutions. For example, HIV/AIDS work related problems are generally settled within the applicable trade dispute settlement laws. That is, there is no special procedure or institution that is designated to settlement of HIV/AIDS related issues in general or in particular sectors. This therefore means that issues surrounding HIV/AIDS issues are settled within the court system

The court system has fundamental institutional and structural problems in so far as settlement of disputes involving litigants who are living with HIV/AIDS. In the first instance, the court system is generally expensive. This is critical given that there is no state funded legal aid in general and for PLHWA in particular. Second, the court process in general tends to be lengthy, a factor which may disadvantage those litigants who are terminally ill. It is often difficult to secure compliance with the confidentiality rule once a matter is registered with the courts. Given these problems with the court system, it seems to us that the possibility of establishing a human rights commission to
deal with all issues of human rights in the country including those of HIV/AIDS and human rights should be given serious consideration.

Mention should be made of the numerous human rights/civil society organisations, in particular Ditshwanelo and BONELA in fighting and protecting the interests of PLWHAs in courts and other fora. A number of labour cases that ended in the industrial court did so following the intervention of these two bodies. *It would be necessary to consult and discuss the possibility of these organisations being given greater role in the enforcement of the rights of PLWHA while retaining their NGO status.*

*We are of the view that no fundamental changes in the institutional set up is necessary. We are accordingly of the view that NACA should continue to play its current coordinating role. This means that the implementation of the recommendations contained herein should be left to NACA as part of the coordinating function. In particular we recommend that:*

1. Current policy, service provision and coordinating institutions should be left as they are.
2. The location of NACA within the Office of the President should be retained and there is currently no sufficient case for making NACA a Parastatal.
3. The powers and functions of NACA should be given statutory basis to ensure certainty, accountability and consistency in service delivery.
4. NACA, as part of realising Goal 5 of the National Strategic Framework for HIV/AIDS, that is of to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’ the National response’ should spearhead proposed legislative and policy changes which would arise as a result of the recommendations of this Report.
5. The possibility and or desirability of establishing a human rights commission to investigate alleged violations of human rights generally and HIV/AIDS related cases in particular should be considered.
CHAPTER 9: A SURVEY OF APPROACHES FROM OTHER JURISDICTIONS

9.1 Introduction
This chapter provides a general overview of the human rights based approaches in selected countries. The purpose is to learn from other countries how they have dealt with the issues of general nature in their specific environments. We will try to draw lessons from as many jurisdictions as possible.

We wish to note the potential dangers and limitations of comparative legal studies. The legal framework, including creation of legal institutions, is much a reflection of each country’s political, economic and legal history. Each country has its unique history. One must, therefore, exercise caution when borrowing from other jurisdictions. Legal principles cannot be transplanted like plants. One has, always to keep in mind the historical evolution of different countries’ legal systems and institutions. This is so even in cases of human rights since the content and application of universal human rights takes place within specific and unique settings found in each country. In any case, the general review provided herein is strictly not comparative in the sense that no attempt is being made to put each reviewed regulatory regime with the country’s historical, political, social, regulatory and legal setting.

9.2 SOUTH AFRICA
Given the similar legal history and constitutional set up, South Africa offers an interesting lesson for Botswana. It suffices to say that like South Africa, Botswana has a written constitution. The constitutions of the two countries, albeit the South African one more developed make provision for;

- The protection of the rights and freedoms of the people.
- The Setting out of the powers and existence of all institutions of the state and they depend on the constitution and are subject to it.
- Bills of rights, which deals with fundamental rights and freedom of individuals.
Both Botswana and South Africa follow the Roman Dutch Common Law. Consequently South African case law greatly influences judicial practice in Botswana. Most, if not all of the advocates who appear in our Courts come from South Africa. In fact, the bulk of our case law is based on South African decisions.

The South African Employment Equity Act prohibits unauthorized employment-related HIV testing. In terms of section 7(2) thereof, no employer may ask a job applicant or a current employee to take an HIV test at any time, except if the employer has applied to the Labour Court for permission for such testing, and it has been granted. It also provides that no person may unfairly discriminate an employee or job applicant in any employment policy or practice on the basis of 20 listed grounds unless it is an inherent requirement of the job. “HIV status” is listed as one of the grounds on which an employee may not be discriminated against.

The Criminal Law Amendment Act provides for a higher minimum sentence in the absence of substantial and compelling circumstances for a first-offender rapist who knows that he has HIV than for a first offender who does not have HIV. The Criminal Procedure Second Amendment Act provides for stricter bail measures. It denies bail to a person accused of rape who knows he has HIV unless exceptional circumstances are established.

The Medical Schemes Act ensures that medical schemes may not exclude any person able to pay their contributions (this will include people with HIV/AIDS). HIV-associated diseases are now a category under the Prescribed Minimum Benefits, which provide for the compulsory coverage of medical and surgical management for opportunistic infections or localized malignancies.

The Promotion of Equality and prevention of Unfair Discrimination Act is intended to implement and give greater effect to the quality clause of South Africa’s Constitution. Section 6 of the Act prohibits unfair discrimination on the ground of disability (which may be interpreted to include HIV/AIDS, but this is not expressly provided for in the Act).
Section 34 (1) contains specific directive principles on HIV/AIDS, while section 32 provides for the establishment of an Equality Review Committee mandated to meet within one year of promulgation of the Act to make recommendations to the Minister of Justice on whether “HIV status” and “AIDS” should be included in the Act as prohibited grounds of unfair discrimination.

Both the National Health Act and the National Education Act contain provisions for the drawing up of policies on HIV/AIDS. Following these directives, the National Policy on Testing for HIV was published in August 2000, while the Minister of Education launched the National Policy on HIV/AIDS for Learners and Educators in 1999.

9.3 SWAZILAND

There is not yet any legislation that makes express mention of HIV/AIDS, but some changes to current Swazi laws have been proposed. The process of drafting an Employment Bill is under way. It is likely to incorporate most aspects of the various International Labour Organisation conventions to which Swaziland is a signatory, as well as regional instruments such as the SADC Code on HIV/AIDS and Employment. A Public Health Bill is envisaged that will incorporate issues related to HIV/AIDS, while criminal and correctional services laws are to be amended to address the new challenges posed by HIV/AIDS. Funds have been allocated to assist the Correctional Services department to review legislation in order to make it responsive to the needs of prison inmates with HIV/AIDS.

Under Swazi common law and customary law, the status of women is that of legal minors. Women have to obtain permission from their husbands or guardians in all legal matters or important transactions. Swazi inheritance law prevents a woman from inheriting anything from her deceased husband’s estate in her own right. Rural women can have access to land only through a husband if she is married, or through a male relative if she is single.
9.4 ZIMBABWE

The Sexual Offences Act imposts greater penalties for rape on the perpetrator if he has HIV. Section 15 of the Act makes it a criminal offence to wilfully infect another with HIV, while sections 9 and 11 criminalize sex work.

The Labour Relations (HIC and AIDS) Regulations of 1998 provide for the availability of HIV/AIDS education and information in the workplace and for confidentiality, while prohibiting pre-employment testing and unfair dismissal on grounds of HIV/AIDS.

9.5 LESOTHO

Lesotho has no laws that refer specifically to HIV/AIDS. A Sexual Offences Bill is soon to be enacted that will provide for the following:

- widening the definition of rape to include interpretation of marital rape;
- sentences that will take into account the HIV status of the rapist (a person who, knowing or having a reasonable suspicion that he has HIV, rapes another can be sentenced to death); and
- free medical attention to rape victims.

Another proposed piece of legislation entitled the Married Persons Equality Bill would attempt to rectify inequality between husbands and wives. Currently, under customary law women are regarded as minors, while married women are under the guardianship of their husbands and unmarried women are under the guardianship of their fathers.

9.6 MOZAMBIQUE

An untitled law called Act No. 5 of 2002 contains a number of provisions that deal with HIV/AIDS in the workplace. The Act prohibits pre-employment testing for HIV and guarantees the right to confidentiality with regard to HIV status in the workplace. In the event of occupational exposure to HIV, “guaranteed medical assistance as well as adequate medication” is provided for and must be paid for by the employer. This law
makes it compulsory for employers to provide HIV/AIDS education, information, and advisory services to their employees. Dismissal on the grounds of HIV/AIDS is “regarded as dismissal without just cause”.

No legislation currently exists in Mozambique that provides for the special needs of targets of domestic violence. According to Article 1674 of the Civil Code, the husband is seen as the head of the household, which effectively makes the wife his subordinate. The property of the wife is given to the husband and she can only transact commercially with her husband’s authorization.

9.7 Australia

Australia’s approach is different from the other countries we have reviewed so far. It is based on a comprehensive statute on HIV/AIDS, the HIV/AIDS Preventive Measures Act of 1993.

The HIV/AIDS Preventive Measures Act provide for prevention, treatment and for the protection and promotion of public health. It also addresses the rights of persons infected with HIV/AIDS or at the risk of HIV/AIDS infection including issues of prevention, counselling and care.

Part 2 of the Act for detailed regulation for HIV testing. An interest aspect is the fact that there is a statutory obligation on the Government to provide facilities for testing. Pre-employment testing is specifically prohibited without any qualification. So is the conditioning of provision of services on HIV testing. Part also contains details rules relating to consent, the essence of which is the requirement for consent before HIV testing. If the person to be tested is under the age of twelve, prior written consent of his/her guardian and or parent should be secured. There is also a statutory obligation for pre-test counselling. The Act has detailed rules of privacy and confidentiality. In the case of confidentiality, it does not have a shared confidentiality exception.
The Act gives courts the power to hold proceedings in camera if it of the opinion that the HIV status of one of the parties may be an issue and or that the HIV status of any person may be disclosed. Any communication made by a person undergoing an HIV test, any surgical or dental procedure or counselling under the Act relating to the sexual behaviour of any person is not admissible in any proceeding some sections of the Australian Criminal Code.

Intentional and or deliberate transmission of HIV infection is an offence. In particular it is an offence to knowingly or recklessly place another person at risk of becoming infected with HIV.

9.8 Kenya

Kenya’s proposed Bill on HIV and AIDS Prevention and Control of 2003 is a comprehensive set of proposals that incorporates international human rights on HIV/AIDS. It has borrowed extensively from ILO and UN instruments on HIV/AIDS.

The Bill imposes express obligations on the Government to promote public awareness about the causes, modes of transmission, consequences, and means of prevention and control of HIV/AIDS through a comprehensive nationwide educational and information campaign. Thus it recognises the critical importance of health related information in the battle against the pandemic.

Compulsory testing would be prohibited. So would be HIV testing as precondition for employment, marriage, admission into any educational institution, entry into and or travel out of the country, the provision of health care, insurance cover and or any other service.

HIV testing would be conditioned upon informed consent. Government is obliged to provide testing centres and services. The Bill proposes very strict and progressive rules of confidentiality.
One innovative provision relates to access to health services. All health service providers, public or private, are obliged to facilitate access to health care services to persons with HIV without discrimination on the basis of HIV status. Government is under a general obligation to take all necessary steps to ensure access to essential healthcare services including access to essential medicines at affordable prices by persons with HIV/AIDS and those exposed to the risk of infection. Given this provision, Government may successfully be challenged in court if it does not take advantage of the Doha Declaration paragraph on essential medicines. Intentional transmission of HIV infection is an offence.

The Kenyan Bill were, it to become law, would result in the establishment of an Equity Tribunal for purposes of enforcing the proposed law. The proposed law also contains provisions that would regulate biomedical research generally and clinical trials in particular.

9.9 Ghana & Tanzania

Ghana and Tanzania have opted for a similar approach which is different from that discussed above. Instead of opting for an HIV/AIDS prevention and control law setting out the rights and obligations of PLWHA, the two countries have proceeded by setting up statutory commissions, being the Tanzania Commission for AIDS, 2001 and Ghana AIDS Commission, 2002. The laws of the two countries set up autonomous commissions which mandate include the formulation of policies and strategies on HIV/AIDS and coordinate the fight against the pandemic. In short the functions of the AIDS commissions in the two countries are similar to what Botswana’s NACA does except the said commissions have statutory foundation from they are guaranteed autonomy.

- Our view is that we should avoid the easy option of picking one country’s approach. Instead we are more inclined, at this stage, to consider picking the best elements from different jurisdictions and build on the existing institutions to build a new and more human rights responsive institutional
framework. Substantively consideration should be given to adapting the South African approach to pre-employment testing

- Consider legislating against marital rape as Lesotho
- Legislate to non-discriminatory access to medical services
- Legislate for non-discriminatory access to medical aid schemes services as in South Africa
- make it compulsory for employers to provide HIV/AIDS education, information, and advisory services to their employees (Mozambique)
- Ban Employment HIV testing as in South Africa.
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ANNEX 1


FINDINGS

1.0 Legal Issues

1.1 Constitutional Issues

Majority of the informants felt that the constitution should be amended to provide for social an economic right such as the right to health. They maintained that health is one of the basic core fundamental rights that we expect as the member of society. It should be constitutional because it is one of the basic core needs. It was emphasised by most discussants and respondents that it should be written in ‘black and white in the constitution’. The right to health should be made more explicit.

One key informant buttressed the point by arguing that:

*The constitution should be amended to provide for social and economic rights such as the right to health because health is one of the basic right of an individual. And the Constitution of Botswana should ensure protection of that right for its citizen, big and small, adult, children, men and women. Having it in the constitution will ensure that all attempts and efforts will be made in the promotion of one’s health. Internationally, it is not the right to health that is included in the constitution but the highest attainable standards of health. From State’s perspective, the state explains to us but cannot guarantee the right to health but cannot make sure that everybody is healthy, however, it can make sure that the highest attainable standard of health can be reached.*

There were however, those who cautioned that while it would be ideal for Botswana to subscribe to all International Instrument trends in terms of human rights and democracy, these come with resource implications. One key informant contended that:
There is a belief in Government that those kinds of rights come with responsibilities which Government may not necessarily be ready in terms of financial and other resources to actually comply with them. Government's intentions are always noble. As we know, Botswana has not ratified that particular International Instrument on economic and social rights, reasons being that—Government is preoccupied with other pressing developmental issues. But with time, when people start appreciating those international issues, if they are really asked for, Government will be more comfortable and relaxed about these rights. So far, the constraining issue is the resource issues but ideally I think the Constitution should be amended.

Those opposed to this argued that health is part of life. That health is someone's choice. That people should make informed choices themselves how they want to lead their lives. They argued that health is not only about the absence of the disease or infirmities but social, economic and cultural phenomenon. They argued that from public health perspective, amending the Constitution will be tantamount to setting people against their will, thus making them do things that are not right. Others argued that the Constitution as it is accommodates all rights to the extent that amending it will be going too far. They argued that Botswana already provides free health care.

1.2 Mandatory HIV testing

Majority of respondents explicitly stated that Botswana's priority should be its citizens. They stated that the constitution should discriminate non-citizens by screening them before they come to reside in Botswana. They argued that there are certain benefits and rights that should exclusively be enjoyed by Botswana citizens. One legislator argued that:

It is a fair undertaking if HIV testing was mandatory for non-citizens when they come to Botswana, in the sense that one will not want to burden the already burdened economy as additional loads of no-citizens will eat away limited resources which otherwise should be availed to the citizens. …The other factor being that non-citizens may bring different strands of HIV/AIDS related diseases which we may not know and this may require more drugs which are expensive as those may have no have been identified with our local HIV people.
Those who support mandatory testing of non-citizens posit that this will help identify non-citizens who are likely to put a serious strain on the Botswana meagre resources thus burdening the already burdened health-care system. One key informant argued that “even under International Law Botswana has no obligation to admit aliens at all cost”. Another key informant stated: ‘Non-citizens must pay for the medical services and I do not think that if we are asking people to pay for the services it is necessarily discrimination’. Some in this category contended that only emergency health care should be provided to everybody.

A few felt that both citizens and non-citizens should have access to health because as one informant contended:

‘we cannot discriminate against non-citizens because a single person that comes to the hospital with a particular infection condition can cause or result in the entire health of the population being put at risk. Therefore, whatever is being put in place from the health perspective should not be discriminatory because diseases do not consider whether one is white or black, Motswana or Ugandan. ....We should provide health holistically as broad as we can for all people within the country at any point in time. Whether we eventually have some cost recovery mechanisms, it is a different argument but the fact of the matter is we should ensure that the health system covers everybody within the country at any point in time.

Those who supported non-discrimination maintained that some Batswana who have foreign partners are experiencing serious problems as while some of them are eligible to ARVs, their foreign sex partners are not and this creates problems. One key informant (District Aids Coordinator) lamented:

It is painful in that right now there is no policy with regard to how if a citizen is married to a foreigner and they are both positive they can be helped. Because what happens in hospitals is that citizens are the only ones that are helped, but the policies are silent on this. The other thing being in Botswana we have developed a culture of cohabitation
whereby people will stay together for many years and have children outside marriage but when they become HIV positive, it becomes difficult in that the other one who is non citizen will not be helped with ARVs. Right now there is a case like that in ..., where a couple has stayed together for six years with two children, the first born being negative and the other positive and so is their parents. Right now these people are involved in alcohol abuse trying to relieve the stress that the husband who is non citizen is not enrolled in ARVs. However, we are making efforts with the Roman Catholic Church to help the husband have access to ARVs and also working on counseling them for behavioural change with regard to their alcohol abuse.

The above citation indicates the dilemma that Batswana who are cohabiting with non-citizens face. While almost all respondents and discussants concurred on the economic ramifications of amending the Constitution to prohibit expressly discrimination based on nationality as when foreigners get to know that there is free medication for ARVs then they will come to Botswana to exploit our resources, some called for the policy to assess marriage of non-citizens to Batswana.

1.3 Pre, Periodic and Post HIV employment Testing

Majority of respondents and discussants contended that while ideally it would be a good idea to do pre, periodic and post employment HIV testing, pre employment HIV testing poses a difficulty. Those who advocated for pre-employment HIV testing contended that it would be difficult for the employer to provide for the staff's welfare if the employer does not know the serostatus of his/her prospective employee. A few argued that it should not be mandatory to test before employed but once employed, it is important for one to take periodic testing such that one could maximise the opportunity of available services such as HIV/AIDS ARVs. They argued that periodic and post employment HIV testing was important so that people could enrol early for anti-retroviral therapies that are available. They expressed mixed feelings towards pre employment HIV testing. That it would be difficult to detect those who would deny PLWHA jobs. They contended that as long as the motive for HIV testing was to come up with programs aimed at helping the employee, it should ideally be encouraged. Some reported cases where people were denied jobs or have their jobs terminated on the basis of HIV seropositivity. They
cautioned that pre HIV employment testing was dicey as some employers engage in covert discrimination. One PLWHA key informant argued:

…a total ban may not actually be the answer. Firstly we need to know what is their aim of that test, what is that test aiming to achieve, whose interest is it serving? The company’s interest or my interest? Well, if the aim of the test is not to employ someone because the company believes he/she is HIV/AIDS positive and that in two or three years he/she might not be as much productive then that is wrong. It depends on why are people being given pre, periodic testing, but if it is just the routine then it is fine but if it is being used as the criteria to discriminate from giving people a job no matter how qualified they are than other people, then that is wrong. So, it basically depends on what are our aims of testing people.

Those opposed to the pre, periodic and post employment HIV testing cautioned that human rights of privacy and confidentiality would be eroded if mandatory testing was required.

Those with public health background argued that pre, periodic and post HIV employment test should be based on scientific and epidemiological principles. One medical doctor argued that:

When testing someone at one point, the principle epidemiologically is that you should be in a position to track them all along at different time points, find out what their status is, if at all he/she becomes positive then you should be in a position to contact track…. So, there is no point in saying you are going to test one person at one cross sectional point and not have in place systems to track them. By doing pre employment testing that is probably the least decision that one got to take. if committed to do that, then he/she should be committed to tracking people and that is where the basic principles are and provide for employees and have whatever resources they should have in future if at all you were to need those because one have changed HIV status say positive. Do have antiviral therapy.
There was a few who felt that certain professional jobs should mandate pre employment HIV testing such as medical profession, pilots and cooks. Some argued that pre-employment medical examination should include HIV/AIDS. They maintained that the HIV exceptionalism fuels the stigma and it is time to normalise HIV/AIDS and treat it like any type of ailment.

One key informant said:

*From the epidemiological perspective, if you are pre testing before employment, you should be able to track throughout and should be able to have put in place programs to ensure that if somebody were to enter negative subsequently following them up over time to ensure that as soon as they become positive, they are provided with programs and assistance to ensure that they remain healthy and they have positive productive period of employment.*

There were those who argued that HIV/AIDS should be part and parcel of each and every examination that was being done. It should be looked at as a holistic picture. One medical specialist summed it all up when he retorted:

*Personally; I have now come to a point that even with the counseling of HIV/AIDS it is like we are actually hiding behind it. If it is counseling it should be done for any other diseases such as diabetes, hypertension and the same principles should be applied to HIV/AIDS too. It should be part of the wellness program where people will be examined to ensure that they are well in employment and all tests has to be done just like we screen for TB, high blood pressure we should screen for HIV/AIDS in the same manner without in anyway discriminatory.*

A few that advocated for pre HIV employment testing was polarised on whether this should be done with or without consent. Some argued that pre employment medical examination that includes HIV should be done with consent of the person while some felt that it should be done the same way high blood pressure and other diseases are tested.

**1.4 Informed Consent**
The issue of which criterion should be used for informed consent for HIV testing elicited many responses. However, most people felt that instead of either using sexual activity or age threshold criterion or both, the crucial thing was to determine the capacity to comprehend what was involved. It was asserted that when referring to informed consent, since the rationale was to ensure that people understand the nature of risks of a particular disease, education on nature of diseases should become before people are even exposed to that particular risk. One key informant (Medical doctor) dismissing the sexual activity criterion argued that:

*You do not normally wait for a person to become obese and then say this person has a high risk of having hypertension, so, why should you wait for one to be sexually active and then say one is at risk. The point here is that, all screening should be done early as we educate people against the dangers of a particular illness or situation.*

Informed consent should be based on the capacity to understand. One key informant (PLWHA) put it succinctly:

*It should be based on sexually active, age plus more. It depends on the context that an individual is at because sometimes one is testing not that he/she is sexually active, some did it because they want to plan life. Saying if a parent is taking a child of 9 years for HIV testing, it depends whether the parent consent for the child taking that test, it does not necessarily mean you are looking at the age of that child not necessarily looking at whether that child have started sexual activity or not; so the consent can be given by the parent because they could be other reasons that are motivating that parent to give that consent for the child who is at least below age 16 as per the current policy guideline for young children. Maybe informed consent from a guardian is important but we need to redefine what a guardian is because if the uncle abuses children sexually, then he cannot take the children for testing. Should come with other things that guardian can either be a chief, social workers etc and the term guardian should not mean relatives only.*

The criterion for determining the capacity to understand was controversial as some argued for age 16 while others asserted that age 16 was too late as most adolescents initiate sexual intercourse as early as age 10. Some argued that as soon as adolescents
are in secondary school, that is form 1 level, it will be reasonable for the kids to understand the implications of the disease by themselves and if they do understand; the consent of the minor should be accepted before talking to the parents. When the parents or guardian are not available and if at all the minor does not understand, they should not be compelled. One key informant reported that

There are children who are HIV infected who are 12 years or 13 and now there is no way that they will come to the doctor and say they need the consent of parents in that situation. The child has to understand that they take their medication for life; they understand how they got exposed in getting infected. If the doctor does not get their consent for him to be able to draw their blood to monitor them, then they are not going to be complied in giving medication, find ways and means of running away from that responsibility. They have to be empowered enough in terms of education and in terms of them being seen taking the decisions themselves as long as they do understand. And this is where the issue is not really all about only informed consent, it should be laid with an assessment of understanding why the consent is needed, then age and sexually active become irrelevant.

Still some questioned the logic of using either sexual activity or age threshold on grounds that HIV was not only transmitted through sex. Some questioned why HIV was not treated like other medical problems. ‘The problem is that people are stigmatising HIV/AIDS by putting it in a category as an exclusive disease whereby we need to get a password into getting into it’, retorted one key informant. Overall, the conclusion was that age and sexual activity are related. Looking at age alone was not enough, what goes with age was very important. The level of maturity and mental ability should be taken into consideration.

1.5 Public Disclosure and Stigma
Respondents and discussants were polarised on the claim that if the people publicly disclose their HIV status, this would deal with stigma.
One medical doctor argued that:
I don’t absolutely agree with it because it is like smoking tobacco in the air. There is no reason for us to say a particular disease should be publicly disclosed… Basically this depends on who you are because some people will say “this person is fit and healthy” he/she is lying he does not have the virus, but for somebody who is absolutely sick; fully blown and coming out on air, people start looking at that particular person as having particular impact than one who says he/she is positive but no signs of the disease. For distigmatisation to occur we need the people when they are sick, when they do have the signs, they do have something we can show people what is really AIDS. And these are the people who need to come on air and tell people that they are HIV positive and then people will look at them and see how serious it is. Basically what should be done to people is just by telling them that HIV/AIDS is a disease like any other but there are some people who are still psychologically programmed that a disease is when somebody is ill. However there is differentiation between somebody who has HIV and somebody who got AIDS. So we want to see more people who have HIV/AIDS coming forward and thus when may be we can talk about distigmatisation but for the large part it does not distigmatisate for coming out.

On the contrary one PLWHA argued that:

It shouldn’t be a law to go public about your status, it should be from one’s will. Going public is okay as it can deal away with stigma. There are many ways of going public, does it mean on TV, community or what. What does public disclosure mean? Because definition of public disclosure most people may think its being in TV of which will be just for 35 minutes. It does not help because to reduce stigma we need to mentor people. Stigma is a process, we need mentoring program. With stigma, it is attached to so many other things in our lives. They should come up with a policy that talks about public disclosure as a strategy to reduce stigma and need to be clear that when we talk of public disclosure what is it necessary that we are talking about. Is it the person who is disclosing, are they motivated to do that and why are they disclosing. The most important thing, is not to get people talk, the real strategy will be for us as the country to create an enabling environment where if people disclose they do not feel the negative feedback from the community. Like right no, there is a question in our country that what
is so special about HIV/AIDS that people will go public. Why can’t that happen for other diseases. Disclosure could be offering PLWHA opportunities to work with communities as public speaker’s body. Its not just a recipient of services, to engage, provide services in the community and this is the strategy to deal with stigma and not for people to go on BTV or Radio Botswana. For public disclosure even if you stand in Africa Square then that is not the kind of public disclosure. What one has disclosed to people is allowing yourself to utilize yourself within the community as a factor or agent of change. People are stigmatizing HIV/AIDS people for no good reasons… Public disclosure also depends on how much information does the public have. They shouldn’t be any incentive for declaring one’s status. … right now when it comes to public disclosure people feel if they disclose they are going to be given money. The incentive should be an individual himself/herself, why disclosing, is it for yourself or for your children. HIV/AIDS is not only for that particular individual as the children can be affected as well. What goes around comes around. People are very selfish when it comes to their HIV/AIDS status. For people living with HIV/AIDS, education is very important to reduce self stigma.

Some people were sceptical about public declaration of HIV status. They argued that stigma could not be killed by going public, stating that all that was needed was for people to understand the disease and accept the situation of the disease as it is now and that will reduce stigma. It was argued that stigma emanated from fear, denial and lack of societal acceptance and all these could be curbed by education as they border on ignorance. As long as people could be educated, stigma would be reduced.

1.6 Confidentiality and shared confidentiality
Almost all respondents and discussants felt that confidentiality should never be incorporated into statute because doctors, nurses and other health professionals are regulated by their professional code of ethics. All respondents with health background emphasised that medical practitioners and public health experts are either bound by the public health act or Hippocratic Oath to observe the individual rights and dignity and strict adherence to the principle of medical confidentiality. They argued that rules of confidentiality in doctor or nurse-patient relationships are included in codes of medical
professionals. They argued that even for ordinary citizens, some malicious individuals may misuse it if it is turned into a law whereby the aggrieved can sue.

One medical doctor commenting on whether confidentiality rule should be made into a legal rule commented:

*Doctors are blamed for things they have always done in terms of confidentiality between doctors, clients, lawyers or whatever of which it is professional. And as far as I am concerned, it should be left at that end. There are specific professional codes that should be left in charge of that and the processes and mechanisms of dealing with people who get to breach people’s confidentiality. If it becomes a legal entity, am afraid that it will lose a lot of technical professional experts. You cannot legislate for something like that; it should be left within professionals.*

Another doctor buttressing this point argued that:

*There is what is called Hippocratic Oath, which is based on the Constitution of the country because as the country, you swear under the ethic of your Constitution. Say if High court instructs the doctor to reveal some information about medical record, the doctor has to do it. It is the law of the land. So, I do not see how medical confidentiality can be divorced from legal confidentiality because it is the law of the country which has established the Hippocratic Oath that one takes. So, everyone who works with some kid of clients, if they disclose one’s status, they should be sued. We shouldn’t be separately talking about medical confidentiality and other confidentiality. Confidentiality is a basic human ethic.*

Even respondents and discussants without medical background expressed displeasure with confidentiality rule being made into law. Their concerns were that people would spend time in courts trying to resolve baseless allegations that their confidentiality has been breached. Others argued that this also poses a problem of shared confidentiality. Some raised the issue of PLWHA care, support and treatment process that it involves engaging many persons such ad the medical, paramedical, social workers, administrative staff and pharmacists who must have knowledge of all or part of the
medical and personal data of the person living with HIV/AIDS. If this person were to sue for the breaching of his confidentiality, who would he really sue in this continuum? The issue of shared confidentiality elicited heated debate. The overwhelming majority of respondents and discussants supported it and were against it being incorporated into statute to be law. They maintained that shared confidentiality was introduced so that people could disclose their status to their caregivers. One key informant said: ‘If it is parents, then with their greetings, they tend to inadvertently disclose other people’s HIV status without intending to do any harm’. It was argued that parents would innocently disclose the status of their HIV infected children or relatives without noticing that they were doing anything wrong. The Setswana culture of greeting intrinsically requires that you divulge the health status of your family members. This, therefore, means that before thinking of the any legal measures, culture should be considered.

Very few respondents and discussants strongly felt that confidentiality rule should be made legal. They asserted that some people make life of PLWHA very difficult, especially at work by passing information to other workmates without the prior consent of the person concerned, thus violating the privacy of this person. They argued that some deterrents should be put in place. Breaching confidentiality fuels discrimination and marginalize people living with HIV/AIDS.

1.6.1 Storage of HIV/AIDS related information
All respondents who had knowledge about how HIV/AIDS related information was stored mentioned that it was stored like any other medical records. They mentioned that like any other information; it was locked if at all the files of people with high blood pressure is locked. They argued that HIV/AIDS should not be treated any differently. All medical records should be treated with same strict code to ensure that they are kept appropriately irrespective of whether they are for HIV/AIDS or not. This sentiment was expressed by all respondents and discussants who knew how medical records were kept.

1.7 Why HIV/AIDS is not a Notifiable Disease.
Almost all respondents with medical and public health background mentioned that HIV/AIDS was not a notifiable disease because it had some ethics and confidentiality attached to it. The other reason was that HIV/AIDS became a human right issue instead of a medical problem and they mentioned that this had created problems. They alleged that routine testing was introduced to make it notifiable so as to be able to track its incidences. They also reported that a notifiable disease is a disease that action could be taken to make sure that a person having that disease did not die from it or spread it to others. However, with HIV/AIDS, it was different because a person could not be treated for it and released back to the society after being assured that he was HIV/AIDS free. They argued that it would not help to make HIV/AIDS a notifiable disease until there was a cure for it.

One doctor responding to this question stated that:

*HIV is not a notifiable disease for two main reasons. We looked at the wrong model when HIV/AIDS hit us. We didn’t look at the public health model but rather at the human rights perspective and model of HIV/AIDS. And if at all we genuinely followed the basic public health-related models of infections contagious disease it should have been in my opinion a notifiable. The second issue is that it is a chronic illness and most of the notifiable diseases until now have been the acute rapidly progressive infectious contagious type diseases like Ebola, SAS and these sorts of diseases. Malaria for us is still notifiable because it is relatively acute and we need to know how many cases of malaria we are getting. Diseases like whooping cough, these sorts of diseases like TB, that when you get them you infect a person in a relatively very short period of time. Most of the notifiable diseases have been for the large part the acute ones, now for chronic ones such as HIV/AIDS, the question was if at all it were to have been classically notifiable, which means we have to put in place the principles of test, track and contact trace. And that is what notifiable disease should do. You test, track and contact trace.*

All the health professionals who knew why HIV/AIDS was not a notifiable disease stated that Botswana adopted the human rights perspective rather than the public health perspective when HIV/AIDS came out here. They contended that this might have
emanated from the fact that from the beginning, HIV was associated with homosexuals, people who were lobbying for certain rights in a population other than ours. It was argued that here in Botswana, HIV was occurring among heterosexuals. It was contended that it was wrong to have copied the model adopted by people who were marginalized like homosexuals. While it made sense for homosexuals who were stigmatized for spreading HIV/AIDS to lobby for rights like access to medication and fair treatment, it was hard to comprehend why HIV was not treated as a public health issue in Botswana but a human right one. To buttress this, one key informant argued:

*The human right model was the wrong model and a lot of people will argue now that it was a wrong model to adopt, and in that way I think we are accessories to genocide. Certainly as a profession we should have stood up and screamed and shouted and even now we are not shouting and screaming enough.*

The overall sentiment however was that HIV should have been treated like any other diseases. Nevertheless, they argued that as professionals they should have advocated for the public health model even though they were cognizant that some people would say by so doing, professionals were driving people underground. They contended that concerted effort on educating people was the solution for allaying all these concerns.

1.8 Guidelines for HIV testing and Partner notification

Almost all respondents and discussants, in exception of Tebelopecle respondent mentioned that they did not have any guidelines for HIV counselling aimed encouraging or motivating PLWHA to disclose their HIV status to their sex partners. They all reported that they employ their professional tool in the form of expertise to persuade or convince the patient to notify his/her sex partners about his/her HIV seropositive status. They reported that in most cases when encouraging people to disclose their HIV status to their sex partners, they are more based only on their initiative to assess the situation that one was in.

Some reported that only lay counsellors have general guidelines for people including to disclose their HIV status to their partners. However, some felt that there was no need to have guidelines because is situational, even in the case of HIV/AIDS. HIV/AIDS affects
individuals differently, so, blanket guidelines may not be appropriate. They, however, reported that if the patient was reluctant to reveal his HIV status to his/her unsuspecting sexual partner or intending not to modify his/her behaviour so as to minimize chances of viral transmission, there was nothing they could do. They also mentioned that even though they encouraged couple counselling, this had mostly proven unsuccessful because some partners, especially male sex partners, refuse to accompany their partners for HIV counselling.

Some respondents and discussants argued that in a situation where the patient is reluctant to reveal his/her status to her sexual partner, the HIV counsellor should forfeit the duty to protect confidentiality and warn the potential victim. However, others felt that this would be violating the confidentiality and privacy of the patient. They argued that the counsellor could not breach the confidentiality of his/her client at the expense of third parties.

One key informant reported that:

_VCT is for individuals to promote disclosure. Tebelopele statistics shows that 20% disclose to their partners and 80% don’t. With 196 000 people that have tested from Tebelopele since 2003, it actually shows that 8-9 percent of couples are discordant and about 6% of them do not disclose…the chances are that they are living with a negative partner and overtime they are going to infect that particular partner if they do not disclose. There are guidelines included in the protocol how one is going to inform his/her partner and the counsellor role plays it with the client on how partners will share the results. But the chances are that people do not disclose because of fear of losing the support that they are getting from another partner. Measures are included in the protocol to make sure that the counsellor follows it when doing his/her sessions. Thereafter, there is clients’ survey on how the was._

One medical doctor grappling with this issue argued:

_The contact person in my opinion is at need to know person. Anybody who you are sexually in contact with is a need to know person and for me I have no doubt about it_
they can sue me but confidentiality does not arise in that context and should not arise in that context because they are exposed. And if anything, this is where we should tap issues, I would be adjudicated to have failed in my profession if at all denied the consent to go and discuss with a contact, I don’t overrule that. And I believe that is a very important issue. 20% of relationships are discordant, where we have got a husband and a wife who consistently have sexual contact; unprotected sexual contact, 20% if you go at any one point in time, you will find that one is positive and the other negative and if you go to that same relationship after about 5 years we find that that rate has gone down. We will find that has dropped down to as little as 5% which means 15% of those people that could have been protected and prevented that infection from occurring have now become positive. Because it is not that we get HIV/AIDS simultaneously one party will have HIV and it will take a number of sexual contacts before the other party becomes positive. Our immunity levels are different one may get the infection far much more easily because of the weakened immunity for whatever reason. The other one the immunity level may be far much stronger genetically and therefore it takes far much higher exposure for them to get infected but with repeated exposure eventually if we track them, that’s the word, if you track them these people who were discordant, we find eventually that partner who was negative will eventually also get infected with HIV.

This question engendered a lot of arguments with most people feeling that even though it would be a noble idea to notify unsuspecting sexual partners, the snag is that most Batswana are in multiple sexual relationships and this might prove daunting for the HIV counselor to locate all these. However, some argued that married and long-term cohabitants should be the ones targeted.

All respondents and discussants suggested that measures should be put in place to ensure that people disclose their status to their stable known sex partners. They also suggested that with partners who are asked to voluntarily disclose their status to their partners and even go to the extent of infecting other new partners, something must be done in terms of behavioral change processes that include punishing those who willingly infects the other partner. Several incidences were cited whereby some sex partners
were caught by their unsuspecting partners waking up in the middle of the night to take ARVs without the knowledge of their sex partners. This was expressed as a sorry state of affairs that needed legal redress.

1.9 Mandatory HIV Testing of Sex Offenders
Almost all the discussants and respondents supported the compulsory testing of persons accused of sexual offences such as rape and defilement. They argued that it was justified in order to know the kind of help to be given to the victim. Some informant decried that the application of the law on sex offenders was flawed. This is because the accused is compelled to test only a few days before the sentencing which, in some cases, takes place a year or more after the offence incident. They argue that in this instance, therefore, the mandatory testing as a basis for sentencing the accused is neither useful to the victim nor to the court proceedings. However, a few raised the dilemma of establishing who really infected who. As one District AIDS Coordinator commented:

*With rape we are looking at basically two issues. That whose human rights are better than the other? The rapists might refuse to test; and also, one who has been raped should be sure whether it is the rapists who infected him/her. When raped, the two should be tested.*

The other key informant (PLWHA) also echoed the same sentiments when he said:

*In case of rapists, mandatory testing is right because we need the results to protect the person raped because sometimes the person need to be given PEP (Post Exposure Prophylaxes) but if mandatory testing is for other purposes like employment, then testing shouldn’t be mandatory because then it will lose its own value, because testing is personnel. In cases of rapists, if the victim is the one who is HIV positive then how does the law determine who passed the virus to one another?*

The overarching argument against mandatory testing of sex offenders was based on the problems of evidence, given that in Botswana, the accused is only compelled to test for HIV after the court hearing, which, in most cases, is protracted. The issue of defilement
was also reported as a thorny issue in this era of HIV, in that some parents are allowed to withdraw or coerce their children to withdraw court cases. This was reported as a serious violation of children’s human rights. This also means that if the offender, who might be an uncle or father is HIV positive, all necessary precautions are not taken into consideration.

1.10 Employment/Training and Insurance Differential treatment of PLWHA

While the majority of respondents and discussants were generally against pre-employment screening of job applicants for HIV, there were those who were sympathetic to prospective employers’ plight. Almost all respondents and discussants argued that employers like insisting on pre-employment HIV testing mainly because they do not want to compromise productivity. They were also bent on pursuing profit maximisation, hence, are risk averse when it comes to dealing with uncertainties like employing PLWHA. They also mentioned that this was particularly true if the employer was expected to bear costs of medication and death benefits.

All respondents and discussants lamented that the practice of insurance companies treating PLWHA differently in life cover was not fair and that they should not do that only on HIV/AIDS, instead they should treat HIV/AIDS like any other disease. The notion of treating PLWHA differently was premised on minimising risk. The insurance companies asserted that the differential treatment was not peculiar to PLWHA as even those with other ailment are asked to pay higher premium than those who were medically fit. However, some people said insurance companies only started treating people differently after the advent of HIV/AIDS.

The bank creditors were reported to be hiding behind the insurance companies in discriminating PLWHA in that they would tell their customers that if they needed a certain amount of money, say P100 000.00, they would need insurance cover called credit life cover. This would normally mean that for insurance to agree to insure that amount they require HIV status which if happens to be positive, in most cases, they decline to cover the client. It was also mentioned by the insurance that if one has been having a policy that they abandoned without any explanations, if the client wants to
revive the policy, he/she is asked for HIV test. The argument put forward was that some people start wanting to continue their policy that they abandoned when they realise that they were HIV positive. It was also stated that every insurance employee is entitled to four years annual salary for death benefits/compensation. However, if the four times annual salary compensation amount is more than P1.2 million, the beneficiary is required to test for HIV before he dies. It was stated that many eligible employees always opt for less than what they qualify for fear of undertaking HIV test. One key informant criticising the insurance’s discriminatory practises argued:

*Insurance companies should now have models that should facilitate for these people to be treated like people with any other chronic illness. Insurance should be about modeling according to the survival care of any people with any particular diseases and they should not decline to insure them. If declining PLWHA to join insurance company then that is discriminatory.*

However, some were quick to mention that this, however, is a function of ignorance based on false notion that HIV positive employees will not perform and that they will either be mostly absent from work or may die sooner, thus, requiring the employer to pay for employment benefits and other costs. One key informant argued that:

*There is a bill that is being drafted now, Public Health Act. Government has said they probably do not want to pronounce itself very explicitly on pre, periodic and post employment HIV test, because this closes all options. The current policy that is being done by Ministry of Labour and Home Affairs which says employers have got responsibility to take care of the employee and that will probably mean the employer must know the status of the employees. Then if that is the case, it means before employers hire anybody they must know their status, such that they can take care of them. But it becomes a problem when one is HIV positive but the employer likes that individual’s qualifications and experience then the only thing the employer does not like is that individual’s HIV status, it means then it is cost to the employer to take care of that individual. Then if the employer does not hire that individual it basically means the employer has discriminated that individual on the basis of his/her HIV status*
The issue of pre-employment testing elicited a lot of ambivalence among respondents and discussants. Some argued that if employers are obliged to take care of their employees, they should also be allowed to know the health status of their employees including whether they are HIV positive or not. This was necessary for planning and budgeting purposes. Some in this category argued for exceptional cases, saying that there could be an arrangement whereby employees are asked to test but not to disclose their status because with the disclosure, there will be a potential for discrimination. They were however; quick to caution that there should be mechanism that ensures that employers do not deny PLWHA jobs.

The other contenders argued that from the epidemiological perspective, if pre testing before employment is required, employers should put systems in place that will be able to track the employees. They argued that programs should be put in place that will follow overtime those HIV negative employees to ensure that as soon as they become positive, they are provided with programs and assistance to ensure that they remain healthy and they have positive productive period of employment. This group also maintain that HIV/AIDS should be part and parcel of each and every examination that is being done. It should be looked at holistically. They contended that HIV/AIDS testing should be part of the wellness program where people will be examined to ensure that they are well in employment. All tests have to be done just like screening for TB, high blood pressure, HIV/AIDS should be screened in the same manner without in anyway being discriminatory.

They also mentioned that employers like insisting on HIV testing as a condition for future training because education is investment. Any employer who sends an employee for future training expects investment returns. They reported that no employer would like to invest on uncertainties. Sending employees on training is investment. All training of any sort should be based on the wellness or the capacity of the medical fitness of the person to undergo that training and to be able to come back, function in role that have trained for and able to recoup the cost of training. Some also mentioned the formidable costs of repatriating corpses from overseas to Botswana. That employer is not prepared
to bear those burdens. Its all about cost effectiveness but still HIV infected people go for training all the time and come back to continue with their work.

1.11 Condom Distribution in Prisons
Nearly all people concurred that condoms should be distributed in prisons even though they were cognizant of the fact that some people would then say prisoners were encouraged to practice homosexuality. They argued that prisoners have sexual feelings and that could not be stopped by their incarceration, therefore, what remains is that they should be protective measures to help them practise safer sex. They argued that many people who went to prison being HIV negative came out HIV positive. They also claimed that there were endless cases of rape that occurred in prisons and authorities were aware of these. They also reported that the hierarchical and crowded prison environment created conducive circumstances that even those who are not willing to practice homosexuality, can be easily coerced. They lamented that the reason why AIDS cannot finish is because Botswana is very slow to catch up with international practices. Some argued that there was a tendency among Batswana to deny reality thus being overtly hypocrites. Moralising on the issue was stated as the main reason for resistance. One key informant lamented that ‘It is criminal offence to distribute condoms in prisons but still these people are going to go back to the society of which then they can infect their wives’. One respondent emphatically said “Condoms should be availed and with information as these are adults who have been involved in sexual activity”.

They decried that prisoners are not even given IEC materials. They are treated as complete outcasts and this was reported to be contributing to the spread of HIV/AIDS. They argued that prisoners have the right to information in the context of the battle against HIV/AIDS, as such; they are entitled to relevant sex education including preventive services such as being availed condoms. Very few people opposed the distribution of condoms in prisons on the ground that it would be tantamount to licensing them to practise sodomy.

1.12 Distribution of Condoms in Schools
On the issue of condom distribution in schools, one key informant said: 

*I am not against distribution of condoms as long as they can help the society. They can be provided to schools, prisons and public at large. But with primary schools they should not be distributed but rather sex education should be taken to primary school children, mainly talking about the productivity of sex, that the body was created to have sex, what they should do when they experience it and how to handle it. Also, sex education should be done by a person who has been well trained for it, who knows how to communicate about it to children.*

Another key informant argued:

*Condoms should be distributed in primary schools, taking in consideration nowadays standard 5 pupils already know about sex. Sex education should be started as early as when a child can understand. For children to understand we need to pick them when they are still young so that they will grow up with it. We should make sure that these kids are safe as we are a caring nation “Vision 2016”; they should know that no condom no sex. Children between standard 5 and 7 are adolescents; they are exposed to a lot of stimulus. We need to teach children life survival skills. Let’s speak openly with our children. When we talk about HIV/AIDS is like we are talking to adults as if children are not living with HIV/AIDS.*

The general consensus was that primary school children should be informed to be educated. That for primary, condom is not the answer; it is a choice that is done later but that choice should be informed choice. It was argued that what should be brought upfront is the information which children will have clear understanding of the disease and once they know, they will make decisions to abstain and other different types of decisions including looking for a condom. They asserted that the question of the distribution of condoms in primary school have been in every country. With associated questions like, what age? When should we start saying what to who? The overall argument was that information, education and communication should be the focus and distributions of condoms should not be construed as an answer to anything.

1.13 Decriminalisation of Sex Work and Homosexuality
Issues of legalising sex work and homosexuality engendered ambivalence and deep-rooted and entrenched prejudices among most respondents and discussants. Very few respondents and discussants were of the view that sex work and homosexuality should be legalised. Whereas almost all concurred that these practices have always been there since time immemorial, they were of the view that legalising them would de-stigmatise them, thus, encouraging them to flourish.

Those who advocated for decriminalization of sex work argued that this would enable government to regulate it and ensure that if one has registered as a sex worker, one has to be given medical certificate every 3 or 6 months to ensure that she is not going to pose a risk to her clients and that will be in conformity with what public health is all about. They also argued that this would facilitate working in a safe environment as sex workers are working in a violent environment.

They further argued that everybody knows that sex work activity is happening and there is no point in condemning it or debating about it as the best thing to do would be to “to trap the spread of HIV/AIDS and other STI’s . It should be ensured that these people are able to be identified, they are out in the open and therefore legislation is the best way forward for that”. This was argued by one key informant who supported decriminalisation of sex work. They argued that health should be provided to everybody irrespective of profession of that particular person if they chose that for themselves their profession is going to be sex work; they should not be denied access to health or police protection. Their health should be safeguarded and protected. One key informant commenting on why sex work is outlawed said:

*It is because Botswana is myopic. There is this thing that Botswana is ruling with morality of which is not necessarily ours. Something that is not cultural-based, in that they are trying to preserve culture in that they are outlawing sex work and consensual sex between same sex adults. Morality of the church and the State are supposed to be separate but on the other side they are combined for preserving culture-whether homosexuality or sex works, these are things that are not peculiar to Botswana. These are people like everybody else; they also contribute to the spread of HIV/AIDS.*
Reinforcing the above view, one key informant asserted:

Well, Botswana is outlawing sex work and homosexuality because we are supposed to be a Christian country. Our Laws are colonially equipped with British country which is a Christian country. So, we outlaw homosexuality and sex work because they are considered not morally good, they are unchristian practices. The law should be changed looking at the reality of society that homosexuality and sex work are there and happening.

The other proponent of decriminalisation argued:

Culturally what do we say about homosexuality and sex work? As these used to be there in the past and now it should be the time we speak openly about them. With sex work, people are being driven by some circumstances to do that. Sex workers should not be discriminated but regulated to a certain level because it allows for people to know health seeking behaviour. People involved in sex work should be allowed to do regular check ups.

However, those opposed to the legalization of sex work and homosexuality were proportionally more than those who endorsed the practices.

One key informant argued:

It has been a view that relates much to morals. Therefore, homosexuality has never been an accepted practice in our culture. … It is very difficult to regulate such business on morality but I think it is sufficient for the public to know that a particular behaviour is not acceptable and by so doing, if we continue public awareness, public education at some point, we may record some positive impact. If we were to find the ways of finding the buyers of this service (sex workers), then we will be able to minimize infection from one’s sector.

In the same vein, one key informant defended the status quo by retorting:

Law was meant to protect human dignity as it was, so if changing the law, are we then saying sex work is okay. Prostitution whether there is AIDS or not is bad. With their marketing strategy whether a client uses a condom or not to them it is okay so what is it
that we are saying? Should the younger generation know that sex work is okay. Botswana society must speak clearly what it believes.

Another key informant opposed to legalization of sex work and homosexuality maintained:

*Botswana is a religious country, so they look at sex work as a shameful, dehumanising activity. Without legalising homosexuality it actually helps keeping it at lower levels.*

The general contention was that both sex work and homosexuality were immoral and unacceptable. In the minds of majority of respondents and discussants, sex is something which should never be sold. The overall contention of some people was that homosexuality and sex work are more of cultural and moral things. Although all respondents and discussants agreed that these practices have always been there, they were suppressed. Some feel that time has arrived for proper consultation with electorates and other key stakeholders, including surveys that could be reliable in terms of gathering the current people’s opinions about these issues. Others feel that the law is there to guide people, so, there is a need to legalise homosexuality and sex work so that they could be regulated as opposed to being abolished.

### 2.0 Institutional Arrangement

It was reported that initially NACA was under the Ministry of Health. It was during the Medium Term Plan II that there was a paradigm shift that stipulated that HIV/AIDS was not necessarily a health problem. It was concluded that HIV/AIDS was actually a developmental problem. Within the context of that paradigm shift, it was presumed logical that NACA should move out of the Ministry of Health and be placed under the Ministry that would “give it that complexion or even assist to deliver the message that we are now dealing with a developmental problem more than just a health problem”. It was stated that because NACA needed some authority as well as coordinating agency, that is why it was put under the Ministry of State President. It was further stated that NACA was not established by any Act of Parliament. It was established by Presidential Directive.
The rationale for NACA to fall under the Office of the President was succinctly put by one key informant:

*The idea of NACA being under the office of the president is that the office of the president has got some clouds when we are talking about coordination of other ministries and other organisations. With the experience that when it comes to office of president, people take it seriously, and because of this point, it is good for coordination and it is very central, it is not just another ministry. Because the head of NACA is the president, then it has its own unique opportunities to coordinate. It is not only coordinating ministries, it is coordinating even private sector into HIV/AIDS. However, so far, NACA has done very well.*

Another key informant opposed to the arrangement said:

*They missed the boat 15 years long back when the epidemic came about. It was 1985 the first person got infected with HIV/AIDS in Botswana and only in 2001 when NACA came in, then it goes under Office of the President. This issue should be left with the Ministry of Health where the technical expertise lies. We should have had NACA as a unit; long time ago we had AIDS unit which did not have resources and autonomy that were needed This is where we have politicized it; saying HIV/AIDS needs political will. Then, every disease needs that. With me HIV/AIDS is misplaced under NACA being under the Office of the President. Still there is need for the technical expertise to monitor that NACA. NACA should be under the one principle Ministry with the technical expertise and they should have been supported with the various other tools and instruments that they needed to combat the HIV/AIDS. But we are basically saying that things have to be under Office of the President for people to take note and be serious about them and this is sending the wrong signal.*

While almost all respondents and discussants stated that they were happy with the current arrangement whereby NACA falls under the Office of the President and not the Ministry of Health, they were equally dissatisfied with its operations. They argued that NACA was not fulfilling its mandate because it was understaffed. They argued that in terms of organisational arrangements, there was a conflict of roles. They strongly felt that NACA should coordinate and monitor and not engage in any program or project.
implementation. This is because at districts, the District Commissioner automatically becomes the NACA coordinator and things become confused. They argued that NACA needed to wield more power and to be much stronger so that it has constant authority in all sectors to provide support, guidance, leadership and to streamline and standardise procedures.

The majority who supported the current arrangement argued that the whole idea was that people looked at HIV/AIDS as the aspect of being sick only but it was clear that HIV/AIDS was not an aspect of disease process only; it also impacted on other aspects. Although it was good for NACA to be under the Office of the President, they were not happy with the management as they felt that NACA did not have the right people for its mandate. They also alleged that there was role conflict and confusion.

They reported that at the district level, there were many problems. While the District AIDS coordinator was supposed to be coordinating all the HIV/AIDS activities, this was not the case on the ground. The Social and Development Community staff operating under the ministry of local government was not always cooperating with the district health team staff and they were not necessarily reporting to the same person. The existence of AIDS STD Unit (under the Ministry of Health) and AIDS Coordinating Unit (under Ministry of Local Governments) was also a bone of contention for people on the ground. Their roles were not very clear and sometimes the duplication of their role created conflicts.

It was reported that while in almost all the countries UNAIDS have helped to establish NACA. Also helping to relieve the Ministry of Health by putting it under of the Office of the President, with the main purpose of defining HIV/AIDS as a social and developmental problems rather than a medical one and to put sufficient authority behind whatever entity was put in place to the voice on addressing HIV/AIDS. It was lamented that while these were well conceived thoughts, the reality was that now all the implementation was under the permanent secretary not under NACA, NACA is just there without any supervision of the Local Government people in the field or supervising people under the ministry of health. Some felt that it was clear that putting NACA under the Office of the President was not effective because the NACA coordinator’s voice is
never construed as that of the president hence people in line ministries never take NACA’s instructions seriously. Some suggested that the position of the NACA coordinator should be elevated to that of a Ministerial post so that he could sit with ministers at political level and reason with them.

Almost all respondents and discussants pooh-poohed the idea of NACA being made into Statutory Parastatal or as a separate new agency dealing with monitoring, coordination and protection of PLWHA human rights. They argued that NACA should not be made into a statutory parastatal because it would lose its authority and people might not take it seriously.

In conclusion, most people felt that NACA might not have the technical aspect in the Health Sector under the Office of the President, but being under the Office of the President gives it authority, that it draws authority from the Office of the President. They suggested that there should be clear definition of roles, so that NACA concentrates on advocacy, coordination, and monitoring and resource mobilisation.

3.0 PUBLIC HEALTH ISSUES
3.1 Research Guidelines for HIV Clinical Trials.

Almost all respondents and discussants asked about the guidelines for HIV clinical trials mentioned that they did not know them. Only one medical doctor reported knowing them and this is what he said:

*Research guidelines used are definitely not adequate and comprehensive to protect the country and the subjects of the trials. I think human subjects related legislation is very poor; therefore we need legislation right from the scratch to deal with issues of the age of consent, deal with issues of utilization of animals in clinical research as there is no law governing these issues of organ donation including cadava and the subject themselves. The question of research related injury and compensation for research related injury has to be absolutely clear as to whose responsibility should it be. Should it be researcher or the industry whose product is being used for research. And the long term benefits from participating research not only for the individual involved in that research but for a country for example if involving in HIV vaccine research; what are the...
benefits for individual, country if there may be any. And these should be put and
clarified in whatever legislation will be going to cover clinical trials. At the moment, we
use various International Convention Conferences on codes of conducts on research
and clearly this cannot be homogeneous, they may be cultural differences that need to
be resolved so it is important to adapt them to our local environment. Because in
cultural situation, for example, we find that if looking at informed consent, the elders can
consent, on behalf of the entire community and this is acceptable culturally. For
instance in kgotta; whatever decision is taken is final, then how do we deal with such
issues in a local context; people have not been taken on board.

In responding to how people who participate in/or are suspects of clinical trials are
treated and on whether their benefits take priority over the institution or vice versa this is
what he said:

People who participate in clinical trials it is emphasized that they should do that with
their own free will and by that we imply that they should not be direct benefits to
themselves, they do so for the well being and the eventual benefit of all human kind.
There is no real direct benefit not to themselves and even to the researchers. It is being
done for the common good of the entire community if it is going to be a benefit for
society. If this is done in a valid way, nobody should benefit other than the society. It
should not be individual who comes out and benefit out of any particular product. I think
the International Convention ensures that if at all there is intervention that will benefit a
particular person in any clinical trial that benefit should be guaranteed. Because some
of the research we really do not know what the long term outcomes are, the current
standard is that those people who participate in clinical trials, they should be monitored
for 5 years. Their records should be kept nicely to ensure that they are ready
accessible when anything happens.

It was clear from these responses that there are no locally produced guidelines for HIV
clinical trials. However, it was mentioned that the international guidelines are adapted to
Botswana under the direct observation of Botswana Medical Research Council Board. It
was clear that even District AIDS coordinators and doctors interviewed in the Ministry of
Health who deal with HIV/AIDS issues did not know about these guidelines. They could
only speculate that whatever is being done their guess was that it was being done in conformity with the international standard of ethics and humans rights.

3.2 Routine Testing

While majority of respondents and discussants were happy that Botswana adopted the routine testing, they were polarized on whether it should have been an opt-out policy. Those supporting the opt out policy argued that it would enable people to be guided to make the right decisions and that it would facilitate informed consent as well as encouraging people to utilize health facilities. They also argued that this would minimize chances of victimization as through counselling, clients would see the need to take a test. However, those opposed to the routine test that gives people chances to opt out criticized government for being half-hearted in making decisions about routine testing. They argued that just like other STDs, and high blood pressure, whenever a client visits the hospital, they should be tested for HIV without asking for their consent. They were saying this would be more effective than what is being done now. They contended that in having routine testing, we shouldn’t have had any people opting out. “We should be arguing about mandatory, voluntary testing. The important word here is routine and wellness”, said one key informant. They argued that Botswana should have a holistic approach to testing for diseases including HIV/AIDS that is public health driven not the one riddled with human rights nuances. One key informant said “I believe we should have wellness programs that encourage routine testing which is inclusive of all testing through HIV with no opts out”.

3.3 Process of Enrolling for ARVs

The following stages were described for enrolling in ARVs. That client are tested for HIV, if found positive, they go for CD4 and viral load check up. Thereafter they go for liver function test and other ailment of concern. CD4 and viral load check take longer time because in places where there is no CD4 count machine it has to be done either in Gaborone or Francistown; it sometimes takes two to three months. It was reported that the process takes a long time due to the limited number of staff in IDCC because dealing with HIV person is not like dealing with a person with headache. They mention
that somebody who has to take this treatment for life, has to do that right and do that at the right time (have to stick to time if it is 2300 hrs, then it should be like that always) and they should understand. It was reported that it takes long to book for ARVs because unlike any other treatment they are not prescribed by nurses, only the doctors can do that. Nurses are for counselling in IDCC. It can take close to two hours to help new person enrol in ARVs.

Most people disputed that the place where people collect ARVs impact on PLHWAs privacy because people already know that people who get to IDCC are the ones who have the virus. They argued that experience shows that “if you get to these people in IDCC basically you are going to get something different because that is where they can freely talk everything’.

Firstly clients have to understand that they have a problem and what should be done about that problem. Health professionals have to discuss with clients when they meet them for the first time that they will be examined and do blood test that will determine the nature of their problem. The blood test will then confirm the nature of the problem. Secondly, after confirming that there is a problem; discuss the nature of the problem again and better understand what that problem is. And then during that discussion, we also discuss the way forward; how you are going to intervene and combat that problem. And in doing that, so there is need to be guided by certain test and during that process then do a blood test and CD4 viral load. Thirdly, if the client now knows the magnitude of the problem; CD4 tells how serious it is and at that point in time you then finalize your long term care plan. And in the other place we are saying that at that point in time the person to get assisted with medication and include partners or other people who assist them in that process in understanding how they had to take care of the patient. By the way it takes at least three visits before one can start on antiretroviral therapy and having started the follow up period is actually quiet steep; at clinics its 1 month (longest period).
It was reported that the place where people collect ARVs have a huge bottleneck in terms of pharmacy and distribution of ARVs. Issues of security of ARV’s so that they are not hijacked, abused and black marketed was raised as a serious concern as well as issues of concern surrounding the distribution of ARVs. It was lamented that there was no privacy in IDCC and the counselling for people to take the medication was very paramount. One key informant said “explaining to clients how they take the medication is paramount and packaging is part of the confidentiality that one sign up to when becoming a client therefore it should be ensured that these people who collect ARVs in IDCC are happy”.

3.4 Home Based Care Issues

The process for getting home based care patients was described as follows by HC nurse:

The hospital discharges patients and makes referrals to the nearest clinic. Then the clinic which usually has HBC volunteers informs these volunteers about the patients. The other way is that the family welfare educators are working within the community and during their home visits they come across the clients. Sometimes other member of the community report patients to the clinic especially where there are AIDS committees. The patient’s whereabouts is told to the HC volunteers who then visit the said sick person.

It was reported by all respondents and discussants that HBC volunteers take care of patients at homes not knowing their diagnosis. However, some patients volunteer information to HBC volunteers while some HBC volunteers just assume that the person is HIV positive. All respondents and discussants mentioned that there was no any legal protection for HBC volunteers. However, the HBC volunteers themselves contended that even though they were volunteering, they should be protected. They said they faced risk of cross infection and attack by other members of the family who do not welcome them.

One key informant had this to say about HBC volunteers, which is representative of majority’s sentiments:
HBC volunteers are doing a full time job (full profession). I feel it is one other area where we are neglecting our responsibility because sometimes what becomes home based care becomes home based neglect. And we dump these people out in the homes and our responsibility to ensure that they are equipped with necessary skills for the people they are going to take care for. They should be courses for HBC volunteers; given some form of care, form of skills to be able to look for people in their homes. And because it is a full time job, they should be compensation. Because they have been equipped with the skills, part of the protection associated with those skills, would also be impacted to them so risks to exposures would have been addressed through the training mechanism such that they can be able to do that job as reasonably as they can.

3.4 Work Place Programs
It was reported that workplace HIV-related issues use code of conduct mainly used by public service but for private sector there is an initiative that ILO encourages companies to develop. ILO is attached to Ministry of Home Affairs; they do have a draft policy which is not yet finalized. Even though most respondents and discussants in Government did not know about “The Public Service Code of Conduct on HIV/AIDS in the Workplace” document, the District AIDS Coordinator in Selebi Phikwe furnished us with it and it is titled “The Public Service Code of Conduct on HIV/AIDS in the Workplace: Every Officer is a Change Agent, Peer Educator as well as an HIV/AIDS Manager”. It was noted that the current practice is that it is stated in the HIV/AIDS policy that people should not be discriminated on the basis of their status, even the ILO one goes along with those lines. One key informant said: By looking at the case of BBS that could have taught us that we should come out with a legislation that will govern all HIV/AIDS issues. There should be legislation specifying what actions should be taken for one who discriminate others on the basis of his/her status at the work place.
There was a consensus that there was a need to come up with a comprehensive legislation dealing with workplace HIV/AIDS related issues.

4.0 Conclusion and Recommendations
In soliciting the major stakeholders’ views and attitudes on the existing legal, institutional and regulatory framework and policies, the study covered issues of constitutional amendment, HIV testing for employment purposes, informed consent, stigma, confidentiality and shared confidentiality as well as whether HIV should be a notifiable disease. The study also elicited information on *inter alia*, mandatory testing, voluntary testing, counselling and partner notification as well as whether there are any guidelines used in voluntary counselling.

The response on constitutional amendment for the provision of social and economic rights such as right of health was overwhelmingly positive. However, it was cautioned that that endeavour requires financial resources that may not be available. There was unanimous decision suggesting that Botswana should discriminate non-citizens in health provision. However, there was a concern among some people that while doing that exceptional clauses should be enshrined in our policies providing for the emergency cases like for non-citizens raped in Botswana and for Batswana that are either married or cohabiting with non-citizens in term of access to medicine and drugs.

There was clear ambivalence regarding pre employment HIV testing. While there was a recognition that since ARVs are available and that employers should endeavour to assist their employees with medication such as provision of ARV, there was a concern that some employees might use this as ‘witch-hunt’ to discriminate PLWHA. However, very few advocated for the total legislative ban on pre, periodic and post employment testing.

The criterion for determining informed consent engendered many responses, with the overall conclusion being that either age threshold or sexual activity should not be used. Instead, some people calling for maturity and mental capacity to make informed consent. There was also a concern that some so-called parents and guardians were the ones abusing children, therefore, there was a need to re-look at the concept of parent or guardianship. Also raised was the issue of being accompanied by parents, people were
calling for youth friendly HIV/AIDS services that would easily understand the plight of the adolescents and youth.

Almost all refuted the allegation that public disclosure was a strategy for dealing with stigma. There were those who called for explicit legalisation or policy on what was meant by public disclosure. This was to be backed with the coping strategy such as enabling environment where if people disclose they do not feel the negative feedback from the community. These were observed to be the commonplace occurrence for people who do public disclosure.

There was an outright rejection of the proposal to make confidentiality into statute. The prevalent sentiments were that this might be abused and cause unnecessary conflict and a series of baseless law suits. It was also contended that issues of confidentiality and shared confidentiality should be assessed in cultural context. The Setswana culture of greeting inherently requires that you divulge the health status of your family members. This, therefore, means that before thinking of any legal measures as a deterrent, there should be a consideration of health seeking and healing behaviour in cultural context. The social etiquette of Batswana dictates that during greetings, people easily and innocently disclose the ailments of members of their families. Thus, legalising this would temper with the social arrangement. However, there was an emphasis that instead there should be a policy aimed at educating people about breaching confidentiality, especially in the workplace where some people have been terminated on the basis of their HIV positive status. It was asserted that that some people make life of PLWHA very difficult, especially at work by passing information to other workmates without the prior consent of the person concerned, thus violating the privacy of this person. They argued that some deterrents should be put in place. Breaching confidentiality fuels discrimination and marginalize people living with HIV/AIDS.

All respondents who had knowledge about how HIV/AIDS related information was stored did not express any concern that the information could easily be leaked thus breaching the confidentiality and privacy of their clients. They stated that HIV related information was kept like any other information. This might call for assessment. A large
proportion of respondents save for medical doctors did not know anything about the concept of notifiable disease. Those who knew, however, mentioned that HIV was not a notifiable disease because it was just a chronic illness without any cure and that it was not an infectious contagious disease. Some argued that that HIV/AIDS was not a notifiable disease because it had some ethics and confidentiality attached to it.

It was strongly felt that people there should be a law that deals with PLWHA who willingly infect their unsuspecting sexual partners. It was said that at the moment, HIV counsellors and health professionals can’t do much about people who refuse to disclose their status to their partners and those who never modify their behaviour and instead go around infecting new partners or strangers. This was raised as an issue that needed timely response. There was a call for legislation that would minimize chances of wilful viral transmission.

It was also argued that in a situation where the patient is reluctant to reveal his/her status to her sexual partner, the HIV counsellor should forfeit the duty to protect confidentiality and warn the potential victim. Others counteracted this by saying that the counsellor could not breach the confidentiality of his/her client at the expense of third parties. This was stated as something that needed prompt policy and legal response as put people’s lives in danger.

Even though the issue of mandatory testing of sex offenders received overwhelming endorsement, each and everyone acknowledged the daunting task of unravelling the evidential aspect of infection. There was also a concern raised that as long as the accused was only compelled to test for HIV after the court hearing, which, in most cases, is protracted, this was a void exercise. There was a call that laws should be enacted that prevent parents of sexually abused children to coerce or withdraw their children’s case. This was reported to be a violation of their human rights and security of a person.

Almost all respondents and discussants were generally against pre-employment screening of job applicants for HIV. They were also against differential treatment of
PLWHA for future training and insurance cover. They called for legislation that ban these discriminatory practices.

There was also a consensus that condoms should be distributed in prisons. The issue of decriminalisation of sex work and homosexuality was discussed with charged emotions. With majority saying these were immoral and unacceptable practices while others were arguing it was high time Botswana stopped hiding behind Christianity and change the laws to conform to the international laws, that is, Botswana should be progressive and dynamic in its legal framework.

Most people felt that NACA should still be under the Office of the President, but should be focussed. It was suggested that NACA should have clear definition of roles, so that it can concentrate on advocacy, coordination, and monitoring and resource mobilisation.

It was also observed that research guidelines used for HIV clinical trials were definitely not adequate and comprehensive to protect the country and the subjects of the trials. There was a proposal that there should be human subjects related legislation that is explicit on issues of the age of consent, issues of utilization of animals in clinical research as there is no law governing these issues of organ donation including cadava and the subject themselves. The question of research related injury and compensation for research related injury was also not clear as to whose responsibility should it be. Should it be researcher or the industry whose product is being used for research. There was a recommendation that these should be put and clarified in whatever legislation will be going to cover clinical trials as at the moment, only various International Convention Conferences on codes of conducts on research were used and these were not homogeneous, as suffered from cultural differences that need to be resolved so as to adapt them to our local environment.

There was a feeling that Botswana should pursue a policy of wellness program instead of the one that is lopsided towards HIV. There was also a plea for Botswana to develop a comprehensive workplace HIV related program that will be understood and utilised by government, private sector and NGOs.
ANNEX 2:
CONSULTANCY SERVICES TO REVIEW LAWS AND POLICIES RELATING TO HIV/AIDS

SUMMARY OF ISSUES AND RECOMMENDATIONS FOR LEGISLATIVE REVIEW DISCUSSION DOCUMENT FOR STAKEHOLDERS’ WORKSHOP TO BE HELD IN GABORONE ON 28 SEPTEMBER 2005.

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SUMMARY OF OBJECTIVES OF THE CONSULTANCY

The Consultancy has three main objectives:

- Review of all laws, regulations or policies providing for /or having a bearing on HIV/AIDS.

- Analysis of Botswana laws, regulations and policies constitutionality and their compatibility with international human rights instrument to which Botswana is a signatory.

- Review different legal options of dealing with HIV/AIDS and human rights and propose the appropriate legislative and institutional approach that would be underpinned by a human rights perspective.

- Prepare draft instructions to the Attorney –General to prepare legislation to give effect to the consultant’s recommendations aimed at mainstreaming human rights into Botswana’s human rights approach to HIV/AIDS.
SUMMARY OF METHODOLOGY

- Literature review
- Interviews with selected stakeholders
- Stakeholder Consultations
SUMMARY OF ISSUES AND PRELIMINARY RECOMMENDATIONS

1 PUBLIC HEALTH – HUMAN RIGHTS INTERFACE

**ISSUE:** Would a human rights approach to HIV/AIDS compromise an effective public health response to prevention, control and treatment of the epidemic?

**Main Findings:**
Promoting human rights (for example through prohibiting non-discrimination) helps ensure a more effective HIV prevention programme; Marginalisation intensifies the risk of HIV infection; Botswana can respond effectively to HIV/AIDS by respecting the basic right of people to participate in decisions which affect them.

The human rights approach is in line with Botswana’s political system founded on general and fundamental democratic principles. In addition, such an approach is line with internationally accepted way of dealing with HIV/AIDS and would enhance Botswana’s compliance with its international human rights obligations.

Currently there is no coherent approach towards the integration of human rights into Botswana’s response to the HIV/AIDS pandemic. However, the human rights approach seems to generally have been accepted (as reflected for example in the National HIV/AIDS Policy and Botswana National Strategic Framework for HIV/AIDS).

**Recommendation**
There is no contradiction between the protection of human rights and public health objectives. We accordingly recommend the adoption of a human rights approach to legislative review.
2 CONSTITUTIONAL ISSUES

ISSUE: Should the right to health be given a constitutional foundation?

Main Findings:
Although the Constitution of Botswana is generally protective of fundamental human rights, it does not include other social and economic rights. It accordingly does not guarantee the right to health. It thus fails in some ways to protect the rights of PLWHA. In some cases Botswana’s constitutional provisions fall short of the country’s international human rights obligations as provided, for example, in the African Charter on Human and People’s Rights.

Recommendation:
i. In the long term, a constitutional review process should be initiated the outcome of which would be the incorporation of social and economic rights, such as the right to health and the right to work in the Constitution, and an express prohibition of discrimination on the basis of status, sexual orientation, health and or nationality.

ii. Given the procedural difficulty of amending the constitution, amendments of existing laws and or on enactment of new laws on a sector-by-sector basis to give effect to these objective is the most practical way to proceed.

3 Legal and Policy Aspects of Protection of Children

ISSUE: Do the current legal and policy framework sufficiently protect the human rights of children in the context of HIV/AIDS pandemic?

Main Findings:
We found that there is no law and or policy dealing with children’s rights in the context of HIV/AIDS. Accordingly issues such as the provision of children friendly health services including sexual information and prevention services such as condoms appear not to be handled in a coherent manner. A study on the review of the Children’s Act from a human rights perspective has been carried out. Its recommendations have not yet been implemented.

**Recommendation**

A National Policy on Children and HIV/AIDS should be promulgated as a prelude to possible amendments to the Children’s Act. Such an amendment (to the Children’s Act) should specifically address issues of sexual abuse of children, child trafficking, strengthening of children’s right to sexual reproductive information and other children’s specific human rights such as the right to child friendly sexual reproductive health services.

4 Customary Law and Human Rights Approach

**ISSUE 1:** Should there be legal intervention to outlaw customary law/practices/culture and or traditions perceived to be inconsistent with a human rights approach to the prevention and treatment of the HIV/AIDS pandemic?

**Main Findings:** A lot of Batswana are subject to customary law in personal law matters such as marriage. However, in any case where customary law is repugnant and or inconsistent with the Constitution and or any Act of parliament, the constitution and or legislation prevails to the extent of the inconsistency. Individuals can opt out of customary law out of choice and or through judicial determination.
Recommendation

We are not recommending any legislation on customary law and human rights since the current legislation, if understood by the subjects, can sufficiently address issues surrounding HIV/AIDS. Customary law, cultural and traditional practices would, provided sufficient information on HIV/AIDS and legal options is made available to citizens, evolve to address the human rights and public health issues raised by the pandemic. We however, recommend that the Law Reform Committee and or any agency charged with law reform be expressly required to perform an educational role on the effect of the dual legal system on personal rights including options for opting out of the Customary Law and other areas where being subjected to common law, statutory and or customary law may yield different results.

5 HIV/AIDS and Employment

**ISSUE 1:** Should HIV testing for employment purposes be regulated by legislation?

**Main Findings:**
Currently there is no legal regulation of HIV testing for employment purposes. Save where the employment contract provides otherwise, employers have the common right to demand pre-employment testing. However in the Public Service the Government does not require citizens to undergo pre-employment HIV testing. Foreigners seeking employment in the Botswana public service are required to undergo pre-employment HIV testing.

**Recommendation**

i) There should be statutory intervention (by amending the Employment Act for example) so as to prohibit HIV testing for pre-employment purposes subject to permissible exceptions. Such an intervention should be intended to:
• Create certainty and clarity on the legality or otherwise of HIV testing as a specific form of discrimination in the employment relationship.

• Prohibit testing where it constitutes unfair discrimination

• Protect job applicants and existing employees in order to enable the fair allocation of employee benefits.

• Give the responsibility of determining whether employment HIV testing is permissible in given job categories to an independent third party (e.g. the Commissioner of Labour and or the Industrial Court) with clearly defined factors to take into account, so as to ensure that the concerns of employers are as well addressed.

• Ensure that the prohibition on HIV testing in the workplace is not absolute but allows for exceptions to testing where testing is allowed under legislation and in certain circumstances where it is deemed to be fair and justifiable provided prior set conditions are met.

• The burden to show that HIV testing under specific circumstances is fair and therefore justifiable and necessary should rest upon the employer.

ii) The practice of requiring foreigners seeking employment in the public service to undergo pre-employment HIV testing should be reconsidered with a view to abolishing it as it amounts to unfair discrimination. In the event this practice is retained, it should be founded on clear statutory provisions as it is a deviation from the fundamental right of non-discrimination.

**ISSUE 2:** Is there need for legal intervention to outlaw discrimination on the basis of HIV status at workplace?
Main Finding:

Just as in testing there is no law regulating issues of HIV/AIDS once one has entered employment.

Recommendation

iii. The Employment Act, Public Service Act, Workers Compensation Act and other employment related legislation should be amended to provide for a general non-discrimination and non victimisation right on the basis of an employee or potential employees’ HIV status.

iv. The provision in the Public Service Act banning sexual harassment at work should be transposed into the Employment Act to protect private sector workers from sexual harassment as well.

ISSUE 3: Should there be statutory intervention to ensure that employers do not disclose the HIV status of employees without the concerned employee’s informed consent?

Main Findings:

Save as may be provided in the employment contracts, employers do not generally have a statutory obligation not to disclose health information of their employees. The Public Service has a general non-disclosure provisions which is of limited application to HIV/AIDS situations.

Recommendation:

There should be a statutory obligation on employers to respect workers rights in relation to confidentiality of health-related information in their possession and only disclose same pursuant to the employee’s informed consent. A consideration should be given to protect confidentiality in the dispute settlement process.
**ISSUE 4:** Should the principle of accommodation be given statutory basis in the employment setting? Should dismissal motivated solely by the HIV status of an employee entitle the employee to the remedy of reinstatement?

**Main Findings:**
The principle of accommodation although recognised by the Constitution, has not been given statutory backing in the employment setting. However the Industrial Court, through its decisions and rulings has incorporated it into Botswana labour law. The Court also views any solely HIV status motivated dismissal as being unfair.

**Recommendation**

v. The accommodation principle should be incorporated into Botswana labour law through statutory intervention.

vi. Unlawful termination of an employee solely on the basis of his/her HIV status should be one of the factors entitling the employee to the remedy of reinstatement.

**ISSUE 5:** Should there be statutory intervention to ensure that individual and collective labour agreements are non-discriminatory?

**Main Findings:**
There is no statutory regulation of the content of individual employment contract and collective labour agreements in so far as HIV/AIDS is concerned.

**Recommendation:**

Among the statutory grounds (in Trade Unions and Employer’s Organisations Act) on which the Commissioner of Labour may decline to register a collective labour agreement must be added provisions that are directly and or indirectly
discriminatory on the basis, inter alia, of gender, health (including HIV) status and or any provision which is prejudicial to vulnerable and marginalized groups. Similarly the Employment Act should be amended to ensure that contracts of employment which permits discrimination on the basis of one’s HIV status are void.

**ISSUE 6:** How should the Draft Botswana National Policy on HIV/AIDS and the World of Work be treated in relation to this study’s recommendations?

**Main Findings:**
There are ongoing efforts to come up with a national HIV/AIDS policy at the workplace. We reviewed the latest draft of the policy which we found to be in line with a human rights approach.

**Recommendation**
The Draft Botswana National Policy on HIV/AIDS and the World of Work should be finalised as soon as possible, preferable before the proposed amendments to the labour legislation in this Report.

**ISSUE 7:** Is the National Industrial Relations Code of Practice in line with a human rights approach to HIV/AIDS approach?.

**Main Findings:**
The *National Industrial Relations Code of Practice*, although not legally binding has a persuasive force. It is therefore an important document within the industrial relations set up. The Code has very little to say on HIV/AIDS and nothing on human rights approach to same.
**Recommendation**

The National Industrial Relations Code of Practice should be amended to reflect the national approach to HIV/AIDS as reflected in the National HIV/AIDS Policy, Draft Botswana National Policy on HIV/AIDS and the World of Work and other current developments, which took place since the Code was adopted.

6: HIV/AIDS and Public Health

**ISSUE 1:** Should the requirement for confidentiality in medical care and home-based care services be regulated through legislation?

**Main Findings:**

In short we found that the requirements of confidentiality and informed consent are generally complied with within the public health facilities. However, since the introduction of routine testing, the extent to which patients seeking assistance in Government health services are given sufficient information to understand that they can opt out of routine testing is not clear.

Some testing service providers do so without clear guidelines as to how to handle the issue of confidentiality and partner notification. Compulsory testing is allowed by law only in the event of sentencing of convicted rapists and other sexual offender. The regulatory framework for medical/clinical and or vaccine trials in Botswana is rudimentary. HIV/AIDS is currently not a notifiable disease.

**Recommendation**

1. An extensive public education directed at informing the public about the benefits of testing and the fact that individuals seeking medical services in Government health facilities have the right to opt out of routine testing should be embarked upon.

vii. There is need to provide clear guidelines in respect of different types of HIV testing, confidentiality, informed consent and circumstances under which the rules of confidentiality may be waived. We note in this regard that the proposed amendments to the National Policy on HIV/AIDS have detailed proposals on this point.
viii. The Minister should exercise her powers in terms of the Public Health Act to make HIV a notifiable disease to provide the legal basis for data collection in respect of the disease and the handling and distribution of information about HIV/AIDS patients generally.

**ISSUE 2:** What factors should be taken into account in determining when a person has the capacity to give informed consent for purposes of testing for HIV?

**Main Findings:**
There is uncertainty as to when a person can be said to have the capacity to give informed consent for purposes of testing for HIV/AIDS. In law different statutes provide for different age limits for different circumstances.

**Recommendation**
The capacity for giving informed consent for purposes of testing for HIV should be based on a combination of age (16), the fact of sexual activity, reasons for wanting to have the test and or whether the person seeking to undergo the testing has the capacity to understand the consequences for such tests. That is, any person aged 16 and above should be presumed to have the capacity to give consent for HIV testing and sexual reproductive health services. However, if a person under 16 is shown to be sexually active then, such a person should be presumed to have the capacity to give informed consent for purposes of HIV testing and obtaining of sexual reproductive services such as condoms. In addition any person at any age should be allowed to give consent for testing if circumstances he/she is in warrant it. The health worker should be given the discretion to determine whether a person requesting HIV testing meets the above factors.
ISSUE 3: Should the practice of denying non-citizens access to free health services and or ARVs be continued? Is this practice in line with Botswana’s constitution and or the country’s international human rights obligations?

Main Findings:
There is no statutory right to health in Botswana; the Government of Botswana provides citizens with free access to ARVs but non-citizens are not entitled to same. This practice sits uneasily with Botswana’s international obligations assumed through such international treaties as the African Charter on Human and Peoples’ Rights; Regulation in all aspects of HIV/AIDS, including testing and access to treatment, is effected mainly through Presidential and other executive directives, circulars, guidelines and instructions. Botswana has not yet taken advantage offered by the Doha Ministerial Declaration to investigate alternative access to cheaper generic drugs for HIV/AIDS and other essential drugs such as those for the treatment of malaria.

Recommendations

1. Government should reconsider the practice of denying non-citizens access to ARV drugs while the same is offered to citizens with a view to reversing the practice in order to align Botswana’s practice with Botswana’s international human rights obligations in particular, the African Charter on Human and Peoples’ Rights which prohibit discrimination on the basis of nationality.

v. In the event that it is desired to maintain the practice of denying non-citizens access to free state supplied ARVs, it should then be based on a statutory basis (since it is a derogation from the constitutional principle of non-discrimination), rather than a Presidential Directive, and should have clearly spelt out flexible exceptions to take account of the fact that citizens do have intimate relationships with non-citizens and a recognition that an inflexible application of the law in this regard may seriously undermine public health objectives of managing the pandemic.
vi. To ensure equitable access to medical services, there should be a statutory obligation on medical aid schemes and medical facilities to generally provide services on a non-discriminatory basis.

vii. Government should undertake a dedicated study to find out the opportunities (if any) offered by the Doha Declaration in the area of access to essential medicines for HIV/AIDS and other conditions such as malaria.

viii. An enactment of legislation and/or statutory regulation to regulate the conduct of medical and clinical trials in general and HIV preventive vaccine trials in particular informed by a human rights approach.

7 HIV/AIDS, Criminal Law and Rehabilitation

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<th>ISSUE 1: Is Botswana’s criminal law consistent with a human rights approach to HIV/AIDS?</th>
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**Main Findings**

We found that there are no HIV/AIDS specific offences; The Penal Code assigns different punishment (enhanced) for convicted rapists and those convicted of defilement; There is uncertainty as to whether marital rape exists or not; Same sex activities (homosexuality), sodomy and other acts considered to be against the order of nature have been criminalized; and Living on the proceeds of sex work and or operating brothels is a criminal offence.

**Recommendations**

iii. The so-called ‘acts against the order of nature’ such, as homosexuality should be de-criminalized if they take place in private and between consenting adults.

iv. An educational programme targeted at providing information and education on prevention, care and treatment of HIV/AIDS related conditions to the marginalized such as homosexuals and or sex workers should be put in place.

v. Consideration should be given to abolishing the legal position of enhanced sentences for HIV-positive convict’s ion rape and other sexual offences.
vi. A ‘for the avoidance of doubt’ amendment must be made to the Penal Code creating the offence of marital rape and generally protecting the autonomy of women over sexual activity and or reproductive health.

vii. Sex work and related services should be de-criminalized and regulated with a view to providing safe working environment for the workers and their clients and improve access to sexual health information and other services.

**ISSUE 2:** To what extent does Botswana’s rehabilitation system comply with a human rights approach to HIV/AIDS?

**Main Findings**

The Prisons Act does not have an express provision on any aspects of HIV/AIDS; the distribution of condoms in prison is prohibited as a policy measure and; there is no provision for ‘conjugal’ visits for prisoners regardless of the nature of offences they have been convicted of.

**Recommendation**

I. Condoms and other HIV prevention products should be distributed freely in prisons and the Prisons Act should accordingly be amended to provide for this.

li In the long term the Government should consider allowing married and or prisoners with stable partners ‘conjugal’ visits to partners/spouses serving a prison term.

8- HIV/AIDS and Insurance and Finance Services

**ISSUE:** Is there any need for legal intervention in the insurance and financial services sector to ensure compliance with a human rights approach?

**Main Findings**
Insurance companies generally require applicants for life-cover to take pre-life cover HIV test where the insured amount is in excess of P100,000.00; Insurance service providers are under a statutory obligation to provide services for life cover in respect of applicants whose lives insured have an equal expectation on a non-discriminatory basis; The non-discrimination obligation referred to above do not apply in certain circumstances including where the amount insured is in excess of P100,000.00 and; There is no express obligation on financial service providers to provide service on a non-discriminatory basis.

**Recommendation**

There should, as a general rule, be a statutory obligation on insurance and financial service providers to provide services on a non-discriminatory basis. The exceptions to this rule must be in accordance with prior set conditions, approved by the relevant sector regulator.

9: **Education and Training**

**ISSUE:** Should there be legislation to deal with HIV/AIDS issues in the education setting?

**Main Findings**

There is no legislation dealing with HIV/AIDS in the education setting; Applicants to education and training institutions in Botswana are not required, as condition for admission, to take HIV test; Some big employers, notably, Desman, condition further training by its employees at the expense of the company on the outcome of an HIV test; and; The school heads have the power to remove from school medically unfit pupils and can order the pupils to be medically examined without consent of parents and or guardians. The provision of child friendly services in the schools is not regulated.

**Recommendation**

i) There should be statutory obligation on education and training institutions to provide access on a non-discriminatory basis.
ii) Scholarships and bursaries should be granted on a non-discriminatory basis by all public bodies including private companies in which the Botswana Government has substantial financial and other interests. Any exceptions to this rule should be based on the need to ensure the health of the applicant.

iii) The Education Act should be amended to align the powers of the school-heads with the human rights approach.

iv) Condoms should be made available in all learning institutions as part of the provision of child friendly health services.

10: Sports

**ISSUE:** In which sports should there legislative control to ensure compliance with a human rights approach to dealing with HIV/AIDS?

**Main Findings**

There is no legislation addressing issues of HIV/AIDS in Sports. Even the Botswana National Sports Council Act is silent on issues of HIV/AIDS and sports; and; There is risk, albeit small, of HIV transmission in sports in particular contact sports such as rugby and boxing.

**Recommendations**

i) In order to secure the safety of sportspersons and the human rights of PLWHA, a detailed Policy on HIV/AIDS and sports should be developed following consultations.

ii) Legislation should await the promulgation of the policy.

iii) Should it be felt necessary to legislate before policy formulation, we recommend that a general provision be inserted in the Botswana National Sports Council Act that expressly obligates the Sports Council to ensure the health and safety of all the players in different sports codes and promote equitable and non-discriminatory access to sports facilities. This flexible approach would ensure that the special concerns of different sports codes are taken into account.

11 Institutional Issues

**ISSUE:** What institutional changes are necessary for the effective implementation of a human rights approach to HIV/AIDS?
Main Findings:
The political leadership over the fight against HIV/AIDS lies with the National AIDS Council chaired by His Excellency, the President; The national body for coordinating national efforts in the sphere of HIV/AIDS is the National Aids Coordinating Agency, which falls under the Office of the President; Given the nature of HIV/AIDS issue, a multiplicity of Government ministries and departments are rightly involved including the ministry of Ministry of Health and Ministry of Local Government; In cases of disputes HIV/AIDS related issues are settled through the court system; there is no special organ for enforcement of human rights in general and PLWHA in particular; and There are a number of non-governmental organisations involved in the promotion and protection of human rights of PLWHA.

Recommendation:
vi. Current policy, service provision and coordinating institutions should be left as they are.

vii. The location of NACA within the Office of the President should be retained and there is currently no sufficient case for making NACA a Parastatal.

viii. The powers and functions of NACA should be given statutory basis to ensure certainty, accountability and consistency in service delivery.

iv. In the long term, perhaps as part of the possible constitutional review to incorporate social and economic rights, the possibility of setting up a human rights commission to investigate alleged violations of human rights and PLWHA rights in particular.

ix. In the short term, civil organisations working in the area of human rights in general and in the area of HIV/AIDS should continue to be provided with financial assistance targeted towards promotion and protection (including through litigation) of the rights of PLWHA by Government.

x. NACA, as part of realising GOAL 5 of Botswana Strategic Framework for HIV/AIDS, of creating a supportive ethical, legal and a human rights based
environment, should spearhead and coordinate the proposed legislative review.

12 – Comparative & Legislative Approaches

ISSUE: What is the best legislative approach to HIV/AIDS?
Our main finding in this respect is that there is no universal legislative approach to the HIV/AIDS issue.

Recommendation
A sectoral legislative approach, which is in line with Botswana’s legal tradition and practice, should be adopted.
CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF THE CONSTITUTION OF BOTSWANA (AMENDMENT) BILL

A.PURPOSE

To request approval from Cabinet for the Constitution of Botswana (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach.

The study has recommended that there should be amendments to the Constitution of Botswana so as to entrench a human rights approach to HIV/AIDS and facilitate Botswana’s compliance with her human rights obligations assumed through international agreements such as the African Charter on
Human and Peoples Rights. The Constitution of Botswana is the fundamental law of the country and thus sets the basis of all other laws. It should accordingly address fundamental human rights issues in a manner that takes account of emerging challenges such as those posed by the HIV/AIDS pandemic.

C. PROPOSAL.

The proposal is to amend the Constitution of Botswana so as to effectively address constitutional limitations as regards the protection of the human rights of People Living with HIV/AIDS (PLWHA). The proposed amendments would achieve this objective by guaranteeing human rights of PLWHA, including the right to non-discrimination in the social, economic and political sphere and ensure that Botswana complies with international human rights standards by entrenching in its constitution social and economic rights (for example the right to work and the right to health) and prohibition against discrimination on the basis of status (including health status and sexual orientation).

The proposal as regards the express prohibition of discrimination based on status and or nationality would be merely an improvement and or tightening up of existing provisions of the Constitution of Botswana guaranteeing and protecting fundamental human rights. On the other hand, the proposed amendments in relation to the inclusion of social and economic rights such as the right to health is a completely new approach intended mainly to address the challenges brought about by the HIV/AIDS pandemic and to protect PLWHA from discrimination in the social and economic sphere as well as to ensure that Botswana meets her international obligations contained in international treaties to which Botswana is a party such as the African Charter on Human and Peoples Rights, the SADC Treaty and international best practice as reflected in numerous United Nations treaties, conventions, declarations and initiatives such as the Millennium Development Goals and the groundbreaking work carried out by UNAIDS.

While on the face of it, social and economic rights appear to have serious financial implications, in reality it is not necessarily so. The enforcement
of social and economic rights inevitably takes account of, and is subject to Government budgetary constraints. The importance of social and economic rights lies in the fact that access to available resources would be on a non-discriminatory basis and Government policy would take account of the need to achieve and or protect such rights as the right to health and the right to work. In addition human rights are interdependent on each. The laudable provisions on civil and political rights in the Constitution of Botswana are to a large extent dependent on social and economic rights and vice and versa.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A provision incorporating the right to health in the Constitution of Botswana. The right to health provision would ensure that Government, private and public medical service providers (such as hospitals, clinics, medical aid/insurance schemes) avail services on a non-discriminatory basis. This would be in line with both the Botswana National HIV/AIDS Policy and Botswana National Strategic Framework for HIV/AIDS and align Botswana’s approach to international best practice.

2. A provision incorporating the right to non-discrimination on the basis of status. An express constitutional prohibition of discrimination on the basis of status (including health status), sexual orientation and or nationality would strengthen existing constitutional provisions on fundamental individual rights. The provision would facilitate Botswana’s compliance with the provisions of African Charter on Human and Peoples’ rights by outlawing discrimination on the basis of status and nationality. It would also provide a basis on which public health objectives of prevention, treatment of the pandemic and generally management of HIV/AIDS would be realised as it would be the basis for legislation prohibiting stigmatisation, victimisation and discrimination against PLWHA. From a public health perspective, discrimination inspired by health status and sexual orientation is one of the fundamental obstacles to the effective prevention and control of the diseases. Health status discrimination leads to stigma and victimisation which in turn leads to the exclusion of PLWHA from benefiting from mainstream programmes, services
and facilities intended to deal with and mitigate the impact of the pandemic.

2 In the era of regional integration and globalisation in which there are limited, if any, geographic and nationality barriers on interpersonal relationships including intimate/sexual relationship between people from different countries, discrimination on the basis on nationality should be dealt with. Botswana international human rights obligations also necessitate the need to prohibit discrimination based on nationality. It is, however, proposed that parliament retain the right to legislate to justify ‘discrimination’ against foreign nationals if it is in the national interest to do so.

3 A provision guaranteeing the right to work. This provision would provide the basis for anti-discriminatory employment related legislation. It would provide a constitutional basis for policies and legislation intended to ensure that PLHWA and other people inflicted by incurable conditions are provided with opportunities to work to the extent reasonably possible. Not only will this reduce the burden on the care-givers and the state, but would also bring the Constitution of Botswana in line with emerging trends on constitutionalism.

4 Lastly, provision should be made for consequential amendments to other sections of the Constitutions.

SIGNED: MINISTER OF PRESIDENTIAL AFFAIRS AND PUBLIC ADMINISTRATION.
Gaborone,
2005.
APPENDIX 2 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF EMPLOYMENT ACT (AMENDMENT) BILL

Cab. Memo/
Ministry of Labour and Home Affairs

A. PURPOSE

To request approval from Cabinet for the Employment Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and, in particular, to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Employment Act so as to reflect a human rights approach to prevention, treatment and generally deal with issues related to HIV/AIDS. The proposed amendment
C. PROPOSAL.

The proposal is to amend the Employment Act so as to deal effectively deal with issues of discrimination against People Living with HIV/AIDS (PLWHAs) at all levels of the labour market, that is, pre-employment stage when people are seeking employment (in particular the question of testing), within employment in areas such as promotion, enjoyment of work related benefits and lastly on the area of employment termination. It is proposed that detailed provisions are required to deal with the issue of employment related HIV testing with a view to prohibit undue discrimination against PLWHA while taking into account the specific demands of each job. This would be achieved by a general ban on employment related HIV test with in-built flexibility where testing would be allowed based on an objective assessment by a third party. It is proposed that the power to determine whether a particular profession and nature of particular job falls within the exceptional circumstances justifying pre-employment test be left to the Industrial Court. The intention is to minimise the cost of implementing the proposed changes by not creating new institutions where it is feasible to do so.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1 A new provision prohibiting discrimination on the basis of health status, stigmatisation and or victimisation on the basis of health status (including HIV status and sexual orientation) should be inserted into the Act. The anti-discrimination provision should apply in all aspects of employment including, regulation of employee benefits, dismissal etc. Consequential amendments to a number of sections including section 32 (relating to the employer’s right to refuse to repatriate the body of a dead employee on the basis of the outcome of the general pre-employment medical examination,) section 35 (employer’s right to refuse to allow an employee’s family to accompany her/her to work in Labour Areas, and section 26 (dealing with constructive dismissal). The proposed amendment would be such as to entitle a HIV infected and or affected employee who is being subjected to
victimization, stigmatisation and discrimination on the basis of his/her health status including HIV status to leave employment and claim remedies for constructive dismissal. In addition any clause in the contract of employment that discriminates on the basis of health status should be void,

2 The amendment of section 46 to regulate pre-employment HIV testing so as to distinguish it from general pre-employment medical examinations. It should also deal with the issue on testing as it relates to expatriate workers in the private and parastatal organisations. The main objective should be to ensure that pre-employment HIV test is prohibited except where it is done pursuant to written law and or justifiable under pre-set criteria. The purpose of pre-employment general medical examination, where it is allowed, should be intended only to ascertain the potential employee’s ability to perform the work for which he/she is engaged and should exclude HIV testing. The amending section should, in particular, provide for the following:

2.1 Creation of certainty and clarity on the legality or otherwise of HIV testing as a specific form of discrimination in the employment relationship.

2.2 prohibit testing where it constitutes unfair discrimination

2.3 Protect job applicants and existing employees in order to enable the fair allocation of employee benefits.

2.4 Give the responsibility of determining whether employment HIV testing is permissible in given job categories to an independent third party (Industrial Court) with clearly defined factors to take into account, so as to ensure that the concerns of employers are as well addressed.

2.4 Ensure that the prohibition on HIV testing in the workplace is not absolute but allows for exceptions to testing where testing is allowed under legislation and in certain circumstances where it is deemed to be fair and justifiable provided prior set conditions are met.
2.5 The burden to show that HIV testing under specific circumstances is fair and therefore justifiable and necessary should rest upon the employer.

2.6 The practice of requiring foreigners seeking employment in the country to under pre-employment HIV testing should be expressly be prohibited.

3 A new section that puts a general obligation on the employer to modify an employee’s contract in relation to the content of the job, time of work etc (duty to accommodate) so as to enable an HIV infected and or affected worker to continue work to the extent reasonable possible. Such a modification would have to be with the consent of the employee and where the employee’s condition is such that he/she cannot continue to perform the work for which he/she was original engage for and such an employee refuses to be transferred and or to the modification of his/her contract, then the employer shall be entitled to terminate the concerned employee on the basis of ill-health. That is, before an employer dismisses an employee on the basis of ill-health (including HIV/AIDS related illness), then such an employer should first comply with the following conditions;

- the employer is obliged to ascertain whether the employee is capable of performing the work for which he was employed;

- if the employee is unable to perform the work, the extent to which he is unable to perform his duties should be ascertained;

- the employer is thereafter obliged to ascertain whether the employee’s duties can be adapted;

- If the employee cannot be placed in his former position, the employer must ascertain whether alternative work, at a reduced salary if necessary can be found.
Only when the above conditions have been met, would the dismissal on the ground of poor/ill health be justified. The test of whether an employer satisfied the accommodation obligations should be an objective one so as not to place undue economic burden on the employers.

4 A new section dealing with the handling of employee health related information. The provision should put an obligation on the employer and or his/her representative not to disclose the health status (including HIV status) of employees to third parties unless with the prior written consent of the concerned employee. This provision would encourage employees to test which is a good public health objective and also allow such employees the option to disclose their status to the employers and other employees.

5 A new provision that prohibits sexual harassment at the workplace with clearly spelt out penalties for employers and or employees who breach such a provision. An anti-sexual harassment provision would help deal with stigma and victimisation of HIV infected and or affected employees. Sexual harassment should be widely defined to include any verbally or sexual advance, derogatory and or discriminatory sexual statement that causes the recipient discomfort, or humiliation and or creates a threatening or intimidating work environment.

6 Lastly, provision should be made for consequential amendments to other sections of the Act, the Trade Disputes Act and their accompanying Regulations.

SIGNED: MINISTER OF LABOUR AND HOME AFFAIRS
Gaborone,
…………………… 2005.
APPENDIX 3 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF PUBLIC SERVICE ACT (AMENDMENT) BILL

Cab. Memo/

Ministry of Presidential Affairs and Public Administration

A. PURPOSE

To request approval from Cabinet for the Public Service (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and, in particular, to give effect to Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Public Service Act so as to reflect a human rights approach to prevention, treatment and generally in dealing with issues related to HIV/AIDS.
C. PROPOSAL.

The proposal is to amend the Public Service Act so as to deal effectively with issues of discrimination against People Living with HIV/AIDS (PLWHA) within the employment setting. The objective is to create general non-discrimination principle in relation to recruitment, promotion, dismissal and other aspect of employment in the public service. The proposed non-discrimination principle should be applicable to citizens and non-citizens. In addition the proposed amendments seek to ensure that health related information, including information on the HIV status of civil servants should not be disclosed to a third party without the consent of the concerned employee, the purpose being to protect the privacy of employees.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1 A general non-discrimination clause provision that would ensure that there is no discrimination generally and discrimination based on health status in particular at all levels and for all purposes in the public service except as allowed by written law. It is proposed that pre-employment HIV testing should be prohibited.

2 A provision guaranteeing the right of privacy and confidentiality to civil servants in relation to health related information that their supervisors may have.

3 A provision giving the legal basis for such HIV/AIDS codes as may be promulgated from time to time. It is imperative that HIV/AIDS codes be given statutory basis given that it can easily be amended to take account of new developments.

4 Lastly, provision should be made for consequential amendments to other sections of the Act, related legislation and accompanying regulations.
SIGNED: MINISTER OF LABOUR AND HOME AFFAIRS
Gaborone,

........................ 2005.
APPENDIX 4 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF EMPLOYMENT OF NON-CITIZENS ACT (AMENDMENT) BILL

Cab. Memo/
Ministry of Labour and Home Affairs

A. PURPOSE

To request approval from Cabinet for the Employment of Non-Citizens Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and, in particular, to give effect to Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Employment of Non-Citizens Act so as to reflect a human rights approach to prevention, treatment and generally in dealing with issues related to HIV/AIDS.
C. PROPOSAL.

The proposal is to amend the Employment of Non-Citizens Act so as to protect non-citizens who seek employment and or are in employment in Botswana from discrimination based on their health status and or HIV status. The objective is to create a general non-discrimination principle in relation to workers and or job applicants regardless of their nationality and or place of origin. The proposed amendment would greatly enhance the Constitution of Botswana’s provisions on non-discrimination as well as bring Botswana into compliance with the African Charter on Human and Peoples Rights and United Nations requirement as reflected in the work of UNAIDS.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A provision to the effect that in the consideration of applications for work permits from foreign nationals and or consideration of applications for contract renewal, one’s HIV status shall not be one of the factors to be taken into account.

2. A provision that provide for exceptions to the non-discrimination treatment of foreign nationals in the employment sphere to the grounds listed in the Employment Act and or any written law. This is to create the necessary flexibility. It also gives recognition to the fact that national interest may in some cases justify differential treatment between nationals and foreigners.

3. Lastly, provision should be made for consequential amendments to other sections of the Act, other related Acts and their accompanying regulations.

SIGNED: MINISTER OF LABOUR AND HOME AFFAIRS

Gaborone,

………………… 2005.
APPENDIX 5 – CABINET MEMORANDUM
CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF TRADE UNIONS AND EMPLOYERS ORGANISATIONS ACT (AMENDMENT) BILL

Cab. Memo/
Ministry of Labour and Home Affairs

A. PURPOSE

To request approval from Cabinet for the Trade Unions and Employers Organisations Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and, in particular, to give effect to Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Trade Unions and Employers Organizations Act so as to reflect a human rights approach to prevention, treatment and generally in dealing with issues related to HIV/AIDS.
C. PROPOSAL.

The proposal is to amend the Trade Unions and Employers Organizations Act so as to deal effectively with issues of discrimination against People Living with HIV/AIDS (PLWHA) within the employment setting in particular within collective labour relations. Botswana’s industrial relations law and practice encourages formation of trade unions and the process of collective bargaining to deal with employment related issues. Since the issue of discrimination affect all sections of society and given the critical importance of collective labour relations in the country, it is crucial that issues of discrimination are specifically addressed in relation to same. The objective is to ensure that collective labour agreements entered into by and between management and trade unions do not contain discriminatory provisions against PLWHA. Similarly, it is crucial to ensure that trade unions themselves do not discriminate against their members on the basis of health status (including HIV status) as regards members’ rights.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A provision that would make any clause of a collective labour agreement which is discriminatory on the basis of health status (including HIV status), sexual orientation and or gender void. This would constrain both the union and or employers from being discriminatory and where such discriminatory clauses found their way intentional or unintentional into concluded agreements, then such discriminatory clauses would not have any legal force. In this way, the rights of the union members who are either affected and or infected by HIV/AIDS would be protected and thereby ensuring compliance with the Constitution of Botswana, the National Response to HIV/AIDS and National HIV/AIDS policy.

2. A provision entitling the Commissioner of Labour to decline to register a collective labour agreement that contains a clause and or clauses that are directly and or indirectly discriminatory on the basis, inter alia, of gender, health
(including HIV) status and or any provision which is prejudicial to the vulnerable and marginalized groups. The proposed provision would strengthen an already existing provision of the Act which entitles the Commissioner of Labour to refuse to register a collective labour agreement under certain circumstances which currently do not include discriminatory clauses in the collective labour agreement which is sought to be registered.

3 Lastly, provision should be made for consequential amendments to other sections of the Act, other related Acts and their accompanying regulations

SIGNED: MINISTER OF LABOUR AND HOMEAFFAIRS
Gaborone,

....................... 2005.
APPENDIX 6 – CABINET MEMORANDUM
CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF WORKERS COMPENSATION ACT (AMENDMENT) BILL
Cab. Memo/
Ministry of Labour and Home Affairs

A. PURPOSE

To request approval from Cabinet for the Workers Compensation Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and, in particular, to give effect to Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National AIDS Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’s approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a right based approach. The study has recommended that there should be amendments to a number of key existing laws including the Workers Compensation Act so as to reflect a human rights approach to prevention, treatment and generally in dealing with issues related to HIV/AIDS.
C. PROPOSAL.

The proposal is to amend the Workers Compensation Act so as to deal effectively with issues of discrimination against People Living with HIV/AIDS (PLWHA) within the employment setting. The objective is to create a general non-discrimination principle in relation to the provision of insurance for workers, computation of compensation for work related injuries and death. In addition the proposed amendments seek to ensure that the procedures and processes precedent to payment of compensation are non-discriminatory. The proposal is critical in addressing issues of stigma and discrimination. It will ensure that the privacy of workers who get injured in the course of their employment is protected in the process of claiming payment.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

2. A general non-discrimination clause that would ensure that there is no discrimination generally and discrimination based on health status in particular in the area of compensation of workers under the Workers’ Compensation Act. This provision would prohibit direct and or indirect discrimination at the following stages;

   (a) Inclusion of workers under the insurance plan required under the Act

   (b) Scope of coverage in relation to injuries, diseases and or death that qualify for compensation.

2 A provision guaranteeing the right of privacy for the injured worker in the procedures for claiming compensation. This would ensure that workers are not subjected to HIV testing without their consent.

3 Lastly, provision should be made for consequential amendments to other sections of the Act and or other related legislation and their accompanying regulations.

SIGNED: MINISTER OF LABOUR AND HOME AFFAIRS
Gaborone,

APPENDIX 7 – CABINET MEMORANDUM
CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF THE NATIONAL AIDS COORDINATING AGENCY BILL

Cab. Memo/

Ministry of Presidential Affairs and Public Administration

A. PURPOSE

To request approval from Cabinet for the National Aids Coordinating Agency Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and, in particular, to give effect to Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’s approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that the National Aids Coordinating Agency (NACA), which existence is currently based on a Government directive be given a statutory basis so as to reflect a human rights approach in its functions and for a better delivery on its mandate.
C. PROPOSAL.

The proposal is to enact a law that would transform NACA from being an agency founded on a Government directive to a statutory body. The objectives of this proposal are threefold; to mandate NACA through an Act of parliament to mainstream human rights into its functions and the manner which it carries out its mandate; to introduce certainty and clarity of roles as regards NACA’s relationship with other agencies and ministries of government, private sector and Parastatals; and to empower NACA, especially in respect of collection of information, directing Government policy and coordinating implementation of the national response to HIV/AIDS. The proposal seeks to transform NACA so that its functions, powers and duties are spelt in an Act of parliament for clarity and consistency. NACA would continue to be under the Office of the President.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

2 A part on the powers and functions of NACA. This would reflect the role of NACA under the National Strategic Framework for HIV/AIDS and would include, the responsibility for overseeing planning at all levels, capacity building for managing and implementing the National Response to HIV/AIDS, resource mobilisation, manage and coordinate policy issues on HIV/AIDS, manage information on HIV/AIDS, harmonisation of the planning and implementation by all Ministries, sectors, districts, civil society, and the private sector to ensure appropriate alignment with the vision and Goals of the National Response. This would be intended to ensure effective coordination of the National Response and avoid overlapping of mandates and jurisdictional conflict. One way of ensuring efficient intervention is by having the powers of NACA clearly spelt out in law to avoid situations where other Government agencies bureaucratically situated at the same level as NACA or even higher may feel that they should not be expected to comply with NACA advice and or instructions.
3 A part on the leadership of NACA. This would be a statutory confirmation of the National AIDS Council as the political and overall policy head of the National Response to HIV/AIDS. The President would continue to be the Head of National Aids Council.

4 A part of the general institutional operational principle. The proposal seeks to mandate NACA to mainstream human rights in its work, organisational structure, and in executing its mandate generally. In particular NACA requires the statutory power to promote the respect for human rights for PLWHA and to advise Government on the issues relating to mainstreaming of human rights into the National Response to HIV/AIDS.

5 A part on the financing of NACA. Since NACA would continue to be an agency of Government, and not a Parastatal, it would be mainly funded by Government. However given the large amount of financial resources required to effectively address the challenges brought by HIV/AIDS, NACA should be allowed to receive grants from other sources such as international civil society organisations, gifts, etc.

3 Lastly, provision should be made for consequential amendments to other related legislation and their accompanying regulations.

SIGNED: MINISTER OF LABOUR AND HOME AFFAIRS
Gaborone,
...................... 2005.
A. PURPOSE

To request approval from the Cabinet for the amendments to the Penal Code (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’s approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and
the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Penal Code so as to reflect a human rights approach to prevention, treatment and generally deal with issues related to HIV/AIDS.

C. PROPOSAL

The proposal is to amend the Penal Code so as to harness the Botswana’s criminal law outlawing sex-work and consensual homosexual activity and other acts considered to be against the order of nature with the human rights approach and Botswana’s obligations at international law to fight the HIV/AIDS pandemic. It is proposed that all criminal laws within the Penal Code prohibiting specific sexual activity between consenting adults in private, such as adultery, sodomy, fornication or acts against the order of nature or social order or morality be abolished in so far as criminalization of such acts cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS by driving underground many of the people at risk of infection. This approach appears to run counter to the implementation of effective education programmes in respect of HIV/AIDS prevention. It is further proposed that the criminal law prohibition in areas of prostitution or sex-work be abolished in so far as it impedes the provision of HIV/AIDS prevention and care by driving people engaged in the industry underground. The decriminalisation of sex-work where no victimization is involved and occupational health is regulated and other safety conditions to protect sex-workers and their clients enhances prevention of HIV/AIDS. Victimization including the use of children as sex-workers and adults who are trafficked or otherwise coerced into the industry should continue to be subject to criminal penalties. Victims should be prosecuted for their participation but removed from the industry and provided with medical and psychological support. Finally, it is proposed that such cases of HIV/AIDS be tried under general criminal law, public or mental health law provisions provided that such application is appropriate.
D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions to be amended namely:

1. (a) Section 153 of the Penal Code dealing detention of
persons for immoral purposes including the operation of brothels.

(b) Section 158 dealing with brothels.

(c) Section 157 dealing with premises used for prostitution.

(d) Section 156 dealing with persons aiding for gain prostitution.

(e) Section 155 dealing with persons living on earnings of
prostitution or persistently soliciting the same.

(f) Section 164 dealing with unnatural offences.

(g) Section 165 dealing with attempts to commit unnatural
offences.

2. In substance it is proposed that the law should allow sexual acts between
consenting in private, namely, homosexual acts, fornication or adultery, street
sex-work and brothel or escort sex-work. The proposal further seeks the
decriminalisation of sex-work and abolition of any prostitution related
offences. The said sex-work industry should be regulated for occupational
health and safety both by clients, workers, owners and/or managers of such
institutions. All sex-work related services should be decriminalized and
regulated with a view to provide a safe working environment for the workers,
their clients and improved access to sexual health information and other
services.
3. Lastly, it is proposed that a new provision that recognises marital rape and generally protecting the autonomy of women over sexual activity and other reproductive health be provided for.

4. Lastly, provision should be made for consequential amendments to other related legislation and their accompanying regulations

SIGNED: MINISTER OF PRESIDENTIAL AFFAIRS AND PUBLIC ADMINISTRATION

Gaborone, 2005.
APPENDIX 9 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF EDUCATION ACT (AMENDMENT) BILL

Cab. Memo/

Ministry of Education

A. PURPOSE

To request approval from the Cabinet for the amendments to the Education Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a Rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Education Act so as to reflect a human rights approach to prevention, treatment and generally deal with issues related to HIV/AIDS.
C. PROPOSAL

The proposal is to amend the Education Act and other consequential Acts to deal effectively with issues of discrimination against people living with HIV/AIDS (PLWHAs) at all levels of the learning environment, that is to say, learners, educators, principals, parents and the community. The right of the educator being the right to educate, the right to be treated with respect and dignity, the right to be resourceful, the right to be able to voice concerns and feelings, the right to improve and maintain a good standard of education and the right of protection.

Rights in relation to HIV/AIDS must be protected and the protection includes to be protected from unfair discrimination within the school, the right keep the HIV/AIDS status confidential and to be protected from stigma, abuse and discrimination should they choose to reveal such status and finally the right not to be required to take an HIV/AIDS test unless the interactions with learners take on the form of providing some form of health services. On the other hand the learners should have a right to attend school, the right to non-discrimination and equality, the right to privacy regarding HIV/AIDS information and the right to a non-mandatory HIV/AIDS test. The absence of legislation on HIV/AIDS in education setting has in a way made it possible for some learning institutions/sponsors to require potential students and trainees to undergo HIV test as a condition for sponsorship. In addition potential government sponsored students are required to undergo HIV test in cases where such students study outside Botswana.

In the circumstances, given that there are no clear and consistent guidelines to tackle issues of discrimination, stigmatisation privacy and victimisation of teachers and students on account of HIV status and there is a need to address this issue.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:
1. A new section prohibiting discrimination on the basis of health status, stigmatisation and/or victimisation of teachers and/or students on the basis of health status should be inserted which will create a statutory obligation on education and the training institutions to provide access on a non-discriminatory basis. The proposed amendment would further oblige scholarship and bursaries to be granted on a non-discriminatory basis by all public bodies including private companies in which the Botswana Government has substantial financial and other interests. It is proposed that any exception to this rule should be based on the need to ensure the health of the applicant (for scholarship or bursary).

2. A new section dealing with the handling of students and teachers’ health related information is further proposed. The provision should place an obligation on the educator and/or sponsor and or his/her representative not to disclose the health status (including HIV status) of students/teachers to third parties unless with the prior written consent of the concerned student/teacher. This provision would encourage students/teachers to test which is a good public health objective and also allow such students/teachers the option to disclose their status to the educators and other students/teachers.

3. A new provision that prohibits sexual harassment at the all learning institutions with clearly spelt out penalties for breach. An anti-sexual harassment provision would help deal with stigma and victimisation of HIV infected and or affected students/teachers. Sexual harassment should be widely defined to include any verbally or sexual advance, derogatory and or discriminatory sexual statement that causes the recipient discomfort, or humiliation and or creates a threatening or intimidating learning environment.

Lastly, provision should be made for consequential amendments to other sections of the Act and other related Acts of Parliament including their accompanying regulations namely;
a) Tertiary Education Act Cap;
b) University of Botswana Act;
c) Botswana College of Distance and Open Learning Act Cap;
d) Botswana Training Authority Act Cap;

SIGNED: MINISTER OF EDUCATION
Gaborone, 2005.
APPENDIX 10 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF BANKING ACT (AMENDMENT) BILL

Cab. Memo/

MINISTRY OF FINANCE AND DEVELOPMENT PLANNING

A. PURPOSE

To request approval from Cabinet for the Banking Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Banking Act so as to reflect a human rights approach.
in the area of financial services provision.

C. PROPOSAL

The proposal is to amend the Banking Act and other consequential Acts to deal effectively with issues of discrimination against people living with HIV/AIDS (PLHWAs) in accessing financial services provided by private, Government, parastatals and other statutory bodies. The objective is to ensure that PLWHA are not unduly denied access to financial services such as operating bank accounts, obtaining loans with or without security, etc. Other than the fact that denying PLWHA access to financial services on account of their health status is discriminatory, it can also negatively affect PLHWAs right to health and consequently the right to life, if the denial results in the applicant not being able to access medical services.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A new section prohibiting discrimination on the basis of health status (including HIV/AIDS status) in the provision of financial services. The objective is to create an obligation on all financial service providers to provide services on non-discriminatory basis. Access to financial services is important enabling the consumers of financial services to meet their other needs and human rights such as shelter, medical services, food and nutrition. Non-discriminatory access to financial service would be secured by creating a general non-discrimination obligation on all financial service providers and by giving the regulator (the Central Bank) the power to ensure that the licensed financial service providers comply with the non-discrimination principle in the conduct of their businesses.

2. An amendment to section 9 to provide that the Central Bank would be required in exercising its powers of licensing to condition such licence to non-discriminatory provision of services. In this way, licensed financial
service providers who discriminate against PLWHA and or any person would be in breach of their licence and accordingly subject to regulatory censor.

3. A new provision that empowers the Central Bank to authorize differential treatment of consumers of financial services by specific service providers, where it is satisfied on application by the service provider, that there are justifiable reason why the concerned service provider needs to discriminate against a specific class of persons. In addition, the provision should empower the Central Bank on licensing to indicate in advances circumstances which may entitle the service provider to discriminate in the provision of service. It is important to maintain some form of flexibility to address circumstances which could not be foreseen. Leaving enforcement of the non-discriminatory principle to the Central Bank is the better option than criminal law. Financial services sector is very complex and it is therefore advisable to leave the enforcement of its rules to a specialist body such as the financial services regulator which in the case of Botswana is the Central Bank.

4 Lastly, provision should be made for consequential amendments to other sections of the Act and other related Acts of Parliament including their accompanying regulations namely;

a) Bank of Botswana Act;

d) Botswana Savings Bank Act;

e) Hypothecation Act;

d) Hire Purchase Act;

e) Consumer Protection Act

f) National Development Act

SIGNED: MINISTER OF FINANCE AND DEVELOPMENT PLANNING
Gaborone, 2005.
APPENDIX 11 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF INSURANCE INDUSTRY ACT (AMENDMENT) BILL

Cab. Memo/

MINISTRY OF FINANCE AND DEVELOPMENT PLANNING

A. PURPOSE

To request approval from Cabinet for the Insurance Industry Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Ethics, Law and Human Rights Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’s approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a rights based approach. The study has recommended that there should be amendments to a number of key existing laws including the Insurance Industry Act so as to reflect a human rights approach in the area of service provision.
C. PROPOSAL

The proposal is to amend the Insurance Act and other consequential Acts to deal effectively with issues of discrimination against people living with HIV/AIDS (PLHWAs) in accessing life cover insurance services. The objective is to ensure that PLWHA are not unduly denied access to insurance services, in particular, life cover services. Other than the fact that denying PLWHA access to insurance services on account of their health status is discriminatory, it can also negatively affect PLHWAs right to health and consequently the right to life, if the denial results in the applicant not being able to access medical services.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A new section prohibiting discrimination on the basis of health status (including HIV/AIDS status) in the provision of insurance services. The objective is to create an obligation on all insurance service providers to provide services on non-discriminatory basis. Access to life insurance services is important in enabling consumers of insurance services to meet their other needs and human rights such as shelter, medical services, food and nutrition. Non-discriminatory access to financial service would be secured by creating a general non-discrimination obligation on all financial service providers and by giving the regulator (the Registrar of Insurance) the power to ensure that the licensed insurance service providers comply with the non-discrimination principle in the conduct of their businesses.

2. An amendment to section 96 by adding a proviso that the exemption from the non-discrimination in life cover for over P100,000.00 excludes circumstances where the basis for differential treatment is the health status (including HIV status of the applicant for life cover). Where differential treatment is sought on the basis of health status that should be permissible only with the permission of the Registrar on application by the insurance service provider and or pursuant to conditions that may been
imposed by the license of the service provide. In this way, licensed insurance service providers who discriminate against PLWHA and or any person would be in breach of their licence and accordingly subject to regulatory censor. Leaving enforcement of the non-discrimination principle to the Registrar is the better option than criminal law. Insurance services sector is very complex and it is therefore advisable to leave the enforcement of its rules to a specialist body such as the insurance services regulator which in the case of Botswana is the Registrar of Insurance.

4 Lastly, provision should be made for consequential amendments to other sections of the Act and other related Acts of Parliament including their accompanying regulations.

SIGNED: MINISTER OF FINANCE AND DEVELOPMENT PLANNING

APPENDIX I2 – CABINET MEMORANDUM

CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF PRISONS ACT (AMENDMENT) BILL

Cab. Memo/
Ministry of Labour and Home Affairs

A. PURPOSE

To request approval from the Cabinet for the Prisons Act (Amendment) Bill to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Law and Ethics Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on an appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a right based approach. The study has recommended that there should be amendments to a number of key existing laws including the prisons Act so as to reflect a human rights approach to prevention, treatment and generally deal with issues related to HIV/AIDS.

C. PROPOSAL
The proposal is to amend the Prisons Act so as to deal effectively with issues of discrimination against People Living with HIV and AIDS (PLHWAs) at all the prisons, that is to say, the right to health care of prisoners, the right to information of prisoners, the right to confidentiality and non-discrimination of prisoners. It is proposed that detailed provisions are required to deal with issues of the right of the prisoners to refuse to undergo an HIV test, the right of the prisoners to medical and health care and the right to confidentiality about private things like their health, their HIV status, etc and the right not to be segregated against by reason of HIV status. It is proposed that the power to subject prisoner to medical examination for health reasons be a preserve to an independent tenure constituted for that purpose. The intention is to minimise infringement of the prisoner’s right to confidentiality and to refuse to undergo HIV tests. It is proposed that the proposed Bill will require the following provisions: a new section prohibiting discrimination on the basis of health status, stigmatisation and or victimisation on the basis of health status including HIV/AIDS or sexual orientation should be inserted into the Act. Anti discrimination provision should apply in all aspects of detainees

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A new section prohibiting discrimination on the basis of health status, stigmatisation and or victimisation on the basis of health status (including HIV status and sexual orientation) should be inserted into the Act. The anti-discrimination provision should apply in all aspects of detainees
rehabilitation compulsory HIV testing for prisoners, the right of access to medical facilities and treatment and regulation of issues of segregation within the prison settings and the exceptions to the general rule of non-discrimination. The section should provide for condoms accessibility in the prisons and conjugal visits. The Act should further allow the use of bleach and lubricants in prisons and their accessibility guaranteed. A statutory provision should further be made to government's liability in cases of exposure by the inmates and or prison waders. Section 56 would further have to be amended to be in line with a human rights approach to HIV/AIDS with relevant statutory exceptions.

E. Lastly, provision should be made for consequential amendments to the regulations of the Prisons Act.

SIGNED: MINISTER OF LABOUR AND HOME AFFAIRS

Gaborone,

2005.
CABINET MEMORANDUM: APPROVAL FOR DRAFTING OF PUBLIC HEALTH ACT (AMENDMENT) BILL

Cab. Memo/
Ministry of Health

A. PURPOSE

To request approval from Cabinet for the Public Health Act (Amendment) Bill, to be drafted.

B. BACKGROUND.

As part of its strategy to effectively tackle the HIV/AIDS pandemic and in particular to give effect to the Government declared objective of mainstreaming human rights into Botswana’s approach to HIV/AIDS (as reflected, for example, in the Botswana National Strategic Framework for HIV/AIDS, Goal 5 which commits Government to ‘create a supportive, ethical, legal and human rights based environment conforming to international standards for the implementation of the National Response’, the Botswana National HIV/AIDS Policy and other policy documents), the National Aids Council, through its Law and Ethics Sector, commissioned a study to review all existing policies, laws, practices and directives with a bearing on HIV/AIDS to assess the compatibility of the current approach with the Constitution of Botswana, the extent to which Botswana’ approach to HIV/AIDS meets Botswana international human rights obligations as spelt out in treaties to which Botswana is a party and to advise on an appropriate ways of effecting a rights based approach to HIV/AIDS in Botswana and the institutional framework for delivery of a right based approach. The study has recommended that there should be amendments to a number of key existing laws including the Public Health Act so as to reflect a human rights approach to prevention, treatment and generally deal with issues related to HIV/AIDS.
C. PROPOSAL

The proposal is to amend the Public Health Act and consequential regulations so as to deal effectively with issues of discrimination against People Living with HIV/AIDS (PLHWAs) at all levels of the health environment. It is proposed that a statutory right to health be provided and the minister of health must exercise his/her powers in terms of the public health Act to declare the HIV/AIDS a notifiable disease. The necessity of this arose out of concern to determine the incidence of HIV/AIDS infection with a view of devising ways and means to combat its spread. It is hoped that through the reporting of HIV/AIDS cases, the ministry of health will be armed epidemiological, which will place it in better position to mount a campaign against the disease. It is further proposed that the capacity to give informed consent be set at sixteen years. However, if a person under sixteen is shown to be sexually active then such a person should be presumed to have the capacity to give informed consent for purposes of HIV/AIDS and obtaining sexual reproductive services. It is further proposed that legislation be enacted to regulate the conduct of medical and clinical trials in general and HIV preventive vaccine trials in particular be informed by a human rights approach. It is further proposed that there be a statutory obligation on medical aid schemes and medical facilities to generally provide services on a non-discriminatory basis.

D. THE PROPOSED BILL.

It is proposed that the proposed Bill would require the following provisions:

1. A provision recognising the right to health and access to health care services.

2. A new section in the Public Health Act, alternatively in the regulations that declares HIV/AIDS a notifiable disease. This will provide the legal basis for data collection in respect of the disease and the handling and distribution of information about HIV/AIDS patients generally.
3. A new section is hereby proposed which determines the capacity for giving informed consent for purposes of testing for HIV to be based on a combination of age (16), the fact of sexual activity, reasons for wanting to have the test and or whether the person seeking to undergo the testing has the capacity to understand the consequences for such tests. That is any person aged 16 and above should be presumed to have the capacity to give consent for HIV testing and sexual reproductive health services. However, if a person under 16 is shown to be sexually active then such a person should be presumed to have the capacity to give informed consent for purposes of HIV testing and obtaining of sexual reproductive services. It is further proposed that any person at any age should be allowed to give consent for testing if circumstances so warrant.

4. A new section prohibiting discrimination on the basis of status is proposed. The section should provide for equitable access to medical services, by medical aid schemes and medical facilities.

5. A new provision is hereby proposed to regulate the conduct of medical and clinical trials in general and HIV preventive vaccine trials in particular informed by a human rights approach. This provision would give the Minister the power to promulgate detailed regulations on medical trials but condition those regulations a rights based approach.

6. Lastly, provision should be made for consequential amendments to other sections of the Act and relevant regulations.

SIGNED; Minister of Health

GABORONE,…..2005
APPENDIX 14: RECOMMENDATIONS FOR AREAS WHICH NEED DETAILED SECTORAL AND OR SPECIFIC POLICIES/GUIDELINES AND PROPOSED AMENDMENTS FOR EXISTING POLICIES

1. **The Revised National Education Policy** is silent on issues of HIV/AIDS. This is a serious omission and in our view, the Policy should be reviewed to include issues of HIV/AIDS including instruction in relation to sex education and the provision of sexual reproductive services and facilities such as infection and pregnancy prevention such as condoms in all learning institutions as part of the provision of child friendly services.

3. **The Promulgation of a National Policy on Children and HIV/AIDS:** The proposed policy would provide guidelines on how to handle children specific HIV/AIDS related problems; how best to address and realise the right to health and the right to life for children, infected or affected by HIV/AIDS (for example orphans), defining the right to health as it relates to children, the right to reproductive health and facilities, the right to children friendly health services, the right to be protected from trafficking and the duty on the state to provide for orphans. The proposed policy would be based on a human rights approach.

4. **The Promulgation of a National Policy on HIV/AIDS and Sports:** The proposed policy would address issues of HIV/AIDS within the various sports codes, define the role of sports administrators, Government and other stakeholders in handling HIV/AIDS related problems such as protection of sportspersons from possible infections during sporting activities and at the same time ensuring that PLHWA are not unduly discriminated against.

5. **Developing of Guidelines on testing, maintaining confidentiality and informed consent:** The proposed guidelines would ensure uniformity in all the concerned areas regardless where one obtains medical services including testing for HIV. In addition following the same guidelines based on a human rights approach would help in ensuring that the human rights of PLHWA are
respected and areas where confidentiality and informed consent may be waived would be clarified.

6. **The Reversed Botswana National Policy on HIV/AIDS and Employment (August 2005, Ministry of Labour and Home Affairs):** The Reversed Policy needs to amended with a view to avoiding entrenching discrimination against foreign nationals in the area of pre-employment HIV testing. Whatever concerns Government may have regarding the possibility of giving employment to HIV/AIDS infected and or affected foreign applicants can be addressed a host of policy instruments other than pre-employment HIV testing. If the main employment is the possibility of transportation of the body of deceased in the event such foreign workers die while employed, then the possibility of demanding that all foreign workers join an insurance scheme that would cover transport costs in the event of death before contract expiry.

7. **National Industrial Relations Code of Practice:** We propose that this Code be amended to take account of policy documents promulgated before it came into being (such as the National Policy on HIV/AIDS, the Botswana National Strategic Framework for HIV/AIDS) and to general align it with the emerging human rights approach to HIV/AIDS in Botswana.
APPENDIX 15: RECOMMENDATION ON ISSUES THAT NEED FURTHER STUDY AND OR CONSIDERATION.

1. **Law Reform Commission:** In order to continuously monitor justifications and the pace for law reform we suggest that Government should consider forming a statutory Law Reform Commission, which will replace current Law Reform Committee. In addition to its core function of spearheading law reform professional standpoint, the Commission would also play an educational role. In the case of HIV/AIDS the Commission be charged with informing the nation about the duality of our legal system, options for opting out of customary law and related personal law matters such as marriage which may impact on the national efforts to fight pandemic.

2. **Human Rights Commission:** Government should consider and study the possibility of creating a human rights commission which help in developing and nurturing a human rights culture in Botswana. The commission would investigate allegations of human rights abuses and violations, advise Government on the promotion and protection of human rights and help victims of human rights abuse in seeking remedies.

3. **Sustainability of Government freely supplied ARVs:** Government should consider undertaking a study assessing the sustainability of the current practice where Government freely supply patented ARVs. The objective should be study the options, if any, of using generic drugs possibly by exploiting the Doha Declaration paragraph on access to
essential medicine such as those for HIV/AIDS and malaria.