

**REVIEW OF ADOLESCENT SEXUAL REPRODUCTIVE
HEALTH (ASRH) LAWS, POLICIES AND PRACTICES**

FINAL REPORT

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Structure of the Report

This report is divided into four chapters. Chapter one sets the background to the consultancy, states the problem and outlines the methodological approach adopted. Chapter two reviews the legal / policy framework and practices on ASRH issues.

Chapter three discusses the gaps, strengths and opportunities

Chapter four makes recommendations on advocacy strategies.

Executive Summary

This Report contains a review of laws, Policies and Practices on adolescent sexual reproductive health issues. The review exercise has revealed that at the level of the policy framework the issues, challenges and strategies around adolescent sexual reproductive health are clearly articulated. There has also been a commendable attempt to incorporate strategies or actions that needs to be undertaken in various National Plan of Actions. For instance, the National Implementation Plan of Action for the National Population Policy Programmes (1998-2008) proposes specific interventions on areas of adolescent sexual reproductive health issues and emphasises the importance of promoting, youth, male and female shared responsibilities and participation in reproductive life and the need to increase access to family planning and reproductive health services. Further, the Botswana National Population Communication Strategy (1998-2008) is alive to ASHR issues and explicitly recognizes the role of Non – Governmental Organisations like Botswana Family Welfare Association (BOFWA) in providing family planning services, counseling and other sexual and reproductive health services to the youth.

More significantly, the draft National Action Plan for the Youth (abridged version) (1999-2005) recognizes the need to take concrete steps to, *interalia*, support and extend in service training to upgrade the skills of health workers in the provision of reproductive health care services for male and female youth.

The Botswana Sexual and Reproductive Health Programme (February 2001) is perhaps the best in the manner in which it has carefully isolated special considerations pertaining to adolescent sexual reproductive health issues.

The area of ASHR has been well researched. There is general agreement emanating from the research process that adolescents are an extremely vulnerable group that needs to be equipped with life skills and properly guided. A majority of researches on adolescent's sexual reproductive health single out the pervasive problem of teenage pregnancies that suggests widespread-unprotected sex. Most researches have correctly identified poverty,

and gender inequality as some of the issues that compromise adolescent sexual reproductive health.

It does appear however that the law has lagged behind policy changes as clearly reflected in the research output and the progressive policies and plans of actions that have been put in place to address ASHR issues. This is one major gap that needs to be addressed.

The opportunities for remedial action appear to be great because the entire Government structures appear sufficiently sensitized on ASHR issues and have policies in place to guide the much needed remedial action. There is also a good network system of health facilities at different levels in the country at 15 km radius from home (Referral hospitals, District hospitals, Mine hospitals, clinics). There is also a number of Non – Governmental Organisations, such as BOFWA that are committed to assisting to improve access to reproductive health facilities by adolescents BOFWA and other NGO's such as YWCA undertake a number of activities including production of information and educational materials and also organize advocacy seminars.

CHAPTER ONE

1.1 Introduction and Background

This report presents recommendations of a consultancy commissioned on the 18th of June, 2001, by the United Nations Population Fund, whose overall objective was to conduct a desk review on existing ASRH related laws, policies and practices. The specific terms of reference were as follows:

- to discuss with relevant nationals in order to identify data on existing adolescent sexual reproductive health related laws, policies and practices in Botswana.
- develop a list of the above documents
- review the above documents and identify gaps, strengths and opportunities
- compile a report including recommendations for policy advocacy strategy
- debrief relevant stakeholders on the findings

1.2 Statement of the problem

It is abundantly clear from the researches conducted¹ that adolescents are vulnerable to delinquent behavior, sexual abuse, sexual risk taking which results in unplanned pregnancy and STD/HIV transmission. Studies have shown that adolescents make up close to 64% of the total population of Botswana.² Research³ has also established the following demographic facts about adolescents in Botswana:

- The 15-24 age group constitute 20.9% of the total population
- The average age at first intercourse is 17.5 years and first birth is 18.6 years
- Only 24% of adolescents are using contraceptives
- Teenage pregnancy rate is approximately 30%
- HIV infection and sexually transmitted diseases among the adolescents is high.

¹ See Government of Botswana: Situation Analysis Report on Youth in Botswana, 2000

² Botswana Sexual and Reproductive Health Programme Service Standards and Guidelines, (2001)

³ Note 2. above

- HIF prevalence has consistently been above 30% among women aged 15-19 in the past five years.
- Clandestine abortion among the adolescents is rampant.
- Coercive sexual activities which include incest, defilement and rape amongst adolescents are rampant.⁴

As the above demographics show, contraceptive use among adolescents is low, which explains the high levels of unwanted pregnancies and vulnerability to sexually transmitted diseases including HIV. The pervasive nature of sexual offences such as rape, incest and defilement pose serious health problems for the girl child such as sexually transmitted diseases, including HIV infection and unwanted pregnancies that may lead to unsafe abortions.

1.3 Methodology

The first stage of the study involved identification and holding discussions with relevant nationals who helped identifies data on ASRH related laws, policies and practices in Botswana. (The names of this national appear in Annexure “A” of this report). The second stage of the study was a desk review of the existing laws, policies and practices on ASRH.

1.4 Limitations

The terms of reference in so far as they required a review of existing ASRH laws, policies and practices were too broad. This is particularly so, if one has regard to the time frame of twenty three days (23) to collect data, review it, write a report and debrief stakeholders. In the circumstances it became necessary to select key laws, policies and practices that are relevant to ASRH issues.

⁴ See Report of a Study of Rape in Botswana, commissioned by the Botswana Police Service. Ministry of the State President, December, 1999. See also Women and the Laws Research Project in Southern Africa. Report on Incest and Defilement, 2001. (unpublished)

1.5 Review and Findings

The review and findings are discussed in chapter two of this report, whilst the strengths, gaps, strengths and opportunities are discussed in Chapter 3.

1.6 Recommendations

Recommendations for policy advocacy strategy are discussed in Chapter 4.

CHAPTER TWO

A Review of the Existing Laws, Policies and Practices on ASRH issues.

We have identified the following laws, policies and practices on ASRH.

Laws

The laws herein reviewed are statutory laws. It must be understood however that Botswana has a dual legal system in terms of which the general law (statutory law) exist side by side with customary law. Customary law is dynamic, unwritten and is not homogeneous; it varies from one community to another. The relationship between customary law and statutory law is spelt out by the **Customary Law (Application and Ascertainment) Act of 1969, Cap 14:03** and **Customary Courts Act Cap 04:05** which provide that customary law means, in relation to any tribe or tribal community, the customary law of that tribe or tribal community so far as it is not incompatible with the provisions of any written law or contrary to morality, humanity and natural justice. It must be noted further that Botswana parliament provides no guidelines for standards of morality, humanity and natural justice. The effect of the above provisions is to subordinate customary law to statutory law.

The Penal Code

The Penal Code (Amendment) Act of 1991

The Marriage Act

Regulation 34 of the Education Act

The Interpretation Act

The Children's Act

The Public Health Act

Botswana National Population Policy (1999)

Botswana National Health Policy (1995)

Botswana Family Planning General Policy

Botswana National Policy on HIV/AIDS (1993)

National Plan of Action for Children, (1995)

Botswana National Population Communication Strategy
Policy on Women and Development, (1995)
National Gender Programme Framework (1998)
Second Medium Term Plan on HIV/AIDS
National Action Plan for Youth 1999 – 2005
Botswana National School Health Policy (1994)
National Youth Policy, (1996)
Botswana Sexual and Reproductive Health Programme (1998)
Policy Guidelines on the Implementation of Guidance and Counseling in
Botswana's Education System.
Vision 2016

A Review of the Existing Laws, Policies and Practices on ASRH Issues

Laws

The law that governs termination of pregnancy is the Penal Code (Amendment) Act of 11th October, 1991. This law provides that pregnancy could be legally terminated within the first sixteen weeks of pregnancy on certain prescribed conditions. These conditions are the following:

- Where the continued pregnancy constitutes a serious threat to the health of the woman;
- Where there exists serious risk that the child to be born will suffer from physical and mental defect of such a nature that the child will be irreparably and seriously handicapped.
- Where the fetus is alleged to be a result of rape and incest.

The law requires that under the circumstances mentioned above, two medical practitioners duly qualified must certify in writing that in their opinion, one of the above described situations exists.⁵

⁵ Oagile Key Dingake, 'Key Aspects of the Constitutional Law of Botswana' (Pula Press, 2000) p157

It is clear from the provisions of the Penal Code (Amendment) Act of 1991 that the circumstances under which women can obtain abortion is heavily circumscribed. The law as it stands will not permit a teenager who, owing to the tendency to experiment with unprotected sex, mistakenly falls pregnant, to terminate the pregnancy at the earliest opportunity. There other sections of the Penal Code that renders certain acts crimes and therefore punishable. This is meant to discourage the commission of some acts deemed undesirable by society in general. In this way, the Penal Code, and the criminal law in general, is used to protect, the sexual and reproductive health of members of society in general, including adolescents.

Section 147 guards against the unlawful carnal knowledge of any person under the age of 16 years. This is called defilement. It does not matter whether that person has his/her consent to such sexual intercourse. The important point to note here is that the law regards a person who is under the age of 16 years to be incapable of having sexual intercourse, hence the term “unlawful”. However, the section envisages lawful carnal knowledge of a person under 16 years. This occurs where that person is lawfully married. Section 150 provides that any person who procures the defilement of any person under that age of 16 by threats or fraud or through administering drugs is guilty of an offence. The minimum sentence for defilement is 10 years imprisonment.

Section 141 deals with rape. Where a person has sexual intercourse with another person without the consent of that other person, that person is guilty of rape. The minimum sentence for rape is 10 years imprisonment to a maximum of life imprisonment. Where the victim was injured as a result of the rape, the minimum sentence becomes 15 years imprisonment. In all rape cases, the culprit is subject to a compulsory HIV test after he is convicted.⁶ Where it turns out that the culprit is HIV positive and he/she was aware of his/her status at the time of the rape, and the victim was infected in the process, the minimum sentence becomes 20 years imprisonment.⁷ Where the culprit is HIV positive but it is established that he was not aware of his status at the time of the rape, the

⁶ Penal Code (Amendment) Act of 1998

⁷ Note 6, above

minimum sentence remains at 15 years imprisonment.⁸ Where injury has been caused to the victim the culprit also receives a compulsory corporal punishment.

Abduction, which has been described as the taking away and / or detaining of any person against their will with the intent of having intercourse with them or marrying them is catered for under section 144. Section 145 deals with the abduction of persons under the age of 16 years.

Marriage Act²

The Marriage Act prescribes different ages for marriage for men and women. Men can marry with parental consent at 16 years. Whilst females can marry at 14 years. The ages prescribed above are inconsistent with those recommended by the Botswana Family Planning Guidelines.

The Family Planning Policy argues that since pregnancy before the age of twenty years (20) places the health and welfare of the teenager at risk, individuals should be encouraged to delay the first pregnancy until the age of 20 years.¹⁰ It is obvious that marriage imposes an obligation on the parties to engage in sexual intercourse. The right to sexual intercourse is commonly referred to as conjugal rights. In many cases marriages have been dissolved on account of unreasonableness evidenced by one of the party's denial of conjugal rights to the other. Marriage is also considered as complete once it has been consummated through sexual intercourse. The above goes to show how integral sexual intercourse is to marriage.

It is generally accepted that parents hardly discuss issues of sexuality with children at the age of 14 or 16 years. The result is that at that age children are fairly ignorant on issues of sexuality. Marriage at that age clearly compromises adolescent reproductive health. Further at the age of 14 adolescents are not physiologically and mentally ready to bear children.

⁸ Note 6, above

⁹ Cap 29:01 Laws of Botswana

¹⁰ Botswana Family Planning General Policy Guidelines and Services Standards (1994) p3

Children's Act¹¹

Issues of child welfare are governed by the children's Act. This is one Act where one would expect an elaborate exposition of adolescent sexual reproductive health, but that is not the case. One section that has a bearing on adolescent sexual reproductive health concerns is Section 12 that makes corruption of a child illegal. It further provides that a child is corrupted when he is induced or coerced into immoral acts.

Public Health¹²

The Public Health Act is an Act that regulates issues of public health. There can be no doubt that issues of adolescent reproductive health are integral to public health. Unfortunately there is no clear or separate articulation of adolescent's reproductive health issues in the Act. There is however a general provision that has a bearing on reproductive health, including of course adolescent sexual reproductive health, which prohibits willful spread of infectious diseases. This is in fact a repetition of a provision in the Penal Code.

¹¹ 1981

¹² Cap 63:01, Laws of Botswana

Regulation 34 of the Education Act

Regulation 34(1) provides, *inter alia*, that a pregnant girl student shall be withdrawn from school for at least one calendar year and there after only admitted after the cessation of pregnancy with the approval of a minister.¹³

Subsection 2 of the same regulation on the other hand provides that a boy student, responsible for the pregnancy in question shall be required to be withdrawn from school and shall be readmitted only on the approval of the minister.

It is submitted that if the promotion of female student's health and physical welfare is the purpose of regulation 34, then why suspension should be the inevitable result of the pregnancy. This argument is premised on the following considerations.

- a) Firstly, a pregnant student constitutes no health risk to anybody else in school.
- b) Secondly, her own health and physical condition is not necessarily or invariably prejudiced to a degree warranting her suspension.

The practical effect of Regulation 34, aforesaid, is that student's end up spending more than twelve months away from school because students lose the school year they are currently in when they are withdrawn. As soon as they are discovered to be pregnant, they are required to spend a few more months out of school until they give birth, then they lose twelve months after birth. Thereafter they have to wait for the next school year to start, because they cannot re-enroll late in the school year.

The implications for adolescent sexual reproductive health are obvious. This is so because education can be regarded as a form of a contraceptive in that students who attend school are unlikely to have unplanned pregnancy. It is our view that school environment minimizes the chances of failing pregnant. It is generally acknowledged that a significant number of students who are suspended from school as a result of

¹³ The difficulty with the regulation is its uniform sanction, namely the pregnancy during the academic year always means suspension for the remainder of that year. It matter not whether the pregnancy occurs early in the academic year or not.

pregnancy don't return to school and outside the school environment the girl child is vulnerable and chances of repeat pregnancy are high, thus undermining the reproductive health of the child.

The Interpretation Act

The Interpretation Act provides that a minor is any person who has not attained the age of 21 years. The implication of this is that persons under the age of 21 years do not have full legal capacity and cannot take decisions on their own.

This contradicts the policy guidelines issued by the Ministry of Health in terms of which women and men in the reproductive age shall be eligible to use family planning methods without the consent of relatives or partners with exception of sterilization.¹⁴

Other than the clear contradiction alluded to above, it is not clear why sterilization is excluded.¹⁵ The Interpretation Act has a host of implications on counseling and access to family planning services by adolescents without parental consent.

Policies

Botswana National Population Policy

The Botswana National Policy makes provision for the following:

- The need to recognize the family as the basic unit of production and reproduction and provides it with the necessary protection and support.
- The basic right of couples and individuals to reproductive health and to decide freely and responsibly the number and the spacing of their children and to have access to information and education to make informed choices and the means to do so.
- The need for gender equality and equity to enhance effective participation at all levels of public and productive life.

¹⁴ See note 10, page 4

¹⁵ This exclusion was also questioned in a Report on the review of all laws affecting the status of women in Botswana. (1998) p4

Botswana National Health Policy

The Botswana National Health Policy recognizes the enjoyment of a level of health that allows every citizen to lead an economically and socially productive life as a human right. It also emphasises the role of Government as policy maker, professional guide and supervisor of health care in its entirety in Botswana, irrespective of the providers or institutions. It accordingly commits the Government, through the Ministry of Health, to ensure that all institutions that provide health care are provided with information on recognized standards of care in line with WHO recommendations.

Botswana National Sexual and Reproductive Health Programme

The National, Sexual and Reproductive Health Programme reaffirms steps taken by Government to shift from MCH/FP to SRH by signing of the Reproductive Health Program Development and Capacity Building Project (with UNFPA BOT/98/PO2) and subsequent development of National Sexual Reproductive Health Policy and Program. It also sets the goal of improving the sexual and reproductive health of all people living in Botswana through 9 (nine) specific objectives. In terms of priorities these are:

- To improve understanding of SRH by parents and children / youth
- To improve ASRH
- To reduce maternal and prenatal mortality
- To enhance gender equality and equity
- To control STD's and HIV/AIDS
- To meet family planning needs
- To prevent and manage infertility, reproductive tract cancers and midlife concerns.
- To ensure national capacity to conduct operations research and manage functional Health Information System.

The Programme further recognises the critical nature of both management and service delivery issues and their interactions in facilitating the process of expanding SRH services and enhancing quality of care.

Botswana Family Planning Policy Guidelines and Service Standards

As earlier indicated, the above policy recognises and reiterates the fact that all individuals of reproductive age are entitled to use family planning without the consent of relations or partners.¹⁶ This ensures that family planning methods are accessible and available to all who need them. It further provides that all persons shall be given adequate information, education and counseling to enable them to reach informed decisions about their reproductive lives and the means of effecting those decisions.

The Family Planning Policy provisions clearly takes on board the adolescent sexual reproductive health concerns, as clearly demonstrated by its liberal provisions on access by adolescents to family planning services.

Botswana National Policy on HIV/AIDS

The policy came about in the wake of the ever increasing statistics of HIV/AIDS in a number of ways and below we proceed to capture those related to adolescents.

- a) To ensure the integration of AIDS and STD education into all levels and institutions of education.
- b) To ensure that other services related to HIV/AIDS and STD control and care are accessible to students in need.
- c) To provide appropriate health – facility based care for persons with HIV related conditions and AIDS.

There are other provisions which deal with the promotion and efficient distribution of condoms to appropriate population subgroups. The promotion of gender equality in all

¹⁶ Guideline 11.

spheres of life and generally the empowerment of women for more effective participation in decision making about safe sex is another goal.

National Youth Policy¹⁷

The National Youth Policy recognises that the youth have to be protected from exploitation, discrimination and abuse. It also aims to promote health amongst young people. The policy however does not address adolescent sexual reproductive health issues in any detail.

Botswana National School Health Policy¹⁸

Ordinarily, one would have expected the National School Health Policy to make provisions on adolescent sexual reproductive health issues and even go further to guide teachers on how to implement, among other things, access to family planning services. Unfortunately the policy does not do so. Its reference to health issues of school going children is very general. The policy simply says the school going children of Botswana are entitled to adequate school health services. Obviously issues of adolescent sexual reproductive health are contemplated by the policy, but not clearly spelt out.

¹⁷ 1996

¹⁸ July, 1994

Policy Guidelines on the Implementation of Guidance and Counseling in Botswana's Education System¹⁹

The policy guidelines make provision for guidance and counseling in school. It does not require parental consent when counseling school children, probably in line with the family planning policy. The policy also suffers from the weakness of being general, for instance it makes reference to the need to develop a clear understanding of children's sexuality and other "family life education issues and concerns"²⁰

National Action Plan for Youth (abridged version) 1999 - 2005²¹

Compared to other policies reviewed above, the National Action Plan highlights the problem of teenage pregnancy and the consequent exposure to HIV/AIDS among the youth. More significantly the action plan identifies the area of reproductive health as strategic area and recommends, *interalia*, the following actions:

- Enhance the capacity of parents to participate meaningfully in reproductive health information for modern youth.
- Support and extend in service training to upgrade the skills of health care services for male and female youth of all age categories.
- Sensitive development planners and policy makers throughout the health service to the link between poverty and reproductive behavior among the youth.
- The National Action Plan has put in place time frames for certain actions. For instance the action plan says research on male reproductive health will commence by the year 2000 and counseling will be in place from the first quarter of 2001.

¹⁹ 1996

²⁰ Policy Guidelines on the Implementation of Guidance and Counseling in Botswana's Education System, (1996) p21

²¹ The National Action plan (undated)

A National Programme of Action for the Children of Botswana (1993 – 2003)²²

This Programme addresses various issues related to the situation of children in different circumstances, such as orphans, disabled children, street children and working children. The programme doesn't say anything about adolescent sexual reproductive health.

Botswana National Population Communication Strategy (1998 – 2008)²³

The population communication strategy recognises the importance of adolescent sexual reproductive health and sets out the following objectives:

- The need to educate parents and children and adolescents on the nature of their bodies.
- Educate families and individuals on appropriate relationship between children and adults.

Policy on Women in Development²⁴

The policy on Women in development addresses issues of sexual reproductive health and calls, inter *alia*, for the following:

- Promotion of the health of mothers and children by improving the quality of existing MCH / FP services and their utilization.
- Encourage collaboration with NGO's to promote safe motherhood, adolescent health / family life education.
- Strengthen intersectoral collaboration on issues affecting health to reduce the incidences of adolescent fertility and unsafe abortions.

²² 1995

²³ 1998

²⁴ 1995

National Gender Programme Framework (1998)

The national gender programme, noting that there are high levels of teenage sexual activity and that teenagers remain seriously vulnerable to sexually transmitted diseases including HIV, proposes that there is a need to ensure that adolescents, among others, have access to services that are appropriate to their needs and sensitive to their situations.

Significantly, the framework, laments that the existing health system in Botswana has been conspicuous for its deficiencies in involving men, as reflected by lack of health programmes, services and data for and on men.²⁵ The strength of the framework lies in recognizing the importance of involving men in sexual reproductive health issues.

Second Medium Term Plan on HIV/AIDS

The Second Medium Term Plan on HIV/AIDS, like other policies reviewed above, expresses concern on the high rate of teenage pregnancy. More significantly, the plan recommends the following measures in the area of adolescent sexual reproductive health:

- Development of a youth sexual and reproductive health policy.
- The establishment of youth recreational facilities, peer sexual and reproductive groups or clubs and multi – purpose youth sexual and reproductive health centers.
- Development of specific guidelines and standards for the establishment of adolescent sexual and reproductive health services.
- Develop specific guidelines on school reproductive health service.

²⁵ National Gender Programme Framework (1998) p22

Vision 2016

Vision 2016 provides for Sexual and Reproductive Health issues in broad terms. It provides that;

- Facilities will be made available for the special needs of the disabled and for women in adolescence.
- High rates of pregnancy among young women are placing them at a disadvantage in education and employment.
- The responsibility of parents for the behavior and problems of youth must be emphasized.
- Child abuse is on the increase in Botswana, and must be nipped in the bud.
- Holistic programmes must be developed together with the National Youth Council, which will establish multipurpose youth centres.
- No person should be allowed to marry before the age of eighteen years.
- The policy of expelling teenage mothers from school must be reviewed.
- Family planning and education services to the youth must be expanded to reduce the incidence of HIV/AIDS, along with other sexually transmitted diseases and teenage pregnancies.

Practices

The following practices by service providers have been inhibitive to adolescents accessing relevant ASRH information or accessing family planning services:

Attitude of service providers

Attitude of leaders

Attitude of parents
Counseling adolescents on ASRH issues
Provision of family planning services
Non-provision of emergency contraceptive pill

It is reported that critical service providers such as health workers and teachers discourage adolescents accessing ASRH services in that this service providers are often unfriendly or hostile.²⁶ Further, the relationship between the adolescents who may wish to access these services and service providers is characterized by power imbalance occasioned, by among other things, by the age and status of the service providers.

Attitudes of Leaders

It has been further reported that the country's leaders (political, religious and traditional) are uninterested and less knowledgeable on issues of ASRH and their respective roles.²⁷

Attitude of Parents

Parents are very central in the education of adolescents on ASRH issues, yet there are reported reluctant or unable to talk to their children on issues of sexuality.²⁸

²⁶ Interview with Dr. Mashalaba 28/06/01

²⁷ Interview with Dr. Mashalaba 28/06/01

²⁸ Interview with Ms. Seema and Segametsi 26/06/01

Counseling Adolescents on ASRH Issues

It is reported that most counseling centres do counsel adolescents without parental involvement.²⁹

Provision of Family Planning Services

It is also reported that most family planning service centres provide family services to adolescents without parental involvement.³⁰

Non Provision of emergency contraceptive pills

Emergency contraceptive pills may be used to prevent pregnancy following unprotected sex during a woman's fertile days. Some people working in the area of family planning consider this service necessary, but most report it is not authorized either by policy or statute.³¹

²⁹ Interview with Dan Motsatsing, Botswana Family Welfare Association. Programme officer 29/06/01

³⁰ Interview with Dan Motsatsing, Botswana Family Welfare Association. Programme officer 29/06/01

³¹ Dan Motsatsing (note 5, above)

CHAPTER THREE

Gaps, Strengths and Opportunities

Gaps

A review of the legal / policy framework has revealed the following gaps.

- There is a huge disparity between policy and legal prescriptions. Most of the policy prescriptions that are conducive to the promotion of ASRH issues are not matched by statutory prescriptions. For instance, the law does not reciprocate the policy prescriptions contained in the family planning policy permitting access to family planning to all persons of reproductive age regardless of age.
- Contradiction/tension and or uncertainty between actual practice and the law. There is at best uncertainty and or tension and at worst contradiction between practice and the law. In practice counseling of adolescents and provision of family planning services takes place without parental involvement, whilst the law on the other hand, regards adolescents, in so far as they are under the age of 21 years, minors and therefore lacking legal capacity to take decisions in their own right.
- The policy framework is silent on whether a teenager who has had unprotected sex and fears that she may have fallen pregnant may be given emergency contraceptive.
- The policy framework gives prominence to consumers as compared to an equally mighty consideration of service providers. It is all well and good to provide for the rights of adolescents to access ASHR information and family planning services, but it is another thing to fail to prescribe for youth friendly services probably manned by their peers.
- The policy framework tends to emphasise multi- sectoral collaboration/ strategies, but the role of each player is not clearly articulated.
- The policy framework provides very little about the need to focus on the boy child, as emphasise tends to be on the girl child. Failure to provide for boys

may be counter productive because it means that boys grow up without the necessary orientation on ASHR issues and may compromise ASRH of girls who may have been the necessary education on ASRH issues.

- The policy framework recognises the importance of other service providers (NGOs) but doesn't commit itself unequivocally to providing technical and financial assistance to these service providers.
- The policy framework does not appear to provide who is an adolescent. We think it is necessary to provide for a standard definition of an adolescent so that certain age groups are not excluded in ASRH programmes.
- The policy framework provides for adolescents counseling, but fails to extend client / counselor privilege to counselors, which is necessary for counselors to feel protected and do their job effectively.

Strengths

The major strength of the policy framework is that generally it provides for a conducive environment to take care of adolescents sexual reproductive health needs. It is significant that the policy framework frees adolescents from seeking parental consent in seeking counseling and access to family planning services. The provision of family life education at schools is a major advance that must be enhanced by giving teachers adequate training to ensure that there are technically competent to assist and do not act as a barrier.

Opportunities

In so far as the policy framework recognises the importance of multi- sectoral approach and strategies and the importance of effective collaboration between Government structures and NGOs working in the same area, this presents opportunities for enhanced collaboration between Government and other service providers.

The generally conducive policy framework offers an excellent opportunity to simply transform the policy prescriptions to a higher level of statutory (legal) prescriptions.

Since the policy framework reflects the view of Government and other critical stakeholders, the opportunity to lobby politicians and other leaders (religious and traditional) to speak out on ASRH issues is clearly open for utilization.

CHAPTER FOUR

Recommendations on Advocacy Strategies

In order to give effect to the policy framework, (that is supportive to adolescents sexual productive needs) it is important to frame specific advocacy strategies that are informed by the policies reviewed above.

The specific strategies are adopted to ensure the following:

- Those policy prescriptions are transformed into programmes and are actually implemented.
- That national legislation is reformed to ensure a conducive environment to address adolescent sexual reproductive needs.
- That the attitude of leadership, (broadly defined to include political, religious and traditional), parents and other service providers are changed to facilitate a more effective process of addressing ASRH issues.
- To make sure that ASRH information is available to adolescents from all points of contact, homes, schools and churches.

Advocacy strategies

Social context

- Advocate for the empowerment of parents at home to accept that their children, both females and males, must be given information on ASRH.
- Encourage parents who cannot talk to their children about ASRH issues to form neighborhood groups and or groups generally and approach their children from that perspective.
- Churches must be lobbied to provide ASRH services.
- Lobby that family life skills must be taught at all schools.
- Lobby that no teacher should be permitted to qualify without adequate knowledge of ASRH issues.

- Political, traditional and religious leadership to be sensitized on issues of ASRH and their roles.

Service delivery

- Lobby and advocate for the establishment of adolescents/youth friendly services.
- Lobby and advocate for involvement of adolescents in planning and running family planning services.
- Lobby and advocate for the attachment of nurses to all schools to provide treatment and IEC to both teachers and students.
- Encourage continued training of health workers in order to improve the quality of care.
- Promote community participation especially male involvement in adolescent sexual reproductive health issues.
- Lobby and advocate for provision of condoms at schools.
- Lobby and advocate that necessary support be given to those sections of adolescents or youth who are not sexually active and want to remain so.
- Lobby that minors who are at least 18 years should be able to undergo HIV testing and counseling without parental consent.

Information, education and training communication and training measures

- Provide appropriate IEC information to the public, particularly adolescents on ASRH issues, such as HIV and STD through mass media, women and men's groups and NGOs.
- Advocate for dissemination of information on the prevention of STDs and teenage pregnancy.
- Promote the use of condoms both as contraceptives and as a measure against STD and HIV /AIDS and support male and female condom promotions.
- Publicise the availability and location of counseling, testing, support and medical care services in the print and electronic media.

- Develop and conduct gender sensitive human rights education for the public, which includes women and men's health rights.

Infrastructural measures

- Ensure that facilities are suitably resourced and staffed with adequately trained personnel to meet service demands.
- Advocate for the improvement of access and availability of female condoms.
- Make provision for emergency contraceptives in all health care services centre.

Legislative measures

- Review and amend all legislation that inhibits adolescent's access to ASRH information and services.
- Amend restrictive legislation such as the Marriage Act to provide that marriageable age for females shall be 20 years in line with the family policy.
- Lobby and advocate for legislation that should remove legal, regulatory and social barriers to adolescent sexual reproductive health information.
- Lobby and advocate for legislation that ensures that the programmes and attitudes of health care providers do not restrict services for adolescent and safe guards the rights to privacy, confidentiality and informed consent.
- Lobby and advocate that teenage mothers should be able to continue their schooling whilst pregnant and that accordingly regulation 34 of the Education Act should be repealed. A supportive system must be put in place that can assist them to cope with their studies.
- Amend the Penal Code to provide that teenagers who are pregnant should have the right to terminate their pregnancies, without the need to obtain their parental consent, within the first twelve weeks of pregnancy.
- Amend the Interpretation Act to reduce the age of majority to 18 years.
- Amend the Penal Code to make provision of contraceptive pills.

Research policy on adolescent sexual and reproductive health

- Provision should be made for periodic research that will inform policy and legislative formulation in accordance with current trends and problems as they emerge. Critical aspects that need regular research include the following;
- Appropriate and accurate data.
- The status of contraceptive information, counseling and services for youth, including the quality of such services.
- The status of peer involvement in peer counseling.
- The status of family like skills at schools.

Annexure “A”

(Nationals who helped identify data on ASRH related Laws, Policies and Practices)

Name	Institution
Ms. R. Mandevu	Head, AIDS/STD Unit
D. Motsatsing	Programme Officer
I. Modisaotsile	UNICEF, Project Officer, ARH
Ms. T. Shashane	WHO
Ms. Seema	National Youth Centre
Mrs. P. Vanqa	Executive Director, YMCA
Dr. Mashalaba	President of BOFWA and the Chairperson of the Population Secretariat