

Workshop Report:

“Using complaints to address healthcare violations in Botswana, Malawi and Zambia”



21-22 February 2017

Gaborone, Botswana

**SOUTHERN AFRICA
LITIGATION CENTRE**



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Background

The Southern Africa Litigation Centre (SALC) is a regional non-profit organisation that works to advance human rights and protect the rule of law in southern Africa. Research conducted by SALC in 2016 ([“Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia”](#)) detailed experiences of discrimination in healthcare faced by women living with HIV, lesbian, gay, bisexual and transgender (LGBT) persons, sex workers, and people with disabilities. The research identified a number of processes outside of the courts and available at local levels for healthcare users to seek accountability and redress when experiencing human rights violations and discrimination in healthcare. The research indicated, however, that there is a capacity gap amongst healthcare users, community-based organisations (CBOs) and non-governmental organisations (NGOs) working with human rights, health rights, key populations and vulnerable populations, to make effective and safe use of complaints processes to advance accountability and redress when human rights violations and discrimination occurs in healthcare settings.

With funding from the Africa Regional Grant on HIV, SALC has developed a Guidebook on [“Using complaints to address healthcare violations”](#) in an effort to address these capacity gaps. Through the same Grant, SALC hosted workshops in Botswana, Malawi and Zambia on *“Using complaints to address healthcare violations.”* A workshop was held in Botswana on 21-22 February 2017 for participants from CBOs and NGOs and representatives of complaints bodies.

Workshop Objectives

The purpose of the workshop was to develop the capacity of in-country CBO and NGO partners to identify and take up cases through complaints processes and to be able to support healthcare users when doing so. The training aimed to expose participants to knowledge and skills to promote and improve the rights of persons living with HIV and persons disproportionately affected by HIV (key populations) and vulnerable groups through the use of these processes. It aimed further to expose

representatives of complaints bodies to information about the experiences of key populations and vulnerable populations in healthcare and when making a complaint.

Outcomes

The ultimate outcome of these workshops will be the increased, safe and effective use of complaint processes to achieve accountability and redress for victims of discrimination and human rights violations in healthcare settings, particularly for key populations and vulnerable groups. SALC seeks to work with CBO and NGO partners to:

- Build partner capacity through working with partners to identify cases and make complaints.
- Provide appropriate support to complainants.
- Identify strategic interventions to improve the accessibility, effectiveness and sufficiency of complaint processes.

Welcome and Introduction

SALC commenced the workshop by welcoming participants and explaining the background and purpose of the research and workshop aims. It was noted that discrimination has devastating effects on people’s dignity and in relation to HIV treatment and prevention efforts, particularly when occurring in healthcare settings. It was noted that using complaints processes has some potential to advance access to justice but that there is work to do to improve their sufficiency, availability and effectiveness to fulfil the right to a remedy for human rights violations.

Participants noted what they wanted to get out of the training. Participants wanted to share experiences and develop solutions for healthcare violations. Participants noted in particular that discrimination, being a covert behaviour, is difficult to trace – what role could complaints processes play in this regard?

Participants noted the limits of legal aid in Botswana and that alternatives outside of the formal legal process were needed.

Complaints body representatives stressed that there was a shared goal with CSOs and NGOs to advance the welfare of citizens.

Experiences of discrimination in healthcare

SALC commenced the session with the presentation of the findings of its research report on [Accountability and Redress for Discrimination in Healthcare in Botswana, Malawi and Zambia](#).

The report details anecdotal accounts from people with disabilities, sex workers, women living with HIV, and LGBT persons in the three countries showing serious and varied experiences of discrimination in healthcare in Botswana, Malawi and Zambia, based on a number of grounds. These include health and HIV-status, gender, sexual orientation, disability, socio-economic status, occupation, and rural location.

The conduct described by vulnerable persons through various focus groups across the three countries included:

- Treatment denial.
- Abusive language.
- Failure to properly examine healthcare users before providing treatment.
- Sexual coercion and abuse.
- Physical abuse such as slapping and hitting.
- Failure to observe healthcare users' confidentiality, including health-status confidentiality and confidentiality relating to healthcare users' sexual orientation, gender identity, and occupation.
- Failure to conduct proper informed consent procedures.
- Failure to provide reasonable accommodation for persons with disabilities.

- Denial of access to sexually-transmitted infection (STI) and HIV testing, counselling and treatment, in the absence of (heterosexual) sexual partners.
- Blaming healthcare users for their health status.
- Segregation and the use of identifying practices for people living with HIV.
- Failure to accommodate the particular healthcare and access needs of sex workers, persons with disabilities, gay and transgender persons in particular.

Research consultants and CSO partners involved in the research presented on their experiences from focus group discussions.

It was noted that for many LGBT persons, it is understood that stigma and discrimination is based on personal and religious beliefs. A representative of the Lesbians, Gays and Bisexuals of Botswana ([LEGABIBO](#)) stated that many people, including healthcare workers, interpret criminal sanctions against certain sexual acts as criminalising *being* a lesbian, gay, or bisexual person. It was noted that the [decision of the Court of Appeal](#) on the unlawfulness of the state's refusal to register LEGABIBO is an important affirmation that it is not illegal to *be* LGBT. The concern amongst LGBT persons of being refused to donate blood by healthcare workers due to the perception that they had a "gay gene" was cited as an example of the discrimination that LGBT persons face in healthcare.



A representative of [SISONKE](#) described that sex workers in Gaborone, Palapye and Phikwe experience being insulted by healthcare workers particularly when accessing healthcare services for sexually transmitted infections (STIs). It was noted that healthcare workers falsely believe that sex workers are to blame for spreading HIV. To the contrary, sex workers are skilled in using protection but need access to resources such as condoms to do this. The practice of limiting condoms to sex workers was described as abusive and inappropriate. Police may attempt to use condoms as evidence of supposed criminality and extort sex workers for bribes when they are caught with condoms in their possession. The insecurity of sex workers in relation to police was stressed:

“The police are our clients. They know where sex workers live. We cannot report rape cases – we will be judged.” – SISONKE representative.

Sex workers are also particularly concerned about their confidentiality when accessing healthcare services and had experienced healthcare workers calling colleagues to come into examination rooms without their permission.

“They preach to us. But we just need healthcare services” – SISONKE representative.

A research consultant described focus group discussions run with the Botswana Council for the Disabled. The severity of abuses in the context of healthcare settings was stressed:

“People seek healthcare services when they are already broken, when they are already wounded.” – Research consultant.

It was noted that people with disabilities struggle to access healthcare facilities, which are not designed to accommodate different abilities. The absence of ramps or sign language interpreters excludes healthcare users with disabilities from accessing healthcare services equitably. It was described that persons with disabilities are also frequently discriminated against in the context of sexual and reproductive healthcare services. Persons with disabilities report being denied contraceptives and mistreated when accessing antenatal services. Most acutely, however was the concern that confidentiality is seldom respected. While acknowledging that healthcare workers are typically very busy, it was described that persons with disabilities are seldom treated as individuals, seldom informed of their health condition, or asked permission to conduct testing and treatment.

Participants reflected on the experiences of stigma and discrimination in healthcare. It was raised whether it is a realistic goal to talk about discrimination and access to services at an individual level when restrictive legal and policy environments are not enabling.

“We need to work at individual and systemic levels. We can educate healthcare workers but if laws affirm that [certain groups of people] are not a part of society, we will continue to face these issues.” – BONELA representative.

Participants recognised that while the fight to change discriminatory and restrictive laws and policies must not be lost, change will not happen overnight. Even once law reform is achieved, change does not always follow, such has been the case in South Africa.

“There is a luminal space between laws, policies and people.” – Participant.

Health and Human Rights

Two legal experts, Tshiamo Rantao of (Rantao Kewagamang Attorneys) and Lesego Nchunga (of Dow and Associates) provided insights into the human rights that healthcare users enjoy and the legal and ethical obligations of healthcare workers in Botswana.



It was noted that stigma and discrimination violate human rights and are barriers to effective HIV prevention and treatment. Legal protections and policy commitments in Botswana prohibit discrimination in broad terms and emphasise commitments to equitable access to quality healthcare. It is not a crime to be a sex worker in Botswana and LGBT persons are not criminalised in themselves – even if certain same-sex sexual acts are criminalised.

Healthcare workers are ethically and legally bound not to discriminate unfairly against healthcare users and need to respect their inherent human dignity.

Participants engaged with resource persons in detail on the issues of informed consent, stressing that a healthcare user has a right to decline a healthcare services without risking penalties or denial of other healthcare services. The need to secure access to information as a recognised human right was discussed to ensure easy access to medical records without needing to secure a court order.

Participants also engaged on the issues of lawful limitations of human rights. It was recognised that while human rights can be limited, these limitations must be justified in terms of the Constitution.

Participants finally noted difficulties with the provisions of the Public Health Act that compromise confidentiality with respect to HIV status disclosure and testing.

Dealing with Health Rights Violations

Participants discussed strategies to deal with human rights violations in healthcare.

There are various options to relate complaints of discrimination in healthcare outside of the formal court process. However, these processes provide for varying levels of availability, effectiveness, and sufficiency in holding healthcare workers and systems to account and in providing healthcare users with the right to redress.

The complaints bodies analysed included processes at healthcare facilities or through the Ministry of Health, the Office of the Ombudsman, the Botswana Health Professions Council (BHPC), the Nursing and Midwifery Council of Botswana, and the Botswana Office of People with Disabilities (BOPD).

Participants discussed that healthcare workers may be interested in issues concerning key populations but that progress required exposure to the issues. Some participants suggested the value of working with certain complaints on an operational level, where

underlying causes and effects of discriminatory behaviour could best be addressed.

The importance of addressing knowledge gaps was stressed in participants' discussion:

“When healthcare users are well informed, they know what to demand. We need to ensure that communities are treatment literate.” – LEGABIBO Representative.

Making a complaint

Participants and presenters shared information about best practices in making complaints. The participants worked through the complaint process, including sharing guidance on how to select a complaint process that best serves the complainant's needs and interests as detailed in the Guidebook.

It was noted that regulatory bodies (such as the health professions and nursing councils) have clear procedures written in law. While healthcare users may perceive that these bodies may be biased and “protect their own”, they in fact offer strong procedural advantages which are protected in law to ensure that decision-makers are impartial.

It was noted that while the mandate of the Office of the Ombudsman is to deal with maladministration, it considers human rights violations as a form of maladministration and, in fact, receives many human rights complaints. It was noted in addition that the Office of the Ombudsman has *mero motu* powers that permit the Office to investigate issues on its own accord.

Supporting vulnerable complainants

Participants discussed the needs of complainants who are vulnerable to abuse and secondary victimisation when complaining and shared strategies on how CBOs and NGO could support complainants.



A number of issues were discussed including the impact of criminal law regimes on the safety and security of sex workers and LGBT persons, the important role of support organisations, the need for healthcare users to understand their rights and the processes to enforce them, and fears of treatment denial, breaches of confidentiality, and social reprisals leading people to fear making complaints. The value of considering anonymous, confidential and third-party complaints was stressed in these cases.

“[Sex workers] fear rejection, especially from [their] families. [They] are mothers.” – SISONKE Participant.

“Many young LGBT people are dependent on their families because they are unemployed. They rely on their families and may be afraid that their family is

going to get involved or find out about their identity if they complain.” – LEGABIBO Participant.

Participants discussed that it may not always be necessary for a complainant to reveal their status (for example, as a sex worker or LGBT person) to the extent that the information may not be relevant in a complaint. Participants stressed that sex workers risk arrest and may end up being victimised if being revealed as having made complaints. Men who report being sexually violated may similarly risk incriminating themselves under sodomy laws, concerns that drive fear of seeking legal redress.

Participants underlined the value of developing relationships with “friendly” police stations and service providers as a strategy to ensure immediate relief and assistance for vulnerable complainants. LEGABIBO noted its work in this regard in conducting mapping exercises and working with chiefs and traditional leaders. SISONKE noted its intentions to develop a 24 hr helpline to connect sex workers with paralegal support.



It was noted that persons with disabilities are in the majority located in rural areas, where preferences may be to find “cultural solutions” when rights violations occur. It was noted that police often do not take persons with disabilities seriously and criminal complaints are often dismissed in the result. It was emphasised that in supporting persons with disabilities, the autonomy and will of the person is the most important concern and that persons with disabilities should not be considered from only a

health perspective but as enjoying all human rights comprehensively.

Participants discussed that robust systems need to be developed between complaints bodies and civil society to ensure appropriate feedback, monitoring and documentation of cases as well as to strengthen referral systems. Information from these processes should inform advocacy efforts.

Complaints body representatives suggested that partnerships across organisations are vital and stressed the need for more dialogue between communities and service providers:

Participants stressed the importance of building strategic allies within government departments and complaints systems, noting that it is important to be able to talk to implementers as escalating complaints directly to politicians may risk sensitive issues becoming politicised. Some participants drew discomfort from the suggestion finding that ordinary citizens should not need inside contacts to facilitate access, a process that perpetuates a culture of disenfranchising citizens from accountability processes.

Q&A with Complaints Bodies

On the second day of the training, a representative of UNAIDS assisted with facilitating a question and answers session between participants and representatives of the Office of the Ombudsman, and the BHPC.

In terms of jurisdiction, it was discussed that the Office of the Ombudsman deals only with complaints relating to government agencies or parastatals. The understanding of “maladministration” as the key to its mandate is broadly understood to include any action or inaction where there is a duty to act that is contrary to law. The BHPC governs the conduct of both healthcare workers in the public and private sectors and deals with all healthcare professionals (such as doctors, pharmacists, radiotherapists etc.) but not nurses.

Participants questioned whether processes were accessible for persons with disabilities. One participant asked complaints bodies directly: “If I submitted a complaint in braille, would you accept it?” The complaints body representatives generally acknowledged that they were ill-prepared to deal with such a complaint but that the onus was on them as recipients of the complaint to ensure a complaint made in braille is translated, for example.

Participants questioned whether complaints bodies analyse complaints to address systemic issues on recurring violations. The BHPC stated that it only deals with matters on a case-by-case basis but that when registering professionals, information on common complaints is provided.

Case Study

Participants raised a concern about “contact slips” being used to deny access to sexually transmitted infection (STI) treatment. The issue was discussed as a case study for possible complaint.

Healthcare users, particularly sex workers, have complained that when seeking treatment for STIs, they are refused treatment unless they provide a “contact slip” to enable “contact tracing” (the identification of other persons possibly infected with an STI that they can be tested and treated). While it was understood that the policy of contact tracing is useful from a public health perspective to ensure STIs are effectively treated, the concern is that the policy of “contact tracing” is being applied in a manner to either deny access to services to people who refuse or are not able to provide a contact slip, or being applied to indirectly discriminate against people who are not able to provide contacts due to having multiple sexual partners or sexual engagements that are criminalised.

Participants vigorously debated the issue and what the best way would be to deal with the matter effectively. It was suggested that a formal complaint be addressed to the Ministry of Health on the issue of contact slips, which is empowered to issue savingrams to clarify misapplications of policy and conduct workshops to ensure the interpretation of the policy is understood. Participants agreed to address a letter to the Ministry of Health to a request a meeting on the issue.

Next steps



In giving feedback on the workshop, participants noted a need for further support, training and resources on the following issues:

- The development of a compendium of legal, regulatory, policy, and ethical frameworks that govern discrimination in healthcare in Botswana.
- Efforts need to be undertaken to gain access to Health Service Standards and National Healthcare service Standards developed by the previous Health Minister.
- National stock-taking efforts in reaching the 90/90/90 target will be held toward the end of March which will include stakeholder consultations. CSO and NGO partners were encouraged to engage in that process.
- It is important to involve the police in these discussions.

Copies of the training materials and research report are available for free download on SALC’s website:

Guidebook: Using complaints to address healthcare violations:

<http://www.southernafricalitigationcentre.org/2016/12/15/guidebook-using-complaints-to-address-healthcare-violations/>

Research Report: Accountability and redress for discrimination in healthcare in Botswana, Malawi and Zambia:

<http://www.southernafricalitigationcentre.org/2016/09/28/research-report-accountability-and-redress-for-discrimination-in-healthcare-in-botswana-malawi-and-zambia/>

**Hardcopies can be requested at
Enquiries@salc.org.za**

Addendum: Agenda

Tuesday, 21 February 2017	
08:30-09:00	Registration
09:00-09:30	Welcome, overview and introductions
09:30-11:00	Experiences of discrimination in healthcare
11:00-11:30	Health Break
11:30-12:30	Health and Human Rights
12:30-13:30	Lunch
13:30-14:00	Dealing with health rights violations
14:00-15:30	Making a complaint
15:30-16:00	Health Break
16:00-17:00	How to support complainants
Wednesday, 22 February 2017	
09:00-09:30	Welcome and day 1 recap
09:30-10:30	Q&A with complaints body representatives
10:30-11:00	Health Break
11:00-12:30	Workshopping cases
12:30-13:00	Feedback and close