Universal Periodic Review of Botswana
43rd Session
May 2023
Joint Stakeholder Report
Joint stakeholder report by:

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SRHR Africa Trust (SAT) is an innovative organisation with a regional footprint contributing to improved systems for Sexual and Reproductive Health and Rights (SRHR) of girls, adolescents, and women in East and Southern Africa (ESA). Through its UN- ECOSOC consultative status, SAT connects community voices and experiences to national, regional, and international networks while bringing global best practices in adolescent and youth SRHR to communities through strategic partnerships, innovation, and advocacy.
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Sexual Rights Initiative
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Keywords
Adolescents, Gender Based Violence (GBV), Sexual Rights, comprehensive sexuality Education, Young People, Right to Health

EXECUTIVE SUMMARY

1. In September 2022, SAT Botswana, a youth-focused organisation, convened a workshop to consult with other youth-led and focused organisations, with ten organisations present. The objective of the meeting was to deliberate and develop a report for the Universal Periodic Review (UPR) on critical issues, focusing on the state of adolescent and youth sexual and reproductive health and rights in Botswana. In addition, the workshop discussed issues concerning adolescents and young people, highlighting some of the increasing sexual health challenges emanating from the COVID-19 pandemic.
2. The government of Botswana allocates 12% of its health budget to the Ministry of Health, while the Abuja declaration (2001) requires 15% to be dedicated to the national health budget. Within this 12% of the national health budget, only 1% of it goes to Sexual Reproductive Health department, with this figure including the procurement of contraception.
3. This report assesses the government of Botswana's fulfilment of adolescent and young people's sexual reproductive health and rights. It provides follow-up recommendations on critical areas of concern that the government should prioritise in the coming cycle, especially access to contraception. In addition, the report analyses the implementation of recommendations from the previous UPR process, highlighting successes and gaps for continued execution. It further applauds the government 's efforts and makes recommendations in areas of improvement.
4. Three key areas identified for strengthening with regards to adolescent health are:
    a. Limited access to adolescent sexual and reproductive health and rights (ASRHR) Services
    b. High prevalence of gender based violence (GBV)
    c. Lack of comprehensive Sexual Education (CSE)

Introduction

5. The government of Botswana puts 12% of its national budget into health - less than the 15% required by the Abuja Declaration on Health and only a fraction is channeled into sexual and reproductive health.
6. Botswana faces myriad problems that directly affect the health and well-being of young people. Out of a population of 2.3 million, 34.7% of the population is youth (15 to 35 years) while adolescents and young people aged 15 to 24 make 22.5% of the total population - this is a sizeable segment of the population struggling to fully enjoy their sexual and reproductive health and rights. Botswana has several policies in place that are meant to support access to SRH services for adolescents and young people. These include the National Health Policy 2011 which aims to provide oversight and overall strategic direction for the health sector, including the budgeting and how much each sector should occupy within the given budget. Other key laws and policies are: the Revised Public Health Act 2013, the Integrated Health Services Plan 2010, and the Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition strategy (2018-2022) which translates existing national policies and strategies into implementable priority actions, such as how to implement youth-friendly clinics and strengthening integration.
7. Botswana has signed and committed to the Eastern and Southern Africa Ministerial Commitment, which requires the country to ensure the full and thorough implementation of CSE. However, Botswana has been slow in rolling out training of teachers to ensure that they are able to deliver CSE. Few teachers have been trained, and the education curriculum covers life skills with some topics adopted from CSE. As for the implementation of CSE for out-of-school adolescents and young people, civil society organisations (CSOs) have been left to implement it, however there is limited support to CSOs in terms of funding to cover the entire country.

8. Adolescents face a range of challenges in enjoying their sexual and reproductive health and rights. These challenges range from a lack of access to comprehensive sexuality education in schools and in communities (particularly in the rural areas), to the dearth of youth friendly clinics, to maternal mortality due to the criminalisation of abortion in the country, to child marrige and sexual and gender based violence.
9. The difficulties experienced by adolescents in enjoying the highest possible standard of sexual and reproductive health are increased by persistent sexual and reproductive health commodity stockouts. There have been stockouts of contraception, HIV test kits, and condoms which were worsened by the COVID-19 pandemic. The outbreak of COVID-19 has had an adverse impact on the funding of health services in Botswana.

Access to comprehensive sexuality education

10. Botswana reviewed and accepted the following relevant recommendations from the last review:

- 127.61 Continue efforts to promote comprehensive education policies, particularly by implementing the national strategic education plan (2015–2020) (Brazil).
- 127.73 Implement gender equality policies that foster girls' access to health and education and raise awareness among the population about sexual and gender-based violence (Mexico).

11. The government of Botswana is currently reviewing the school health policy of 1999, in order to incorporate the facilitation of comprehensive sexuality education in schools. Through the Ministry of Education, the government developed a comprehensive sexuality education (CSE) framework to enhance the provision of Reproductive Health and Sexuality Education (RHSE) in schools. The RHSE was previously part of the school curriculum through Moral Education and Life Skills however, it was phased out since Moral Education is no longer part of the school curriculum, and Life Skills is taught in a discretionary and subjective manner, with little standardisation across institutions. There is some resistance to the adoption of a truly comprehensive sexuality education syllabus as some teachers perceive CSE as promotion of sexual immorality, and others do not understand what CSE is about.
12. One of the Eastern and Southern Africa (ESA) Ministerial Commitments indicates that countries should make sure that 95% of adolescents and young people are reached with good-quality, age-appropriate, culturally relevant and evidence-based sexuality education through in- and out- of-school programmes. Botswana's report on its ESA commitments (2020) indicates that the country is still lagging behind in reaching the targets as expected, and implementation of comprehensive sexuality education is progressing very slowly indeed. It is quite clear that Botswana is struggling with the implementation of CSE for both in and out of school adolescents.
13. Presently each secondary school only has 1 teacher on average in training on CSE, and their training is still ongoing. The curriculum currently being used in schools is not really a CSE manual, rather it is a variation of the Life Skills syllabus, with the inclusion of some topics that you would expect to see in a CSE curriculum. In order for CSE to be well implemented, there is a need to ensure that the government adopts and uses a truly comprehensive CSE manual in schools. The current curriculum has insufficient information on sexual reproductive health and rights, and it does not guide teachers on how to teach the subject. This makes it more challenging to meaningfully implement CSE.
14. The government has not formulated a strategy nor created a programme to ensure that CSE is provided to adolescents who are out of school. This work has been entirely left to civil society organisations. This limits the coverage, as civil society organisations do not have the necessary resources required to service the entire country, and do not receive any funding or grants from the government to facilitate the implementation. The government needs to better collaborate with civil society organisations to ensure that all young people are reached. The government could maximise on

the use of radio, television and social media to provide information to adolescents.

15. A lack of access to comprehensive sexuality education, sexual and reproductive health information, coupled with inadequate sexual and reproductive health services, increases the risk of unintended pregnancies, unsafe abortions and maternal mortality, sexually transmitted infections (STIs), and HIV increase. These risks are compounded by social determinants of health, such as exposure to violence, poverty, illiteracy, discrimination based on gender, and child marriages

Access to sexual and reproductive health services, access to contraception, and access to HIV services

16. We regret that Botswana did not receive any recommendations which were specific to strengthening reproductive health services for adolescents, which would ensure that adolescent and young people have access to contraception and safer sex commodities. We also regret that no recommendations on access to contraception were made. However, Botswana received and accepted the following relevant recommendations on HIV/AIDS during the last review:

- 127.55 Further strengthen its national programme to reduce HIV prevalence, especially among young people. (Indonesia)
- 127.54 Further improve the healthcare infrastructure in Botswana and pay special attention to awareness-raising programmes among women and adolescent girls in rural areas for addressing the challenge of HIV/AIDS. (India)

17. Adolescents have highlighted that they experience various impediments to accessing quality health services, including the fact that there are few youth-friendly clinics. There is slow implementation and decentralisation of adolescent-friendly services. Botswana is said to have 35 youth-friendly clinics across the country - however twenty-three (23) of these clinics whilst operational are operational but centralised. It is important to note that there are 380 clinics in the country, and less than 10% are conducive for young people. To give an example, the capital city Gaborone has 1 government clinic which is designated as a youth-friendly clinic although the population of Gaborone is more than that of any other area.
18. The centralisation of the clinics makes them inaccessible to young people who live in the rural areas who must travel longer distances to where youth-friendly clinics are located- if they are present in the area they are in at all. Additionally, the clinics may not provide healthcare services of good quality, as there have been reports of adolescents living in the rural areas receiving bad service such as being told to return the next day to access services, because the service they needed was not categorised as illness or emergency. Other barriers to the quality of services, include a longer waiting time before they access the services, centralisation of adolescent health services, and age restriction of other services such as HIV testing for adolescents. To strengthen youth-friendly services, the government has trained a few nurses on YFS, which is a great initiative, but more nurses need to be capacitated for easy integration of services.
19. Policy in Botswana states that the age of consent to access HIV testing is 16 years, and those below the age of 16 can only access HIV testing when there is a guardian or parent to consent for them, hence this acts as a barrier. Another issue surrounding HIV is that the administration of Pre- Exposure Prophylaxis (PreP) or Post exposure Prophylaxis (PeP) by health professionals hinders access to HIV services by adolescents and young people. Most of the time, young people highlighted that government hospitals do not give them Prep and Pep when they request them, especially as sex workers. This is prevalent in health facilities in rural areas, as they usually have only a few nurses working in the clinic, and sometimes just one nurse working in a health post to provide general health services. This means that adolescent services are not treated as a priority, as the nurse will have to attend to all other

emergencies that come through.

20. Despite the acceptance of the above recommendations on HIV/AIDS, Botswana has not fully implemented the recommendations. The HIV/AIDS response has since 2018 been hampered by an unstable supply of health commodities, particularly condoms, and HIV test kits, thereby weakening the prevention response. Generally, youth friendly clinics experience low stocks of SRH commodities and COVID 19 has worsened condom and HIV Test Kits stock outs, as most funding has been shifted to COVID-19 response and condoms and HIV Test kits were not prioritised, thus no procurement was made during the COVID-19 lockdown era.
21. Adolescent pregnancy is high in Botswana, with Kweneng district leading all other districts, and unplanned pregnancies are even higher amongst 15–19-year-olds. It has been reported that among sexually experienced adolescents, 48.9% of them had more than one sexual partner. However, adolescents still face barriers in having their sexual and reproductive health needs met.
22. Adolescents have had challenges in accessing contraception as there has been a contraception stock out and as clinics lack youth-friendliness, as nurses usually judge adolescents and young people who are sexually active. Policies in Botswana allow adolescents to access contraception without parental consent, however there are barriers that still hinder them from accessing them. Some of the barriers include discrimination by professional health workers, as they provide abstinence-only sexual health counselling, as well as the shortage of contraception within clinics. Young people have complained about the bad attitudes of health professionals when they need contraception. Having to queue in line with adults to access services also makes it more difficult as culturally, they are expected to abstain. Further, whilst the government made an effort to hire nurses for secondary schools to provide health services - they need to be permitted and equipped to provide access to contraception. This is another gap that the government needs to close.
23. Access to contraception by adolescents and youth is a sustainable investment that the government of Botswana can make to improve the health and future of adolescents since it will reduce unwanted pregnancies, which can lead to unsafe abortions, given the continued criminalisation of abortion in Botswana, to maternal mortality, and to new HIV infections.

Maternal mortality amongst adolescents and young women

24. We regret that Botswana did not receive any recommendations on addressing maternal mortality, or increasing access to safe abortion.
25. The government of Botswana has various initiatives in place that aim to reduce the maternal mortality rate. As part of this drive, there is a need to underscore how unsafe abortion is one of the leading causes of the high mortality rate among adolescents and young women. Complications that adolescents and young women experience after undergoing unsafe abortions are among the leading causes of maternal mortality. These cases of maternal mortality and those of maternal morbidity indicate that abortion services need to be decriminalised, and safe abortion services need to be provided in all hospitals, such that they are easily accessible for adolescents and young people on demand.
26. Abortion is currently criminalised in Botswana under section 160 of the Penal code (as read with sections 135 and 136), with abortion only being permitted in three exceptions, namely: where the pregancy is the result of unlawful sexual conduct such as rape or incest, where the pregnacy endangers the life or physical or mental health of the pregnant person, and where the is foetal abnormality or disease. For the latter grounds, there is an additional requirement for two doctors to attest that the pregnant person is eligible for access to a safe abortion. If the pregnant person meets any of the three grounds, they are permitted to access abortion up to sixteen weeks. The law does not

allow adolescents and young people to access safe abortion services on demand, in either private or public hospitals.

27. Criminalisation of abortion violates the right to bodily autonomy, the right to health, the right to life, and the right to be free from dehumanising treatment, as criminalisation does not curb the need for abortion - it just means that abortions will be unsafe. Further, women and girls are denied the freedom to make decisions about their bodies, and to have a safe abortion provided like any other health service in a safe environment. Botswana only freely provides post-abortion care in most public hospitals.

High prevalence of GBV

Child marriage and GBV

28. We regret to that no recommendations on child marriage were made to Botswana in the last UPR cycle. However, Botswana did a number of recommendations on gender-based violence that it accepted, including:

- 127.66 Take measures aimed at ending violence against women and girls and the discrimination suffered by them by influencing traditional practices that undermine gender equality and promoting greater participation of women in all sectors of society (Spain).
- 127.31 Implement further measures to combat gender-based violence and take steps to strengthen legal protections for victims of gender-based violence (Australia)

29. The United Nations defines Gender Based Violence (GBV) as any act of violence that results in physical, sexual, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts. In May 2021 the permanent secretary responsible for Gender Affairs reported that in Botswana, GBV prevalence stands at 67%[1] among women. Since the outbreak of the COVID-19 pandemic, and between January 2019 and June 2021, Botswana recorded 11 294 cases of GBV, with many more instances going unreported.
30. Botswana has partially achieved these recommendations as there has been some efforts made to establish gender specific courts and to train police officers on gender issues. Additionally the government has made an effort to address sexual and gender based violence through establishing the Standard Operating Procedures (SOPs), and a Gender and Child Protection Unit in Molepolole. Additionally, the government has since 2018 introduced 24-hour service in all Police GBV Units. The government 's introduction of childcare and gender courts will optimise police functionality and help address GBV.
31. However, these efforts are not enough as poor implementation of the legal and policy framework on GBV under the Domestic Violence Act (2008) limits the administration of justice, and fails to adequately address the scourge. Additionally, all of the above measures require strengthening and scaling up. For example, there is currently only 1 police officer trained on gender issues in each police station, hence there are delays in case reporting in their absence. Furthermore, there is a need to also train and include other stakeholders such as magistrates, teachers, traditional leaders and social workers as they are sometimes also seized with addressing GBV cases.
32. For adolescent girls in Botswana, sexual gender-based violence manifests itself in child marriages, defilement, and rape. Child marriage in Botswana is often justified in the name of cultural values and traditions, is a form of violence against girls, and contributes to the incidence of SGBV in the country.

[1] *Botswana National relationship Study (2018)*

The Botswana Children's Act prohibits parents or anyone to marry a child aged 18[2] and below. However, Botswana still experiences child marriages in the northern part of the country, specifically the Ngamiland region, where children are married off under customary and religious laws.

33. UNFPA reported that 3000 children were trapped in child marriages, which they expected to increase in the year 2019 if there were no strategies put in place to facilitate ending child marriages in Botswana[3]. Even though the country made efforts to end child marriages across the country by putting in place the Children's Act and Marriage Act, the country still experiences unregistered child marriages in certain parts of the country within the Bazezuru and Baherero tribe who still practice child marriage as their culture.
34. Although the Children's Act takes precedence in protecting children, its implementation is very weak. While the Children's Act is progressive, the Marriage Act specifies that no child aged 18 and below should be married, but that it does not regulate religious and customary marriages as they will be facilitated within their institutions. This leaves a gap which religious and customary laws use to marry off adolescent girls, justifying the practices as social and cultural beliefs.
35. Further adolescent pregnancy is often used to justify marrying off adolescent girls. In 2019, 14 districts recorded the highest number of adolescent pregnancies, with a total of 4786 adolescent pregnancies. Within this figure, the number of cases that were defilement cases was notable; however, these cases of sexual exploitation often do not reach the police as they go unreported. In September 2021, the Deputy Commissioner of Botswana Police announced that the government was piloting a programme whereby they would aim to resolve defilement cases that were reported at the Child Friendly Service Centre within six months. He further stated that out of the 76 cases that were reported that year at the Child Friendly service Centre, 38 cases were concluded.

RECOMMENDATIONS

We call on Botswana to:

1. Commit to a consistent and transparent, data-driven process for allocating SRHR budgets within the health budget and adequately fill the SRHR budget.
2. Strengthen its commodity supply chain system and enhance accountability so that it no longer experiences stockouts in health commodities particularly HIV testing commodities, condoms, anti-retroviral medication, and contraception
3. Train healthcare professionals (i.e. nurses, doctors) in SRHR for adolescents and young people, both via pre-service training in tertiary institutions, as well as by in-service training.
4. Utilise youth-led models for SRHR services for young people so as to better connect with the whole lived experience of young clients.
5. Ensure that free abortion services are accessible in all healthcare facilities by decriminalising abortion.
6. Further strengthen inclusion of CSE in the curriculum and increase the number of teachers trained in CSE.
7. Adequately resource the implementation of CSE in schools through collaborating with civil society organisations.
8. Decriminalise sex work.

[2] *Botswana Children's Act (2009)*

[3] *UNFPA (2016) The Anti-Child Marriage Campaign*

9. Continue to improve programming to prevent GBV and to provide access to justice and support services for victims of GBV and child marriage.