BOTSWANA HAS A MORAL DUTY TO EXPAND ACCESS TO ANTIRETROVIRAL THERAPY TO SURVIVAL MIGRANTS

by

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Abstract

Social, political and economic problems since Zimbabwe's post-independence period have resulted in the creation of survival migrants that flock to neighboring countries for a better life. In the same period, HIV/AIDS had become a global epidemic affecting Botswana and Zimbabwe severely. While Botswana has become a beacon of success in controlling the epidemic by having the political will and international collaborations to provide preventative and therapeutic care to its citizens, the government has overlooked the survival migrants that are residing in Botswana. This population does not receive any HIV/AIDS preventative or therapeutic care from the Botswana national Antiretroviral Therapy (ART) program.

In this paper, I argue that Botswana's national ART program should be broadened to include survival migrants with HIV/AIDS. In doing so, I seek justification for the argument from 1) Utilitarian Moral Theory Perspective; and 2) Social Justice Perspective.

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Introduction

Africa is leading the world in expanding access to antiretroviral treatment (ART). As of December 2012, 7.6 million people across the continent were receiving ART, including 7.5 million in sub-Saharan Africa. Eastern and Southern Africa had scaled up faster, more than doubling the number of people on treatment between 2006 and 2012.[1]

"Botswana, a country of high HIV prevalence, has achieved high rates of testing and treatment coverage. Since 2016 Botswana has adopted the treat all strategy, providing ART to all HIV infected citizens.[2] This means all Botswana citizens who test HIV positive, regardless of their CD4 count and viral loads, are offered treatment free of charge. Rates of knowledge of HIV status, ART initiation, and virologic suppression are close to the UNAIDS 90-90-90 targets, at 82%, 86%, and 95%, respectively."[3]

In 2002, when the government of Botswana decided to make ART available to its HIV positive citizens with CD4 counts less than 200 cells/mm^3, Merck, the pharmaceutical company agreed to donate its drugs in the contemporary Botswana ART regimen for free.[4] An analysis of nine years of data shows that the Botswana ART program achieved excellent results since its inception. The overall mortality rate for those initiated on antiretrovirals was 8%.[5] Mortality rates were highest during the first three months of starting ART and fell dramatically during subsequent years of therapy. However, there are strong indications that non-citizens face substantial barriers in accessing essential health services and have inadequate access to ART.

The Botswana government-run ART program, which is a free and public service, is restricted to its citizens and excludes all HIV infected non-citizens whether in the country legally

or illegally. In contrast, some health services like antenatal care and delivery services are provided with nominal fees to all that present themselves at a government run health care facility. Non citizens who have the financial capability, get their HIV care from private practitioners and pay the medical expenses out of pocket.

Thesis Statement

In this paper, I argue that Botswana should expand the eligibility criteria of its universal HIV/AIDS care and management policy to include immigrants who earn minimum wages or otherwise cannot afford to pay private practitioners or buy health insurance whether they reside in the country with legal immigrant status or do not possess a legal residence permit.

The majority of Botswana's immigrants come from Zimbabwe, having fled social injustice and structural violence in their native country. In this paper, I describe the geographic and historical context that explains the migration from Zimbabwe to Botswana. The term "survival migrants"[6] is used to differentiate this group from other immigrants such as those that have naturalized or those that enjoy international protection as refugees. Then I draw on utilitarian and social justice perspectives to make a case for expansion of eligibility and access to ART for these migrants.

The Migration from Zimbabwe to Botswana

Zimbabwe borders Botswana to the North East and was one of the wealthiest countries in sub-Saharan Africa in the years following its independence from British rule in 1980.[7] Soon after independence, the government implemented a range of progressive social policies, including

increasing education and health expenditures. Economic policies were enacted to redistribute income, and credit was extended to low-income farmers. These structural changes resulted in marked improvements in human development indicators.[8] The percentage of immunized children increased from 25% to 42% between 1982 and 1984 in rural areas. Under-five mortality dropped from 182 deaths per 1000 live births in 1960 to 113 in 1988. Life expectancy rose from 45 years in 1960 to 59 years in 1987. Women's literacy increased from 47% in 1970 to 67% in 1985, and literacy among men increased from 63% in 1970 to 81% in 1985.[8]

However, the Zimbabwean government has become increasingly more repressive under the nearly four-decade-long rule of President Robert Mugabe. Government agencies function without transparency or accountability, with considerable violence against political opposition. Drastic policies, including the dislocation of thousands of citizens, seizure of commercial farms, and assaults on the informal trading sector have resulted in severe social and economic disruption for massive numbers of people.[9]

Between 1999 and 2007, political violence and state-sponsored human rights violations escalated. Under the government's 'fast track' land reform program commercial farms were occupied, and many farm workers were displaced.[10] During election periods, large numbers of political activists were assaulted and displaced.[11]

In 2005, the government launched Operation Murambatsvina (Clear the Filth), a campaign of forcible evictions and demolitions in urban areas.[9] Tens of thousands of houses and thousands of informal business structures were destroyed. Authorities defended the campaign as a plan to clean up the urban areas, restore order, rid the cities of criminal elements, and restore dignity to the people.[9]

The humanitarian consequences of Operation Murambatsvina were catastrophic. An

estimated 6% of the total population lost their homes, livelihood, or both, as the result of the evictions.[12] Two million four hundred thousand people, some 18% of the population, have been either directly or indirectly affected.[12] The evictions have also revealed the stigma and discrimination that people living with HIV and AIDS (PLWHA) often face. Zimbabwe was facing one of the world's most severe HIV and AIDS crises, with an estimated adult HIV/AIDS prevalence rate of 24.6% in 2003[13]. Zimbabwe initiated its national ART program in April 2004.[14] However, following the destruction of their homes by government forces, PLWHA were afraid to openly declare their HIV status because they risked becoming evicted again by relatives or landlords where they had taken shelter.

The repressive political environment has also prevented activism and debate about HIV/AIDS and human rights in civil society. Non Governmental Organizations (NGO) representatives acknowledged that they were afraid to speak out about the negative impact of government policies on their programs for fear of having their services constrained or shut down by the government. Government officials, including members of the government's Central Intelligence Organization, were regularly intimidated and harassed.[15]

The economic and political problems described above have led to significant increases in migration to Botswana starting in the early 2000s. By 2003, it was estimated that there were 40,000 Zimbabwean migrants in Botswana, of whom only one-third were residing legally.[16] The majority of people migrating from Zimbabwe are difficult to classify. They do not fall within the legal definition of a 'refugee.' They are not voluntary, economic migrants. If anything, they fall within a broader category of survival migration,[6] which occur when people flee a threat to which they have no domestic remedy.[16] The reasons for the flight of Zimbabweans are a combination of state collapse, livelihood failure, and environmental disaster.

Zimbabwean immigrants who are living in Botswana have been rendered invisible to the international community as result of not being refugees.[16] This has created difficulties for the international community to identify and address the issues these populations have, especially when it comes to HIV. Most of the migrant workers who are without a legal residence permit in Botswana work in different private sectors such as farm work, domestic work and artisanship. They may receive minimum wage or less than minimum wage, which in Botswana is 3.8 Botswana Pula per hour (USD 0.35) for most full-time workers in the private sector; 2.7 Pula per hour (USD 0.25) for domestic workers; and 550 Pula per month (USD 50) for workers in the agriculture sector, who reside on farms and are not compensated on an hourly rate.[17] These income levels will not be enough to access health care costs in the private sector where the average national income is USD 16,000[18] per annum, whether it is general health care services or services associated with HIV/AIDS. Moreover, the pathway to citizenship is a long and complex process in Botswana. It requires legal residence for 10-15 years and lengthy application processes.[19]

Policies that limit access to life-saving anti-HIV medication to survival migrants are morally wrong for several reasons. Among them are utilitarian considerations.

Utilitarian Ethics

According to the moral theory of utilitarianism, right acts maximize the good and the good to be optimized is the welfare of individuals. Classical utilitarianism understands well-being as happiness. '"A happy life is one filled with experiences of pleasure and lacking experiences of pain."[20]

From a utilitarian perspective, the Botswana government has a moral duty to maximize

the welfare of HIV infected immigrants, who cannot afford to buy insurance or pay private practitioners for HIV/AIDS treatment. By offering treatment and care to HIV infected individuals, pain and suffering are minimized, death is prevented, and pleasure is maximized for a significant number of people. HIV is a chronic condition which, if not treated, causes a depletion of the patient's immunity thereby predisposing the person's body susceptible to opportunistic infections or malignancies. The depletion of the body's immunity progressively worsens until the person is unable to resist any attack even from minimally pathogenic organisms. If it is possible to replace the pain and suffering caused by HIV with health and well-being, happiness and pleasure will be maximized.

HIV causes both physical and psychological distress and usually affects more than one family member. The joy and general satisfaction people get by being alive and well is reduced or absent in most individuals that have been affected by HIV. Telling patients they are HIV infected but ineligible for treatment because of their social status and citizenship is the same as sentencing them to a slow death. Psychological distress is experienced by parents who, when they learn about their condition, are afraid their children may be orphaned, or by individuals who are struggling to keep the jobs necessary for daily sustenance despite being sick. Without treatment, HIV/AIDS is a fatal disease in the majority of cases. However, with treatment, the immune deficiency problem is resolved, the person will return to his/her previous health status, and can work without worrying about absenteeism due to ill health. Securing employment will allow children to attend school and get the provisions they need from their parents.

According to utilitarianism, a negative utility exists when a phenomenon or action causes more harm than good.[21] The suffering brought about by the absence of treatment for immigrants results in negative utility. The Botswana ART policy that excludes some members of the society

causes both short-term and long-term harm. In addition to the immediate suffering and unnecessary death, the nation as a whole is harmed by the failure of the ART program to eliminate HIV from the community. As long as there are potential spreaders, people who are interacting with these spreaders will be at a risk of being infected by HIV. The virus does not discriminate based on social status or geographic origins of the person.

Another potential problem is the development of drug resistance with suboptimal HIV treatment. HIV drug resistance can happen when HIV is not treated sufficiently with effective ART or when patients fail to take their medication continuously. It is easy to imagine failure to adhere to medication in the survival migrant and displaced population because of unaffordability of medical care and drugs. They can only buy the medicine when they have money, the amount of which may vary from month to month. When the income is insufficient to purchase food and pay rent, medicines will be skipped resulting in interruption of treatment. The occurrence of a resistant HIV strain in the society is a looming threat to the success of ART and the control of the HIV epidemic, throughout the nation not just the survival migrant community. Although caring for immigrants may result in some loss of utility to the citizens of Botswana because of the additional burden placed on the healthcare system, the overall utility is maximized by providing access to ART for poor immigrants.

Policy makers and community members may argue that when one “good” is offered to non-citizens, in this case, ART care, another “good” is taken away from citizens. In other words, the overall standard of health care may suffer if resources are finite. But I argue that in both the short and long term, the benefits to the citizens are greater if the virus and exposure to potential spreaders are nearly eliminated. Therefore, in the long run, the containment of HIV by offering ART to immigrants is adding utility to the community as a whole.

Zimbabwe has its own national ART program implemented in April 2004.[14] Therefore, offering treatment to the survival migrants in Botswana will not attract others who may come seeking free HIV/AIDS care. This argument applies to possible migration from the rest of Africa as well.[1]

According to John Stuart Mill, Utilitarianism is both universalist and impartial, where "what is right…is not the agent's happiness but that of all concerned''.[21] This is often articulated as "the greatest good for the greatest number of people". This implies that the Botswana government and policymakers are morally obligated to be impartial in their policy-making and to do what it takes to control the epidemic and minimize suffering for all those who are affected by it.

While I agree that additional resources are needed to roll out ART care for everyone, there are ways of obtaining the resources to expand coverage. One suggestion is to reduce the frequency of HIV RNA (viral load) and CD4 T lymphocyte (CD4) cell count monitoring for all patients. Under the current Botswana guidelines, these two tests are repeated every three months. HIV RNA and CD4 are the two surrogate markers of antiretroviral treatment (ART) responses and HIV disease progression that have been used for decades to manage and monitor HIV infection.[22] An argument can be made that with the current robust ART the intervals between tests can be widened to reduce the number of times one has to be tested. Studies have shown that once a patient is stable on ART, monthly monitoring is not essential if resources are limited.[23] Reduced frequency of routine CD4 monitoring improves the value of care for all stable, virologically suppressed patients with HIV. Given the still unmet medical needs of people living with HIV/AIDS, a recommendation for at most annual CD4 monitoring in stable, virologically suppressed patients offers a high value opportunity for a wise reinvestment of care.[23] The patient

can continue refilling medications and undergo a review once a year unless there is an indication to see a doctor because he/she is not feeling well.

Utilitarianism also requires that harm to health care workers be minimized. How are healthcare workers affected by the Botswana policies regarding access to ART for immigrants? As a physician who has practiced in Botswana, I have experienced the consequences of not being able to treat someone for HIV/AIDS because the country's policy does not allow it. Healthcare professionals who work in government facilities are ruled by procedures and guidelines that are developed by politicians and policymakers. Health care workers don't have much voice in deciding whom they will treat or link to HIV care. Patients are screened and triaged by the administrators/receptionists and sent to doctors' examination rooms to receive treatment. Therefore, health care professionals may not come into direct contact with non-citizen patients on a regular basis unless they are emergency room doctors. Those who come in contact with immigrants at the emergency room or wards are often helpless, They may be able to treat the critical condition and discharge the patients, but with an HIV diagnosis they are unable to help immigrant patients much. It may be morally distressing to send a sick child, woman or man to his or her home to die a slow death. These groups of patients are not benefitting from the discoveries and advances in HIV care that have been made over the years just because they are poor and from another country. This leads to conflict and moral distress in the health care workers due to professional obligation, sense of justice and personal values. Avoiding this distress is morally justifiable as it can be harmful to the happiness and well-being of these care providers.

According to the Hippocratic oath, nurses and doctors must treat the sick regardless of their ability to pay. That is how most physicians see their professional responsibilities. The core

principle of 'do no harm" will not be adhered to if doctors don't refer patients who need ART to treatment centers. I argue that if this moral obligation to treat and do no harm is not executed because of restrictive health policies and laws, it may well lead to moral distress which causes harm to health care providers. They are being denied their responsibilities to abide by the primary purpose of their chosen profession. In addition to the utilitarian arguments for maximizing the welfare of all HIV-infected individuals and those who care for them, there are social justice arguments.

Social Justice

Paul Farmer in his book *Pathologies of Power,* claims that the "language of social justice is increasingly absent from public health parlance."[24] And that there is a new environment in health care where inequalities of access and outcome characterize medicine. However, he argues "these inequalities could be the focus of doctors' collective action as morally engaged members of the healing profession to prevent social inequalities from being embodied as bad health outcomes."

In the current system, citizens of Botswana and immigrants are not treated equally. The citizens enjoy free HIV/AIDS prevention care and management services while the immigrants don't have those rights. For non-citizens who have HIV, the cost of adequate therapy must be borne by the patient. As raised earlier, these populations are at a great risk of contracting HIV because of their social situation and their displacement. Being marginalized will further hinder their access to HIV preventative information and services. If a fair and equitable treatment of HIV infected people, results in a social good, then it would be right to provide access to life-saving medication to all infected individuals.

The only effective way to treat HIV is with ART combination therapy for life. For a lifelong treatment, the commitment to the poor and marginalized individual may be unsustainable. The situation worsens when the health care system rejects HIV infected survival migrants.

All the advances in HIV medicine, the therapy and preventative methods and all the knowledge acquired in the past few decades largely remain irrelevant to these populations. As a result of the inequalities in accessing ART, many people are at the receiving end of suboptimal care. What exacerbates this inequality is that immigrants are also subject to being hunted down by local police. If they are afraid of the police, they may avoid hospitals and health care centers where the probability of police patrol is high. Most patients do not seek help until they are so sick that they take the risk of going to the hospital.

Paul Farmer also argues "promoting the social and economic rights of the world's poor is the most important human rights struggle of our times."[24] He further claims that suffering and injustices are mostly a product of human action or inaction; it happens due to structural violence. Thus, the suffering experienced by immigrants in Botswana must be understood in the broad context of history and geography including interrelated social factors such as gender, ethnicity, and socio-economic status.

It is essential to understand how Zimbabwean migrants in Botswana are victims of structural violence, which contributes to the social injustices they experience. The social structure harmed these people by depriving them of their fundamental human rights and needs. Madison Powers and Ruth Faden point out that “some voices simply do not get a hearing because they are the voices of persons who are members of groups whose claims are not judged worthy of concern by the larger society”.[25] This phenomenon they claim is a characteristic of

systematic disadvantage. This lack of acknowledgment of their voice is what is happening to the survival migrants. These are the people who come from the lowest socioeconomic status, and live in poverty and alienation from the rest of society. As a result of this alienation, they are barely noticed by the rest of the community; they are mainly invisible, their suffering unnoticed. If someone would ask the average citizen of Botswana what he or she thinks of the survival migrants, they will not have much to say. They may point to some negative consequences such as the rise in crime rates since the survival migrants arrived but no one understands their plight and the daily life and death struggles they go through to survive. Their suffering starts in their own country Zimbabwe and persists even after they migrate in search of a better life. Their social status prevents them from benefitting from both scientific and social progress.

How can the injustices be corrected? I suggest that the first step is to acknowledge their existence and recognize their problems. They are not getting government-supported ART care, either therapeutic or preventative, just because they are poor and non-citizens. A pregnant woman may not have the awareness or the means to screen for HIV and be able to take ART for prevention if she is found to be HIV positive. The harm is now being transmitted vertically to the unborn child, and the cycle of injustice and suffering continues. Because of the insidiousness of structural violence, it is difficult to identify and stop it.

John Rawls "Principle of Justice"[26] states that social and economic positions are to be a) to everyone's advantage and b) open to all. This principle should not refer only to people who belong to the same nationality. We also have a responsibility to ensure some economic and social rights to immigrants. Based on Rawls' principles, "by applying fair equality of opportunity, we may eliminate all forms of discrimination and discretion of races, ethnic origin, social standards and religious intolerance and beliefs."[26]

If social justice is to prevail some resource allocation is needed so that ART coverage can be expanded. This expansion will follow a revision of the ART treatment guidelines to be inclusive of HIV affected non-citizens.

Although the immigrants are employable and do find jobs, they still are marginalized, and their voices are not heard. Most survival migrants are paid below subsistence level, so they have to do work at multiple jobs to make ends meet. Iris Marion Young argues that "Justice should refer not only to distribution but also to the institutional conditions necessary for the development and exercise of individual capacities and collective communication and cooperation."[27] Her perspective on social justice, as well as those put forth by Paul Farmer, John Rawls, and Ruth Faden[28] all point to the moral imperative to provide equal access to ART for immigrants in Botswana.

Conclusion

I argue there is an ethical requirement and obligation to reform a discriminatory practice at the health policy level in Botswana.

The plight of survival migrants in Botswana that are affected by HIV/AIDS should be viewed as a moral issue. Even though HIV/AIDS is no longer a death sentence, as it was decades ago, these survival migrants continue to suffer and die from opportunistic diseases subsequent to HIV infection because of their social status and citizenship status.

Social justice demands that health policy makers correct the unjust system by providing HIV treatment and prevention services to these populations for the immediate benefit of the poor and marginalized, and long term benefit of the society as a whole. The provision of treatment to migrants can also be argued from the utilitarian perspective. The utilitarian approach to

HIV/AIDS treatment will require treating the greatest number of people. These two approaches, utilitarian and social justice approaches should play a role when the HIV/AIDS treatment policy is formulated.

The State of Botswana must realize its responsibility and obligation to start correcting the social injustices and offer HIV/AIDS preventive and therapeutic care to all people within its borders. Its HIV/AIDS policies and programs should be designed to be responsive not only to the needs of its citizens but also to the migrant workers that are members of society. The nation can flourish if all its people have equal access to the best healthcare available and if health care workers are free to practice according to principles of medical ethics without risking moral distress.

In closing, I offer a relevant quote from Powers and Faden that "the twin moral impulses that animate public health are to improve human well-being by improving health and doing so in particular by focusing on the needs of those who are the most disadvantaged."[25]

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Curriculum Vita

The author, Aida Asmelash, is from Gaborone, Botswana. She earned her Medical Degree while attending Jimma Institute of Health Sciences in Jimma, Ethiopia. After a brief clinical stint in the remote northern parts of Ethiopia, she moved to Finland where she earned a degree in Master of Public Health from the University of Kuopio, Kuopio, Finland. Subsequently moving to Botswana, she worked for 12 years in clinical research with the Botswana Harvard AIDS Institute. In 2016, she moved to Baltimore, Maryland to enroll and begin her studies in Master of Bioethics at Johns Hopkins University. She currently is a full time student and a full time mother, living with her husband and their two children, Dehab and Amanuel.