BONELA

The Botswana Network on Ethics, Law and HIV/AIDS

ARASA AIDS & Rights Alliance for Southern Africa

A BRIEF LEGAL ANALYSIS ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS, POLICY, LAW AND PRACTICE IN BOTSWANA

Sisonke Botswana Organisation

Rainbow Identity

SUCCESS CAPITAL
YOUTH LED, MANAGED & SERVING

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GLOSSARY OF TERMS

i. **Adolescents:** Persons aged 10–19 years. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age.

ii. **Gende**r-based violence: Violence that is directed against an individual due to their gender or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.

iii. **Health care:** Services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring, restoring health and preventing illness.

iv. **Health:** state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined.

v. **Human rights**: Rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include civil, political, social and economic rights. For instance, these include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.

vi. **Key populations:** Groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviours that increase their vulnerability to HIV. They include: men who have sex with men; people in prisons; people who use drugs; sex workers; transgender people and young key populations who are increasingly denied sexual and reproductive health services and are vulnerable to HIV infection. The key populations are important to and access to sexual and reproductive needs and the dynamics of HIV transmission. They also are essential partners in improving access to sexual and reproductive needs and in effective response to HIV epidemic.

vii. **Men who have sex with men (MSM):** All men who engage in sexual and/or romantic relations with other men. The words "men" and "sex" are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities and various identifications with any particular community or social group.

viii. **People who inject drugs (PWID):** People who inject psychotropic (or psychoactive) substances for nonmedical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as "therapeutic injection" – are not included in this definition.

[1]The definitions are adopted from the Southern African Development Community

The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. definition

ix. **People who use drugs (PWUD):** People who use illegal, psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. This definition does not include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods.

x. **Sex workers**: Female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services. Sex work is consensual sex between adults, can take many forms and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less "formal", or organized. As defined in the Convention on the Rights of the Child, children and adolescents under the age of 18 who exchange sex for money, goods or favors are "sexually exploited" and not defined as sex workers.

xi. **Sexual and reproductive health:** A state of complete physical, mental and social well-being in all matters relating to the reproductive system and sexuality; it is not merely the absence of disease, dysfunction or infirmity. For sexual and reproductive health to be attained and maintained, the sexual and reproductive health rights of all persons must be respected, protected and fulfilled. Sexual and reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

xii. T**ransgender:** An umbrella term for people whose gender identity and expression do not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. It includes people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.

xiii. **Vulnerable populations:** Groups of people who are particularly vulnerable to HIV infection and denied sexual and reproductive health services in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers.

xiv. **Young key populations:** This term refers to individuals between the ages of 15 and 24 who due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviours that increase their vulnerability to HIV.

1.0 INTRODUCTION

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Globally, key population groups experience poor sexual and reproductive health rights (SRHR) outcomes due to social norms, taboos, legal, physical and economic barriers to access to SRHR services. The lack of SRHR policies and access to affordable appropriate health services often lead to stigmatization and marginalization of key population groups from society, high adolescent fertility rates, early and forced marriage, increased risk of maternal mortality, and a high unmet need for contraception. It is therefore critical for key population groups to universally access comprehensive sexual and reproductive health services, information and have their rights fulfilled. This calls for renewed commitment by world leaders to address gaps and emerging issues for sexual and reproductive health and rights for all, including key population groups. It is also an issue of social justice to empower key population groups, and promote gender equality, equity across the world in pursuance of Sustainable Development Goals (SDGs).

Sexual and reproductive health rights (SRHR) policies are vital to empowering key and vulnerable population groups, and the SDGs, can only be fulfilled with full enjoyment of sexual and reproductive health and rights. As countries implement SDGs roadmap, it is critical to reflect on the extent to which the world is realizing human rights for all, without leaving anybody behind. Whilst the rhetoric has been on the inalienable rights of all, in some communities, the reality on the ground has been characterized by the violation of rights of key population groups. In Botswana, sexual activity is one of the leading modes of transmission of STIs, including HIV. The main concerns for key populations are not just HIV or sexually transmitted infections, but other sexual reproductive health issues.

In providing SRHR services to key population groups, distinctions between sexual health, reproductive health and reproductive rights are not always made. The World Health Organization (WHO) and Southern African Development Community (SADC) acknowledge that sexual health deals with the enhancement of life and personal relations, not merely counselling and care related to reproduction and sexually transmitted diseases. It refers to the integration of the somatic, emotional, intellectual and social aspects of sexual beings in ways that are positively enriching and that enhance personality, communication and love. The SADC Member States also recognize that reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Furthermore, reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents.

Implicit in these definitions are the rights of people to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law, and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant. These rights rest on the recognition of the basic rights of all people, including key population groups, to attain the highest standard of sexual and reproductive health services, and the right to make decisions concerning reproduction free of discrimination, coercion and violence. Key population groups should also have the right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.

Whilst SRHR programmes have seen some impressive successes for the general population in Botswana, such positive approaches have not been effective in reaching the key population groups. There is growing recognition of the importance of addressing the SRHR issues of key population groups in Botswana. This paper provides a brief overview of the desk review of legal, policy, social and any other barriers that affect key population's access to SRHR. The review is based on the premise that sexual and reproductive health is a basic human right that seek to protect an individual's access to information and appropriate services. The review addresses the needs of people at all stages of their lives and aims at enabling individuals, families and communities to take necessary action to promote and protect their own health and that of their partners. Furthermore, SRHR are an essential part of universal health coverage (UHC). It is therefore important for Botswana to embrace a comprehensive approach that ensures SRHR needs of people, regardless of their sexual orientation, are met throughout the course of each person's life, from infancy and childhood through adolescence and into adulthood and old age. A comprehensive approach to SRHR entails adopting the full definition of SRHR and providing an essential package of SRHR interventions with a life course approach, applying equity in access, quality of care, without discrimination, and with full accountability across the entire implementation spectrum.

[2]Reproductive Rights and Sexual and Reproductive Health Framework United Nations Population Fund (May 2008).
[3]Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage 8 November 2019.

2.0 ANALYSIS OF THE SRHR LEGAL, POLICY AND PRACTICE ENVIRONMENT FOR KEY POPULATION

2.1 SEXUAL REPRODUCTIVE HEALTH RIGHTS AND LEGAL ENVIRONMENT

2.1.1 INTERNATIONAL AND REGIONAL HUMAN RIGHTS FRAMEWORK

International and regional pieces of law provide a framework for HIV and human rights law issues in Botswana, and are sets out in treaties, charters and conventions. A State is obligated to uphold the rights, obligations, and provisions in a treaty upon signature and ratification. Indeed in this respect, The African Commission on Human and Peoples' Rights has stated succinctly that "International treaties which are not part of domestic law and which may not be directly enforceable in the national courts, nonetheless impose obligations on State Parties."

The above, notwithstanding, the position remains that treaties concluded and ratified by Botswana are only binding and enforceable against her internationally. They do not automatically become a part of our domestic law, save to a limited extent in employment matters and in the construction of its Constitution. As such, they do not create rights and obligations that are enforceable by the courts. The courts can only enforce these rights and obligations when specifically incorporated into domestic law by an Act of Parliament. That is so because the conclusion of treaties with foreign states is an Executive Act that is carried out by the President. The position differs in, for instance, Namibia and South Africa where the legislature of those countries must consent before any treaty negotiated by the Executive is ratified. In Botswana, Parliament is neither consulted nor involved in the negotiation or ratification of the treaties that Botswana is party to. Although Botswana is a signatory to and has ratified a number of Human Rights Treaties and Conventions, such as:

- African Charter on Human and Peoples' Rights, 1986;[8]
- African Charter on the Rights and Welfare of the Child, 2001;

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4 Legal Resources Foundation v Zambia, Comm. 211/98, para 60, available at http://caselaw.ihrda.org/doc/211.98/pdf.

5 See for instance Diau v. Botswana Building Society [2003] 2 BLR 409 (IC). This exceptional circumstance is to be found in that in establishing an Industrial Court at section 15(1) of the Trade Disputes Act [Chapter 48:02], Parliament made the Court one not only of law but also one of equity. All the other Courts in Botswana; (save for this one exception); are Courts of Law.

6 In *Attorney* General of Botswana v Unity Dow 1994 (6) BCLR 1 the Court of Appeal specifies that Botswana Courts must interpret domestic statutory laws in a way compatible with international treaties. This is scant comfort to a litigant before any Court who is dealing with a clear provision of domestic law that cannot be bent to fit any such interpretation.

7 *Constitutional* Law in Botswana, D.D Ntanda Nsereko at page 45.

8 Dates listed are Botswana's dates of ratification.

- Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment, 2000;
- Convention on the Rights of the Child (CRC), 1995;
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1996 (individual complaint mechanism also ratified);
- Convention on the Elimination of All Forms of Racial Discrimination (CERD), 1974;
- ILO Convention Concerning Discrimination in Respect of Employment and Occupation, 1997;
- International Covenant on Civil and Political Rights (ICCPR), 2000;

The country has also signed, though not yet ratified the following:

- Convention on the Rights of Persons with Disabilities;
- International Covenant on Economic, Social and Cultural Rights (ICESCR; and
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

However, due to the nature of the country's legal system, these treaties and conventions do not confer any actionable legal rights on its residents and citizens. At best, therefore, though its Government may be held accountable in the international sphere (which is not likely to happen due to how Nation States relate with each other), residents and citizens of Botswana are not able to use these international instruments to fight for their SRHR rights. These are only woefully inadequate local laws. It is imperative for Parliament to be intensively lobbied to pass enabling legislation to domesticate international Treaties and Conventions and also, to pass appropriate domestic laws that protect and or enhance the protection and enforcement of SRHR.

2.1.2 CONSTITUTION OF BOTSWANA

At the corner stone of every modern democratic country's supremacy lies its Constitution. It is this document, virtually always the world over, which forms the basic structure of any government because a Constitution lays down all the legal and cultural aspects under which its people and governmental bodies will be governed. It enshrines and protects the fundamental rights of its citizens, and upholds the fundamental principles that govern the nation. The Constitution of Botswana has a Bill of Rights, which guarantees the fundamental rights and freedoms of all people, free from discrimination on any grounds (including the ground of "sex") to, amongst others, the rights to life, liberty and security of the person, privacy and freedom of conscience, of expression and of assembly and association.

The country's Constitution has important rights, though not explicit to SRHR. These rights include the right to life, liberty, freedom of conscience, of expression and of assembly and association, privacy, personal liberty, and security of person, protection from inhuman treatment, secure protection of the law and protection from discrimination. However, economic, social and cultural rights including the right to

health are not specifically guaranteed in the Constitution. This failure presents a formidable hurdle to the enforcement of sexual and reproductive health rights before the Courts.

2.1.3 PUBLIC HEALTH ACT (2014)

Progressive public health legislation protects and improves health care across all rungs of society. In Botswana, the Public Health Act, 2014 regulates many aspects of the provision of healthcare and services. In the context of SRHR, the Public Health Act has identified HIV as a significant public health issue in the country. The Act promotes HIV-related rights that are aligned to international human rights goals of universal access to prevention, treatment, care and support services . These progressive provisions (Section 104(1)(a); Section 104(2); Section 105(a); Section 110; Section 113; Section 122; Section 116(4); Section 121 and Section 122) advocate for the provision of sufficient information to individuals for informed and voluntary decision to be tested, post-test counselling, referrals to appropriate services and protection of patient confidentiality. Furthermore, the Public Health Act provides for consent, counselling and confidentiality as fundamental rights in the context of HIV testing and treatment.

However, the Public Health Act, 2014 is silent about key populations in the context of their rights to equitable SRHR services, and several provisions of the Public Health Act are inconsistent with Constitutional and human rights, medical ethics, international standards, and an effective public health response, including in the context of SRHR. In addition, some provisions are not clearly defined and may be misinterpreted and misapplied. For example, the Public Health Act defines "communicable disease" as any disease which can be transmitted directly or indirectly from one person to another. While it might make sense to allow for detention in cases of highly infectious diseases if appropriate human rights standards are met, detention would be ineffective and inconsistent with international standards in the context of sexually transmitted communicable diseases. In the same vein, the Public Health Act defines HIV and AIDS as "notifiable diseases" as well as "any other disease declared a "notifiable disease" in terms of Section 52. In the same Act, Section 57 broadly authorises (i) the isolation of persons who have communicable diseases when medical practitioners believe detention is necessary to prevent the spread of the disease (ii), authorises such detention to endure for a period that is left to be determined by medial health authorities and (iii), makes it an offence for a detained person to escape or attempt to escape.

However, the Act does not include sufficient safeguards that ensure that isolation and detention are a last resort and meet the legal requirements of limiting the rights to liberty, security of person and

[9] https://www.cambridge.org/core/journals/journal-of-african-law/article/justiciability-of-socioeconomic-rights-in-botswana/.

[10] Heywood MJ. The routine offer of HIV counselling and testing: A human right. HIV AIDS Policy Law Rev.2006;11: 71 - 72. PMID: 17375428.

freedom of movement, including amongst other international human rights norms, the The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights. The isolation of people living with HIV or other communicable diseases associated with it cannot invariably be necessary since HIV is not spread through casual contact, yet the Public Health Act does not provide clarity as to when isolation or detention may be necessary. The Public Health Act does not allow for a legal or other remedy in cases of unlawful detention nor provide for oversight mechanisms or guidelines as to appropriate circumstances for and length of detention.

In addition, Section 104 (3)(b) of the Public Health Act broadly allows for mandatory HIV testing, including at sections 104(4) and section 104(7), thus undermining the protective aspects of the Public Health Act and international requirements which require testing to be conducted voluntarily, with informed consent, protection of patient confidentiality with provisions for counselling. Authorising the involuntary testing of 'categories of persons' is a concern as it could be interpreted as targeting key, vulnerable or stigmatised sections of the population.

In a far reaching provision that undermines the free will and consent of a patient in the context of a doctor-patient relationship, section 105 (2) (b) even permits a person's doctor to conduct an HIV test without the consent of that person if such medical practitioner believes that such a test is clinically necessary or desirable in the interests of that person. Similarly, this section interferes with the rights to, amongst others, privacy and liberty which require voluntary and informed HIV testing. Furthermore, Section 105(3)] indemnifies the concerned Health Care Worker against any civil or criminal liability that may arise out of the non-consensual HIV testing, thus possibly providing a blank cheque/open season for abuse and denial of SRHR services.

More debatable, however, is section 108 which authorises mandatory HIV testing for persons convicted of rape. An arguable case can be made out, in this specific context that this section seeks to address public interest concerns in this area, by attempting to balance the rights of victims against those of offenders. The section attempts to resuscitate, somewhat, a previously impugned amendment of the Penal Code [Chapter 08:01]. Section 142 of the Penal Code [Chapter 08:01] was amended in 1998 to read:

142. Punishment for rape

(1) ...

(2) ...

(3) Any person convicted of the offence of rape shall be required to undergo a Human Immunodeficiency Virus test before he or she is sentenced by the court.

(4) Any person who is convicted under subsection (1) or subsection (2) and whose test for the Human Immunodeficiency Virus under subsection (3) is positive shall be sentenced-

[11] https://www.jstor.org/stable/762035?origin=crossref.

(a) *to a minimum term of 15 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that such person was unaware of being Human Immunodeficiency Virus positive; or*

(b) *to a minimum term of 20 years' imprisonment or to a maximum term of life imprisonment with corporal punishment, where it is proved that on a balance of probabilities such person was aware of being Human Immunodeficiency Virus positive.*

In the matter of Makuto v State [2000] 2 BLR 130 (CA) the Court of Appeal ruled that enhanced sentencing on the basis of HIV status is only constitutional and non-discriminatory if an accused person was HIV positive at the time of the rape. Section 108 does not prescribe a procedure or other method that may be applied to ascertain this important question, thus making it fraught with difficulties in implementation. Though the Parliament of Botswana may have been well meaning in its interventions under the Public Health Act it appears to have crossed the line, thus calling for a serious review of a lot of provisions of the Act to accommodate SRHR issues affecting key populations and any other person.

2.1.4 PENAL CODE [CHAPTER 08:01]

The regulatory framework in Botswana, in part hinders progress in the national efforts towards the empowerment and enforcement of SRHR. For instance, the Penal Code includes clauses such as "carnal knowledge against the order of nature", "nuisance", "public disorder", "cross-dressing", "impersonation" and similar offences which are in turn are used to target, blackmail, harass, abuse, arrest and otherwise commit human rights abuses against LGBTI people and sex workers. Key sections in the Penal Code, such as section 164 which makes "carnal knowledge against the order of nature" a criminal offence that is punishable with up to seven years of imprisonment and section 165 which criminalises attempts to commit such an offence and imposes a five years imprisonment term had previously received the wholescale sanction and enforcement of the Courts.

The matter of Kanane v The State 2003 (2) BLR 67 (CA) aforestated also affirmed Section 167 of the Penal Code which criminalises "indecent practices between persons," which are defined as "acts of gross indecency" or procuring or attempting to procure another person to engage in "acts of gross indecency" whether in public or private. A hopeful sign that favourable winds that recognise the SRHR rights of, at least, LGBTI people started to blow in Botswana in 2019. However, when in cases such as Attorney General v Rammoge & 19 Others (Unreported CACGB - 128 - 14) His Lordship of Appeal the Judge President I Kirby found occasion to note that attitudes towards homosexuality appeared to have softened in Botswana. Notable in that utterance is the fact that Justice of Appeal I Kirby was part of the

[12] Gaolete v State [1991] BLR 325 (HC). See also Kanane v The State 2003 (2) BLR 67 (CA) in which a Full Bench of the Court of Appeal held that (i), the time had not yet arrived to decriminalise homosexual practices even between consenting adult males in private and (ii), Gay men and women did not represent a group or class which at that stage had been shown to require protection under the Constitution.

Full Bench that handed down the *Kanane* v The State 2003 (2) BLR 67 (CA) decision. Even more notably, in ND v *Attorney General of Botswana & Another* (Unreported MAHGB - 000449 - 15) in a case involving a transgender person, the State was ordered to change the gender that was recorded in their identity document, thus marking yet a further remarkable step.

In a seminal decision of three Judges of the High Court in *Letsweletse Motshidiemang v Attorney General & LEGABIBO* (Unreported MAHGB - 000591 - 16) a one hundred and eighty degree reversal of the fundamental mind-set that informed the Court of Appeal's decision in *Kanane* v The State 2003 (2) BLR 67 (CA) then occurred. The High Court, in *Letsweletse Motshidiemang v Attorney General & LEGABIBO* (Unreported MAHGB - 000591 - 16) held that sections 164(a), 164(c) and 165 of the Penal Code are ultra vires sections 3, 9 and 15 of the Constitution and accordingly struck them down and also, amended section 167 of the Penal Code by severing and excising the word "private" therefrom. The State has indicated its intention to appeal the decision. It is still an open question, therefore, whether the Court of Appeal will affirm or reverse the High Court decision.

Section 176 of the Penal Code prohibits *"common nuisance"*. Sub-section 1 thereof provides that any persons "*... who does an act not authorized by law or omits to discharge a legal duty and thereby causes any common injury, or danger or annoyance, or obstructs or causes inconvenience to the public in the exercise of common rights, commits the offence termed a common nuisance and is liable to imprisonment for a term not exceeding one year.* To be read with such section is section 179 which allows authorities to prosecute *"idle and disorderly persons", including anyone who "publicly conducts himself in a manner likely to cause a breach of the peace", and/or who "without lawful excuse does any indecent act."* Section 182 thereof also contains provisions that criminalize so called *"rogues and vagabonds"*.

Even though these section do not say so in clear, express terms, these are the sections that Botswana uses to criminalize sex work, including any conduct by LGBT persons who engage in such work. There is, in fact, no specific law that criminalizes sex work/buying sex in Botswana.[14] The Penal Code only criminalises acts associated with sex work, including procurement,[15] solicitation or living off the earnings of sex work,[16] and brothel keeping.[17] As a result of the ambiguity and contradictions that surround this industry, sex workers are often subjected to violence, deprivation of their rights, and when they attempt to seek assistance from the State, they are often left in the cold. [18]

[13] https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Transgender-rights-in-Botswana.pdf.
[14] https://www.mmegi.bw/index.php?sid=1&aid=34&dir=2008/February/Friday22, http://spl.ids.ac.uk/sexworklaw/countries.
[15] Section 149.
[16] Section 155.
[17] Section 158.
[18] https://aidsfonds.org/partner/sisonke-botswana.

Experiences of stigma, discrimination, exposure and threats of reports discourage sex workers from accessing health care services. When accessing health care, they often conceal their occupation and don't speak openly about their health issues which may result in misdiagnosis and inadequate treatment and care. That is so because they fear complaining about poor treatment from health care providers and the reprisals that may follow. Anecdotal evidence exists that Health Care Workers have violated the confidentiality rights of sex workers, including disclosing their HIV status and that individuals are sex workers. This places their health at further risk. Indeed, the continued criminalisation of aspects of sex work leads to victimisation and societal marginalisation of sex workers by perpetuating stigma, violence, harassment, blackmail and discrimination by State and non-state actors in custody and outside of custody. Sex workers in Botswana have been raped and beaten by police officers and clients with impunity, and arrested for the purpose of extortion. The continued criminalisation of sex work is also used as justification for police to confiscate or destroy condoms in the possession of sex workers, who are then unable to protect themselves from HIV and other STIs.

In the event that they become pregnant from any consensual intercourse, LGBT persons and sex workers cannot procure a safe, legal abortion as sections 160(1), 161 and 162 of the Penal Code criminalise abortion. The only exception to the general prohibition is with respect to, under section 160(2), the first sixteen weeks of pregnancy where the pregnancy is the result of a defined criminal act, or there is a health risk to either the woman or the child were the pregnancy to be allowed to run its full term. Arising from this prohibition, not only does the State deny LGBT persons and sex workers their internationally recognised right to the freedom and choice of their reproductive health and well-being, but also, grievous harm continues to be the order of the day as they end up resorting to unsafe, illegal abortions. Social mores and not only legal prohibitions have also been identified as one of the bars, however, that stand against SRHR in this sphere.

Non-citizen resident sex workers or sex workers desiring to reside in Botswana are given a further incentive to conceal their occupation by the Penal Code as read together with section 50(1)(e) of the Immigration Act, 2011 which prohibits the entry into and presence in Botswana of any person who lives or has lived or knowingly receives or has received any part of the earnings of prostitution, or has procured another person for immoral purposes. Section 50(2) of the Immigration Act, 2011 authorises

[19] Focus Group Discussion, Sisonke, October 2016.
[20] https://www.iasociety.org/Web/WebContent/File/IAS2017_PPT_NEO_2.pdf, https://www.youtube.com/watch?v=nttC6usgU5k.
[21] Focus Group, Sesonke, October 2016, Gaborone; Open Society Initiative for Southern Africa, Rights Not Rescue, A Report on Female, Male, and Trans Sex Workers' Human Rights in Botswana, Namibia, and South Africa (2009).
[22] https://www.researchgate.net/publication/323231400_Management_of_post_abortion_complicat. https://www.academia.edu/6529147/Reproductive_Health_and_the_Question_of_Abortion_in_Botswana_A_Review.
[23] https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjGiN21.

the Minister to issue a deportation order against *"undesirable immigrants"* and if they do not comply with the same, *"undesirable immigrants"* are subject to involuntary removal.

2.1.5 EMPLOYMENT ACT [CHAPTER 47:01]

The only law in Botswana which specifically provides for the rights of LGBT persons and persons living with, amongst others, HIV is the *Employment Act*. That is so because the *Employment Amendment Act, 2010* added gender, sexual orientation and health status or disability as prohibited grounds on which an employer may not terminate a contract of employment. Section 3 of the said amendment added a section 23(e) to the Employment Act by specifically providing that an employee cannot be dismissed for *"any other reason which does not affect the employee's ability to perform that employee's duties under the contract of employment".*

There is no meaningful scope for debate on whether the *Employment Amendment Act, 2010* will be embraced by our Courts. That is so because as far back as in 2003, the Industrial Court had already embraced the protection of HIV rights in *Diau v. Botswana Building Society* [2003] 2 BLR 409 (IC). Hot on the heels of the amendment herein, the Botswana High Court accepted gender identity and the imperative to protect it in ND v *Attorney General of Botswana & Another* (Unreported MAHGB - 000449 - 15) in the following words:

> *... the recognition of the Applicant's gender identity lies at the heart of his fundamental right to dignity. Gender identity constitutes the core of one's sense of being and is an integral part of a person's identity. Legal recognition of the Applicant's gender identity is therefore part of the right to dignity and freedom to express himself in a manner he feels psychologically comfortable with.*

This paper can posit, with a measure of confidence, that should such a question arise in any employment matter, the fact that the Employment Amendment Act, 2010 specifically recognises gender rights will result in their resounding protection by our Courts. Arguably, in addition to protecting LGBT and persons living with HIV, the new section 23(e) also protects sex workers. Since sex workers ordinarily ply their trade outside normal working hours and away from their employer's premises, their occupation as such *"does not affect ... [their] ... ability to perform that employee's duties under the contract of employment"*. It can thus be argued that an employer cannot validly terminate a contract of employment, simply because they have realized that their employer is also engaged in sex work, outside their normal working hours. However, this posit is yet to be tested in any Botswana Court.

2.1.6 MISCELLANEOUS DOMESTIC LEGISLATION

In addition to the major legislation that this paper has discussed above, there are also some additional domestic legislation that merits a mention. These include:

- Section 141 of the Penal Code was amended by the Penal Code (Amendment) Act, 1998 to make the same gender neutral. The amendment was discussed and accepted without demur by the Court of Appeal in Chanda v The State [2007] 1 BLR 400 (CA), which Court emphasized the fact that either males or females could now commit the crime of rape. The gender neutrality means, therefore, that LGBT persons now enjoy protection even against acts of sexual violence by persons other than persons of the male sex.

- The Domestic Violence Act, 2008 should also be of assistance to LGBT persons who experience violence from family members, romantic or sexual partners, or from people with whom they share a house. The Act has a broad definition of "domestic relationship" and "domestic violence" includes emotional, verbal and psychological abuse, intimidation and harassment.

- Because it is not a crime to be homosexual per se and/or to be a sex worker, an LGBT person or sex worker has the right to access any complaints mechanism when they have experienced stigma and/or discrimination. Such complaint can, in theory, be made to such authorities as the Botswana Police Service, Traditional Courts, the Botswana Health Professions Council, the Nursing and Midwifery Council of Botswana and Office of the Ombudsman.[24] Therefore, LGBT persons and sex workers are entitled to a), protection of all their fundamental rights and freedoms, including the right to dignity and to associate freely b), specific protection in the workplace c), remedies in cases of sexual and domestic violence d), support from the State to facilitate access to justice including access to complaints mechanisms, health and reproductive facilities.

Unfortunately, however, due to social and religious *mores* lagging behind, these avenues though theoretically available, continue to be difficult if not almost impossible to obtain. In addition, common law and customary law are not in harmony regarding marriage provisions concerning adolescent and youth. Similarly, gender disparities exist within the minimum age at which one can marry differs among males and females with the latter being lower than that of their male counterpart.

In brief, punitive policies and restrictive laws against key populations do exist creating barriers to their access to SRHR services. Further, restrictive legislative environment in accessing SRH commodities and services e.g. age restrictions, requirement of parental consent has created barriers to access of the services by adolescent key populations. Inadequate legal frameworks for addressing practices that hinder enjoyment of SRHR such sexual based violence are a challenge to accessing SRH services and rights.

[24] SALC (2016) 48 to 59.

2.2 SEXUAL AND REPRODUCTIVE HEALTH RIGHTS AND POLICY ENVIRONMENT FOR KEY POPULATION

The case for investing in SRHR was realized after the adoption of the ICPD in 1998. Botswana shifted its focus from the Maternal Child Health and Family Planning (MCH/FP) to SRHR by signing the Reproductive Health Programme Development and Capacity Building Project with UNFPA (BOT/98/P02). The paradigm shift set the goal of improving SRHR of all people living in Botswana and recognized the critical nature of both management and service delivery issues and their interactions in facilitating the process of expanding SRHR services and enhancing quality of care. In pursuance to the shift, Botswana adopted the SDG roadmap and has since made a commitment to transform its SRHR services in accordance with the 2030 Agenda's SDG target 3.1 (reduction in maternal mortality ; SDG target 3.2 (preventable deaths of newborns and children) and SDG target 5.6 (universal access to SRHR) . In line with global commitments, the country has developed several initiatives (national planning instruments, strategic plans and operational plans) that embrace adolescents' SRH needs, and creates an enabling environment for programming.

The Ministry of Health and Wellness recognises access to SRHR as a cost effective and strategic choice for improved maternal, neonatal and child health outcomes. Although the country has put in place various policies that support SRHR, policy instruments are not inclusive on the basis of diverse sexuality. The country does not have an enabling policy and legal environment for promoting access to SRH services and rights by key populations. Although Lesbians and Men who have sex with other Men (MSM) have been allowed to register based on the constitutional clause on freedom of association, they are not recognised in other spheres of life such same sex marriages or provision of lubricants as a commodity appropriate for their sexual orientation and preference. Furthermore, key population adolescent females are denied modern contraceptive services based on the various definitions such as minor or child, although the service standards provides for access to modern contraceptives on the basis of being sexually active irrespective of age. In practice, some health care workers deny such service seeking parental consent.

The limited capacity for coordination at national level and fragmented SRHR programming across public institutions, development partners and donor organisations including the various implementing civil society organisations (CSOs) overstretches the limited resources. The lack of involvement and participation of key population (due to unfavourable legal environment) across the SRHR value chain and continuum of care perpetuates programming that is not based on expressed needs. Most districts either do not have committees to promote coordination, participation multisectoral and multidisciplinary teams in SRHR for a concerted effort resulting in lack of support, duplication and lack of key population voice. Socio economic factors associated with family background e.g. poverty, high rates of unemployment, heterogeneity of key population groups affects access to SRHR services in terms of coverage/reach, availability of commodities, stock outs and limited choices especially in rural and remote settings. In addition, several assessments have demonstrated that funds are spent on generic and long hanging strategies that have minimal impact. The risk communication and education messages do not meet the needs of the heterogeneous group of key population in terms of language, material type: televised, radio, social media and print attributed to factors such as: visual or hearing impairment, illiteracy, geographical area, lack of internet connectivity and or smart phones. Further, the country does not provide adequate political commitment, leadership and funding for implementation of strategies on SRHR among key population. The country continues to struggle to meet the requirements for a functional Monitoring and Evaluation System resulting in lack of data and information on the SRHR issues for key population groups.

[25] By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

[26] By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

[27] Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

3.0 LESSONS LEARNT

Despite the achievements made for SRHR in the country, the review has identified several challenges to SRHR response among key populations as outlined below:

- Review of policies and response identifies that the there is a gap in addressing the needs and rights of key populations including young women, mobile/migrants and displaced populations, prisoners, People with Disabilities (PWD) and sexual minorities.
- Low attention on the "R" of SRHR. There is low focus on the rights components of sexual reproductive health.
- There is poor disaggregation of data on SRHR response by age, sex and geographic location. This lack of disaggregated data creates challenges in designing specific and tailored SRHR programs.

4.0 RECOMMENDATIONS TO MEMBER STATES

- Support development and implementation of policies, laws and other legal frameworks that promote access SRHR services by key populations.
- Strengthen health systems including ensuring availability of uninterrupted SRHR commodity supplies for all, including key populations,
- Improve domestic resource mobilization based on country specific needs
- Increase recruitment, development and training and retention of the health workforce
- Designing and scaling up campaigns against all discriminatory socio-cultural attitudes and practices that limit her ability to seek health services, and sexual and gender-based violence including harmful traditional practices.