Health advocacy on the margins: human rights as a tool for HIV prevention among LGBTI communities in Botswana

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Abstract
ABSTRACT

Human rights discourse in health advocacy is largely correlated with experiences of vulnerability, marginalisation and discrimination, with the global story of HIV activism the most visible example. In a domestic context where culture, consensus and belonging are highly valued, both human rights and lesbian, gay, bisexual, transgender and intersex (LGBTI) people face critiques of being foreign, un-African, new, individualistic and threatening to tradition. Why, when and how do civil society actors draw on human rights to advocate for LGBTI health in relation to HIV in Botswana? I examine this paradox through a case study of the key civil society actor in this sector. I argue that while formal structures and belief shape why the group engages with human rights, when and how human rights are invoked is shaped by perceptions of threat, cultural context, and belonging.

KEYWORDS: Human rights, civil society, Botswana, health, LGBTI

Internationally, human rights discourse in health advocacy is largely correlated with experiences of vulnerability, marginalisation and discrimination, with HIV activism the most visible example. Rights-based health advocacy appears to be more common where health status or access to health care can be linked to an identifiable and marginalised group, identity or behaviour, usually beginning with a rights-based claim to non-discrimination in access to information, prevention, or care. Despite its correlation with these trends, the use of human rights-based advocacy on HIV in relation to LGBTI[1] populations in Botswana is an unusual and unexpected choice. In a domestic context where culture, consensus and belonging are highly valued, both human rights and LGBTI people are critiqued as foreign, un-African, new, individualistic and threatening to tradition.

Why, when and how do civil society actors draw on human rights to advocate for LGBTI health in relation to HIV in Botswana? Why do advocates regularly choose an advocacy frame that duplicates domestic critiques and challenges that are levelled at the population for whom they advocate? I examine this paradox through a case study of the key civil society actor in this sector, the Botswana Network on Ethics, Law and HIV (BONELA) and its Lesbians, Gay and Bisexuals of Botswana (LEGABIBO) program (now an independent organisation).[2] I argue that two critical factors shape why the organisation makes this choice: organisational legacy, and a belief in the human rights frame and its specific purpose of highlighting marginalised groups. While formal structures and belief shape why the group engages with rights, I argue that *when* and *how* BONELA and LEGABIBO invoke human rights is shaped by perceptions of threat, cultural context, and belonging. The health threat posed by HIV is seen as catastrophic enough to allow some opening in the discussion of marginalised sexualities, including targeted public health advocacy and initiatives. In this context they conceptualise and articulate both human rights and public health in ways that emphasise belonging and connection.

This paper begins by contextualising the research question by locating it in reference to the international theoretical context. This broad context is followed by a discussion of critical facets of the domestic setting including human rights, HIV and LGBTI issues. Next, the paper outlines the research methodology and the organisations. A final section offers analysis and conclusions.

Theoretical context

As this research seeks to examine whether and how global phenomena transfer to the context of Botswana, this section outlines theory in relation to three areas: framing, human rights as a frame, and human rights as a frame in health.

Defined as 'conscious strategic efforts […] to fashion shared understandings of the world and of themselves that legitimate and motivate collective action' (Snow as quoted in McAdam, McCarthy, and Zald 1995, 6), framing offers insight into the internal processes of civil society groups. Key features affecting frame formulation and selection include 'political opportunity structure, cultural opportunities and constraints, and the targeted audiences' (Benford and Snow 2000, 628). While advocacy language such as human rights must be viewed as international in order to be 'politically powerful', in order to function effectively they must also 'challenge' and 'resonate with existing ideologies' so as to grain traction (Levitt and Merry 2009, 457).

Why then, might groups choose to frame their claims as human rights? Supported by a foundation of universality, they call upon a sentiment of solidarity, and are useful as a rallying call. The rights frame has also been used to recategorise issues, increasing their profile and facilitating international networking (Bob 2007, 167–193; Carpenter 2007, 199–120; Forman 2008, 37–52). It also wields potential legal enforceability (Gloppen 2008, 21–36) and 'normative power' (Forman 2008, 40). The power of rights also explains why groups might deliberately avoid it. Structured around blame and violation, rights are far more threatening than frames based on charity or development. Rights can also be seen as ill-fitting foreign imports. In the African context rights are sometimes described as overly individualistic and incompatible with more collective African values. Southern Africa's *ubuntu*/*botho* [3] has been both contrasted with and equated to human rights (Cobbah 1987, 320).

Why health advocates draw on the human rights frame is intimately linked to experiences of marginalisation and discrimination. Although rights have long been applied to health,[4] the HIV pandemic is its most visible global application (Gruskin, Mills, and Tarantola 2007). Globally, most early prevention campaigns employed scare tactics, with the unintended effect of fuelling discrimination against those already living with the virus (Mann and Tarantola 1998, 5; Mann 1999). In response to these layers of discrimination, human rights were increasingly highlighted as an essential component of HIV responses, linking marginalisation not only to discrimination in access to care, but also to increasing risk of infection.

The use of human rights by African LGBTI groups is linked to lived experience of exclusion, violence and marginalisation, with 'personal experience of rights violations' as critical 'motivators of activists' (Theron, McAllister, and Armisen 2018). Human rights can also help address health alongside broader contextual factors. Beyrer et al. found that 'addressing discrimination in health care access, ensuring protection and not harassment as policing policy, and decriminalizing same-sex behaviour' increases service uptake and consequently reduces new HIV infections (2011, 310). Theron et al raise concerns, however, noting that the focus on the rights framework 'contribute[s] to invisibilize the lives of previous generations' and the 'shaping of the early African queer/LGBTIA+ movement' around 'HIV management' reflects donor rather than local priorities and replicates structures of inequality by focusing primarily on gay and MSM (men who have sex with men) men (2018).

National context

Civil society

Although Botswana civil society is diverse, active and generally free, it is frequently described as 'weak' (Holm et al as cited in Somolekae 1998, 5). While there are notable exceptions, Botswana civil society does not typically hold demonstrations, confront overtly, or criticise government directly. As local civil society groups argue, this approach to defining a 'strong' civil society may limit the appreciation of how civil society operates differently in small consensus-oriented societies. In a country of 2.25 million people, government and civil society actors often know each other personally and this shapes their interaction. Dialogue is the dominant approach, with concerted efforts made to include all parties, a process described as 'mutual criticism in each other's presence' (Maundeni 2004). Rights-based civil society groups are uncommon, with two main groups (BONELA and Ditshwanelo – The Botswana Centre for Human Rights (Ditshwanelo)) filling this niche. The NGO sector has played a major role in responding to the HIV/AIDS pandemic and is largely supported by foreign donors. Botswana became a middle-income country in the 1990s, and an upper-middle income country in 2003, both advances that resulted in the departure of some funders (Phaladze and Tlou 2006, 32–33), a withdrawal exacerbated by the 2008 recession.

Human rights

Botswana has ratified most major United Nations and African Union human rights treaties.[5] The constitution's bill of rights recognises a range of civil and political rights including the right to non-discrimination. In relation to health, however, there are notable omissions. Botswana has not ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), which codifies the right to health.[6] Although Botswana has a national health service and was at the vanguard of fee-free citizen access to HIV medication in Africa, the right to health care is not legally secured.

More broadly, human rights discourse is not prominent in official government statements or documents, nor in the larger Botswana society. Although little writing has been done on perceptions of human rights in Botswana, literature on African perspectives of human rights place greater emphasis on the individual's relationships and duties within the group, what Cobbah terms 'a conception of man in society' (1987, 318, 320). The right to 'become part of the group' (Howard 1980, 731) is often emphasised, with freedom conceptualised as 'belonging rather than autonomy' (Englund 2004, 17). Some Batswana human rights activists view human rights as a synonym to *botho* and interpret human rights in ways that reflect core aspects of this concept (ie belonging and mutual respect) (Kenyon 2015, 2019).

HIV in Botswana

The HIV pandemic has had a significant impact since the mid-1990s. Botswana has since reported some of the world's highest prevalence, with recent estimates for those aged 15–49 at 20.3% (UNAIDS 2018). In Botswana HIV is a generalised pandemic affecting every community and nearly every family in the country. This pandemic has reduced life expectancy by more than twenty years, and has had a dramatic effect on all aspects of society, including labour shortages, budget allocations, and social norms. HIV/AIDS is considered a multisectoral issue, with coordinators in every government ministry, and the National AIDS Coordinating Agency working to link initiatives in different sectors.

Government, donors, and civil society groups have actively addressed the pandemic, with a fee-free national anti-retroviral programme for citizens and free testing sites throughout the country. Nevertheless, gaps in access to information, modes of prevention, and treatment continue to exist with regard to: remote populations (such as the San), sexual minorities[7], sex workers, prisoners, people with disabilities, non-citizens, and refugees. In 2012 Botswana first established baselines to guide prevention for 'key populations' including men who have sex with men (MSM) a group for whom health services and prevention initiatives were having a limited reach (Botswana Ministry of Health 2013). This document noted the need to 'improve[e] the legal environment for marginalized populations' including MSM (Botswana Ministry of Health 2013).

LGBTI context in Botswana

LGBTI individuals in Botswana face a number of challenges that affect their ability to enjoy their health and other rights. Despite increasing visibility and targeted health interventions, arguments that LGBTI people are non-existent or foreign-influenced persist. Although there are well-known gay hangouts and LGBTI people, sexual minorities continue to be marginalised and understood as 'other' in relation to dominant religious and cultural beliefs. While some 'claim [homosexuality] is 'unAfrican' and was brought by whites' (Olivier as quoted in Fombad 2004, 167) others counter with the existence of Setswana terms to refer to LGBTI people (McAllister 2012, 96). McAllister (2012) argues that the existence of non-heterosexual relationships in pre-colonial times indicates that the 'unAfrican' argument may be based on 'resentment of the Western cultural dimension of gayness' which has been depicted in media as 'decadent, hedonistic and anti-family' (90).

In a society that highly values belonging and social and familial networks, LGBTI people often face social isolation and stigmatisation (Selemogwe and White 2013; Jacques 2014) which can result in expulsion from family homes, loss of social and support networks (LEGABIBO 2013) job loss and even physical assault (Fombad 2004, 167). The print media have periodically ambushed private parties, posting photos, names and cell phone numbers of attendees. LGBTI people are also financially vulnerable due to inheritance, loan, and financial structures formed around heterosexual marriage. Although social barriers persist, there are indications of change including popular songs and festival performances highlighting LGBTI people and relationships, and changing attitudes. While little data is available on attitudes towards transgender and intersex people, in a 2016 poll 43% of Batswana said they would 'like' or 'not care' if they 'lived next to homosexuals' with higher rates among youth and those with higher levels of formal education (Dulani, Sambo, and Dionne 2016).

Despite predominantly heterosexual transmission, sexual minorities have attained a higher level of visibility in Botswana largely due to increasingly inclusive HIV interventions. LGBTI people in Botswana, however, continue to face specific challenges in accessing health care and information and methods of HIV prevention. Cultural and social disapproval have direct health impacts (Ehlers, Zuyderhuin, and Oosthuizen 2001, 848). Sexual minorities report high levels of distress (Ehlers, Zuyderhuin, and Oosthuizen 2001), including elevated levels of suicidality and substance abuse among MSM (Selemogwe and White 2013). Denial of sexual identities and practices inhibits open communication with health care providers (Selemogwe and White 2013) and is linked to HIV infection among MSM (Phaladze and Tlou 2006). Researchers recommend '[e]nhanced collaboration between health professionals and human rights activists' to improve 'quality of life' for LGBTI people (Ehlers, Zuyderhuin, and Oosthuizen 2001, 848) and note a need for targeted HIV/AIDS interventions that respond to their needs (Selemogwe and White 2013).

LGBTI legal context

The legal context of LGBTI rights has changed dramatically with all legal prohibitions against same sex sexual activity declared *ultra vires* in June 2019.[8] As research was carried out prior to this landmark decision, this section provides a historical chronology. At the time of research, section 164 of the penal code prohibited 'carnal knowledge against the order of nature' providing for up to seven years in prison and, under section 165, five years for 'attempts'. Section 167 criminalised 'gross indecency' 'whether in public or in private'. Both were categorised as 'unnatural offences' under the broader heading of 'offences against morality' which also includes rape, defilement, incest, prostitution, abortion, and indecent assault (sections 141–171). These provisions have their roots in British influence and are identical to those of many other former British colonies and protectorates.

While infrequent, there have been prosecutions related to sections 164 and 167. In Kanane vs. The State, the High Court ruled in 1995 that the Constitutional rights to freedom of expression, association and privacy could be limited for reasons of public morality, elaborating that 'sexual liberation has been a social, spiritual and physiological disaster' that harmed both individual and society. While distancing themselves from the above statement, the Court of Appeal 't[ook]: judicial notice of the incidence of AIDS' and noted that the legal provisions 'reflect[ed] a public concern' adding that social attitudes did not reflect 'liberalisation of sexual conduct by regarding homosexual practices as acceptable conduct' but rather 'show[ed] a hardening of a contrary attitude' (Kanane v the State 2003). Tabengwa and Nicol note that the use of AIDS to contextualise these provisions implied that the Court saw a connection between the spread of HIV and same sex sexual activity (Tabengwa and Nicol 2013, 343).

In 1998 the government conducted a review of all laws pertaining to women aiming to eliminate discriminatory provisions (Botswana Ministry of Labour and Home Affairs). As a result, male pronouns and references to 'male persons' were amended to be gender neutral. This ostensibly progressive initiative expanded the criminalisation of same sex sexual activity to apply in an equally punitive manner to women who have sex with women. Affirming these changes, then vice-President Seretse Ian Khama noted that, 'human rights are not a license to commit unnatural acts which offend the social norms of behaviour' noting that homosexuality was illegal whether in public or private or between men or women (Midweek Sun as cited in Human Rights Watch 2003).

Between 2010 and 2018, there was a softening towards sexual minorities. Former President Festus Mogae stated that when in power he advised police not to enforce section 164 (BBC 2011). Once out of office he admitted that he did not change the law while President as he 'was not willing to lose an election on behalf of the gays' and felt society needed to change first (SAPA-AFP 2011). He explained '[w]e do not want to discriminate. Our HIV message applied to everybody' noting that while he did not understand homosexuality, 'there are men who look at other men. These are citizens' (SAPA-AFP 2011). At the behest of BONELA and LEGABIBO (Sunday Standard 2016), the Employment Act was amended in 2010 adding 'health status' and 'sexual orientation' to the list of prohibited grounds for dismissal (ILO n.d.). In 2010, then President Ian Khama made the distinction between identity and sexual behaviour noting, 'I don't think being gay is illegal. If you see someone and you know that they are gay, they are not going to be arrested and charged [even though] there are certain acts, which are performed by such people, which are illegal' (The Voice, as cited in McAllister page 2012, 92). In March 2016 a motion at the Gaborone City Council received unilateral support recommending lobbying for the decriminalisation of same-sex sexual activity, calling for increased LGBTI inclusion in HIV/AIDS interventions and, training of health care providers with respect to LGBTI health (LEGABIBO 2016).

In September 2016, a pastor from the US-based Westboro Baptist Church, well-known for its homophobic actions and rhetoric, was ordered deported from Botswana with then President Ian Khama explaining 'We don't want hate speech in this country' (Reuters 2016). In 2018 President Mokgweetsi Masisi raised the plight of same-sex couples when speaking at the annual Sixteen Days of Activism Against Violence on Women and Children. He stated: '[t]here are also many people of same sex relationships in this country, who have been violated and have also suffered in silence for fear of being discriminated' adding '[j]ust like other citizens, they deserve to have their rights protected' (Igual 2018).

After a lengthy delay, on 11 June 2019 The High Court of Botswana unanimously struck down all elements of the Penal Code criminalising same sex sexual activity in Motshidiemang v Attorney General (2019), with LEGABIBO acting as *amicus curiae*. Pronouncing that 'this Court shall interpret our Constitution as a living and dynamic charter of progressive human rights' (76,78) the court found Sections 164(a), 164(c) and 165 of the Penal Code *ultra vires* to sections 3 (fundamental rights), 9 (privacy) and 15 (non-discrimination) of the Constitution. The judges argued that 'over regulation' of sexual activity impaired 'Constitutionally ordained, promised and entrenched fundamental rights' (3). Deeming privacy 'essential to who we are as human beings' (113) the court determined that it was 'inviolable' (114) according to Botswana's domestic and international human rights commitments. The court found existing provisions 'impair[ed] the applicant's right to express his sexuality in private with his preferred adult partner' (127).

Judges concluded that 'sexual orientation is innate to a human being' as it is an 'important attribute of one's personality and identity' consequently '[t]he right to liberty therefore encompasses the right to sexual autonomy' (142). On the basis of this reasoning they found Motshidiemang's 'liberty has been emasculated and abridged'. The court determined that dignity had been impugned as sexual intercourse 'constitutes an expression of love and intimacy' (150) and denial and criminalisation of the ability to participate in this expression 'violat[es] his dignity and selfworth' (157). The court decided that the word 'sex' in section 3 of the Constitution was 'wide enough to include sexual orientation' citing similar interpretations in other jurisdictions and in the ICCPR.

Judges gave scant attention to the issue of public interest and morality. Finding that 'criminalizing consensual same sex in private between adults is not in the public interest', the court noted that there was no victim, asking 'should private places and bedrooms be manned by sheriffs to police what is happening therein?' (189). Referencing the national Vision 2016 describing Botswana as a 'compassionate, just and caring nation' the court posited that discrimination 'pollutes compassion' (198). In addition to striking down sections 164(a), 164(c) and 165 of the Penal Code the court 'severed and excised' the word 'private' from section 167 so as to limit 'gross indecency' to public acts, and ordered the respondent to pay the applicant's costs.

Methodology

To examine the question why, when and how Botswana civil society actors draw on human rights to advocate for LGBTI health in relation to HIV I focus on the dominant actor in this sector – BONELA and what was, at the time of research, its LEGABIBO program. To better understand BONELA's advocacy choices I conducted semi-structured interviews with eleven employees,[9] as well as with other relevant actors in Botswana.[10] Participants were selected with the aim of a representative sample across areas of work. I employed a combination of inductive and deductive research with interview questions formulated based on related literature, past experience in the field,[11] and informed by emerging themes. I applied

qualitative coding using atlas.ti using inductive and deductive codes which were then used to sort interview data according to themes.

Organisational context: BONELA and LEGABIBO

BONELA and LEGABIBO are strongly influenced by Botswana's legal and epidemiological context, with discrimination and the HIV pandemic playing critical roles in the formation, structure and orientation of both groups. Both groups also share a common genealogy – having originated as programs of Ditshwanelo, the country's sole broad-based human rights organisation. This genealogy largely explains the initial choice to employ the human rights framework.

BONELA

In 2001 BONELA was inaugurated as a Ditshwanelo program as a joint initiative of the United Nations Development Program and the Botswana government. BONELA was explicitly founded to be a human rights-oriented group, and its sole initial employee and Founding Director came to the position a human rights orientation. Founding Director Christine Stegling noted that BONELA used a human rights approach because it was 'set up like that from the start' and influenced by an emerging international policy framework that favoured human rights. The organisation's mission includes an explicit reference to human rights, stating:

BONELA's activities are aimed at ensuring that ethics, the law and human rights are made an essential part of the national response to fighting this pandemic in Botswana … . (BONELA website)

The organisation has five areas of principle programming: education and training, legal assistance, a media campaign, advocacy, and research (BONELA website). Its listed areas of advocacy include: (1) HIV/AIDS and employment, (2) testing, confidentiality and informed consent, (3) sexual and reproductive health rights for women living with HIV, (4) HIV and human rights in relation to people with disabilities, (5) access to condoms in prisons, and (6) access to health care and human rights for gay, lesbian, bisexual and other groups marginalised on the basis of sexuality (BONELA website). Initially focusing on non-discrimination, confidentiality, access to services, stigma and unfair dismissal the organisation has, over time, shifted towards specific vulnerable populations such as sex workers, prisoners, refugees and undocumented migrants and sexual minorities.

Based in Gaborone, BONELA had expanded to more than twenty-five employees by 2010, faced funding cuts that led to staff layoffs, and has gradually grown back to this number. BONELA has become a network organisation with a reach throughout the country and linkages with likeminded organisations throughout Africa and the world. At the time of research it housed LEGABIBO and Sisonke (a sex worker's rights organisation).

LEGABIBO

In 1998 a group of people gathered under the name LEGABIBO as a project of human rights organisation Ditshwanelo (LEGABIBO 'Current Situation Summary'). Initially an informal gathering of 10 people, the group aimed to overcome the isolation faced by LGBTI Batswana (Mmolai-Chalmers and Meerkotter 2016). Facing limited resources alongside 'constant homophobia, stigma and discrimination' the group ceased to meet until 2004 when it

regrouped under BONELA's auspices (Mmolai-Chalmers and Meerkotter 2016). As LEGABIBO mobilised it sought to register as an independent civil society organisation under the Societies Act. More than two years after filing to register, the application was rejected in September 2007 on the basis that 'the country's constitution does not recognise LGBTIs' and the Societies Act (7(2)(a)) prohibits the registration of a society which 'is, or is likely to be used for an unlawful purpose or any purpose prejudicial to or incompatible with peace, welfare or good order in Botswana' (as quoted in Tabengwa and Nicol 2013, 352).

A subsequent attempt to register in 2012 met with a parallel result despite an appeal (Mmolai-Chalmers and Meerkotter 2016, 94–97). Arguing that this denial was in violation of Constitutional rights to equality, association and expression, LEGABIBO supporters took the case to the High Court in April 2013. Once able to legally operate they aimed to 'provide an opportunity for lesbians, gays and bisexuals to form part of an association which will provide them with information on human rights and advocate for their rights, particularly the right to access to health services' (Southern Africa Litigation Centre 2013). The group argued that the failure to register was based on 'moral disapproval' rather than legitimate objections (Southern Africa Litigation Centre 2013).

In November 2014, the High Court found in favour of LEGABIBO, determining that the group was legally entitled to register as an organisation, noting that 'there is no provision' of the Constitution that 'expressly states it does not recognize homosexuals' and that 'it is not a crime for one to be attracted to people of one's own sex' (Rrammoge 2014). Separating behaviour from identity, the court determined that the prohibition of 'engaging' in same-sex sexual activity did not extend to prohibiting 'being' attracted to others of the same sex. This decision was appealed by the Attorney General and supported by several religious groups but was upheld on appeal in March 2016 (Groundup Analysis 2016). LEGABIBO registered and officially opened their new premises in July 2017.

Analysis: why, when and how

If the organisational genealogy and leadership provided the explanation for BONELA and LEGABIBO's initial human rights orientation, this orientation was affirmed and cemented through changes in leadership, and by the recruitment or socialisation of a workforce with a strong personal investment in human rights. In interviews respondents typically explained the use of the human rights frame as based in passionate personal belief (see Kenyon 2017). Human rights were described as 'inherent to existence as a human being' and 'the reason we exist'.[12] Former employees, board members and affiliates also advocated a human rights approach and tended to continue working in this vein, indicating that the belief in this concept, whether it came before or through BONELA, appeared sincere rather than strategic.

BONELA respondents understood a human rights approach as one that necessitates a focus on those left out of mainstream HIV interventions. An emphasis on marginalised populations formed the bulk of press coverage of the organisation's activities and was described as central to the organisation's work by virtually all respondents. Five respondents noted that a human rights approach increases the likelihood of, or inherently entails, addressing 'different or sensitive issues'[13] particularly those pertaining to vulnerable populations. One respondent explained how a human rights approach involves highlighting the issues affecting specific groups, stating:

> BONELA is set up to bring in a human rights response or to strengthen a government's response to HIV through the human rights approach which mainly brings the government's attention to populations that are marginalised because of

> what they are or who they are and what they do, which in Botswana are mainly men who have sex with men, sexual minorities – basically, you know gay, lesbian and sex workers – so that HIV interventions reach them as well.[14]

Respondents reflected interplay between the specific (human rights being more necessary or appropriate for identified vulnerable groups) and the universal (human rights is useful because it applies to everybody). Several respondents noted that a human rights approach's main feature was that it 'concerns everyone',[15] while elaborating that this universality actually served to highlight groups neglected by other approaches. Non-human rights approaches, one respondent argued, 'tend [..] to look at a certain group of people that we consider normal and forget that other people are there' while 'human rights calls for reality … we do have people with disabilities, we should look at LGBT, look at sex workers'.[16] One person identifying as an LGBTI activist who has had interactions with BONELA's LEGABIBO programme noted that 'an LGBTI person is a human, right, before an identity', and if 'the government is saying 'I'm providing interventions for human beings' then an LGBTI should be in the position to access those, but if they are not there then it's a human rights issue'.[17] The cited benefits of a human rights approach to the populations noted included accessible and relevant prevention, treatment and care;[18] enabling the population to 'protect themselves' by becoming 'empowered enough to own their rights, know their rights and to articulate them';[19] and facilitating the participation of populations in developing programmes relevant to them.

How BONELA employed human rights in LGBTI advocacy mirrored the cultural importance of belonging and *botho* reflecting an understanding of human rights as the 'right to belong'. BONELA often drew on the theme 'we are all in this together' to gain support for marginalised sexualities, including posters with a child asking their parent 'would you still love me if you knew I was gay?'. They highlighted familial connections, emphasising that LGBTI Batswana are a 'part of' rather than 'apart from' families, communities and Botswana society.

Even though the majority of respondents favoured, and claimed BONELA used, a rights-based approach, there was some jockeying between the prominence of human rights and public health in each campaign. This involved negotiating political and cultural sensitivities around LGBTI issues and the threat posed by the HIV pandemic. Two BONELA respondents noted that it was challenging to engage with the public using human rights language with reference to same-sex relationships. One respondent noted, 'that what I perceive to be my right may be what someone else perceives to be […] taboo'[20] while another adding 'you are also fighting cultural tendencies'.[21] Pragmatically, working collaboratively on these issues was seen as difficult where other NGOs 'would rather not be seen at the forefront'.[22]

When addressing particularly sensitive topics BONELA was more likely to 'retreat' to a public health-emphasising discourse. Several respondents specifically highlighted the importance of focusing on marginalised groups to achieve a comprehensive response to the national HIV pandemic. In several instances this point was made by emphasising the connections between target groups and the larger population noting 'we are having interactions with them'.[23] Even among those who strongly favour rights language, the argument was often made that not only do LGBTI people have a right to prevention and treatment but that ignoring this population would also put the majority at risk. One person, who had worked with a group nested within BONELA, noted interaction is the critical point to highlight to buy-in by government and the broader community. Speaking hypothetically to these audiences she said:

> So, what should be your interest in this? You might in one way or another have contact at one point, or have a link at one point with someone who practices gay sex,

> which we know scientifically is more risky than heterosexual sex, so our interest then should be to protect all of ourselves by making sure that these guys are covered.[24]

This comment highlights and acknowledges interaction between sexual minorities and the broader population and puts forward the idea that there is an understood shared health risk.

Most BONELA respondents saw human rights and public health as complimentary, and in several cases, understood public health as a subset of human rights. The manner in which BONELA invoked both human rights and public health reflected similar cultural values of belonging and inclusion. While human rights were predominantly interpreted as 'the right to belong', an epidemiological inclusion was prominent in more public health-influenced approaches. Such approaches emphasised that LGBTI Batswana are part of social and sexual interactions and Botswana society, regardless of whether they are acknowledged as such by communities or political leaders.

Conclusions

For BONELA, human rights language is an organisational legacy that continues to be consciously and deliberately chosen. The organisation has shifted over time to deal primarily with specific marginalised groups, particularly the LGBTI community. While producing a number of publications highlighting the issues facing LGBTI Batswana, BONELA focuses on access over identity, at the same time drawing on arguments melding human rights and public health.

When conducting health advocacy with respect to sexual minorities BONELA is engaging with two societal perceptions of threat. First, the LGBTI community is viewed as threatening to families and morals because some view them as defying tradition, culture and family structure. Sexual minorities, when acknowledged, are sometimes dismissed as foreign-influenced, and portrayed as modern and new people that Botswana is 'not yet ready for'. The HIV pandemic, however, is viewed as threatening to the country's survival. Of the two, government action suggests that the latter is seen as a more serious threat. This has opened room for dialogue related to public health and criminalised populations in the interest of the public good. BONELA's work with marginalised groups benefits from the umbrella of HIV and aims to bring these groups into the fold of the national response.

Rights are seen as 'politically powerful' (Levitt and Merry 2009, 457), but can be threatening, particularly when used to address sensitive populations. As Epprecht (2012) argues, there are a variety of sensitivities and exigencies to navigate when conducting health LGBTI advocacy in Africa. In a context where consultation and consensus are socially and politically important, the power of rights can inhibit rather than facilitate dialogue. While BONELA explicitly understands its work in relation to sexual minorities as rights-based, it does not always exclusively use this frame in government-oriented advocacy, instead strategically merging it with a public health approach. When down to brass tacks the argument of epidemiological inclusion prevails – that LGBTI Batswana are part of society, that they are part of sexual interactions and that ignoring this population will threaten the collective. This argument is a double-edged sword, while often effective in broadening HIV interventions it holds stigmatising potential for LGBTI people who are implicitly depicted as health risks to the broader population.

Like LGBTI people, human rights are often depicted as foreign, un-African or contrary to core cultural principles. In invoking human rights, BONELA deliberately draws on cultural concepts and values to situate, contextualise and interpret human rights. Instead of articulating human rights as a 'right to be different', BONELA describes them as a right to belong or 'become part of the group' (Howard 1980, 731). Just as Setswana terms for LGBTI

people are used to localise sexual minorities, *botho* is used as a way of culturally anchoring human rights and insisting that, '[o]ur ancestors have been singing this song forever' (see Kenyon 2015, 116). Jacques' (2014) turn of phrase 'coming out or coming in' could be applied here to represent LGBTI advocacy as a desire to 'come in' to Botswana society and be seen as 'part of' rather than 'apart from' the group.

For BONELA human rights are understood as both universal ('we are all the same') and specific (used to draw attention to specific groups). BONELA used the idea that 'we are all in this together' to gain support for marginalised sexualities and reflect cultural concepts of inclusion, respect and *botho.* Like human rights, *botho* applies to all humans, with BONELA personnel rejecting that idea that individual behaviour could exclude an individual from either one (Kenyon 2015). This inclusive perspective is applied to LGBTI populations in Botswana even in the face of criminalisation and is reflected in aspects of the state's response. Mogae's statement, for example that these 'men who look at other men', are nonetheless 'citizens' affirms that their behaviour does not exempt them from belonging to the community of the state.

In the time that has passed since this research was carried out Botswana has experienced change that is at once incremental and dramatic. LEGABIBO is now an independent organisation which continues to employ the human rights frame within and beyond the health sector as they tackle a broader mandate of LGBTI rights. Human rights language is no longer only applied to LGBTI people in the context of HIV in Botswana. Human rights were referenced liberally and meaningfully in the Motshidiemang decision. In this judgment the consequences of the Penal Code on the health and well-being of LGBTI people was considered within a human rights framework, and an inclusive interpretation of the Constitution's Bill of Rights was used to protect dignity, liberty and equality. Similarly, HIV and health are no longer the only contexts in which this long overlooked population is mentioned and importantly, where health is mentioned, the health of LGBTI people *themselves* is foregrounded rather than their potential impact on 'population health'. The Motshidiemang case has already been referenced as a 'landmark' that 'sets a precedent on which other African courts can rely' (Viljoen 2019).

LEGABIBO personnel noted that the ability to show evidence of societal change, as well as concrete harm perpetuated by the law were critical factors in the June 2019 decision, as were parallel changes elsewhere in the world and Botswana's international human rights commitments.[25] While celebrating legal victory, they also note the need for concurrent social change, noting 'now the law has moved so fast and our work is to ensure that the community moves fast enough to catch up with the law' (Youngman as quoted in Fleischmann and Chadwick 2019).

Despite many changes some elements of past strategies remain. In a LEGABIBO press release heralding the decision, LEGABIBO Chief Executive Officer, Anna Mmolai-Chalmers stated:

> It has taken a long time for our community to be where it is. This incredibly life-changing decision, although it does not right all the wrongs done to individual members of the LGBT community, is a step towards restoring our dignity as human beings. The decision has several implications for the LGBTIQ community. Not only does it provide legal affirmation and recognition of the rights of LGBTIQ persons, but it allows an important space for addressing public health more efficiently and effectively. We can finally start building a more tolerant society. The real work starts now. (LEGABIBO 2019)

While emphasising the broad and profound impact of this judgment on LGBTI/LGBTIQ Batswana, Mmolai-Chalmers draws on a familiar technique of emphasising both human

rights and public health in a comment that moves between individual and collective rights, and traces different forms of belonging (community, society) and recognition (social and legal). Does health continue to be an olive branch, offering an ‘important space’ to broaden the dialogue to include those in society who have not yet kept pace with Botswana’s legal change?

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

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Notes

1 LGBTI is used here as it is the acronym in use by the group studied, in Botswana and in much of theregional literature. It is important to note, however, that the majority of LEGABIBO’s work, including that analysed in this article deals with lesbian, gay and bisexual health as well as health of men who have sex with men and women who have sex with women who do not identify with these labels. As a wide variety of acronyms are used globally, variations are made in the text where indicated in quotations.

2 This paper was initially submitted in May 2016 based on research carried out in 2010, since that time LEGABIBO has officially registered as an organisation and the legal landscape in Botswana has radically changed.

3 A relational concept that has been explained as ‘people are people through other people’ (South African white paper as cited in Louw 2006, 161).

4 See e.g. the Declaration of Alma Ata and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

5 For e.g. Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Elimination of Racial Discrimination, Convention against Torture, International Covenant on Civil and Political Rights.

6 The right to health is also recognised in CEDAW and the CRC but only in reference to each convention’s target population.

7 A term used in Botswana to refer to LGBTI people.

8 There are no specific laws related to transgender and intersex people.

9 Including nine current and two former staff members.

10 Interviews were also conducted with government at local and national levels (nine interviewees), UN agencies (one interviewee), other NGOs both domestic (four interviewees) and international (three interviewees), development partners (two interviewees).

11 I worked with BONELA from 2004 to 2006 as the Human Rights Research Officer.

12 Author's interview, Program Manager, BONELA, 28 June 2010, Gaborone, Botswana.

13 Employee 4. 2010. BONELA, Gaborone, Botswana. Interview by author, June 29.

14 Mmolai-Chalmers, Anna. 2010. BONELA, Gaborone, Botswana. Interview by author, June 29.

15 N. Kumbawa, Doris. 2010. BONELA, Gaborone, Botswana. Interview by author, June 30.

16 Employee 3. 2010. BONELA, Gaborone, Botswana. Interview by author, June 29.

17 Mogapi, P. Skipper. 2010. LGBTI activist in Botswana, Gaborone, Botswana. Interview by author, June 29.

18 Often cited were problems in access to condoms for sex workers, discrimination by health care workers towards sex workers, inadequate access to information and prevention materials for men who have sex with men, and stigma and discrimination in all sectors in relation to these and other marginalised sexual groups.

19 Employee 3, 2010. BONELA, Gaborone, Botswana. Interview by author, June 29.

20 Kumbawa, op. cit. 16.

21 Mmolai-Chalmers, Anna. 2010. BONELA, Gaborone, Botswana. Interview by author, June 29.

22 Uyapo Ndadi, BONELA, Gaborone, Botswana. Interview by author, June 27.

23 Ibid., 19.

24 Author's interview, Diana Meswele, Human Rights Activist, 13 July 2010, Gaborone, Botswana.

25 Personal communication, LEGABIBO employee 13 June 2019.

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