LINKING HEALTH AND HUMAN RIGHTS TO ADVANCE THE WELL-BEING OF GAY, LESBIAN AND BISEXUAL PEOPLE IN BOTSWANA

by

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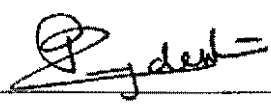
DECLARATION BY THE CANDIDATE

I declare that **LINKING HEALTH AND HUMAN RIGHTS TO ADVANCE THE WELL-BEING OF GAY, LESBIAN AND BISEXUAL PEOPLE IN BOTSWANA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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SUMMARY

This study explored how the well-being of the gays, lesbians and bisexuals (GLBs) in Botswana could be promoted. The health and human rights approach that places dignity before rights was selected as a framework for investigation. The respondents' (n=47) levels of well-being were assessed through a questionnaire with 76 items that included the General Well-Being Schedule.

The findings indicated that varying degrees of distress were experienced by 64% of the GLBs in this study. The GLBs identified a need for HIV/AIDS education and had concerns about their general health, discrimination and vulnerability for violence including sexual attacks. Their levels of well-being were influenced by both positive internal acceptance of their sexual orientation and negative external acceptance by society. Levels of involvement of health professionals was poor, and linkage between health and human rights was proposed to reduce dignity violations and improve the quality of life of the GLBs in Botswana.

LINKING HEALTH AND HUMAN RIGHTS TO ADVANCE THE WELL-BEING OF GAY, LESBIAN AND BISEXUAL PEOPLE IN BOTSWANA

KEY CONCEPTS:

The following key words form the core of this study:

- Bisexual
- Botswana
- Dignity
- Gay
- Health
- Health promotion
- Human rights
- Lesbian
- Nursing
- Well-being

ABBREVIATIONS

AIDS:	Acquired Immuno-Deficiency Syndrome
Batswana:	Citizens of Botswana (plural)
CINAHL	Cumulative Index to Nursing and Allied Literature
DITSHWANELO:	DITSHWANELO - The Botswana Centre for Human Rights
GLB:	Gay, lesbian and bisexual person
GLBs:	Gays, lesbians and bisexuals
GWBS:	General Well-Being Schedule
HIV:	Human Immuno-deficiency Virus
LeGaBiBo:	Lesbian, Gay and Bisexual Group of Botswana
LeGaBiBo Charter:	Human Rights Charter launched 1998 in by LeGaBiBo
Motswana:	Citizen of Botswana (singular)
NISC	National Information Services Corporation
PsycLIT	Psychological Literature
RSA:	Republic of South Africa
SPSS:	The Statistics Package for Social Sciences
STD(s):	Sexually transmitted disease(s)
UDHR:	The Universal Declaration of Human Rights
UK:	The United Kingdom
UNISA:	University of South Africa
USA:	The United States of America
WHO:	World Health Organization

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This study researched how the well-being of the gays, lesbians and bisexuals (GLBs) of Botswana could be advanced by linking the health and human rights disciplines.

GLBs deliberately broke the silence about their existence when they launched their Human Rights Charter in November 1998, in Gaborone, Botswana. The GLBs argued that their claim for so called "gay rights" was not a claim for special rights: it was a claim to equal rights and equal dignity applied in the same way as to Botswana's heterosexual citizens.

Chapter 1 contains background information about Botswana in general, the democratic structure and the rule of law, and its health service. The target population for this study, the GLBs of Botswana, is described, followed by a brief outline about the Health and Human Rights movement of the 1990s. The problem statement and the objectives of this study are explained. The purpose and significance of this study for nursing are highlighted, and the scope and limitations described.

Chapter 2 provides a review of the literature that already existed on the topic at the time of the study, and explains how this study relates to previous research and how previous research gave rise to particular issues that this study addressed.

Chapter 3 outlines the methodology used to investigate this sensitive topic. The three research questions that guided the study are described in Chapter 1. The ethical concerns pertinent to conducting sensitive research are detailed in Chapter 3, followed by a discussion of the methods, data collection process and the data analysis.

Chapter 4 introduces and describes the findings of the research. The questionnaire contained 76 questions, and the answers of the GLBs are described and cross-tabulated.

In Chapter 5, the findings outlined in Chapter 4 are discussed and analysed. The findings are compared with the literature reviewed and aim to answer the three research questions which are outlined in Chapter 1.

The last chapter, Chapter 6, contains the conclusions. The nature of this study limited the generalisation of the findings to all GLBs in Botswana. The reasons for this are given. This first study of the GLBs generated information that could be further explored. The new directions for research that were identified, and possible methodological improvements, were outlined as recommendations for further studies.

1.2 BACKGROUND INFORMATION

Botswana is a landlocked country of 582,000 km^2 located in the centre of the Southern African plateau, sharing borders with Namibia, Zimbabwe, Zambia and the Republic of South Africa (RSA). In 1997, the estimated population was 1,553 million. Since Independence in 1966, Botswana has extended its physical infrastructure and basic social services throughout the country. In spite of rapid economic growth, 47% of the population were living below the poverty line in 1993/4. Botswana has one of the highest rates of Human Immuno-deficiency Virus (HIV) prevalence in the world, with 32% of the adult sexually active population HIV infected in 1997 (Botswana Human Development Report 1997:2).

1.2.1 Gays, lesbians and bisexuals in Botswana

The target population of this study were the GLBs in Botswana. Within each society an estimated five to 10 per cent of the population is engaging in same-sex sexual relations (Foreman 1999:110). Even if an estimate of two per cent is applied, 30,000 Batswana could be inclined to same-sex sexual activities, but not all would self-identify as gay, lesbian or bisexual (Batswana is the name of the people of the country of Botswana (plural)).

A few academics have hinted at the existence of GLBs in Botswana. For example, Boko (1998), in a commentary on the Penal Code of Botswana, Sections 164, 165 and 167, pointed out that there are homosexuals in Botswana but was vague about details:

"There emerged in Botswana a visible though very small community of homosexuals who have openly identified themselves as a distinct and insular group entitled to equal protection of law."

Boko emphasised that the open identification of GLBs as a distinct group was of relevance to Botswana because of the law that criminalises same-sex sexual activities. Going public about being GLB could be seen as an act of defiance to the Botswana authorities.

1.2.2 Homosexuality and Botswana law

To acknowledge or announce one's homosexual orientation is legal in Botswana. The law punishes only the actual engagement in the male to male or female to female sexual union. In Botswana, the amended Penal Code, Sections 164 and 165, stipulates:

"Any person who-

a) has carnal knowledge of any person against nature;

b) has carnal knowledge of an animal; or

c) permits any other person to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for a term not exceeding seven years."

Section 167 stipulates:

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

The Penal Code does not provide any definition of "order of nature" or of "carnal knowledge" (Botswana [National Assembly] Penal Code CAP 08:01 1964: Section 164 as amended by Penal Code 1998: Section 21; Penal Code CAP 08:01 1964: Section 165; Penal Code CAP 08:01 1964: Section 167 as amended by Penal Code 1998: Section 22).

1.2.3 The LeGaBiBo Human Rights Charter of Botswana

In mid 1998, members of a GLBs of Botswana group, later known as "LeGaBiBo", launched their Human Rights Charter in response to the amendments to the Botswana Penal Code made at that time.

LeGaBiBo publicly claimed that their basic human rights to sexual orientation were violated and that this abuse was believed to be linked to their levels of well-being or health status. The Universal Declaration of Human Rights includes many rights which LeGaBiBo claimed are seriously compromised by the current Penal Code: more specifically, their rights to life, liberty, privacy, association, information and dignity as outlined in Articles 2, 3, 12, 19 and 22 (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a; the Universal Declaration of Human Rights adopted and proclaimed by the United Nations General Assembly Resolution 217 A(III) (December 10, 1948)).

1.2.4 The Universal Declaration of Human Rights

The Universal Declaration of Human Rights, which was adopted by 48 member states of the General Assembly of the United Nations in 1948, was the first attempt to establish "a common standard of achievement for all peoples and all nations" to promote human rights.

The 30 Articles of the Universal Declaration of Human Rights are based on the principle that all human beings are born free and equal in dignity and rights. It includes both civil and political rights, and economic, social and cultural rights (the Universal Declaration of Human Rights, adopted and proclaimed by the United Nations General Assembly Resolution 217 A(III) (December 10, 1948)).

1.2.5 "Gay rights"

According to Botha (1998), a South African human rights lawyer, the claim by lesbian, gay, bisexual and transgendered communities for the recognition of their rights is not a claim for a separate, new category of human rights. It is a claim for equal access to existing, classical first-generation rights available to every other human being in the country concerned. Claims to equal protection by the law, to non-discrimination, to privacy, dignity, freedom of association and freedom of expression are required to apply

to lesbian and gay people in the same way that they apply to all heterosexual people. The call for so-called "gay rights" is not a claim to special rights. It is a claim for equal rights, equal dignity, equal freedom - rights often denied simply because the claimant is gay or lesbian.

1.2.6 Health promotion

Health promotion is concerned with people and their well-being from their perspective. Health promotion and disease prevention are complementary concepts, with the focus of health promotion on wellness, empowerment of communities, and enabling people for self-care and self-help (King 1994:211). From a human rights perspective, health is also regarded as a precondition for the capacity to realise and enjoy human rights and dignity (Driscoll 1997:69).

1.2.7 People's participation in health

King explored health promotion as an emerging paradigm in health care from a nursing perspective, and suggested that health promotion is all about enabling people to have control over the quality of their lives and allowing people to enhance their well-being, and said:

> *"Health promotion is not apolitical, rather it is an explicit, politically orientated activity"* (King 1994:213).

In Botswana, concern has been expressed about the lack of meaningful participation in health by the population. The level of health education for each community is generally limited, and the Botswana Human Development Report identified ineffectiveness of Village Development Committees as being a contributing factor to poor participation in health (The Botswana Human Development Report 1997:38).

1.3 PROBLEM STATEMENT

1.3.1 Invisibility of the gay, lesbian and bisexual people of Botswana

Information in Southern Africa, more specifically in Botswana, on the GLB community is very difficult to obtain (Ngulube 1998:1). Altman (1998:18) said that there was a scarcity of information on the GLBs in general, and argued that this lack of information

might be a symptom of the discomfort of most African governments with acknowledging the existence of gays, lesbians and bisexuals. In 1996, the scarcity of information on the GLBs in Namibia, for instance, was questioned and challenged by Hartmann (1998:165), speaking at a human rights and democracy conference, who said:

> *"Gays, lesbians and bisexuals are so invisible that at times one may doubt the presence of such individuals at all. But it is generally accepted that between five and 10 per cent of any given population are homosexually active."*

1.3.2 Human rights violations

Between 1993 and 1999, DITSHWANELO - the Botswana Centre for Human Rights published several reports describing local human rights concerns. Since 1995 DITSHWANELO has advocated for the rights of the GLBs of Botswana, especially since an incident with the Police, who, in December 1994, invaded the bedroom of two Maun residents in order to be able to punish their homosexual behaviour. This incident was evidence of not only a lack of respect for the rights and dignity of this section of the population, but ultimately for all Batswana as far as their right to privacy was concerned (Amnesty International 1997:47; Daily News, October 5, 1995:5; The Voice, February 11-24, 1995:3).

Threats by representatives of the Office of the President to have openly gay and lesbian public servants face disciplinary action at work, after being charged and convicted, were made in the local press as recently as June 1998 (The Midweek Sun, June 3, 1998b:4).

1.3.3 Linking health and human rights

An article by Mann (1995:229) suggested that the human rights approach will be instrumental in uncovering the critical societal conditions that need to be addressed in order to improve people's well-being.

Globally, according to Mann, Gostin, Gruskin, Brennan, Lazzarini & Fineberg (1999:17), the lack of respect for basic human rights is now slowly being accepted as an important factor in causing the failure of prevention (for example HIV/AIDS) strategies:

> *"The evolving HIV/AIDS epidemic has shown a consistent pattern through*

which discrimination, marginalisation, stigmatization and, more generally, lack of respect for human rights and dignity of individuals and groups heightens their vulnerability to becoming exposed to HIV."

Literature about the links between health and human rights indicated that much of the scholarly debate on the effects of health rights violations was mostly provided by public health specialists, doctors and epidemiologists. The literature reviewed did not yield much information about how nursing was involved or contributed, neither were the discussions presented from a nursing care perspective (Thomas & Wainwright 1996:97).

1.4 RESEARCH QUESTIONS

To discover the relationship between health and well-being and the activities of human rights activists involved in human rights protection of vulnerable communities, such as GLBs in Botswana, the following questions have guided this study:

1.4.1 What are the levels of well-being of the gays, lesbians and bisexuals in Botswana?

1.4.2 What are the health needs and demands of the gays, lesbians and bisexuals?

1.4.3 How can linking the fields of health and human rights assist in the advancement of the well-being of the gay, lesbian and bisexual people in Botswana?

1.5 PURPOSE OF THE STUDY

The goal of this study was to learn more about ways to promote the health of GLB people whose human rights are allegedly being violated in Botswana. In order to do so, data about the current levels of well-being of the GLBs in Botswana was collected. The study also aimed to find out what the health needs of the GLBs in Botswana were and to investigate concerns expressed by the GLBs themselves, as to law, societal attitudes, relationships, health, and community organisations. Guided by literature, the barriers and opportunities for collaboration between the two distinct fields of health and human rights was explored.

1.6 OBJECTIVES OF THE STUDY

1.6.1 To obtain objective information about the current levels of well-being of the gay, lesbian and bisexual people in Botswana through administering a community survey

1.6.2 To discover the health care needs and demands of gay, lesbian and bisexual communities

1.6.3 To develop a plan of action to advance the well-being of the gay, lesbian and bisexual people in Botswana through exploring the linkages between the health and human rights disciplines

1.7 SIGNIFICANCE OF THIS STUDY FOR NURSING

This study was considered significant for three reasons. Firstly, the literature reviewed did not reveal the existence of any prior research on the levels of well-being and the health needs and demands of GLBs in Botswana. Consequently there is a gap in the existing body of nursing knowledge about how nurses can support the efforts of this marginalised group to promote their health. The level of involvement of nurses that can be reasonably expected in controversial issues, such as promoting the health of people whose same-sex sexual conduct is labelled as criminal activity, was explored through a review of the literature. Furthermore, the GLBs were asked to identify the roles of health professionals in health education on protection against HIV/AIDS infection, the level of trust during consultations at clinics and hospitals, and the role that health professionals would play in promoting their well-being in the year 2000.

Secondly, this research explored the links between the disciplines of health and human rights and aimed to identify actions that will advance the well-being of the GLBs in Botswana. Through exploration of the link between health promotion and human rights protection, the findings of this study might be used in the debate on whether or not there is potential for collaboration between these two fields (if, for example, the Articles of the Universal Declaration of Human Rights can serve as an additional tool in deciding upon a framework for assessing GLBs' health needs and demands).

Thirdly, identification of critical problems experienced by the GLBs could lead to recommendations on how best to provide solutions to the needs of GLBs. This first exploration and description might assist in the development of interventions for health professionals as well as human rights activists. The decision about who will be responsible for what issues, and an agreement on areas for joint intervention, might be long-term results.

1.8 DEFINITION OF TERMS

Ambisexuals: See bisexuals

Batswana: Citizens of Botswana (plural).

Being completely out: A GLB who "goes public" and tells everybody about his or her sexual orientation.

Bisexuals: Women or men who love and are emotionally and sexually attracted to both men and women (Fine 1992:3).

Dental dam: Thin 6" x 6" square of latex used to make oral-genital sex safer. Used as a latex barrier between the mouth and the vaginal area when oral-genital contact with a woman is being performed.

Gays: Homosexuals who seek legal and social acceptance of the right to live with a partner of the same sex. Generally understood to refer to male homosexuals (Foreman 1999:110).

Half in and half out: A GLB who only tells selected people about his or her sexual orientation but keeps it a secret from other people.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization (WHO) 1986 in Stanhope & Lancaster 1992:22).

Health promotion: In the Ottawa Charter for Health Promotion, health promotion is defined as the process of enabling people to increase control over, and to improve, their health (Ottawa Charter for Health Promotion 1986).

Heterosexuals: Women who love and are emotionally and sexually attracted to men, or men who love and are emotionally and sexually attracted to women (Fine 1992:4).

Homosexual activity: Engaging in sexual or romantic physical contact with members of one's own sex (Corvino 1997:xvi).

Human rights: Human rights are generally accepted principles of fairness and justice. They are universal moral rights that belong equally to all people simply because they are human beings. Human rights have also been called natural or God-given rights. People are equally entitled to them regardless of their sex, race, colour, language, age, class or religious or political beliefs (Donnelly 1989:12).

In the closet: A GLB keeping information about his or her sexual orientation private (Chekola in Murphy 1994:70).

Lesbians: Women who have sex with or primary emotional partnerships with women (Corvino 1997:151).

Mostly in the closet: A GLB who has only informed very few people about his or her sexual orientation.

Mostly out of the closet: A GLB who has informed family and friends about his or her sexual orientation but is still keeping the information secret from others.

Motswana: Citizen of Botswana (singular).

Outing: Forced disclosure of a person's same-sex sexual orientation.

Safe sex: Prevention of exchange of body fluids, such as semen, blood or vaginal and cervical fluids containing disease-causing organisms such as HIV, during sexual

activities between a man and a woman, two women, or two men.

Sexual orientation: Sexual orientation is most often described as including affective behaviour such as desire or attraction, and cognitive behaviour including identity dimensions that occur along a continuum. The degree of same-sex sexual behaviour, current desire, current or past same-sex behaviour or current identity as homosexual or bisexual vary from person to person (Solarz 1999: http//.www.hrc.org/issues/lesbianh/iomrept.html).

Straight: See heterosexuals.

Transgendered: Persons who identify themselves with members of the opposite biological sex, but who have no desire to actually become members of that sex.

Unsafe vaginal sex: Exchange of body fluids, such as semen, blood or vaginal and cervical fluids containing disease-causing organisms such as HIV, during sexual activities between a man and a woman or two women.

1.9 LIST OF ABBREVIATIONS - See page iii

1.10 SCOPE AND LIMITATIONS OF THE RESEARCH

During the proposal development phase, ideas for this study were generated through discussions with GLBs of Botswana; through the interpretation of the intentions of the LeGaBiBo Human Rights Charter and other relevant literature; and through the feedback of members of DITSHWANELO, members of LeGaBiBo and selected health professionals. A detailed research proposal was submitted to LeGaBiBo for this Nursing Science study of limited scope.

This study aimed to gather information by sending out through the Secretariat of LeGaBiBo, 100 questionnaires to GLB people all over Botswana. The GLBs were asked to fill out and then return the questionnaires anonymously to the Secretariat. This is the first study to be supported by LeGaBiBo members, a support group for GLBs that meets every first Monday of the month in Gaborone.

This first formal study, of limited scope, generated new information about the current levels of well-being of members of the GLB community in the whole of Botswana, as well as about their health needs and demands. The findings of this study might contribute to discussions on how to enhance the well-being of GLBs.

1.10.1 Limitations

1.10.1.1 Difficult to reach the target group

The development and growth of LeGaBiBo was difficult to assess due to the continued stigma GLB people face in Botswana, and in recognition of the fact that, under the current law, "going public" might increase the risk of the Police observing "acts against nature". This initial anonymous mapping of the GLB communities' well-being, needs and demands was influenced by the current legal conditions and by the researcher's respect for the choice of most GLBs to remain "in the closet".

1.10.1.2 Exploration of a hidden gay, lesbian and bisexual lifestyle

Most literature on GLB issues is produced outside the African context. Specific problems with health services have been identified by GLB members who were open about their sexual orientation and then faced problems with homophobic health care providers. The level of concealment of identity by the GLBs in Botswana is unknown, and this study was one of the first attempts to gain more insight into how the GLBs cope in a hostile social environment in which human rights violations may or may not occur.

1.11 ETHICAL CONSIDERATIONS

Due to the nature of the study, care was taken to protect the identities and the interests of the participants involved. The data collection instrument was designed to maintain anonymity. The abbreviation "GLB" was used throughout instead of terms such as "queers" or "homosexuals", since it was accepted as the least offensive and most representative of the target groups' composition. Confidentiality of all information provided was guaranteed, and the researcher gave the participants sufficient information about the nature of the research so that they could make informed decisions whether or not they wished to participate in the study (Appendix I Cover Letter). Participants could independently decide to withdraw from the study by not returning the questionnaire.

1.12 CONCLUSION

This first chapter gave an orientation to the study. Chapter 2 contains the literature review that describes issues such as health promotion, well-being, health needs and demands, and the link between health and human rights. Since the majority of the GLBs are "deep in the closet" or completely concealing their sexual identity, very little is known about their specific health needs and demands. Few have advocated for GLBs' rights on behalf of the hidden GLB community of Botswana, and most studies on homosexuality are done outside Southern Africa. One of the objectives guiding this study was to find out how Sections 164, 165 and 167 of Botswana's Penal Code, criminalising GLBs' same-sex sexual orientation, affected GLBs' health.

How both the disciplines of health and human rights contributed to improve the health of this marginalised group was explored. In the Human Rights Charter, the GLBs of Botswana demanded both an end to discriminatory practices (a human rights issue) but also equal access to appropriate health information and respect (a health issue) (Botswana [LeGaBiBo], The Lesbians, Gays and Bisexuals Human Rights Charter, 1998a).

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

One of the important functions of doing the literature review of aspects of well-being was to become aware of how health and improving the quality of life of vulnerable groups could be realised in practice. In this study the process followed for the literature review was to go from the broader issues (such as reading nursing literature on well-being, dignity and health promotion in general), followed by a review of the literature about the more specific issues, such as types of human rights violations, and health needs and problems of the GLBs.

This literature review chapter has been divided into two sections. The first section is concerned with the conceptual definition and strategies for health promotion. The existing body of literature was reviewed to find information about how the health of sections in society, who claim that their human rights are abused, can be advanced. This first section describes a health and human rights approach to health promotion that was selected for this study. The researcher aimed to link the findings in the literature about health promotion and nursings' role in the protection of human rights with an identification of literature, that would assist in meeting the challenges of designing a study with practical value for GLBs, nursing and human rights activists.

The literature review was instrumental in deciding upon the inclusion of the Universal Declaration for Human Rights as a framework for assessing certain aspects of dignity for this nursing study.

After the decision was made about using the health and human rights approach, the literature was reviewed to find relevant information that could assist in answering the three research questions that guided this study. This is described in section II of this chapter. This section describes, firstly, the literature on well-being: especially, how previous research defined and objectively measured "well-being", a largely subjective concept.

Secondly, the literature was analysed to find out what lesbian, bisexual and gay health needs and demands were in other countries, in order to identify these aspects that were to be included in the questionnaire for this study. Due to the nature of the target population, literature was reviewed that discussed methodological issues of doing "sensitive research" on hidden populations or taboo subjects. The outcomes and recommendations of previous studies that applied a health and human rights approach to advancing the well-being of vulnerable populations were reviewed.

Thirdly, the health and human rights approach directed the evaluation of the relevant literature from other countries and from Botswana on specific violations of the rights of the GLBs and the effect of certain violations on their well-being.

The University of South Africa (UNISA) librarian consulted the following databases for the researcher:

Medline Express 1/98-9/98
CINAHL (r) database1993-1998/04
NISC Disc report South African studies 1987-1998
PsycLIT 1996/8
(http://libinf1.unisa.ac.za/CGI-BIN/webspirs.bat)

2.2 SECTION I

2.2.1 Health promotion

Health promotion is an element of primary prevention strategies of health care. Health promotion assumes that the client or community is in good physical and emotional health and that no therapeutic intervention or symptom identification is needed (Dreyer, Hattingh & Lock 1993:27). In the literature reviewed, different definitions of health promotion were proposed but, more importantly, nurse commentators commented on the different interpretations and their effect on health promotion in nursing.

2.2.1.1 The definition of health promotion

Edelman & Mandle (1990:10) defined health promotion as nursing interventions that are directed at developing the resources of persons to maintain or enhance their well-being.

Delaney (1994:831) doubted the effectiveness of such nursing interventions, and pointed out that nursing in the Unites States of America (USA) focused to a large extent on individual disease prevention or positive well-being, and generally played down structural issues of conditions of living. As a consequence, nursing is less effective in the socio-political strategies for health promotion.

The WHO definition emphasises the importance of giving persons control over strategies that can be employed to improve their health, and stated:

> *"Health promotion is the process of enabling people to increase control over and improve their health"* (WHO 1986 in Stanhope & Lancaster 1992:22).

Thomas & Wainwright (1996:99) believed that the WHO definition of health promotion raises questions about control, and go on to say that any assumption that such control over, for example, poverty or unemployment, for many people is ill-founded:

> *"These issues may not only be beyond the control of the individual but may also be beyond the influence of health professionals."*

Various research studies proposed that the previously relied upon methodology of identifying individual risk factors and stimulating individual behavioural change is not sufficient to advance well-being. The approach is at times ineffective, or even unethical, when individuals are blamed for being ill (Davis, Aroskar, Liaschenko & Drought 1997:90; Irwin 1997:170; Thomas & Wainwright 1996:98).

From these few nursing opinions, it can be deducted that understanding health promotion in nursing is problematic. More importantly, different interpretations of the concept of health promotion contribute to confusion about what nurses ought to be doing to promote health. According to Delaney (1994:830), the issues that contribute to different interpretations about what nurses ought to do are:

- The poorly defined concept of health;
- The role and place assigned to health education in health promotion strategies;
- Different assumptions about disease causation; and

- The place assigned to policy and the potential for producing policy change as health promotion tasks.

For example, a study by Adler, Boyce, Chesney & Cohen (1994:22) suggested that social class is among the strongest known predictors of illness and health, and yet paradoxically, a variable about which very little is known.

In this literature review, the ideas on how to promote the health of people whose rights are allegedly abused, and the different assumptions about disease causation and health, were of interest. For example, King (1994:213) argued that since health promotion is concerned with increasing people's well-being, it is not apolitical but rather an explicitly politically orientated activity.

However, Purtilo (1993:249-250) pointed out the importance of setting priorities between the political and professional responsibilities of health professionals. Purtilo, cited Jonsen & Jameton, who set three criteria of suitability to judge the appropriateness of a nurse's involvement in health care issues:

- The most binding are those directly related to patient care;
- The second most binding are those related to broader public health issues that all health professionals share; and
- The least binding are other opportunities for involvement.

Purtilo further argued that it is critical to consider these issues in a larger framework of mutual respect and care, and to be able to see the difference a nurse's presence would make. Here Purtilo considered the "symbolic weight" of respected professions, such as nursing, supporting certain issues, without elaborating on what these special issues were.

Sofaer agreed with Purtilo about the possibility for nursing to put its "symbolic weight" behind issues, since nursing is the largest body of health professionals involved in saving and preserving lives. However, Sofaer strongly disagreed with the separation of nursing's professional and political responsibilities, as nurses worldwide witness unnecessary suffering, indignity and death as a result of both man-made and natural disasters. Sofaer argued that nursing is egocentric by prioritising direct patient care and

taking very little account of the world of war, poverty and famine, and human rights. Sofaer advocated for extending the roles of nurses to include a concern for the welfare of the whole world and "be our brothers' keepers" (Sofaer 1994:174, 175 and 177).

Another two nursing ethicists presented their views on what they believed nurses ought to do to enhance the well-being of people. Driscoll (1997:73) presented a paper to the United Kingdom (UK) Forum on Health Care Ethics and the Law in 1996, and defended patient/person human rights within national health care provision in the UK. Driscoll pointed out the importance of nurses respecting their clients' or communities' dignity, freedom and worth. Dillon (1992:108) proposed a wedding of the concepts of respect and care, arguing that attention and respect involved caring for others by responding to their needs, promoting their well-being, and participating in self-actualisation of patients/clients and their ends.

The ethicists Purtilo, Dillon, Driscoll as well as Sofaer agreed that nurses ought to respect and care for clients and communities but did not agree on when, or when not, to get involved.

2.2.2 Opportunities for involvement

Agreement on a conceptual definition of health promotion could not be deducted from the literature. Consequently, the literature proposed different levels of involvement for nurses depending on the understanding of health promotion roles for nurses. Since the objective of this study was to explore how well-being of the GLBs could be promoted, the literature was further reviewed to consider if human rights issues in general ought to be regarded as areas nurses ought to be involved in, or if human rights violations could be regarded as causes of disease.

Two medical doctors referred to the violation of human rights in disease terms and called it a "hidden epidemic". The writers of the article pointed out the effects of human rights abuses, such as depression, anxiety attacks and bone fractures in torture victims. Lucas & Pross went on to state that both prevention and stronger international activism on the part of professional medical associations and other organisations was needed (Lucas & Pross 1995: http://www.healthnet.org/MGS/lucas/1995.html).

Grodin, Annas & Glantz (1993:8) stated that:

> *"We believe it is time for the physicians and the lawyers of the world as the two major professions dedicated to promoting human welfare and human rights to prevent governments from using physicians as instruments of killing, torture, persecution and involuntary human experimentation."*

The writers argued for the institution of an international medical tribunal with power to impose criminal sanctions against physicians who are guilty of crimes against humanity. This action by health professionals referred to the second criteria mentioned by Purtilo, that the second most binding issues were those related to broader public health issues shared by all health professionals (however, in this article the writers excluded nursing).

In reviewing the literature, this phenomenon was confirmed in various articles. Geiger & Cook-Degan (1993:616, 617) also stressed the role of physicians, but mentioned the skills of medical and forensic scientists and other health workers as being uniquely valuable in human rights investigations and documentation. Nurses were mentioned in one particular instance as being valuable members of missions which go out to investigate violations of human rights and humanitarian law.

Middleton pointed out the need for nurses in the UK to take a dual role in the promotion of human rights. Middleton (1997:27) focused on the rights of the child and stated that, firstly, nurses should ensure that those in need of health care services receive them, and secondly, as advocates ensure that clients - in this case children - enjoy the highest attainable standard of health. Gaylord & Grace (1995:11) agreed with Middleton about the need for an advocacy role for nursing, and based it on the need to support individuals in promoting their well-being as understood by that individual. Patients' rights advocacy would be included if these rights had been infringed.

These statements refer to direct patient care and do not address the nursing profession's role regarding the broader societal conditions. Mallik (1997:311) examined the claim to patient advocacy by nursing in the UK, and concluded that nurses advocate for their patients, take action to protect patients from bad practice, and assist with upholding their rights to freedom of choice. But concluded, however, that political models for advocacy for the rights of groups of patients/clients are conspicuous in their absence.

Tombjerg & Jacobsen (1985:179) pointed out that no effort should be spared to ensure that the ethical responsibility of the nursing profession in Denmark did not become politicised, since such development was clearly at variance with already adopted ethical codes and statements.

In the UK, nurses continue to believe that human rights are political and therefore not of immediate relevance to nursing (Evans 1995:27). This concern was confirmed by Driscoll (1997:66) as well, who noted that in the UK:

> *"The notion of human rights remains inconspicuous and peripheral to the real world of clinical nursing practice."*

Nursing's over-reliance on theories that define nursing in terms of one-to-one relationships, might be at the expense of consideration of other factors such as social, political and economic influences which shape the health of a society. Butterfield (1990:2) cited McKinlay, who used the image of a swiftly flowing river to represent illness: in this analogy, physicians are so caught up in rescuing victims from the river that they have no time to look upstream and see who is pushing their patients in. The analogy described the dilemma of nurses in the USA as well, according to Butterfield: the individual-based care provided had not achieved health gains, so the focus of nurses should be on where the real problems lay.

Further exploration of what nurses think in general about protection and promotion of human rights, and whether they consider it to be a political activity, was beyond the scope of this study. This review attempted to evaluate those approaches that claim to be valuable in advancing well-being.

2.2.3 Health promotion and halting the HIV/AIDS epidemic

In the absence of a cure for the HIV/AIDS infection, disease prevention and health promotion strategies have gained significantly more interest than prior this epidemic. Traditional medical approaches to disease prevention failed to stem the rapid spread of the HIV/AIDS epidemic in the world (McFadden 1998:32). The realities of the HIV/AIDS epidemic, for which there is no medical cure, challenge all nurses involved in health promotion activities. Some writers argued that the failure of the medical

profession to halt the HIV/AIDS epidemic has been instrumental in opening the eyes of most health professionals to the realisation that issues such as poverty, discrimination and lack of privacy lie at the root of individual and community vulnerability to HIV infection, and cannot be ignored (Beyrer 1998:85; Mann & Tarantola 1998:5).

For example, the editorial of the American medical journal, The Lancet (1993:1625), stated:

> *"Human rights issues, as illustrated by AIDS, have to be seen in a wider context and conversely, one cannot contemplate the totality of public health without the human rights component."*

In contrast, Schepers-Hughes (1993:967) compared the Cuban AIDS campaign, which lacks a human rights agenda, with the American and European AIDS campaigns, where human rights issues were regarded as being central. Right from the start of the epidemic in 1983, Cuba implemented routine testing with contact tracing and partner notification, close medical surveillance, and isolation of infected cases, and has achieved protection from AIDS for the Cubans. The writer concluded that until all people share equal rights, an AIDS programme built on individual and private rights, as promoted by the USA and Europe, cannot represent the needs of all groups, especially not those of women and children. Furthermore, this author remarked that one can survive violations of dignity and respect, but one cannot survive AIDS.

Different strategies for advancing well-being as a replacement for the individual risk reduction approach have been offered. An epidemiologist suggested a societal based analysis; Krieger (1994:887) pointed out that uncovering human rights violations, failure of rights realisation, and burdens on dignity - which constitute the societal roots of health problems - might be the way forward to advance people's well-being. Krieger is critical of epidemiology that uses terms such as "special populations" without exposing what makes them so special, for example their forced marginalisation from positions of power.

Modern human rights provide a better guide for identification of factors causing ill health, and are a better tool for analysis and action aimed at improving health than the traditional approaches of public health (Mann 1996:925). Public health is concerned

with promoting and protecting health and with preventing or reducing suffering and premature deaths. Traditional approaches of public health are screening for certain diseases, and the design and implementation of public health policies and programmes, either through legislation compelling or prohibiting actions by public or private sector actors, or through executive functions such as operating government ministries or offering public services (Gostin & Lazzarini 1997:44).

The study by Andrews (1997:4) suggested that the human rights approach will be instrumental in uncovering the critical societal conditions that need to be addressed in order to improve people's well-being. Followers of this school of thought, which has attracted growing interest among both health professionals and human rights activists since its inception in 1994, argue that identification of health impacts associated with violations of rights and dignity will benefit both the health and human rights fields. Furthermore, they argue that a start should be made by using rights violations as an entry point for recognition of health problems (Brundtland 1998:21-26; Mann 1995:229-233; Mann 1998a:15-23).

The literature reviewed supported the researcher's decision to explore the health and human rights framework as a strategy to investigate and describe the well-being and health needs and concerns of the GLBs in Botswana. A broad all-inclusive framework assisted in the formulation of questions about a wide range of topics that focused on individual health needs, such as the need for health education, and broader societal conditions, such as the right to privacy.

2.2.4 Strategies for health promotion

A conceptual framework which would enable practitioners to understand health problems at micro and macro levels, should express concerns about:

- The omission of theories that relate nursing to the social context of behaviour;
- The minimal understanding of practitioners responsibilities to facilitate change at the societal level; and
- The lack of tools to promote societal change in an effective and systematic manner (Butterfield 1990:7).

If the health and human rights movements' assumptions were accepted, then violations of the right to sexual orientation could be regarded as "a disease-causing agent". Furthermore, increased understanding about the impact of discriminatory practices may help to uncover previously unrecognised burdens on the Botswana's GLBs' physical, mental and/or social well-being. According to proponents of the health and human rights movement, the duration and extent of health impacts from severe abuses of human rights and dignity remain generally under-appreciated by health professionals (Mann et al 1999:7-20).

The literature reviewed did not reveal many studies documenting the link between the two fields in practice. Douglas (in Bywaters & McLeod 1996:185) discussed a practical example of health promotion strategies which did address social inequalities, such as poverty and other environmental, political and cultural factors that affect health. Effective health promotion strategies and programmes must be directed at community empowerment. Only with the contribution of local people, community workers and health workers, can effective programmes be designed. However, Douglas acknowledged that employment-creation strategies are beyond the realm of short-term health promotion strategies. The roles of nursing and the scope of competence of nurses were not clarified by Douglas.

2.2.5 Summary

This study was designed to contribute to answering the question of what the essential conditions are for GLBs, in which they can achieve the highest level of well-being in Botswana. The health and human rights approach, placing the importance of dignity before rights, was selected as an appropriate framework for investigation. Nursing ethicists quoted in the literature review, appeared to agree about the importance of dignity and respect as an important aspect of care. From the literature reviewed, levels of involvement in health promotion by nurses could be distinguished. No agreement was found about the definition of health promotion, nor about nursing's responsiblility for what happens outside the immediate context and setting of health care. Effective strategies for nurses to attain the goal of health promotion, defined by King (1994:213) as to increase the well-being of their clients, were apparently not well documented in the literature reviewed.

The literature search did not reveal any research done about the nursing and health care provided to GLBs in Botswana. Based on the literature from other countries, this study attempted to assess the involvement of the nurses in direct care of the GLBs. The level of trust between doctors and nurses and the GLBs when they go to the clinic or hospital for assistance was assessed (Question 51). An attempt to identify if nurses play a role in health education on HIV/AIDS for the GLBs was made (Question 37). An assessment was made whether the GLBs thought health professionals would be important in advancing their well-being. This statement gauged the level of the GLBs' expectations about the involvement of nurses in the promotion of their health (Question 76).

2.3 SECTION II

2.3.1 The current levels of well-being of the gay, lesbian and bisexual population in Botswana

2.3.1.1 Definition of well-being

The most widely used and modern definition of health was developed by the WHO (1978) which stated that:

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*

The specific inclusion of mental and social dimensions of well-being is of relevance to this study about the GLBs of Botswana, since the study explores the relationship between violations of human rights as identified by the GLBs and the alleged impact of those violations on their health.

This broader definition of health as a state of well-being was further confirmed in the Ottawa Charter for Health Promotion (1986), that proposed that:

> *"The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable socio-economic system, sustainable resources, social justice and equity."*

Braun & Bauer defined well-being as the condition of health, happiness and freedom from want. The writers pointed out that as an individual's or family's needs grow,

support measures have to intensify as well. The majority will experience positive well-being since their basic needs are met and thus do not need much support. Those who are vulnerable or "at risk" need a lot of support (Braun & Bauer 1999: http://www.cyfernet.org/welfare/wellbeing.html).

2.3.1.2 Enhancing the health of the gays, lesbians and bisexuals of Botswana

The literature did not yield any specific information about GLB health issues within the context of Botswana. This section of the population remains largely invisible and marginalised, and is possibly put at a disadvantage as compared with their heterosexual peers as far as health and well-being is concerned.

According to the model of Braun & Bauer, the largest section of the GLBs will experience positive well-being and have little or no need for support. A smaller vulnerable section of the GLBs might experience acute needs for support (Braun & Bauer 1999: http://www.cyfernet.org/welfare/wellbeing.html).

The GLBs in Botswana identified disrespect as one of their serious problems and said:

> *"We have the right to a full life, respect and dignity. We should not be prosecuted, condemned or shunned"* (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a).

The literature reviewed in the previous section of this chapter, in which the different levels of involvement in health promotion issues were analysed, indicated that the realisation of health for communities such as the GLBs cannot be achieved through reliance on the traditional medical model of identification of (individual) risk factors and stimulation of individual behaviour changes only, without considering the societal conditions, such as disrespect which fall outside the immediate area of health care.

2.3.1.3 Dignity

In one of his last articles, written in November 1998, Mann (1998c:34) argued that dignity is the unifying concept linking both health and human rights. Lack of respect for dignity, or the humiliation of one person by another person, can take the form of "not being seen". This amounts to being ignored and is identified as a source of injury to well-being. Mann further argued that human rights can only become meaningful when people accord to others the dignity they assume for themselves.

Following the suggestions in the health and human rights literature, disrespect in this study was regarded as being both a risk factor and as a pathogenic force.

Since this study aimed at exploring the merit of a health and human rights approach to advance the well-being of the GLBs, the literature was reviewed to identify measures or data collection methods that could assist with obtaining objective information about levels of well-being of the GLBs in Botswana.

The literature reviewed about the GLBs in Botswana did not offer information about positive levels of well-being. The focus of the literature was on distress of the GLB people in Botswana. Distress was implied in:

- The description of the effects of sections of the current Penal Code (Amended) Act, No. 5 of 1998, on the GLBs. This law punishes the actual engagement in sexual union between two consenting adults of the same sex (Botswana [National Assembly] Penal Code CAP 08:01 1964: Section 164 as amended by Penal Code 1998: Section 21; Penal Code CAP 08:01 1964: Section 167 as amended by Penal Code 1998: Section 22).
- Advocacy for the right to sexual orientation by human rights activists.
- Publication of a Charter for GLB Human Rights.

2.3.1.4 Measuring well-being

A group of psychologists in the USA studied well-being in relation to the use of the Internet. The study aimed to find out if the Internet was improving or harming participation in community life and social relationships. Three different data collection instruments were used to measure three aspects of well-being of 169 people in 73 households during their first two years online. The study used three measures of well-being associated with social involvement:

- Loneliness;
- Stress; and
- Depression.

(Kraut, Lundmark, Patterson, Kiesler, Mukopadhyay & Scherlis 1999: http://www.usyd.edu.ay/su/social/papers/kraut.html).

McDowell & Newell (1996:206) described three approaches to measuring well-being:

- Well-being seen in terms of life satisfaction;
- Recording affective responses to experiences/the feeling states; and
- Questions screening for psychological distress.

The General Well-Being Schedule (GWBS) falls in the last category. McDowell & Newell pointed out that the GWBS assesses how the individual feels about his or her inner personal state rather than about external conditions. Six dimensions are covered in 18 questions:

- Anxiety;
- Depressions;
- General health;
- Positive well-being;
- Self control; and
- Vitality.

The GWBS was selected as a tool to obtain objective information about a subjective concept in this study. Three levels of well-being were distinguished in this data collection instrument and the respondents fell in one of the three groups: positive well-being, moderate distress or severe distress. Distress is often a stimulus to seek care and is often influenced by environmental and social circumstances. Mentally healthy individuals are not immune to depression and/or anxiety, making this a suitable tool for the measurement of the GLBs' well-being (McDowell & Newell 1996:177, 178).

2.3.1.5 Summary of the current levels of well-being

The literature reviewed about well-being revealed a lack of a clear "operational definition of the concept well-being". To explore the added value of linking health and human rights to advance the well-being of the GLBs an attempt was made to identify a data collection instrument to obtain information about current levels of well-being of the GLBs.

Section I of the questionnaire, questions 9 to 26, were the 18 items of the GWBS. The data collection instrument used in this study attempted to measure levels of depression

(Questions 12, 20, 26), anxiety (Questions 10, 13, 16, 24), vitality (Questions 17, 22, 25), positive well-being (Questions 9, 15, 19), self control (Questions 11, 15, 21) and general health (questions 18, 23).

2.3.2 What are the health needs and demands of the gays, lesbians and bisexuals in Botswana?

2.3.2.1 Identity formation

Four essential stages were identified in the process of developing a GLB identity:

- Awareness;
- Testing and exploration;
- Identity acceptance; and
- Identity integration.

In the majority of cases, disclosure to others about their GLB identity started when the identity was accepted, but many variations existed (Sophie in Penn 1997:68).

2.3.2.2 Internalised homophobia

The literature reviewed suggested that, because of society's display of fear and hatred against GLBs and the lack of visible positive homosexual role models, GLBs were in difficult situations and often felt alone and isolated. Paroski researched, through a self-administered questionnaire, the health care delivery concerns of 120 adolescents between 14 and 17 years old in the USA, who were attending a gay and lesbian community clinic. The GLB adolescents indicated that when homophobia is internalised, this might result in feelings of poor self-esteem, low self-image and self-hatred (Murphy 1994:354; Paroski 1987:191; Penn 1997:335).

GLB youth in the process of discovering their identity, might be especially vulnerable when their same-sex attraction is discovered. Incidences of violence and abuse, such as blackmail, are evidence of blatant homophobia which may go under-reported due to feelings of shame and/or guilt of the GLB (Isaacs & McKendrick 1992:26; Penn 1997:455). The literature on GLB vulnerability pointed out that before identity acceptance was achieved, GLBs had to come to terms with their discovery (Taylor & Robertson 1994:561).

Anderson (in Peterson 1996:65) pointed out that:

> *"Children or adolescents with same-sex attractions must develop a false self to survive, often resulting in isolation and alienation from their own families."*

The literature reviewed appeared to disagree about the choices GLBs have - being GLB or heterosexual. The presidents of Namibia, Kenya and Zimbabwe have publicly stated that homosexuality is against African norms and traditions, that it only occurs on the continent as a result of pernicious Western influences, and that even religions considered homosexuality to be a great sin (Kiama 1998: http://www.oneworld.org./ips2/aug98/14_27_054. html; Ngulube 1998:1).

In 1998, four Chiefs, Botswana's traditional leaders, spoke about homosexuality. Kgosi Linchwe II lambasted homosexuals as being worse than animals, and that to liken them to animals was an insult to the animals. Kgosi Seepapitso IV likened the presence of homosexuals in society to a house that is dirty and whose owner would be irresponsible if he did not sweep it clean. Kgosi Masunga stated that: "It should remain illegal because it is against our morals and, should I find one in the tribe, he would be publicly flogged in full view of the tribes people, just as witches of yore were punished." However, Kgosi Tawana II said homosexuality was not a new phenomenon in Botswana, as it had existed for centuries, though as taboo, and saw no reason why homosexuals should be legislated against because of their sexual orientation (The Midweek Sun, June 17, 1998c:5).

According to Bowman, a predominantly heterosexual society makes life for gays in the USA so miserable that many gay teenagers commit suicide:

> *"Then upon this unfortunate individual the church heaps more coals. If he is Roman Catholic, he is told he has an "intrinsic disorder" and an inclination to moral evil. If he is evangelical, he is told that he must repent of his perversion and get treatment to restore him to normalcy."*

Bowman argued that there is a need for churches in the USA to hold out some hope of a life of companionship and fulfilment, and to find a place within Christian morality for

love and relationship for those born gay (Bowman 1997: http://users.marble.net/~vonz/homosexuality.html).

In a response to increased violence against homosexual persons around the world, the Rt. Reverend Steven Charleston, President and Dean of the Episcopal Divinity School, published "The Cambridge Accord". The Accord seeks specifically to respond to expressions of homophobia, such as the pronouncements of the presidents of Uganda, Kenya and Zimbabwe against homosexual persons, especially when these acts are vindicated on a biblical basis. All Anglican bishops were asked to add their names to the list of those affirming this Accord, stating:

- That no homosexual person should ever be deprived of liberty, personal property or civil rights because of his or her sexual orientation;
- That all acts of violence, oppression and degradation against homosexual persons are wrong and cannot be sanctioned by an appeal to the Christian faith; and
- That every human being is created equal in the eyes of God and therefore deserves to be treated with dignity and respect (Charleston 1999).

Pollack & Schwartz (1995:73), describing the American point of view of GLB youth, did not accept the premise that GLBs were forced by outsiders to become GLBs and pointed out that:

> *"Would anyone choose to be in a minority that is the target of bigotry, hatred and violence?"*

The GLBs in Botswana confirmed this sentiment. The LeGaBiBo Human Rights Charter declared:

> *"We need to educate our family, friends and society. We are human beings like everyone else and do not deliberately choose to be GLBs and be subjected to discrimination and prejudice"* (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a).

2.3.2.3 Access to health care

When and where GLBs seek and obtain health care in Botswana was not clear from the literature reviewed. If GLBs can afford it and/or have health insurance, they can choose their private general practitioner and/or go to the Private Hospital in Gaborone. Public health care services are provided by the Ministry of Health which provides technical guidance and operates 20 hospitals around the country. The local authorities run the primary health care system through a network of 200 clinics, just over 300 health posts, and nearly 700 mobile stops. Eighty-eight per cent of the population lives within 15 kilometres of a health facility (Botswana Human Development Report 1997:37).

2.3.2.4 The risks of informing others or "coming out"

"Coming out" is a process that GLBs face all their lives. In the health care system, each encounter requires a decision about what, if anything, they will share with their health care providers. According to Taylor & Robertson (1994:565), for appropriate care one should be able to reveal his/her sexual identity and share intimate information, but this is only possible in a safe, non-homophobic environment.

The literature reviewed warned of hospitals around the world whose staff display negative attitudes towards their clients after "coming out". Disclosure of one's sexual orientation can lead to care being compromised, avoidance of the client and active discrimination. Improving the health status of GLB clients can substantially improve if health professionals were to provide them with a safe environment for disclosure exploration (Peterson 1996:2; Wells 1999:73).

2.3.2.5 Sexually transmitted diseases

HIV/AIDS

In the Western world the AIDS epidemic was first (mistakenly) identified as a disease found among gay men only. In the late 1980s, when more was known about HIV and its spread, gay men and AIDS service organisations pointed out the violations and demanded an end to the rejection, isolation and prejudice against gay HIV positive men by society.

"While homophobia and the "second class" status of gay men have always been

present in the health care system, they have become more blatant with the AIDS epidemic" (Schwartz in Peterson 1996:21).

In Africa, HIV infection has always been accepted as a threat to heterosexuals, to the extent that no attention has been given to the risks of transmission in men who have sex with men. Young men use sexual encounters to learn more about the homosexual life style, and ignorance often puts youth at risk of HIV infection (Paroski 1987:189; Penn 1997:334).

2.3.2.6 Depression and (para)suicide

Fear of discovery and humiliation, and trying to cope in hostile heterosexist environments, might lead to depression and (para)suicide. In a recent online survey of 2,000 GLB youths, originated in the USA, it was reported that 23% of the respondents had thought about or attempted suicide at an average age of 14 years (!OutProud! Survey 1999: http://www.outproud.org/survey.html; Taylor & Robertson 1994:560).

2.3.2.7 Use of alcohol and other drugs

Alcohol and other drugs might also facilitate approaching others and engaging in sexual activities, which some GLBs would not easily dare to initiate if they were sober. Abusing substances might be one way of dealing with feelings of the shame of becoming a member of a stigmatised group before self-acceptance is achieved (Anderson in Peterson 1996:62; Denenberg 1995:89).

2.3.2.8 Gay health

Concealing identity

The first time a citizen of Botswana voluntarily came out to the public was in November 1998, at a human rights conference organised by DITSHWANELO. On June 14, 1999, the same person chose to be interviewed and photographed in a local daily newspaper that is distributed for free by the government.

The full-page article appeared in English and encouraged all GLBs to be open and together form a loud voice advocating for decriminalisation of same-sex activities. The article mentioned some health needs, including the need for safer sex workshops, but the main focus of the article was the need for law reform, an issue not normally part of any

health professional's duties (Daily News, June 14, 1999:5).

In a study in the USA, a non-randomly selected group of 222 HIV-negative gay men volunteered to be studied for five years. The men answered questionnaires and were subjected to biannual HIV testing. Increased incidences of cancer and several infectious diseases such as pneumonia and tuberculosis were linked to gay men who concealed their identities, as opposed to men who did not conceal their identities (Cole, Kemeny, Taylor & Visscher 1996:250). However, it was also suggested by Saddul (1996:2) that "coming out" would not necessarily improve gay men's health since this will not guarantee support and acceptance.

Manifestations of sexually transmitted diseases (STDs) and Hepatitis B appear to be very common in the gay population in USA (Taylor & Robertson 1994:562). Traumatic rectal problems, secondary to sexual practices, was another specific health concern of gay men (Paroski 1987:188).

2.3.2.9 Lesbian health

Double jeopardy

Most women, identified as lesbians in the USA, have or have had sexual contact with men, whether in the context of a relationship, sex for money or sexual assault, thus increasing their risks for STDs (White 1997:134).

Stevens in the USA did a study and interviewed 45 self-identified lesbian women older than 21 years. The women were found through snowball sampling and were asked open-ended questions on an individual basis about what it was like to get health care. Three focus group sessions were done. A multi-stage narrative analysis was performed and one woman said:

> *"We are dying of cancer and AIDS and substance abuse, but there are no statistics about us. So, we don't exist. Everyone seems comfortable continuing to ignore us. We're invisible"* (Stevens 1995:27).

Women's health needs and demands in general, and more specifically lesbian health, are not automatically addressed, and all women will have to lobby in order to be taken

seriously and to be included in health programming (Denenberg 1995:84; Sanders 1996:67-106; Solarz 1999: http://www.hrc.org./issues/lesbianh/iomrept.html).

Brogan (1997:42) investigated the health risk factors and health seeking behaviours in lesbians in the UK, and discussed the experiences of lesbians in a prejudiced health care system. Brogan concluded that until health care providers examined their own values about homosexuality, they would be unable to provide the humanistic, nonjudgmental, non-heterosexist and sensitive care which lesbian women wanted and had the right to expect.

An American study investigated the health risk factors and health seeking behaviours of a convenience sample of 324 lesbians through a self-administered questionnaire. The researchers identified one of the main problems of lesbians being their delay in seeking health care due to difficulty in talking to their primary care givers (White & Dull 1997:103).

GLBs appear to have to find ways to get what they need from the health care system: as one lesbian in the qualitative study by Stevens (1995:27) said:

> *"Health information is geared towards straight women. Lesbians have to filter it all. We have to translate it and figure out if any of this applies to us."*

Trippett & Bain (1992:148) discussed five reasons why lesbians failed to seek health care from traditional health care providers in the USA:

- Low-cost, natural or alternative care was not provided;
- Holistic care was not provided;
- Little preventive care and education were provided;
- Communication and respect were lacking; and
- Few women-managed care clinics were available.

Sexually transmitted diseases

A 1990 study conducted in the USA cautioned against assuming that lesbians were a low-risk group for STDs and allied disorders, as there were virtually no contemporary

data about the true prevalence of STDs in this group nor of the risk factors for female-to-female transmission of infections (Thin 1990:178).

This lack of information is also applicable to the lesbians of Botswana. However, Denenberg (1995:84) referred to 17 lesbian health articles and reports, researched between 1981 and 1993 in the USA, and suggested that the problem was not a lack of knowledge nor a "paucity of research" but that this argument was used as an excuse for the refusal to apply the knowledge in practice.

HIV/AIDS

In 1997, a USA study about lesbian health warned that female-to-female sexual transmission of HIV is possible, and that the medical and scientific communities should recognise the need to address HIV risk assessment and prevention among lesbians and women who have sex with women. This was 13 years after the first case of probable female-to-female transmission of HIV through sexual contact was reported in 1984. Apparently lesbians in 1997 were at the same stage as gay men were 15 years earlier in terms of HIV education and prevention (White 1997:136).

Cancer

Lesbians do not go to clinics for Papanicoloau smears or breast examinations as often as heterosexual women do, since they need neither contraceptive nor antenatal services. This delay may result in seeking care at later stages of illness and in treatments being more invasive and with increased risk of death (Peterson 1996:37; Stevens 1995:27).

2.3.2.10 Bisexual health

In the literature reviewed, there seemed to be agreement about the fact that bisexuality is harshly criticised by both homosexuals and heterosexuals. For example, in the RSA, bisexuals were accused of taking advantage of heterosexual rights and privileges that interfere with the struggle for gay and lesbian rights (Isaacs & McKendrick 1992:26). In Kenya, official and societal disapproval of homosexuality often obliges men to marry women. A Kenyan journalist pointed out:

> *"Some women know of their husbands' sexual and emotional relationships with men, while others remain ignorant. Those women who find out seek counselling,*

hoping that their husband will change, or, if economically independent, they walk out" (Kiama 1998: http://www.oneworld.org/ips2/aug98/14_27_054. html).

Gochros & Bidwell (in Peterson 1996:5) described special sub-populations in the American gay and lesbian community:

- Experimenters;
- Bisexual-Ambisexuals;
- Ethnic minorities and immigrant youth;
- The disabled;
- Rural youth; and
- Transgendered and cross-dressing youth.

As far as bisexuals/ambisexuals were concerned, the researchers pointed out that some people grow up with a capacity for attraction to both sexes, yet encountered various social forces pressing them to choose.

> *"Labelling oneself as bisexual may therefore be a defensive step in the long-term process of "coming out" for some youth"* (Gochros & Bidwell in Peterson 1996:5).

In Botswana, some hostility towards bisexuals was displayed when forming LeGaBiBo in 1998. Bisexuals were openly accused of "sitting on the fence" or "wanting the best of two worlds", and criticised for their refusal to come out as "pure" gay or lesbian. However, their Charter includes the concerns of all three groups: gays, lesbians and bisexuals (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a).

Cuijpers (1997:8), a Namibian feminist writer, described the misunderstandings and myths about people who have love relationships with both men and women:

> *"People think I am a hermaphrodite and that I have to set an alarm clock in the middle of the night to change lovers."*

In assessing the health needs and demands of the GLBs an inclusive approach was used, and therefore the questions were to be answered by the GLBs.

2.3.2.11 Summary of health needs and demands

Section II of the questionnaire contained 25 questions, numbered 27 to 51. The following issues were explored:

- Aspects of identity formation - questions 27, 28, 29, 30, 36, 48;
- Aspects of "coming out" - questions 30, 31, 32, 33, 34, 35, 49;
- Financial barriers to the access of health services - question 37;
- HIV/AIDS knowledge, attitudes and practices - questions 38, 39, 40, 41, 42, 43, 44, 45;
- (Para)suicide - questions 46, 47;
- Alcohol use - questions 50; and
- Importance of sharing intimate information with doctors or nurses - question 51.

2.3.3 Linking health and human rights

2.3.3.1 The right to freedom of peaceful assembly and association

Under the auspices of DITSHWANELO approximately 30 GLBs organised themselves during 1998 and formed the Lesbian, Gay and Bisexual Group of Botswana (LeGaBiBo), which launched the LeGaBiBo Human Rights Charter during November 1998. The Charter detailed areas of concern, such as societal attitudes and lack of education, and declared:

> *"There is a need to establish an environment in which we, the GLB community can accept ourselves, raise our self-esteem and regain our dignity"* (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a).

Due to the criminalisation of same-sex sexual activities in Botswana, LeGaBiBo cannot be registered formally in Botswana since a list of members is required (see also Section 1.3.2).

Article 20 of the Universal Declaration of Human Rights states:

> *"Everyone has the right to freedom of peaceful assembly and association"* (the

Universal Declaration of Human Rights adopted and proclaimed by the United Nations General Assembly Resolution 217 A(III) (December 10, 1948)).

2.3.3.2 Right to information

The Director-General of the WHO confirmed that within WHO, the link between health and human rights is now recognised but not completely explored. The WHO identified three elements to guarantee health security for communities:

- Knowledge;
- Freedom of choice; and
- Empowerment.

These three conditions are essential to allow communities to effect desired changes for themselves. Further:

> *"The Universal Declaration of Human Rights can be used as a document that sets out the conditions for health"* (Brundtland 1998:21).

The Human Rights Charter of LeGaBiBo, as produced in 1998, proclaimed GLB rights and specifically stated that:

> *"We believe that discriminating against people on the basis of their sexual orientation is not only unjustifiable in an open and democratic society based on freedom and equality, but is also against the spirit and the letter of the Constitution of Botswana"* (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a; Botswana [National Assembly][1966]. Constitution of Botswana: Chapter 1).

2.3.3.3 Violations of human rights

Academics and human rights activists publicly raised concern about the violations of the right of freedom of association, assembly, conscience, expression, and protection of privacy and liberty on behalf of the GLB population in Botswana during 1995-1999 (Boko 1998; DITSHWANELO 1998; DITSHWANELO 1995).

However, this concern was expressed in general terms and mainly focused on the laws that violated certain rights. The GLBs themselves tried very hard to remain "in the closet". From the literature reviewed, various types of violations were identified, such as physical violence including rape as well as "outing".

Physical violence, including rape, can be described as a crime of violence and power. Many people believe that only gay men get raped and that these assaults are only committed by gay men, yet according to an American statement on facts on men and rape, the rapists who rape men are heterosexual in 98% of the cases (Male Survivors of Sexual Assault 1999: http://pubweb.ucdavis.edu/documents/rpep/mrape.html).

GLBs who want to conceal their sexual orientation are vulnerable to forced disclosure of their same-sex sexual orientation, also described as "outing". Forced disclosure in the local media of two gays was resented, and the irresponsible conduct of some journalists caused serious problems for the men involved (Boko 1998:10; Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a; DITSHWANELO 1995). Outing, according to Mayo & Gunderson (in Murphy 1994:53), is the same as the crime of theft: it is theft from that person of the control of private information. However, it is also different from most thefts since this crime may be irreversible. The Universal Declaration of Human Rights' Article 12 states:

> "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour or reputation. Everyone has the right to protection of the law against such interference or attacks" (The Universal Declaration of Human Rights, adopted and proclaimed by the United Nations General Assembly Resolution 217 A(III) (December 10, 1948)).

2.3.3.4 The right to respect

In describing the reality of being gay in Botswana, a LeGaBiBo representative warned that:

> *"The issue of homosexuality has always been a taboo subject in Botswana; making it very easy for Tswana society to indulge in denial, and if this does not work and gays become too visible, society uses another strategy - elimination"* (Olivier 1998).

2.3.3.5 The media in Botswana

The local media indirectly played an influential, apparently negative, role in the levels of well-being of the GLBs, judging by the headlines in the press. In the literature reviewed, in Botswana positive GLB role models were not portrayed in the media.

After LeGaBiBo was launched in April 1998, a local newspaper carried this front-page message:

> *"Sodom and Gomorrah: Churches warn against the decriminalisation of homosexuality"* (The Midweek Sun, May 27, 1998a:1-2).

and

> *"Evangelical backlash on gays"* (The Botswana Gazette, May 27, 1998a:2).

These were followed a week later by more front-page news quoting a Tswana Chief:

> *"Kgosi Seepapitso's view on homosexuals: Whip them or jail them"* (The Midweek Sun, June 17, 1998c:5).

Most of the media attention was sensationalist and aimed at portraying a negative image of the GLBs. Throughout the debate which took place just after the Penal Code was amended in 1998, only one positive statement was published, demanding a more sober and open debate, titled:

> *"Rights are indivisible and apply equally to all"* (The Botswana Gazette, June 17, 1998b:8).

From July 1998 up to May 1999, no attention has been paid to GLB issues in the local newspapers.

2.3.3.6 Summary of linking health and human rights

Most concerns raised in the LeGaBiBo Human Rights Charter can be seen as focussing on issues that impact on GLBs daily lives: concern with the law, societal attitudes, education, health, the work place, finance and setting up their own organisation. Questions 52 to 76 focused on the issues as identified in the literature, and/or on those

issues about which no information was available but which were mentioned in the Universal Declaration of Human Rights as basic rights for all:

- Obtain GLBs' opinions on the role of the local media - question 52;
- The importance of GLB role models for the GLBs - questions 53, 67;
- Do GLBs have access to information - questions 54, 55, 63;
- Are GLBs verbally insulted - question 56;
- Are GLBs experiencing physical violence - questions 57, 58, 59, 61;
- Blackmail/threaten to tell someone else - questions 58, 62;
- Organisation - questions 64, 68, 74;
- Social life and support of peers - questions 65, 66;
- Right to a family - questions 69, 70;
- Sexuality as obstacle in GLBs lives - question 71;
- Discrimination at work - question 72;
- The Penal Code, Sections 164/167 - question 73;
- Acceptance of bisexuals - question 75; and
- Group that is most likely to effect a positive change in the well-being of the GLBs next year - question 76.

2.4 SUMMARY OF LITERATURE REVIEWED

Few studies rendered practical suggestions on how to promote the health of vulnerable groups such as the GLBs. The literature offered no statements of agreement by professionals engaged in health promotion on what the root causes were, or what the essential conditions were, that need to be addressed to enhance positive well-being. The literature reviewed failed to indicate how "lack of well-being" should be "treated". More importantly, the level of involvement of nurses that can reasonably be expected was discussed. The literature ranged from suggestions that nurses be only involved with issues related to direct patient care, for example HIV/AIDS education, to "all other relevant issues", for example using the "symbolic weight" of the nursing profession to provide support (depending on the ethical stance of the nurse regarding what the individual nurse believes a nurse "ought to do").

In this study, the lack of previous research on GLBs in Botswana required - within the limitations of "sensitive research" - the generation of detailed background information

about the GLBs, such as the demographic data obtained in responses to questions 1-8 in the questionnaire (see Appendix II).

The literature review revealed limited information about the current levels of well-being of the GLBs of Botswana. Their own writings focused on the need to decriminalise same-sex sexual activity between consenting adults in the privacy of their own homes. Foreign studies described the negative effects of discrimination on the mental and physical health of GLBs, with the three different groups suffering their own specific health problems while sharing the risk of HIV infection and internalised homophobia. Literature on the lack of respect for the rights and dignity of vulnerable groups in general, and the resulting effects on the marginalised groups' health, was evaluated. The concept of discrimination as a pathogenic force was introduced and applied to assess how societal attitudes, family rejection, lack of access to care, and stigma and internalised homophobia impacted on the well-being of the GLBs.

Furthermore, information about the most significant findings on health needs and human rights violations in previous studies informed the selection of issues that were to be explored with the GLBs. The relationship between certain findings in this study and their effect on the levels of well-being of the GLBs, was explored to assess the differences and similarities with the findings of previous studies.

2.5 CONCLUSION

The literature related to the topic under investigation was reviewed throughout the study. The literature was reviewed in general to appraise the current scholarly thinking about the effective promotion of well-being of marginalised groups whose basic human rights might be abused. As this was a nursing study, the researcher looked specifically for information about the role of nursing, as part of the community of (health) professionals that seek to promote the health of marginalised groups. The purpose of the literature review was to find out what could contribute towards advancing the well-being of the GLBs in Botswana. The "health and human rights approach" was selected to explore the health needs and problems of the GLBs. Chapter 3 will expand upon the methodological issues already briefly touched upon in this chapter, explaining aspects of the research design in greater detail.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides a description of the research methodology. Attention is given to the ethical concerns when doing "sensitive research". The rationale for the study design and methods are described. The methodology section contains the sample design, data collection methods, data preparation and analysis plan. The problems encountered with the population surveyed, data collection techniques, and the limitations encountered through the use of the data collection instrument are discussed.

3.2 STUDY DESIGN

3.2.1 Research questions

To discover the relationship between health and well-being and the activities of human rights activists involved in the human rights protection of vulnerable communities in Botswana, such as the GLB group, the following questions guided this study:

- What are the levels of well-being of the GLBs in Botswana?
- What are the health needs and demands of the GLBs?
- How can linking the fields of health and human rights assist in advancement of the well-being of the GLBs in Botswana?

For this first study on the GLBs in Botswana, quantitative research methodology was selected to develop a comprehensive description of the GLBs. Conducting research on the GLBs of Botswana can be described as "sensitive research". Sensitive research topics are moderately or severely threatening to those who are studied. Some areas in which research would be more threatening than others include:

- Research that intrudes into the private sphere or into deeply personal experiences;
- Where the study is concerned with deviance or social control;
- Where the research impinges on vested interests of powerful persons, where coercion or control is exercised; and

- Where it deals with things sacred to those being studied which they do not wish to be profaned (Renzetti & Lee 1993:6).

This study met the first and second criteria of being "sensitive research" since it was concerned with both deviance and the personal experiences of GLBs (such as discrimination, homophobia and criminalisation of GLBs' same-sex sexual behaviour among Botswana's residents).

3.2.1.1 Gaining access

The first challenge was to learn the perspectives of the GLBs as well as the "gatekeepers" of the intended research, and to design the study with those perspectives in mind.

Platzer & James (1997:626) mentioned problems associated with doing sensitive research on gay and lesbian health, such as:

- Difficulty in gaining access and rapport with subjects;
- Ethical concerns; and
- Stigma contagion.

To gain access, a preparatory phase of more than one year was used to establish a relationship between the researcher and LeGaBiBo members. To minimise problems, the study design aimed to maintain anonymity by not making the answering of open questions compulsory. It was believed that the GLBs could fear that their handwriting might be recognised.

The GLBs were likely to fear being identified, stigmatised or incriminated if they could be recognised in the study. Prior to the organisation of LeGaBiBo in 1998, GLBs were reluctant to participate in organised activities that might draw attention to their existence for fear of being "outed".

3.2.1.2 Proposal development

The research proposal was developed mid 1998 concurrent with the process of the development of the Human Rights Charter of the GLBs in Botswana, published under

the auspices of DITSHWANELO in November 1998. The Charter stated specifically under the health section the desire of LeGaBiBo to sensitise health professionals to the needs and demands of GLBs in Botswana (Botswana [LeGaBiBo], The Lesbian, Gays and Bisexuals Human Rights Charter 1998a). This sensitisation is one of the objectives of this study.

3.2.2 Ethical considerations

3.2.2.1 Dialogue

The ethical issues pertinent to conducting sensitive research relate to whether or not :

> *"individuals or communities may be helped or harmed by the conduct, publicity and results of the research"* (Sieber in Renzetti & Lee 1993:14).

According to Bowser & Sieber (in Renzetti & Lee 1993:169), it is a prerequisite for research on populations that are stigmatised to empower participants and get them to identify with the goal of the research. The researcher should accept them as peers for their experience and knowledge and provide them with an opportunity to make a genuine contribution.

There are no "easy solutions" such as the strict following of ethical codes to guide the researcher's behaviour, and the ethical quality of the research further depends on continual communication and interaction with research participants throughout the study (Glesne 1999:128, 129).

In accordance with these recommendations from the literature, discussions were held with members of LeGaBiBo who functioned as "consultants". The consultants were "out of the closet" to such an extent that they were known and trusted by the subject population, and they were willing to share insights, knowledge and experiences with the researcher. The consultants were asked to help with the design of the study, questionnaire development and distribution of the questionnaires. The consultants met to discuss the report of the findings before sharing the findings with others. Furthermore, the consultants had the opportunity to see the completed report and delete any material they wished not to reveal before the study was finalised.

3.2.2.2 Informed consent

Communicating respectfully and openly with the small LeGaBiBo consultant group throughout the study, and providing debriefing about the nature, findings and value of the research, was an essential component for obtaining informed consent. This notion of informed consent went beyond the "consent statement" given by individual participants who were asked to fill out the questionnaire, as the respondents knew that the study was based on the approval and support of their peers, as represented by LeGaBiBo.

Despite the fact that the return of the questionnaire could be regarded as a reflection of "informed consent", a cover letter (Appendix I) was attached to the questionnaire to explain what would be done with the information. It also indicated whom the GLBs could contact if they needed to talk to somebody should they experience negative or positive feelings after reading the questions and/or after participating in the study (Polit & Hungler 1993:368).

3.2.2.3 Anticipated benefits to the gays, lesbians and bisexuals

Nobody was paid for their contributions to avoid placement of undue pressure or coercion arising from the monetary incentive (Polit & Hungler 1993:359). However, an anticipated benefit was that the GLBs could make a positive contribution to the GLB community, and could learn from other GLBs when discussing the needs and demands of the GLBs in Botswana. It might also be of interest to the GLBs to read some of the articles and books about other GLBs in the Southern African region or internationally, which were reviewed for this study.

3.2.2.4 Right to decide to participate

The consultants and the respondents in the study were free to decide whether they wanted to participate in the study or not, and not filling out the questionnaire was the easiest way to decline participation. The GLBs also had the right to decide at any point in time to terminate their participation at any stage of completing the questionnaire, or not to answer specific questions. The respondents exercised these rights which resulted in different totals (n) for different questions.

3.2.2.5 Right to privacy

The LeGaBiBo consultants were known to the researcher. The researcher guaranteed the confidentiality of the information they shared, which may or may not have involved personal experiences. The respondents of the questionnaire were not identifiable by the researcher. The consultants "hand-picked" GLBs until all 100 questionnaires had been handed out; which GLBs were approached was unknown to the researcher.

3.2.2.6 Anonymity

Due to the sensitive nature of the study, the researcher designed the data collection process in such a manner that the researcher could not identify the respondents. The questionnaire was distributed by LeGaBiBo group members and returned to the researcher without bearing any identifying information. This anonymous process was selected to guarantee the respondents' rights to privacy.

3.2.2.7 Risk/benefit ratio

In the absence of reliable information about the needs and demands of GLB people in Botswana, this exploratory study may help to document, and share information about, the target group.

This in-depth description of the GLBs may also assist LeGaBiBo in formulating a plan of action for the year 2000. An anonymous survey method was selected to increase the opportunity for GLBs to provide information without fear of being identifiable. The consultants took a certain risk by their willingness to share their knowledge with the researcher. The consultant group was therefore kept small and consisted of people who were "out" to their friends. This was a calculated risk taken by the consultants and the researcher to increase the quality of the study and to increase the sense of ownership of the study by the target group. The LeGaBiBo group had known the researcher since May 1998, and it was anticipated that the lengthy preparatory phase helped in the building of trust. However, there appeared to be no way of accessing those GLBs who were not "out" because they could not be identified. This might impose a limitation on the generalisability of the research findings, as the group of GLBs who were "out" and participated in this research, might not experience the same problems and challenges in Botswana as those GLBs who remained "in the closet".

3.3 METHODS

3.3.1 The population and sampling procedure

The population

All respondents had to be citizens of Botswana. Self-identified gay men, lesbian women and bisexual men and women 15 years of age or older could participate in this study. They needed to be "out" to themselves and to at least one other person, the person who asked them to participate in the study. Proficiency in basic English was required to be able to complete the questionnaire. Because anonymity was guaranteed no personal interviews could be conducted. This approach might have imposed some limitations on the generalisability of the research findings. This is the case because it cannot be assumed that those GLBs who were proficient in English had the same experiences in the Botswana study as those who did not have this capability. Future research should attempt to involve GLBs in Botswana who are not proficient in English and who might be unable to respond to questionnaires.

The sampling procedure

In collaboration with the LeGaBiBo consultants, convenience or snowball sampling was selected. According to the consultants an attempt had to be made to reach 100 GLBs in this manner throughout the whole country. The LeGaBiBo group members (not the researcher) identified and approached the GLBs. Then each of those GLBs approached another GLB and asked him/her to participate in the study. Through snowball sampling the geographical scope was determined, the starting point being Gaborone, the capital of Botswana. The LeGaBiBo group participants were asked to try to get diversity across age groups, socioeconomic background, gender and ethnicity to minimise possible bias when selecting prospective respondents.

In Chapter 2, previous studies of GLB populations were reviewed. All those studies used non-random sampling methods (see Chapter 2, Section II). Snowball sampling techniques were used in both quantitative and qualitative research studies, since truly representative samples were impossible to obtain according to Flowers, Smith, Sheeran & Beail (1997:76), who cautioned about generalisations of the findings from any one study to the whole GLB population.

Platzer & James (1997:628) pointed out that, since it was unlikely for gays and lesbians

to reveal themselves, researchers are generally unable to rely on probability samples, even if the whole population of a country could be identified.

Solarz identified methodological limitations in research on lesbian health in the USA, including the:

- Failure to state a definition of sexual orientation;
- Failure to state a reason for using certain definitions of sexual oreintations if stated;
- Use of small non-probability samples which limits the potential to generalise the research;
- Lack of control and of comparison groups; and
- Lack of longitudinal data which limits the understanding of lesbian development over time.

Remedies for these problems, according to Solarz, are:

- The use of computer-assisted interviews;
- The provision of additional funding for more sophisticated studies to advance scientific knowledge; and
- Adding questions regarding sexual orientation to existing studies (Solarz 1999: http://www.hrc.org/issues/lesbianh/iomrept.html).

One advantage of the convenience or snowball sampling method is that a confidential and/or anonymous study with hidden populations who are otherwise not identified is possible. The method is low-cost, and the availability of extensive previous information or research is not essential to explore, for example, the GLBs in Botswana. The GLBs were unlikely to participate in studies failing to guarantee their anonymity. The respondents would not have looked for other GLBs, nor encouraged them to participate in any study, which did not guarantee total anonymity. The seriousness of this situation is compounded by the reality of conviction and imprisonment for GLB same-sex activities in Botswana.

In this study, the participants were identified through LeGaBiBo. This is a common starting point for referral chains (Platzer & James 1997:626); other studies approached

GLBs at gay and/or lesbian health clinics (Paroski 1987:188), or through the readership list of GLB newsletters (Isaacs & McKendrick 1992:169). Thus the research approach adopted in this study seemed to be in line with other surveys conducted among GLBs.

3.3.2 Data Collection

3.3.2.1 Data collection method

Since not much was known about the GLBs in Botswana, 76 basic questions across a wide range of topics were asked in the least threatening way possible. The structured questionnaire tool was selected for three reasons: firstly, the literature pointed out that it is the least threatening tool for data collection, since it can be completed in total privacy and anonymity can be guaranteed; secondly, non-threatening questions have a better chance of being answered candidly by the GLBs; and thirdly, in this study the low-cost aspect was also regarded as an advantage (Aday 1989:86). The disadvantages with the use of this closed-ended questionnaire were identified:

- The GLBs had only fixed alternatives to choose from so that they might have been predisposed to answer in certain ways;
- GLBs who could not understand English were excluded; and
- The cost of the reproduction of cover letter and 13 page questionnaire for 100 GLBs and the cost of distribution (Polit & Hungler 1993:208).

3.3.2.2 Design of the survey questionnaire

The questionnaire was designed to provide a profile of the GLBs in Botswana at a particular point in time. The study objectives informed the selection of topics and the relationships between these topics. The GLBs were asked to report their perceptions about their well-being. The questionnaire was subdivided into four parts: a section on background information of the GLBs, and Sections I, II and III.

In Section I, the GWBS was selected to measure the well-being concept. This questionnaire was positively reviewed by McDowell & Newell (1996:207), who recommended its use in community surveys for its high scores on both validity and reliability. The GWBS offered a brief but broad-ranging indicator of subjective feelings of psychological well-being and distress. The GWBS covered both positive and negative feelings and dimensions of anxiety, depressions, general health, positive well-

being, self-control and vitality. The 18 questions of the GWBS used a six point response scale representing intensity or frequency. The last four questions used 0-10 point rating scales defined by adjectives at the end (see Appendix II).

The questionnaire aimed to counter-balance negative and positive statements to avoid response set by the respondents (Polit & Hungler 1993:259).

Two surveys on GLB issues by Isaacs & McKendrick (1992) in the RSA, and !OutProud! (1999), an Internet survey originating in the USA, were the starting point for the selection of questions for Sections II and III. The Universal Declaration on Human Rights informed the selection, and appropriate questions were replicated from the RSA study which also asked about the age of first awareness and the age of coming out to others (Isaacs & McKendrick 1992:241); these are questions 27 and 33 in this questionnaire. Thirteen questions in Sections II and III were drafted by the researcher, since no appropriate questions were available: these were questions 37, 45, 51, 52, 54, 63, 64, 67, 68, 73, 74, 75 and 76. The remaining 33 questions in Sections II and III were adapted from the Internet survey by !OutProud! (1999: http://www.outproud.org/survey.html) (see Appendix II).

Those variables identified in the literature as being potentially influential to the well-being of the GLBs were considered in designing the questionnaire. These variables, such as education level or level of concealment of identity, could have been independent or extraneous variables and were included to obtain a full description of the GLBs of Botswana.

Certain "sensitive variables" were excluded, including the results of HIV tests if any were done, the number of sex partners during the preceding year, the age at having the first same-sex sexual contacts, actual suicide attempts and drug abuse. To avoid feminist critique, as for example stated by Brunskell (in Seale 1998:44), who asserted that researchers often appropriate information from respondents solely for the formers' use, care was taken to structure the questionnaire based on the needs of the GLBs in Botswana. The questions were discussed with and approved by the GLB consultants prior to finalising the questionnaire. In this questionnaire a limited number of questions were included.

Care was also given to the placement of the questions to minimise upsetting the GLBs and to prevent the GLBs skipping sensitive questions.

3.4 TIME FRAME

All questionnaires had to be returned within a four-week period after they had been distributed, in order to proceed to the data analysis phase of the research.

3.5 RELIABILITY AND VALIDITY

Since not much was known about the GLBs, the variables researched were observed as they happened, and no inferences could be drawn from the data. The exploratory questions will have to be followed by higher level questions if new knowledge is to be gained, and probably by in-depth qualitative research, including focus groups and individual interviews. These qualitative approaches fell beyond the scope of the current study.

The available reliability and validity test of the GWBS showed extremely good results in previous studies - the internal consistency was higher than for other scales and there was agreement with other purpose-built depression and anxiety scales (McDowell & Newell 1996:213).

The GWBS was selected in this study for its comprehensiveness, since the scope of this study did not allow for the use of different scales for depressions, social isolation or anxiety. The scores of the respondents were grouped into three categories:

- Positive well-being: 73-110 points;
- Moderate distress: 61-72; and
- Severe distress: 0-60.

Since no previous data about the GLBs in Botswana existed, the reliability and the validity of the results as discussed in Chapter 4 could not be ascertained.

The questions or the issues to be focused on were based on the literature reviewed. The validity or meaningfulness of the questionnaire was determined by piloting the questionnaire with GLB respondents in Botswana; the consultants of the LeGaBiBo

group themselves provided feedback during this phase. An exploratory study with a small group of GLBs was done and the GLBs commented on:

- Wording of the questions;
- Whether the questions were easily understood;
- Whether alternatives offered covered the responses the GLBs wanted to give; and
- The length of time it took to complete the questionnaire as a whole.

No questions were removed, and the length of time needed to complete the questionnaire (40 minutes) was acceptable to the GLBs (Aday 1989:198; Weiss 1994:48). It was accepted that the consultants had reasonable prior knowledge of particular problems as well as the range of the responses likely to occur, since they lived the experiences of being GLBs in Botswana (Bryman 1988:109). Although the GLBs had no prior experiences in commenting on research designs and data collection methods, they provided worthwhile inputs about their personal experiences and perceptions concerning the phrasing of specific questions.

3.6 FIELD PROCEDURE

The questionnaires were distributed by members of the LeGaBiBO group to 100 GLBs, and pre-stamped and addressed envelopes were provided to facilitate the return of the forms at no cost to the participants. The questionnaires were designed in such a manner that the respondents could not be identified. The forms were returned to the secretariat of LeGaBiBo which passed them on to the researcher.

Due to the anonymous character of the study, the researcher was not able to make follow-ups to encourage the return of questionnaires in good time for them to be included in the study. The GLBs responsible for the distribution were contacted and reminded once about the need for completion of the survey.

3.7 DATA PREPARATION AND ANALYSIS PLAN

The survey data were translated into numerical codes by the researcher to allow computer-based analysis. The open-ended questions were not coded but inserted in the findings verbatim. The Statistics Package for Social Sciences (SPSS) was used for statistical analysis procedures. A member of staff of the Statistics Department at the

University of Botswana assisted with the data analysis of the collected data. The nominal data were classified and cross-classified using frequencies. The ordinal data were rank ordered and percentages given to the variables.

The researcher decided which variables needed to be cross-tabulated based on the findings obtained. The relationships between certain variables and their effects on the levels of the GLBs' well-being were further explored.

Chi-square significance tests were not used for testing associations between the variables. No agreement in the literature seemed to exist about the requirement of random sampling, which is essential to use in statistical tests of significance (Ball 1999: http://www.georgetown.edu/cball/webtools/web_chi_tut.html)). A tutorial on the Internet pointed out that random data are assumed. With non-random sample data, significance cannot be established, though significance tests are sometimes utilised as crude "rules of thumb" (Chi-square Significance tests 1999: http://www2.chass.ncsu. edu/garson/pa 765. html).

The Chi-square is more likely to find significance to the extent that:

- The relationship is strong;
- The sample size is large; and
- The number of values of the associated sample is large.

The risk of applying chi-square tests to small samples could lead to an unacceptable rate of errors. There is no accepted cut-off point, according to Aday (1989:245); however, some set the minimum sample size at 50 and adequate cell sizes are also assumed. Aday required five or more in all cells of a two-by-two table and five or more in 80% of the cells in larger tables, but no cells with zero counts. This was confirmed by Seale (1998:172) who stated that:

> *"The principles underlying chi-square require that the expected values in at least 20% of the cells in a contingency table are more than five."*

In this study, no generalisations were made from the sample to the whole GLB population since the sample was a small convenience sample (n=47). Furthermore, the

convenience (snowball) sample was limited to GLBs who were "out" to at least one other person and who were proficient in English. Thus the findings might not be generalisable to GLBs in Botswana who are "in the closet" and/or who are not proficient in English. If participation by subgroups such as lesbians and or bisexuals had been greater, it might have been possible to analyse the differences between these subgroups on specific variables related to this study's principal objectives as stated in Section 1.6.

3.8 LIMITATIONS

3.8.1 Limitations of non-random sampling methods

The general background questions did solicit information about the respondents as far as age, nationality, sexual identity and other factors were concerned. The consultants were asked to seek variety and tried to reach GLBs all over Botswana. The consultants made deliberate attempts to include women in the study but only five women participated. The hand-picking of respondents possibly led to the exclusion of those GLBs with very few social contacts, simply because they were not known to others. GLBs not attending LeGaBiBo meetings might also have been more difficult to reach. The ability to read and write in English might have resulted in bias, as illiterate or non-English speaking GLBs could not participate unless they asked a friend to assist them which would consequently reduce the anonymity aspect.

3.8.2 Limitations encountered through the use of the structured data collection instruments

This survey would have greatly benefited from a more flexible design, using open-ended questions and an ability to change and add questions. However, at the initial stages of the design of this study, the GLBs might not have been accessible nor comfortable with face-to-face interviewing. Tape recordings of the discussions, and allowing other relevant people to be interviewed to validate some of the information provided by the GLBs, was feared to add to the suspicion of the GLBs about the study.

3.9 CONCLUSION

The design of this study was informed by the challenges of doing a survey with a hidden population in Botswana, the GLBs. The GLBs were not willing to "come out" and be

known to the researcher nor at times even to the other respondents of this study. The LeGaBiBo consultants who assisted in the design of the study, and, more importantly, in the decision making process about which questions had to be included and which questions had to be excluded considerably enhanced the validity of this study. Ethical considerations of confidentiality, privacy, informed consent, and anonymity were key aspects of this study. These concerns resulted in the selection of a non-random sampling method, which limited the scope of this study in reaching only a small number of GLBs. These decisions during the early stages of the study negatively affected the possibility of generalising the findings to a larger population and limited the statistical tests that could be used. However, the 76 questions yielded information in a format that was not primarily known to the GLB community nor to other interested parties in Botswana. The findings of this study are presented in Chapter 4 and discussed in Chapter 5.

CHAPTER 4
DATA ANALYSIS

4.1 INTRODUCTION

The findings of this research project are presented by describing the GLBs of Botswana through a review of their backgrounds, their levels of well-being, health needs and problems, and a description of issues that are relevant for both the disciplines of health and human rights.

4.1.1 Background information

Through this survey, 100 GLB people were approached to complete questionnaires. Out of these 100, 47 GLBs (47%) returned their completed questionnaires.

The population studied (n=47) consisted of 42 males, five females and no transgendered individuals (persons who identify themselves with members of the opposite biological sex, but who have no desire to actually become members of that sex) (Question 1). Twenty-two (46.8%) of the respondents were between 20 and 29 years old, the ages ranged from 15 years to 60 or more years of age (Question 2). All GLBs (n=47) were Batswana (Question 8).

Table 4.1 What is your age? (Question 2) and How would you describe your sexual orientation? (Question 4)

		What is your age? (Question 2)						
		15-19	20-29	30-39	40-49	50-59	60+	Total
How would you describe your sexual orientation (Question 4)	Lesbian		2				1	3
	Bisexual		1		1			2
	Gay	3	19	12	7	1		42
	Total	3	22	12	8	1	1	47

Of the 47 respondents, three women (6.4%) identified themselves as being lesbians, two

women (4.2%) identified themselves as being bisexuals and 42 men (89.4%) identified themselves as being gay. None of the respondents identified themselves as heterosexual or questioning/unsure about their sexual orientation (see Table 4.1).

Of the three lesbian women, two reported to have only women as sexual partners and one lesbian reported not to be in a relationship with a partner. The two bisexual women dated men and women equally. The 42 gay men reported that they only dated men as their sexual partners (Question 5).

Thirteen GLBs (27.7%) lived by themselves, 12 GLBs (25.5%) lived with one or both parents. Eleven GLBs (23.4%) were living with their same-sex partner, and another seven GLBs (14.9%) lived with their same-sex partners and children. Three GLBs (6.4%) lived with friends, and one GLB (2.1%) answered "other" (Question 3) (see Table 4.16).

All the respondents (n=47) had attended school, two GLBs (4.2%) up to primary school level and 18 GLBs (38.3%) completed their secondary education. Twelve GLBs (25.5%) completed college or vocational training and 15 GLBs (32.0%) had a degree (Question 7).

Table 4.2 How do you spend your days? (Question 6) and What is your age? (Question 2)

	How do you spend the day? (Question 6)					
		Full-time employment	Part-time employment	Looking for work	Student	Total
What is your age? (Question 2)	15-19				3	3
	20-29	15	2	3	2	22
	30-39	11		1		12
	40-49	7		1		8
	50-59	1				1
	60+	1				1
	Total	35	2	5	5	47

Five GLBs (10.6%), including the three youngest, were students. Another five (10.6%) were unemployed and looking for work. The remaining 37 GLBs (78.8%) were employed (Question 6) (see Table 4.2).

4.2 SECTION I - WELL-BEING

The GWBS offered an indicator of subjective feelings of psychological well-being and distress. The scale, which reflected both positive and negative feelings, assessed how the GLBs felt about their inner personal states rather than external conditions. In the well-being questionnaire, six aspects of well-being were assessed (Question 9-26):

- Vitality;
- State of depression;
- Anxiety;
- General health;
- Positive well-being; and
- Self-control.

Positive well-being was reported by 17 GLBs (36.2%). The majority, 22 GLBs (46.8%), reported moderate distress and eight (17.0%) of the GLBs reported experiencing severe distress.

Table 4.3 Well-being (Section I combined: Questions 9-26) and Description of sexual orientation (Question 4)

	Levels of well-being (Questions 9-26)				
		Positive well-being	Moderate distress	Severe distress	Total
How would you describe your sexual orientation? (Question 4)	Lesbian	1	2		3
	Bisexual		2		2
	Gay	16	18	8	42
	Total	17	22	8	47

Of the five women, one lesbian reported positive well-being and none reported to be in severe distress. Of the 42 (89.4%) gay men, eight (19.0%) (n=42) reported to be in

severe distress (see Table 4.3). Thirty-five GLBs (74.5%) (n=47) did not think that their sexuality was an obstacle in their lives, 11 GLBs (23.4%) thought it was an obstacle, and one GLB (2.1%) did not know (Question 71).

4.3 SECTION II - GAYS', LESBIANS' AND BISEXUALS' SELF-ACCEPTANCE, COMING OUT ISSUES, HEALTH AND SOCIAL ASPECTS

4.3.1 Self-acceptance

Forty-three GLBs (91.5%) believed that they were born GLB. One lesbian commented to question 30:

> *"Most people imagine that the individual has a choice in their sexual orientation and for some perverse reason chooses to be GLB."*

Four GLBs (8.5%) reported that they were GLB by choice (Question 30). Thirty-three GLBs (70.3%) were very comfortable about being GLB with another eight GLBs (17.0%) being comfortable. One GLB (2.1%) was uncomfortable with being GLB, and five GLBs (10.6%) were neither comfortable nor uncomfortable (Question 29) (see Table 4.4).

Table 4.4 How comfortable do you feel about being gay, lesbian or bisexual (Question 29)

	How comfortable do you feel about being GLB (Question 29)	
	Frequency	Percentage
Very comfortable	33	70.3
Comfortable	8	17.0
Neither comfortable nor uncomfortable	5	10.6
Uncomfortable	1	2.1
Total	47	100.0

Reading about being GLBs in books and magazines helped ten GLBs (21.3%) in accepting that they were attracted to people of the same sex. Contact with other GLBs assisted 15 GLBs (31.9%). None of the respondents underwent therapy and most of the respondents, 21 GLBs (44.7%), reported that they accepted it "just happened". One GLB (2.1%) did not specify (Question 48).

Forty-two GLBs (89.4%) would not change their sexual orientation even if they could, since they were happy with who they were. Five GLBs (10.6%) said they might change their sexual orientation if they could (Question 36).

4.3.2 Coming out issues

The average age that the GLBs were first aware that they were GLB was 12 years. The overall span of ages ranged from five years to 22 years. On average it took another 6.2 years after being first aware before the GLBs accepted their sexual orientations (see Table 4.5).

Table 4.5 Average age of awareness (Question 27) and Average age of acceptance (Question 28)

Descriptive statistics					
	N	Minimum	Maximum	Mean	Standard Deviation
At what age were you first aware that you might be GLB? (Question 27)	47	5	22	12.04	4.72
At what age did you first accept your sexual orientation? (Question 28)	47	8	47	18.23	6.54

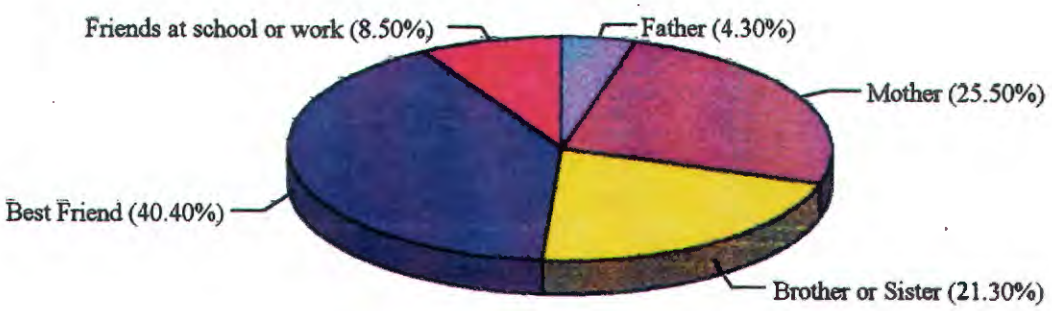
Thirty-one GLBs (66.0%) told their parents that they were GLB (Question 31). The remaining 16 GLBs (34.0%) did not for the following reasons: three GLBs (18.8%) (n=16) were worried about how their parents might react, six GLBs (37.5%) (n=16) reported that the time had not been right, and the remaining seven GLBs (45.7%) (n=16) reported that they were still coming to terms with being GLB themselves (Question 35) (See Appendix III Table A.III.1). Siblings were told by 22 GLBs (46.8%) (n=47) at some stage, another 22 GLBs did not tell their siblings (46.8%), and for three GLBs (6.4%) the question was not applicable (Question 34).

Nineteen GLBs (40.4%) chose to tell their best friend first that they were GLB. Fathers were informed first by only two GLBs (4.3%) (Question 32) (see Table 4.6).

Table 4.6 Who was the first person you told you were gay, lesbian or bisexual? (Question 32)

		Frequency	Percentage
Who was the first person you told you were GLB? (Question 32)	Father	2	4.3
	Mother	12	25.5
	Brother or sister	10	21.3
	My best friend	19	40.4
	Friends at school or work	4	8.5
	Total	47	100.0

Figure 4.1 Who was the first person you told you were gay, lesbian or bisexual? (Question 32)



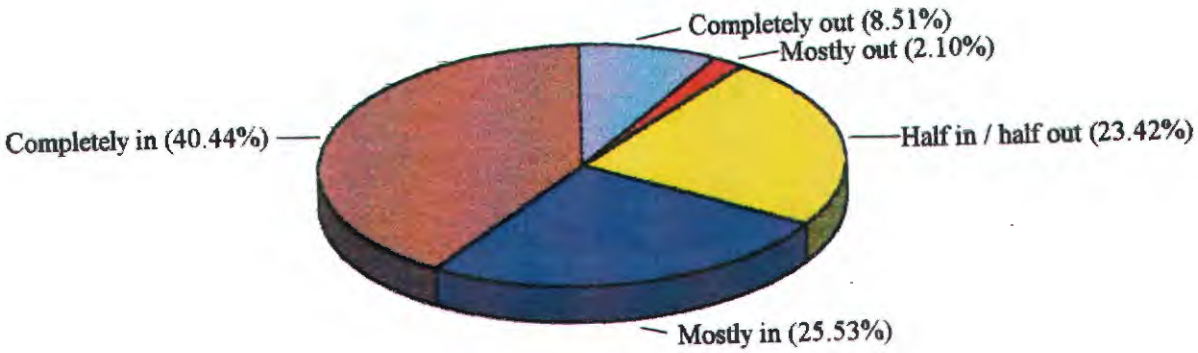
The age of first disclosure was on average in the age range of 15 to 29 years by 36 GLBs (76%). Five GLBs (10.6%) could not remember at what age they came out to another person (Question 33) (see Appendix III Table A.III.2).

The degree of concealment by GLBs of their sexual identity when not with close friends was reported, and five GLBs (10.6%) were completely or mostly "out of the closet". The majority, 42 GLBs (89.4%), concealed their sexual identity to varying extent when not in the company of close friends (Question 49) (see Table 4.7).

Table 4.7 What is the degree of concealment of your sexual identity when you are not with close friends? (Question 49)

		Frequency	Percentage
What is the degree of concealment of your sexual identity when you are not with close friends. (Question 49)	Completely out	4	8.5
	Mostly out	1	2.1
	Half in and half out	11	23.4
	Mostly in	12	25.5
	Completely in	19	40.4
	Total	47	100.0

Figure 4.2 What is the degree of concealment of your sexual identity when you are not with close friends? (Question 49)



Of the five GLBs who were "out" or "mostly out", two reported positive well-being, one moderate distress, and two GLBs severe distress (see Appendix III Table A.III.3). One gay man who was completely out stated:

> *"Everybody knows about me and I couldn't care less - they can take it or lump it."*

Of the five GLBs who were "out" or "mostly out", two did not fear the risk of criminal charges for their same-sex sexual activities, two were quite concerned, and one GLB was very concerned. Thirty-one GLBs (66.0%) were "in" or "mostly in", and of that group 15 GLBs were not concerned at all, while seven GLBs were very concerned. The remaining nine were not very concerned (see Appendix III Table A.III.4) (Question 73).

4.3.3 Access to health care

Thirty GLBs (63.8%) used public health clinics and hospitals and seventeen (36.2%) attended private hospitals and doctors (Question 37). Concern about illness and/or pain was expressed by 32 (68.1%) of the GLBs (Question 18).

Twenty GLBs (42.6%) did not trust their doctor or nurse sufficiently to reveal their sexual identity or to share intimate information with their care providers. Ten GLBs (21.3%) would have liked to disclose but never did, eight GLBs (17.0%) used to disclose but no longer did so, and seven GLBs (14.9%) felt that they needed to disclose and actually came out to their care providers in order to receive appropriate medical care. Two GLBs (4.2%) had never considered "coming out" to their health care providers (Question 51) (see Appendix III Table A.III.7).

4.3.4 Role of health care professionals in decision-making regarding gays, lesbians and bisexuals and safer sex

Forty GLBs (85.2%) felt they had enough knowledge about AIDS and other STDs to make decisions about safer sex in their own lives. Two GLBs (4.2%) reported that they lacked sufficient knowledge and five GLBs (10.6%) were not sure (Question 38).

Table 4.8 Enough information about safer sex (Question 38) and Revealing intimate information (Question 51)

	Do you feel that you have enough knowledge about AIDS and STDs to make decisions about safer sex in your own life? (Question 38)				
		Yes	No	Unsure	Total
For appropriate medical care GLBs should be able to reveal their identities and share intimate information with doctors or nurses? (Question 51)	I agree, and I do disclose if it is relevant	5		2	7
	I agree, but have personally never disclosed my orientation	8	2		10
	I never trust my doctor or nurse fully	19		1	20
	I used to disclose, but no longer do it	7		1	8
	Never thought about it	1		1	2
	Total	40	2	5	47

Of the 40 GLBs who were confident that they had enough knowledge about safer sex, five GLBs (12.5%) (n=40) revealed their sexual orientations and shared intimate

information with their health care professionals when relevant (see Table 4.8).

Nurses played a very limited role in HIV/AIDS awareness-raising among the GLB respondents since only one GLB (2.1%) reported having obtained information about safer sex from nurses. Information was obtained from friends/word-of-mouth by 20 GLBs (42.7%), 16 obtained information from the local media (34.0%), five from their family (10.6%), and five (10.6%) from other sources (Question 40) (see Table 4.9).

Table 4.9 Condom use during anal sex? (Question 42) and Where information about safer sex was obtained? (Question 40)

How would you describe your sexual orientation? (Question 4)	When having anal sex, do you use a condom? (Question 42)						
			Always	Most of the time	Sometimes	Never	Total
Gay	Where do you obtain most of your information about safer sex and about AIDS and other STDs? (Question 40)	Friends, word-of-mouth	10	5	5		20
		Family	3			1	4
		Nurses	1				1
		Local media	8		4		12
		Other	1	4			5
		Total	23	9	9	1	42

The one gay man who had received his information about safer sex and AIDS and other STDs from a nurse did report consistent condom use during anal sex. Of the 20 GLBs who obtained their information from friends or by word-of-mouth, 10 (50%) (n=20) reported consistent condom use when having anal sex (see Table 4.9).

4.3.5 Safer sex practices

When having oral sex, three GLBs (6.4%) always used protection such as condoms or dental dams, the majority, 44 GLBs (93.6%) used protection sometimes or not at all (Question 41) (see Appendix III Table A.III.5).

Forty-two men and two women (93.6%) reported not having vaginal sex. The other three women (6.4%) who did, never or only sometimes used condoms (Question 43).

None of the women practised anal sex. Of the 42 gay men who did, 23 (54.7%) (n=42) always used condoms. The three youngest gay men did not practise safe sex (see Table 4.10).

One young gay man commented:

> *"As a 20 year old gay guy I want to comment on the young gay guys. My fear is old people or old gay guys have the habit of cheating on young ones. I should think there has to be some kind of counselling to young gay guys immediately one knows one. So that the future of young gay guys can be good as well. People who cheat are mostly people who think they have money. So they lie to kids, tempting them and giving them frustrations which lead to low performance when it comes to the kids' school work."*

Sixteen GLBs (34.0%) would prefer to have sex with someone with whom they were not in a long-term relationship. In contrast, nine GLBs (19.1%) would not engage in sex without having any further commitments to each other (Question 44) (see Appendix III Table A.III.6).

Table 4.10 Condom use during anal sex (Question 42) and Sexual orientation and age (Question 4)

How would you describe your sexual orientation? (Question 4)	When having anal sex, do you use a condom? (Question 42)						
			Always	Most of the time	Some-times	Never	Total
Gay	What is your age? (Question 2)	15-19 years		1	1	1	3
		20-29 years	13	2	3		18
		30-39 years	6	3	3		12
		40-49 years	3	3	2		8
		50-59 years	1				1
		Total	23	9	9	1	42

4.3.6 Testing for HIV/AIDS

Forty-three GLBs (91.5%) reported to be aware of confidential and anonymous

HIV/AIDS testing being available at many local public health clinics, hospitals, private practices of doctors, and at the University of Botswana. Of those 43 GLBs (91.5%) being aware of these services, four GLBs (9.3%) (n=43) had been tested for HIV/AIDS (Question 45) (see Table 4.11).

Of these four GLBs (9.3%) (n=43) who went for a test, one GLB revealed information about his/her sexual orientation to doctors or nurses (see Table 4.11).

Table 4.11 Awareness about testing facilities (Question 45) and Sharing intimate information with health care professionals (Question 51)

Are you aware that confidential and anonymous HIV/AIDS testing is available at many local health clinics, hospitals, private practices of doctors and the university? (Question 45)					
		Yes, I am aware of this and was tested for HIV/AIDS myself	Yes, I am aware of this but never went for an HIV/AIDS test	No, I am not aware of this and I do not want to be tested	Total
For appropriate medical care GLBs should be able to reveal their identity and share intimate information with the doctor or nurse? (Question 51)	I agree, and I do disclose if it is relevant	1	5	1	7
	I agree, but I have personally never disclosed my orientation		10		10
	I never trust my doctor or nurse fully	2	17	1	20
	I used to disclose, but no longer do it		6	2	8
	I never thought about it	1	1		2
	Total	4	39	4	47

Ten GLBs (21.3%) reported that they were not interested in learning more about HIV/AIDS. Twenty-three GLBs (48.9%) reported that there were issues related to HIV/AIDS which they did not completely understand and would like to know more about. Fourteen GLBs (29.8%) were not sure (Question 39).

A bisexual woman commented:

"I feel DITSHWANELO and other relevant organisations should regularly conduct workshops on safer sex for GLBs. This is very important because most of us, even heterosexuals, are very ignorant. At least we should be reminded time and again about sex... how safe it can be made. Thanks."

4.3.7 Suicide

A majority of 19 GLBs (40.4%) had never considered taking their own lives. Fourteen GLBs (29.8%) had considered suicide at some point previously, while another 14 GLBs (29.8%) sometimes thought about taking their own lives (Question 46).

Of the 28 GLBs who had considered suicide, nine GLBs (32.0%) (n=28) reported that their suicidal thoughts had no relation to their being GLB. One GLB (3.6%) (n=28) reported that his/her suicidal thoughts were strongly related to being a GLB (Question 47) (see Table 4.12).

Of the 14 GLBs (29.8%) (n=47) who had previously considered taking their own lives, six GLBs (42.8%) (n=14) never trusted their doctors or nurses fully and did not disclose their sexual orientation nor reveal intimate information about themselves. Of the 14 GLBs (29.8%) (n=47) who still sometimes consider suicide, four (28.6%) (n=14) used to disclose their sexual orientation but no longer did so (see Appendix III Table A.III.7).

Table 4.12 Have you ever seriously thought about taking your own life? (Question 46) and How much were these thoughts related to being GLB? (Question 47)

		How much were these thoughts related to being GLB? (Question 47)						
		Very much related	Very related	Some what related	Not very related	Not at all related	N/A	Total
Have you ever seriously thought about taking your own life? (Question 46)	Never			1			18	19
	At some point in time in the past	1	3	2	6	2		14
	Sometimes		2	1	4	7		14
	Total	1	5	4	10	9	18	47

4.3.8 Alcohol use

Of all the GLB respondents, seven GLBs (14.9%) never drank any alcohol. Of the rest, 10 GLBs (21.3%) reported having two or fewer alcoholic drinks per day, and 30 GLBs (63.8%) reported drinking more than two alcoholic drinks per day. Of those 30, 18 GLBs (60%) (n=30) drank five or more alcoholic drinks per day; of those 18, 13 (72.2%) (n=18) reported moderate or severe distress (Question 50) (see Appendix III Table A.III.8).

Of the 30 GLBs (63.8%) who drank more than two alcoholic drinks per day, 25 (83.3%) (n=30) did not disclose their sexual orientations nor share intimate information with their health care providers. Out of the 25 GLBs (83.3%) (n=30) who did not disclose, seven GLBs (28%) (n=25) used to do so but have discontinued the practice (see Appendix III Table A.III.9).

Table 4.13 Drinking patterns (Question 50) and Feelings of sadness, hopelessness and having so many problems that you wonder if anything is worthwhile? (Question 12)

		How would you describe your drinking? (Question 50)				
		Abstai-ner	Two or fewer alcoholic drinks per day	Four or fewer alcoholic drinks per day	Five or more alcoholic drinks per day	Total
Have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything is worthwhile? (Question 12)	Extremely so-to the point that I have just about given up	3		1		4
	Very much so			3	2	5
	Quite a bit	1		2	5	8
	Some- enough to bother me		2		2	4
	A little bit	2	7	4	8	21
	Not at all	1	1	2	1	5
	Total	7	10	12	18	47

Of the 18 GLBs (38.3%) who drank more than five alcoholic drinks per day, one reported having no problems that bothered him/her whatsoever. Three GLBs who did not drink at all, reported that they wondered whether anything was worthwhile to the point where they had just about given up (see Table 4.13).

4.4 SECTION III - LINKING HEALTH AND HUMAN RIGHTS

4.4.1 The public image

Twenty-seven GLBs (57.4%) did know a GLB Motswana whom they viewed as being their role model, and for 20 (74.0%) (n=27) of these GLBs this knowledge assisted them in feeling better about their own sexual orientation (Question 67). Thirty-two GLBs (68.1%) reported that knowing a celebrity who was GLB made them feel better about their own sexuality (Question 53).

4.4.2 The local media

The contribution of the local newspapers, as far as the portrayal of the GLBs was concerned, was rated positively by one GLB (2.1%). It was rated as very negative by 21 GLBs (44.7%). Two GLBs (4,2%) said they did not know, and 14 GLBs (29.8%) rated it mostly negative. Nine GLBs (19.2%) said the media's contribution was sometimes positive, sometimes negative (Question 52).

4.4.3 Lack of access to information

Forty-three GLBs (91.5%) had no access to Internet and E-mail (Question 55). Fifteen GLBs (31.9%) bought GLB-focused magazines; out of the 32 GLBs (68.1%) who had never bought such a magazine, 14 (29.8%) never bought the magazines because they were afraid people would see them when buying such magazines (Question 54). All 47 respondents (100%) said that they were in possession of a copy of the Charter of the GLBs in Botswana, published in 1998, and all GLBs (100%) reported to have read it (Question 63).

4.4.4 Violence

During the last year (August 1998 to August 1999), 15 GLBs (31.9%) had been threatened with physical violence because they were thought to be GLB. Of the eight gay men in severe distress, seven (87.5%) (n=8) had never been threatened with physical violence, and one (12.5%) had been threatened once (Question 57) (see Appendix III Table A.III.10). Actual beatings, like kicks or punches, were reported by four GLBs

(8.5%) (n=47) (Question 59). None of the GLBs were threatened with knives, guns or other weapons (Question 60).

Table 4.14 Sexual orientation (Question 4) and How many times have you been attacked sexually? (Question 61)

		How would you describe your sexual orientation? (Question 4)			
		Lesbian	Bisexual	Gay	Total
How many times have you been attacked sexually because you are thought to be GLB (Question 61)	Never	3	2	37	42
	Once			3	3
	Twice			1	1
	Three or more			1	1
	Total	3	2	42	47

During the last year, five GLBs (10.6%) were attacked sexually (raped) because they were perceived to be GLB. The survivors of these sexual attacks identified themselves as gay men (see Table 4.14). Two of them reported positive well-being, two moderate distress and one severe distress (Question 61 and Questions 9-26).

The five gay men that were attacked sexually reported feeling depressed, two a little of the time, two some of the time and one a good bit of the time (see Appendix III Table A.III.11).

4.4.5 Right to privacy

During the last year, 12 GLBs (25.5%) were threatened by someone who said that they would tell others about them being GLB (Question 62), and 20 GLBs (42.6%) were threatened with blackmail because they were or were thought to be GLB (Question 58). One gay man commented:

> *"The Botswana society is ignorant when it comes to human values. It is as if in some indescribable way they have been brainwashed not to understand the goodness of caring for what is of human origin. I wish every anti-gay, lesbian or bisexual would think again with solemnity in what bad way do the GLBs of Botswana affect the heterosexuals' lives, or the lives of those who are in combat with the GLBs of our country."*

Table 4.15 The current law in Botswana (the Penal Code of 1998) criminalises same-sex activities. Are you afraid to be at risk for being charged and/or jailed for having unlawful same-sex activities (Question 73) and Well-being (Questions 9-26)

		Levels of well-being (Questions 9-26)			
		Positive well-being	Moderate Distress	Severe Distress	Total
The current law in Botswana criminalises same-sex activities. Are you afraid to be at risk for being charged or jailed? (Question 73)	Not at all	8	12	3	23
	Only a little	1	2		3
	Some, but not enough to be worried about		2	1	3
	Some, and I am a little concerned	3		1	4
	Some, and I am quite concerned	1	2	1	4
	Yes, very much and I am very concerned	4	4	2	10
	Total	17	22	8	47

The provisions of the Penal Code did not worry 23 GLBs (48.9%). The other 24 GLBs (51.1%) were concerned to varying degrees, with 10 GLBs (21.3%) being very concerned. Out of the 10 GLBs that reported to be very concerned, six reported moderate or severe distress (see Table 4.15).

4.4.6 Right to marry and found a family

Table 4.16 Number of males and females living with children by gender (Question 3 and Question 1)

		With whom do you live? (Question 3)						
		By my-self	Living with same-sex partner	Living with same-sex partner and child(ren)	With friends	With one or both parents	Other	Total
Gender (Question 1)	Male	10	11	7	3	10	1	42
	Female	3				2		5
	Total	13	11	7	3	12	1	47

The five women in this study lived alone or with their parents. Of the men, 18 (38.3%) lived with partners and children (see Table 4.16).

Twenty-one (44.7%) GLBs affirmed that they would like to be officially and publicly married to someone of the same gender; eight GLBs (17%) did not know whether they would like to do that or not; 18 GLBs (38.3%) did not want to marry (Question 70).

Table 4.17 Do you want to have children some day? (Question 69) and Sexual orientation (Question 4)

		Do you want to have children one day? (Question 69)			
		Yes	No	I don't know	Total
How would you describe your sexual orientation? (Question 4)	Lesbian		1	2	3
	Bisexual	2			2
	Gay	8	18	16	42
	Total	10	19	18	

Of all the GLBs (n=47), 10 GLBs (21.3%) definitely wanted to have children of their own some day, 18 (38.3%) were unsure; and 19 GLBs (40.4%) did not want to have children (Question 69) (see Table 4.17).

4.4.7 Right to association

One gay man commented:

> *"We need the government of the nation to accept and legalise LeGaBiBo, for their human rights as they deserve to be."*

Table 4.18 Which of the following organisations that advocate for the rights of gay, lesbian and bisexuals are you most familiar with? (Question 64)

Which of the following organisations that advocate for the rights of GLBs are you most familiar with (Question 64)		
	Frequency	Percentage
LeGaBiBo	28	59.6
DITSHWANELO the Botswana Centre for Human Rights	19	40.4
Total	47	100.0

Twenty-eight GLBs (59.6%) were more familiar with LeGaBiBo than DITSHWANELO (Question 64) (see Table 4.18).

Attendance at LeGaBiBo meetings was confirmed by 30 GLBs (63.8%). Two (4.2%) never attended meetings, and distance was a problem for 15 GLBs (32.0%) who reported to be living too far away from Gaborone to attend the meetings (Question 68).

4.4.8 The role of LeGaBiBo

On gay man commented:

> *"Please help us to feel free by counselling the community at large to know how important we GLBs are, so that they try and accept and know that these things really exist."*

The statement most true about LeGaBiBo, according to 28 GLBs (59.6%), was that it could provide information relevant to GLBs. Five GLBs (10.6%) thought that LeGaBiBo could assist GLBs with "coming out". Four GLBs (8.5%) reported that LeGaBiBo bored them (Question 74) (see Appendix III Table A.III.12).

4.4.9 Social contacts and well-being

Forty-five GLBs (95.8%) socialised with other GLBs in the place where they lived. Two GLBs (4.2%) reported not knowing any other GLBs where they stayed at the time of completing the questionnaires, and reported that this did not negatively influence their levels of well-being. The eight gay men in severe distress knew between one and 10 GLBs where they lived (Question 65) (see Appendix III Table A.III.13).

4.4.10 Discrimination

During the last year, 27 GLBs (57.4%) had been verbally insulted (yelled at, criticised) at least once because they were or were considered to be GLB (Question 56).

One lesbian woman commented:

> *"The general attitude towards GLBs in Botswana is very negative. This is partly because of the churches, partly because of the traditional beliefs and customs and partly because of ignorance."*

Table 4.19 Levels of well-being (Question 9-26) and Times verbally insulted (Question 56)

Levels of well-being (Question 9-26)					
How many times have you been verbally insulted because of you are, or thought to be GLB. (Question 56)		Positive well-being	Moderate well-being	Severe distress	Total
	Never	9	8	3	20
	Once	5	4	2	11
	Twice		2		2
	Three or more	3	8	3	14
	Total	17	22	8	47

Of the 17 GLBs (36.2%) experiencing positive well-being, eight (47.0%) (n=17) were verbally insulted during the past year. Of the other 30 GLBs (63.8%) in moderate or severe distress, 11 (36.7%) (n=30) were never insulted (see Table 4.19).

The bisexual people appeared to be criticised by both homosexuals and heterosexuals for not making definite choices. The GLB respondents in this study were asked whether they agreed with the need to choose between homosexuality and heterosexuality (Question 75). Twenty-eight GLBs (59.6%), including the two bisexuals, reported that the bisexuals would be wise if they came out as "pure" gays or lesbians. Total disagreement with that statement was reported by 16 GLBs (34.0%); three GLBs somewhat agreed (6.9%) (see Appendix III Table A.III.14).

Discrimination at their workplace was not an issue for 23 GLBs (48.9%). For the other 20 GLBs (42.6%) it was something of an issue; four GLBs (8.5%) were fired at least once when their employers found out or suspected they were GLBs (Question 72).

4.4.11 Support and Advocacy

When having a problem, merely 28 GLBs (59.6%) reported to be able to call upon one or two other GLBs around their own age; within the group eight GLBs (17.0%) knew more than two GLBs whom they would call upon when encountering problems. Yet 11 GLBs (23.4%) did not know other GLBs around their own age whom they could call under such circumstances. Out of the eight GLBs in severe distress, six (75.0%) (n=8)

only knew one or two people to call upon when they had problems, while the other two GLBs in severe distress did not know any GLBs around their own age to call upon when they encountered problems (see Table 4.20).

Table 4.20 Do you know other gays, lesbians or bisexual people around your own age who you call upon when you have a problem (Question 66) and Well-being (Questions 9-26)

		Levels of well-being (Question 9-26)			
Do you know other GLB people around your own age who you can call upon when you have a problem? (Question 66)		Positive well-being	Moderate well-being	Severe distress	Total
	Yes, one or two people	7	15	6	28
	Yes, I know many GLB people of my own age	3	5		8
	No	7	2	2	11
	Total	17	22	8	47

Table 4.21 Well-being (Questions 9-26) and GLBs bothered by illness, bodily disorder, pains or fears about health (Question 18)

		Levels of well-being (Questions 9-26)			
		Positive well-being	Moderate distress	Severe distress	Total
Have you been bothered by any illness, bodily disorder, pains or fears about your health? (Question 18)	All the time		2	4	6
	Most of the time		5		5
	Some of the time	4	10		14
	A little of the time	4	1	4	9
	None of the time	9	4		13
	Total	17	22	8	47

Only 13 GLBs (27.7%) reported not being worried about their health (see Table 4.21). None of the respondents (n=47) expected health professionals to effect positive changes in their well-being during the following year 1999/2000 (Question 76).

The group that was most likely to effect positive change in the well-being of the GLB community in Botswana in the coming year was expected to be the human rights activists, according to 22 GLBs (46.8%). The GLBs themselves could be effective as well, according to 21 GLBs (44.7%). Three GLBs (6.4%) expected politicians to affect change, and one GLB (2.1%) lawyers (Question 76).

One lesbian woman commented:

> *"The only solution I can see is for a lot of quiet education through the media, radio, books and personal contact of GLBs with straight people, but I do not know how long it will take."*

4.5 CONCLUSION

The findings of the study were presented and analysed. The written comments were inserted throughout the text as they appeared on the last page of the questionnaire, where comments were solicited from the GLBs. This was not a requirement, but an invitation for participants to share their opinions about this study and any other issues GLBs wanted to raise. The non-random sampling method and the small number of participants, especially from lesbian and bisexual communities, resulted in fewer possibilities for statistical calculations to establish the correlation between the variables. The findings, presented in this chapter, are discussed in Chapter 5.

CHAPTER 5
DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

The findings of this study presented the perspectives of a small non-random sample of 47 GLBs in Botswana across the life-span from adolescence (15 years of age) to persons over 60 years old.

5.2 BACKGROUND

The surveyed GLBs unquestioningly applied the labels "gay", "lesbian" and "bisexual". Open questions were added to the survey and comments were elicited about the usage and/or meaning of these labels in the Botswana context, but none were received. In this study, it was not clear if the GLBs included social, emotional and political elements of their identity when ascribing to being gay, lesbian or bisexual, or whether these labels referred only to their same-sex sexual behaviour (Foreman 1999:110; Isaacs & McKendrick 1992:xiii; Vargo 1998:1; White 1997:128).

All GLBs reported the "typical" patterns of partner choice by sexual orientation. The gays dated only men, the lesbians dated only women and the bisexual women dated men and women equally. No bisexual men responded. No self-report was given about deviations from this pattern. According to Taylor (USA) (1999:520), self-labelling is not always consistent with one's sexual history; men might have dated women, for example, but rather than report to be dating "mostly men", they reported to be dating only men instead.

Several studies have alluded to the fact that within this hard-to-reach population, layers of invisibility exist (Dawson Scanzoni & Mollenkott 1994:84; McKenna 1999:4; Peterson & Bricker-Jenkins in Peterson 1996:33). From the data on the GLBs' sexual partners, it can be deduced that this study failed to reach married men. For example, men having wives and children and secretly engaged in same-sex contact is a phenomenon often reported in studies of homosexual populations (Foreman 1999:110-126; Vargo 1998:58).

The well-documented tendency among bisexual men not to disclose same-sex contacts was confirmed in a limited sense, in that no male bisexuals participated in this study (McKenna 1999:9).

Indeed, reports from the USA indicated that women, both bisexual women and lesbians, are a discriminated group in an already marginalised section of society. Both the perspectives of lesbian health and human rights, and the difficulties bisexual men and women face within the gay/lesbian subcultures, show in that their perspectives are under-represented in studies on homosexuality (Denenberg 1995:81-91; Solarz 1999: http://www.hrc.org/issues/lesbianh/iomrept.html; Vargo 1998:xvii). Despite purposive sampling methods and the efforts by the LeGaBiBo consultants to encourage participation by women in this study when distributing the questionnaires, the findings pointed out the domination of the gay male perspective in this study, corresponding to these authors' reports.

Research Question I: What are the levels of well-being of the GLBs in Botswana?

Objective I: **To obtain objective information about the current levels of well-being of the GLB people in Botswana through administering a community survey.**

5.3 SECTION I - LEVELS OF WELL-BEING

Administration of the GWBS was included in this study to measure the levels of well-being. Mann, Gruskin, Gostin & Annas (1999:446), as well as Irwin (1997:170), pointed out that it is not easy to agree upon an operational definition of well-being. The meaning of the concept of well-being or health depends on the personal values of the GLB, and its meaning might change over time.

The GWBS was selected because of its reported outstanding reliability and validity results (McDowell & Newell 1996:207). In this study, the schedule did assist with obtaining quantifiable information about the subjective feelings of psychological well-being and distress at the time of completing the questionnaires. The reliability and validity of the GWBS to measure the well-being of the GLBs could not be ascertained. To avoid errors the six subscores were not reported since lower internal consistency for

the subscales than for the instrument as a whole were reported (McDowell & Newell 1996:213).

A section of the GLBs (36.2%) was ranked in the category of "positive well-being". These GLBs felt good about their "inner personal state". The remaining 63.8% were in distress, including the eight gay men in severe distress (17.0%). The negative feelings referred to feelings of anxiety, depression, poor general health, lack of self-control and vitality. The anonymous character of the study prohibited identification of those eight gay men in severe distress. It was not possible to provide any assistance to them other than to make their plight known through this study. Weiss (1994:181) stressed the importance of researchers honouring their pledge of confidentiality:

> *"We have engaged them in a partnership in which they are expected to do their best to provide the study with observations. It is our responsibility to make their lessons known."*

Research question II: What are the health needs and demands of the GLBs?

Objective II: **To discover the health care needs and demands of gay, lesbian and bisexual communities.**

5.4 SECTION II - HEALTH NEEDS AND DEMANDS

This study found that first awareness of homosexual sensations occurred at a mean age of 12 years. This corresponded with findings from a survey conducted in the USA which reported a mean age of first awareness of 12.2 years, and an RSA study which reported a mean age of 13 years (Isaacs & McKendrick 1992:179; !OutProud! 1999:http://www.outproud.org/survey.html; Taylor & Robertson 1994:561).

Studies by Stevens (1995:27) as well as by Taylor & Robertson (1994:561) pointed out that GLBs are very vulnerable when they are coming to terms with the fact that they are not heterosexual. They grow up in a hostile environment and are at risk from mental and physical health problems which arise from a lack of support received when coming to terms with their sexuality.

In this study, self-acceptance of sexual orientation followed on average six years later, at a mean age of 18.2 years. The GLBs admitted to themselves that they were GLBs and started telling others, although in some cases GLBs told others before accepting their own sexual orientation. In the USA survey of GLB youth, the GLBs came out at a mean age of 16 years, two years earlier than the Botswana GLBs; in the RSA study of 1992 a mean age of 22 years was reported, three years later than the GLBs in Botswana (Isaacs & McKendrick 1992:179; !OutProud! 1999: http://www.outproud.org/survey.html).

The study explored how self-acceptance occurred, and "it just happened" according to 45% of the GLBs. This interesting phenomenon was also found in an RSA study on homosexual identity formation, culture and crisis, by Isaacs & McKendrick (1992:189). As Isaacs & McKendrick pointed out, people develop from a state of being into having sexual desires as young persons. Those desires develop into sexual behaviours, and as the persons grow up the behaviours develop into sexual identities. The "it just happens" partly refers to the realisation that a young person is becoming aware of "homosexual sensations" instead of "heterosexual sensations".

One other interesting finding of this study was that, of the surveyed GLBs, only 10.6 % were completely or mostly "out". Nearly 90% of the GLBs were to some degree "in the closet" when not with close friends. This finding confirmed the invisibility of the GLBs in Botswana and in Africa in general, a situation also referred to by Hartmann (1998:165) and Boko (1998).

Gochros & Bidwell (in Peterson 1996:17) pointed out that the average adolescent years can be marked by great opportunities for self-discovery and growth but also by real dangers. Experiences of GLB youth pose even greater challenges, and most of them are invisible and carry with them hidden secrets with attendant guilt and fears. In this study, harbouring their "hidden secret" did not negatively influence the GLBs self-esteem: internal levels of self-acceptance were found in this GLB community. Nearly 75% of the GLBs did not think sexuality would be an obstacle in their lives, and only one GLB was uncomfortable with being GLB. Nearly 90% would not change their sexual orientation even if they could. These findings of positive self-esteem among the GLBs contrasted with the study of Isaacs & McKendrick (1992:35-36), which stated that stigma (moral judgements and homophobic responses, and feelings of uncertainty and/or

hostility pertaining to the legal position of homosexuals) threatened homosexual persons' self-esteem and sense of identity by denying them positive social and emotional support (see Section 2.3.2.2).

5.4.1 The health care system

In previous studies conducted outside Africa, findings indicated that heterosexism and homophobia in the health care system was causing non-disclosure of sexual orientation by GLBs to their care providers, barring high standards of care for the GLBs (Brogan 1997:39; Morrissey 1996:980; Peterson & Bricker-Jenkins in Peterson 1996:33; Stevens 1995:25; Taylor & Robertson 1994:560).

Taylor, as well as Brogan, suggested that personal risking by GLBs was affected by interpersonal conditions, the relationships between the health care providers and their clients, and external conditions such as homophobic posters on the walls of the waiting rooms. When the GLBs did not feel accepted, the GLBs might decide not to take any personal risks to avoid ostracism and/or stigmatism, even when appropriate care was not obtained as a consequence of these actions (Brogan 1997:39; Taylor 1999:520) (see Section 2.3.2.9).

Non-disclosure was noted in this study as well. Irrespective of the heath care settings, public or private, only 15% of the GLBs shared intimate information about their sexual orientations with their doctors or nurses. However, with 90% of the GLBs potentially being "in the closet", implications for the health care system need to be further explored.

A significant number of GLBs (70%) expressed concern about their health, but nearly 45% of the GLBs also reported that they did not trust their doctors or nurses. Internalised homophobia by the GLBs, referred to in studies by Brogan (1996:39) as well as Morrissey (1996:980), resulted in negative actions, such as the GLBs anticipating discriminating behaviour by health care professionals without having experienced it themselves (see Section 2.3.2.2).

Further research will be needed to clarify why 45% of the GLBs did not trust their health care professionals. This result could be explored together with a study to find out why 17% of the GLBs, who were open about their GLB status previously, reported that they

no longer trusted their health care providers and no longer disclosed their sexual orientations. Curtin & Flaherty (1982:7) stressed the importance of recognition of the humanity of other persons, the rights of patients to be recognised and respected as human beings. It is only because human rights exist independently of either law or public opinion that the weak can claim equal rights with the strong:

> "Respecting persons in small matters requires sensivity to their human needs and presents a tremendous challenge for nurses" (Curtin & Flaherty 1982:15).

5.4.2 HIV/AIDS

The findings of the 1999 Panos study on HIV/AIDS and men who had sex with men in the developing world, indicated a famine of AIDS information for GLBs (McKenna 1999:9). The findings in this study contrasted with those of the Panos study, as 85% of the GLBs in this study felt that they had enough information about HIV/AIDS and STDs to make informed decisions about safer sex. That information was mainly provided by friends and by word-of-mouth (42.7%) and by the local media (34.0%) (confirmed by Paroski 1987:189) (see Section 2.3.2.5).

To assess the type and quality of information on HIV/AIDS that motivated the GLBs to practise safer sex fell beyond the scope of this study. However, it is of concern that 10 out of the 20 men who reported having anal sex, reported inconsistent or no condom use despite being educated by their friends. The GLBs identified a need for training on HIV/AIDS and other STDs, and the GLBs reported not having been educated by health professionals (with the exception of one gay man who was educated by a nurse, and he reported using condoms consistently).

5.4.3 Function of alcohol

Alcohol use was very common in this group of GLBs: 64% drank more than two alcoholic drinks per day. In a study conducted in the USA on substance abuse and dependency among gay men and lesbians, Anderson (in Peterson 1996:59) pointed out that alcohol use or abuse was believed to function as a social lubricant. Being drunk could be a way of coping with feelings of shame before self-acceptance could be achieved by gays and lesbians. The findings of this study did not confirm that premise: since 90% of GLBs were happy with who they were, the GLBs reported having

achieved self-acceptance. Of the four very depressed GLBs, three did not drink alcohol at all and did not use alcohol as a means to cope (see Table 4.13).

The variety of health care needs and demands and human rights issues elicited by the GLBs were mostly consistent with previous studies. For example, high prevalence of thoughts about suicide was cited in both this Botswana study, where 30% of the GLBs had thought about it and another 30% continued to have these thoughts sometimes, and the studies of Taylor & Robertson (1994:561).

5.5 SECTION III - LINKING HEALTH AND HUMAN RIGHTS

The assessment in this study of GLBs' health needs and demands was based on the holistic definition of health, and included physical, mental and social well-being. The previous section explored "typical" health problems being mostly disease orientated. The third section of the questionnaire asked questions about issues of importance when considering the links between health and human rights violations (for example, how GLBs were treated in the dominant heterosexist culture, feelings of belonging to a GLB subculture, and the effects of the absence of affirmative legal identities).

External levels of acceptance of the GLBs ranged from low to absent in the local media, which largely portrayed the GLBs negatively in Botswana according to 45% of the respondents. General homophobia was confirmed by 57% of the GLBs who were insulted during the last year. Penn, the American author of the gay men's wellness guide, linked the threat of both physical violence and exposure as powerful agents that could lead to submitting to aggression, and noted that this might be especially true on a first date (Penn 1997:506). The findings of this study suggested that male-to-male rape (10.6%) is a problem in Botswana, and further studies are warranted to gain additional information on this topic (see Section 2.3.3.3).

5.5.1 Right to privacy

The findings of this study indicated that the absence of affirmative legal identities concerned the GLBs to a limited extent. The majority of the GLBs (62%) were not too concerned about being jailed or charged with criminal offences for having same-sex relations or "being caught in the act" (see Section 1.2.2). The GLBs were more afraid of violations of their right to privacy in general, and more specifically about

blackmailing (43%) and involuntary public exposure (outing: 25%) that might lead to violence and/or rejection by society. The GLBs wanted to remain "in the closet". Chekola (in Murphy 1994:82) pointed out that being "in the closet" can have two functions: protection from harm and protection related to shame. Mayo & Gunderson (in Murphy 1994:47) argued that in the absence of a compelling justification, outing is immoral and a violation of privacy. Outing can also be regarded as an affront to the dignity of the GLBs.

5.5.2 Gay men's rights to have children

Article 16 of the Universal Declaration of Human Rights addresses rights relating to the family. In this study, eight gay men reporting not having sexual relations with women expressed their desires to have children of their own, whilst 16 gay men were unsure. If these reportedly gay men exclusively had sexual encounters with men, then their options were limited to the artificial insemination of women. Various forms of relationships were identified by Penn, who argued that in the USA, co-parenting and the utilisation of surrogate mothers were some of the options available for gay parentage. However, he also noted that finding a match between a gay man and a woman - not unusually a lesbian - was difficult; and using a surrogate mother willing to carry a child for a gay man was often very expensive. Therefore in the USA, single-parent adoption is increasingly available to qualified gay men and is becoming the professed alternative. This issue was explored in the Botswana context, based on findings in other studies in which the GLBs did claim equal rights with other citizens, including the rights to marry and have families (Gostin & Lazzarini 1997:21; Levy in Peterson 1996:49; Penn 1997:497). What the available and acceptable options were for the GLBs in Botswana wishing to have children of their own, and if the desire to have children included the desire to raise children, were not further explored since this fell beyond the scope of this study.

5.5.3 The role of LeGaBiBo

The formation of LeGaBiBo under the auspices of DITSHWANELO in 1998 was a reaction to the further criminalisation by the Government of Botswana of the same-sex behaviour of GLBs. In that sense LeGaBiBo is not an expression of a GLB subculture (see Section 2.3.3.1).

According to Kiama, as well as Ngulube, the Western model of GLB organisations is often based on maintaining a separatist and "gay" identity for the group. This "in your face" gayism is often imported into African countries, including the RSA (Kiama 1998: http://www.oneworld.org/ips2/aug98/14_27_054.html; Ngulube 1998:1). Another school of thought on homosexual subcultures exists as well, in which GLBs fit naturally into society without making an issue of their GLB status. Bronski, cited by Isaacs & McKendrick (1992:72), identified a strategy for change that was based on demystifying gay life styles and challenging the autonomy of heterosexist philosophy. Gradual assimilation might lead to acceptance.

LeGaBiBo was not formed because the GLBs saw their sexuality as an obstacle in their lives. Rather, the GLBs saw the primary role of LeGaBiBo as being an information resource for GLBs themselves (60%). Only 11% of the GLBs thought LeGaBiBo could assist with "coming out" issues as well. Even though there is only one openly gay person in Botswana, awareness of GLB celebrities was important for 68% of the GLBs feeling better about their sexuality (Daily News, June 14, 1999:5).

5.5.4 Empowerment and change

Positive change would be made possible through the actions of human rights activists (45%) or GLBs themselves (45%). Little is known about the perceived role of GLBs or human rights activists in either "demystifying GLB life styles" or "challenging heterosexist philosophies". The written comments by some GLBs were, however, more in favour of giving information about GLBs and gaining acceptance from the straight community.

Summary of the current health needs and problems based on the findings in this study

Health need/problem	**True for % of GLBs**
1. Lesbians and bisexuals practising unsafe vaginal sex (Section 4.3.5)	100% (n=3)
2. GLBs practising unsafe oral sex (Section 4.3.5)	94% (n=47)
3. GLBs concerned about illness and/or pain (Section 4.3.3)	68% (n=47)
4. Discrimination of Bisexuals by GLBs (Section 4.4.10)	60% (n=47)
5. Alcohol use over 5 drinks/day by GLBs (Section 4.3.8)	60% (n=30)
6. GLBs insulted (Section 4.4.10)	57% (n=47)
7. Gays practising unsafe anal sex (Section 4.3.5)	55% (n=42)

Health need/problem	True for % of GLBs
8. GLBs suffering discrimination at work place (Section 4.4.10)	51% (n=47)
9. GLBs who want safer sex education (Section 4.3.6)	49% (n=47)
10. GLBs who want to marry (Section 4.4.6)	45% (n=47)
11. GLBs bothered by negative portrayal in media (Section 4.4.2)	45% (n=47)
12. GLBs who fear/experience blackmail (Section 4.4.5)	42% (n=47)
13. GLBs threatened with violence (Section 4.4.4)	32% (n=47)
14. GLBs threatened with outing (Section 4.4.5)	25% (n=47)
15. Lack of social peer support when having problems (Section 4 4.5)	23% (n=47)
16. GLBs very concerned about penal code (Section 4.4.5)	21% (n=47)
17. GLBs who want to have child (Section 4.4.6)	21% (n=47)
18. GLBs thinking about suicide (Section 4.3.7)	14% (n=47)
19. Actual rape of gay men (Section 4.4.4)	10% (n=47)
20. Depression (Section 4.3.8)	8% (n=47)
21. GLBs who experienced actual physical violence (Section 4.4.4)	8% (n=47)

Research Question III: How can linking the fields of health and human rights assist in the advancement of the well-being of the GLB people in Botswana?

Objective III: To develop a plan of action to advance the well-being of the GLB people in Botswana through exploring the linkages between health and human rights disciplines.

In a discussion of the Universal Declaration of Human Rights, Mann (1998c:32) pointed out the importance of dignity and cited the first Article:

> *"All human beings are born free and equal in dignity and rights"* (the Universal Declaration of Human Rights adopted and proclaimed by the United Nations General Assembly Resolution 217 A(III) (December 10, 1948)).

Dignity seems to flow from two components, one internal (how I see myself) and the other external (how others see me). The common denominator is the fact of being seen and the perceived nature or quality of this interaction (Mann 1998c:33-34).

Results based on the 47 GLB respondents' perspectives have uncovered inadequacies in the external component of dignity of the GLBs in Botswana. The 47 respondents struggled with the negative perceptions of the Batswana about them. Bias might have been introduced because of the selection of the respondents by LeGaBiBo members. GLBs who have not accepted their being GLB would probably not attend meetings or have contact with other GLBs. However, the self-accepting GLBs (89.4%) as well as those who might want to change their sexual orientation (10.6%) reported a range of health and human rights concerns including:

- HIV/AIDS;
- Concerns about general health, illness and bodily pain;
- Discrimination;
- Alcoholism;
- Depression and (para)suicide; and
- Vulnerability to physical violence as well as to sexual attacks.

The main finding of importance to health care professionals specifically, was that the GLBs were, for largely unexplored reasons, prevented from discussing health concerns and problems with their health care providers. Problems such as depression, alcoholism, sexual abuse, suicidal thoughts, desires to have children with same-sex partners, HIV/AIDS, and crises related to "coming out" to others, were identified and could be addressed by qualified health care providers if they were aware of these problems (see Section 2.3.2.4).

The findings of this study indicated that discrimination was a reality in the daily lives of the GLBs. Societal disapproval manifested itself in various ways: violent attacks, rape and fear of outing, dismissal from work, isolation and inability to be honest with their families (especially their fathers), health problems and lack of access to GLB-friendly health care providers.

Health care providers might start to see the HIV/AIDS epidemic as a catalyst for interest in GLB issues. Depending on the link between health (individual nurses' beliefs about disease causation and level of involvement) and human rights, risk reduction measures could be beneficial, yet also potentially damaging for the GLBs if not based on mutual

respect. In contrast with some studies on men having sex with other men, this study dealt with sexual behaviour and sexual identity as a component of the well-being of the GLBs. The findings of this report supported the assumption that GLB health needs are complex, and that a focus on reducing "risky sexual practices" in isolation from the broader societal context might not be helpful. Both the identified health needs, such as the need for health education, and the promotion of human rights such as the protection of the right to have same-sex relationships, need to be addressed to increase the effectiveness of HIV/AIDS projects with GLBs in Botswana. In that sense, working with GLBs is by its nature political, and plans of action to improve the well-being of the GLBs will have to include measures to decrease societal disapproval (see Section 2.2.2) and to change legislation in Botswana.

5.6 CONCLUSION

The levels of well-being of Botswana's GLBs appeared to be influenced by both positive internal acceptance and negative external acceptance of the GLBs in society. The findings indicated that distress of varying degrees was experienced by 64% of the GLBs in this study. The GWBS assisted with quantifying the feelings of well-being and with the identification of eight gay men experiencing severe distress.

Health, as well-being, was explored and described. Health needs, problems and demands were ranked and the urgent need for HIV/AIDS education was identified. Unsafe same-sex sexual activities affected all GLBs in this study. Discrimination was identified as a reality in the daily lives of the GLBs in Botswana and ranged from insults, the dismissal from work, to very negative portrayal in the local press. The concealment of GLB identity was identified as a strategy to avoid harm and being outed, which was identified as one of the worst fears of the GLBs. The GLBs were easy targets for blackmailing because of their fear of being outed.

The removal of the barriers which resulted in non-disclosure to health professionals would require efforts from health professionals to improve the nurse-GLB caring relationships. Trust needs to be established and protected. Nurses' roles in assisting GLBs in improving their knowledge about HIV/AIDS were negligible. Health professionals, as well as lawyers and politicians, were not expected to play an important

role in achieving positive well-being for GLBs in the year 2000 according to the respondents participating in this study.

Chapter 6 contains the conclusions that were drawn from the findings of this study and outlines the limitations of the research. As this is a study of limited scope, recommendations for future research will be based on the findings of this study and on other studies that informed the design of this survey of the GLBs in Botswana.

CHAPTER 6
CONCLUSIONS AND LIMITATIONS OF THE RESEARCH: RECOMMENDATIONS FOR FUTURE RESEARCH

6.1 CONCLUSIONS

Although firm conclusions warrant additional studies, the following conclusions were reached on the basis of the data gathered and analysed.

The literature was reviewed to become aware of current thinking about how health or well-being was defined and how the ideal of complete health could be realised. An in-depth exploration of the argument about what a nurse "ought to do" for GLBs, whose sexual orientation is criminalised in Botswana - a fundamental ethical problem - was beyond the scope of this study. However, to gain an understanding about the views of nurse academics on the setting of priorities between political and professional responsibilities in health promotion, literature on enhancing well-being was explored.

A health and human rights approach was selected to explore the wide range of individual risk factors and the broader societal conditions that influenced the lives of the GLBs in Botswana. The findings of this study suggested that the application of a health and human rights framework could be valuable in describing and gaining an understanding of the health needs of a section of society which claimed that their human rights were being abused.

This study attempted to describe all the factors that might be relevant in assessing the levels of well-being of GLBs in Botswana. The levels of well-being were measured, and positive well-being was reported by only 17 of the 47 GLBs. The largest group, 22 GLBs, was in moderate distress and eight gay men reported to experience severe distress. Health needs and demands, as identified in international studies, were included in order to explore how different or similar the needs and demands of the GLBs were. The identified health needs ranged from typical "health" issues, such as the need for HIV/AIDS education, to typical "human rights" issues, such as the right to freedom of association and the right to privacy.

The design of this study aimed at being in agreement with the definition of health promotion as offered by Edelman & Mandle (1990:10), in the hope that the results of this study would be of some use in developing resources for the GLBs applicable in the maintenance or enhancement of their well-being. How linking health and human rights could assist in health promotion or in advancing the well-being of the GLBs was explored in this study.

The responses of the GLBs were rank ordered to identify pressing needs and problems. From these observations, it was established that the GLBs needed direct care as well as support, to address the broader societal conditions that impacted negatively on their quality of life.

Inadequacies in the external component of dignity at societal level were counter-balanced by the feelings of positive self-esteem and self-respect of the GLBs that chose to participate in this study. Claims for protection of human rights were usually made when legal or other remedies failed. In epidemiological terms these claims could be regarded as "early warning signs" that something might be wrong. The GLBs were not enjoying the rights they intrinsically have - their basic human rights.

Health professionals (especially nurses) with the mandate to care, "ought to" engage in meaningful discussions with the GLBs in order to explore their own role in promoting the dignity of the GLBs at micro and macro levels.

Sharing the findings of this study might assist towards breaking the silence about the existence of GLBs in Botswana. Publication of the findings of this study could make positive contributions towards the GLBs' rightful claim for equal rights, dignity and health.

6.2 LIMITATIONS OF THIS STUDY

6.2.1 Participation of the target group in the design of the study

This study of limited scope was a first attempt to explore and describe the GLBs of Botswana. The study aimed to be relevant primarily to the GLBs needs, but also to enable health and human rights professionals to learn about the quality of life of the

GLBs. This premise limited the research as far as the generalisation of the findings to all GLBs in Botswana was concerned. However, since not much was known prior to this study, consultations with selected GLBs were important to determine the issues that were to be explored through the 76 questions.

6.2.2 Role of the researcher

The GLBs organised themselves in the LeGaBiBo grouping, and the researcher gained access to this group since the LeGaBiBo functioned under the auspices of DITSHWANELO, the employing organisation of the researcher. Without this relationship between the researcher and the target group, the research would most likely have been impossible. The GLBs had never participated in any official research project prior to this study, despite attempts from other researchers. The year-long phase during which trust was established prior to the study, was essential. That this association increased the possibility of introducing bias was acknowledged and conscious efforts were made throughout the study to document all findings objectively.

6.2.3 Design of the study

A quantitative design was selected and a structured questionnaire was administered. This limited the possibilities of exploring a wide range of topics. A more flexible design in which questions could have been added or modified, or comments elicited about certain answers given, was not feasible under the circumstances. It was anticipated that the researcher's presence might have barred the respondents from answering truthfully, and the respondents would not have accepted tape recordings of their narratives.

6.2.4 Sampling

The respondents were approached by active members of LeGaBiBo, which limited the selection of respondents to those whom they knew. GLBs who were not associating with other GLBs, were thus excluded from participation. A non-random sampling method had to be adopted, although generalisation of these findings might increase the risk of introducing errors. Out of the 100 questionnaires that were distributed, 47 were completed and returned to the researcher.

The resultant data might be prejudiced in unknown ways, insofar as information was obtained from willing participants only. No way could be found to determine whether

the respondents or non-respondents experienced the same prejudices and/or problems. Reasons for not responding to the questionnaire could not be ascertained as the respondents could not be traced.

Proficiency in basic English was required to be able to complete the questionnaire. Because anonymity was guaranteed no personal interviews could be conducted. This approach might have imposed some limitations on the generalisations of the research findings, because it cannot be assumed that those GLBs who were proficient in English had the same experiences in the Botswana study as those who did not have this capability.

6.2.5 Data analysis

In this study, no testing of the significance of relationships between variables was attempted in order to avoid errors, since the non-random sample covered only 47 GLBs of the estimated 30,000 Batswana that might be engaging in same-sex sexual activities. Only rudimentary explorations of possible combinations between levels of well-being and other variables were attempted. The conclusions drawn can only refer to the sample of 47 GLBs. Therefore, no statistical support for answering the research questions was provided.

6.3 RECOMMENDATIONS

Certain recommendations can be considered in this setting on the basis of the findings obtained in this study:

- Further studies on the quality of life of GLBs in Botswana need to be done. A further larger study would allow for larger numbers and allow greater confidence in the data obtained. It would be desirable to compare the results with a control group of marginalised people in order to highlight the differences between these two groups.

- In-depth qualitative research methods, including focus groups and individual interviews, could be used in future studies.

- The findings of this study suggested that male-to-male rape in Botswana (10.6%) might

be a problem, warranting further studies to gain additional information about this problem.

- The combination of complex internal and external dignity-related variables, and the many questions raised about what levels of involvement could reasonably be expected of health professionals (more specifically nursing), could also provide direction for further studies.

- Further research is needed to identify critical elements in the caring nurse-GLB patient relationship, as well as those necessary to establish a trusting relationship in which the GLBs could disclose private information in confidence without fear of prosecution, shunning or other dignity violations.

- Human rights activists and nurses in Botswana need to explore the link between health promotion and human rights protection, and to debate whether there is potential for collaboration in HIV/AIDS prevention strategies in order to empower self-identified GLBs, and all other men and women who engage in same-sex sexual behaviour, with the skills and knowledge to protect themselves against HIV infection.

- Plans of action to improve the well-being of GLBs will have to include measures to decrease societal disapproval.

- Future research should attempt to involve GLBs in Botswana who are not proficient in English and who might be unable to respond to questionnaires.

6.4 THE WAY FORWARD

Botswana looks to the future with the hope of providing better lives, including better health care, to all its citizens. As long as Botswana's GLBs remain invisible, with their human rights unclaimed, suffering unacceptable and/or inaccessible health care services, the needs of the estimated 30,000 GLBs in Botswana cannot be met. While the challenges are great, nurses and other health care professionals should continue to conduct research among Botswana's GLBs in order to render effective inputs into future policy developments and in designing future health care delivery systems acceptable and

accessible to the GLBs. Attitude changes among the Batswana, including health care professionals and nurses, seem to be required so that barriers marginalising the GLBs in Botswana from society, and from health care services, can be addressed. Qualitative research methods might be more fruitful in identifying health care needs and problems of the GLBs. However, this exploratory descriptive quantitative research succeeded in uncovering some of the GLBs health needs and human rights required to enhance the well-being of the GLBs in Botswana.

"Nursing, and perhaps only nursing, has the ability to deliver a reforming health agenda that is flexible and responsive to the patient, which delivers care in the most appropriate setting, which empowers patients to take charge of their own health and that is cost effective" (Jolley & Brykczynska 1995:138).

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Appendix I

APPENDIX I
COVER LETTER

July 25, 1999

Dear Participant,

Early in 1998, DITSHWANELO - the Botswana Centre for Human Rights, organised a workshop for Gays, Lesbians and Bisexuals in Botswana to discuss Human Rights issues and concerns. Subsequently, LeGaBiBo was formed under the auspices of DITSHWANELO. In September 1998, as a response to the amendment of the Penal Code Act in which the criminalisation of same-sex sexual behaviour was made more severe, LeGaBiBo produced a Charter that describes the rights and aspirations of the Gay, Lesbian and Bisexual (GLB) section of the community. The LeGaBiBo group continues to meet in Gaborone on a monthly basis.

DITSHWANELO and LeGaBiBo would like to request you to participate in an assessment about the GLBs in Botswana. The goal of the assessment is to explore how to promote the well-being of the GLBs by linking health and human rights. In order to protect your privacy we decided to do this survey on an anonymous basis. Your name will not appear anywhere and the questionnaires are not numbered. We anticipate that between 50 and 100 GLB Batswana will participate.

Your were identified by a representative of the LeGaBiBo group as a possible participant in this assessment. By returning this questionnaire after completion by mail to DITSHWANELO, we trust that anonymity is guaranteed as DITSHWANELO does not know who was approached by LeGaBiBo. A pre-stamped addressed envelope is enclosed for your convenience.

It will take less than an hour to complete the questionnaire and, as you will understand, the findings can only be useful when you answer all the questions truthfully. The questionnaire asks about background information, well-being, health needs and explores the links between health and human rights. In the last section you can assist us further by writing down your own comments and suggestions. You do not have to do this; you can also stop after question 76.

This assessment study will assist with mapping the needs and demands of the GLB people in Botswana. It will also give an insight on how human rights violations, such as discrimination and lack of respect, have an impact on the health and well-being of the GLB. It is anticipated that LeGaBiBo and DITSHWANELO will consider the results of the assessment study and use it as a basis for further plans of action.

Your contribution is of the greatest value in this process. We are very grateful for your support and we are looking forward to "hear" your voice and that of other GLBs!

If you have any questions please contact me at tel. 306998 at DITSHWANELO. For LeGaBiBo you can write to The Secretary of LeGaBiBo, P/Bag 00416, Gaborone, Botswana.

Yours sincerely,

Ms Anneke Visser
Programmes Coordinator DITSHWANELO

Appendix II

APPENDIX II
QUESTIONNAIRE

BACKGROUND INFORMATION

READ - For each question, write in your answer box the number of your choice of the answer which best applies to you.		For office use only ☐☐ 1-2
1. Gender	1. Male 2. Female 3. Transgender Your answer ☐	Q1 ☐3
2. What is your age?	1. 15-19 years 2. 20-29 years 3. 30-39 years 4. 40-49 years 5. 50-59 years 6. 60 years or over Your answer ☐	Q2 ☐4
3. With whom do you live?	1. By myself 2. Living with a same-sex partner 3. Living with a same-sex partner and child(ren) 4. With friends 5. With one or both parents 6. Single with child(ren) 7. Other Your answer ☐	Q3 ☐5
4. How would you describe your sexual orientation?	1. Lesbian 2. Bisexual 3. Gay 4. Questioning/Unsure 5. Heterosexual Your answer ☐	Q4 ☐6
5. Who are your sexual partners?	1. Only women 2. Mostly women 3. Men and women equally 4. Mostly men 5. Only men 6. None Your answer ☐	Q5 ☐7
6. How do you spent your day?	1. Full-time employment 2. Part-time employment 3. Looking for work 4. Student 5. At home / child care 6. Retired 7. Other Your answer ☐	Q6 ☐8

7. What is the highest level of education you have completed?	1. Primary school 2. Secondary school 3. College/vocational training 4. University Your answer ☐	Q7 ☐9
8. Nationality	1. Motswana 2. Other African country 3. Outside Africa Your answer ☐	Q8 ☐10

SECTION I: WELL-BEING

9. How have you been feeling in general? (DURING THE PAST MONTH)	1. In excellent spirits 2. In very good spirits 3. In good spirits mostly 4. I have been up and down in spirits a lot 5. In low spirits mostly 6. In very low spirits Your answer ☐	Q9 ☐11
10. Have you been bothered by nervousness or your "nerves"? (DURING THE PAST MONTH)	1. Extremely so - to the point where I could not work or take care of things 2. Very much so 3. Quite a bit 4. Some - enough to bother me 5. A little 6. Not at all Your answer ☐	Q10 ☐12
11. Have you been in firm control of your behaviour, thoughts, emotions, or feelings? (DURING THE PAST MONTH)	1. Yes, definitely so 2. Yes, for the most part 3. Generally so 4. Not too well 5. No, and I am somewhat disturbed 6. No, and I am very disturbed Your answer ☐	Q11 ☐13
12. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (DURING THE PAST MONTH)	1. Extremely so - to the point that I have just about given up 2. Very much so 3. Quite a bit 4. Some - enough to bother me 5. A little bit 6. Not at all Your answer ☐	Q12 ☐14
13. Have you been under or felt you were under any strain, stress, or pressure? (DURING THE PAST MONTH)	1. Yes - almost more than I could bear or stand 2. Yes - quite a bit of pressure 3. Yes - some, more than usual 4. Yes - some, but about usual 5. Yes - a little 6. Not at all Your answer ☐	Q13 ☐15

14. How happy, satisfied, or pleased have you been with your personal life? (DURING THE PAST MONTH)	1. Extremely happy - I could not have been more satisfied or pleased 2. Very happy 3. Fairly happy 4. Satisfied - pleased 5. Somewhat dissatisfied 6. Very dissatisfied Your answer ☐	Q14 ☐16
15. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? (DURING THE PAST MONTH)	1. Not at all 2. Only a little 3. Some - but enough to be concerned or worried about 4. Some and I have been a little concerned 5. Some and I am quite concerned 6. Yes, very much so and I am very concerned Your answer ☐	Q15 ☐17
16. Have you been anxious, worried, or upset? (DURING THE PAST MONTH)	1. Extremely so - to the point of being sick or almost sick 2. Very much so 3. Quite a bit 4. Some-enough to bother me 5. A little bit 6. Not at all Your answer ☐	Q1 ☐18
17. Have you been waking up fresh and rested? (DURING THE PAST MONTH)	1. Every day 2. Almost every day 3. Fairly often 4. Less than half the time 5. Rarely 6. None of the time Your answer ☐	Q17 ☐19
18. Have you been bothered by any illness, bodily disorder, pains,or fears about your health? (DURING THE PAST MONTH)	1. All the time 2. Most of the time 3. A good bit of time 4. Some of the time 5. A little of the time 6. None of the time Your answer ☐	Q18 ☐20
19. Has your daily life been full of things that were interesting you? (DURING THE PAST MONTH)	1. All the time 2. Most of the time 3. A good bit of time 4. Some of the time 5. A little of the time 6. None of the time Your answer ☐	Q19 ☐21
20. Have you felt down-hearted and blue? (DURING THE PAST MONTH)	1. All the time 2. Most of the time 3. A good bit of time 4. Some of the time 5. A little of the time 6. None of the time Your answer ☐	Q20 ☐22

21. Have you been feeling emotionally stable and sure of yourself? (DURING THE PAST MONTH)	1. All the time 2. Most of the time 3. A good bit of time 4. Some of the time 5. A little of the time 6. None of the time Your answer ☐	Q21 ☐23
22. Have you felt tired, worn out, used up or exhausted? (DURING THE PAST MONTH)	1. All the time 2. Most of the time 3. A good bit of time 4. Some of the time 5. A little of the time 6. None of the time Your answer ☐	Q22 ☐24

For each of the four scales below, note that the words at each end of the 0 to 10 scale describe opposite feelings. Circle any number along the bar which seems closest to how you have generally felt DURING THE PAST MONTH

23. How CONCERNED or WORRIED about your health have you been?	0 1 2 3 4 5 6 7 8 9 10 |___|___|___|___|___|___|___|___|___|___|___| Not concerned at all — Very Concerned	Q23 ☐25-26
24. How RELAXED or TENSE have you been?	0 1 2 3 4 5 6 7 8 9 10 |___|___|___|___|___|___|___|___|___|___|___| Very relaxed — Very tense	Q24 ☐27-28
25. How much ENERGY, PEP, VITALITY have you felt?	0 1 2 3 4 5 6 7 8 9 10 |___|___|___|___|___|___|___|___|___|___|___| No energy AT ALL, listless — Very ENERGETIC, dynamic	Q25 ☐29-30
26. How DEPRESSED or CHEERFUL have you been?	0 1 2 3 4 5 6 7 8 9 10 |___|___|___|___|___|___|___|___|___|___|___| Very depressed — Very cheerful	Q26 ☐31-32

Section I ☐ ☐ ☐85-86-87 and ☐ 88 (for office use only)

SECTION II: GAYS, LESBIANS OR BISEXUALS (GLBs) COMING OUT ISSUES, HEALTH AND SOCIAL ASPECTS

27. At what age were you first aware that you might be GLB?	1. _____years 2. I cannot remember Your answer ☐	Q27 ☐33-34
28. At what age did you first accept your sexual orientation?	1. _____years 2. Not yet accepted Your answer ☐	Q28 ☐35-36

29. How comfortable do you feel about being GLB?	1. Very comfortable 2. Comfortable 3. Neither comfortable nor uncomfortable 4. Uncomfortable 5. Very uncomfortable Your answer ☐	Q29 ☐37
30. How do you believe that you came to be GLB?	1. I was born this way 2. I chose to be GLB 3. I have no idea 4. It's the result of how my parents raised me 5. I was convinced to be GLB by someone else 6. I was rejected by someone of the opposite gender 7. Other Your answer ☐	Q30 ☐38
31. Have you told your parents that you are GLB?	1. Yes 2. No Your answer ☐	Q31 ☐ 39
32. Who was the **first person** you told you were GLB?	1. Father 2. Mother 3. Brother or sister 4. My best friend 5. Friends at school or at work 6. Other Your answer ☐	Q32 ☐40
33. How old were you when you told the first person that you were GLB?	1. 10-15 years 2. 16-20 years 3. 21-29 years 4. 30-39 years 5. 40-years or over 6. Cannot remember Your answer ☐	Q33 ☐41
34. Have you told your brothers and sisters as well?	1. Yes 2. No 3. Not applicable Your answer ☐	Q34 ☐42
35. *Skip if question 31 was answered with yes.* Why haven't you told your parents that you are GLB?	1. I'm scared of how my parents may react 2. The time just hasn't been right 3. I don't want to be GLB, and hope that I might change 4. My parents seem to be very homophobic 5. My parents expect me to have children 6. I am still coming to terms with being GLB myself Your answer ☐	Q35 ☐43

36. If you could change your sexual orientation, would you?	1. Yes, I want to change it 2. Yes, but I have tried and failed 3. Yes, and I believe that I have successfully done so 4. No, I am happy with who I am 5. Maybe Your answer ☐	Q36 ☐44
37. How do you pay for use of health services like doctors and clinics?	1. I attend government sponsored clinics and hospitals 2. I have health insurance 3. I pay cash for private doctors and private hospitals 4. I use both government and private doctors and hospitals and pay cash Your answer ☐	Q37 ☐45
38. Do you feel that you have enough knowledge about AIDS and other sexually-transmitted diseases to make decisions about safer sex in your own life?	1. Yes 2. No 3. I'm not sure Your answer ☐	Q38 ☐46
39. Are there issues related to HIV/AIDS which you don't completely understand and would like to know more about.	1. Yes 2. No 3. I'm not sure Your answer ☐	Q39 ☐47
40. Where do you obtain most of your information about safer sex and about AIDS and other sexually-transmitted diseases? (Select one answer)	1. Friends, word-of-mouth 2. Family 3. Nurses 4. Local media 5. Other Your answer ☐	Q40 ☐48
41. When having oral sex, do you use protection such as a condom or dental dam?	1. Always 2. Most of the time 3. Sometimes 4. Never 5. I don't have oral sex Your answer ☐	Q41 ☐49
42. When having anal sex, do you use a condom?	1. Always 2. Most of the time 3. Sometimes 4. Never 5. I don't have anal sex Your answer ☐	Q42 ☐50
43. When having vaginal sex, do you use a condom?	1. Always 2. Most of the time 3. Sometimes 4. Never 5. I don't have vaginal sex Your answer ☐	Q43 ☐51

44. Would you have sex with someone with whom you were not in a relationship, in other words have sex but no commitment to each other afterwards?	1. Yes, I prefer not to have long term relationships 2. Yes, since it might be the start of a relationship 3. No 4. Maybe Your answer ☐	Q44 ☐52
45. Are you aware that confidential and anonymous HIV/AIDS testing is available at many local health clinics, hospitals and private practices of doctors and the university?	1. Yes, I am aware of this and was tested for HIV/AIDS myself 2. Yes, I am aware of this but never went for a HIV/AIDS testmyself 3. No, I am not aware of this and I do not want to be tested 4. No, but if I had known I would have gone for a HIV/AIDS test Your answer ☐	Q45 ☐53
46. Have you ever seriously thonght abont taking your own life?	1. Never *(skip question 47)* 2. At some point in time in the past 3. Sometimes 4. Often Your answer ☐	Q46 ☐54
47. How much were these thoughts related being GLB?	1. Very much related 2. Very related 3. Somewhat related 4. Not very related 5. Not at all related Your answer ☐	Q47 ☐55
48. What helped you in accepting that you are attracted to people of the same-sex?	1. Reading about it in books and magazines 2. Through contact with other GLBs 3. Through therapy 4. Supportive parents 5. It just happened 6. Some other way Your answer ☐	Q48 ☐56
49. What is the degree of concealment of your sexual identity when you are not with close friends?	1. Completely out 2. Mostly ont 3. Half in and half out 4. Mostly in 5. Completely in Your answer ☐	Q49 ☐57
50. How would you describe your drinking? (DURING THE LAST MONTH)	1. Abstainer 2. Two or fewer alcoholic drinks per day 3. Four or fewer alcoholic drinks per day 4. Five or more alcoholic drinks per day 5. Recovering drinker, stopped taking alcoholic drinks Your answer ☐	Q50 ☐58

51. For appropriate medical care GLBs should be able to reveal their identity and share intimate information with the doctor or nurse.	1. I agree, and I do disclose if it is relevant 2. I agree, but I have personally never disclosed my orientation 3. I never trust my doctor or nurse fully 4. I disagree 5. I used to disclose, but no longer do it 6. Never thought about it Your answer ☐	Q51 ☐59

SECTION III: LINKING HEALTH AND HUMAN RIGHTS

52. How do you rate the contribution of the local newspapers as far as the portrayal of GLB people in Botswana is concerned?	1. Very positive 2. Mostly positive 3. Sometimes positive, sometimes negative 4. Mostly negative 5. Very negative 6. I don't know Your answer ☐	Q52 ☐60
53. Does knowing that a celebrity is GLB make you feel better about your sexuality?	1. Yes 2. No 3. I don't know Your answer ☐	Q53 ☐61
54. Have you ever bought any GLB magazines in Botswana? (DURING THE LAST YEAR)	1. Yes, at a store 2. Yes, from friend 3. No, I am afraid people will see me 4. No 5. No, I cannot get them where I live Your answer ☐	Q54 ☐62
55. Do you have access to the Internet and e-mail to get information about GLB issues?	1. Yes 2. No 3. Sometimes Your answer ☐	Q55 ☐63
56. How may times have you been **verbally insulted** (yelled at, criticized) because you are, or were thought to be, GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q56 ☐64
57. How many times have you been threatened with **physical violence** because you are, or were thought to be GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q57 ☐65
58. How many times have you been threatened with **blackmail** because you are, or were thought to be, GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q58 ☐66

59. How many times have you been punched, kicked or **beaten** because you are, or were thought to be, GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q59 ☐67
60. How many times have you been **threatened with a knife, gun or another weapon** because you are, or were thought to be, GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q60 ☐68
61. How many times have you been **attacked sexually** (forced to have a sexual experience, raped), because you are, or were thought to be, GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q61 ☐69
62. How many times has someone threatened **to tell someone else** that you are GLB? (DURING THE LAST YEAR)	1. Never 2. Once 3. Twice 4. Three or more times Your answer ☐	Q62 ☐70
63. Do you have a copy and/or have you read the Charter of the Gays, Lesbians and Bisexuals in Botswana that was published in 1998?	1. Yes 2. No 3. No, but I would like to get it and will contact DITSHWANELO at phone 306998 Your answer ☐	Q63 ☐71
64. Which of the following organisations that advocate for the rights of GLBs are you most familiar with? (select one answer)	1. LeGaBiBo-Botswana 2. DITSHWANELO- the Botswana Centre for Human Rights 3. GALZ-Zimbabwe 4. Other Your answer ☐	Q64 ☐72
65. Do you socialise with other GLB people in the place where you live at present?	1. Yes, I know between 1 and 10 GLBs here 2. Yes, I know between 11 and 50 GLBs here 3. No, I do not know any other GLBs where I stay now (skip question 66) 4. No, I prefer to socialise with heterosexual friends Your answer ☐	Q65 ☐73
66. Do you know other GLBs around your own age who you can call upon when you have a problem?	1. Yes, one or two people 2. Yes, I know many GLBs of my own age 3. No Your answer ☐	Q66 ☐74
67. Do you know a Motswana GLB who you view as a role model?	1. Yes 2. No 3. I don't know Your answer ☐	Q67 ☐75

68. Have you ever gone to a GLB group such as LeGaBiBo in Botswana?	1. Yes, I went to at least one LeGaBiBo meeting 2. No, I live too far away to attend 3. No Your answer ☐	Q68 ☐76
69. Do you want to have children some day?	1. Yes 2. No 3. I don't know Your answer ☐	Q69 ☐77
70. Would you like to get officially and publicly married to someone of the same gender?	1. Yes 2. No 3. I don't know Your answer ☐	Q70 ☐78
71. Do you think that your sexuality will be an obstacle in your life?	1. Yes 2. No 3. I don't know Your answer ☐	Q71 ☐79
72. Have you ever been fired or left a job voluntarily when employers found out or suspected you were GLB?	1. Yes, I was fired at least one time 2. Yes, I left my job because of rumors about my sexual orientation 3. No, but I chose carefully where I want to work 4. No, this was never an issue for me 5. No, nobody knows I a GLB Your answer ☐	Q72 ☐80
73. The current law in Botswana (the Penal Code, Section 164, 165 and 167) criminalises same-sex activities. Are you afraid to be at risk for being charged and/or jailed for having unlawful same-sex sexual activities?	1. Not at all 2. Only a little 3. Some-but not enough to be worried about 4. Some-and I am little concerned 5. Some-and I am quite concerned 6. Yes, very much so and I am very concerned Your answer ☐	Q73 ☐81
74. Select the statement that is most true about the Lesbian, Gay and Bisexual group of Botswana (LeGaBiBo).	1. I have never heard about LeGaBiBo 2. It alleviates loneliness 3. It facilitates meeting GLBs 4. It helps people to "come out" 5. It bores me 6. It could provide information relevant to GLBs Your answer ☐	Q74 ☐82
75. Bisexuals are often harshly criticized by both homosexuals and heterosexuals alike for not making a choice. Do you agree they would be wise if they came out as "pure gay" or "pure lesbians"?	1. Yes, I fully agree 2. Yes, I somewhat agree 3. No, I somewhat disagree 4. No, I totally disagree Your answer ☐	Q75 ☐83

76. Tick the **group** that is most likely to effect a **positive** change in the well-being of the GLB community in Botswana in the coming year?	1. GLBs themselves 2. Human Rights activists 3. Health professionals 4. Politicians 5. Lawyers 6. Academics Your answer ☐	Q76 ☐84

SECTION IV: YOUR COMMENTS PLEASE!

Please feel free to contribute your comments, suggestions or thoughts that you may have had during or after answering all these questions.

Do you think research on the GLBs of Botswana is a good idea? Furthermore, can you tell me how tolerant and healthy Botswana's society is for GLBs in your opinion? What concerns you most right now and more importantly what action must be taken, if any, in your opinion to improve your well-being?

Thank you so much for taking the time to fill out this questionnaire. A pre-stamped addressed envelope is enclosed for your convenience. Please return the document without your name and address as soon as possible to :

DITSHWANELO- the Botswana Centre for Human Rights
Att: Programmes Coordinator
P/Bag 00416 Gaborone Botswana

APPENDIX III

APPENDIX III

TABLES

Table A.III.1 Why gay, lesbian and bisexual people did not tell their parents about their sexual orientation

		Frequency	Percentage
Why haven't you told your parents that you are gay, lesbian or bisexual? (Question 35)	I am scared of how my parents may react	3	6.4
	The time just has not been right	6	12.8
	I am still coming to terms with being GLB myself	7	14.9
	Not applicable	31	65.9
	Total	47	100.0

Table A.III.2 Age at which gay, lesbian and bisexual people told the first person about their sexual orientation

		Frequency	Percentage	Cumulative percentage
How old were you when you told the first person that you were gay, lesbian or bisexual? (Question 33)	10-15 years	2	4.3	4.3
	16-20 years	18	38.3	42.6
	21-29 years	18	38.3	80.9
	30-39 years	2	4.3	85.2
	40 years or over	2	4.3	89.4
	Cannot remember	5	10.5	100.0
	Total	47	100.0	

Table A.III.3 Influence of degree of concealment of sexual orientation on the level of well-being of the gays, lesbians and bisexuals

	Levels of well-being (Questions 9- 26)				
		Positive well-being	Moderate distress	Severe distress	Total
What is the degree of concealment of your sexual identity when you are not with close friends? (Question 49)	Completely out	1	1	2	4
	Mostly out	1			1
	Half in and half out	4	6	1	11
	Mostly in	3	6	3	12
	Completely in	8	9	2	19
	Total	17	22	8	47

Table A.III.4 Degree of concealment of sexual identity related to fear to be at risk for being charged with a criminal offence under current laws that criminalises same-sex sexual activities

	What is the degree of concealment of your sexual orientation when you are not with close friends? (Question 49)						
		Com-pletely out	Mostly out	Half in and half out	Mostly in	Com-pletely in	Total
The current law in Botswana criminalises same-sex activities, are you afraid to be at risk for being charged or jailed? (Question 73)	Not at all	2		6	8	7	23
	Only a little			2	1		3
	Some-but not enough to be worried about				1	2	3
	Some-and I am a little concerned		1	1		2	4
	Some-and I am quite concerned	1			1	2	4
	Yes, very much so and I am very concerned	1		2	1	6	10
	Total	4	1	11	12	19	47

Table A.III.5 Protective measures when having oral sex

		Frequency	Percentage
When having oral sex, do you use protection such as a condom or dental dam? (Question 41)	Always	3	6.4
	Most of the time	2	4.2
	Sometimes	11	23.4
	Never	31	66.0
	Total	47	100.0

Table A.III.6 Sex outside a relationship

		Frequency	Percentage
Would you have sex with someone with whom you are not in a relationship (Question 44)	Yes, I prefer not to have long term relationships	16	34.0
	Yes, since it might be the start of a relationship	14	29.9
	No	9	19.1
	Maybe	8	17.0
	Total	47	100.0

Table A.III.7 Thoughts about taking their own life and the ability of gays, lesbians and bisexuals to share intimate information with the doctor or nurse for appropriate medical care

	Have you seriously thought about taking your own life? (Question 46)				
		Never	At some point in time in the past	Some-times	Total
For appropriate medical care GLBs should be able to reveal their identities and share intimate information with their doctors or nurses. (Question 51)	I agree and I do disclose if it is relevant	3	3	1	7
	I agree, but I have personally never disclosed my orientation	3	4	3	10
	I never trust my doctor or nurse fully	8	6	6	20
	I used to disclose, but no longer do it	4		4	8
	Never thought about it	1	1		2
	Total	19	14	14	47

Table A.III.8 Levels of well-being linked to the drinking patterns of the gays, lesbians and bisexuals

	Levels of well-being (Questions 9-26)			
	Positive well-being	Moderate distress	Severe distress	Total
How would you describe your drinking? (Question 50)				
Abstainer	3	3	1	7
Two or fewer alcoholic drinks per day	4	6		10
Four or fewer alcoholic drinks per day	5	4	3	12
Five or more alcoholic drinks per day	5	9	4	18
Total	17	22	8	47

Table A.III.9 Description of drinking patterns and the ability of gays, lesbians and bisexuals to share intimate information with their doctor or nurse for appropriate medical care

	How would you describe your drinking? (Question 50)					
		Ab-stainer	Two or fewer alcoholic drinks per day	Four or fewer alcoholic drinks per day	Five or more alcoholic drinks per day	Total
For appropriate medical care GLBs should be able to reveal their identity and share intimate information with their doctors or nurses. (Question 51)	I agree and I do disclose if it is relevant	3	1	1	2	7
	I agree, but I have personally never disclosed my orientation		4	2	4	10
	I never trust my doctor or my nurse fully	4	4	6	6	20
	I used to disclose, but no longer do it		1	3	4	8
	Never thought about it				2	2
	Total	7	10	12	18	47

Table A.III.10 Levels of well-being and number of times gays, lesbians and bisexuals have been threatened with physical violence

	Levels of well-being (Questions 9-26)				
		Positive well-being	Moderate distress	Severe distress	Total
How many times have you been threatened with physical violence because you are, or were thought to be, GLB (during the past year). (Question 57)	Never	12	13	7	32
	Once	1	3	1	5
	Twice	1			1
	Three or more times	3	6		9
	Total	17	22	8	47

Table A.III.11 Being sexually attacked and feeling depressed

		Have you felt down-hearted and blue during the past month? (Question 20)				
		A good bit of the time	Some of the time	A little of the time	None of the time	Total
How many times have you been attacked sexually because you are or were thought to be GLB (during the past year)? (Question 61)	Never	2	13	23	4	42
	Once	1		2		3
	Twice		1			1
	Three or more times		1			1
	Total	3	15	25	4	47

Table A.III.12 Statements about the role of LeGaBiBo

		Frequency	Percentage
Which statement about LeGaBiBo is true? (Question 74)	I have never heard about LeGaBiBo	4	8.5
	It alleviates loneliness	3	6.4
	It facilitates meeting GLB people	3	6.4
	It helps people to "come out"	5	10.6
	It bores me	4	8.5
	It could provide information relevant for GLBs	28	59.6
	Total	47	100.0

Table A.III.13 Level of social contact with other gays, lesbians and bisexuals

		Levels of well-being (Questions 9-26).			
		Positive well-being	Moderate distress	Severe distress	Total
Do you socialise with other GLB people in the place where you live at present? (Question 65)	Yes, I know between 1 and 10 GLBs here	13	18	8	39
	Yes, I know between 11 and 50 GLBs here	2	4		6
	No, I don't know any other GLBs where I stay now	2			2
	Total	17	22	8	47

Table A III.14 Bisexuals would be wise to come out as "pure" gay or lesbian according to the gays, lesbians and bisexuals of Botswana

		Frequency	Percentage
Bisexuals are often harshly criticised by both homosexuals and heterosexuals alike for not making a choice. Do you agree they would be wise if they came out as "pure gay" or "pure lesbian"? (Question 75)	Yes, I fully agree	28	59.6
	Yes, I somewhat agree	3	6.4
	No, I totally disagree	16	34.0
	Total	47	100.0

APPENDIX IV

Botswana's gays fight for their rights

By Mabel Kebotsamang

Gays and lesbians are shunned in most African societies. They are regarded as outcasts who should be locked away. In Some African communities they believe that a homosexual brings shame brings not only shame but misfortune to the family.

To protect themselves, homosexuals - people sexually attracted to individuals of the same sex, keep their sexual orientation a top secret. They remain "hidden" and only open up to those who sympathise with them.

Despite the stigma and open hostility, homosexuality is prevalent in many African societies. It is possible that millions of Africans, including Batswana, are homosexuals.

In Europe, North America, Australia and other so-called developed regions, gays, lesbians and bisexuals have come out in the open and they hold annual colourful parades, resembling the famous Brazillian carnivals appearing in bikinis, G-Strings and other fanciful attires and painted faces.

Perhaps, it is only a matter of time before such a spectacle surfaces in Botswana. There are efforts to decriminalize homosexuality with prospects looming large in the minds of perpetrators.

Botswana's homosexuals are working to win their rights for free socialisation. They want to come out of the closet and be counted. They want the Penal Code amended to recognise them, hence the inception of the Lesbians, Gays and Bisexuals Organisation of Botswana (LEGABIBO) in May 1997.

LEGABIBO is part of a long term strategy to form a coherent group to bring homosexuals together, with the ultimate goal of fighting for their rights, mainly decriminalisation of consensual homosexual conduct in statute books.

One of the few Batswana who publicly declared his sexual status, a top Radio Botswana personality, Mr Mike Olivier and also the convenor of LEGABIBO, feels it will take time to achieve their goals as did other countries like Zimbabwe that took about 10 years, but are getting there.

To be a homosexual "is not a choice. It's just who you are and should be taken from a human rights point of view since about 10 per cent of any given population is homosexual."

Going by this figure, according to Mr Olivier, a lot of gays, lesbians and bisexuals in Botswana are in the closet, hence the need to assist them get in the open with a large voice for their cause to be heeded.

The association, like any other, is perturbed by HIV/AIDS. Consequently, it has, among its local projects, planned to have a workshop on the pandemic. Mr Olivier said they will contact the National AIDS Control Programme to sponsor the workshop because a lot of homosexuals seem not to be using condoms.

On the question of reproduction, he said, people nowadays do not go to bed to conceive children, it is time people stop living in a dream land. However, some succumb to societal pressure and get married.

Justifying a weird type of behaviour adopted by some gays, he cautioned against assumption that any man with such an attitude is gay. He, however, alluded this to a form of mental orientation as they are trying to conform to the societal stereotype about the issue.

Political Affairs' Permanent Secretary in the Office of the President, Mr Molosiwa Selepeng explained last year that homosexual practice remains a crime in the country as it is perceived by the majority of Batswana.

As a democratic government, the government cannot take the risk of going against the people's will.

"Governments have to act according to the wishes of the people," he said explaining that Batswana "find it unnatural and abhorrent."

Two sections of the Penal Code, 164 and 167, though they do not specifically mention homosexuality, address the issue.

Section 164 provides that: "any person who (a) has carnal knowledge of any person against the order of nature; (c) permits any other person to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for a term not exceeding seven years."

While Section 167 says: "any male person who, whether in public or private commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or in private, is guilty of an offence."

Thus, social reality has been construed around a heterosexist standpoint while the act of those whose sexuality is not 'straight' should be punished. However Section 167 does not have any mention of a female person.

It is not only Botswana laws backed by the majority of Batswana who detest homosexuality, other state giants, Namibia, Zimbabwe and Zambia even term it unAfrican and that it only occurs on the continent as a result of pernicious Western influence.

Mr Olivier

According to Namibian President Sam Nujoma, gays and lesbians have no place in his society this must be condemned and rejected: "It is a foreign and corrupt ideology and such elements are exploiting our democracy."

President Robert Mugabe of Zimbabwe is also infamous among gays and lesbians as he terms them "worse than beasts and their sexual activities are un-Christian. Animals in the jungle are better than people because at least they know that this is a man or a woman."

To raise the issue of the right to sexual orientation in public fora Ditshwanelo; The Botswana Centre for Human Rights focus was to openly discuss it as an issue that dealt with human rights rather than with culture and morality as mst Batswana did.

"The second step has been to group the concerned citizens and given them the necessary and support to enable them to fight for their right to sexual orientation.

"We have also produced a charter for the lesbians, bisexuals and gays of Botswana, spelling out the rights of lesbians, gays and bisexuals," said Ditshwanelo Information Consultant, Mr Peter Tshukudu.

The charter calls for tolerance and understanding by the government and people of Botswana in order to counteract the prejudice and discrimination the group faces, he said, explaining that it is a statement of the aspirations and beliefs of such group.

To people who pour scorn on homosexuals, he described them as those who need education to understand issues involved in one's sexuality and stereotypes as well as cultural beliefs surrounding sex.

According to Mr Tshukudu people who detest other people whose sexuality is not necessarily heterosexual are oppressed by their cultural orientation.

He felt it was quite possible to change people's mindset and law for the recognition of homosexuality, explaining it would be achievable under prevailing conditions.

"Our country is a liberal democracy where consenting adults are free and justified in engaging in any form of sexual relationship. The concerned groups themselves must come out and set the stage for debate and perceptions about the right to sexual orientation in a conservative environment like this."BOPA

Ditshwanelo discusses rights of homosexuals

By Kebonye Seretse

President of Zimbabwe, Mr Robert Mugabe has called the organisation of Gays in Zimbabwe an "organisation for sodomists and sexual perverts". President Daniel arap Moi believes homosexuality and lesbianism is unknown to Africa.

The Centre for Human Rights - Ditshwanelo hosted a forum entitled "Does Mugabe speak for us too? Gay rights in Botswana" on September 26 and it was facilitated by Mr Log Raditlhokwa.

Mr Raditlhokwa, a social worker lecturer at the University of Botswana, believes that the gays in Botswana are not likely to face as strong an opposition as in Zimbabwe.

"The problem with the Zimbabwean state is that it believes itself to be the custodian of the culture," he said.

He said in Botswana the custodian of culture is the House of Chiefs but its powers have been weakened hence an advantage to the gay community.

He said many theories have tried to explain gay behaviour but what it is known is that the gays themselves would not know why they are gay jnst like heterosexuals cannot explain why they are heterosexual.

Mr Raditlhokwa said in a democratic state, people should be allowed to do what they want to do as long as it does not interfere with the rights of others "and homosexuality and lesbianism does not interfere with anyone's rights".

He said every human being has physiological needs to be fulfilled and those include sexual needs. He said fulfilling sexual needs include those of gay people.

Mr Raditlhokwa said gays have been suppressed by hetropatrachal societies in Africa which promote hetrosexism because they believe a woman was created for a man.

He argued that in this kind of society, a man is supposed to show power by producing children, so homosexuals are considered inferior because they cannot procreate.

He said some men never got married in the past, giving the example of Shaka Zulu who never married or had children, adding that there is a possibility that he was gay.

He said if it was a foreign thing then there would not be words like "matanyola" in Setswana.

He reasoned that we see a lot of gays now because socialisation of these years is different. In the past people did not talk about their sexuality but now it is easy to do that."

He said the family has changed, he said there is no pressure to have children so gays have the opportunity to come out of the closet.

Mr Raditlhokwa said people tend to fear things they do not understand. He said that beliefs also conld be very influential whether right or wrong.

He added that people should understand that culture is dynamic.

The participants were divided in their view on the issue of gay rights. One doctor said people should learn not to be judgemental especially about things they do not understand.

She said the issue of why these people are gay should not even arise because it could be anything ranging from genetic makeup to arrested development. She said it has always been there but was suppressed like many other things.

She said in the past there were said to be no albinos because they were killed at birth.

She gave another example that left handed people were forced to be right handed because the society did not understand that it was their biological make up. She stressed that the prejudice against the gays must be stopped.

Another participant said Mr Mugabe's statement was very "unstatesmanlike". He said being gay and being in the minority does not make them bad.

Others said sex between two consenting adults should not be questioned. They said they are not harming anyone so a law against them perpetrates injustice.

They said even hetros indulge in homosexual acts. They said asking the gays to change to being hetros is not right.

"Suppose hetros were asked to change and become gays?" they asked.

They said gays are presumed guilty before proven guilty which is not how the law should work.

They emphasised that the gay community need to strategise in order to succeed.

One lawyer said it should not be said that being gay is unnatural. He said it is just like during the apartheid era in South Africa when it was considered unnatural for blacks to sleep with whites.

One member of the gay community said they were treated shabbily in this country.

He said they are even called animals but, he said if they are animals then it means their parents are also animals because it is them who brought them in this country like that.

He said he discovered that he was gay at 14 but did not understand it because he did not know what being gay was. He felt bad about it until he came to town and met people who knew what it was all about at the age of 17.

He then accepted it when he found out that he was not the only one.

He is now 23 and lives with a man. He says his parents do not know about him being gay.

Those who were against the gays said people should be allowed to question values when they have to.

Another lawyer said the approach that is being used to introduce to them the concept of gays is very assertive.

He said human rights is the imperialist way of imposing things on people.

He said foreign believes are imposed on people under the cover of human rights.

He acknowledged that "matanyola" happened in the past but was not common.

He said he does not understand it all and need it to be explained to him. He said at the moment he thinks it is pervasion.

He feels the law against homosexuality should be retained until it is explained to them.

Another one said that being gay is unnatural. He said God has made a woman to complement a man.

He believes that being gay is an anormally. He felt it should not be discussed as a human right issne because it is in human.

He said it is unwarranted behaviour and there was a need for some devine intervention to help with this anormally. BOPA

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Gay campaigner feels insulted

By MESH MOETI
Staff Writer

THE 23 year old young man who last week openly declared to a Botswana Centre for Human Rights audience that he was gay is disillusioned with his country of birth.

Patrick Modisaemang told Mmegi: "I am planning to leave this country because I am not free. Do you know how insulting it is for someone to suggest that we are gays for economic reasons....that some apparently rich men pay us to provide them with sex?"

Modisaemang says he has always been gay. He first realised that he had no interest in the opposite sex between the ages of 14 and 15, but tried to suppress it. More than anything else it was the thought of what society would think of him that had a major contribution in Modisaemang's suppression of his true feelings. Eventually, confusion set in and his mind was in perpetual turmoil "as I felt I was the only human being who felt that way".

Mind you, this was in rural Molepolole where none of his peers had ever heard of homosexuality except, of course, the occasional *matanyola or maotwana* among ill-bred boys at the cattlepost.

"I lived with that until I was about 17 years when I came to Gaborone, and met someone who explained that there was nothing strange about the way I felt, and that I was absolutely normal."

It was the fear of being ostracised which forced Modisaemang into an unloving relationship with one girl before he came to terms with his sexuality. He has now put all that behind him, and is in a happy and steady relationship with another man.....only that he is haunted by the Botswana penal code.

Modisaemang says there are a lot of Batswana gays and lesbians, but fear does not allow them to come out of the closet. He contends that the estimation that 2-5 percent of Botswana population could be gay is far too conservative. They are quite a sizeable constituency, he asserts.

A lot of Batswana men, he claims, are locked into unhappy heterosexual marriages simply because society and its laws do not permit them to practise their sexuality.

Modisaemang is all praises for his work-mates who, he says, "give me a lot of support".

Gay man comes out fuming

By MESH MOETI
Staff Writer

PATRICK Modisaemang is an angry young man.

He is angry with a society that does not allow him to practise his sexuality in peace. He is resentful of African leaders like Robert Mugabe and Daniel Arap Moi, — presidents of Zimbabwe and Kenya respectively. He feels oppressed in his own country, Botswana, which continues to criminalise homosexuality.

Last week, Modisaemang became the first local gay to publicly declare his sexual orientation. But what is it that drives a man to risk the wrath of family and society?

"I am sick and tired of this talk that homosexuality is unnatural, unAfrican and that our behaviour is comparable only to that of animals," he says in reference to Mugabe's statement that gays and lesbians are worse than pigs and dogs.

Refusing to bend to pressure from the human rights movement and individuals, subsequent press reports further quoted Mugabe as saying "it cannot be right for human rights groups to campaign to dehumanise us to the status of beasts". Moi joined the bandwagon of gay-bashers a few weeks later with his "it is unAfrican" declaration.

It was in the wake of these developments that the Botswana Centre for Human Rights last Tuesday invited University of Botswana academic, Log Ratilhokwa, to lead a discussion whose topic was "Does Mugabe speak for us too? - gay and lesbian rights in Botswana".

After the discussion, Modisaemang told *Mmegi*: "Listening to all these people talk about homosexuality in such negative terms makes me nervous. I feel pity because their own children are gay but are afraid to tell them. Being gay can be a traumatic experience when you are a child and have no-one to talk to."

Ratilhokwa says to label homosexuality cultural imperialism imposed on Africa is incorrect. Such an attitude, he says, fails to recognise that most homosexuals did not choose to be that way.

"This is a complex phenomenon. We have theories trying to explain homosexuality, but we don't have one theory which tries to explain heterosexuality. We always want homosexuals to explain to us why

Mmegi/The Reporter, Vol 12, No 39 6-12 October 19955

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Academic dismisses Mugabe gay rights stance

By Dawood Dithato

CONTRARY to the contention by both Presidents Robert Mugabe of Zimbabwe and Daniel Moi of Kenya, the phenomenon of lesbians and homosexuals in Africa is not a function of cultural imperialism because as a practice and form of lifestyle it is universal and has been known to be practised in the continent since time immemorable, according to University of Botswana lecturer in Social Work Mr. Log Raditlhokwa.

Raditlhokwa was the discussant during a talk organised by

Mugabe

Ditshwanelo the Centre for Human Rights whose topic was "Does Mugabe speak for us too. Gay and Lesbians rights in Botswana". He told the audience that it is believed that in any country in the world today, 2-3 per cent of the population are gay, and unlike in Zimbabwe, homosexuals and lesbians in Botswana are unlikely to face some violent repression. He said many arguments used to explain the phenomenon of gay people is mostly based on hearsay and therefore not convincing. Some people he says use psychoanalysis approach in trying to understand human behaviour and why some people become gay, but said that this approach has suffered heavy criticism that it has not been able to withstand.

According to Raditlhokwa, some people maintained that homosexuality and lesbianism is gained through learning through observation and that it is socially acquired such as in the cattle-posts and in the army in Botswana where boys and young men living without their female counterparts tend to satisfy their sexual needs through acquiring a partner of the same gender.

Others, Raditlhokwa said, argue that the advent of homosexuality may be influenced by subjective experiences to explain the world and after experiencing it, such a person might end up accepting it, while others say that the phenomenon is biologically determined, even though many people still disagree with all these approaches in trying to understand the gay community and its causes.

He said that gay people have to be recognised by the greater society just like heterosexuals to be having similar needs like the need for security, affiliation, self-esteem and self-actualisation and Botswana as a democratic society

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Academic dismisses Mugabe gay rights stance

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must create the necessary climate for these people to develop and fully contribute to the development of the country without hindrance.

Raditlhokwa argued that people tend to choose different ways of fulfilling their needs and that society must appreciate that human kind is unique and of necessity gay people need recognition and confidence to develop and not be stifled because they are different and must be accepted as such.

He said that the reason for pervasive prejudice against gay people in African societies is because they are male dominated and such domination has been institutionalised starting with the family where a man is regarded as head of the family, who "does and knows it all"

He said that in as much as some people find sex to be meant for procreation, they must also put up with those who want it purely for enjoyment in what ever way they prefer. Raditlhokwa challenged leaders like President Mugabe and Moi and all those who deny the existence of homosexuality and lesbianism in Africa saying that due to the patriarchal nature of African societies there was probably never a need to talk about it the past and that since most African languages have names for homosexuality such as "matanyola", it follows that people cannot use a language without an experience to support it. He said that the breakdown in marriages and extended family relationships may be another pointer to increasing societal preference to being gay.

In particular reference to President Mugabe's recent outbursts against gays, Raditlhokwa said that Zimbabwe suffers from an intense cultural phobia similar to the attack on the women's rights movement which is similarly alleged to be a product of cultural imperialism and colonialism. He said that the state in Zimbabwe wishes to present itself as a custodian of culture, but in Botswana there is much less such commitment since the institutional custodians of Tswana culture have collapse and their powers, especially those of the chiefs, have been considerably eroded.

Raditlhokwa felt that there was a need to be sensitive to the rights of gay people as a group and that the correct understanding of democracy is not that the majority must have it all but that even the rights of the minority must be respected.

Sunday Tribune
October 15, 1995 page 15
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Rights are indivisible and apply equally to all

HISTORICALLY development of universal human rights protection instruments has been biased towards Europe and Americas. As a result such mechanisms have been met with mixed feeling amidst individual nations' cultural practices and laws. Central to this, the right to equality and choice enshrined in the constitution could never be realised, unless men and women are allowed to make their own choices regarding sexual orientation.

Recently I followed with keen interest a bit of an interesting debate elsewhere and in local media, which under circumstances raises quite serious questions about our institutions' perceptions as regards human rights for the minority groups in our society. It also raises questions about the society's attitudes towards issues of human rights and also reflects by extension on the future of the human rights in our country.

The exchange was between Ditshwanelo – Botswana Centre for Human Rights, Concerned Human rights activists and the Evangelical Fellowship of Botswana, which I understand happens to represent concert of pentecostal and charismatic churches.

Essentially the debate is about who has rights and who does not have rights. Implicit in the debates is the desirability of human rights in Botswana context and culture. This debate is not concerned about culture but rather with broader questions that interests you as well: should we abandon the minority rights in pursuit of purity and the never existed but so highly claimed moral uprightness? Or should the fact that morality is in the liberal sense, the foundation of society, be used to further disadvantage and exclude certain sections of the community from the mainstream society?

In any society the individual is the social being. This surfaces through the manifestation of his/her life, though it does not appear directly in a communal form but it is accomplished in association of other men and women. This therefore, it is a manifestation and above all an affirmation of social life.

From the onset, one has to accept that like other humans, lesbians and homosexuals have rights, including the basic right; the rights to choose and associate. They also have a right to defend their interests and reject any order imposed on them merely on flimsy basis that some victims of their masters' tongue has run out of creative ideas. The confusion that is apparent from reading Pastor Biki Butale's sentiments is that homosexuality is culture specific.

Homosexuality is as old as mankind. Therefore, homosexuality is and has never been culture specific. It has to be noted also that it is a taboo in our culture to even openly discuss sexuality or even plain sex.

However, it is a fact that in African culture homosexuality is not documented, it only remains in the realm of oral culture. This partly explains why Pastor Biki Butale and his concert fails to make a distinction, hence failing to understand the dynamics of the subject.

In present day Botswana,

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which considers itself to be a liberal democracy, we can rightfully assume that rights are universally indivisible and equally applicable to all citizens. As such it is somewhat contradictory to talk about human rights within any one specific context i.e. Europe or Africa, even Botswana, as these rights are intended to be universal, interrelated, indivisible and interdependent. However, the reality of human rights is not abstract but rather it is prefaced with in particular cultural context, socio-economic order and political values.

I thought it was appropriate that the issue be understood from a historic perspective. Limiting ourselves to the context of contemporary Botswana, which over time it comes to be influenced by other conditions, the notion of individual human rights, if based on natural rights, is not foreign to ancient African societies.

Although political, economic, social, cultural rights were commonly held these were reflecting individual will. This is a matter of principle, which should not be confused with issues pertaining to the evolution of the African societies.

Historically in Bo-tswana, rights were traditionally accorded to those who were members of dominating powerful tribes [*merafe*], itself grounded on social, economic and political background. A careful study of history of minority groups in Botswana reveals that Basarwa and other minority groups are victims of this socio-economic order and political value system. Implicit here is exclusions and prejudice.

Therefore, the socially, culturally and politically invisible have their right to expression suppressed and their identity overshadowed by those of the dominating social groups; the homosexuals and lesbians suppressed by the heterosexuals. There is also a question of power involved here. The early religious social groups used their both religious and economic power to impose their morality on the minority social groups.

Out of this was a systematic pattern of oppressions, denials, exclusivity and loss of identity. If morality was a factor here whose morality and why? The very social classes are informed by various objectives and moods. The criminal law reinforces this position and also reflects that law too is influenced by the objectives, moods and interests of the dominating social classes.

On these bases I wonder if the naive sentiments expressed by "the Evangelical Fellowship of Botswana" warrants a backlash on gays and lesbians in our present day Botswana context. It must be remembered that our success as a nation in this era of human rights, our respect for our culture will be reflected not so much in what we deem desirable, as social classes, but in how we respect values of other previously invisible social classes, and further more, culture will have to be used in solving class conflicts in the 21st century Botswana.

The pastor and his Evangelical Fellowship of Botswana warns that "homosexuality and lesbianism can lead, he says with a bit of uncertainty "to the downfall and destruction of nations as happened to the biblical ancient cities of Sodom and Gomorrah who indulged in the same wicked acts of sodomy and homosexuality".

Implicit in this exposition is the understanding that homosexuality is uncultural, and this raises some critical questions about whose culture? Several issues can be identified and these relate to genetics, human sexuality, social psychology and the potential conflicts between the purists and the dominant sub-cultures, new technologies.

Perhaps one may ask Pastor Biki Butale that why did you and your fellow so-called christians abandon African traditional religion, itself a reflection of African personality, culture and ubuntu in favour of European oriented Pentecostal churches? In my opinion this reflects a "colonised mind".

Another important issue concerns the conflicts between societal morals and individual rights. Unquestionably, society's understanding of human sexuality and human sex is conditioned by a set of ideas which has been created in their home and social environment. Thus they will have very different notions, expectations of and ways of approaching sexual behaviour in the community.

There is a belief that heterosexuality is the only permissible sexual expression in the context of the social practices in which it is acquired and practised. Therefore, the thinking that homosexuality and lesbianism are "sinful and disgusting" seem to encourage exclusion and social prejudice.

Momentarily, I had my own doubts about Evangelical churches in Botswana, which I believe should be fighting social prejudice and playing a pro-active and dynamic role in helping the oppressed. I also wonder whether the Evangelical churches should regard themselves as the moral guardians of our nation.

The class bases of the Evangelical churches poses more serious questions and probably explains their reactionary position. Like abortion and capital punishment the issue of homosexuals and lesbians needs an open and sober debate. It will take us longer than it should, if we base our analysis on feelings and experiences.

Evangelical backlash on gays

By Outsa Mokone

THE Evangelical Fellowship of Botswana, which represents a number of Evangelical, pentecostal and charismatic churches are embarking on an anti-gays crusade. They are fiercely opposing the Botswana gays and lesbians pact with Ditshwanelo which is trying to decriminalise same-sex sexual relations.

In a statement to The Gazette, Pastor Biki Butale, National Secretary of the Evangelical Fellowship of Botswana expressed "disgust" at attempts by gays and lesbians, with the support of "so called pressure groups and foreign elements to have our laws changed to accommodate such animalistic and satanic acts under the pretext of human rights."

The Evangelical Fellowship of Botswana further called on "all christians and all morally upright persons within the four corners of Botswana to reject, resist, denounce, expose, demolish and totally frustrate any effort by whoever to infiltrate such foreign cultures of moral decay and shame into our respectable, blessed and peaceful country."

They warn that homosexuality can lead "to the downfall and destruction of a nation as happened to the Biblical ancient cities of Sodom and Gomorrah who indulged in the same wicked acts of sodomy and homosexuality."

This evangelical backlash follows the May Day meeting of Botswana Gays and Lesbians at Ditshwanelo, the Human Rights Centre where a discussion paper, believed to be Botswana's first gay rights document was put together.

Ditshwanelo, which has thrown its support behind Botswana gays and lesbians will be circulating the paper which opposes the criminalisation of behind closed door sex between consenting homosexuals.

Director of Ditshwanelo Ms Alice Mogwe argues that the criminalisation of consensual same-sex sexual relationship "is not justifiable in an open and democratic society based on freedom and equality."

The Botswana Gazette
May 27 1995 page 2

Kgosi Seepapitso's view on homosexuals

The Midweek Sun 17/6/98 page 5

WHIP OR JAIL THEM

by Billy Kokorwe

BOTSWANA'S traditional leadership this week joined the fray against the decriminalisation of homosexuality saying the law should remain as it presently stands.

And, among four chiefs whose opinion on the subject was canvassed by *The Midweek Sun*, only one felt that homosexuals were being sinned against rather than sinning.

Bakgatla Kgosi Linchwe II lambasted homosexuals as being worse than animals.

"To liken them to animals is an insult," said Kgosi Linchwe.

Bangwaketse Kgosi Seepapitso IV told the *Sun* that people who are gay need to be whipped or sent to jail.

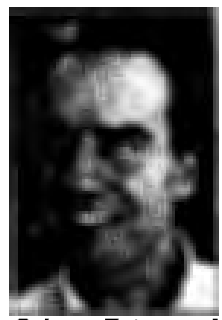
Asked whether it was not wise to ignore homosexual people, Kgosi Seepapitso likened the presence of homosexuals in society to a house that is dirty and whose owner would be irresponsible if he did not sweep it clean.

Kgosi Christopher Masunga advocated that homosexuals be publicly flogged if found within the ranks of any morafe in Botswana, as they are a manifestation of *bothodi* - bad omen.

"It should remain illegal because it is against our morals and, should I find one in the tribe, he would be publicly flogged at the *kgotla* in full view of tribespeople, just as witches of yore were punished."

But Batawana Kgosi Moremi Tawana II said homosexuality was not a new phenomenon in Botswana, as it has been in existence for centuries, though as taboo and saw no reason why homosexuals should be legislated against because of their sexual orientation.

"No one chooses to be gay. They are born that way," said Tawana adding that he believed that the phenomenon arises from genetic coding.



Brian Eaton of Ditshwanelo.

He said he was glad that people had started to deliberate about the phenomenon.

The human rights organisation Ditshwanelo has reacted by dismissing Political Affairs Permanent Secretary in the Office of the President Molosiwa Selepeng's statement that "any civil service employee found practising homosexuality would be charged, prosecuted and, hopefully, convicted after which they would face disciplinary action at work."

"Ditshwanelo trusts that this statement does not reflect the official position of the government. If it does, this would be a regressive step in the development of respect for human rights in Botswana."

"The criminalisation of same sex sexual relations between consenting adults is unlawful, as it is in conflict with the basic human rights principles enshrined in the Constitution of Botswana," Ditshwanelo said.

"Such laws are in conflict with the individual's basic human rights of freedom of association, assembly, conscience, expression, protection of privacy and liberty, all of which are guaranteed in the Constitution."

Ditshwanelo this week called on Parliament to repeal sections 164, 165 and 167 of the Penal Code.

Selepeng however reassured those civil servants who are gay that they would not be prejudiced in their jobs because of their sexual orientation, save when they are actually caught in the commisssion of the act for which they would be charged, prosecuted and, hopefully convicted.

"As far as the government is concerned, nobody is gay in Botswana until he is caught in the act," Selepeng said.

For anybody to come out into the open and admit his homosexuality is not a crime, emphasised Selepeng adding that trouble would only start when such a person is actually caught 'red-handed.'

The people say no to homosexuality

And the government abides by their will

by Sun Reporter

THE Botswana government is a democratic government reflecting majority opinion hence homosexuality remains a crime, says Political Affairs secretary in the Office of the President, Molosiwa Selepeng.

"Homosexual practice remains a crime in Botswana and this reflects the overwhelming majority attitudes in this country," he said, adding that the government cannot take the risk of going against its people's will.

On the question of the human rights lobby's call for the decriminalisation of homosexuality, Selepeng said the lobby does not account to the electorate as they do not reflect the attitudes of organised society.

"Governments, on the other hand, have to act according to the wishes of the people," he said, adding that it remained a crime because the majority of Batswana "find it unnatural and abhorrent."

Selepeng was responding to a *Midweek Sun* questionnaire following a Ditshwanelo commentary on the Penal Code Amendment Act, 1998 which described the illegality of sexual relations between consenting adult, gay men which carries a maximum sentence of seven years imprisonment.

It has, according to the amended Act, now been broadened to include sexual relations between lesbians.

"Criminal law should be used to prosecute rapists and other criminals, but not to discriminate against people on the basis of their sexual orientation," commented the human rights organisation.

Church groups also lambasted the organisation and its protagonises for calling for the decriminalisation of the practice, saying it was importing foreign cultures to the detriment of the indigenous one.

Any civil service employee found practicing homosexuality would be charged, prosecuted and, hopefully, convicted, after which they would face disciplinary action at work, according to Selepeng.

Botswana Democratic Party (BDP) executive secretary Botsalo Ntuane said his party could not even debate the issue of homosexuality as that would shock the Batswana nation.

Homosexuality is a criminal offence and should remain so, according to Ntuane.

Botswana National Front publicity secretary, Paul Rantao, said his party had not yet sat down to discuss the issue.

On a personal basis, Rantao said that while he found the practice unnatural and abhorrent, he did not deem it necessary to legislate against the practice, calling it "*bolgole*" - sickness - which needed to be treated with sympathy and understanding.

Although he thought that it was a natural and biologically determined phenomenon, as a basic it was a mad one.

Botsalo Ntuane of BDP. BDP could not debate the issue of homosexuality.

WEDNESDAY
MAY 27 1998 BOTSWANA'S LEADING MIDWEEK SUN

Churches warn against the decriminalisation of homosexuality

by Sun Reporter

THE Evangelical Fellowship of Botswana this week took the lead in condemning the human rights lobby for advocating the decriminalisation of homosexuality and the setting up of gay and lesbian associations here, according to its national secretary Bekezela Nkomo.

"We call on all Christians and morally-upright people to reject, resist, denounce, expose and totally frustrate efforts by whoever, to infiltrate any such foreign cultures of moral decay and shame," the fellowship's strongly-worded statement reads.

The fellowship, which represents over 500 congregations belonging to the Evangelical, Pentecostal, Charismatic and other Bible-punching ministries countrywide, also lashed out against the Ditshwanelo Human Rights Organisation for seemingly being at the head of calls to decriminalise what they called "sexual perversion" and the establishment of gay and lesbian associations.

"Ditshwanelo is infiltrated by gays and lesbians with the set aim of desecrating traditional African moral values on the altar of perceived constitutional rights," Nkomo told *The Midweek Sun* on Monday.

"All efforts to infiltrate foreign cultures of moral decay and shame into our respectable, lovely, blessed and peaceful country of Botswana should be frustrated," the Pastor said, adding that they had learnt with shock and disgust that such an association to decriminalise homosexuality was being mooted.

"Ditshwanelo needs to draw a line somewhere betwen what is right for them and what is not and, when they try to destroy our culture, we will do everything in our power to stop them," Nkomo said.

Ditshwanelo, however, brushed aside the churches' remarks reiterating its position that the criminalisation of consensual same-sex sexual relations is not justifiable in an open and democratic society based on freedom and equality.

"Criminal law should be used to prosecute rapists and other criminals, but not discriminate against people on the basis of their sexual orientation."

They would, however, not comment on the accusations levelled against them by the churches.

Several attempts to get a comment from the Roman Catholic church which is known for its conservative moral standing drew a blank despite being promised that they were going to comment.

Church of the Nazarene pastor, Lovemore Chikova, said that they do not tolerate perverse sexual behaviour in their church as they believe that it is sinful before God.

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Sodom and Gomorrah

From Page 1 ◁

While they would pray and counsel members who were gay, such members would, however, not be allowed to participate fully in the church's rituals.

He condemned Ditshwanelo for behaving like lawyers who know that their clients have committed, for instance, murder but would still go to court to defend them as if they were innocent.

"It is not normal for a black person to regard gay as the right thing," said Chikova.

United Congregational Church of Southern Africa (UCCSA) Reverend Albert Gaobotse said the decriminalisation of homosexuality would be a violaton of God's supreme law saying that God's outrage against it had resulted in Him destroying the ancient cities of Sodom and Gomorrah during biblical times.

But, the Anglican Church's Diocese of Botswana, Reverend Benjamin Moleko, had a cautious approach to the issue.

He said they were still having a tough debate on the issue in the church and hoped that it would be one of the burning doctrinal issues to be discussed at the Lambeth Conference in July.

He, however, advocated a sympathetic attitude towards homosexuals saying he was, on an individual basis, still grappling with the issue and was trying to find out if homosexuality was acquired or a result of a genetic make-up.

He would not excommunicate homosexuals from his church and, while he knew of no one of such sexual preference within the church, he reckoned that there were some in other countries.

Botswana Christian Council senior programmes officer, Simon Makgowe, said the council has not formulated a policy position with regard to homosexuality as its member churches have not yet brought the issue to their attention.

The Midweek Sun
May 27 1998 page
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