

The well-being of gays, lesbians and bisexuals in Botswana

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Aims. To investigate the level of well-being of gays, lesbians and bisexuals (GLBs) in Botswana, how this level of well-being could be promoted and whether their health care needs were met by health care professionals.

Rationale. It is illegal to engage in same-sex activities in Botswana, punishable by imprisonment. Although Botswana's citizens have one of Africa's best health care systems, little is known about the health status, health care needs and general well-being of Botswana's GLBs. This survey attempted to uncover some of these potential health care needs, impacting on the GLBs' well-being.

Design/methods. The research framework adopted was the health and human rights approach, placing dignity before rights. A survey design, with structured questionnaires, was used. Snow-ball sampling techniques were used.

Results. Results indicated that varying degrees of distress were experienced by 64% of the GLBs in this study. The GLBs identified a need for human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) education and had concerns about their general health, discrimination against them and vulnerability to violence including sexual assaults.

Conclusions. The well-being of the GLBs in Botswana was influenced by both positive internal acceptance of their sexual orientation and negative external acceptance by society. Health care professionals played insignificant roles in the promotion of GLBs' well-being, and could make greater inputs into health education efforts, and more significant contributions towards enhancing the GLBs' levels of well-being. Enhanced collaboration between health professionals and human rights activists are recommended to reduce violations of Botswana's GLBs' dignity and to improve their quality of life, including enhanced access to and utilization of health care services.

Keywords: bisexual(s), Botswana (citizens of Botswana), Botswana, gay(s), health needs, health promotion, human dignity, human rights, lesbian(s), nursing, vulnerable population, well-being

Background

Information in Southern Africa, including Botswana, about gay, lesbian and bisexual (GLB) persons proved difficult to obtain. Altman (1998) stated this scarcity of information might be a symptom of most African governments' problems in acknowledging the existence of GLBs. According to Foreman (1999), within each society an estimated 5–10% of the population is engaging in same-sex sexual relations. Even if a conservative estimate of 2% is applied, then in Botswana with a population of 1.5 million, 30 000 Botswana (citizens of Botswana) could be inclined toward same-sex sexual activities.

No prior research on the levels of well-being and the health needs of the GLBs in Botswana could be identified, probably because of the inaccessibility of this population who might fear legal prosecution should they be identified as GLBs. This fear is justified because in 1994, the Botswana police invaded the privacy of a gay person's bedroom in order to punish his homosexual behaviour. The Botswana media attacked GLBs regularly from 1995 to 1998. The office of the President threatened gay and lesbian public servants that they might face disciplinary actions at work (*Daily News* 1995, *The Voice* 1995, Amnesty International 1997, *The Midweek Sun* 1998). Botswana's laws punish the actual engagement in same-sex sexual union by imprisonment for a term not exceeding 7 years (Penal Code 1964 Chapter 08:01, Section 164 as amended by Penal Code 1998: Section 21).

Botswana's GLBs included their need to be respected in their Charter: 'We have the right to a full life, respect and dignity. We should not be prosecuted, condemned or shunned' (LeGaBiBo 1998). A study endeavouring to enhance the well-being of GLBs should thus be approached from a human rights' perspective.

Aims of and rationale for the study

The aim of the study was to investigate the level of well-being of GLBs in Botswana, how this level of well-being could be promoted and whether their health care needs were met by health care professionals. The linkages between the health and human rights disciplines were explored. The underlying assumption remained that if more health needs of the GLBs could be met, then their levels of well-being might be enhanced.

Research methodology

Literature on enhancing well-being was explored. An answer was sought to the question as to what could be expected from

health professionals in controversial issues, such as promoting the health of people whose same-sex sexual conduct was criminalized in Botswana. Health needs, as identified in reports from Europe and the United States of America (USA), were utilized in a questionnaire to identify the health needs of the GLBs in Botswana.

Mallik (1997) examined the claim that patient advocacy by nurses in the United Kingdom (UK) protected patients from bad practices, and assisted them to exercise their rights to freedom of choice. No agreement was found in the literature concerning the nursing professions' responsibility for what happens to patients' rights outside health care settings. Some authors were convinced that human rights remained political rights and were therefore irrelevant to nursing (Evans 1995).

According to Mann (1996), modern human rights philosophy provides a guide for the identification of factors causing ill health, and a tool for analysis and action aimed at improving health. Violations of human rights could be used as an entry point for recognizing health problems (Mann 1995, 1998a, Andrews 1997, Brundtland 1998). Conversely, meeting health care needs could enhance the general well-being of vulnerable populations, including GLBs in Botswana.

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 Botswana's GLBs. A broad all-inclusive framework, including the Universal Declaration of Human Rights (UDHR 1948), the definition of health developed by the World Health Organization (WHO 1978), and the definition of health promotion as provided in the Ottawa Charter (1986) for health promotion, assisted in the formulation of questions on a wide range of topics focussing on individual health needs of the GLBs and the societal context such as the right to privacy, and the right to freedom of association to enhance their levels of well-being.

Research design

The research design was determined by the challenges encountered in conducting a survey with a hidden GLB population in Botswana. Because of the criminalization of their sexual orientations most GLBs were not willing to 'come out' and be known to the researcher nor to other respondents participating in this study. The study design was determined by the legal conditions and by the researcher's respect for the choice of most GLBs to remain 'in the closet' (by not disclosing their GLB status). The study design assured anonymity because the respondents were unknown to the researcher and were never contacted by the researcher. Large

numbers of open-ended questions remained unanswered, probably because the GLB respondents feared that their handwriting might be recognized.

To gain access, a preparatory phase of 1 year was used to establish relationships with the members of the Lesbian, Gay and Bisexual Organization of Botswana (LeGaBiBo).

Ethical considerations

The ethical questions pertinent to conducting sensitive research (Sieber 1993) related to whether or not individuals or communities could be helped or harmed by conducting research or by publishing research results. This survey could be described as researching a sensitive topic, as participation might have been threatening to the respondents (Renzetti & Lee 1993). This study was concerned with the personal experiences of the GLBs, such as discrimination, homophobia and criminalization. The purpose of conducting the research was to promote the health care and well-being of GLBs in Botswana. According to Bowser and Sieber (1993) it is a prerequisite for research on stigmatized populations to empower the participants and to enable 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 opportunities to make real contributions. Prior to conducting the survey, discussions were held with members of LeGaBiBo, who acted as consultants throughout all stages of the research. The four consultants were 'out of the closet' to such an extent that they were known and trusted by the GLB population. These consultants shared their insight, knowledge and experiences with the researcher. They helped to finalize the research instrument and distributed the initial questionnaires to GLBs known to them. The researcher knew the consultants, but their responses did not form part of the research data. The consultants' combined inputs were only utilized to finalize the questionnaire.

Informed consent

Communicating respectfully and openly with the LeGaBiBo consultants throughout the study, and providing debriefing about the nature, findings and value of the research, were essential components of informed consent. The notion of informed consent went beyond the consent statement given by individual participants who completed the questionnaires, as the respondents knew that the study was based on the approval and support of their peers, as represented by LeGaBiBo. The consultants and respondents participated voluntarily in the survey. Not completing the questionnaire presented a way of totally declining participation, whilst

omission of answers to open-ended questions offered an opportunity for partial participation. Neither coercion nor persuasion was used and no remuneration for participation was offered. Participation remained anonymous and voluntary throughout the survey. Addressed stamped envelopes were provided enabling the participants to post the completed questionnaires where and when they preferred to do so.

Right to privacy

The respondents were not identifiable by the researcher. An anonymous survey method was selected to increase the opportunity for GLBs to provide information without fear of being identified.

The research population and sample

The research population constituted all GLBs in Botswana. However, as GLB behaviour is criminalized in Botswana, the research population had to be limited to Botswana citizens who were self-identified gay men, lesbian women and bisexual men and women aged 15 years or older. Each respondent had to be 'out' to him/herself and to at least one other person who asked him/her to participate in this study. Proficiency in reading and understanding English was required as the questionnaire was available in English only.

Sampling method

Solarz (1999) identified methodological limitations in lesbian health research conducted in the USA because these studies frequently use small nonprobability samples, limiting the generalizability of the research findings. Other limitations mentioned by Solarz involve the lack of control and comparison groups and the lack of longitudinal data imposing further limits on the understanding of lesbian behaviours over time. However, Platzer and James (1997) point out that, as gays and lesbians might not reveal themselves, researchers might generally be unable to rely on probability samples, even if the whole population of a country should be accessible. There could be no guarantee that those GLBs who were 'out' had similar experiences to those who remained 'in the closet' and thus inaccessible to researchers. The nonprobability snow-ball sampling technique imposed limitations on the generalizability of the research findings. Because of the anonymous character of the survey, the researcher could not send follow-up letters to encourage nonrespondents to return the questionnaires within the allotted time of 4 weeks. Therefore only the 47 completed

questionnaires provided the data for this exploratory descriptive survey.

In this study, ethical considerations of confidentiality, privacy, informed consent and anonymity necessitated the selection of a nonrandom (snow ball) sample. In most quantitative and qualitative studies on GLBs snowball sampling techniques have been used (Denenberg 1995, Morrissey 1996). Representative GLB samples remain almost impossible to obtain (Flowers *et al.* 1997). Through snowball sampling the geographical scope was determined, with the starting point being Gaborone, the capital of Botswana. The consultants hand-picked GLB respondents and handed at least two questionnaires to each one. In this way each known GLB could complete one questionnaire and hand another questionnaire to another GLB known to him/her. This process of 'snow-ball' sampling was continued until 100 questionnaires had been handed out. The respondents, comprising the hidden GLB population in Botswana, could not be reached in any other way. Anonymity and confidentiality could be guaranteed. In this study the participants were identified through their organization, LeGaBiBo. This is a common starting point for referral chains according to Platzer and James (1997).

Data collection instrument

As not much was known about the GLBs in Botswana, 76 basic questions across a wide range of topics were asked. The questionnaire was the least threatening tool for data collection, as it could be completed privately and anonymously (Aday 1989).

The questionnaire was designed to provide a profile of Botswana's GLBs. In section I of the questionnaire, the GLBs were asked to report their perceptions about their well-being. The general well-being schedule (GWBS) was used to measure this concept as it was positively reviewed by McDowell and Newell (1996), recommending its high validity and reliability scores. The GWBS offered broad-ranging indicators of subjective feelings of psychological well-being and distress. The GWBS covered both positive and negative feelings and dimensions of anxiety, depression, 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 10 point rating scales – defined by adjectives at the ends of each scale.

Two surveys on GLBs by Isaac and McKendrick (1992) in the Republic of South Africa (RSA), and the USA Internet Outproud Survey (1999), provided indications for questions utilized in Sections II and III of the questionnaire. Certain

sensitive variables were excluded, including the results of HIV tests, the number of sex partners, the age at having the first sexual contact, actual suicide attempts and drug abuse.

All questionnaires had to be returned within a 4-week period after they had been distributed, in order to proceed to the data analysis phase of the research.

Reliability and validity

As not much was known about Botswana's GLBs, the variables' frequencies were recorded, but no inferences could be drawn from the data. The exploratory questions would need to be followed by in-depth qualitative research, including focus groups and individual in-depth interviews.

The validity or meaningfulness of the questionnaire was determined by pretesting the questionnaire with GLB consultants in Botswana. No questions were removed and the length of time needed to complete the questionnaire (40 minutes) was acceptable to the GLB consultants.

Data analysis

The Statistics Package for Social Sciences (SPSS) was used for analysing the data. The small number of responses to the open-ended questions were not coded but included verbatim in the discussions of the relevant themes. The nominal data were classified and cross-classified using frequencies. The ordinal data were rank ordered and percentages given to the variables.

Research results

Out of 100 questionnaires distributed, only 47 GLBs (47%) returned their completed questionnaires. Although more than half of the GLBs failed to complete the questionnaires, this response rate is much higher than reported for social surveys, where the response rate could be between 25% and 30% (Burns & Grove 1989).

Background information

The population studied ($n=47$) consisted of 42 males and five females. The small number of female respondents could not be accounted for from the questionnaire data. However, all four consultants distributing the questionnaires were males, and probably knew few female GLBs in Botswana. Twenty-two GLBs (46.8%) were between 20 and 29 years old, the ages ranged from 15 to 60 years of age, all were Botswana citizens. Three women (6.4%) identified themselves as lesbians, and two women (4.2%) identified

themselves as bisexuals whilst 42 men (89.4%) identified themselves as gay. No self-identified male bisexual person returned a completed questionnaire – excluding this category from the sample.

Thirteen GLBs (27.7%) lived alone; whilst 18 GLBs (38.3%) lived with same-sex partners and four GLBs (8.4%) lived with friends. Two GLBs (4.2%) acquired only primary school education, and 45 GLBs (95.8%) completed their secondary school education (12 years of schooling). Five GLBs (10.6%) were unemployed, five GLBs (10.6%) were students and the remaining 37 GLBs (78.8%) were employed.

The level of well-being of the GLBs in Botswana

Positive well-being was reported by 17 GLBs (36.2%), 22 GLBs (46.8%) reported moderate distress and eight GLBs (17%), stated that they experienced severe distress. Of the five women, one lesbian reported positive well-being and none reported severe distress. Of the 42 gay men, eight (19%) reported severe distress.

Awareness of GLB status

First awareness of homosexual sensations occurred at a mean age of 12 years. Self-acceptance of sexual orientation followed 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 orientations.

Self-acceptance 'just happened' according to 45% of the GLBs. Of the surveyed GLBs, only five GLBs (10.6%) were completely or mostly out. Forty-two GLBs (89.4%) were to some degree in 'the closet' unless they were among close friends. Internal levels of self-acceptance were found to be high in this GLB community. Forty-two GLBs (89.4%) would not change their sexual orientation, even if they could do so. Thirty-four GLBs (75%) did not think their sexual orientations posed obstacles in their lives.

GLBs' interactions with the health care system

Only seven GLBs (14.9%) shared intimate information about their sexual orientations with their doctors or nurses despite the fact that 32 GLBs (68.1%) expressed concerns about their health. Twenty GLBs (42.6%) reported that they did not trust their doctors or nurses. Eight GLBs (17%) who had previously disclosed their GLB status reported that they no longer trusted their health care providers and no longer disclosed their sexual orientations.

HIV/AIDS

Forty GLBs (85.2%) in this study felt that they had sufficient information about HIV/AIDS and STDs to make informed decisions about safe sex practices. Information was provided by friends to 20 GLBs (42.7%), whilst 16 GLBs (34%) received this information from the local media. Ten out of 20 gay men (50%) who reported having anal sex, used condoms inconsistently or not at all despite being educated by their friends. One gay man who was educated by a nurse reportedly used condoms consistently.

Alcohol

Alcohol use was common with 30 GLBs (63.8%) drinking more than two alcoholic drinks per day. Of the four very depressed GLBs, three did not drink alcohol at all.

Suicide

High prevalence of thoughts about suicide was noted, with 14 GLBs (29.8%) having considered suicide at some stage and another 14 GLBs (29.8%) continuing to foster suicidal thoughts at times.

Health and human rights of GLBs in Botswana

External levels of acceptance of the GLBs ranged from low to absent in the local media. Twenty-one (44.7%) reported that GLBs were portrayed negatively in the Botswana media. General homophobia was confirmed by 27 GLBs (57.4%) who had been insulted, and by five (10.6%) who were attacked sexually (raped).

Twenty-three GLBs (48.9%) did not worry about being jailed or charged with criminal offences for having same-sex relations. Out of the 10 GLBs who reported to be very concerned, six reported moderate or severe distress. The GLBs were more afraid of violations of their right to privacy, specifically about being blackmailed, as experienced by 20 GLBs (42.6%). Twelve GLBs (25.5%) reported that persons threatened to tell other people about their sexual preferences. The GLBs feared that such acts might lead to violence and/or rejection by their significant others and by society as a whole.

The right to have a family

Eight gay men who reported not having sexual relations with women expressed desires to have children of their own, whilst 16 gay men were not sure. These gay men did not indicate how they perceived themselves to be fathering children. (None of the female respondents indicated any desire to have children. The reasons for this apparent discrepancy could not be ascertained.)

The role of LeGaBiBo

Twenty-eight GLBs (59.6%) regarded the primary role of LeGaBiBo to be an information resource. Only five GLBs (10.6%) thought LeGaBiBo could assist them with 'coming out' issues as well. Although there was only one openly gay person in Botswana during 1999, an awareness of GLB celebrities was important for 32 GLBs (68.1%) in feeling better about their sexuality. Positive change in the well-being of the GLB community would be made possible through actions of either human rights activists according to 22 GLBs (46.8%) or GLBs themselves according to 21 GLBs (44.7%).

Health needs and problems

Forty-two GLBs (89.4%) who reportedly accepted themselves as they were, as well as the five GLBs (10.6%) who might want to change their sexual orientations, reported a range of health and human rights concerns: HIV/AIDS, concerns about their general health, illness and bodily pain, discrimination, alcoholism, depression and (para)suicide, vulnerability to physical violence as well as to sexual attacks.

Discussion of research findings

Background information

The surveyed GLBs accepted the labels 'gay', 'lesbian' and 'bisexual'. No answers were provided to open ended questions about the usage and/or meaning of these labels in the Botswana context. It was not clear whether the GLBs included social, emotional and political elements of their identity when ascribing to being GLB, or whether these labels referred only to their same-sex behaviour (Isaacs & McKendrick 1992, White 1997, Vargo 1998, Foreman 1999).

Several studies alluded to the fact that within this hard-to-reach population, layers of invisibility exist. Reports from the USA indicate that women are a discriminated group in an already marginalized section of society. Despite purposive sampling methods the findings pointed out the domination of the gay male perspective in this study, corresponding to the findings reported by a number of other authors (Denenberg 1995, Vargo 1998, Foreman 1999, Solarz 1999).

GLBs' level of well-being in Botswana

The GWBS assisted with quantifying the feelings of well-being and assisted with formulating an operational definition of well-being. The GWBS was valuable in the identification of

the eight gay men experiencing severe distress in this study (Irwin 1997). The levels of well-being of Botswana's GLBs appeared to be influenced by both positive internal acceptance and the negative external acceptance of GLBs in society. The findings indicated that distress of varying degrees were experienced by 64% of the GLBs in this study.

Awareness of GLB status

The findings of positive self-esteem among the GLBs contrasted with the RSA study of Isaacs and McKendrick (1992), which stated that stigma and feelings of uncertainty and/or hostility threatened the homosexual persons' self-esteem by denying them positive social and emotional support. In this study harbouring their 'hidden secret' did not appear to influence their self-esteem negatively, as only one GLB was uncomfortable with being GLB.

GLBs' interactions with the health care system

GLBs' participants in this study were largely 'in the closet'. Nondisclosure to health care professionals could be explained as a symptom of internalized homophobia. The GLBs might anticipate discriminating behaviour making them keep quiet about their sexual orientations. This silence might result in inappropriate care (Morrissey 1996, Brogan 1997).

HIV/AIDS

The HIV/AIDS epidemic might alert health care professionals to the health care needs of GLBs globally. Issues such as poverty, discrimination and lack of privacy might contribute to individual and community vulnerability to HIV infection, issues not to be ignored in the total onslaught against HIV/AIDS (Beyrer 1998, Mann & Tarantola 1998). Depending on the link between health professionals' beliefs/actions and human rights, risk reduction measures (including the use of condoms) could be beneficial, yet also potentially damaging for the GLBs if not based on mutual respect.

Function of alcohol

Alcohol abuse was very common in this group of GLBs. In a USA study, Anderson (1996) pointed out that alcohol abuse was believed to function as a social lubricant among gay men and lesbians. Being drunk could be a way of coping with feelings of shame. The findings of this study did not conform with this assumption as 90% of the GLBs were happy with being who they were.

Suicide

Fear of discovery and trying to cope in hostile heterosexual environments, might lead to depression and suicide. The findings in this study were consistent with previous research findings (Taylor & Robertson 1994, Corvino 1997). Health professionals should spearhead programmes for improving the mental health care of the GLBs.

Health and human rights

The third section of the questionnaire asked questions about the links between health and human rights violations (for example, how GLBs were treated in the dominant heterosexual culture, feelings of belonging to a GLB subculture, and the effects of the absence of affirmative legal identities).

Penn (1997), the author of the gay men's wellness guide, linked the threat of both physical violence and exposure as powerful agents leading to submission to perceived or real aggression. Penn noted that this might be especially relevant on a first date. The findings of this study suggested that male rape was indeed a (previously unreported) problem in Botswana.

Right to privacy

Article 12 of the UDHR states: 'No one shall be subjected to arbitrary interference with his privacy...' The majority of Botswana's GLBs wanted to conceal their sexual orientations and were therefore vulnerable to forced disclosure by others. Chekola (1994) pointed out that being 'in the closet' could serve two functions: protection from harm, and protection related to shame. Botswana's GLBs have no legal protection against such interference or attacks. Reported incidences of blackmail and/or abuse, providing evidence of homophobia, remained unreported because of shame, guilt or fear of prosecution by the State.

Right to have a family

In Botswana, neither artificial insemination nor surrogate motherhood has not been reported. The options available for GLBs wishing to have children were not identified in this study. Further research should investigate this issue as well as the reason(s) why no female respondents indicated that they wished to have children.

The role of LeGaBiBo

Article 20 of the UDHR states: 'Everyone has the right to freedom of peaceful assembly and association'. The formation

of LeGaBiBo under the auspices of DITSHWANELO, a local human rights NonGovernment Organization (NGO), in 1998 was a reaction to the criminalization of the same-sex behaviour of men and women in Botswana. (The GLBs did not attempt to register their own organization. A required list of names of members could not be obtained in Botswana where same-sex behaviours remained criminal actions punishable by imprisonment). According to Kiama (1998) the Western models of GLB organizations were often based on maintaining a separatist and 'gay' identity for these groups. This 'in your face' gayism was often imported into African countries. Another school of thought on homosexual subcultures aimed to demystify gay life styles and hoped for gradual assimilation leading to acceptance of their sexual orientation in their respective societies. Apparently limited knowledge existed about the perceived role of GLBs or human rights activists in either 'demystifying' gay lifestyles or in challenging heterosexist philosophies.

Limitations of the survey

Because of the inaccessibility of Botswana's GLB population, face-to-face interviewing, tape recordings, focus group interviews and in-depth personal interviews proved to be impossible. Each of these approaches could have yielded additional information, adding to the significance of the research findings. The major limitation of the survey resides in the convenience sample of Botswana GLBs who were able and willing to complete the questionnaires and posted these to the researcher. No assurance could be given that other GLBs in Botswana would have encountered experiences and/or problems similar to those reported by the respondents. However, this exploratory descriptive survey uncovered some of Botswana's GLBs' health needs required to enhance their general well-being.

Health and human rights and the well-being of the GLBs in Botswana

In his discussion of the UDHR, Mann (1998b) pointed out the importance of dignity by citing the first article: 'All human beings are born free and equal in dignity and rights'. Dignity seemed to flow from two components, one internal ('how I see myself') and the other external ('how others see me'). The common denominator was the fact of being seen and the perceived nature or quality of this interaction (Mann 1998b).

Results based on the 47 GLB respondents' perspectives uncovered inadequacies in the external component of dignity of the GLBs in Botswana. The 47 respondents struggled with

the negative perceptions of the Botswana. The findings of this study indicate that discrimination was a reality in the daily lives of all the respondents. Societal disapproval manifested itself in various ways: violent attacks, rape, fear of outing, isolation, health problems and lack of access to GLB friendly health care providers.

In contrast with some studies on men having sex with 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 support the assumption that GLB health needs were complex. A focus on reducing 'risky sexual practices' in isolation from the broader societal context might not be helpful. Both the identified health needs, including the need for health education, and the promotion of human rights, including the right to have same-sex relationships, should be addressed to increase the effectiveness of HIV/AIDS prevention projects with GLBs in Botswana.

Working with GLBs has political implications. Plans to improve the well-being of the GLBs would need to include measures to decrease societal disapproval and to change legislation in Botswana. Attitude changes among the Botswana, including health care professionals, would be required so that factors contributing to the marginalization of the Botswana GLBs could be addressed.

Recommendations for future research

Further studies on the quality of life of GLBs in Botswana should be carried out, obtaining responses from larger numbers of GLBs, enhancing the confidence in the data obtained. In-depth qualitative research methods, including focus groups and individual interviews could be used in future studies to portray some aspects of the GLBs' qualitative life experiences.

Specific issues warranting further exploration would include violence, including male-to-male rape, and the design of HIV/AIDS prevention interventions to empower self-identified GLBs and all other men and women engaging in same-sex sexual activities. The findings of this study suggest that an application of a health and human rights framework was valuable in describing and gaining an understanding of the health needs of the GLBs who claimed that their human rights were abused.

Conclusion

The majority of Botswana's GLBs experience levels of distress because of social isolation, criminalization of same sex behaviours, and unmet health care needs. The health care

professionals were reported to render insignificant contributions towards enhancing the GLBs' levels of well-being.

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, suffering unacceptable and/or inaccessible health care services, the health care needs of the estimated 30 000 GLBs cannot be met. Whilst the challenges are great, nurses and other health care professionals should continue to conduct research among Botswana's GLBs to render effective inputs into future policy developments and to contribute to measures aimed at decreasing societal disapproval, and enhancing the well-being of the GLBs. '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 which is cost effective' (Jolley & Brykczynska 1995).

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