CENTER for HEALTH and GENDER EQUITY

The Case for Comprehensive: Botswana

The Importance of Comprehensive, Rights-Based Approaches to Sexual and Reproductive Health

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SITUATION AT A GLANCE

Maternal Health

Maternal Mortality:	380 deaths per 100,000 live births[1]
Births attended by skilled health personnel:	95%[2]
Legal status of abortion:	Legal up to 16 weeks in cases of rape, incest, fetal impairment, or to save health of mother; requires two certifying doctors

Family Planning

Contraceptive prevalence:	48%[3]

HIV/AIDS

HIV prevalence, 15-49 year olds:	24.1% (2nd highest globally)[4]
Number of people living with HIV:	300,000 (170,000 women)
HIV prevalence among 15-19 year olds:	10% (young women); 4% (young men)[5]
HIV prevalence among pregnant women:	32%[6]
Access to VCT under age 21:	Only with parental consent

U.S. Funding

PEPFAR has poured millions of dollars into Botswana to fight and treat HIV and AIDS -- over $47 million between 2004 and 2008. Despite high numbers of HIV discordant couples, PEPFAR's prevention focus has been very heavily weighted toward abstinence and faithfulness. In 2008, over $200,000 was spent on abstinence and faithfulness activities, while only $38,000 was spent on all other prevention activities, including promotion of HIV testing, education on risk avoidance, and social marketing of condoms.[7] The U.S. gives no funding to Botswana for family planning, reproductive health, or maternal health.

CHANGE Field Study Findings

The Bottom Line

Botswana appears to be a series of contradictions. Although **economically better off than its neighbors**, with relatively good roads, solid communications network, and 24-hour hospitals fairly well distributed throughout the country, Botswana nevertheless has **serious barriers to comprehensive sexual and reproductive health care**. While the government requires that sexual and reproductive health services, including family planning, prenatal care, delivery, post-abortion care, and STI services are provided at no cost by maternity care providers, hospitals and government clinics, indicators such as maternal mortality, feminization of HIV, and contraceptive prevalence do not reflect a system that meets the needs of its population.

Although sexual and reproductive health services are available, they are **not accessible, particularly for young people**. Despite the fact that 90% of people in Botswana live within 15 kilometers of a health center, use of these centers for SRH services is very low, especially among young people. Young people

say they are kept away by inconvenient hours, poor information about services, and unwelcoming attitudes toward youth among service providers.[8]

Marital rape is not recognized by the civil legal system in Botswana, and a study found that 39% of men believed that women do not have the right to refuse sex with their husbands or boyfriends.[9] Because women must present a police report certifying a rape to access post-exposure prophylaxis or emergency contraception, **married women who are raped by an HIV-positive husband do not have access to these medications**.[10]

Limited Promises

While Botswana is heralded as a success story in the battle against HIV because of its universal access to ARVs (Antiretrovirals), the reality on the ground is much more nuanced. What emerges is a strong illustration of how programming that is not integrated or rights-based affects the most vulnerable groups in society, particularly women and youth.

In general, **sexual and reproductive health services in Botswana are fragmented and not comprehensive**. Piecemeal projects focused mainly on HIV prevention and treatment, and while many of these are quality projects, there is little coordination between their efforts and the public health sector that provides family planning and maternal health. For example, Tebelopele, the major U.S.-funded VCT (Voluntary Counseling and Testing) NGO in the country, does not offer any family planning, STI treatment or other sexual and reproductive health service.[11]

The International Planned Parenthood Federation member association BOFWA – the **Botswana Family Welfare Association – comes the closest to providing comprehensive care in Botswana**. They provide antenatal care, breast exams, pap smears, STI management, VCT and pregnancy tests. They distribute male and female condoms. Like Profamilia in the Dominican Republic, they combine clinic space for their HIV, family planning and maternal health services to reduce stigma. They have a **youth-friendly clinic that serves ages 10 to 29**. However, they do not have a lab, so clients must go to the hospital for all lab tests. Moreover, they do not provide ARVs or PPT, but refer clients to government services instead. While they screen for gender based violence, they do not provide more than counseling, referring survivors to Gabarone's shelter for other services.[12]

CHANGE researchers heard of **widespread discrimination against those living with HIV and AIDS. Botswana law prohibits youth access to VCT under the age of 21 without parental consent**, violating confidentiality rights and discouraging testing for youth. The government does not currently have a mechanism to monitor HIV-related human rights abuses. While in office, the former Minister of Health said in the media that women are the ones spreading HIV.[13]

This environment has a clear impact on how sexual and reproductive health programs are implemented. One project targeting women who are HIV positive and pregnant enlists counselors, all mothers living with HIV, who must sign a contract in order to receive their stipend. The contract asks that they pledge not to become pregnant while in the program. If they become pregnant, they lose their position and their stipend—violating their fundamental right to decide to have a baby or not. Moreover, **women who are HIV positive and become pregnant tend not to seek out PMTCT** (Prevention of Mother to Child Transmission) services because of **associated stigma**, as well as abuse and discrimination by service providers.[14] Health workers and clients report that the stigma is so significant that they breastfeed children because formula use is associated with HIV.[15]

Heavily reliant on PEPFAR funding that emphasizes abstinence and faithfulness, HIV prevention programs in Botswana have nevertheless succeeded in raising awareness about condoms but not significantly increasing their use. In a study on HIV knowledge, attitudes and behaviors, Physicians for Human Rights found widespread awareness that condoms could prevent the transmission of HIV. However, this knowledge did not translate into behavior, as **46 percent of sexually active respondents reported unprotected sex over the past year**. Over half of the women who had not used a condom in the past year reported that at least one instance of unprotected sex was due to partner refusal to use a condom. One pregnant woman who was HIV+ explained that she had not increased condom use because, "if he refuses, I have no say."[16]

Impact of U.S. Policy on SRHR in Botswana

In Botswana, the large PEPFAR budget and lack of any USAID funding for reproductive health has created booming – but vertical – programming just on HIV. As a result, while there is a growing civil society movement on HIV and AIDS, there is little to no advocacy around reproductive rights.

A U.S.-funded group that does youth programming was careful not to criticize restrictions on U.S. funding they received. But when asked how they would want things done differently in the future of PEPFAR, the youth responded unanimously that they would like the **U.S. to fund all prevention methods equally – not just abstinence and fidelity**. One youth leader who had recently begun receiving U.S. funding commented that the switch in funding made them "sacrifice our holistic program to meet our funder's demands."[17]

The requirement that PEPFAR grantees have a policy against the practice and legalization of prostitution has had varied effects in the field. CHANGE found **two organizations in Botswana who have ended their efforts with sex workers**, despite the high risk of HIV transmission for this population.

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[4] UNAIDS 2006
[5] Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland. Physicians for Human Rights. 2007. http://physiciansforhumanrights.org/library/documents/reports/botswana-swaziland-report.pdf.
[6] UNAIDS. 2008. Government of Botswana Country Report, 2007. Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS, December 2007.
[7] The Power of Partnerships: Fourth Annual Report to Congress on PEPFAR. 2008. http://www.pepfar.gov/documents/organization/100029.pdf.
[8] UNFPA. 2003. Case Study: Botswana: Reproductive Health for Youth at the Workplace, May 1, 2003, New York, TSD.
[9] Andersson, N, A Ho-foster, S Mitchell, E Scheepers and S Goldstein. 2007. "Risk factors for domestic violence: National Cross-sectional household surveys in eight southern African countries." BMC Women's Health 7 (11).
[10] Interview with program manager. April 2008.
[11] Ibid.
[12] Ibid.
[13] Interview with advocate. April 2008.
[14] Interview with program manager. April 2008.
[15] Interview with health workers. April 2008.
[16] Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland. Physicians for Human Rights. 2007. http://physiciansforhumanrights.org/library/documents/reports/botswana-swaziland-report.pdf.
[17] Interview with youth leader. April 2008.