ASSESSMENT OF LEGAL AND REGULATORY FRAMEWORK FOR HIV, AIDS AND TUBERCULOSIS

FINAL REPORT

November 2017
FOREWORD

Botswana has made significant progress in addressing the HIV epidemic. Although this Legal Environment Assessment (LEA) report has shown that progressive laws, policies and jurisprudence in Botswana has helped to safeguard the rights of all people to equality and non-discrimination, including people living with HIV and TB and vulnerable populations such as women, there remain gaps and challenges that have been identified within Botswana’s current legal and policy framework that create barriers to access to prevention, treatment, care and support for all people, including vulnerable and key populations.

It is imperative for all of us to take cognisance of the recommendations in the report if we are end AIDS by 2030. Botswana has adopted the Treat All strategy, developed HIV Testing Services (HTS) Strategy and reviewed the treatment guidelines. To achieve these targets by 2020, it is essential that the legal environment supports the national response in programming and ensure unrestricted access to services among all people of Botswana regardless of race, colour, religion, creed, sex, sexual orientation, gender identity, national origin, disability, vocation or other status. This report is a fundamental step in ensuring that each stakeholder plays a role in the fight against the epidemic.

As highlighted by the UN Secretary General: “Whatever our role in life, wherever we may live, in some way or another, we all live with HIV. We are all affected by it. We all need to take responsibility for the response.” Ensuring no one is left behind is essential since vulnerable and key populations bear much of the burden of the epidemic today. We must uphold the value of Botho as Batswana, which promotes the social contract of mutual respect, responsibility and accountability that Batswana have always cherished. We need to continue to uphold the basic tenets of human rights in order to maintain the significant achievements that we have made in the national response.

The Government of Botswana recognises that rights are intricately linked with the spread and impact of HIV on individuals and communities around the world. It is therefore imperative for us to continuously address the prevailing social, legal and economic conditions, including those that affect key and vulnerable populations such as women and children, and particularly those living in poverty.

The Ministry of Health and Wellness will play an essential role in steering the implementation of the recommendations of this report. This Legal Environment Assessment report provides clear and practical recommendations to remove legal barriers that impede the HIV and TB responses and to ensure that Botswana has an enabling, evidence-informed legal environment. We have come so far, but to make further progress in the HIV and TB responses, to save countless lives and prevent unnecessary deaths, we must ensure that our laws reflect our national commitment to leaving no one behind. Indeed, an enabling legal environment has the potential to transform the HIV and TB responses in Botswana.

The level of progress and commitment already shown is very encouraging. While the Government of Botswana remains committed to achieving further progress, a collective resolve and concrete actions must be undertaken by the LEA Steering Committee, all ministries, agencies, the private sector, civil society, development partners, individuals, families and communities to ensure realisation of an enabling legal and policy environment.

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ACKNOWLEDGEMENTS

The Ministry of Health and Wellness acknowledges the contributions and inputs from the following institutions and individuals.

Botswana National Steering Committee:

We are grateful for the leadership and invaluable support provided by the Legal Environment Assessment Steering Committee including Haruna B. Jibril (Ministry of Health and Wellness—MOHW), Bornapate Nkomo (MOHW), Mavis Bengtsson (UNDP), William Bapati (UNDP), Gang Sun (UNAIDS), Elizabeth Koko (MOHW), Chipo Petlo (MOHW), Rinso Sebako (MOHW) Nthabiseng Phaladze (University of Botswana), Kelebileng Kokoro (AG Chambers), Allan Tshekedzi (BONEPWA), Mosarwa Segwabe (USAID), Doug Johnson (PEPFAR), Cindy Kelemi (BONELA), Rodger Bande (BONELA), Phazha Molebatsi (BONELA), Boipelo Marumo (MYSC), Mpho Mmelesi (UNAIDS), G.G. Rabasha (MOHW), Bose A. Senome (MOHW), John Chambo (MOHW), Lentswe Motsamai (MLHA), Caine Youngman (LEGABIBO), Jonathan Moalosi (MOHW), Elijah Tsaposa (Botswana Police Service), Bulayani Bengani (Botswana Police Service), Moses Khunwane (Botswana Police Service), Molebatsi (Botswana Parliament), Maikutlo Pitlagano (Botswana Prisons Service), Motlaepleu Vakalisa (Botswana Prisons Service) and Martin Keabona (MOE).

Overall Coordination:

We sincerely appreciate the overall coordination by a number of individuals including Bornapate Nkomo (MOHW), Mavis Bengtsson (UNDP), Elizabeth Koko (MOHW), Chipo Petlo (MOHW), William Bapati (UNDP), Anders Pedersen (United Nations), Deena Patel (UNDP-RSCA), and Tilly Sellers (UNDP-RSCA).

Consultants:

We are grateful for the technical expertise and services of consultants including Drew Aiken (UNDP-National), Peter Chibatamoto (UNDP-National) and Kitty Grant (UNDP-RSCA) who conducted the assessment and compiled the report.

External Contributors to Supporting Evidence:

Thank you to the key informants and focus group participants for informing the findings and recommendations of this report.

Funding:

We acknowledge the generous financial support from Global Fund to Fight AIDS, Tuberculosis and Malaria and UNDP.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>ARASA</td>
<td>AIDS and Rights Alliance for Southern Africa</td>
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<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<td>AU</td>
<td>African Union</td>
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<td>BBSS</td>
<td>Behavioural and Biological Surveillance Survey</td>
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<td>BHPC</td>
<td>Botswana Health Professions Council</td>
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<td>BIAS</td>
<td>Botswana AIDS Impact Survey</td>
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<td>BNTP</td>
<td>Botswana National Tuberculosis Programme</td>
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<tr>
<td>BONELA</td>
<td>Botswana Network on Ethics, Law and HIV and AIDS</td>
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<td>CD4</td>
<td>Cluster Differentiation 4</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All forms of Discrimination against Women</td>
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<td>CERD</td>
<td>International Convention on the Elimination of All Forms of Racial Discrimination</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DRU</td>
<td>Drugs Regulatory Unit</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GCHL</td>
<td>Global Commission on HIV and the Law</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<tr>
<td>IDCC</td>
<td>Infectious Diseases Control Clinic</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<td>IOM</td>
<td>International Organisation for Migration</td>
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<tr>
<td>IP</td>
<td>Intellectual Property</td>
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<tr>
<td>IPRs</td>
<td>Intellectual Property Rights</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<td>KP</td>
<td>Key Population</td>
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<td>LEA</td>
<td>Legal Environmental Assessment</td>
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<tr>
<td>LGBTI</td>
<td>Lesbians, Gays, Bisexuals, Transgender and Intersex</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MOH</td>
<td>Ministry of Health and Wellness</td>
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<td>NACA</td>
<td>National AIDS Coordinating Agency</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NMCM</td>
<td>Nursing and Midwifery Council of Botswana</td>
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<td>NSF I</td>
<td>First National Strategic Framework</td>
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<td>NSF II</td>
<td>Second National Strategic Framework</td>
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<tr>
<td>OHCHR</td>
<td>United Nations Office of the High Commissioner for Human Rights</td>
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<td>OPD</td>
<td>Office of People with Disabilities</td>
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<tr>
<td>PAC</td>
<td>Post-Abortion Care</td>
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<td>PNC</td>
<td>Postnatal Care</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SADC PF</td>
<td>Southern African Development Community Parliamentary Forum</td>
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<td>SALC</td>
<td>Southern Africa Litigation Centre</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TRIPS</td>
<td>Trade Related Aspects of Intellectual Property Rights</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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EXECUTIVE SUMMARY

As the Global Commission on HIV and the Law (GCHL) has shown, a country’s legal environment plays a critical role in reducing vulnerability to HIV infection and improving the lives of people living with HIV. This is the case in Botswana where the legal and policy environment includes protective aspects that safeguard the rights of the marginalised and vulnerable, as well as punitive and discriminatory provisions that threaten to undermine human rights and progress the country has made against HIV, AIDS and TB.

Botswana is a Constitutional democracy and the Constitution is the supreme law of the land. Chapter II of the Constitution protects the fundamental rights and freedoms of every person in Botswana regardless of race, place of origin, political opinions, colour, creed or sex. Many constitutional rights are relevant in the context of HIV, AIDS and TB including the rights to life, privacy, personal liberty, and security of person, protection from inhuman treatment, secure protection of the law and protection from discrimination. Since economic, social and cultural rights are not expressly guaranteed in the Constitution, inclusion of the right to health would strengthen the protection of this right, as would inclusion of additional economic, social and cultural rights relevant to HIV, AIDS and TB and the express prohibition against discrimination on the basis of HIV and health status. While Botswana has ratified a number of human rights treaties, the country has not yet ratified the Convention on Economic, Social and Cultural Rights, among others.

This Legal Environment Assessment identified a number of laws that protect the rights of people living with and vulnerable to HIV and TB and that otherwise guarantee the right to non-discrimination and facilitate access to justice when violations occur. For example, the Domestic Violence Act, the Children’s Act, the Labour Act, protective penal code provisions and a number of other laws prohibit violence, harmful practices, and discrimination. However, in some contexts protective and enabling laws are not fully implemented and/or enforced, while in other contexts individuals are not aware of their rights and/or are not enabled to pursue legal or other recourse.

This Legal Environment Assessment identified a number of ongoing challenges relating to HIV, TB, law and human rights in Botswana. First, while there are provisions in the public health framework that support the rights of people living with HIV, including the right to confidentiality, prohibition of pre-employment testing and the right to informed consent prior to HIV testing, there are a number of health-related provisions in the Public Health Act that undermine these protections and are not conducive to ensuring a human rights-based approach to HIV, TB and public health including coercive and punitive provisions, provisions that allow for required testing and disclosure of HIV status and isolation and detention of all people with communicable diseases regardless of risk of transmission. Second, there are a number of vulnerable and key populations including women, children, young people, people with disabilities, gay men and other men who have sex with men, sex workers, prisoners and migrants, among others, who have been shown to be at higher risk of HIV exposure and/or to experience the impact of HIV, AIDS and TB more severely.

Third, HIV-related stigma and discrimination remains an issue in Botswana and exacerbates the impact of HIV. Further, stigma and discrimination on the basis of sexual orientation, gender identity and on the basis of being a sex worker hinders access to health and other public services by members of these groups to HIV prevention, treatment and support services. There is insufficient protection from discrimination provided in law, in general and with respect to access to health services, for people living with HIV, AIDS and TB, as well as for populations vulnerable to HIV including people with disabilities, gay men and other men who have sex with men, lesbian, gay, bisexual, transgender and intersex (LGBTI) people, sex workers, migrants, prisoners and remote area dwellers. Fourth, some populations have specific needs that should be addressed through the enactment of laws to regulate and manage challenges that can increase vulnerability to HIV, TB and make access to services a challenge including for people with disabilities, prisoners, migrants and remote areas dwellers. Legal gaps in these contexts include: (i) the absence of a law regulating disability that provides a framework on the rights, needs, management and provision of HIV, TB and other health services for people with disabilities and (ii) the absence of legal frameworks that adequately address HIV and TB-related health needs of migrants and remote area dwellers. Fifth, citizens but not non-citizens are provided HIV treatment and services free of charge, though Botswana does provide TB treatment to all persons at no cost, including non-citizens.
Sixth, although protective laws and provisions were identified, (such as criminal laws prohibiting violence, the Domestic Violence Act and the Children’s Act), many laws do not specifically deal with HIV, AIDS and TB or the inequalities and human rights abuses experienced by people living with HIV, TB and other key populations and vulnerable populations at higher risk of exposure. While there are a number of laws protecting the right to gender equality and the rights of children and youth, there remain barriers in these contexts including: section 15(4) of the Constitution which restricts the right to gender equality; non-enforcement of protective laws and jurisprudence; inadequate awareness of the law and gender equality, including under customary law; the non-prohibition of marital rape; inadequate equality protections under customary law; inappropriate and inconsistent age of consent laws which are a barrier to accessing HIV-related health services for adolescents. Seventh, access to justice and law enforcement for human rights violations is limited. Individuals are not fully aware of their rights or how to enforce these rights and enforcement and redress mechanisms are not always accessible, well-resourced and meaningful. Other challenges in the justice system include the slow pace of litigation, high case backlogs, and mistrust of the justice system amongst the general public, and inadequate monitoring and oversight of police officers, law enforcement and other government officials. While legal aid services have been expanded in recent years, there remain challenges ensuring sufficient provision, particularly in rural areas.

Eighth, there are a number of punitive and coercive provisions in law, many of which create barriers to the response to HIV, AIDS, and TB. These include laws that criminalise consensual sex between adults of the same sex and aspects of sex work. Ninth, while Botswana has implemented aspects of the TRIPS Agreement to increase access to medicines, there remain legal barriers in this context including an unnecessary TRIPS-plus measure which criminalises patent infringement and the preclusion of intellectual property rights from anti-competition legislation, among others. Tenth, there is inadequate provision of age-appropriate information and education on HIV, AIDS, TB, sexual and reproductive health and human rights to children, adolescents, youth and adults which inhibits their ability to protect themselves from HIV and TB infection and abuse. Tenth, existing policies, HIV and TB frameworks, programming and plans do not adequately address the specific needs of at-risk populations, including women, children, young people, people with disabilities, gay men and other men who have sex with men, LGBTI people, sex workers, prisoners, migrants and remote area dwellers.

Based on this Legal Environmental Assessment, in accordance with the Botswana Constitution and regional and international human rights commitments, public health and human rights evidence, the following recommendations should be prioritised to strengthen human rights protections and to end AIDS by 2030:¹

1. Consider the following constitutional amendments:
   - Inclusion of the right to health to strengthen adequate protection of this right;
   - Prohibition of discrimination on the basis of HIV and health status to strengthen the legal protections of people living with HIV and TB.
   - Inclusion of additional economic, social and cultural rights for all persons, some of which are especially relevant in the context of HIV, AIDS and TB including the rights to education and information, the right to work and the right to social welfare to strengthen the protection of these rights.
   - Removal or amendment of the restrictive provisions of Section 15, sub-section 4(c) which severely restricts, inter alia, the right to gender equality.

2. There are inadequate legal protections for people living with and vulnerable to HIV, AIDS and TB. To address these gaps, consider:
   - Enacting a law expressly prohibiting discrimination on the basis of HIV, AIDS, TB and health status which is applicable to all other laws (i.e. through enactment of a general non-discrimination law or otherwise).
   - Amending existing laws to expressly prohibit discrimination on the basis of HIV, AIDS, TB and health status, including the Public Health Act and other relevant legislation.
   - Enacting into law a provision prohibiting health and other discrimination for people with disabilities, gay men and other men who have sex with men, LGBTI people, sex workers, migrants, prisoners and remote area dwellers.

¹ See infra, Part V, Recommendations for comprehensive recommendations.
3. Consider reviewing and aligning the Public Health Act and other health-related laws and policies with international guidelines and ensure consistency with constitutional rights and enabling provisions of policies such as the National Policy on HIV, including by ensuring that the law is rights-based, guarantees the right to non-discrimination for people living with and vulnerable to HIV and TB, and by removing provisions that are inconsistent with a human rights-based approach to HIV, TB and effective public health responses, including coercive and punitive provisions, provisions that broadly allow for required testing and disclosure of HIV and TB status and isolation and detention of all people with communicable diseases.

4. For populations who have specific HIV, TB and other health needs and challenges, ensure adequate legal and policy frameworks that fully support access to HIV and TB-related prevention, treatment, support and services which is evidence informed.
   - Consider enacting a law that provides a framework on the rights, needs, management and provision of HIV, TB and other health services for people with disabilities.
   - Consider strengthening Prison Act to ensure HIV and TB prevention, testing and management in prisons would provide clarity on the rights of inmates, the scope of available HIV and TB-related prevention, treatment and management services available in prison, and ensure that medical officers and other prison staff have clear guidance that informs them of the scope of their duties and otherwise enables them to protect the rights of inmates and ensure the provision of health and other services.
   - Consider enacting legal and policy frameworks that adequately and meaningfully address the specific needs of migrants and remote area dwellers in the context of HIV and TB including by provision of: non-discriminatory access to health services; clarifying the rights of agricultural and hourly workers to medical leave and provision of transportation to health facilities; and ensuring the availability of HIV and TB-related information in appropriate languages and formats, including for those without formal education.

5. Through provision in law and policy, ensure that non-citizens are provided with HIV-related health services free of charge, regardless of immigration status.

6. Ensure full implementation and enforcement of all existing protective laws and strengthen access to justice and law enforcement including by:
   - Strengthening of stigma and discrimination campaigns;
   - Provision of law and human rights information, trainings and sensitisation on the law, human rights, HIV and TB;
   - Provision of education and training for all, including key populations and service providers such as health workers;
   - Strengthening legal support services and mechanisms for enforcing HIV and TB-related human rights complaints and redress mechanisms, including by ensuring full accessibility and sufficient availability of resources, including in rural areas;
   - Sensitising law-makers, judicial officers (civil and customary) and law enforcers on HIV, TB, law and human rights; and
   - Ensure adequate oversight mechanisms for law enforcers, health providers, educators and in other provision of public services contexts.
7. Consider taking further action to ensure full implementation and enforcement of laws protecting the right to gender equality and the rights of children and youth and addressing existing barriers though provision in law including through the following:
   - Review, with a view towards removing or repealing Section 15(4)(c) of the Constitution which restricts the right to gender equality;
   - Provision in law for the specific prohibition of marital rape;
   - Implement, enforce and otherwise give effect to laws protecting gender equality and court decisions that uphold and protect the rights to gender equality and non-discrimination, including in the context of customary law;
   - Full implementation and enforcement of laws prohibiting gender discrimination and inequality;
   - Conduct sensitisation and trainings on law and gender equality, including under customary law, with a focus on remote areas;
   - Ensure that the rights to equality and non-discrimination of all persons in Botswana are guaranteed in the context of marriage including by aligning the customary, Muslim, and Hindu and other marriage laws and regulations with rights applicable to civil marriages and in line with the Constitution, and regional and international and regional obligations and standards;
   - Review existing age of consent laws and align with international and regional guidelines and to ensure legal harmonisation, clarity as well as harmonisation with enabling policies. In particular, (i) ensure the age of consent to HIV testing, medical treatment and all related health services allows access to such services for persons younger than 16 without parental consent; (ii) align national laws with the Southern African Development Community Parliamentary Forum (SADC PF) Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage; (iii) ensure that HIV-related prevention and services provided for in law and policy are meaningfully available (i.e., provision of contraception, information and voluntary HIV testing without parental consent to youth).

8. Consider reviewing, with a view towards repealing, punitive and coercive provisions in law which interfere with human rights and create barriers to the HIV and TB responses. These include:
   - Laws that criminalise consensual sex between persons of the same sex;
   - Laws that criminalise aspects of sex work; and
   - Overly broad provisions that criminalise exposure, non-disclosure and transmission of communicable diseases, which are applicable to HIV and TB.

9. Ensure implementation of all TRIPS flexibilities to maximise access to medicines, including removal of the unnecessary TRIPS-plus measure which criminalises patent infringement and the ensuring the inclusion of intellectual property rights from anti-competition legislation.
10. Ensure through law and policy adequate provision of age-appropriate information and education on HIV, AIDS, TB, sexual and reproductive health and human rights to children, adolescents, youth and adults.

11. Consider signing and ratifying human rights treaties which will further safeguard the rights of people living with and vulnerable to HIV and TB including:
   - The Convention on the Rights of Persons with Disabilities;
   - The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa;
   - The International Covenant on Economic, Social and Cultural Rights (ICESCR); and
   - The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

12. Consider enacting policies, HIV and TB frameworks and plans that are evidence informed, and address the specific needs of vulnerable and key populations, including women, children, young people, people with disabilities, gay men and other men who have sex with men, LGBTI people, sex workers, prisoners, migrants and remote area dwellers.
PART I: INTRODUCTION

Background

The Global Commission on HIV and the Law (GCHL) has shown that a country’s legal environment plays a critical role in reducing vulnerability to HIV infection and improving the lives of people living with HIV. The Commission demonstrated how stigma, discrimination, punitive laws, brutal policing and ineffective access to justice fuel the HIV epidemic, resulting in human rights violations and costing lives. The Global Commission reported that an epidemic of bad laws was wasting money and limiting the effectiveness and efficiency of HIV and health investments.\(^2\)

Specifically, in 2012, the GCHL identified the following barriers to HIV infection:

- Some countries enacted criminal laws that punish people for not disclosing their HIV status and hence transmitting HIV without one’s knowledge;
- Laws in some countries were vague, broad and unfairly enforced, exacerbating HIV-related stigma and spreading fear amongst populations;
- Some countries had laws that criminalise acts such as sex work, same-sex relations and drug use increase discrimination, harassment, violence and brutality against these key populations, causing their further marginalisation and driving them away from health care services;
- Women and girls were residing in countries with laws, customs and norms that deny them autonomy, economic power, sanction inequality and fail to limit violence and abuse, undermining their ability to protect themselves from HIV infection;
- In some countries, young people were denied access to crucial services that protect them from unsafe sex; and
- International trade law and intellectual property protections were blocking access to low-cost medicines for many countries.

In view of these findings from GCHL and other studies, it is internationally and regionally recognised that an effective public health response requires the implementation of all human rights as well as fundamental freedoms of all people, in accordance with existing international, regional and national human rights standards.

In recognising that a country’s legal environment is fundamental for an effective response to HIV, Member States of the United Nations (UN) adopted the United Nations General Assembly (UNGASS) Political Declaration on HIV and AIDS\(^3\) which commits them to reviewing national laws and practices that create barriers to effective HIV responses. This was further reiterated in June 2016 by the United Nations General Assembly through a Political Declaration that notes the recommendations made by the Global Commission on HIV and the Law in advancing progress towards ending the AIDS epidemic.\(^4\)

\(^2\) Global Commission on HIV and the Law, Risks, Rights and Health (2012).
\(^3\) UNGASS Political Declaration on HIV and AIDS (2011).
\(^4\) UNGASS Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (2016).
The Global Commission on HIV and the Law has also emphasised that if money is not to be wasted, establishing an enabling legal environment is of paramount interest. As the graph below shows, interventions for enhancing the legal and policy environment will mean a significant reduction in infections by 2030.

**WHY THE LAW MATTERS**

As a UN Member State that adopted the UNGASS Political Declaration on HIV and AIDS, Botswana has been engaged in efforts to curb the HIV epidemic since its outbreak in 1985. The HIV and AIDS epidemic in Botswana continues to gain ground and is recognised by the country’s leadership as one of the most critical challenges to the nation’s future. Through the Primary Health Care model, Botswana promotes access to HIV-related prevention, treatment, care and support services and believes that protection of human rights is essential to safeguard human dignity in the context of HIV.

Botswana has many laws, policies and programmes that protect the rights of all people and promote access to health care and other services, including in the context of HIV. Botswana’s Constitution protects the fundamental human rights and freedoms of all people, including the rights to non-discrimination, privacy, liberty, the rights to freedom of expression and association and the right not to be subjected to cruel, inhuman or degrading treatment or punishment. In improving access to HIV treatment, Botswana launched the “Treat All” strategy in June 2016. The strategy provides treatment for all persons who test HIV-positive regardless of viral load and CD4 count. Additionally, progressive jurisprudence in Botswana has helped to safeguard the rights of all people to equality and non-discrimination, including people living with HIV and vulnerable populations such as women.

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6 AIDS and Rights Alliance for Southern Africa (ARASA), HIV, TB and Human Rights in Southern and East Africa Report, at 78-79 (2016); See also, Diau v. BBS, Industrial Court, Gaborone, No. 50 of 2003; Rapula Jimson v. BBS, Industrial Court, Gaborone, No. 35 of 2003.
There are gaps and challenges that have been identified within Botswana’s current legal and policy framework where discriminatory and punitive laws, policies and practices create barriers to access to prevention, treatment, care and support for all people, including vulnerable and key populations. Women experience challenges realising the right to equality and access to health care services including gender-based violence, harmful social norms, stigma and discrimination and lack of access to resources.\(^7\) Adolescents below 16 years of age struggle to access HIV tests without parental consent.\(^8\) The criminalisation of sex work and same-sex relationships exacerbates negative public attitudes and stigma and discrimination, contributing to the low uptake of services by key populations. HIV-related stigma and discrimination remains a key concern impacting people living with HIV in many contexts, including within their families, communities and workplaces.\(^9\)

To address these challenges and barriers which hinder an effective HIV response, the Ministry of Health and Wellness, in partnership with the United Nations Development Programme (UNDP), is embarking on a process to review and map the current legal, regulatory and policy framework in Botswana and analyse the extent to which it supports or hinders the national and local responses to HIV, AIDS and TB.

**Aims and Objectives**

**Goal of the Assignment**

To assess laws, regulations and policy guidelines, awareness of rights and access to justice as well as law enforcement in the context of HIV, AIDS and TB.

**Specific Objectives**

The national Legal Environment Assessment (LEA) will specifically identify:

- Nature and extent of stigma, discrimination, gender inequality and gender-based violence and human rights violations affecting key populations in law, policy and practice;
- Nature and extent of laws, policies and practices that protect and promote human rights and gender equality;
- Nature and extent of laws, policies and practices that foster stigma, discrimination and human rights violations;
- Impact of the legal framework on effective responses to HIV, AIDS and TB;
- Gaps and challenges within the existing legal framework; and
- Recommendations for developing a strengthened legal and regulatory framework for effective responses to HIV, AIDS and TB.

**Deliverables of the Assignment**

i. Inception report  
ii. Draft LEA Report  
iii. Approved Legal Environmental Assessment Report

The assessment reviewed the national legal and policy framework, identified and examined all important legal and human rights issues affecting people in Botswana, in the context of HIV and TB prevention, treatment and impact mitigation efforts. The approach was based on the importance of the cross-cutting linkages between human rights (civil, political, economic, social, and cultural rights) and HIV and TB response. The human rights dimensions of HIV and TB that were considered include:

- Direct discrimination against people living with HIV and TB or presumed to be infected (e.g. denial of the rights to work, to housing or to medical attention based on HIV or health status);
- Factors that increase vulnerability to HIV and TB infection (e.g. prisoners are vulnerable due to inter alia overcrowding and limited access to health care services) and factors that impede human rights if infection occurs (e.g. lack of access to adequate food, education, and effective health services); and
- Factors limiting the national response to HIV and TB (e.g. denial of the rights to freedom of speech and association of affected groups, police harassment of HIV prevention education workers, etc.).

The assessment also reviewed the implementation and enforcement of HIV and TB-related laws, regulations and policies, including in the context of access to justice and law enforcement. Implementing recommendations from the report will strengthen the legal and regulatory framework, in line with Botswana’s regional and international commitments to protect human rights for all and promote universal access to services in the context of HIV and AIDS, including for vulnerable and key populations.

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**Table 1: The Human Rights Approach to HIV and AIDS Strategy Development**

<table>
<thead>
<tr>
<th>PRINCIPLE</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation and Inclusion</td>
<td>A key principle emerging from years of responding to HIV and AIDS is that people living with and affected by HIV and AIDS should be at the centre of the response. This also includes persons from groups most vulnerable to or at higher risk of HIV exposure.¹⁰</td>
</tr>
<tr>
<td>Non-discrimination and Equality</td>
<td>HIV related stigma and discrimination contribute to social exclusion and marginalisation. However, non-discrimination is key to meaningful inclusion and participation in efforts at boosting prevention and care efforts.</td>
</tr>
<tr>
<td>Accountability and Transparency</td>
<td>States are accountable for the protection and promotion of the rights of people under their jurisdiction. Accountability requires transparency of decision-making, action and inaction.</td>
</tr>
<tr>
<td>Indivisibility and Interdependence</td>
<td>All human rights are universal, indivisible, interdependent and interrelated.¹¹ It is important to ensure that all rights are respected in development strategies.</td>
</tr>
</tbody>
</table>

¹⁰ UNAIDS, From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (1999).

¹¹ For example, with respect to informed consent and mother-to-child transmission, a number of interrelated, indivisible rights are involved which affect the rights of the mother as well as the child. The right to informed consent of the mother, and the right to health, as well as the right to privacy cannot be easily separated.
Research Methodology
The assessment involved a comprehensive desk review of the relevant legal provisions (laws, policies and court cases), secondary materials (guidelines, plans and reports), and discussions with informal focus groups and interviews with key informants from different sectors.

A. Desk Review
The desk review aimed to determine the extent to which Botswana’s legal system is sufficient and effective to protect people living with HIV and TB and key populations from HIV-related discrimination and other violations of human rights based on real or perceived HIV status, and promoting access to health care services. The review also identified gaps in law and policy to address with the view of strengthening the legal environment for HIV, AIDS and TB service delivery to all people in Botswana.

The process involved collecting, organising and synthesising relevant public health, legal and human rights documentation (including civil, common and customary law sources) relevant to Botswana’s legal, regulatory and policy framework in the context of HIV, AIDS and TB and all affected populations. In addition to health-related frameworks, the review examined additional laws and policies affecting the rights of people living with HIV including (but not limited to) labour, immigration and movement of persons, education, criminal law, customary law, common law, intellectual property and laws pertinent to vulnerable and key populations including children, adolescents, women, migrants, people with disabilities, people who use drugs, remote area dwellers, and prisoners.

Desk review activities included scanning the literature and analysing secondary data. A standardised desk review tool was developed to guide data abstraction. The tool was structured around access to essential services; equality of people living with HIV in public and private life; key populations and vulnerable groups; and access to justice.

B. Key Informant Interviews
In this phase, detailed Key Informant Interviews (KII) with a cross-section of key stakeholders from Gaborone (Annexures I and II) were conducted to obtain information on the extent to which Botswana has committed appropriate resources and taken concrete steps to reduce HIV-related discrimination and effectively protect, promote, and fulfil the human rights of people living with HIV and key populations in practice.

C. Focus Group Discussions
BONELA conducted extensive Focus Group Discussions, which will be included in a separate section of this Legal Environment Assessment.

D. Consultative Workshops, Validation And Dissemination Of Study Findings
The LEA Steering Committee facilitated meetings in which the Consultants presented the inception report and findings to relevant stakeholders. The processes provided a platform for stakeholders to discuss critical issues at the intersection of law, human rights and HIV in Botswana as set forth in the assessment. The first draft presentation and validation meeting provided an opportunity to:

- Present findings and recommendations to national stakeholders;
- Provide an opportunity for dialogue on key issues and feedback on findings and recommendations;
- Disseminate the report and discuss potential recommendations based on the assessment;
- Seek consensus on findings and recommendations and at minimum agree on common principles and objectives that can be endorsed by the LEA Steering Committee;
- Prioritise recommendations and key actions for moving forward to strengthen the legal framework for HIV, AIDS and TB; and
- Create a mechanism or forum for ongoing monitoring and evaluation of the process.

E. Oversight By LEA Steering Committee
The mandate of the LEA Steering Committee was to oversee execution of the assignment, dissemination of the report and implementation of all recommendations. The LEA Steering Committee will also oversee monitoring and evaluation of the implementation process.
LEGAL ENVIRONMENT ASSESSMENT FINDINGS

An Overview of HIV and Tuberculosis

The complexity of the HIV epidemic requires visionary leadership and active involvement of stakeholders at all levels, which is inclusive. Through a multi-sectoral response, Botswana has reduced the HIV incidence in the general population from 1.45% in 2008 to 1.35% in 2013. However, women are disproportionately affected by HIV with a prevalence of 20.8% compared to 15.6% for men. Research has indicated that early sexual debut, forced marriage and gender-based violence (GBV) increase women’s vulnerability to HIV. Over two-thirds of women in Botswana (67.3%) have experienced some form of gender based violence in their lifetime and a smaller proportion of men (44.4%) admit to perpetrating violence against women. HIV prevalence among female sex workers is high at 61.9% and 13.1% among gay men and other men who have sex with men.

The country has been successful in providing free antiretroviral treatment (ART) to people living with HIV and with prevention of mother to child HIV transmission (PMTCT). As of March 2016, there were 277,097 (6,978 children and 270,119 adults) HIV-positive people on ART translating to a coverage of about 69% for adults and 84% for children. Research has also shown that 84% know their HIV status, 87% of people living with HIV are on treatment (of people who know their status) and 96% have reached viral suppression (of people who know their status and are on treatment). The PMTCT programme has achieved an ART coverage rate of more than 95% and a very low mother to child transmission rate of 2.49%. The number of new HIV infections has decreased significantly from 15,000 in 2005 to 9,100 in 2013, and AIDS-related deaths have reduced dramatically from 14,000 in 2005 to 5,800 in 2013. Though Botswana has shown significant progress in HIV treatment and care, specific areas within HIV prevention have not been as effective. The level of comprehensive HIV knowledge is low amongst Batswana and condom use has decreased from 90.2% in 2008, to 81.9% in 2012. Although voluntary medical male circumcision (VMMC) is slowly increasing, the number of males aged 15-49 being circumcised has increased from 11% in 2008 to just over a quarter of males in 2013. The same survey (Botswana AIDS Impact Survey IV) has also shown that HIV testing remains low across Botswana, although it increased slightly from 61.7% in 2012.

13 Id.
14 Gender Affairs Department, Gender Based Violence Indicator Study (2012).
According to the National Tuberculosis Programme annual reports and antenatal care sentinel surveillance reports, TB remains a public health emergency in Botswana. In 2015, Botswana reported 356 TB cases (including those co-infected with HIV and TB) per 100,000. The situation is worsened by high TB and HIV co-infection. In the 1990s, tuberculosis rates began to rise due to the increase in HIV prevalence. The number of TB cases increased from 200 cases per 100,000 in 1990 to 620 cases per 100,000 in 2002. In 2015, a total of 2,693 (60%) of TB patients were infected with HIV. The Ministry of Health and Wellness reports that TB incidence has declined from 344 cases per 100,000 in 2013 to 306 cases per 100,000 in 2014.

In 2013, 61% of notified TB cases were co-infected with HIV. A historical analysis of the TB epidemic has revealed that the highest TB notification rates have been in south-western Botswana (mainly in Ghanzi/Charles Hill and Kgalagadi districts compared to all other districts across the country). These two districts have a considerable number of indigenous San people (referred to as Basarwa). The major contributory factors to the high rates of TB transmission in these districts are related to:

- Poverty and social deprivation;
- High population mobility;
- Significant prevalence of substance abuse such as alcoholism; and
- Traditional life style and living and housing conditions.

Other populations at risk of TB transmission include those in congested settings such as Dukwi Refugee Camp where the clinic servicing the refugee camp notified 13 cases of TB in 2012. Other important key populations at higher risk include prisoners, children, remote farming communities, mine workers and mining communities (particularly the three major mines of Orapa, BCL and Jwaneng). The Ministry of Health indicates that although people in these mines are vulnerable to TB, the number of cases has been declining since 2007 as shown in Figure 1 below, due to comprehensive health care infrastructure at the mines. Although a downward trend in absolute cases has been sustained in mining communities, there is still a significant burden.

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25 Id.
26 Id.
Tuberculosis treatment (both first and second line treatment) is free for all TB patients in Botswana, regardless of whether they are citizens. Further, the Government of Botswana is committed to strengthening TB diagnostic capabilities with the view of initiating early TB treatment. The Ministry of Health and Wellness has rolled out use of Gene Xpert machines across the entire country, which is a rapid diagnostic test that can detect tuberculosis in hours instead of weeks or months. Further, due to a high co-infection of TB and HIV, a TB/HIV framework was put in place in which TB patients are tested for HIV and vice versa to ensure that both epidemics are addressed together. However, the government is still faced with treatment adherence challenges and there is further need to scale up infection control practices in all HIV care settings. An additional challenge is effective TB diagnosis and treatment for children. Currently, children do not have paediatric versions of medication (typically syrup) and are given tablets which are not palatable to them, making treatment retention a challenge.

The Botswana Defence Force (BDF) and Botswana Prison Services (BPS) continue to provide TB services through institutional health establishments. In 2012, a total of 76 (1.1% of all TB patients) were notified by BDF, while the BPS reported 34 TB patients.\textsuperscript{30} The estimated burden of TB in prisons, as indicated by the 2008 TB prevalence survey in prisons, was 1,430 per 100,000.\textsuperscript{31} In 2012 efforts were made to finalise a TB infection prevention strategy, specific to the prison setting to include periodic screening during incarceration.

\textsuperscript{31} Id.
PART II: THE INTERNATIONAL, REGIONAL AND NATIONAL HUMAN RIGHTS FRAMEWORK

International and regional law provides a framework for HIV and human rights law issues in Botswana. International and regional human rights law is set out in treaties, charters and conventions. A state is obligated to uphold the rights, obligations, and provisions in a treaty upon signature and ratification.

Background: Signature, Ratification and International Human Rights Norms

Signature of a treaty is an act by which a State authenticates and expresses willingness to continue the treaty making process. Signature without ratification generally does not legally bind a state; however, upon signature a State must refrain from any acts that would undermine the objective and purpose of the treaty. Ratification is the act by which a state consents to be bound by the terms of a treaty. Each state has different national procedures and requirements for ratification. Even if states have not signed or ratified a particular instrument, if its provisions form part of customary international law, they may still be bound to uphold and protect these norms.

When a State signs and ratifies a regional or international instrument, the State is obligated to comply with its provisions, including by ensuring that duties, responsibilities and rights enumerated in the instrument are implemented at the national level. State Parties to a treaty or other regional or international instrument must regularly submit reports to the treaty monitoring body on their compliance with the treaty obligations. However, even in dualist countries that have not domestically implemented treaty obligations, international and regional law can still impose obligations. The African Commission on Human and Peoples’ Rights has stated 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 Application of Treaties in Botswana

Botswana has ratified a number of international and regional instruments including:

- African Charter on Human and Peoples’ Rights, 1986
- 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
- Convention on the Elimination of All Forms of Racial Discrimination (CERD), 1974
- International Labour Organisation (ILO) Convention Concerning Discrimination in Respect of Employment and Occupation, 1997
- International Covenant on Civil and Political Rights (ICCPR), 2000
Botswana has not yet ratified:

- Convention on the Rights of Persons with Disabilities
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
- SADC Protocol on Gender and Development

While some states are monist, allowing for the direct application of international and regional law in domestic courts, Botswana considers itself dualist, requiring domestication into national law to implement the provisions of a treaty. Nevertheless, Botswana Courts recognise the importance of these obligations and have often cited international and regional treaty standards and rights in their decisions. This includes several cases involving HIV-related employment discrimination, which cite ILO and other international standards. For example, in the case of Diau v. BBS, the Court cites international standards that require voluntary testing with informed consent in concluding that the plaintiff’s mandatory test violated her constitutional and other rights. Another example, in the case of Attorney General of Botswana v. Unity Dow, the Court of Appeal specifies that Botswana Courts must interpret domestic statutory laws in a way compatible with international treaties. In finding section 4 of the Citizen Act unconstitutional, the Unity Dow Court further clarifies that Constitutional rights must be interpreted consistently with international norms: “the Constitution must be held not to permit discrimination on grounds of sex which [would] be a breach of international law.”

Through ratification of international and regional treaties, Botswana is obligated to respect, protect and fulfil the rights of all individuals protected by these instruments. International and regional treaties embody the principle of universality in the application of human rights by guaranteeing the rights to equality and non-discrimination to all persons and with respect to all substantive rights, including people living with HIV and TB and persons vulnerable to infection. For example, the ICCPR protects a number of rights and freedoms relevant in the context of HIV including non-discrimination and equality, the right to life, the right to be free from torture, cruel, inhuman and degrading treatment, freedom from arbitrary interference with privacy, and the right to family. Under Section 2(2) of the ICCPR, States are obligated to respect and ensure to all individuals within its territory and subject to its jurisdiction these rights without discrimination.

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39 Diau v. BBS, Industrial Court, Gaborone, No. 50 of 2003.
41 Id.
Limitation of Rights

There are certain circumstances in which international law recognises that the public good may warrant limitation of certain rights. Measures limiting the realisation of human rights may only be imposed in narrow circumstances and must meet the requirements of international law.

The ICCPR allows for derogation, or limitation of rights, during a public emergency “which threatens the life of the nation.” Public goods” for which derogation in the ICCPR is permissible include to protect national security, public order, public health, morality, or the rights and freedoms of others. Where there are rights-restricting measures imposed in the name of public health, there is a risk that the measures will impermissibly infringe on human rights such as the right to non-discrimination, fail to meet the requirements of the law, and/or cause significant harm to individuals and communities - often without achieving stated aims.

Some rights are non-derogable or cannot be limited for any reason. Non-derogable rights include the right to life; freedom from torture, cruel, inhuman and degrading treatment; freedom from slavery and servitude; the right to a fair trial; and the right to freedom of thought.

Any permissible derogation is only legitimate to the extent that is strictly required by the exigencies of the situation, and cannot be discriminatory on the grounds of race, colour, sex, language, religion or social origin. In terms of the Siracusa Principles, any limitation of human rights must meet the following requirements:

i. The restriction is provided for and carried out in accordance with the law;
ii. The restriction is in the interest of a legitimate objective of general interest;
iii. The restriction is strictly necessary in a democratic society to achieve the aim;
iv. There are no less intrusive and restrictive means available to reach the aim; and
v. The restriction is not imposed arbitrarily (in an unreasonable or discriminatory manner).

Further, limitations of rights should be interpreted “strictly and in favour of the rights at issue” and the burden of justifying a limitation of a right lies with the state. Where public health is invoked as a ground for limiting rights, states should give due regard to World Health Organisation (WHO) regulations.

Rights restrictions with the aim of protecting public health have been imposed in a number of contexts, some of which albeit well-intentioned, have been excessive, inappropriate, and have caused significant harm or been counter-productive. Rights-restricting public health measures may include coercive or compulsive measures that apply to persons who have already become infected or who are vulnerable to infection. In the context of HIV, some states have imposed measures restricting the rights to privacy, such as mandatory testing and disclosure of HIV status. In the context of TB, some states have imposed measures that allow for quarantine or isolation of TB patients.

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42 International Covenant on Civil and Political Rights (ICCPR), 999 U.N.T.S. 171, art. 4.
43 Id, art. 4(1).
45 Id, at 6-7.
46 Id, at 6.
However, coercive and punitive measures that interfere with privacy and other rights are often counterproductive, driving people living with HIV and those most at risk of HIV and TB infection underground and away from health facilities by exacerbating fear, stigma and discrimination. While restrictions on the right to liberty of person such as confinement and quarantine in the context of highly contagious diseases may be considered legitimate under the Siracusa Principles in some cases and within limited circumstances, it would be virtually impossible for a state to show that confinement is strictly necessary in the context of HIV given the egregious rights violations inherent in such measures, the existence of alternatives to confinement (to achieve the aim of preventing the spread of HIV), and because confinement is not effective in achieving a legitimate aim since HIV is not spread through casual contact.

The International Guidelines on HIV, AIDS and Human Rights emphasise that “public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with HIV and AIDS.” Failure to protect the rights of people living with HIV and vulnerable and key populations may increase the spread of HIV and worsen the harmful impact in communities and countries. When the human rights of people living with HIV and vulnerable and key populations are respected, protected, and fulfilled on paper and in practice, this facilitates universal access to prevention and treatment, reduces stigma and discrimination, and creates an environment which promotes access to health facilities and other HIV-related public services.

**Additional International Commitments**

Botswana has adopted a number of international and regional commitments to safeguard human rights and scale up comprehensive HIV services. Although not binding, these documents provide guidance on international and regional human rights standards in the context of the HIV and TB responses and specific law and policy recommendations for states to ensure a human rights-based approach in the response. Further, the aim is to provide universal access to HIV-related prevention, treatment, care and support within a context of multi-sectoral national responses. In providing universal access to HIV services, Botswana has committed to mainstream HIV into programmes addressing poverty, human rights, disability and gender, and to target populations most at risk of HIV infection in order to arrest the rate of new infections.

Key international and regional HIV and human rights documents and commitments include:

1. **The UNGASS Political Declaration on HIV and AIDS, 2011**: countries commit to national HIV and AIDS strategies that promote and protect human rights, eliminate gender inequalities, review inappropriate laws and address the specific needs of vulnerable populations.

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49 In the 1980s, several states imposed measures quarantining or confining people living with HIV including Azerbaijan, Algeria, the Kyrgyz Republic, Turkmenistan, and Malaysia (where the measures were enforced) and Costa Rica, Senegal, Russia, Jordan, and Syria (where measures were enacted but not enforced). Pyne, Confront AIDS, International law and the rights of people living with HIV/AIDS, at 85.
2. The UNGASS Political Declaration on HIV and AIDS, 2016: countries commit to review and reform legislation that may create barriers or reinforce stigma and discrimination and to promote access to non-discriminatory health-care services, including for populations at higher risk of and vulnerable to HIV, specifically sex workers; men who have sex with men; people who inject drugs; transgender people; prisoners; women; young people. 51 States also commit to review and reform laws that reinforce stigma and discrimination and restrict access to services, travel restrictions, mandatory testing and punitive laws related to HIV non-disclosure, exposure and transmission by 2020. 52

3. The UNGASS Sustainable Development Goals (2030 Agenda for Sustainable Development Goals and Report of the Open Working Group on Sustainable Development Goals), 2015: SDG targets are aimed at achieving respect for human rights, including gender equality, health and well-being, and quality education.


5. The UNAIDS International Guidelines on HIV and AIDS and Human Rights, 2006: urges governments to use the 12 guiding principles to develop enabling legal and regulatory frameworks for HIV and AIDS. The Guidelines contain specific guidance on (a) the creation of effective structures to manage the national response to HIV and AIDS in a manner that promotes full and equal participation; (b) the enactment of laws to protect basic human rights, reduce vulnerability to HIV and mitigate the impact of HIV on people’s lives; and (c) the promotion of access to justice through legal literacy campaigns, legal support services and monitoring and enforcement of human rights.

6. The Abuja Declaration and Plan of Action on HIV and AIDS, Tuberculosis and other Related Infectious Diseases, 2001: commits member states to prioritise HIV and AIDS and recognises the impact of social and economic inequalities on women and girls as well as the impact of and barriers created by stigma, silence, denial and discrimination.


8. Declaration of the Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria, Abuja Actions Towards the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030, 2013: commits states to review relevant laws and policies at national and regional levels to strengthen rights-based protection for all vulnerable and key populations in the context of the HIV, TB and malaria.


11. The Eastern and Southern Africa Ministerial Commitment: commits Governments to ensure youth friendly health and HIV services including for youth living with HIV (in and out of school). 53

51 UNGASS Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, paras 39, 42, 43, 46, 61 and 63 (2016). See also, paras 28, 60 and 64.

52 Id.

The UNAIDS 2016-2021 Strategy, on the Fast Track to End AIDS for the HIV response includes a number of strategies to end AIDS in the context of addressing legal and policy barriers. Some of these include:

• Implement and enforce laws, policies and practices that enable women and girls to protect themselves from HIV and access HIV-related services, including by upholding their rights and autonomy;
• Removing punitive laws, policies and practices, including overly broad criminalisation of HIV transmission, travel restrictions, mandatory testing and those that block key populations’ access to services;
• Ensure that people living with, at risk of and affected by HIV know their rights and are able to access legal services and challenge violations of human rights;
• Eliminating HIV-related stigma and discrimination among service providers in health-care, workplace and educational settings; and
• Issuing and implementing laws, policies and programmes to prevent and address violence against key populations.

The Application of Specific Human Rights in the Context of HIV and TB

In addition to the Constitution and legislation, common law and customary law are sources of law in Botswana. The Customary Law Act\textsuperscript{54} and the Customary Courts Act\textsuperscript{55} provide rules of application for customary law. Section 3 of the Customary Law Act provides:

The courts of Botswana shall, within the limits of their jurisdiction, apply customary law in all cases and proceedings in which, by virtue of the provisions of this Act or any other law, customary law is properly applied and where it is not properly applied such courts shall apply the common law.\textsuperscript{56}

The common law originates from Roman-Dutch law which was inherited from the Cape Colony through the 1891 Proclamation. As applied through the Proclamation, the Roman-Dutch law included aspects of English common law which had been further developed in South Africa. Judicial precedent also forms part of the common law through stare decisis. Customary law and courts are discussed further below.

In this section we focus on rights set out in the Constitution and what they mean in the context of HIV and TB. In other sections we examine other laws, all of which will be guided by Constitution.

\textsuperscript{54} Customary Law Act, No. 51 of 1969.
\textsuperscript{55} Customary Courts Act, No. 57 of 1968.
\textsuperscript{56} Customary Law Act, No. 51 of 1969.
The Constitution

Botswana is a Constitutional democracy and the Constitution is the supreme law of the land. Chapter II protects the fundamental rights and freedoms of every person in Botswana regardless of race, place of origin, political opinions, colour, creed or sex “subject to respect for the rights and freedoms of others and for the public interest.” Many constitutional rights are relevant in the context of HIV, AIDS and TB including the rights to life, privacy, personal liberty, and security of person, protection from inhuman treatment, secure protection of the law and protection from discrimination. In Botswana, economic, social and cultural rights—including the right to health—are not expressly guaranteed in the Constitution. The possibility of constitutional reform has been discussed by individual Members of Parliament but as of yet, there has been limited action.

Constitution of Botswana, 1966 (as amended)
Protection of Fundamental Rights and Freedoms of the Individual

3. Fundamental rights and freedoms of the individual
   a. the rights to life, liberty, security of the person and the protection of the law;
   b. freedom of conscience, of expression and of assembly and association; and
   c. protection for the privacy of his home and other property and from deprivation of property without compensation
4. Protection of right to life
5. Protection of right to personal liberty
6. Protection from slavery and forced labour
7. Protection from inhuman treatment
8. Protection from deprivation of property
9. Protection for privacy of home and other property
10. Provisions to secure protection of law
11. Protection of freedom of conscience
12. Protection of freedom of expression
13. Protection of freedom of assembly and association
14. Protection of freedom of movement
15. Protection from discrimination on the grounds of race, etc.
16. Derogation from fundamental rights and freedoms
17. Declarations relating to emergencies
18. Enforcement of protective provisions

Recommendations: Constitutional Review and Reform

• Consider inclusion of the right to health in the constitution to strengthen the protection of this right.
• Consider prohibiting discrimination on the basis of HIV and health status in the Constitution to strengthen the legal protections of people living with HIV and TB.
• Consider inclusion of additional economic, social and cultural rights for all persons, some of which are especially relevant in the context of HIV, AIDS and TB including: the rights to education and information; the right to work; and the right to social welfare to strengthen the protection of these rights.
• Consider removing or amending the restrictive provisions of Section 15, including subsection 4 which restricts, *inter alia*, the right to gender equality.

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57 Constitution of Botswana, Section 3.
58 See infra, Section on Gender Equality and Non-discrimination for discussion of this section.
The Rights to Non-Discrimination and Equality

The rights to non-discrimination and equality are protected by the Constitution and by regional and international law. The rights to non-discrimination and equality apply to all persons and to all substantive rights. Section 15 of the Constitution prohibits discrimination on the basis of race, tribe, place of origin, political opinions, colour, creed or sex "whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description."  

The African Charter states that every individual is entitled to the rights and freedoms recognised and guaranteed in the Charter "without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status" and also guarantees every individual the rights to equality before the law and equal protection of the law. The African Charter specifically requires states to "ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."  

While HIV and AIDS are not specified as a grounds of non-discrimination in international instruments, UN treaty monitoring bodies have explicitly stated that the enumerated grounds are non-exhaustive. The Committee on Economic, Social and Cultural Rights has urged states to "ensure that a person’s actual or perceived health status is not a barrier to realizing the rights under the Covenant" and has stated that restrictions on the basis of HIV status for differential treatment with regard to access to education, employment, healthcare, travel, social security, housing and asylum, are discriminatory. The UN Commission on Human Rights (replaced by the Human Rights Council) has on many occasions confirmed that the term "other status"— often comprising non-specified classes in need of protection from discrimination—should be interpreted to cover health status, including HIV status.  

The Human Rights Committee has specified that the non-discrimination provisions of the ICCPR protect against discrimination on the basis of HIV status and has recommended that states ensure that people living with HIV have equal access to treatment and that states extend existing anti-discrimination legislation to protect individuals from discrimination on the basis of HIV status or AIDS.
Similarly, the International Guidelines on HIV, AIDS and Human Rights recommend that “States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.”

In addition to discrimination on the basis of HIV, TB and/or health status, some populations who face legal, social, and other forms of discrimination, marginalisation and stigma are disproportionately impacted by and vulnerable to HIV and TB. The Committee on Economic, Social and Cultural Rights has emphasised that discrimination in access to health care, underlying determinants of health, and means and entitlements for procurement is impermissible under the Covenant which guarantees non-discrimination and equal treatment. Discriminatory grounds include “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.” The Committee also recognises gender identity as a prohibited grounds of discrimination. Similarly, the Human Rights Committee has defined the prohibition of “sex” discrimination under Articles 2 and 26 of the ICCPR as inclusive of discrimination based on sexual orientation and the Committee on the Rights of the Child has specified that ‘other status’ includes discrimination on the basis of sexual orientation.

The International Guidelines on HIV, AIDS and Human Rights recognise that groups suffering from discrimination in the context of HIV include women, children, those living in poverty, minorities, indigenous people, migrants, refugees and internally displaced persons, people with disabilities, prisoners, sex workers, gay men and men who have sex with men and people who inject drugs and recommends that States implement laws and policies to eliminate discrimination against these groups. The International Guidelines further emphasise that discrimination is wrong in itself and creates and sustains conditions leading to societal vulnerability to HIV infection, including lack of an environment that promotes behavioural change and enables people to cope with HIV.

The Right to Privacy

In Botswana, the Constitution and regional and international law protect the right to privacy. Section 9 of the Constitution protects the right to privacy of the home and other property. The right to privacy is also protected by international law including under Article 17(1) of the ICCPR, Article 12 of the UDHR, Article 37 of the CRC and Article 10 of the ACRWC. Article 17(1) of the ICCPR states that “no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.” Courts have protected the right to privacy in the context of HIV. For example, in the case Diau v. BBS, the Industrial Court emphasised that mandatory HIV testing interferes with the rights to privacy and dignity: “[W]e punish an individual for refusing to agree to a violation of her privacy or bodily integrity is demeaning, undignified, degrading and disrespectful to the intrinsic worth of being human.”

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70 Committee on Economic, Social and Cultural Rights, General Comment No. 14, 22nd Session, para. 18 (2000).
71 Id.
72 Id.
73 Committee on Economic, Social and Cultural Rights, General Comment No. 20, 42nd Session, para. 32 (2009).
75 Committee on the Rights of the Child, General Comment No. 4, 33rd Session (2003).
77 Id.
78 Diau v. BBS, Industrial Court, Gaborone, No. 50 of 2003.
Internationally it is held that in the context of HIV, the right to privacy “encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status.” Public health interests do not justify mandatory HIV testing or registration, with the exceptions of blood, organ or tissue donation testing during which the product, rather than the individual undergoes a test. States are obligated to put adequate safeguards in place to ensure that there is no testing without informed consent, to protect confidentiality, and to protect against non-consensual third party disclosure. Additionally, the Human Rights Committee has found that privacy rights protect people from criminal laws that interfere with their private and consensual sexual relationships, such as laws that criminalise consensual sex between adults of the same sex.

**The Right to the Highest Attainable Standard of Physical and Mental Health**

While the right to health is not expressly protected in the Constitution, regional and international law protect this right. The Universal Declaration of Human Rights states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including... medical care.” Article 16 of the African Charter guarantees every individual the right to enjoy the best attainable state of physical and mental health and requires that States parties “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.” Article 18(4) of the Charter also states that “[t]he aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.”

Similar to Article 16 of the African Charter, Article 12(1) of the ICESCR recognises the right of “everyone to the enjoyment of the highest attainable standard of physical and mental health.” The right to the highest attainable standard of physical and mental health specifically includes, “the prevention, treatment and control of epidemic...diseases” and “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” To meet these obligations in the context of HIV, States are obligated to inter alia ensure the provision of appropriate HIV-related information, education and support, including access to services for sexually transmitted infections, to the means of prevention (including condoms and clean injection equipment) and to voluntary and confidential testing, pre-and post-test counselling, testing and support for those living with and affected by HIV.

While there have been non HIV-specific cases before the African Commission on Human and Peoples’ Rights, the Commission has provided guidance on the scope of the right to health under the Charter, including that the right must be applied without discrimination. In Purohit and Moore v The Gambia, the African Commission held that the state’s legislative regime for mental health patients violated articles 16 and 18(4).

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79 Id, at 120.
80 Id, at 121.
83 International Guidelines on HIV/AIDS and Human Rights (2006); See also, Committee on Economic, Social and Cultural Rights, General Comment No. 14, 22nd Sess., para. 16 (2000).
The Commission stated:

The enjoyment of the human right to health as it is widely known is vital to all aspects of a person’s life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.84

The Commission further clarified that right to health under Article 16 also imposes an “obligation on the part of States party to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.”85

While Botswana has not yet ratified the ICESCR, in addition to the African Charter, Botswana is a state party to several other international treaties which protect the right to health including the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women (hereinafter “CEDAW”).86 Since the Committee on Economic, Social and Cultural Rights (ESCR Committee), which monitors the implementation of the ICESCR, has provided the most detailed guidelines on the scope of State obligations on the right to health through General Comment Number 14, these standards are relevant even though Botswana is not a party to the ICESCR.

The right to health is an inclusive right, which includes freedoms and entitlements.87 While the freedoms include the “right to control one’s health and body, including sexual and reproductive freedom,” the entitlements include “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”88 States must ensure that health information and prevention and treatment services are available, accessible, acceptable, and of good quality. These standards are essential in the context of HIV and TB both to protect human rights in service delivery and to achieve public health aims of reducing infection rates and treatment retention.

Availability requires timely, appropriate health care, and adequate provision of the underlying determinants of health including hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.89 Accessibility requires non-discriminatory access to health facilities, goods and services, especially for the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.90 Similarly, the International Guidelines emphasise that “States may have to take special measures to ensure that all groups in society, particularly marginalized groups, have equal access to HIV-related prevention, care and treatment services. The human rights obligations of States require prevention of discrimination that States ensure medical service and medical attention for everyone in the event of sickness, and that no one is discriminated against in the health-care setting on the basis of their HIV status.”91

85 Id. para. 84.
87 Committee on Economic, Social and Cultural Rights, General Comment No. 14, 22nd Session, para. 8 (2000).
88 Id.
89 Id. para. 84.
90 Id. para. 12(a).
91 Id. para. 12.
In addition to non-discrimination, other key dimensions of availability are physical accessibility, economic accessibility, or affordability, and information accessibility.\textsuperscript{92} Acceptability requires respect for medical ethics and confidentiality, and that health facilities, goods and services are culturally appropriate, including for minorities and peoples and communities as well as gender-sensitive.\textsuperscript{93} Quality health services are medically and scientifically appropriate and include skilled medical personnel and adequate hospital equipment and sanitation.\textsuperscript{94}

States are obligated to respect, protect, and fulfil the right to health. To respect and protect the right to health, states must refrain from denying or limiting equal access to health care and also must implement legislation and take other measures to ensure equal access to health care.\textsuperscript{95} To fulfil the right to health, states must ensure \textit{inter alia}, (1) that public health infrastructures provide public sexual and reproductive health services; (2) that health providers are appropriately trained; and (3) that health providers are trained to recognise and respond to the specific needs of vulnerable or marginalised groups.\textsuperscript{96}

\textbf{The Rights to Life and Dignity}

Regional and international law and the constitution also protect the rights to life and dignity. The Universal Declaration of Human Rights protects the right to life\textsuperscript{97} and recognises that human dignity is an inherent and inviolable right in itself and the basis of all other human rights providing, “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” The African Charter guarantees “[e]very human being shall be entitled to respect for his life and the integrity of his person” and “[e]very individual shall have the right to the respect of the dignity inherent in a human being ...”\textsuperscript{98} Article 6 of the ICCPR protects the inherent right to life and the preamble recognises that other human rights derive from the inherent dignity of the human person.

Given the risk of rights violations in the context of HIV, it is essential to respect and protect the right to dignity in law, policy and in practice. The right to dignity is closely linked with the rights to health and life, a prerequisite to realising other human rights and an essential priority in effective, quality healthcare. The International Guidelines recognise this connection: “[t]he protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS.”\textsuperscript{99} Further, the CEDAW Committee considers the right to dignity an essential component of acceptability in the context of health care. CEDAW General Comment number 24 provides:

“Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women’s rights to informed consent and dignity ...”\textsuperscript{100}

\begin{itemize}
  \item \textsuperscript{92} \textit{Committee on Economic, Social and Cultural Rights, General Comment No. 14, 22nd Session, para. 12(b) (2000).}
  \item \textsuperscript{93} Id, para. 12(c).
  \item \textsuperscript{94} Id, para. 12.
  \item \textsuperscript{95} Id, paras. 34-35.
  \item \textsuperscript{96} Id, paras. 36- 37.
  \item \textsuperscript{97} Universal Declaration of Human Rights, art. 3.
  \item \textsuperscript{98} African Charter on Human and Peoples’ Rights, OAU Doc. CAB/LEG/67/3, arts. 4 and 5.
  \item \textsuperscript{100} CEDAW Committee, General Comment 24, 20th Session, para. 22 (1999).
\end{itemize}
Botswana Courts have defined the right to dignity as closely connected to the Bill of Rights, particularly the right to life. For example, in Diau v. BBS the Court emphasises:

"The right to dignity permeates the entire bill of rights in our constitution, it is an intrinsic part of the right to life, broadly construed, for the denial of the right to dignity would denude the right to life of its effective content and meaningfulness."\(^{101}\)

Botswana Courts have specifically linked the rights to dignity, non-discrimination and the right to freedom from inhuman and degrading treatment in the context of HIV. In the case Lemo v. Northern Air Maintenance the Court emphasises that employers should refrain from discriminatory practices towards HIV positive employees and further finds that once an employee is dismissed on the basis of HIV status, the Constitutional right to freedom from inhuman and degrading treatment is immediately implicated: "to dismiss an employee because he is HIV positive is a violation of his right to dignity."\(^{102}\)

**The Right to Freedom of Movement**

The right to freedom of movement is protected by the Constitution and international law. Section 14 of the Constitution guarantees that “no person shall be deprived of his freedom of movement,” which includes “the right to move freely throughout Botswana, the right to reside in any part of Botswana, the right to enter Botswana and immunity from expulsion from Botswana.” The Constitution makes restrictions of the freedom of movement permissible in cases of inter alia, lawful detention;\(^{103}\) for the imposition of restrictions reasonably required in the interest of defence, public safety, public order, public morality or public health so far as the restriction is reasonably justifiable in a democratic society;\(^{104}\) and for noncitizens.\(^{105}\)

The African Charter guarantees every individual the right to freedom of movement and residence within the borders of a State so long as the individual abides by the law and the right to leave any country including his own and to return to his country, subject to limitations on the bases of inter alia, public health.\(^{106}\)

The International Guidelines specify that there is no rationale for restricting liberty of movement or choice of residence on the grounds of HIV status.\(^{107}\) Rather, any restrictions of these rights on the basis of suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and not justified by public health concerns.\(^{108}\) The Guidelines further provide that “where States prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency.”\(^{109}\)

\(^{101}\) Diau v. BBS, Industrial Court, Gaborone, No. 50 of 2003.

\(^{102}\) Lemo v. Northern Air Maintenance, Industrial Court, Gaborone, No. 144 of 2004, at 18.

\(^{103}\) Constitution of Botswana, Section 14(2).

\(^{104}\) Id, Section 14(3)(a).

\(^{105}\) Id, Section 14(3)(b).

\(^{106}\) African Charter on Human and Peoples’ Rights, OAU Doc. CAB/LEG/67/3, art. 4 and 5.


\(^{108}\) Id, para. 127.

\(^{109}\) Id, para. 128.
The Right to Liberty and Security of Person

The right to liberty and security of person is guaranteed by the Constitution and protected by international human rights treaties, including the ICCPR. Section 5 of the Constitution prohibits deprivation of the right to personal liberty except when authorised by law, including in cases of criminal conviction and when authorised by court order. Deprivation of personal liberty is permissible if there is reasonable suspicion that an individual has committed or is about to commit a criminal offence and for the education or welfare of a person under the age of eighteen with court order or with the consent of a parent or guardian.\textsuperscript{110} Notably, Section 5(1)(g) also permits a deprivation of personal liberty “for the purpose of preventing the spread of an infectious or contagious disease.” Persons who have been arrested and detained inter alia, must be informed of the reasons for the arrest or detention and must be brought before a Court as soon as is reasonably practical.\textsuperscript{111}

Article 9(1) of the ICCPR protects the right to liberty and security of person, providing “\textit{No one shall be subjected to arbitrary arrest or detention}” and “\textit{no one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.}”\textsuperscript{112} The prohibition of arbitrary arrest and detention is not limited to criminal cases; rather Article 9 applies in all cases in which there is a deprivation of liberty.\textsuperscript{113} The UN Human Rights Committee defines liberty of person as “freedom from confinement of the body” and is a right which is “precious both for its own sake, and because deprivation of liberty has historically been a principal means by which other human rights are suppressed.”\textsuperscript{114} An arrest is arbitrary where it lacks any legal basis in law,\textsuperscript{115} and the Human Rights Committee has found that “arbitrariness” is not to be equated with “against the law,” but must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability, and due process of law.\textsuperscript{116}

\textsuperscript{110} Constitution of Botswana, Section 5(1)(e) and (f) (1966).
\textsuperscript{111} Id, sections 5(2) and 5(3).
\textsuperscript{112} International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 art. 9(1). Security of person is discussed in a separate section infra.
\textsuperscript{113} Human Rights Committee, General Comment No. 8, 16th Session, para. 1 (1982).
\textsuperscript{114} Human Rights Committee, General Comment No. 35, 112th Session, para. 3 (2014).
\textsuperscript{116} Human Rights Committee, General Comment No. 35, 112th Session, para. 13 (2014).
The International Guidelines on HIV/AIDS and Human Rights provide clarity on the scope of these rights in the context of HIV, specifying that there is no public health justification for arbitrary interference of liberty and security of person through measures such as quarantine, detention or isolation.\textsuperscript{117} Arbitrary deprivations of liberty would include those based “merely on HIV status.”\textsuperscript{118} Further, the right to physical integrity requires that HIV and TB testing takes place on a voluntary basis and with informed consent and compulsory testing “can constitute a deprivation of liberty and a violation of the right to security of person.”\textsuperscript{119}

In the context of TB, states have imposed measures that limit the rights to liberty and security of person such as isolation, quarantine and detention as well as criminalising refusals to take TB medication. Such measures may impermissibly interfere with the rights to liberty and security of person if the measures fail to meet the Siracusa Principles standards that require inter alia that a measure is strictly necessary to achieve the stated aim and that a measure is not imposed arbitrarily. For example, in the 2016 case Daniel Ng’etich & 2 Others v. Attorney General & 3 Others, the Kenyan High Court ruled that imprisoning the Petitioners for refusal to take their TB medication violated their rights to liberty and freedom of movement and was inconsistent with international guidelines on isolation of patients with TB. Indeed, the WHO emphasises that involuntary isolation and detention are methods of last resort, when rights-based and community-based treatment have been ineffective.\textsuperscript{120}

Coercive measures of this nature are especially problematic since they are often used in contexts and within Government institutions in which individuals are least able to protect themselves including soldiers, prisoners, sex workers, people who inject drugs and men who have sex with men.\textsuperscript{121} Restrictions on the right to liberty are only permissible in exceptional cases concerning deliberate and dangerous behaviour and such cases should be handled under ordinary provisions of public health and/or criminal law, with appropriate due process protections.\textsuperscript{122}

**The Rights to Education and Information**

While the right to education is not protected by the Constitution, regional and international law guarantee the right to equal access to education. Article 26 of the UDHR states “Everyone has the right to education. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship...” Article 17(1) of the African Charter protects the right to education for every individual and Article 11(1) of the African Charter on the Rights and Welfare of Children guarantees every child the right to education and Article 11(3)(e) requires States to take all appropriate measures to “ensure equal access to education for all sections of the community.” The Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights also guarantee the right to education, including information on sexual and reproductive health and rights (SRHR).

\textsuperscript{118} Id.
\textsuperscript{119} See Id, para. 135. While the International Guidelines on HIV/AIDS and Human Rights do not specifically address TB in this provision, involuntary and compulsory TB testing can amount to a similar violation.
\textsuperscript{120} World Health Organisation, Guidance on Ethics of Tuberculosis Prevention, Care and Control, at 22 (2010).
\textsuperscript{121} Id.
In the context of HIV, the right to education encompasses three broad components which include: (i) the right of children and adults to receive HIV-related education, particularly regarding prevention and care, which is available in every culture and religion, both inside and outside schools; (ii) protection from discrimination in access to education on the basis of HIV status and (iii) states must promote understanding, respect, tolerance and non-discrimination in relation to persons living with HIV. Access to HIV and TB-related education and information is an essential and life-saving component of effective prevention and care programmes.

The Committee on the Rights of the Child considers the right to access information aimed at the realisation of physical and mental health and the right to sex education among the most important rights in the context of HIV. The Committee has expressed concern that adolescents are vulnerable to HIV because their first sexual experience "may take place in an environment in which they have no access to proper information and guidance." While access to information on HIV and SRHR may be lacking in countries where provision of such information is thought to promote sexual experimentation, studies indicate that access to information has the opposite effect of delaying sexual activity. As such, the non-provision of information is a barrier to HIV-prevention and the realisation of the right to health among children, adolescents and adults.

States must also ensure that education and information programmes are of good quality and respect the rights of learners. For example, the CEDAW Committee recommends that States ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

The Right to Work

The right to work and labour rights are protected by national, regional and international law. The African Charter guarantees every individual the right to work under equitable and satisfactory conditions and the right to equal pay for equal work. Article 7 of the International Covenant on Economic, Social and Cultural Rights protects the right to just and favourable conditions of work, including fair wages, equal remuneration for work of equal value without distinction and equal opportunity for promotion. Further, the right to work is "essential for realizing other human rights and forms an inseparable and inherent part of human dignity." The Committee on Economic, Social and Cultural Rights has defined the right to non-discrimination, including on the basis of HIV status, as a key aspect of the availability component of the right to work under Article 6 of the Covenant:

Under its article 2, paragraph 2, and article 3, the Covenant prohibits any discrimination in access to and maintenance of employment on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, or civil, political, social or other status, which has the intention or effect of impairing or nullifying exercise of the right to work on a basis of equality.
The International Guidelines emphasise that, like all people, people living with HIV have the right to work and the right to just and favourable work conditions. To realise these rights, non-discrimination and confidentiality must be safeguarded in public and private sector workplaces. Mandatory HIV testing which results in refused employment, dismissal, or refusal of employee benefits on the ground of HIV status violate an individual’s right to work. States should ensure that people living with HIV are allowed to work as long as they can carry out the functions of the job, ensure provision of reasonable accommodation when needed, and when persons are no longer able to work, States should provide people living with HIV equal access to sickness and disability schemes. The Guidelines also recognise that while most occupational settings do not impose a risk of HIV transmission, where there is a risk of transmission, such as in health-care settings, States should ensure proper training of health workers that allow them to avoid transmission as well as the means to implement these measures.

Employment rights are not addressed in the constitution, but are regulated through national laws including the Employment Act and Employment Amendment Act. The national framework is discussed below.

**Freedom from Cruel, Inhuman or Degrading Treatment or Punishment**

The Botswana Constitution and regional and international law prohibit cruel, inhuman and degrading treatment and punishment. Section 7(1) of the Botswana Constitution prohibits torture, inhuman and degrading punishment and other treatment. The ICCPR does not expressly define cruel, inhuman or degrading treatment, but does provide that it is any such act that is “an offence to human dignity not amounting to torture.”

While the right to freedom from cruel inhuman or degrading treatment and punishment can arise in a variety of settings in the context of HIV, the International Guidelines focus on the risk of such violations in prison. States owe a duty of care to prisoners including to protect their lives and health. Failure to meet obligations to provide HIV-related information, education and means of prevention (bleach, condoms, and clean injection equipment), voluntary testing and counselling, confidentiality and HIV-related health care, access to voluntary participation in treatment trials and to prevent rape and sexual victimisation which can expose prisoners to HIV, can amount to cruel, inhuman or degrading treatment.

Additionally, the Committee against Torture has on several occasions linked dismal prison conditions to the spread of HIV and TB in prisons, recommending that states ensure that prison conditions meet the United Nations Standard Minimum Rules for the Treatment of Prisoners and address HIV and TB in prisons. For example, the CAT Committee expressed concern about the prevalence of HIV, AIDS and tuberculosis and the high contamination rate of prisoners and prison officers in Zambia due to overcrowding and the lack of adequate health care.

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131 Id, para. 150.
132 Convention against Torture, 1465 U.N.T.S. 85, art. 16.
Similarly, the CAT Committee expressed concern about the high rate of tuberculosis amongst detainees in South Africa and recommended that the State “adopt effective measures to improve the conditions in detention facilities, reduce the current overcrowding and meet the fundamental needs of all those deprived of their liberty, in particular regarding health care.”

The International Guidelines also specify there is no public health or security justification for mandatory HIV testing of prisoners and further recommend that terminally ill prisoners, including those with AIDS, should be considered for early release and should have access to appropriate health services outside of prison.

The Special Rapporteur on torture, cruel, inhuman and degrading treatment or punishment has highlighted a number of practices in the context of HIV that may amount to ill or degrading treatment including being turned away from hospitals, summary discharge, denial of access to medical services unless persons consent to sterilisation, and providing poor quality care that is dehumanising and damaging to persons with already-fragile health status. Forced HIV testing when done on a discriminatory basis and/or without respect for consent and necessity, may also constitute degrading treatment and the Special Rapporteur also notes that “unauthorised disclosure of HIV status to sexual partners, family members, employers and other health workers is a frequent abuse against people living with HIV that may lead to physical violence.”

### The Right to an Adequate Standard of Living and Social Services

Article 25 of the Universal Declaration of Human Rights provides that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” Article 9 of the ICESCR recognises the right of everyone to social security, which includes social insurance. The International Guidelines recognise that an adequate standard of living may reduce vulnerability to HIV and may be an essential lifeline to people living with HIV and their families, who are impoverished as a result of AIDS-related morbidity and/or discrimination on the basis of HIV status. States should prioritise the availability of funding for such services for people living with HIV and should ensure that people living with HIV are not denied adequate standard of living and/or social security and related service on the basis of HIV or health status.
PART III: NATIONAL LAWS, POLICIES, REGULATIONS AND PLANS RELEVANT TO HIV, TB AND KEY AND VULNERABLE POPULATIONS

Health Laws, Policies, Regulations and Plans Concerning HIV, TB, and Human Rights

A) Background

Botswana has been engaged in efforts to curb the epidemic since its outbreak in 1985 and the operating environment has been characterised by a series of successive strategic plans and policies that are guided by the constitution and other laws. This section analyses Botswana’s national laws, policies and strategic planning processes in relation to HIV and TB.

Rights-promoting laws, policies and strategic plan are essential for meaningful and sustained universal access to human rights and to reduce HIV transmission. Although Botswana has the third highest HIV prevalence in the world after Lesotho and Swaziland, 138 (18.5%) there has been strong political commitment to Botswana’s HIV response. The response is coordinated by the National AIDS Council (NAC) with National AIDS Coordinating Agency (NACA) serving as its secretariat which was established through a Presidential Cabinet Directive on 14th December 1999.

B) Legal and Policy Framework

While there are no specific constitutional provisions that guarantee the right to health or health services in Botswana, the country has enacted laws that promote access to health care and other services and courts have upheld the rights of people living with HIV.

The enactment and enforcement of protective laws is crucial in the contexts of HIV and TB, since HIV and TB often affect the most vulnerable and a number of human rights issues arise in these contexts. The Global Commission on HIV and the Law and other international and regional treaty bodies have emphasised the need to safeguard the rights to informed consent and confidentiality of HIV status, and have prioritised addressing stigma and discrimination from health providers. Additional human rights issues that arise in the context of HIV and TB include restrictions of the right to liberty and freedom of movement, where individuals who are thought to be HIV or TB positive are isolated or detained, in some cases without proper procedures or due process protections. Similarly, punitive public health measures are sometimes imposed which punish “exposure” of HIV, TB or other illness to the public. Problematic at best, overly-broad punitive provisions tend to be ineffective as they increase stigma and drive people underground and away from health facilities. In Botswana, the Public Health Act regulates these and other aspects of the provision of healthcare and services in Botswana and in the context of HIV and TB, policies, plans and strategic frameworks complement these regulations.

Health care and services must be available and accessible to all persons, requiring physical and information availability, affordability, and non-discriminatory access to health facilities, goods and services, especially for the most vulnerable or marginalised, in law and in fact, without discrimination. While Botswana has made significant steps towards these goals, there remain gaps which can be addressed through law and policy. For example, TRIPS flexibilities, which have the effect of reducing the cost of essential medicines, have not been fully implemented. Further, a number of populations experience stigma and discrimination, in law and society, including people living with HIV, TB and other vulnerable and key populations.

Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality, and coverage of services; restrictive factors such as human rights violations, punitive laws or harmful social and cultural norms. These factors may create or exacerbate vulnerability to HIV.

Key populations refer to people who are at higher risk of acquiring or transmitting HIV. UNAIDS considers gay men and other men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and prisoners and other incarcerated people as the main key populations. The Global Fund includes the following as key populations: (a) gay, bisexual and other men who have sex with other men; (b) transgender persons; (c) people who inject drugs; (d) sex workers and (e) all people who are socially marginalised, often criminalised and face a range of human rights abuses that increase their vulnerability to HIV. However, each country identifies key and vulnerable populations in within their national context. In Botswana, NSF II identifies key and vulnerable populations including women and girls, orphans and other vulnerable children, men who have sex with men, female sex workers, migrants and mobile populations, people with disabilities, adolescents and young men and women.

A review of the current strategic framework and operational plan has indicated that although the HIV epidemic in Botswana is widespread, there are several key populations that are heavily impacted by HIV. HIV prevalence amongst men who have sex with men is 13.1% and 61.9% amongst sex workers. Despite their vulnerabilities to HIV and alarming statistics, the current national response does not have specific guidelines that enhance interventions targeting key populations such as sex workers and gay men and other men who have sex with men. Whilst there is an increasing effort at the national level to support these populations, stigma and legal barriers including criminalisation and inadequate enforcement of protective laws make HIV prevention and support efforts a challenge. Only 44.9% of key populations are reached with services and many key populations only receive support from civil society organisations. It is estimated that 75% of HIV programmes and services for men who have sex with men and transgender persons are provided by civil society.

As the country is in the process of developing the third national strategic framework (NSF III), it is essential for stakeholders to address vulnerable and key population needs, including through ensuring laws and policies protect their rights and address vulnerabilities and specific challenges accessing HIV and TB-related health services of these populations.

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Id., at 31.


As illustrated in NSF II, services are often provided in a generic manner and do not target populations based on their specific needs and social-cultural and political conditions. NSF II recognises that non-targeted programming is a major prevention gap amongst some of the most vulnerable, including prevention interventions for key populations including youth, female sex workers and men who have sex with men.\textsuperscript{145} Key informants during the LEA process also emphasised that there are no specific interventions that have been implemented to ensure access to friendly and equitable services by key populations. Due to criminal laws that further stigmatise them, LGBTI persons and sex workers experience challenges accessing quality health services including breaches in confidentiality, poor quality and/or degrading treatment by providers, as well as societal stigma and discrimination which leads to targeting, blackmail, violence, unemployment and poor educational outcomes which exacerbate vulnerability to HIV and TB.\textsuperscript{146}

This section examines health-related laws, policies and guidelines to ascertain the extent to which the existing framework protects the right to health and access to services. The section analyses the Public Health Act, No. 23 of 2013; the extent to which policies, strategies and plans protect against discrimination and facilitate access to services; relevant intellectual property laws; and existing frameworks that regulate health centres.

C) The Public Health Act

A progressive public health legislation protects and improves health care across all cadres of society and also clarifies some of the contentious issues surrounding the intentional spread of HIV. The Public Health Act of 2013 consolidates and amends the law relating to public health. The Public Health Act also addresses many public health concerns in Botswana and identifies HIV as a significant public health issue in the country.

The Public Health Act is progressive in addressing the following public health issues related to the HIV response in Botswana:

- Supports access to confidential HIV testing for everyone 16 years and above (Section 104(1)(a));
- Prohibition of HIV testing in relation to employment (Section 104(2));
- Providing for the routine offer of HIV tests in accordance with guidelines (Section 104(3)(a));
- The requirement of prior informed consent for HIV testing (Section 105(a));
- Provision of pre-test information and counselling (Section 110);
- Protection of confidentiality (Sections 113, 122);
- Support to disclosure upon request of someone living with HIV (Section 116(4));
- Regulation and quality of services and testing commodities; and
- The use of in camera proceedings in court where it is necessary to disclose information relating to HIV status, to protect confidentiality (Section 121).

\textsuperscript{146} Key Informant Interviews.
These provisions are in line with the international human rights goals of universal access to prevention, treatment, care and support services¹⁴⁷ which emphasise ensuring provision of sufficient information to individuals to allow them to make an informed and voluntary decision to be tested, facilitate post-test counselling and referrals to appropriate services and ensure the protection of patient confidentiality. Consent, counselling and confidentiality are fundamental rights in the context of HIV testing and treatment.

However, 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 HIV and TB. Further, some provisions are not clearly defined and may be misinterpreted and misapplied.

In general, the Public Health Act could be revised to focus more on the rights of patients and how human rights and public health interact, ensuring that human rights are protected and only limited when limitations are justifiable and reasonable and strictly necessary to meet a specific public health aim. The Public Health Act does not expressly guarantee the right to non-discrimination in the provision of health services or access to health services for all. An overarching non-discrimination provision could provide protection against discrimination on the bases of inter alia, HIV and health status, sex, gender, race, ethnicity, tribe, place of origin, political opinions, colour, creed, disability, citizenship, immigration status, sexual orientation and gender identity.

**D) Communicable Diseases**

The Public Health Act defines “communicable disease” as any disease which can be transmitted directly or indirectly from one person to another. Because HIV and TB would fall within this description, provisions that apply to “communicable disease” would apply to HIV and TB.

**E) Notifiable Diseases**

The Public Health Act lists a wide range of diseases as notifiable including HIV and AIDS as well as any other disease declared a “notifiable disease” in terms of Section 52.

**Section 52**

Section 52 provides that notifiable diseases shall be under surveillance and reported within such a period as may be prescribed in the Integrated Diseases Surveillance and Response Guidelines prepared by the Minister. Section 52(3) requires every officer in charge of a health facility, medical practitioner or health officer to notify the Director about a notifiable disease that he or she comes across during the course of that officer’s work. Section 52(4) makes it an offence if a person contravenes Section 52(3).

The Public Health Act is not clear regarding the purpose of notification in general, or for specific diseases, although in public health terms, notification is generally understood to be required for disease monitoring, planning and control purposes. Section 52 is written broadly and does not provide a general, or disease-specific process for notification, for confidentiality of personal information when a disease is notified, or for penalties for breaches of confidentiality during notification. Further details regarding the process of notification may well be included within the routine surveillance\textsuperscript{148}, referred to in section 52(1) of the Act. Confidentiality of HIV test results is additionally provided for in section 3.2.2 of the Ministry of Health, Botswana National HIV Testing Services Guidelines, 2016.

Section 53

This section allows for a health officer or authorised officer to enter and inspect premises which he or she has reason to believe any person is suffering, has recently suffered, or was recently exposed to any communicable disease and to examine any persons on the premises. This provision broadly allows for entry into premises and medical examination and applies to all communicable diseases.

Section 57

This section broadly authorises isolation and detention of persons who have communicable diseases when medical practitioners believe detention is necessary to prevent the spread of the disease. However, the Act does not provide clarity as to what considerations are to be taken into account when determining whether isolation or detention is necessary to prevent the spread of a disease. Section 57(2) requires detention until the “medical practitioner, health officer or an authorised officer, in writing, by the Director is satisfied that he or she is free from infection or can be discharged without danger to the public health.” Section 57(3) makes it an offence for a person detained under this section to escape or attempts to escape.

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, including HIV. In terms of the internationally recognised Siracusa Principles, it is not clear that limiting an individual’s rights to liberty, security of person and freedom of movement through isolation is strictly necessary to prevent the spread of the disease, since HIV is not spread through casual contact.

This position is confirmed by the UNAIDS International Guidelines on HIV and Human Rights, 2006. The WHO Policy on TB infection Control in Health Care Facilities, Congregate Settings and Households furthermore suggest that there is little evidence that detention of people with TB is an effective intervention.\(^{49}\) In addition, there are potentially less intrusive and restrictive means available to achieve this aim, through education, prevention, access to comprehensive treatment, care and support. Furthermore, the Act does not provide for oversight mechanisms or guidelines as to appropriate circumstances for and period of detention, nor require authorisation by a court, which would also allow for a court to set out specific conditions of detention, periods of detention, and for the appointment of legal representation for detainees. Finally, the Act does not allow for a legal or other remedy in cases of unlawful detention.

**Section 58**

Section 58(1) makes it an offence for a person suffering from any communicable disease to wilfully expose himself or herself without proper precautions in any public place. The provision is discussed in detail in the section of the report dealing with Criminalisation and Punitive Laws and Law Enforcement, below.

**HIV Testing, Prevention and Control Provisions**

**A) Consent for HIV Testing**

Section 104 (3)(b) provides “[t]he Director, or any person authorised by him or her, may, where necessary and reasonable require a person or a category of persons to undergo an HIV test.” This section broadly allows for mandatory HIV testing, undermining the protective aspects of the Act and international requirements which require testing to be conducted voluntarily, with informed consent, protection of patient confidentiality and provided with counselling. It also provides limited guidance on what conditions may be considered “necessary and reasonable” for HIV testing and what would be done to obtain voluntary and informed consent from such person in that situation.

Section 104(4) further provides that, if a person who is required to undergo an HIV test by the Director refuses to do so, the Director may apply to a magistrate for an order that the person undergoes the HIV test. The procedure is to be in camera and section 104(6) and (7) provide that a magistrate may order such testing if, on a “balance of probabilities” the magistrate is satisfied that it is in the public interest / the interest of public health, based on considerations such as whether a third person has been exposed to the risk of HIV transmission and his or her right to information regarding the risk of transmission.

\(^{49}\) World Health Organisation, Policy on TB Infection Control in Health-Care Facilities, Congregate Settings and Households (2009).
This implies that the section 104 provision for mandatory HIV testing is based on supporting a person who has been exposed to the risk of HIV transmission by another, and ultimately preventing the spread of HIV. However, this is not clearly stated, nor is the issue of disclosure of the HIV test results to a third party discussed. A further concern is that authorising involuntary testing of ‘categories of persons’ could result in the arbitrary targeting of key, vulnerable or stigmatised populations, particularly since there are no guidelines provided as to when involuntary testing of a class of persons would be necessary and reasonable. In the region, involuntary testing of vulnerable groups has led to serious HIV-related rights violations. For example, involuntary testing of sex workers in Malawi\textsuperscript{150} and involuntary testing of domestic workers in Uganda.\textsuperscript{151}

Based on the Siracusa Principles as aforementioned, a limitation of the right to HIV testing with voluntary and informed consent should only take place where it is, amongst other things, strictly necessary to achieve the aim (in this case, the aim possibly being to support a person exposed to HIV and ultimately to prevent the spread of HIV) and cannot be achieved by less intrusive or restrictive means and/or is not imposed arbitrarily (i.e. in a manner that is unreasonable or discriminatory). Similar considerations should apply to disclosure of a person’s HIV status that follows upon mandatory HIV testing.

It is desirable that both the discretion provided to a Director, as well as the power given to a magistrate in terms of this section, be guided by the abovementioned considerations in order to ensure that mandatory HIV testing (and potential disclosure to a third person) only be permitted where it is a “justifiable and reasonable limitation” of the rights of the patient and whether the limitation of rights is strictly necessary to meet a specific aim. If these provisions are retained, the Act should require the provision of guidance as well as orientation for magistrates on the objectives and implementation of the provision.

Section 105(1)(d) provides that an HIV test can be conducted where it is required under any law, but does not clarify whether informed consent is required.

Section 105 (2)(b) provides “[a] medical practitioner responsible for the treatment of a person may conduct an HIV test without the consent of that person where — (a) that person is unconscious and unable to give consent; and (b) the medical practitioner believes that such a test is clinically necessary or desirable in the interests of that person.” Amending the section to require that testing of an unconscious person unable to give consent is clinically necessary AND desirable in the interests of the person would strengthen the existing safeguards. Ensuring there are sufficient safeguards against improper and unnecessary HIV testing is especially crucial when individuals are unconscious.

Section 108 authorises mandatory HIV testing for persons convicted of rape but does not provide further conditions or guidance as to application, including the extent to which this information is available to the public or the purpose of the mandatory HIV test (i.e. for sentencing, etc.). The National Guidelines on HIV testing provide that mandatory testing of a person convicted of rape should still only occur on the basis of a court order, but this is not guaranteed in law.

**B) Age of Consent**

Sections 104(1)(a) and 105(b)

Under Sections 104(1)(a) and 105(b), the age of consent to HIV testing is 16 years. The Ministry of Health Botswana National HTS Guidelines, 2016 confirm that a person below 16 years cannot consent independently to an HIV test and must obtain consent from a parent or legal guardian.


There are circumstances where a person below the age of 16 years can get consent for an HIV test without a parent or legal guardian. In terms of Botswana law, an emancipated minor may consent to health services such as medical treatment, and including HIV testing.\textsuperscript{152} In terms of health policy, a minor who is a mother may access health services, which should include an HIV test.\textsuperscript{153} Additionally, the Botswana National HTS Guidelines provide that if a person below the age of 16 cannot get consent from a parent / legal guardian, a medical practitioner may administer an HIV test where he or she determines the need for such.

However, there is global research to suggest that requiring parental consent for adolescents under 16 impedes access to testing and treatment.\textsuperscript{154} Furthermore, there was public support for lowering the age of consent during the October 2007 public hearings held on HIV and AIDS. It may be important to consider whether a lowered age of consent for HIV testing is appropriate, in the circumstances.

C) Surgeons and Dentists

Section 109(3) provides, “[w]here, in the opinion of a medical practitioner, nurse or dental practitioner, the surgical or dental procedure is not urgently required in respect of a person, the medical practitioner, nurse or dental practitioner may require the person to undergo an HIV test before carrying out that procedure”. The purpose and nature of this provider-initiated testing is unclear; however, it suggests HIV testing may be set as a condition for access to a procedure or surgery in certain circumstances. However, in other respects the Public Health Act, as well as the Ministry of Health Botswana National HTS Guidelines, 2016 clearly require HIV testing with voluntary and informed consent.

It may be important to conduct further research in the future to ensure that there is not abuse of this provision, which could be interpreted as allowing for mandatory testing.

D) Confidentiality and Disclosure

Section 115 (1) provides that a person shall not disclose information about “the result of an HIV test, including the HIV or HIV antibody status, the sexual behaviour of a person or the use of drugs by a person” to any person except –

a) With the consent of that person;

b) Where the person died, with the consent of the person’s partner, representative or executive;

c) Where the person is under 16, with the consent of the parent;

d) Where the personal has a disability which renders that person incapable of giving consent, with the consent of a parent or guardian;

e) To an approved health care worker, medical practitioner, dental practitioner or nurse who is directly involved in the treatment of counselling of that person;

f) For the purpose of research authorised by Minister;

g) To a court where information in medical records directly relevant in proceedings; or

h) Where authorised or required to do so under this Act."

While there are limitations as to when such information can be disclosed, Section 15(1)(g) allows for broad disclosures and should specify that a court must first hear an application for admission of such evidence.

Section 116(1) provides “[a] person who is aware of being infected with HIV or is carrying and is aware of carrying HIV antibodies shall — (a) take all reasonable measures and precautions to prevent the transmission of HIV to others; (b) inform, in advance, any sexual contact or care giver or person with whom sharp instruments are shared, of that fact; and (c) not place another person at risk of becoming infected with HIV”. This article may be interpreted as conferring exclusive responsibility for the health and well-being of others on people living with HIV. The principle of “shared responsibility” in preventing HIV transmission should be promoted to ensure that both HIV-positive and HIV-negative persons have the responsibility to prevent transmission.

\textsuperscript{152} Botswana Ministry of Health (2012). National HIV and AIDS treatment guidelines. Section 2.3 page 23-24

\textsuperscript{153} Botswana Ministry of Health (2009). HIV Testing Guidelines

Section 116(4) provides that a person may, in writing, request that a medical practitioner or health care worker informs that person’s care-giver or sexual contact of the person’s HIV status.

Section 116(7) provides “[a] medical practitioner who is responsible for the treatment of a person and who becomes aware that the person has not, after a reasonable opportunity [disclosed their HIV status] may, after consultation with an approved specialist medical practitioner, inform any sexual contact or care giver of that person of the HIV or HIV antibody status of that person.” Section 116 authorises mandatory HIV disclosure to sexual partners and care givers and also allows for isolation and detention of people living with HIV. This section interferes with the right to privacy, increases risk of stigma and discrimination for people living with HIV, and ignores the complexities of domestic violence.

While disclosures of HIV status are recommended when third parties are at risk, the section is broadly stated and does not set forth specific steps which must take place to safeguard the rights of patients. In line with the SADC PF Model Law on HIV in Southern Africa and the International Guidelines on HIV and the Law, disclosure by a health care provider should be guided by a “step-by-step” process that does not violate the right to privacy and balances the rights and responsibilities of all parties. Further, the provision does not take into account risk of domestic violence in determining whether disclosure is appropriate.

Section 15 of the Model Law on HIV provides that a person providing treatment, care or counselling services to a person living with HIV may notify a third party of the HIV status of that person only where the notifying person is requested by the person living with HIV to do so or where specific circumstances exist:

(i) the third party to be notified is at immediate risk of HIV transmission; and
(ii) the person living with HIV, after appropriate counselling, does not personally inform the third party at risk of HIV transmission; and
(iii) the person providing treatment, care or counselling services has:
   (aa) properly and clearly informed the patient that he or she intends to notify the third party under the circumstances; and
   (bb) ensured that the person living with HIV is not at risk of physical violence resulting from the notification; or
(i) the person living with HIV is dead, unconscious or otherwise unable to give consent to the notification; and
(ii) is unlikely to regain consciousness or the ability to give consent; and
(iii) in the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner(s).

Guideline 3(28)(g) of the International Guidelines on HIV/AIDS and Human Rights provides further guidance, specifying that disclosure of a person’s HIV status by a medical practitioner to a sexual partner “should only be made in accordance with the following criteria:

• The HIV-positive person in question has been thoroughly counselled;
• Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
• The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
• A real risk of HIV transmission to the partner(s) exists;
• The HIV-positive person is given reasonable advance notice;
• The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice;
• Follow-up is provided to ensure support to those involved, as necessary.”

While Section 122(1) does provide that information concerning sexual behaviour disclosed during an HIV test is confidential and cannot be disclosed without consent, Section 122(2) states that confidentiality of this information does not apply where (a) the court orders the disclosure of the information; or (b) the information is required by a medical practitioner or by any legal representative who requires or is entitled to the information in the course of his or her professional duties. Section 122(2)(b) is written very broadly and seems to allow for disclosure of information concerning individuals’ sexual behaviour to legal representatives suing them without a court order. This is inconsistent with the right to doctor-patient confidentiality.
E) Additional Provisions

Section 116(9) allows a Director to apply in writing to a magistrate for an order, where the Director reasonably believes that a person with HIV “knowingly or recklessly places another person at risk of becoming infected with HIV without the knowledge of that person of the infected person’s HIV status.” Section 116(10) allows the magistrate to order that the individual with HIV undergoes medical and psychological assessment; to impose restrictions on the behaviour or movement of that person for a period of up to 28 days; or to isolate and detain that person for up to 28 days, which can be renewed.

Section 116(11) states that the magistrate must take the following factors into account when making a determination under Section 116(10):

a) Whether, and by what method, the person transmitted HIV;
b) The seriousness of the risk of the person infecting other persons;
c) The past behaviour and likely future behaviour of the person; and
d) Any other matter the magistrate considers relevant.

Sections 116(15) and (16) require in camera proceedings and prohibit publication of information from the proceedings.

One concern with these Sections is whether a magistrate will be in a position to determine whether a person transmitted HIV to another person or to make an assessment of HIV risk. Notably, although isolation and detention would amount to serious rights violations, the purpose(s) of detention and/or isolation are not made clear. As discussed above in the context of Section 57, isolation and detention in the context of HIV is inconsistent with international standards and is ineffective to prevent transmission since HIV is not spread through casual contact. Further, the Section does not clarify whether the state will provide an attorney to individuals detained under the provision or the remedies available in instances of illegal detention. Finally, because this section is HIV-specific, it has the potential to stigmatise HIV above other communicable diseases.

Section 117 allows the Director of Public Prosecutions to institute proceedings against a person who committed the offence of publicly promoting participation in a sexual activity of a kind which is likely to cause damage to health through the sexual transmission of HIV. This provision is extremely broad and the application is unclear. An additional concern is the potential for disproportionate and/or discriminatory application to key populations, such as gay men and other men who have sex with men and sex workers.

Section 119 limits HIV testing services to approved facilities, which seems to have the effect of prohibiting home or HIV self-testing in Botswana. While, ethical implications of self-testing must be considered, home testing has been shown to improve access to services and the provision should allow for home testing in appropriate circumstances.

Sections 136-138 provide for the rights of persons with non-communicable health conditions to: basic health services, pharmacy management, efficient management prevention and control of non-communicable diseases, which amounts to discriminatory treatment for individuals with communicable diseases.
National HIV Policy

The Botswana National Policy on HIV provides a regulatory framework to address HIV policy issues and priorities. The National Policy on HIV and AIDS was first developed in 1992, in 1998 and later in 2012 to keep pace with the evolving HIV trends.

The current policy creates an environment for the provision of adequate and equitable care and support to those infected and affected with HIV and AIDS; advocates for the reduction of HIV and AIDS related stigma and discrimination towards persons infected with or affected by HIV and provides a platform to support legislative and legal reform that recognises the impact HIV and AIDS has on individual and community rights.

The National Policy provides general principles to manage the national response to HIV and AIDS. Stated objectives include the following:

2.1.1 Prevent the spread of HIV infection and reduce the socioeconomic impact of this disease.
2.1.2 Create a policy environment for the provision of adequate and equitable care and support to those infected and affected with HIV and AIDS.
2.1.3 To reduce HIV and AIDS related stigma and discrimination towards persons infected with or affected by HIV and AIDS and draw attention to the compelling public health rationale for overcoming stigmatization and discrimination against them in society.
2.1.4 Promote coordination in order to enhance implementation of the National Response to HIV and AIDS.
2.1.5 Provide platform to support legislative and legal reform that recognizes the impact HIV and AIDS has on individual and community rights.

The National Policy provides that HIV testing will only be performed with informed consent. The Policy also provides however that HIV testing will be mandatory prior to sentencing for all persons convicted of a sexual crime.

The policy recognises that "discrimination especially in relation to an individual’s HIV status has a detrimental effect on the ability of individuals to make informed choices about their own welfare and, further, limits the efficacy of the national response to the epidemic." The policy prohibits mandatory testing as a precondition to employment but also specifies that "where circumstances demand, HIV testing may be required." Mandatory HIV testing is to be regulated through guidelines.

The policy emphasises the rights of citizens to access inter alia HIV and AIDS-related care, counselling, medications and health interventions. However, it is critical that access to health care services is available to all in need, including non-citizens. This is not only in line with the principles of the Sustainable Development Goals, which recognise the importance of “not leaving anyone behind” and reaching all vulnerable populations. It is furthermore in keeping with promoting human rights to equality and to attaining public health goals, since preventing the spread of HIV requires meeting the needs of all populations at risk of HIV, particularly vulnerable and key populations. As shown in the GCHL findings, the exclusion of vulnerable populations such as non-citizens from HIV-related health services is not only discriminatory, it also hinders the effectiveness of the HIV response.

156 Id, 5.7.
157 Id, 7.1.
158 Id, 7.1.1.
159 Id, 7.1.2.
160 Id, 7.1.3.
162 GCHL, Risks, Rights & Health (2012).
Strategic Plans

The National Framework on HIV and AIDS recognises the need to address all forms of stigma and discrimination that “collude to constrain the coverage and effectiveness of HIV and AIDS interventions and increase the vulnerabilities of particular groups in society.”

• First National Strategic Framework for HIV & AIDS (NSF I), 2003-2009: The first national strategic framework (NSF I) was analytical, consultative and built on lessons learned through implementation of previous frameworks. It sought to address many of the weaknesses that were becoming increasingly evident in national responses across Africa. The strategic framework articulated and disseminated the agreed strategies for emerging areas of national concern within the scope of Vision 2016 and provided clearer guidance to Ministries, districts, civil society and the private sector to enable them to work in a collaborative manner in achieving the intended goal to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana. However, the framework can also be characterised by a lack of focused and coordinated implementation, weak management of the national response, an inadequate legislative and policy environment, and insufficient strategic guidance for implementing sectors.

• Second National Strategic Framework for HIV & AIDS (NSF II), 2010-2017/2018: This framework currently guides the national HIV response through multi-sectoral partnerships. The multi-sectoral approach focusses on HIV prevention, treatment, and care and support strategies and plans that guide HIV interventions in the public sector, the civil society sector and the private sector. NSF II identifies key and vulnerable populations including women and girls, orphans and other vulnerable children, men who have sex with men, female sex workers, migrants and mobile populations, people with disabilities, adolescents and young men and women.

The National AIDS Council, a coordinating body for the national response, established several sectors that implement HIV interventions according to their specific mandates. These sectors include the Ethics, Law and Human Rights Sector (ELHR Sector), the Women Sector, the Men Sector and the Youth Sector. The current NSF II guides the various sectors through the National Operational Plan (NOP), and the different sector strategic plans including the Health Sector Strategic Plan (HSSP), the NAC Women Strategic Plan; NAC Men Sector Strategic plan, NAC ELHR Sector strategic plan, and the various civil society organisation strategic plans.

Additional Policies, Guidelines and Charters

A number of health-related policies, guidelines and charters provide human rights protections. The 2012 National HIV Treatment Guidelines provided a framework for HIV-related care in the country and recognised that “reproductive rights are derived from fundamental human rights which are protected by the Constitution of Botswana. Therefore, women and men living with HIV have the same reproductive rights as individuals without HIV infection.”

The 2016 Integrated HIV Clinical Care Guidelines implement the Treat All strategy and provide a framework for HIV-related services in Botswana. The Guidelines have a number of protective, rights-based provisions including for example:

• Allowing for minors to access family planning methods in appropriate cases.
• Recognising that people living with HIV have a fundamental right to “a satisfying and safe sexual and reproductive life.”

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165 Id, at 7.
166 Id, at 8.
The Botswana Charter on HIV/AIDS and Human Rights\(^\text{167}\) emphasises that people living with HIV have a full range of human rights including the right to equality, and all other legal, civil, political, social and economic rights applicable to everyone.

The Botswana TB/HIV Policy Guidelines\(^\text{168}\) create a framework for coordinating HIV and TB systems to reduce disease burdens and strengthen the response.

**Trade Related Aspects of Intellectual Property Rights (TRIPS) Flexibility**

The Ministry of Health and Wellness plays a critical regulatory role with respect to access, quality, production and distribution of medicines in Botswana. Discussions with key informants from the Ministry of Health and Wellness indicate that the Ministry’s role is to ensure a safe, secure, cost effective and efficient drug distribution system for accessibility and availability of essential medicines at all health facilities. The key informants also indicated that patented medicines are expensive, especially drugs for oncology (cancer), cardiovascular diseases, and second and third line antiretroviral medicines. In addition, Botswana is one of the first countries to roll out national free treatment programme that has supplied people living with HIV with free anti-retroviral medicines. Through good governance and management of public funds and support from development partners, Botswana has made life expectancy gains, and in particular has made major achievements: 96% of babies born to HIV positive mothers are born HIV negative through the PMTCT Programme.

To maintain these public health gains and ensure that access to HIV and TB-related health services is equitable and available for all, access to affordable medicines remains a critical aspect of the public health strategies of Botswana. Due to the intensive research and resources used to produce medical drugs, the drug manufacturers protect their ownership of the medical drugs through registration of patents against each drug or specific diagnostic process. Patents protect the intellectual property rights (IPRs) of the company and limit the actions of third parties over use of the specific drug. The use of IPRs has a direct effect on the accessibility of specific medicines across the world.

The production, procurement, distribution, use and pricing of medicines is subject to both domestic and international legal and policy post-environments. Domestic level patents are protected through various intellectual property laws which make provision for restrictions on the exploitation of protected products. At the international level, patents are part of the World Trade Organization (WTO) intellectual property regime as governed by the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).

These domestic and international frameworks have an effect on the extent to which public health initiatives can be delivered at a cost-effective rate. TRIPS provides minimum standards of patent protections but also includes ‘flexibilities’ that allow developing countries to access essential medicines at a lower cost. In 2001, the WTO Ministerial made the Declaration on the TRIPS Agreement and Public Health, or the ‘Doha Declaration’, which states that the TRIPS Agreement “does not and should not” prevent WTO Members from protecting public health.\(^\text{169}\)


While Botswana has taken steps to implement TRIPS flexibilities through domestic legislation, there remain barriers in the legal environment.

In 2013, a national workshop was held on TRIPS and Access to Medicines. A technical working group was set up to review priority recommendations by using TRIPS flexibilities. Through the Industrial Property Act\textsuperscript{170} and the Industrial Property Act Regulations of 2012, Botswana has domesticated TRIPS flexibilities including compulsory licensing, parallel importation, pre- and post-patent application challenges, patent examination and a list of exclusions from patentability.\textsuperscript{171} The Attorney General’s Chamber’s has specifically noted that the Industrial Property Act is TRIPS compliant. However, the legal environment can be improved further, including by implementing recommendations identified during the 2013 meeting.\textsuperscript{172} Of particular concern is that intellectual property rights are excluded from the competition legislation, meaning that pharmaceutical companies and others cannot be legally challenged on the grounds of anti-competitive practices.

The Working Group made a number of recommendations with respect to creating an enabling legal environment to facilitate access to essential medicines. Importantly, Botswana has legislated an unnecessary TRIPS-plus measure by criminalising patent infringements. At the 2013 meeting, with regard to this TRIPS-plus provision, the working group found:

\textit{This is a controversial provision that has the effect of stifling innovation and the provision of affordable medicines that can come with such processes as reverse engineering in the context of the creation and procurement of generic medicines. The provision should be repealed.}

\textbf{KEY CHALLENGES INCLUDE:}

- Inconsistent legal provisions, particularly the complete exclusion of intellectual property rights issues from the competition legislation resulting in the prospect of anti-competitive practices going unchecked in the medical drugs industry and services.
- Botswana has also legislated an unnecessary TRIPS-plus measure by criminalising patent infringements which goes against accepted international practice and dissuades innovation and flexible procurement since the fear of criminal law is real in this case.
- The regulator can conduct patent examinations in a scientific manner but this process can also be circumvented through the use of ministerial powers that permit the minister to designate certain applications for patents as unexaminable by the regulator.
- Further the powers granted to the regulator in the context of patent examination require the office of the regulator to be capacitated technically and financially in order for these powers to be fully implemented.
- The omission (possibly a mere oversight by the drafters of the regulations) of a procedure for filing patent grant oppositions by interested persons.

The LEA assessment has shown that as part of the efforts to enhance access to HIV-related products and/ or other health products, Botswana has made progress in addressing these challenges. In 2013, a national workshop was held on TRIPS and access to medicines.

\textsuperscript{170} Republic of Botswana, Industrial Property Act, No. 8 of 2010.
\textsuperscript{171} ARASA, HIV, TB and Human Rights in Southern and East Africa Report (2016).
The workshop, which involved a broad range of government, civil society and private sector stakeholders, made recommendations aimed at ensuring the implementation of public interest oriented policy space or “flexibilities” afforded by the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) in Botswana. However, there was slow progress in implementing the 2013 workshop recommendations. One of the key impediments to the introduction of further flexibilities as recommended by the 2013 workshop has been stagnation in the process of formally establishing the Technical Working Group (TWG) for the coordination and monitoring of TRIPS flexibilities in Botswana. To remedy this, a follow-up workshop was convened from 7-8 December 2016. The workshop developed a road-map for the implementation of TRIPS flexibilities in Botswana and Terms of Reference (TORs) for the TWG.

Although there was slow progress in implementation of the 2013 recommendations, it is important to note that Botswana has established an autonomous body, the Companies and Intellectual Property Authority (CIPA), which is the custodian of the country’s intellectual property (IP) laws. The country incorporates flexibilities such as international exhaustion to facilitate parallel importation and compulsory licensing. On implementation of the legal reforms recommended in the 2013 workshop, it was indicated that the Industrial Property Act came into force shortly prior to the 2013 workshop. However, CIPA has started an internal process of reviewing the Industrial Property Act in light of the 2013 workshop recommendations and held a stakeholder consultation on 29 November 2016. There is need for further consultations with stakeholders to determine the desirability of introducing certain TRIPS flexibilities that are omitted by the Industrial Property Act. For example, there is a need to determine whether the generic industry in Botswana has the capacity to effectively exploit a “Bolar” exception should it be legislated.

Consultations with NCPI stakeholders have indicated that the Industrial Property Act and the Medicines and Related Substances Act of 2013 are not harmonised. Further, the Medicines and Related Substances Act (which does not have implementation guidelines) has not yet been implemented. Further, the December 2016 workshop recommended adoption of the generic substitution and pooled procurement initiatives as prioritized in the SADC Pooled Procurement Strategy to ensure availability of less expensive medicines. This can be facilitated through the recently launched Medicines and Patent Licenses Database (MedsPaL) of the Medicines Patent Pool (MPP). The Companies and Intellectual Property Authority is also encouraged to collaborate with MPP in this regard.

**Regulation of Health Centres and Health Providers**

Medical centres are regulated by the Public Health Act. The Act inter alia establishes a National Health Council which is responsible for providing advice to the Minister on health-related law and policy, provides for administration of the Act and regulates prevention, introduction and control of disease.\(^{173}\)

The Medical Professions Act regulates and controls the practice of medicine, dentistry, pharmacy and allied health professions and establishes the Botswana Health Professions Council. The Council is responsible for registration of health professionals, setting and monitoring standards for the training of health professionals, monitoring standards on ethical behaviour and practice and investigating cases of professional misconduct and public complaints lodged against practitioners.

Similarly, the Nurses and Midwives Act regulates the control, training, discipline, regulation and practice of nurses, midwives and nursing assistants. The Botswana Nursing Council sets professional standards for the training, practice as well as registering registration of nurses and midwifery professionals. The Act prohibits a wide range of professional misconduct including negligence and incompetence as well as “unkindness to or ill-treatment of patients.” Professional misconduct would subject a nurse or midwife to a disciplinary hearing.

The Drug Regulation Services is responsible for approval of drugs and medicines to ensure that medicines used in Botswana meet set standards of safety, efficacy and quality, as well as authorisation of the import of medicines for use in clinical trials.

The effectiveness of these regulatory bodies is discussed below in the Access to Justice in the Context of Healthcare section.

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\(^{173}\) Public Health Act, No. 23 of 2013.
**RECOMMENDATIONS: Health Laws, Policies and Plans Concerning HIV, TB, and Human Rights**

**GENERAL RECOMMENDATIONS**

- Consider legal provision for the right of all people to available, accessible, appropriate, affordable and quality medicines, diagnostics and related technologies for HIV, AIDS, and TB without discrimination for prevention, treatment, care and support of HIV and AIDS;
- Consider legal provision for prioritisation of the HIV and TB-related needs of vulnerable and key populations in access to health care services, including HIV and TB-related health services;
- Consider provision in National Strategic Frameworks, policies and plans for needs-based HIV and TB-related services targeting key and vulnerable populations;
- Consider provision of a specific strategy or framework that addresses the HIV and TB-related needs of key and vulnerable populations;
- Ensure health care workers have training, including rights-based and sensitisation training, to adequately implement and provide non-discriminatory services to key and vulnerable populations.

**TUBERCULOSIS**

- Ensure through provision in law and policy that there is access to high quality preventative TB medication, TB treatment (including MDR (multi-drug resistant) and XDR (extensively drug resistant)), diagnostics, care and support for all, including paediatric formulations of TB medication for children.
- Facilitate provision in law and policy that the needs of populations at high risk of tuberculosis (including prisoners, children, remote farming communities, mine workers, mining communities, asylum seekers, health workers, remote area dwellers, people living with HIV, pregnant women and Basarwa) are being adequately met including through provision of tuberculosis information, prevention, treatment, care and support, including in remote areas and in all appropriate languages and formats. Such legal and policy frameworks should address the specific occupational, practical and other risks, concerns and challenges faced by individual populations (i.e. such as prisoners, health workers and mine workers).
THE PUBLIC HEALTH ACT:

It is recommended that provisions of the Public Health Act are reviewed to ensure that the legislation affirms and protects health rights in the context of HIV, AIDS, and TB consistent with the recommendations of the Global Commission on HIV and the Law – that is, that promotes protective, non-punitive and coercive responses to HIV, TB and those affected by HIV and TB. Specifically, the following sections and aspects of the Act should be revised to strengthen protections and ensure a human-rights based approach to HIV and TB:

• Consider expressly guaranteeing the right to non-discrimination in the provision of health services and access to health services for all, through an overarching non-discrimination provision in the Public Health Act. Such a provision could protect the right to non-discrimination in the context of health on the bases of inter alia, HIV, TB and health status, sex, gender, race, ethnicity, tribe, place of origin, political opinions, colour, creed, disability, citizenship, immigration status, sexual orientation and gender identity.

• Section 52: The Act may wish to clearly set out the purpose of notification of diseases. The detailed provision for the notification of HIV, AIDS and TB should be accompanied by clear provision for the confidentiality of personal information, according to the same standards as those provided for in the Ministry of Health Botswana National HTS Guidelines, 2016 for HIV testing. This detail may be provided within the Integrated Disease Surveillance and Response Guidelines.

• Section 53: If the provision is to remain, consider limiting application to a list of specific communicable diseases.

• Section 57: Consider amendment of the section to:
  o Provide safeguards that ensure that isolation and detention are a measure of last resort to achieve the aim of limiting the spread of a disease, in line with the Siracusa Principles regarding reasonable and justifiable limitations of the rights to liberty, security of person and freedom of movement;
  o Allow for detention to be authorised by a court which should also set out specific conditions of detention, periods of detention, and for the appointment of legal representation for detainees;
  o At minimum, ensure (i) there are guidelines in place, including as to appropriate circumstances for and length of detention and (ii) there is an oversight mechanism in place to review decisions on isolation and detention; and
  o Provide for remedies in cases of unlawful detention; and
  o Include schedules to classify the different communicable diseases which emphasise the protection of the rights of patients.

• Section 104 (3)(b), Section 104(4), Section 105 (2)(b)
  o Review these provisions to promote voluntary HIV testing, with informed consent, patient confidentiality and the provision of counselling with testing.
  o Consider the inclusion of broad factors for the Director to consider before ordering a mandatory HIV test.
  o If the Director and the courts are provided with the power to order mandatory HIV testing, it is recommended that HIV testing (and any related disclosures) are reviewed against the international standards set out by the Siracusa Principles, to ensure that mandatory HIV testing is only permitted where it is a “justifiable and reasonable limitation” of the rights of the patient, in that it is strictly necessary to meet a specific aim, there are no less restrictive means to achieve the aim, and is not imposed arbitrarily.
  o If Section 104(4) is to remain, ensure that there is guidance and orientation for magistrates on the application of the provision in a manner consistent with public health and human rights standards.
  o It is recommended that the clause in Section 104(3)(b) that authorises testing of ‘categories of persons’ be removed.
  o If section 105(2)(b) is to remain, consider an amendment which requires that the test is clinically necessary AND desirable in the interests of the individual.
• **Section 108**: It is recommended that the section be reviewed and aligned with the National Guidelines on HIV testing which only allow for mandatory testing of persons convicted of rape by court order. Provision of conditions and guidelines as to application of Section 108 are also recommended, which would clarify and safeguard the rights of the victim and the convicted, including the purpose of the mandatory HIV test (i.e. sentencing) and to whom the test results will be available, ensuring that any limitations on rights are justifiable and reasonable and otherwise meet international standards.

• **Sections 104(1)(a) and 105(b)**: Review these provisions to consider the possibility of lowering the age of consent for access to HIV testing, as well as treatment, care and support and related sexual and reproductive health services, with due consideration for related ages of consent.

• **Section 109(3)**: In the future, there may be a need for research to identify whether this provision is abused, including in terms of mandatory testing or refusal of services.

• **Section 115(1)**: Section 15(1)(g) allows for broad disclosures and it is recommended that the provision should specify that a court must first hear an application for admission of such evidence.

• **Section 116**: Review the section against the SADC PF Model Law on HIV, the International Guidelines on HIV and AIDS and other international standards is recommended. Guideline 3(28)(g) of the International Guidelines on HIV/AIDS and Human Rights provides that disclosure of a person’s HIV status by a medical practitioner to a sexual partner “should only be made in accordance with the following criteria:
  • The HIV-positive person in question has been thoroughly counselled;
  • Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
  • The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
  • A real risk of HIV transmission to the partner(s) exists;
  • The HIV-positive person is given reasonable advance notice;
  • The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; follow-up is provided to ensure support to those involved, as necessary.”

• **Section 116(1)(b)**: It is recommended that obligation to inform a caregiver of HIV status should be removed.

• **Section 116(7)**: The provision of guidelines defining a ‘reasonable opportunity’ for disclosure would provide legal clarity. It is also recommended that the provision allow for screening of violence prior to making a decision on disclosure.

• **Section 116(9)**: This section should be reviewed against international standards.

• **Section 122(2)**: This section should be reviewed against international standards concerning the right to confidentiality.

• **Section 117**: This section should be reviewed against international standards given the potentially broad application, which could be applied in a discriminatory manner against vulnerable groups.

• **Section 119**: Review this section to consider whether home and/or self-testing should be available in Botswana and under which circumstances, taking into account ethical implications.

• **Sections 136-138**: Review these provisions since they provide for different treatment and standards of care for people with communicable and non-communicable diseases.
**NATIONAL HIV POLICY:**

The retention of the protective and rights-based provisions in the HIV policy is recommended. However, it is recommended that the policy also ensure the provision of HIV-related services to non-citizens and key and vulnerable populations and that the provisions allowing for and referring to mandatory testing be reviewed against international standards, to ensure that any proposed limitation of the right to testing with voluntary informed consent only takes place where it is reasonable and justifiable in the circumstances.

**TRIPS FLEXIBILITY:**

Ensure implementation of all recommendations of the Working Group and full implementation of the Industrial Property Act and other relevant legislation, as specified above. In particular repeal the TRIPs-plus measure which criminalises patent infringement.

- Consider amending the law to include IPR in the anti-competition legislation to prevent anti-competitive practices
- Consider amending the law to ensure that all patents are examinable by the regulator
- Consider making provision for and otherwise facilitate a procedure for filing patent grant oppositions.

The LEA process has identified several key issues that require intervention to enable Botswana to achieve a sustainable medicines provision system including:

- Ensuring Bilateral Trade Agreements do not hinder full exploitation of TRIPS flexibilities;
- Implementing the SADC Pooled Procurement Strategy to increase access;
- Strengthening Medicines Supply Chain System and Medicines Regulatory Authority. The technical and financial position of the Drugs Regulatory Unit (DRU) should be strengthened.
- Assist the Government in the process of granting the DRU autonomous status as a drugs regulatory authority which can then raise its own income.
- Enhance the DRU’s collaboration with other regulators on the harmonisation of regulations at regional and continental levels.
- Take steps to harmonise the essential medicines list with the register maintained by the DRU.
- The DRU should take steps to provide guidelines for parallel imports of medicines.
- Increase the national and regional capacity for manufacturing generic pharmaceuticals and diagnostic tools.

**REGULATION OF HEALTH CENTRES AND HEALTH PROVIDERS:**

- Ensure that ethical and other oversight of medical practitioners, nurses and midwives are effective in ensuring the rights of people living with HIV and TB and vulnerable and key populations to comprehensive and high quality health services.
- Key informants indicated that there is a need to provide training and sensitisation for health providers on human rights, the law and HIV and TB-related issues, particularly on LGBTI and sex worker rights and health-related issues. It is recommended that trainings include:
  - information on the universal application of constitutional and human rights, which are guaranteed to people living with HIV and TB and key and vulnerable populations;
  - information on the universal application of medical and professional ethics, which are essential to ensure access to quality health services for people living with HIV and TB and key and vulnerable populations;
  - specific training and information on the specific human rights issues facing people living with HIV, TB and key and vulnerable populations.
- Ensure that effective legal mechanisms exist for patients to report cases of abuse and degrading treatment committed by health professionals and practitioners.
Stigma and Discrimination Against People Living With HIV

Globally, people living with HIV continue to experience stigma, discrimination, marginalisation and verbal and physical abuse in public institutions and in their homes. While there is less information available, people with TB face significant stigma globally. People living with HIV in Botswana experience stigma and discrimination in various forms including:

• Refused employment or work opportunity
• Dismissals from employment
• Pre-employment HIV testing (private and public) and denial of employment in certain employment sectors

The 2014 Stigma Index Survey recognises that stigma against people living with HIV remains one of the major barriers to effective prevention and management of HIV and AIDS in Botswana. The study found that over 10% of study participants experienced external stigma such as gossip and verbal insults and 5% experienced exclusion from social gatherings. Thirteen percent had experienced external stigma at least one time in the previous twelve months.

While there remain significant challenges, many aspects of Botswana’s legal framework protect people living with HIV from discrimination and stigma. Botswana’s constitution, as well as regional and international law, guarantee the rights of all people to equality and non-discrimination, which would include people living with HIV, TB and key and vulnerable populations. However, as mentioned above, neither the right to non-discrimination on the basis of health nor HIV status is expressly protected in the Constitution. Section 15 of the Constitution prohibits discrimination on the basis of race, tribe, place of origin, political opinions, colour, creed or sex “whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description.” The rights to equality and non-discrimination apply with respect to all substantive rights.

While HIV and TB-related stigma and discrimination remains an issue in Botswana and exacerbates the impact of HIV, there is insufficient protection from discrimination provided in law, in general and with respect to access to health services for people living with HIV, AIDS and TB. Neither the Public Health Act nor other health legislation expressly prohibit HIV or TB-related discrimination. Additionally, there is no general non-discrimination or equality law which enforces the right to non-discrimination (similar to South Africa’s Promotion of Equality and Prevention of Anti-Discrimination Act, No. 4 of 2000). However, Botswana has taken important steps to address stigma and discrimination, including through enacting the Employment Amendment Act of 2010 which prohibits dismissal on the basis of inter alia health status and disability. Botswana Courts have also enforced the right to non-discrimination in the context of labour, including from mandatory HIV testing and unfair dismissal.

176 Id.
The National Policy on HIV and AIDS prohibits all forms of discrimination and stigma against people living with HIV and recognises that discrimination in the relation to an individual’s HIV status “has a detrimental effect on the ability of individuals to make informed choices about their own welfare and...limits the efficacy of the national response to the epidemic.” The Policy guarantees that people living with HIV have access to education, insurance, legal and financial services, housing and employment without discrimination or stigma. However, these safeguards would be strengthened if these protective provisions were enacted into law.

To effectively address HIV, it is essential to strengthen the existing frameworks that protect equality and to address legal and social inequality and discrimination that exacerbates vulnerabilities to HIV. This includes addressing HIV and TB-related stigma and discrimination, gaps in the legal framework, and discriminatory laws that exacerbate inequality and disempowerment of vulnerable groups.

**RECOMMENDATIONS: Stigma and Discrimination on the Basis of HIV and Health Status**

- Enact a law expressly prohibiting discrimination on the basis of HIV, AIDS, TB and health status which is applicable to all other laws (i.e. through enactment of a general non-discrimination law or otherwise).
- Amend existing laws to expressly prohibit discrimination on the basis of HIV, AIDS, TB and health status, including the Public Health Act and other relevant legislation.

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179 Id, para. 7.1.4.
Equality and Non-Discrimination Framework for Key and Vulnerable Populations

In addition to stigma and discrimination on the basis of HIV, TB and health status, there are a number of groups in society who are especially vulnerable to and/or disproportionately impacted by HIV, AIDS and TB. The national framework recognises the particular challenges faced by such groups. Recognising that social, cultural and other inequities create vulnerabilities to HIV for some populations, the Botswana Second National Strategic Framework for 2010-2017 identifies a number of marginalised populations who may need targeted programming including women, children, adolescents, gay men and men who have sex with men, female sex workers, transgender persons and people with disabilities.

In line with this framework, and recognising inequities and challenges faced by certain populations due to legal, social, economic, cultural and other factors, this section outlines the legal framework relevant to HIV, AIDS, and TB for the following populations: (a) women; (b) children, adolescents and young people; (c) prisoners and persons in state custody; (d) people with disabilities (e) migrants; and (f) remote area dwellers. While, due to the continued criminalisation of consensual sex between persons of the same sex and aspects of sex work, LGBTI persons and sex workers face significant societal discrimination, marginalisation, and human rights abuses which increase the risk of HIV exposure and impose barriers in terms of access to treatment, the legal frameworks for those groups are located in the Criminalisation and Punitive Laws and Law Enforcement Section. Similarly, people who use drugs also experience discrimination and challenges accessing HIV-related health services. Information pertaining to people who use drugs is included in the Criminalisation and Punitive Laws and Law Enforcement Section.

Gender Equality and Non-Discrimination

A) Current Situation

The Global Commission on HIV and the Law recognises the profound impact of gender inequality on an effective HIV response. Inequality leaves women and girls “undefended from HIV infection and diminishes their ability to cope with the consequences of illness and to care for themselves and their families.” The CEDAW Committee has recommended that due to social factors that result in inequities in the determinants of health status, States should give special attention to the health needs and rights of women belonging to vulnerable and disadvantaged groups, including migrant women, refugee and internally displaced women, the girl child and older women, female sex workers, indigenous women and women with physical or mental disabilities.

Regionally, a larger percentage of HIV-positive individuals are women compared to men, which is attributed to gender discrimination, high prevalence of sexual violence in the region, gender norms that prevent safe sex negotiation, high levels of socioeconomic dependency as well as biological factors that increase susceptibility. These social, cultural, behavioural and economic disparities manifest in Botswana where women have higher HIV infection rates—HIV prevalence amongst women is 20.8% and 15.6% amongst men. In addition, women are at high risk of TB. Globally, TB kills more women than any other single infectious disease and each year, more women die of TB than all causes of maternal mortality combined. Women who are co-infected with HIV and TB—especially pregnant women—are at especially high risk and are more likely to die than co-infected men, particularly in Africa.

While many domestic laws and regional and international protections guarantee gender equality and non-discrimination, inequities and discriminatory provisions and application remain under civil, common and customary law. In some contexts, legal and policy frameworks do not fully protect the rights of women. In other contexts, the non-enforcement of existing protections and inadequate access to justice, including in cases of rape and violence fails to deter gender-based violence and hinders meaningful realisation of the right to equality. Legal inequality exacerbates social inequities between men and women and unequal power dynamics within relationships, making it more difficult for women to be empowered at home, at work, and at school. Unequal power dynamics in domestic settings make it a challenge for women to negotiate safe sex.

Gender-based violence in Botswana is pervasive—67.3% of women in Botswana reported having experienced GBV in their lifetime, which includes sexual, physical, emotional, and/or economic violence by a partner or non-partner. Incidents of GBV could be higher as it is often underreported. Most cases of GBV were committed by an intimate partner—62.3% of all women have experienced intimate partner violence whereas 11.4% of all women have experienced GBV by someone who is not an intimate partner (of the 67.3% of women who have experienced GBV).
Sixty-two percent of women in Botswana have experienced intimate partner violence in their lifetimes and a 2012 study found 29% of women had experienced intimate partner violence in the last twelve months. An unacceptably high proportion of young women are raped in Botswana. The 2013 BIAS IV indicates that 24.8% of females age 15-49 surveyed who had early sexual debut (before the age of 15) did not give consent at the time of intercourse. In the context of HIV, AIDS and TB, sexual and other gender-based violence has devastating consequences in Botswana and globally. Sexual violence is the “accomplice” of HIV, depriving women of agency and the ability to control their lives and health.  

Key informants expressed concern that there is inadequate awareness and knowledge of GBV and its link with HIV by many individuals in Botswana. Some factors that have been identified as interfering with the achievement of Botswana’s vision of “zero tolerance” of all forms of GBV could be addressed through effective policies and frameworks including addressing:

- Lack of male participation and engagement in GBV interventions;
- Inadequate and sometimes ineffective strategies to address negative social and cultural practices and norms that perpetuate GBV;
- Lack of national GBV surveillance system;
- Inadequate capacity for evidence-based and human rights programming and implementation of the GBV response; and
- Lack of comprehensive strategic data to inform policy, planning and resource allocation.

Beyond gender-based violence, laws that discriminate against women and barriers in accessing sexual and reproductive health information and services are further disempowering and increase vulnerability to domestic and other violence. To realise the rights to equality, dignity, health, education, economic independence, and to safeguard women’s equal opportunity to participate in the workforce, women and adolescents must have meaningful access to information, contraceptives and family planning, and safe and legal abortion and post-abortion care.

B) Legal and Policy Framework

The Government of Botswana acknowledges that GBV and gender inequality are complex issues rooted in socio-economic, cultural practices, institutional and legal factors that perpetuate male dominance of women and girls. In cognisance of this, the country has prioritised GBV and enacted a number of laws and policies that protect the rights to gender equality and non-discrimination and prohibit gender based-violence and harmful practices. Botswana is a state party to the UN Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the SADC Declaration on Gender and Development and its Addendum on the Prevention and Eradication of Violence Against Women and Children which commit the government to addressing gender discrimination and inequality.
While Section 15 of the Constitution expressly prohibits discrimination on the basis of sex, sub-section 4 precludes protection from non-discrimination for non-citizens of Botswana and precludes application of the protective provisions with respect to matters concerning adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law. As written, the Constitutional right to non-discrimination does not apply in all contexts; though the Court of Appeal has specifically stated that Section 15(4) does have limitations.

In the case Mmusi and Others v Ramantele and Others, the Court of Appeal ruled in favour of female applicants who had been denied inheritance rights on the basis of a customary rule which, as applied by the Customary Court of Appeal, excluded women from inheritance regardless of birth order and contributions to the property. In its decision, the Court of Appeals notes that for a customary rule to receive the status of a law and be enforceable by the courts, it must not be inconsistent with the values of natural justice; customary law must be applied in accordance with morality, humanity and natural justice “with the object of achieving justice and equity between the disputants.” The Court of Appeal found that “the derogations contained in Section 15(4) of the Constitution are not unchecked. They must be rational and justifiable either as being intended to ensure that the rights and freedoms of any individual do not prejudice the rights and freedoms of others or as being in the public interest.” While this decision is a significant step towards the realisation of the right to gender equality under customary law and matters of personal law, the impact of the ruling is yet to be seen. Removing or amending section 15(4) would strengthen the constitutional right to non-discrimination on the basis of gender for all women, including those who may not have meaningful access to the courts. Remedy Section 15(4) is especially crucial since many individuals in Botswana prefer adjudicating disputes in the customary system and may not have the necessary resources to appeal their cases in the High Court. While, as discussed, there are existing safeguards that limit the application of Section 15(4), key informants indicated that many of those adjudicating customary law matters may not have had formal legal training. A clear constitutional provision that guarantees the right to gender equality in all contexts, regardless of subject matter, would strengthen legal protections for women and help address legal uncertainty.

The Botswana Courts have also upheld the rights to non-discrimination and gender equality in the context of citizenship rights. In the case Attorney-General of Botswana v. Unity Dow the Court of Appeal held provisions of the Citizenship Act inconsistent with Sections 3, 14 and 15 of the Constitution, which effectively denied citizenship to a child whose mother but not father is a citizen, yet would confer citizenship where the father but not the mother is a citizen. The Citizenship Act was amended in 1995 in accordance with this ruling. Botswana has also taken progressive steps to address gender discrimination. In 1998, Botswana undertook a review of laws affecting the status of women and since 2002/03, Botswana has been working to mainstream gender.

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193 Mmusi and Others v Ramantele and Others, Court of Appeal in Gaborone, High Court Case No. MAHLB-000836-10 (2012).
194 Id, para. 49.
195 Id, para. 72.
197 See infra, Protection, Access to Justice and Law Enforcement in Botswana Section for further discussion of customary law.
Several policy documents recognise the need to respond to gender discrimination and disparities in the context of HIV and development, including in Vision 2016, and gender is a cross cutting issue in the 10th National Development Plan (NDP 10). Further, the National AIDS Council Women’s Sector Strategic Plan for 2012-2016 utilises a human-rights based approach in guiding the planning, coordination, implementation, monitoring and evaluation of human rights and gender-responsive HIV interventions that target women and girls in Botswana. Priority areas include:

- Prevention of new HIV infections among women and girls;
- Strengthening of an enabling social, policy and legal environment for the fulfilment of women’s and girls’ rights and their empowerment in the context of HIV;
- Facilitation of evidence-informed policies, programmes and resources allocations that respond to women’s and girls’ needs at all levels of the response; and
- Acceleration of universal access to integrated multi-sectoral services for HIV, TB, sexual and reproductive health services.

The policy also sets forth ambitious goals including:

- Reducing new HIV infections among women and girls aged 10 - 64 by 50% by 2016.
- The rights of women and girls are protected, respected and fulfilled by 2016.
- Botswana attains zero discrimination and stigma associated with HIV and AIDS directed at women and girls by 2016.
- 100% of women and girls with HIV still alive 12, 24 and 36 months after the initiation of antiretroviral therapy.
- Mortality among women and girls co-infected with TB/HIV reduced by 50% by 2016.

The 1996 Policy on Women in Development was replaced by the National Policy on Gender and Development (NPGD) in March 2015. The NPGD recognises that in the context of gender and development, HIV and AIDS, increased incidents of gender-related abuse and violations of human rights and deepening poverty are amongst the most pressing issues that demand attention. With the aim of realising gender equality and guaranteeing and protecting justice and dignity for all citizens, the NPGD prioritises inter alia, poverty reduction, economic development, political power and decision making and access to justice and protection of human rights. The NPGD aims to:

- Eliminate all forms of gender related discrimination as a strategy to achieve gender equality and equity, through the development and implementation of gender responsive legislation, policies, programmes and projects.
- Establish standards, targets, indicators and adopt quality regulatory measures, to ensure uniform promotion of minimum standard performance in gender equality initiatives.
- Address existing gender issues and concerns as they are identified to ensure that policies and programmes are compliant with gender equity objectives, and to prevent emergence of new gender based imbalances.
- Set realistic, measurable targets, time frames and indicators for achieving gender equality and equity.
- Promote research to enhance evidence-based programming.
- Regularly monitor and evaluate the progress made towards gender equality and equity in 5 and 10 year intervals.
- Strengthen community capacity building.

Protection from Violence, Abuse and Harassment

The Penal Code prohibits gender-based and other forms of violence including rape, attempted rape, defilement and indecent assault. Through the Penal Code Amendment Act, the definition of rape was revised to encompass a broader definition of rape than phallus-specific penetration and to ensure gender neutrality in application.\(^{202}\) Section 141 prohibits “unlawful carnal knowledge of another person,” “penetration of a sexual organ or instrument...into the person of another for the purposes of sexual gratification,” or “caus[ing] the penetration of another person’s sexual organ into his or her person,” without consent. Rape is punishable with ten years to life imprisonment and in cases in which an act of rape was accompanied by an act of violence which resulted in injury to the victim, the minimum sentence is fifteen years of imprisonment.\(^{203}\)

Persons charged with the offence of rape are not entitled to bail.\(^{204}\)

Section 146 of the Penal Code criminalises ‘indecent assault,’ including whether or not an individual under the age of 16 consents to ‘indecent assault.’ Indecent assault of boys under the age of 14 is a separate offence under Section 166, though both crimes subject the offender to a maximum of seven years of imprisonment. Defilement of persons under the age of 16 is an offence under Section 147, subject to ten years to life imprisonment.

Sections 142 and 147 of the Penal Code and Section 108 of the Public Health Act require an individual convicted of rape and defilement to undergo an HIV test prior to sentencing and a rapist who knows that he has HIV is required to be sentenced to a minimum of 20 years imprisonment, up to life in prison. Mandatory testing is inconsistent with a human rights-based approach to HIV unless it is a reasonable and justifiable limitation of rights to achieve a specific purpose; several Courts in Botswana have refused to accept HIV tests performed at the time of sentencing as serving the purpose of providing evidence of a person’s HIV status / knowledge of HIV status at the time when the crime of rape was committed.\(^{205}\)

The Criminal Procedure and Evidence (Amendment) Act of 1997 protects the rights of victims by requiring in camera hearings in rape cases.

Marital rape is not expressly prohibited and common law ‘conjugal rights’ effectively prevent the prosecution of such cases.\(^{206}\)

The Domestic Violence Act of 2008\(^{207}\) provides protection against physical, sexual, emotional, economic and other abuse and harassment committed by intimate partners, family members and cohabitants. Domestic violence is defined broadly as “any controlling or abusive behaviour that harms the health or safety of the applicant.” Under the Act, an applicant can apply to a Court for an interim order, a restraining order, a tenancy order or an occupancy order (which gives exclusive rights to the applicant or child to live in a residence.) However, the Act does not specifically criminalise marital rape. As mentioned above, due to the continued existence of common law ‘conjugal rights,’ without specifically criminalising marital rape, it is not possible for a spouse to bring a criminal case of rape against their spouse.


\(^{203}\) The Penal Code, Law 2 of 1964 (as amended through 2005), Section 142(1) and (2).

\(^{204}\) Id, Section 142(1)(iii).

\(^{205}\) Nquibi v The State 2001 BLR 154 (BwCA); Lemoy v The State 2000 (2) BLR 145 (BwCA); and Makuto v The State 2000 (2) BLR 130 (CA).

\(^{206}\) Key Informant Interview, October 2016.

\(^{207}\) Domestic Violence Act, No. 10 of 2008.
The Public Service Amendment Act was amended to recognise sexual harassment as misconduct. The Act defines sexual harassment broadly as “any unwanted, unsolicited or repeated verbal or sexual advance, sexually derogatory statement or sexually discriminatory remark made by a public officer to another, or by a person in authority over another in the public service, whether made in or outside the workplace, which is offensive, or objectionable to the recipient, which causes the recipient discomfort or humiliation, or which the recipient believes interferes with the performance of his job security or prospects, or creates a threatening or intimidating work environment.” An offender is subject to suspension, demotion, removal, dismissal, docked pay or reprimand.

**Gender Equality**

Recognising that gender inequality interferes with women’s constitutional and human rights and increases vulnerability to HIV, Botswana has enacted a number of laws and policies to protect the rights to gender equality and non-discrimination including in the contexts of marriage, inheritance, labour, and health.

**A) Marriage, Marriage Equality and Divorce**

The Marriage Act is divided into three parts. Part I applies to civil marriages and Part II applies to customary, Muslim, Hindu and other religious marriages. Notably, Part I sets a minimum age of marriage and requires parental or judicial consent for minors, whereas these provisions do not apply to customary, Muslim, Hindu and other religious marriages. Under Part II, persons married under customary, Muslim, Hindu and other religious marriages are required to apply for registration within two months of their marriage. Failure to register is an offence, subjecting the parties to a fine and/or imprisonment.

The Abolition of Marital Power Act abolishes the common law rule in which a husband acquires marital power over the person and property of his wife, guarantees women and men married in community of property equal powers in marriage, including to dispose of assets of the joint estate, contract debts and to administer the joint estate.

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208 The Public Service Act, Act 13 of 1998 (as amended through 2005), Section 32(2).
209 Id, Section 33.
211 See infra, Children, Adolescents and Young People Section on age of consent to marriage
212 The Marriage Act, No. 18 of 2001, Section 23.
213 Id, Section 23(4).
214 Abolition of Marital Power Act 34 of 2004.
215 Id.
216 Id, Section 7.
Prior to enactment of the law, women were considered legal minors and decision-making authority was held by the husband. These provisions of the Abolition of Marital Power Act do not apply to customary or religious marriages, except where spouses are married out of community of property and acquire property jointly.

Recognising that the availability of ‘no-fault’ divorce protects parties, including by facilitating divorce for persons in abusive relationships, the Matrimonial Causes Act, as amended through 2008, provides that the sole ground for divorce is irretrievable breakdown. However, this Act does not apply to customary marriages.

The Dissolution of Marriages of Persons Subject to Customary Law (Disposal of Property) Act allows for matters concerning property disposal or devolution that arise from dissolution of a customary marriage to go before a Magistrate Court.

**B) Property and Inheritance**

The Deeds Registry Amendment Act of 1996 provides protections for women including (i) enabling women (married in or out of community of property) to execute deeds and other documents permitted to be registered in the deeds registry without their husband’s assistance and (ii) neither spouse can deal with immovable property which is not excluded from community of property without the consent of the other spouse.

**C) Maintenance**

The Deserted Wives and Children Protection Act provides a mechanism for women and children in need of financial support to apply for maintenance in certain circumstances. While the Act provides important protections, there is a need to update the law including (i) to ensure that maintenance is available in all appropriate circumstances and (ii) to ensure that the law is gender neutral.

**D) Labour**

Under General Orders 1996 which governs the conditions of service of the public service, women employed in the Public Service are entitled to 84 days of maternity leave with full pay for each confinement, with a maximum of three confinements.

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218 Abolition of Marital Power Act, No. 34 of 2004, Section 3.
219 Id., Part IV, Section 15(1).
221 Dissolution of Marriages of Persons Subject to Customary Law (Disposal of Property), L.N. 84 of 1966, Section 2(1).
222 Id, Section 18(3).
223 Id, Section 18(5).
224 The Deserted Wives and Children Protection Act, No. 29 of 1962.
225 General Orders of 1996, Section 9, para. 152.
E) Additional Protective Laws

The enactment of the Abolition of Marital Power Act also necessitated the review and harmonisation of several other pieces of legislation including: the Married Persons Property Act; the Marriage Act of 2001; the Administration of Estates Act; the Matrimonial Causes Act; the Companies Act; the Deeds Registry Act 1996; and the Deserted Wives and Children Protection Act. Further, the Affiliation Proceedings (Amendment) Act; the Mines and Quarries (Amendment) Act, among others, have been enacted as part of a "continuous process of amending laws that had a negative impact on the status of women...so as to achieve gender equality." As discussed below, the Pensions Act provides financial assistance to citizens over the age of 65, including women.

Sexual and Reproductive Health and Rights

The realisation of reproductive rights and access to reproductive and sexual health services is fundamental to women’s health and equality and is especially relevant in the context of HIV. Access to comprehensive, good quality sexual and reproductive health services is essential to prevent HIV infection and mother to child transmission and for effective management of HIV. Barriers in access to family planning, childbirth-related, and other SRHR services interfere with women’s rights to dignity, autonomy, health and equality during pregnancy, childbirth and childcare. The Global Commission on HIV and the Law identifies the following SRHR services as particularly relevant to HIV: access to contraception; antenatal care, skilled attendance at delivery, and postnatal care; prevention and appropriate treatment of sub-fertility and infertility; safe and legal abortion; management of complications from unsafe abortion; prevention and treatment of reproductive tract infections and sexually transmitted infections; and management of obstetric and neonatal complications and emergencies, including provision of safe blood supplies.

It is critical to provide meaningful access to SRHR services to women, particularly adolescents and young people in Botswana who are vulnerable to substance abuse, depression, suicide, sexual abuse, and sexual risk-taking, which results in unplanned pregnancy, HIV and other sexually transmitted infections (STIs). The teenage pregnancy rate is 16% and only 24% of adolescents and youth use contraception. In addition to the risk of exposure to HIV, the non-use of contraceptives results in adolescent pregnancies which have a high risk of complications that can be detrimental to the health, education, well-being and the lives of adolescent girls.

The Sexual and Reproductive Health Policy Guidelines and Service Standards provide a framework on the provision of SRHR services for adolescents and youth which includes the following services:

- Information, Education and Communication (IEC) and advocacy to the general public
- IEC and counselling on ASRH issues and for behaviour change
- Provision of Family Planning services
- Provision of ante-natal care and PMTCT, delivery and post-natal care
- Provision of Post Abortion Care
- Management of STIs/HIV/AIDS
- Provision of HIV Voluntary Testing and Counselling (Pre and Post Test Counselling)
- Family Life Education
- Cervical cancer screening

230 Id.
The framework makes services available to all adolescents and youth and targets a number of vulnerable groups including inter alia, those in poverty, street children, teenage mothers, those with disabilities, adolescents and youth living with HIV, orphans, juvenile delinquents, refugees, and those with substance abuse challenges, though the framework does specify clearly how these groups will be targeted. The Sexual and Reproductive Health Guidelines also prohibit discrimination based on age, requiring all health workers at facilities to provide HIV treatment to “all affected males and females, adolescents and youth irrespective of age, and other attributes.” This creates further uncertainty, given that age of consent laws set the minimum age of independent access to such services at 16 years.

Botswana has made significant progress in improving reproductive health outcomes and has implemented many aspects of existing enabling policies. For example, maternal mortality rates have decreased from 243 per 100,000 live births in 1990 to 129 per 100,000 live births in 2015. More specifically, between 2012 and 2014 there were 216 maternal deaths nationally, the majority of which occurred in the eastern part of the country where there is a higher population density.

Further supporting progress towards achieving full realisation of reproductive health and rights, there are a number of health policies that recognise the rights to sexual and reproductive health and rights. The 2012 National HIV Treatment Guidelines provided a framework for HIV-related care and recognised that “reproductive rights are derived from fundamental human rights which are protected by the Constitution of Botswana. Therefore, women and men living with HIV have the same reproductive rights as individuals without HIV infection.”

The newly introduced 2016 Integrated HIV Clinical Care Guidelines implement the Treat All Strategy and provide a framework for HIV-related services in Botswana. The Guidelines have a number of provisions which guarantee and protect sexual and reproductive health and rights including: (i) allowing for minors to access family planning methods in appropriate cases; (ii) recognising that people living with HIV have a fundamental right to “a satisfying and safe sexual and reproductive life.” The National Health Policy and the National HIV and AIDS Policy advocate for comprehensive HIV and sexual and reproductive health (SRH) services that are equitable and accessible for all persons.

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232 Id, at 46.
238 Id, at 7.
239 Id, at 8.
The 2015 National Sexual and Reproductive Health Programme Framework, Policy Guidelines and Service Standards on Sexual and Reproductive Health (SRH Guidelines), and Adolescent Sexual and Reproductive Health Implementation Strategy provide a framework for the National Sexual and Reproductive Health Programme. The aim of the programme is to “improve the sexual and reproductive health of all people living in Botswana.”

The SRH Guidelines provide that medical and non-medical forms of contraception shall be made available at all health facilities, work places, community outlets and selected public places and state that “[w]omen, men, adolescents and youth, in the reproductive age who are sexually active shall be eligible to use family planning methods without the consent of relatives, partner, parents or guardian with the exception of sterilisation.”

The SRH Guidelines also provide for guidance on post-abortion care (PAC) which is provided to a woman who “has had an abortion in order to save her life, prevent and treat complications and prevent recurrence.” The policy expressly provides that any women, adolescent or youth who has had an abortion and abortion complications and their partners are eligible for PAC and it should be provided on a 24-hour basis in all hospitals and primary care facilities. As such, the policy does not impose barriers to PAC for women who have experienced complications resulting from illegal or unsafe abortions.

The 2010 National Population Policy aims to improve the quality of life and standard of living for all people in Botswana by addressing a number of SRHR-related issues in general as well as aspects that disproportionately impact women. Objectives relevant to HIV and AIDS include to:

- control the spread of HIV, reduce AIDS deaths, and manage the impacts of HIV and AIDS on the economy, and its repercussions on the society;
- control malaria, tuberculosis, and STIs, and prevent their spread;
- prevent and reduce the spread of non-communicable diseases;
- increase knowledge, enhance understanding and modify behaviour related to HIV and AIDS and to other demographic concerns; and
- improve health with a focus on HIV, AIDS and TB.

Several objectives are particularly relevant to women, girls and vulnerable groups including:

- improve teenage and youth reproductive health, and reduce teenage and unplanned pregnancies;
- ensure gender equality and equity in the socio-cultural, political, economic and legal spheres, and eliminate gender-based violence;
- promote the socio-economic status of vulnerable groups, including HIV/AIDS patients through economic empowerment and rehabilitation; and
- develop appropriate legislation and policy framework for the protection of vulnerable groups such as orphans and women, and promote their participation in programme development.

Despite notable progress and a policy framework that recognises and respects sexual and reproductive health and rights, barriers remain in this context. UNAIDS recognises family planning as one of the essential pillars to effectively prevent vertical transmission of HIV. Reducing the number of unintended pregnancies among women living with HIV not only reduces the number of children acquiring HIV, but also improves the lives of women and children.
The United Nations Population Fund has also confirmed that the right to family planning is a fundamental human right tied closely to the recognition of other rights, including the rights to life, education and a life with dignity.246

The most significant factor in adolescent and unintended pregnancies in Botswana is the lack of use of family planning.247 Adolescent pregnancy can have dire consequences on the health, education, well-being and even the lives of girls—adolescent girls run a disproportionate risk of dying during or after childbirth248 and are more vulnerable to pregnancy-related complications.249 These challenges are recognised in the SRH Policy Guidelines and Service standards which note that adolescent pregnancy is high-risk pregnancy as it may predispose girls to (i) unsafe abortions; (ii) poor, late or lack of antenatal attendance; (iii) pregnancy and labour complications such as anaemia, obstructed labour, operative delivery; (iv) poor or lack of social support; (v) interrupted education and (vi) baby rejection or dumping.250 Further, a strong inverse relationship exists between early childbearing, education and economic well-being. A UNFPA report explained, “Adolescent pregnancy brings detrimental social and economic consequences for the girl, her family, her community and the nation at large. Many girls who become pregnant drop out of school, drastically limiting their future opportunities.”251

While the 2016 Integrated HIV Guidelines and the SRH Guidelines expressly provide for access to contraceptives for minors, in practice minors may face challenges accessing such services without parental consent and/or experience inappropriate treatment by health providers who disapprove of their sexual activity, though the introduction of youth-friendly clinics has improved access.252 If parental consent is required to access such services, this may deter health-seeking behaviour. A further barrier, adolescents who do not have access to SRHR-related information on preventing HIV infection and pregnancy are unable to protect themselves effectively.253

While access to legal abortion is available in limited circumstances, punitive and socio-cultural barriers increase the likelihood that women will turn to dangerous underground abortions254 which jeopardise their lives, health and well-being. In Botswana, access to abortion is legally available within the first 16 weeks of pregnancy only in cases in which a pregnancy is a result of rape, defilement or incest, or where there is a risk to the physical or mental health of the woman or foetus.255 Persons who are found guilty of providing an abortion outside of these exceptions can serve up to seven years in prison and women found guilty of intentionally and unlawfully inducing or allowing others to induce abortion can serve up to three years in prison.256

249 Id., at 13-15.
253 See Education and Information Section.
255 Penal Code, Sections 160-161.
256 Id.
UN treaty monitoring bodies have found restrictive abortion laws incompatible with international human rights obligations, including the rights to life, health, freedom from torture and cruel, inhuman and degrading treatment and the right to non-discrimination\textsuperscript{257} and the CEDAW Committee has called on states to decriminalise abortion.\textsuperscript{258} In particular, legal abortion should be available regardless of pregnancy duration where there is a risk to the physical or mental health of the woman or foetus.

**RECOMMENDATIONS: Gender Equality and the Right to Non-Discrimination**

- Review the restrictive provisions of Section 15, including sub-section 4 which restricts, inter alia, the right to gender equality, ensuring alignment with international standards.
- Ensure implementation and enforcement of court decisions that uphold and protect the rights to gender equality and non-discrimination, including in the context of customary law, including the case Mmusi and Others v Ramantele and Others.
- Conduct sensitisation and trainings on law and gender equality, including under customary law, with a focus on remote areas.
- It is recommended that all legal, policy and other necessary measures should be taken to strengthen access to justice for survivors of gender-based violence for crimes in the Penal Code and the Domestic Violence Act. In line with the recommendations of the Global Commission on HIV and the Law, it is recommended that Botswana take concrete steps to:
  - Enact and enforcing specific laws that prohibit marital rape.
  - Ensure that violence, rape and sexual assault is prohibited and there is meaningful access to justice whether perpetrated against females, males or transgender persons.
  - Take judicial or legislative steps to remove any immunity—or interpreted immunity—from prosecution for rape when the perpetrator is a married or unmarried partner. This may include abolishing common law ‘conjugal rights,’ and specifically criminalising marital rape in the criminal code and addressing any customary laws, policies or practices that permit marital rape.
  - Fully enforce existing laws meant to protect women and girls from violence, and prosecute perpetrators of violence against women and girls to the full extent of the law.
  - Formulate and implement comprehensive, fully resourced national strategies to eliminate violence against women and girls, which include robust mechanisms to prevent, investigate and punish violence.
  - Guarantee provision of health services, including post-exposure prophylaxis, legal services and social protection for survivors of violence.
- Ensure that the rights to equality and non-discrimination of all persons in Botswana are guaranteed in the context of marriage including by aligning the customary, Muslim, and Hindu and other marriage laws and regulations with rights applicable to civil marriages and in line with the Constitution, and regional and international treaty obligations and standards.
  - This includes ensuring the protections of the Marriage Act (including minimum age of marriage), the Abolition of Marital Powers Act and the Matrimonial Causes Act are applicable to all marriages, including customary, Muslim, Hindu and other religious marriages.
- Ensure that the law equally protects persons married out of community of property as those married in community of property in every respect.
- Ensure implementation of the National Sexual and Reproductive Health Programme Framework, Policy Guidelines and Service Standards on Sexual and Reproductive Health including access to:
  - Comprehensive SRHR information, including on HIV prevention and pregnancy prevention;
  - Contraceptives and family planning services for all sexually active persons, including adolescents and youth without requirements of parental, partner, or other third party consent; and
  - Comprehensive information on safe, legal abortion and post-abortion care and non-discriminatory quality abortion and post-abortion care services.
- With the aim of reducing illegal and unsafe abortions which risk the lives, health and well-being of all women, with disproportionate impact on adolescents, re-consider the criminalisation provisions with a view toward broadening the categories of circumstances under which termination of pregnancy will be provided.
  - Ensure that those falling within categories of persons lawfully able to access abortion, are in fact able to access and enforce their rights, including by providing trainings to health care workers.


\textsuperscript{258} CEDAW Committee, General Comment 24, 20th Session, para. 31(c) (1999).
Children, Adolescents and Young People

A) Current Situation

Children include persons below the age of 18, adolescents include persons between 10 and 19 years and young people/youth include persons between 15 and 24 years. The SRH Guidelines in Botswana provide that adolescents and youth include persons between 10 and 24 years. While children and adolescents are entitled to many of the rights that protect adults, the Convention on The Rights of the Child also recognises the vulnerabilities of children by providing further protections. This is certainly true in the context of HIV—the Committee on the Rights of the Child has recognised that HIV and AIDS impacts so heavily on the lives of all children that it affects all their rights including civil, political, economic, social and cultural rights. Ninety-one percent of all children living with HIV globally live in sub-Saharan Africa. While significant progress has been made in HIV prevention and access to treatment, many children are still dying, including in Botswana. Access to treatment is especially essential for children. Without treatment, about one-third of children living with HIV die by their first birthday and half die by their second. However, if children living with HIV have access to HIV treatment, their likelihood of survival is significantly improved—children beginning antiretroviral therapy before the twelfth week of life reduces their HIV-related mortality by 75%. Globally, tuberculosis is the leading cause of death from infectious diseases among children and only 39% of child TB cases were notified to TB programmes, due to under-diagnosis. Globally, one major barrier to effective TB treatment for children is inadequate access to needed paediatric formulations of TB medication, particularly for drug-resistant forms of TB.

Children, adolescents and young people are vulnerable to HIV and TB. To effectively address the epidemics in Botswana, HIV and TB prevention, management and support for children, adolescents and young people must be a focus. The 2011 census statistics indicate that children, adolescents and young people make up a significant proportion of the population: over 60% of Botswana’s total population is below 30 years old and 33.5% of the population are between 10 and 24 years. Approximately 34% of the population is under the age of 15 and 12% of the population is under five years of age. Adolescents and youth account for 64.3% of the total population.
Adolescents represent one-fifth (22%) of the population in Botswana and adolescents are some of the most vulnerable groups to HIV infection.\textsuperscript{269} While 5% of adolescents between 15 and 19 are HIV positive, the percentage more than doubles, increasing to 10.3% amongst young people between 20 and 24.\textsuperscript{270} There are higher risks for adolescent girls than boys—HIV prevalence among adolescents between 15 and 19 is 3.6% for boys and 6.2% for girls. While 84% of children living with HIV between 0-14 are receiving antiretroviral therapy,\textsuperscript{271} this means that 16% are not receiving life-saving treatment. One barrier to HIV-related health services, children and adolescents have been denied access to HIV tests without parental consent.\textsuperscript{272} There is a significant need to increase resources and efforts to respond to the specific needs of this population. An additional barrier, HIV knowledge among young people remains dangerously low, with fewer than 50% of people aged 15-24 years able to correctly answer basic questions in relation to HIV.\textsuperscript{273} Some children in Botswana are especially vulnerable including those who were orphaned for all causes, including as a result of HIV and AIDS. In 2015 there were 60,000 children orphaned as a result of HIV and AIDS in Botswana.\textsuperscript{274} While 72.2% of children under 5 have been registered in Botswana,\textsuperscript{275} those who are not registered may have challenges accessing social services including HIV-related and other health services as well as education.\textsuperscript{276} As discussed above, gender-based and sexual violence in Botswana is pervasive which contributes to the disparity of HIV prevalence amongst women as compared to men (20.8% and 15.6% respectively). A high proportion of young women in Botswana are raped—the 2013 BIAS IV found that 24.8% of females age 15-49 surveyed who had early sexual debut (before the age of 15) did not give consent at the time of intercourse.\textsuperscript{277} To address these issues and challenges, Botswana recognises that adolescent reproductive health merits special consideration.

**B) The Legal Framework**

A number of laws, policies and practices are relevant to HIV and to a lesser degree, TB, prevention, care and support for children, adolescents and youth in Botswana including those concerning (i) violence, protection and harmful practices; (ii) access to HIV-related, SRHR and other health services; (iii) access to appropriate and accurate education and information which enables children, adolescents and youth to protect themselves from HIV;\textsuperscript{278} (iv) age of consent laws and policies that may facilitate or hinder access to information and health services and (v) access to support services for inter alia, orphans and vulnerable children, children with disabilities and refugee children.

\textsuperscript{270} UNICEF, Key Demographic Indicators, available at https://data.unicef.org/country/bwa/.
\textsuperscript{271} ARASA, HIV, TB and Human Rights in Southern and East Africa Report (2016).
\textsuperscript{274} UNICEF, Key Demographic Indicators, available at https://data.unicef.org/country/bwa/.
\textsuperscript{275} Children without identity documents also face financial barriers obtaining them later.
\textsuperscript{277} See infra, Education and Information Section.
The International Guidelines outline a number of human rights and freedoms relevant to children to protect them from HIV and to empower children with HIV to effectively access HIV treatment, management and support. These include:

- Protective laws which if enacted, implemented, and adequately enforced, can strengthen protection of children from violence and exposure to HIV including freedom from trafficking, sex work, sexual exploitation and sexual abuse since sexual violence against children increases vulnerability to HIV;
- The freedom to seek, receive and impart information and ideas of all kinds and the right to education provide children with the right to give and receive all HIV-related information needed to avoid infection and to cope with their status, if infected;
- The right to special protection and assistance if deprived of his or her family environment, including alternative care and protection in adoption, in particular if they are orphaned by HIV;
- The right of children with disabilities to a full and decent life and to special care;
- Abolition of traditional practices which are prejudicial to the health of children, such as early marriage, female genital mutilation, denial of equal sustenance and inheritance for girls;
- The right to non-discrimination and privacy for children living with HIV; and
- The rights of children to be actors in their own development and to express opinions and have them taken into account in making decisions about their lives should empower children to be involved in the design and implementation of HIV-related programmes for children.

The Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child provide further safeguards. For example, Section 21 of the African Charter on Children’s Rights prohibits harmful social and cultural practices and obligates states to take concrete action to eliminate harmful practices and to effectively prohibit child marriage.


1. States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:
   (a) those customs and practices prejudicial to the health or life of the child; and
   (b) those customs and practices discriminatory to the child on the grounds of sex or other status.

2. Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

While many of these rights and freedoms are protected within the Botswana framework, regional and/or international law, there remain implementation gaps and/or ambiguity in the law.

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C) Violence, Protection and Harmful Practices

Botswana’s legal and regulatory framework provides a number of important protections applicable to children, adolescents and young people. The penal code provisions discussed above criminalise sexual and other violence against everyone, including children, adolescents and youth. 280

Providing further protection in line with the framework of the Convention on the Rights of the Child, the Children’s Act of 2009 prioritises the best interest of the child and provides a wide range of protections that promote the rights of children relevant in the context of HIV. As guiding principles, Section 7(a) prohibits discrimination on the grounds of inter alia, sex, family, colour, race, economic status, parents, physical or mental status and any other status,281 which should encompass HIV and health status. Section 8 provides that “every child who is of such age, maturity and level of understanding is able to participate in decisions which have a significant impact on that child’s life shall in decision-making and action shall have a right to do so.” 282 The Bill of Child Rights (Sections 9-26) protect inter alia, children’s rights to life, privacy, the highest attainable standard of health and medical care, shelter, education, and the right to protection from abuse. The right to life provision provides broad protection, safeguarding the inherent right to life of every child and further providing, “to ensure the enjoyment of this right, no person shall take any action or make any decision the effect of which will be to deprive a child of survival and development to the child’s full potential.” 283 Section 15 protects the right of every child to the highest attainable standard of health and medical care and also provides that where the parents or other relatives or guardian are unable to ensure the child’s enjoyment of this right due to financial constraints, physical disability, ill health or other reasonable cause, the Minister is obligated to take steps necessary to ensure realisation of this right. Section 25 protects the right of every child to be protected from sexual abuse and exploitation, including prostitution and pornography and failure to report child abuse or exploitation is an offence subject to a fine or imprisonment as is “conniving” with another person who sexually abuses or exploits a child. 284

The Act further defines a number of offences that victimise and exploit children including neglect or ill treatment of children,285 inducing or coercing children to engage in sexual acts, including for payment,286 and harmful social, cultural and religious practices including forced marriage, child betrothal, genital mutilation, and any other cultural “rite, custom or tradition which may inflict physical, emotional or psychological pain or harm to the child, or otherwise violate or endanger his or her bodily integrity, life, health, dignity, education or general well-being.”287 Committing any of these offences subjects the offender to a fine, imprisonment or both. The Act also provides for the establishment of Children’s Courts.

While the Children’s Act is a progressive law that protects against various forms of violence and abuse, and provides for and protects access to justice and human rights for children, the Act has not been fully implemented and there are challenges with enforcement.

280 See supra, Gender Equality and Non-Discrimination Section.
281 The Children’s Act, No. 8 of 2009, Section 7(a).
282 Id, Section 8.
283 Id, Section 10.
284 Id, Section 25(2) and (3).
285 Id, Section 56.
286 Id, Section 57.
287 Id, Section 62.
D) Sexual and Reproductive Health and Rights

The legal and policy framework pertinent to sexual and reproductive health and rights services is discussed in the Gender Section above and SRHR-related Education and Information is discussed below. This framework and ensuring meaningful access to such services is especially essential for adolescents and young people in Botswana who are vulnerable to substance abuse, depression, suicide, sexual abuse, and sexual risk-taking, which results in unintended pregnancy, HIV and other STIs. The teenage pregnancy rate is 16% and only 22% of adolescents and youth use contraception. In addition to the risk of exposure to HIV, the non-use of contraceptives results in adolescent pregnancies which have a high risk of complications that can be detrimental to the health, education, well-being and the lives of adolescent girls.

The Sexual and Reproductive Health Policy Guidelines and Service Standards provide a framework on the provision of SRHR services for adolescents and youth which includes the following services:

- IEC and advocacy to the general public
- IEC and counselling on adolescent sexual and reproductive health (ASRH) issues and for behaviour change
- Provision of FP services
- Provision of ANC and PMTCT, delivery and PNC
- Provision of Post Abortion Care
- Management of STIs/HIV/AIDS
- Provision of HIV voluntary counselling and testing (VCT) (Pre and Post Test Counselling)
- Family Life Education
- Cervical cancer screening

The framework makes services available to all adolescents and youth and targets a number of vulnerable groups including inter alia, those in poverty, street children, teenage mothers, those with disabilities, adolescents and youth living with HIV, orphans, juvenile delinquents, refugees, and those with substance abuse challenges, though the framework does not clearly specify how these groups will be targeted. The SRH Guidelines also prohibit discrimination based on age, requiring all health workers at facilities to provide HIV treatment to “all affected males and females, adolescents and youth irrespective of age, and other attributes.”

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289 Id, at 44.
290 Id, at 8 (2015).
291 Id, at 46.
E) Decision-Making and Age of Consent

One potential barrier for adolescents and youth in accessing HIV and TB information, prevention, testing, treatment and counselling are laws, policies and practices that require parental consent or otherwise restrict children, adolescents or youth from essential information or services on the basis of age. WHO has expressed concern that the “age of consent in many countries remains a significant barrier to uptake of HTC, as adolescents are often reluctant or afraid to seek services that require the consent of a parent or guardian,” further noting that where laws set the age of consent at 18 years, this prevents access to HIV testing for sexually active adolescents below that age.

There are a number of age of consent laws relevant in the context of HIV, TB and access to SRHR-related services and information including the age of consent to sex, marriage, medical treatment, access to contraceptives, HIV testing, accessing harm reduction and drug treatment services, and for participation in medical research. In addition to age of consent laws that prevent or do not facilitate access to information, prevention, treatment, and support without parental consent, lack of clarity within the law and lack of knowledge of the law amongst health workers can also have serious consequences in the context of HIV. Indeed, key informants indicated that in Botswana, there is a need for consistency and clarity in the law and a need to sensitise health workers who are not always aware of the existing laws on age of consent and may as a result, deny access to services for adolescents without parental consent, even if a denial is inconsistent with existing laws and policies.

For example, although the Public Health Act provides that the age of consent to HIV testing is 16 years, health service providers do not always provide services to adolescents without parental consent. In some cases, adolescents may be denied access to contraceptives and other SRHR-related health services by health providers who do not think they should be sexually active and may inaccurately believe refusing such services will prevent sexual activity. Key informants have also expressed concern that schools do not support the provision of condoms despite evidence that pupils even younger than 13 are sexually active, and despite 16 being the inferred legal age of consent to sex.

In Botswana, the Interpretation (Amendment) Act of 2010 provides that the age of majority is 18, however, other laws specifically provide for exceptions, recognising a young person’s legal capacity at different ages for different purposes, as set out below.

Age of Consent to Sex

In Botswana, the age of consent to sex is not specified in the law. Instead, Section 147 of the 1964 Penal Code prohibits unlawful and carnal knowledge of a person under the age of 16 years. There is no lawful age of consent for same-sex sexual activity since consensual same-sex sexual activity is prohibited under Sections 164 and 165 of the Penal Code.

Rather than requiring inference from the Penal Code, enacting into law a specific provision on the age of consent to sex, in accordance with international standards, would provide greater legal clarity to adolescents and health providers.

293 Act No. 9 of 2010.
Age of Consent to Marriage

Part I of the Marriage Act applies to civil marriages and Part II applies to customary, Muslim, Hindu and other religious marriages.\(^{294}\) Part I requires parental consent for persons below the age of 21 to marry and prohibits marriage for persons below the age of 18.\(^{295}\) However, there is ambiguity as to whether marriage for persons under 18 are legal where there is parental consent.\(^{296}\) Part I also allows magistrates and the High Court to authorise a marriage where one of the parents refuses to give consent.\(^{297}\) Part I provisions (including minimum age of marriage and the other provisions listed above) do not apply to customary, Muslim, Hindu or other religious marriages.\(^{298}\)

The 2016 SADC PF Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage defines the minimum age of marriage as "the age of 18 without exception or gender discrimination." As such, there is a need to amend the law on the minimum age of marriage to clearly and effectively prohibit child and early marriage (marriage of those under the age of 18) in all contexts, regardless of whether the marriage takes place under civil, religious (including Muslim, Hindu and other religion) or customary law, and regardless of parental consent, in line with Botswana’s international and regional commitments to prohibit child marriage and abuse.

Age of Consent to Medical Treatment

While the age of consent to healthcare is not clearly stated in the Public Health Act, the Act defines a child as under the age of 16. Further, Section 150(1) allows a medical practitioner to use his or professional judgment and carry out a medical procedure or medical treatment on/for a child in cases where consent is required and a parent or guardian refuses to consent to such services.

Age of Consent to Contraceptives

While the age of consent to contraceptives is not clearly set out in the law, it is likely 16 which is the age of consent to other health care services, such as medical treatment. As described above, the SRH Guidelines provides for contraceptives to be made available at all health facilities, work places, community outlets and selected public places\(^{299}\) and further provides that "Women, men, adolescents and youth, in the reproductive age who are sexually active shall be eligible to use family planning methods without the consent of relatives, partner, parents or guardian with the exception of sterilisation.\(^{300}\) As such, the policy framework does not provide a clear age of consent, but instead recognises that all young people who are sexually active and/or mature should have access to contraception. This may cause conflicting understanding with the law (which implies 16 as the legal age of consent).

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\(^{294}\) The Marriage Act, No. 18 of 2001.
\(^{295}\) Id, Sections 14 and 15.
\(^{296}\) Id. While the language of Section 15 seems to set the minimum age of marriage at 18 in all cases, the Government website indicates that persons under 18 can marry with parental consent. See http://www.gov.bw/en/Ministries--Authorities/Ministries/Ministry-of-Labour--Home-Affairs/Amended-Laws-that-affected-the-status-of-women/?p_id=1437.
\(^{297}\) Marriage Act, No. 18 of 2001, Section 15(i).
\(^{298}\) Id, Section 2.
\(^{299}\) Id, at 13.
\(^{300}\) Id, at 12.
**Age of Consent to HIV Testing**

Section 104 of the Public Health Act provides that confidential HIV testing facilities are available to persons of the age of 16 years or above who request an HIV test. For persons below 16, parental consent is required. Key informants indicated that persons below the age of 16 are sexually active and are unable to access HIV testing and treatment without parental consent which prevents them from doing so in some cases. KIIs recommended that in appropriate cases, persons younger than 16 should have access to HIV testing, treatment and counselling without parental consent. There is currently provision in Botswana for a person younger than 16 years to access HIV testing where a medical practitioner provides for such, or alternatively in the case of emancipated minors or minors with children, as has been set out above; it is also possible that these exceptions are not sufficiently known amongst health care providers.

The SADC PF Model Law on HIV in Southern Africa, 2008 recommends that the age of consent to HIV testing be 16 years or lower. The WHO Guidelines provide that the nature of the country context must be taken into account, but emphasise that offering routine HIV testing in clinical settings in generalised epidemics is particularly important for 10-14 year old adolescents.

As outlined above, there is indication of public support in favour of reducing the minimum age of consent to HIV testing in Botswana. A number of countries in Southern and East Africa have done so: for example, Lesotho, Swaziland and South Africa have set the age of consent to HIV testing at 12, while Namibia has set the minimum age at 14. Information from South Africa indicates that adolescents who had taken an HIV test had a lower incidence of HIV over time compared with those who had not.

**Additional Age of Consent Issues**

There is no provision in law for age of consent to participate in research or for access to harm reduction and drug treatment services.

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301 Public Health Act, No. 95 of 2013. See also, Botswana National AIDS Coordinating Agency, National HIV and AIDS Policy, at para. 5.3 (2012).
302 Id, paragraphs 105(1).
306 Children’s Protection and Welfare Act, No. 7 of 2011, Section 233(1).
308 Republic of South Africa, Children’s Act, No. 38 of 2005, Sections 130 and 133.
**RECOMMENDATIONS: Children, Adolescents and Young People**

- Ensure that penal code provisions prohibiting abuse, violence and other violations and the Children’s Act are fully implemented and enforced including by providing training and conducting sensitisation and outreach on the protective and other provisions of the Children’s Act, including the provisions prohibiting abuse and harmful practices, and those protecting children’s rights to inter alia, health, education and the right to participate in decision making.
  - Trainings and sensitisation should be conducted for law enforcement officers, health workers, educators and community members.
- Encourage reporting of cases of sexual and other violence by providing information (in pamphlets or in other forms), including how to report a case and relevant procedures.
- Ensure that every reported case of sexual and other violence, abuse and harmful practices is handled in a sensitive manner, thoroughly investigated, and where appropriate, prosecuted.
- Ensure that law enforcement officers are adequately trained to deal with issues of sexual and other violence and abuse, including through regular training and ensure adequate oversight.
- Conduct sensitisation on the law and children’s rights, including under customary law, with a focus on remote areas. In particular, provide information on the age of consent laws, the minimum age of marriage and the prohibition of abuse and harmful practices.
- Ensure that in and out-of-school children and adolescents and their parents and guardians are provided with information on their human rights under inter alia, the Children’s Act including the rights to health, education, participation in decision-making, and the right to protection from abuse, exploitation and harmful practices.
  - Ensure that in and out-of-school children and adolescents are provided with information on how to report a case of abuse or violence, including to a teacher, school counsellor, police officer, or another appropriate adult.

**Sexual and Reproductive Health and Rights**

- Through inter alia, provision in law and policy, trainings, sensitisation and oversight, including with service providers, young people and their parents and guardians, ensure that the Ministries of Health and Wellbeing and Education collaborate to provide adolescents and young people with access to comprehensive SRHR information and services without discrimination on the basis of inter alia, age including HIV testing as well as information on TB and those included in the SRH Guidelines:
  - IEC and advocacy to the general public
  - IEC and counselling on ASRH issues and for behaviour change
  - Provision of FP services
  - Provision of ANC and PMTCT, delivery and PNC
  - Provision of Post Abortion Care
  - Management of STIs, HIV and AIDS
  - Provision of HIV VCT (Pre and Post Test Counselling)
  - Family Life Education
  - Cervical cancer screening
- Ensure that all vulnerable groups, including those specified in the SRH Guidelines, have access to comprehensive SRHR services including through targeted programming, outreach and sensitisation.
**Age of Consent Laws**

- Review existing age of consent laws to ensure that they are in line with international and regional guidelines and to ensure legal harmonisation, clarity as well as harmonisation with enabling policies.
- In line with the SADC PF Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, amend the Marriage Act and take any other steps to effectively prohibit marriage for all persons under the age of 18 without exceptions and without discrimination. This includes cases where there is parental consent and civil, customary, Muslim, Hindu and other religious marriages.
- Clarification and harmonisation of the age of consent for accessing all health care services, including medical treatment, contraceptives, harm reduction and drug treatment services and to participation in medical research is recommended.
- In light of evidence that persons below the age of 16 in Botswana are sexually active and are unable to access health services, including HIV-testing and treatment without parental consent, consider review of the age of consent laws to health care services, including medical treatment, HIV and TB testing and treatment, to allow access to services for persons younger than 16 without parental consent.
- Consider enacting a policy, frameworks, strategies and/or plans which provide for and facilitate support to promote child and adolescent adherence, including for those without adequate parental or other support.
- Ensure that adolescents and young people are provided with comprehensive HIV, TB and SRHR-related information (as set out in Education and Information Section below) and information on laws and policies that enable them to realise their human rights.
People with Disabilities

A) The Current Situation

Globally, people with disabilities are at risk of HIV due to lack of societal awareness of their needs, violence and sexual abuse, discrimination in health-care settings and low awareness and risk perception about HIV. Further, people with mental and physical disabilities may have challenges accessing healthcare, education and employment, leading to impoverishment and creating further vulnerability to HIV, TB and poor health outcomes. While there is limited information on HIV prevalence amongst people with disabilities in Botswana, a South African survey found 16.7% prevalence amongst people with disabilities.

The 2011 census found that there are 59,103 people in Botswana with disabilities. People with disabilities in Botswana are not being adequately reached with HIV, TB or other health services. Some barriers identified that impede access or fail to facilitate access to health services for people with disabilities include: (i) lack of legislation targeting people with disabilities; (ii) the revised Policy on Disability is not yet approved; (iii) lack of strategy to address the needs of people with disabilities and; (iv) lack of data on people with disabilities and health needs and gaps. One reason for the lack of data: national surveys such as Botswana AIDS Impact Surveys (BIAS), TB surveys and Demographic Health surveys do not collect targeted data from people with disabilities. Aiming to address this gap, the Ministry of Health and Wellness has been able to provide support to civil society organisations who work with people with disabilities and the Ministry plans to conduct a rapid assessment on issues that pertain to people with disabilities with support from the World Health Organisation. This is intended to lead to the development of a national strategy.

While as stated, there is limited information on people with disabilities, a 2016 report documented some of the challenges and human rights issues facing people with disabilities in the context of healthcare in Botswana, Malawi and Zambia. The report found, inter alia, that people with disabilities in Botswana are not always treated as autonomous persons, including by not having their health-related decisions recognised by healthcare workers. People with disabilities reported that they have been treated with indignity in health facilities and discrimination when accessing sexual and reproductive healthcare; some individuals who sought sexual and reproductive health services were presumed to have been sexually assaulted instead of consensual sexual partners. People with disabilities also reported instances of breaches of confidentiality and failures of healthcare workers to provide reasonable accommodation, including provision of interpreters for hearing impaired individuals. To address discrimination against people with disabilities in health facilities and failures of health facilities to make reasonable accommodation and meet specific needs, participants in the study emphasised the need to update laws and policies on disability, to ensure respect for the rights of persons with disabilities. Participants further stressed that complaint procedures should be included in the new legislation.
B) The Legal Framework

The Office of the President recognises that discrimination on the basis of disability violates the “inherent dignity and worth of the human person and can only be eliminated in an inclusive society.” Indeed, people with disabilities have the same rights as every other person in Botswana and there are a number of constitutional rights that are particularly relevant to persons with disabilities including the rights to equality, non-discrimination and freedom from ill treatment.

While Botswana is not yet a party, the Convention on the Rights of Persons with Disabilities provides useful definitions in the context of disability and HIV. The Convention defines persons with disabilities as those who “have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” While the Convention does not expressly refer to HIV or AIDS, this broad definition of disability would include (i) persons with disabilities who are as a result of disability, vulnerable to HIV infection and (ii) persons suffering from disability as a result of HIV-related illnesses. Discrimination on the basis of disability includes “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, cultural civil or other field.” The Convention further specifies that discrimination on the basis of disability “includes all forms of discrimination, including denial of reasonable accommodation.”

The Continental Plan of Action for the African Decade of Persons with Disabilities (2010-2019), a renewal of the previous version, sets priority actions for Member States. In the context of HIV and AIDS, priority actions include to: develop health care policies and strategies suitable for people with disabilities living with HIV and AIDS; to ensure that people with disabilities have access to HIV and AIDS prevention, treatment, care and support services available to the general public and; to provide information on HIV and AIDS to people with disabilities in all accessible formats. Other objectives include extending social protection schemes for people with disabilities living with HIV and AIDS and for individuals who are disabled as a result of AIDS and developing affirmative action strategies in the context of employment opportunities for people with disabilities living with HIV and AIDS.

There is no comprehensive legal framework addressing disability or the needs of people with disabilities in Botswana. The Disability Bill and the National Disability Strategy were first developed in 2007 but have not yet been finalised or enacted. The revised Policy on Disability was tabled in Parliament in August 2016 but has not yet been enacted. If enacted, the revised policy would replace the 1996 policy which is currently in effect.

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321 Id, art. 2.
323 Id, at 24.
324 Id, at 25.
325 Key Informant Interview, December 2016.
The 1996 National Policy on Care for People with Disabilities is designed to “guide all actors in disability prevention and care, including government ministries and policy making and operational levels, nongovernmental and community organisations, private sector organisations and enterprises and members of the community.” The policy affirms the human rights and dignity of all persons, aims for equal opportunities of all members of society and obligates the state to: (i) maintain a system of care for people with disabilities; (ii) ensure that the welfare of people with disabilities is taken into account in educational, health and other programmes and (iii) to ensure that people with disabilities are not advantaged in securing employment. The policy also sets forth obligations and duties of various ministries and other entities and establishes a National Coordinating Committee on Disability to oversee strategic plans within relevant ministries and to monitor implementation of the National Policy on Care for People with Disabilities and programmes developed under its framework. The National Development Plan indicates that the policy will be amended after enactment of the legislation on disability.

The 2009-2016 National Development Plan provides for additional strategies to address the needs of adults and children with disabilities including establishment of a Centre for Disability and an assessment centre for children with disabilities. However, these were not constructed due to lack of funding. The Plan also includes key strategies for optimising health infrastructure and human resources, with an aim to achieve Vision 2016 targets. In the context of disability, key strategies specified in the plan include:

- Improving rehabilitation services through the development of relevant policies and legislation, as well as improvement to infrastructure and development of human resources to increase access to services. This will cover services such as physical, mental and vocational rehabilitation, as well as provision of assistive devices which provide and/or restore function, or compensate for such a loss, or absence that causes disability.

While the 1966 Immigration Act prohibited entry and presence of persons with physical and mental disabilities as well as people with mental health issues, when this Act was replaced in 2011, these discriminatory provisions were appropriately removed.

**RECOMMENDATIONS: People with Disabilities**

- Take concrete steps to enact into law the Bill on Disability.
  - Ensure that the law prohibits discrimination on the basis of disability.
  - Ensure that the legal framework (i) guarantees the rights of people with disabilities, in line with international standards, and (ii) addresses management of disability. The law should be evidence-informed, addressing human rights issues and practical issues facing people with disabilities. Enact policies, strategies and frameworks that facilitate implementation of the law, including the draft revised Policy on Disability. It is recommended that the law and policy:
    - Provides specific measures and programmes that ensure and facilitate access to health facilities for people with disabilities including for HIV and TB prevention, treatment, support and management for people with disabilities.
    - Provides specific measures and programmes to ensure access to education and information for people with disabilities, including on HIV, TB, SRHR and other health-related information.
    - Includes a complaint mechanism and procedures for people with disabilities to report violations of their rights.

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327 Id, at para. 4.3.1.
329 Key Informant Interview, December 2016.
330 Id, at 296.
331 Immigration Act, No. 19 of 1966, Section 7(b).
• Signature and Ratification of the Convention on the Rights of Persons with Disabilities.
• In line with the Continental Plan of Action for the African Decade of Persons with Disabilities and other commitments, ensure that HIV, TB and SRHR-related information is available and delivered in appropriate and accessible formats (i.e. braille).
• Ensure that HIV, TB, health-related, and other relevant laws, policies, plans and programming address HIV prevention, testing and treatment meet the needs of people with disabilities, including through research, oversight and evaluation.
• Ensure that provisions of the current Policy on Disability and other existing policies and commitments that address disability are fully implemented including *inter alia*:
  o maintaining a system of care for people with disabilities;
  o ensuring that the welfare of people with disabilities is taken into account in educational, health and other programmes; and
  o ensuring that people with disabilities are not disadvantaged in securing employment.
• Ensure all the provisions and strategies in the National Development Plan for 2009-2016 relevant to people with disabilities have been fully implemented including *inter alia* establishing a Centre for Disability and an assessment centre for children with disabilities.
• Implementation of priority action items and other objectives of the Continental Plan of Action for the African Decade of Persons with Disabilities is recommended.
• Facilitate research on the health needs of people with disabilities in the context of health to ensure that policies and programmes are evidence-informed and effective.
  o It is recommended that research includes barriers to HIV and TB-related and other health services for people with disabilities and the extent to which people with disabilities have access to HIV-related health services.
  o The inclusion of people with disabilities is recommended, as well as the collection of information pertinent to people with disabilities in national surveys including BIAS, TB surveys and Demographic Health Surveys. The provision of disaggregated information on people with disabilities would help ensure that their needs can be effectively addressed.
Prison Service

Globally HIV rates amongst prisoners and persons in custody are estimated at two to 50 times higher than the general adult population.\textsuperscript{332} In Southern and East Africa, tuberculosis rates amongst prisoners are extremely high—between .4 to 16.3%.\textsuperscript{333} HIV and TB prevalence rates amongst prisoners and persons in custody in Botswana are not publicly available. In 2012, NACA conducted a study on HIV in prisons but it has not yet been released.

Globally, the health needs of persons in custody are often neglected due to high levels of stigma faced by persons in custody, lack of investment and political will to improve prison health systems, and legal and policy barriers.\textsuperscript{334} Prisoners and persons in custody are at high risk of HIV infection due to sexual violence, unsafe sexual practices and unsafe drug injection practices.\textsuperscript{335} Overcrowding in prisons exacerbates the spread of infections, including tuberculosis, and stress and malnutrition weaken the immune system, increasing the risk of TB infection amongst people living with HIV. Persons living with HIV who are incarcerated and those who acquire HIV and TB in prison often have challenges with adherence and retention, which risks their lives, health and well-being.

A) Botswana Context

The Botswana Prison Service (BPS) indicates that all cases of reported sexual violence are treated as emergencies, including provision of post-exposure prophylaxis and referral to police. Further, BPS reports that in addition to civil and criminal legal remedies against state and non-state actors, prisoners have the right to be heard by the officer in charge and other prison officers, cell monitors, and prisoners also have the right to write to the Office of the Ombudsman, the Commissioner of Prisons, the Minister and to the President concerning any grievances. While some key informants have expressed concern that prisoners do not have effective remedies when sexual and other violence occurs, BPS has emphasized that prisoners are “free to report their cases at the police stations and to any official visitor to the Prison oversight bodies e.g. Ombudsman, Magistrates and visiting committees.”\textsuperscript{336}

In Botswana, overcrowding is an issue in some, but not all prisons. The Prison Service is taking steps to reduce overcrowding and prohibit tattoos, among others.\textsuperscript{337} The Prison Service has also taken steps to improve the health of prisoners by holding meetings between prisoners who are monitors of the cells, health educators, officers and prisoners’ health committees to provide a forum for discussion on prisoners’ health related issues, including HIV and AIDS.\textsuperscript{338} The group submits reports on regular basis. Further, the BPS conducts disciplinary hearings without reference to HIV status of prisoners and depending on the gravity of offences committed, some cases are referred to open courts for hearing.

\textsuperscript{333} Telisinghe et al, HIV and Tuberculosis in Prisons in Sub-Saharan Africa, Lancet (2016).
\textsuperscript{334} Id, at 150.
\textsuperscript{335} Id, at 153.
\textsuperscript{336} Botswana Prison’s Service.
\textsuperscript{337} Id.
\textsuperscript{338} Id.
Key informants identified the following information in terms of access to HIV and TB prevention, testing, treatment and management in Botswana prisons:

- While some KIIs indicated there is limited access to HIV and SRHR-related information for prisoners, other KIIs indicated that:
  - all newly admitted prisoners are provided with health education, including information on HIV and AIDS;
  - there are posters in the prisons that have health information; and
  - prisons provide health information through campaigns, morning health information and on other occasions.
- Local medical officers do outreach to the clinics and the health workers responsible for the facilities refer all clients to the hospitals within reach.
- There is no access to condoms for prisoners, however condoms are provided upon discharge;
- Prisoners are provided with gloves and detergent for cleaning purposes;
- Congestion and overcrowding in prisons leads to health and other issues, including the spread of TB;
- There are limited alternatives to prison for non-violent offenders;
- Civil society does not always have access to prisons or prisoners to ascertain the extent to which there is access to voluntary testing and treatment;
- Some civil society institutions have access to and/or work with the prisons including Prison Fellowship Botswana, Alpha Botswana, Botswana Red Cross Society, Tebelopele, and BOCAIP;
- Official visitors have the right to enquire into any complaints raised by prisoners;
- Education and behavioral change is emphasized to all prisoners;
- There is no mechanism by which civil society or citizens can request public information from government, (i.e. a freedom of information act) which makes it challenging to request statistics or other data;
- The Prison Service sends monthly reports to Ministry of Health and Wellness;
- The Prison Service ensures there is close monitoring of those on ARV treatment;
- Botswana Prison Service indicates that the Attorney General and Others v. Tapela and Others case has been implemented which requires the free provision of voluntary HIV testing and treatment for prisoners. Although the Botswana Prison Services has indicated that a savingram has been issued instructing provision of ARVs to foreign inmates who are HIV positive, some key informants expressed concern that they are lacking detailed information on steps taken to implement the judgment and are unable to monitor implementation; and
- Universal precautions are utilised by the Prisons’ Service for purposes of infection control

Additionally, there have been instances in which transgender persons have been placed in prison cells inconsistent with their gender identity (i.e. placing a transwoman in a male cell), which can increase the risk of violence and abuse.\(^{339}\)
B) The Legal and Policy Framework

Under international human rights law, imprisonment or deprivation of liberty does not justify denial of the human rights to humane treatment and dignity. Prisoners have a right to a standard of health care that is “at least equivalent to that provided in the community outside” and states must allocate adequate resources to prison health care. State agents owe a duty of care to prisoners which includes “the duty to protect the rights to life and to health of all persons in custody.” The International Guidelines on HIV/AIDS and Human Rights state that denying prisoners access to HIV-related information, education and means of prevention—including bleach, condoms, clean injection equipment, voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials—can constitute cruel, inhuman or degrading treatment or punishment. Further, the Guidelines specify that the duty of care also includes a “duty to combat prison rape and other forms of sexual victimization that may result, inter alia, in HIV transmission.”

Mandatory HIV testing interferes with the rights to privacy and liberty and there is no public health or security justification for compulsory HIV testing of prisoners. Although prisoners have restricted rights, like anyone else, they have a range of reproductive health needs which need to be addressed to protect their individual rights. Further, upon release, the realisation of health rights in the context of HIV and TB will have implications on their community.

At the national level, there are legal and policy protections in place that guarantee the right to health services for prisoners, including HIV and TB-related services. The Prisons Act and the Prison Regulations of 1965 provide a legal and regulatory framework for the prisons in Botswana. The Prisons Act provides that every prisoner is subject to provisions of the Act, that a medical officer shall be responsible for the health of all prisoners and cause all prisoners to be medically examined at such times as shall be prescribed, and that a medical officer may...take or cause to be taken or direct to be taken such action....as he considers necessary to safeguard or restore the health of the prisoner or to prevent the spread of disease. Regulation 13 of the Prison Regulations also provides that a medical officer shall:

(a) examine all prisoners who complain of illness;
(b) treat all sick prisoners;
(c) notify the officer in charge of all cases of serious illness or infectious or contagious disease; and
(d) make in writing to the officer in charge such recommendations regarding the treatment, isolation or care of a sick prisoner as he thinks fit.

Further, medical officers are required to report cases in which the life of a prisoner is likely to be endangered by further confinement in prison and cases in which a sick prisoner is unlikely to survive the sentence and also must monitor the sanitary and health conditions in prisons. Inspections must be made “in order to ascertain whether any condition exists which is likely to be injurious or dangerous to the health of the prisoners” and medical officers must report any conditions which are likely to endanger the health of the prisoners.

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342 Id, para. 154.
343 Id, paras. 135, 153.
344 Prisons Act, No. 28 of 1979.
345 Id, Section 65.
346 Id, Section 56(2).
347 Id, Section 57(1).
348 Id; Botswana Prison Regulations, S.I. 141, Regulation 15(a) and (b) (1984).
Botswana Courts have interpreted the Prisons Act and the Prison Regulations as requiring the provision of HIV-related health services for non-citizen prisoners. In August 2015, the Court of Appeals ruled that the government must provide free HIV testing, assessment and ARV treatment to foreign prisoners. This case connotes important recognition of the rights of prisoners in the context of HIV. While the Botswana Prison Service indicates that the judgement has been fully implemented, key informants indicate that one barrier to obtaining information on the steps that have been taken to enforce the court ruling and the extent to which there is access to HIV and TB services and support in prisons in general, is that civil society often does not have access to prisoners or to prisons.

Section 3 and 4 of the Botswana Prisons Service Standing Order provide that officers in charge must report cases of abuse of prisoners, make regular inspections of prisons, make periodic reports to Division Commander on general health matters and ensure health complaints are attended to. In addition, it provides that officers in charge are to incorporate and disseminate HIV-related information to prisoners.

The HIV/AIDS & Health Care Delivery Policies provide a framework on the provision of HIV-related services for prisoners. The policy specifically protects the right to confidentiality, prohibits mandatory HIV testing and provides the right of treatment refusal, except in the case of contagious diseases. Additionally, the policy specifically provides that health education is remains the principal strategy for prevention in prisons which will help to enable behaviour change and as part of broader rehabilitation goals.

The Government has acknowledged that there are legal and human rights barriers in prisons that affect access to HIV interventions, including the non-availability of condoms, lubricants and protective barriers. Due to the continued criminalisation of consensual sexual acts between persons of the same sex, the provision of such protective barriers in prisons is not permitted as this is seen as “facilitating illegal activity,” rather than an essential preventative health measure to prevent HIV and other STIs. Further, the HIV/AIDS & Health Care Delivery Policies specifically prohibits the provision of condoms to prisoners. There is limited information concerning injecting drug use or people who inject drugs in Botswana, nor is there information concerning injecting drug use in prisons. There are no harm reduction services available, such as needle and syringe exchange programmes or opioid substitution therapy.

RECOMMENDATIONS: Botswana Prison Service

• Strengthen ongoing access to acceptable, affordable and accessible quality voluntary HIV and TB prevention, testing, counselling treatment and care services for all persons convicted an on remand, and in particular ensure access to additional services including:
  - Condom programmes
  - Drug dependence treatment
  - Needle and syringe exchange programmes
  - Vaccination, diagnosis and treatment of viral hepatitis
  - Prevention of transmission through tattooing, piercing and other forms of skin penetration
  - Protecting staff from occupational hazards

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351 At time of writing, the policy is being updated but the draft is not yet available.
• Through provision in law and policy, ensure that all prisoners, including citizens and non-citizens, have full access to these services which are delivered in a non-discriminatory manner and with a human rights-based approach.

• Ensure that upon release from prison, former prisoners have continued access to HIV and TB treatment, support and services, regardless of citizenship.

• Review the penal code provisions against international standards with a view towards decriminalising consensual sex between adults of the same sex.

• Review the 2003 HIV/AIDS & Health Care Delivery Policies which specifically prohibit the provision of condoms to inmates while in custody in light of international guidelines and public health goals.

• Regardless of the legality of consensual sex between adults of the same sex, take concrete steps to ensure provision of protective barriers including condoms, dental dams and lubricants to all prisoners to ensure that they have the means to protect themselves from HIV and STIs.

• Take further steps to prevent abuse of all persons in custody, including taking specific measures to protect LGBTI persons, sex workers and other individuals vulnerable to abuse, including through consideration of the need to ensure that transgender individuals are placed in gender-appropriate cells.

• Ensure that effective legal mechanisms exist for prisoners who are victims of violence, or other violations, to report cases committed by fellow prisoners as well as state actors.

• Take concrete steps to prevent sexual and other violence in prisons including by, in line with the International Guidelines, ensuring that all prisoners engaging in rape, violence and sexual coercion are subject to discipline, irrespective of HIV status.

• Facilitate, including through law, policy, programming or otherwise, the early release of terminally ill patients, including those living with AIDS and ensure they have access to proper medical care outside of prison.
**Migrants**

Through the Political Declaration on HIV/AIDS: Intensifying our Efforts to Elimination HIV and AIDS, adopted in 2011, Botswana has committed to: “address, according to national legislation, the vulnerabilities to HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support” and to ensure that financial resources are appropriately targeted to address the needs of vulnerable groups, including migrants. Further, through the 2016 Political Declaration on HIV and AIDS, Botswana has committed to “promote the development of and access to tailored comprehensive HIV prevention services for all ... migrants and key populations” and “address the vulnerabilities to HIV and the specific health-care needs experienced by migrant and mobile populations, as well as refugees and crisis-affected populations...”

The International Organisation for Migration (IOM) definition of migrants includes persons who have immigrated from other countries as well as those who have moved within the borders of one country - encompassing immigrants and non-citizens as well as persons who have migrated within Botswana, such as migrant farm and other workers. An individual is a migrant regardless of legal status and regardless of the reason(s) for the movement. As such, the definition is broad, encompassing persons in a wide range of circumstances including refugees, legal and undocumented immigrants as well as Botswana citizens and non-citizens who move to different locations within Botswana’s borders, whether the purpose of the move is for employment, education, family, or for any other purpose(s). The term migrant worker is narrower, referring to individuals who work in a country in which they are not a national, thereby precluding individuals who are migrants within the borders of the country in which they are nationals.

Migration poses challenges in preventing, treating and managing HIV and TB effectively, particularly for undocumented, mobile and economically disadvantaged migrants. In some cases, migrants may be undocumented, mobile and economically disadvantaged. For migrants who are placed in state custody—whether in detention centres, refugee camps or prisons—they are only able to access those health and other services provided by or otherwise facilitated by the State. If HIV and TB-related health services are not provided for free to those in custody, those unable to pay due to lack of regular income, may have no choice but to forego or delay such services.

The previous National HIV/AIDS Strategic Framework (NSF) recognised that labour sectors with highly mobile workforces, including sex workers, truck drivers and miners are vulnerable to HIV. The 2003-2009 NSF also recognised that sectors employing and interacting with these mobile groups were also vulnerable to HIV including the transport, uniformed services, commercial agriculture, sex work, mining and informal cross-border trade sectors. While not all these groups are expressly included in the current NSF, the 2010-2017 NSF does task the Ministry of Transport and Communications with advocating for policy and legislation development, implementation, monitoring and review that promotes expansion and utilisation of services for mobile and key populations.

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354 Id., para. 60.
355 UNGASS, Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, 8 June 2016, para. 62(e) (2016).
356 Id., para. 63(g).
358 Id.
359 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, A/RES/45/158, art. 2(1).
360 See supra, Section on Prisoners.
Although Botswana is a member of the African Union (AU) and SADC, the country has not domesticated international policies such as the African Union migration policy framework and the SADC labour migration policy. These frameworks regulate voluntary and forced migration at a continental and regional level, with the aims of addressing practicalities and ensuring the human rights of migrants are a priority. Additionally, the national health framework is not aligned with the Code on Social Security of the SADC region, which creates provisions for social safeguards, including migrants. It is crucial for Botswana to implement comprehensive strategies that protect migrants if the national goal of eliminating new HIV infections is to be achieved.

A) Non-Citizen Migrants

The Refugee Act defines an ‘immigrant’ as “any person in Botswana other than a citizen of Botswana.” While citizens in Botswana are provided with HIV-related health services free of charge, non-citizens must pay for these services. Those who are unable to secure employment in the formal sector - or whatsoever - and those who do not have legal status in the country may be especially vulnerable to HIV. Migrant sex workers and other migrant populations vulnerable to HIV are unable to access free HIV-related health services from the state, though some may have access to HIV-related health services from non-governmental organisations (NGOs) or other sources. This places them at further risk of HIV exposure, increase the impact of HIV on them, once affected and hinders the effectiveness of the national response to HIV.

Section 50 of the Immigration Act prohibits entry and presence of persons “infected with or suffering from a prescribed disease, unless the person has the written authority with or without conditions, of an immigration officer to enter and remain in Botswana.” The section does not specify which illnesses are “prescribed.” The Minister can issue a deportation order against undesirable immigrants and if they do not comply with a deportation order, undesirable immigrants are subject to involuntary removal.

While there have been anecdotal reports that immigrant students enrolled in the University of Botswana have been required to undergo HIV testing before they can commence their studies, there is no HIV-specific policy in place. Students are required to undergo a general medical examination upon admission. It is possible that some health practitioners have required an HIV test as part of the medical check-up. It should be clearly stated in law and/or policy that mandatory HIV tests are illegal as a condition of entry and therefore not part of the medical examination requirement for university and other students.

363 Immigration Act, No. 3 of 2011, Section 50(d).
364 Id, Section 50(2) and (3).
365 Key Informant Interview, December 2016.
366 Id.
B) Refugees

Refugees are a special category of migrants to whom Botswana and other states owe specific obligations under international law. A refugee is a person who, “owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.” Article 1(2), of the 1969 Organisation of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country “owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country or origin or nationality.” In 1988, the United Nations High Commissioner for Refugees issued policy guidelines which state that refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for utilising screening to exclude HIV-positive individuals from being granted asylum.368

The Refugees (Recognition and Control) Act of 1967 provides a framework for refugees and asylum seekers in Botswana. The Act defines a ‘recognised refugee’ as an immigrant whom the Minister has recognised as a political refugee. The definition of a ‘political refugee’ is consistent with the UN Refugee Convention.369

The Act does not mention access to health services. While refugees in the Dukwi Refugee camp detention centre have access to basic health services, HIV-related health services are provided by external donors.370

The Refugees Act371 makes reference to Section 14 of the 1966 Immigration Act which allows for a detention in the nearest convenient prison for a period as may be necessary ‘pending removal.’ As such, under the Act, asylum seekers can be placed in prison while their applications are being processed. While key informants indicate that asylum seekers would be held in separate quarters from the general prison population even if they may be held in the same building, at minimum, separation from the general prison population should be guaranteed in law. It is questionable whether it is necessary to detain asylum seekers—particularly in prison settings. The law should be reviewed to ensure that it meets international and regional standards.

C) Migrant Workers

Several international and regional treaties and declarations provide protections for migrant workers. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, which has not yet been signed by Botswana, provides that “migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health.”372

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369 The Act defines a political refugee as “a person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence is unable or, owing to such fear, is unwilling to return to it.” Schedule, para. 1.
372 Id, art. 23.
Several declarations which Botswana has signed have specific provisions concerning migrants and HIV including the UN Millennium Declaration (2000), the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001), and the SADC Protocol on Health (1999), Maseru Declaration and Commitment on AIDS in the SADC region (2003) and the Brazzaville Declaration on Commitment on Scaling up Towards Universal Access to AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006). As such, Botswana is obligated to take steps towards realisation of these rights.

There are a number of factors that make migrant workers vulnerable to HIV and TB. A 2005 report identified some of these factors with respect to persons employed in mining, commercial agriculture, transportation, informal cross border trade, as well as uniformed personnel in Botswana. For example, some factors increasing vulnerability to HIV for commercial agriculture workers include poor living conditions and seasonal mobility; lack of access to health care facilities in commercial farming areas and boredom and loneliness. For miners, some factors include living in single-sex hostels and having limited home-leave which may lead workers to seek other multiple relationships; boredom and loneliness and lack of social cohesion which can lead to risky sexual behaviour. In sub-Saharan Africa, mine workers have some of the highest TB rates in the world, with over 867,000 new cases each year that are linked to mining. These extremely high rates of TB are a result of a number of factors, including HIV infection, exposure to silica dust, and poor working and living conditions. The Global Fund Regional TB Programme for miners aims to address these challenges.

Anecdotal evidence indicates that some migrant farm workers in Botswana—in part due to living and working in remote locations—have challenges accessing health services in general and in the context of HIV and TB. Some may have to travel great distances to the nearest health facility and those who earn on an hourly basis may have no choice but to forego income to seek healthcare. Even when employers of migrant workers allow employees sufficient leave to travel to health clinics for HIV and TB-related health services, practical challenges may impede access including transportation challenges and financial barriers, particularly for hourly wage earners. While there have been efforts to provide mobile clinics in remote areas where migrant farm workers live and work, such services are not always available regularly.

**RECOMMENDATIONS: Migrants**

- Signature and ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

- Ensure implementation of commitments under the 2011 and 2016 Political Declarations on HIV and AIDS, including to address through national legislation the vulnerabilities to HIV of migrant and mobile populations and support their access to HIV prevention, treatment, care and support and ensure financial resources are targeted to address the HIV-related needs of migrants, as well as TB-related needs of migrants.

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373 Id, at 6.
374 IOM, Briefing Note on HIV and Labour Migration in Botswana, at 5 (2005).
377 See infra Remote Area Dwellers Section.
• The inclusion of migrant and mobile populations in national policy documents including National Strategic Frameworks is recommended.

• Clarify which illnesses are 'prescribed' for purposes of immigration. Ensure that HIV and TB status are not a ground for prohibiting entry and presence in Botswana.

• Clear provision in law and policy that mandatory HIV tests, including for purposes of entry, are illegal and therefore not part of the medical examination requirement for university and other students and staff, is recommended.

• Ensure that refugees and those claiming asylum are not being detained or held in prisons with the general prison population. Review the law on refugees against international and regional standards.

• Clear provision in law and policy for access to comprehensive HIV and TB-related health services for refugees, including prevention, testing, treatment, care and support, is recommended.

• Ensure, through provision in law, that all migrants have access to HIV and TB-related health services, including free testing, treatment, care and support. In particular, ensure that the most vulnerable migrants including sex workers have access to such health services.

• Clarify, through law and policy, the rights of agricultural and other migrant workers including minimum monthly medical leave and paid benefits.
  o Ensure that migrant workers, including hourly workers, have adequate medical leave to access health facilities, including workers who must travel to receive HIV and TB treatment and other services.
  o The provision of medical leave payment would promote treatment retention and health-seeking behaviour.
  o Requiring employers, including farms and mines, in remote areas to provide for or help facilitate transportation to health facilities would increase access to health services for their employees.
  o In addition to ensuring adequate paid medical leave, through law, policy and programming, address HIV and TB risk factors of migrant workers including, inter alia, ensuring adequate home leave, the provision of HIV and TB-related information, prevention, testing, treatment and support.

• To ensure that continental and regional voluntary and forced migration practicalities are regulated and the human rights of migrants are protected, domesticate the African Union migration policy framework and SADC labour migration policy.

• To ensure that migrants in Botswana have access to social safeguards, align the national framework with the SADC Code on Social Security.

• To ensure accurate information is available, include migrants and gather information pertinent to migrants in national surveys including BIAS, TB surveys and Demographic Health Surveys. Provide disaggregated information on migrants to ensure that their needs can be effectively addressed.
Persons living in remote areas in Botswana experience challenges accessing all health services, including HIV and TB-related health services. Some cited barriers for remote area dwellers include challenges accessing information on preventive strategies and intervention programmes and limited access to condoms and protective barriers. The Botswana government has taken steps to address the development needs of remote area dwellers through the Remote Area Development Programme which was revised in 2009. The Revised Remote Area Development Programme recognises the particular challenges of people living in remote locations, where some communities “find particular and intractable disadvantages, either for logistical reasons, or because of long standing historical prejudice and subjugation by the dominant groups.” To address these concerns, the Government has adopted an “affirmative action across a variety of sectors to improve access to education, health, employment and economic development opportunities and socio-political institutions, among others” through CAB Memo 39 (B) 2010, the Revised Policy for Rural Development of 2002, the National Strategy on Poverty Reduction and the Revised Remote Area Development Program of 2002.

Remote area dwellers are not mentioned in HIV or TB-related policy documents or frameworks including the National Strategic Framework for 2010-2017. Additionally, there is no information concerning Remote Area Dwellers in submissions for HIV-related commitments including the Progress Reports of the National Response to the 2011 Declaration of Commitments on HIV and AIDS for 2014 or 2015. There is limited statistical information concerning HIV amongst remote area dwellers in Botswana. While now out of date, a 2002 report indicated that Basarwa who were resettled in New Xade experienced increased HIV and TB prevalence. Like all citizens in Botswana, remote area dwellers have access to free testing and anti-retroviral treatment through the Treat All framework and access to TB treatment. However, remote area dwellers in Botswana experience logistical, economic and practical challenges accessing HIV and TB health services due to geographic distance from clinics, language and cultural barriers, financial barriers, low literacy and education levels, and some face additional challenges due to frequent migration, whether within districts or to different districts. In the 2010 report following his visit to Botswana, the UN Special Rapporteur on the Rights of Indigenous Persons commended the recognition of tribal authorities and customary law within a legal framework protecting human rights and gender equality but also recommended that steps should be taken in the design and delivery of social services, including health and education, to accommodate diverse cultural practices and values.

Some remote area dwellers live on private farms, while others live in resettlement areas or are migratory. While persons living in resettlement areas may have health clinics in relative proximity, key informants indicated that those living on private farms may have to travel great distances to access health centres, in some cases 100 kilometres or more. While some private farm owners have been known to provide transportation for their employees, not everyone has this transportation resource. Those with low income may not be able to afford transportation to health centres and even if they are able to afford transportation, there are few transportation options in remote areas. Further, those who are employed at farms or elsewhere may face challenges obtaining sufficient leave from work to travel to distant health clinics and may not have adequate resources to stay overnight, which impacts health seeking behaviour. Those who do not access health clinics may not have adequate information and commodities to prevent HIV and TB infection and may not be tested for HIV and TB. For those on treatment, these barriers impact retention rates of antiretroviral therapy and TB medication.

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380 Key Informant Interview, November 2016.
The tuberculosis notification rate is incredibly high in Botswana, and even more so in some remote areas. Marginalisation and prevalent poverty amongst remote area dwellers coupled with the highly contagious nature of the disease places them at high risk of TB infection. Some remote area dwellers live in close quarters, sharing small spaces and food and in some places there is limited access to water; with varying levels of sanitation.

There have been several initiatives and programmes by non-governmental organisations to target the needs of remote area dwellers including mobile clinics, “Talk for Life” which provided cellular phones to connect persons in remote areas to health providers for medical advice, as well as the production of health materials with graphics and audio-visual presentation of information instead of text. These programmes have had varying levels of success, largely due to resource constraints. Mobile clinics at times circuit once a month, but sometimes less frequently due to inadequate funding. There have also been initiatives to introduce community health workers who trace TB infection and risk by going door to door as well as serving as intermediaries between health clinics and patients in terms of retrieving medicine. These initiatives have been largely successful, though also inadequately funded.

Persons living in remote areas may qualify for the Remote Area Development Programme which has the potential to improve livelihoods and thereby decrease vulnerability to HIV and TB. While the programme has had some success, implementation in some places has been limited and in some cases applicants have not been informed as to the reasons that their application was denied. The UN Special Rapporteur has recommended that Botswana take a consultative approach in development initiatives that impact the lives of remote area dwellers, which should include HIV and TB-related programming, policies and initiatives. He also recommended that the special needs of women and children should be identified and prioritised in the design and execution of development programmes, and further that practices that discriminate against women should be targeted and eliminated.

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382 Key Informant Interview, November 2016.
383 Id.
385 Id, at 80.
Globally, indigenous persons face risk factors and structural and social drivers that increase their vulnerability to HIV and TB including poverty, marginalisation, lack of political and social power, fragmentation of family and community relationships, geographic isolation, low literacy rates, poor general health, limited access to health care, drug use and injection, low individual and community esteem and stigma and discrimination, including double stigma experienced by indigenous peoples living with HIV and AIDS. UNAIDS has identified the lack of political and social power held by indigenous populations as a key risk factor which leaves indigenous persons and communities “acutely vulnerable to HIV” and further states that this vulnerability is “insufficiently recognised in international responses.” Language and cultural barriers, and inadequate access to effective and appropriate health-related information amongst indigenous people, may result in ineffective communication between medical staff and indigenous patients.

International law emphasises that access to healthcare for indigenous persons must be non-discriminatory, with participatory programming and culturally appropriate services. To meet obligations under the Convention on Economic, Social and Cultural rights in the context of the right to health for indigenous peoples, states are required to adopt specific measures to improve access to health services and care which is culturally appropriate and takes into account traditional preventive care, healing practices and medicines. The Committee on the Rights of the Child has also provided guidance on state obligations in the context of HIV. Under the Convention, States are obligated to take all reasonable measures to “ensure that indigenous children, families and their communities receive information and education on issues relating to health and preventative care….in particular HIV/AIDS and tuberculosis.”

**RECOMMENDATIONS: Remote Area Dwellers**

- In the post-2017 National Strategic Framework and other HIV and TB policy documents, consider inclusion of specific measures addressing the needs of all remote area dwellers as well as specific measures addressing the needs of indigenous persons in Botswana.
- Specific provisions through law and policy that protect the rights of remote area dwellers, including the right to non-discrimination and non-discriminatory access to health services, would strengthen their rights.
- Implementation of a specific, multi-sectoral framework, policies and programmes (or otherwise incorporate into existing frameworks, policies and programmes) that address the health needs of remote area dwellers is recommended. It is further recommended that the process of developing frameworks, policies and programmes is participatory and consultative and that frameworks, policies and programmes address the specific needs of remote area dwellers including inter alia:
  - Specific measures to facilitate access to HIV and TB information, prevention, treatment, support and care for remote area dwellers (i.e. mobile clinics).
  - HIV, TB and SRHR-related information which is delivered in appropriate languages and formats, including for example, through audio-visual presentation for those who may not have had formal education or who are illiterate.
  - Frameworks, policies and programmes should take into account traditional preventative care, healing practices and medicines;
- Ensure that the law provides remote area dwellers, including hourly workers, with adequate paid medical leave to allow them to access health facilities, including those who must travel to receive HIV and TB treatment and other services. The law should require employers in remote areas to provide or facilitate transportation to health facilities.

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386 In the 2010 report of the UN Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people, the Special Rapporteur, in line with the Declaration on the Rights of Indigenous Peoples, applies international standards for ‘indigenous peoples’ to indigenous groups in Botswana that have been in non-dominant positions and have “suffered and continue to suffer threats to their distinct identities and basic human rights in ways not felt by dominant sectors of society,” including the Basarwa and the Bakgalagadi. At 6-7.
390 Committee on Economic, Social and Cultural Rights, General Comment No. 14, 22nd Session, para. 27 (2000).
391 Committee on the Rights of the Child, General Comment No. 11, 55th Session, para. 53, (2009).
• Inclusion of remote area dwellers and gather information pertinent to these groups in national surveys including BIAS, TB surveys and Demographic Health Surveys would ensure the availability of accurate information. Provide disaggregated information to ensure that their needs can be effectively addressed.

• Strengthen the (Revised) Remote Area Development Programme by ensuring the programme recognises the need to prioritise remote area dwellers as a vulnerable population, involves all relevant sectors, is fully implemented and available in all areas and to all persons without discrimination.

Criminalisation and Punitive Laws and Law Enforcement

Criminalisation of HIV and Communicable Disease Transmission and Exposure and Other Punitive Provisions

While the Public Health Act has a number of positive aspects, the 2013 Act has several provisions inconsistent with good practices that do not support a human rights-based approach to HIV, AIDS and TB. The Act criminalises willfully exposing the public to any communicable disease, and authorises forced and mandatory HIV testing; non-consensual disclosure of HIV status; isolation and detention of persons with communicable diseases under certain circumstances.

Specifically, section 58 of the Public Health Act provides that a person with a communicable disease who wilfully exposes him or herself to another person, without taking precautions to prevent the spread of the disease, commits an offence. Section 184 of the Penal Code also criminalises intentional transmission of a disease, providing “[a]ny person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, is guilty of an offence.”

Both provisions are vague and could have broad application. While not HIV or TB specific, these provisions could be inappropriately applied to HIV and TB. There are no specific conditions or guidelines as to when an offence is committed under the provisions nor are there human rights safeguards in place to ensure that the provisions are not applied inappropriately.

Criminalisation of HIV transmission, exposure and non-disclosure—particularly when criminal provisions are overly broad—are stigmatising, counter-productive as they drive people living with HIV underground, infringe with human rights, and also lead to further human rights violations. The Global Commission on HIV and the Law (GCHL) has emphasised that the threat of prosecution does not empower people living with HIV to avoid transmission or encourage protection. Instead, fear of prosecution isolates people living with HIV and discourages HIV testing, health-seeking behaviour, and voluntary disclosure of HIV status to partners. Further, the GCHL also found that criminalisation of HIV transmission and non-disclosure creates a dynamic in which “the criminal justice system fights the health care system - one repelling, the other reaching out to people vulnerable to or affected by HIV.” Indeed, criminalisation of HIV increases stigma and derision rather than unity, effectively “dividing populations into the sick and the healthy or the guilty and the innocent” which “denies the complex social nature of sexual communities and fractures the shared sense of moral responsibility that is crucial to fighting the epidemic.” The GCHL recommends that prosecution for HIV transmission should only be available in very limited circumstances, when transmission is actual and intentional and prosecutions are pursued with a high levels of evidence.

392 See supra, Health Laws, Policies and Plans Relevant to HIV, AIDS and TB Section.
393 Public Health Act, No. 23 of 2013, Section 58(1).
394 Id, Section 104(3)(b).
395 Id, Section 116(7).
396 Id, Section 57.
398 Id.
399 Id.
400 Id.
401 Id, at 25.
National courts in the region have struck down laws criminalising HIV transmission and authorising disclosure by health workers in certain circumstances. For example, in 2015 the Kenyan High Court ruled that a punitive law of this nature was inconsistent with the constitutional rights to privacy and non-discrimination, by inter alia interfering with the rights to confidentiality and informed consent and disproportionately impacting women who are often subjected to coercive HIV testing, including during pregnancy. The African Commission on Human and Peoples’ Rights has also called for Uganda to amend the HIV Prevention and AIDS Control Bill which criminalises HIV transmission, allows for mandatory disclosure of HIV status and requires mandatory testing under certain circumstances.

UNAIDS has also provided detailed guidance on ending overly broad criminalisation of HIV. The three main principles of the guidelines are that the use of criminal law in the context of HIV should:
1. be guided by the best available scientific and medical evidence relating to HIV;
2. uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof), and
3. protect the human rights of those involved in criminal law cases.

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RECOMMENDATIONS: Criminalization of HIV and Communicable Disease Transmission and Exposure and Other Punitive Provisions

- Section 58 of the Public Health Act and Section 184 of the Penal Code should be reviewed, to ensure that they are not inappropriately applied to HIV and TB and are in line with recommendations of the Global Commission on HIV and the Law, UNAIDS and other international and regional standards. Guidance should be developed as to application. The Act should affirm and protect the right to health for all, including the rights of people living with HIV and/or TB.

- In line with the Global Commission on HIV and the Law recommendation, Botswana should ensure that prosecution for HIV transmission is only available in very limited circumstances, when transmission is actual and intentional and prosecutions are pursued with high levels of evidence. Additional safeguards should be implemented to ensure that prosecution does not infringe the right to privacy and other human rights, such as disclosure of HIV status.

UNAIDS and UNDP Recommendations Concerning Criminalisation of HIV

UNAIDS and UNDP recommend that criminal law should not be used where there is no significant risk of transmission or where the person:
- did not know that s/he was HIV positive;
- did not understand how HIV is transmitted;
- disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
- did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
- took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts; or previously agreed on a level of mutually acceptable risk with the other person.

UNAIDS and UNDP has also recommended that States:
- avoid introducing HIV-specific laws and instead apply general criminal law to cases of intentional transmission;
- issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining “intentional” transmission, by stipulating that an accused person’s responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution);
- and ensure any application of general criminal laws to HIV transmission is consistent with their international human rights obligations.
Laws Criminalising Consensual Sexual Activity Between Adults of the Same Sex and Other Laws Impacting LGBTI Persons

A) The Legal Framework

Homosexuality itself is not illegal in Botswana. However, consensual sexual conduct between adults of the same sex is a criminal offense. In 1998 the law was expanded to also include sexual conduct between women, which was previously not criminalised. Sections 164, 165 and 167 of the Penal Code prohibit “unnatural offenses” and “indecent practices.” Section 164 makes “carnal knowledge against the order of nature” a criminal offence and punishable with up to seven years of prison. The Botswana Court of Appeal has defined “carnal knowledge against the order of nature” as anal sex and both parties committing such acts can be held criminally liable. Section 165 criminalises attempts to commit the same offences and are punishable with up to five years of prison. Section 167 criminalises “indecent practices between persons,” 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.\(^\text{405}\)

Section 164 of the Penal Code provides, “Any person who;
(a) has carnal knowledge of any person against the order of nature;
(b) has carnal knowledge of any animal; or
(c) permits any other person to have carnal knowledge of him or her against the order of nature,
is guilty of an offences and is liable to imprisonment for a term not exceeding seven years.”

While there are no laws expressly prohibiting gender nonconforming identity or behaviour, transgender and gender nonconforming persons have been arrested and harassed for offences such as nuisance on the basis of their gender expression or appearance. Section 176 of the Penal Code prohibits common nuisance. Sub-section 1 provides “[a]ny person 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.”

B) The Impact of Criminalisation

Even when not enforced, the criminalisation of sodomy, nuisance and other laws stigmatise LGBTI people and makes them vulnerable to blackmail, targeting, violence, illegal detention and other discrimination by state and non-state actors. Indeed, focus group discussions and key informant interviews indicated that criminalisation of consensual same sex in Botswana leads to stigma, discrimination, against those perceived to be LGBTI persons and impedes access to health services by driving vulnerable and marginalised individuals underground and away from public services. This confirms the findings of the Global Commission on HIV and the Law in Africa and across the world.\(^\text{406}\) Another recent study cited breach of confidentiality issues and other rights violations against LGBTI persons in Botswana health facilities. For example, when one young gay man sought treatment for an anal STI, instead of providing treatment, the nurse summoned several other nurses to the patient’s room to see the person with an STI “where it is not supposed to be.”\(^\text{407}\) After this breach in confidentiality, the patient was then refused treatment. Discriminatory and degrading treatment of this nature could understandably dissuade LGBTI persons from seeking health services, including HIV-related services, placing them at higher risk of HIV exposure and increasing the impact of HIV on their lives.

The Global Commission found that marginalisation, together with aspects of physiology, circumstance and sexual behaviour, puts men who have sex with men at far higher risk of HIV – globally at 15 times higher risk. In nearly every country that collects reliable HIV data, the evidence is stark. Criminalisation both causes and boosts those numbers.

\(^{405}\) Penal Code, Section 167.
For example, UNAIDS has reported that in the Caribbean countries, where sex between men is criminalised, 1 in 4 men who have sex with men is infected with HIV. In the absence of such criminal laws the prevalence is only 1 in 15 amongst men who have sex with men. Evidence furthermore shows that in a range of epidemic settings, universal access to HIV services for men who have sex with men combined with anti-discrimination efforts can significantly reduce infections both among those men and the wider community.  

Human rights treaty monitoring bodies have recognised that criminalisation and the consequential stigma and discrimination is inconsistent with rights protected by the ICCPR and impedes health-seeking behaviour in the context of HIV. In 1994, the Human Rights Committee, the UN body that oversees implementation of the ICCPR, found that although the law had not been enforced for eight years, the existence of the provision penalising consensual sexual acts between persons of the same sex constituted a continuous and direct interference with the applicant’s right to privacy under Article 17 of the ICCPR. While the government argued that the criminal law was justified to prevent the spread of HIV, the Human Rights Committee found that rather than preventing the spread of HIV, criminalising consensual sex drives underground those most at risk of HIV infection.  

Similarly, the International Guidelines specify that criminalising consensual sex or relationships between adults in all forms (adultery, fornication, oral sex and sodomy) interferes with the right to privacy and also impedes HIV and AIDS education and prevention.  

Since the 1994 Toonen case, the Human Rights Committee and other treaty monitoring bodies have consistently recommended that States decriminalise consensual sexual acts between adults of the same sex, including in Concluding Observations to, Egypt, Kenya, Lesotho, Togo, Tanzania, and Uganda, among others.

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408 GCHL, Risks, Rights & Health (2012).
412 United Nations Human Rights Committee, Concluding Observations for Kenya, CCPR/C/KEN/CO/3, para. 8 (2012); See also, CCPR/CO/83/KEN, para. 27.
416 CEDAW Committee, Concluding Observations for Uganda, CEDAW/C/UGA/CO/7, paras. 43-44.
The Human Rights Committee has specifically recommended that Botswana repeal the sodomy and other penal code provisions that criminalise consensual sexual activity between consenting adults.

**HRC Concluding Observations to Botswana in 2008**

22. The Committee notes with concern that the State party criminalizes same-sex sexual activities between consenting adults (arts 17 and 26).

The State party should repeal these provisions of its criminal law.

The UN Special Rapporteur on the Right to Health has described some of the ways in which laws criminalising consensual sexual acts between persons of the same sex or otherwise penalising sexual orientation and gender identity inhibit access to health services by interfering with the doctor-patient relationship and undermining patient confidence in public health systems. Health providers may refuse to treat LGBTI people or respond with hostility when compelled to do so. Where patients may be guilty of a criminal offence, by engaging in consensual same-sex conduct, this has the potential to jeopardize the obligations of confidentiality that arise during the course of the doctor-patient relationship, as health professionals may be required by law to divulge details of patient interaction. Breaches in confidentiality and discrimination in health facilities results in avoidance of health facilities amongst LGBTI persons, including in the context of HIV prevention, testing, treatment and management. In the context of healthcare settings, LGBTI persons in Botswana have experienced human rights violations including verbal abuse, treatment refusals on the basis of real or perceived sexual orientation or gender identity, among others.

The National Gender Assessment and National Strategic Framework recognise that while in principle, the national response targets all people including key and vulnerable groups, as a result of stigma and discrimination and a lack of guidelines that informs service provision, men who have sex with men and transgender people face serious challenges accessing HIV-related health services. This is not unique to Botswana—globally, LGBTI persons are vulnerable to HIV and face challenges accessing non-discriminatory HIV and other health services and information that address their needs. Globally, gay men and other men who have sex with men are 19 times more likely to be living with HIV than the general population and 19% of transgender women are living with HIV. In Southern and East Africa, HIV prevalence amongst men who have sex with men is approximately 14%.

A higher percentage of women are living with HIV than men in sub-Saharan Africa which is attributed to a number of factors including gender discrimination, high prevalence of sexual violence in the region, gender norms that prevent safe sex negotiation, and high levels of socioeconomic dependency. Lesbian women and other women who have sex with women in the region are especially vulnerable to HIV since, in addition to these factors, they may also face discrimination and marginalisation on the basis of sexual orientation and/or gender expression which results in exposure to violence and exclusion from educational institutions and employment.

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420 Id, at 203.
While there is limited information available on HIV risk or prevalence amongst women who have sex with women, one study found that 21% of HIV positive lesbians surveyed in South Africa, Zimbabwe and Namibia acquired HIV from their female partners.\textsuperscript{422} While data collection often does not include them, women who have sex with women may experience societal discrimination and stigma similar to men who have sex with men. Societal marginalisation on the basis of sexual orientation combined with higher risk of HIV infection on the basis of biological, social and other risk factors for women may necessitate specific interventions to address the needs of women who have sex with women.

\textbf{C) The Current Situation}

While there is limited data on lesbian women or other women who have sex with women, the 2012 Behavioral and Biological Surveillance Survey (BBSS) study provides valuable information on HIV prevalence, incidence and risk factors for gay men and other men who have sex with men. The 2012 BBSS found that HIV prevalence amongst men who have sex with men is 13.1%\textsuperscript{423} whereas the general population has HIV incidence of 1.35%.\textsuperscript{424} Further, there is concern that unlike projections for the general population, HIV prevalence amongst men who have sex with men may not be on the same downward trend\textsuperscript{425} and since the study had many young participants, there was also concern that prevalence amongst older men who have sex with men may be higher. The BBSS study also found that 65.1% of men who have sex with men were not aware that anal sex has a higher risk of HIV transmission than vaginal sex and only 26.2% had received information on anal sex in the past year. It is estimated that 75% of HIV programmes and services for men who have sex with men are provided by civil society.\textsuperscript{426}

The impact of criminalisation on the access to HIV-related services and realisation of human rights in Botswana is illustrated in submissions to the Regional Dialogue on HIV and the law, including the one below.

\begin{center}
\textbf{Submission to the 1\textsuperscript{st} Regional Dialogue on HIV and the Law from Botswana}
\end{center}

Due to the lack of recognition by law and the acceptance of the gay sexual orientation the LGBTI community in Botswana still largely remains hidden and unrecognised in a homophobic society. Moreover, although little is known about the extent of stigma, discrimination and violence against LGBTI persons in Botswana, public debates and media reports regarding on the subject of homosexuality strongly suggest a hostile environment….

As the LGBTI community, we remain deeply concerned by the atmosphere of disapproval, even hate that prevails in Botswana. By the very fact of being gay, we live a sense of being on the fringes and isolated. Being in a state of mind where you constantly fear being ‘discovered’ thinking outing yourself by telling the truth about being raped or having an anal STI, it is extremely difficult to ‘come out’ to a health care worker or to the police. The attitude we have experience from these service providers is that we are abnormal and acting outside the approval of the law, therefore we have experienced the most demeaning and dehumanising treatment ranging from being judged to being insulted. It is extremely discouraging to go back to seek help after such an experience. The current position held by both politicians and government health officials is that they nobody is asked whom they had sex with. However, presenting with an anal infection clearly indicates engagement in anal sex which in turn is outlawed. As a result we remain hidden and at risk of contracting HIV.

\begin{flushright}
\textsuperscript{422} Matebeni et al., I Thought We Are Safe”: Southern African Lesbians’ Experiences of Living with HIV (2013).
\textsuperscript{423} Botswana Ministry of Health, Mapping, Size Estimation & Behavioural and Biological Surveillance Survey of HIV/STI Among Select High-Risk Sub-Populations in Botswana, at 10 (2012).
\end{flushright}
In a recent report, SALC also documented rights violations in Botswana and other health facilities which occurred on the basis of sexual orientation and/or gender identity including the following cases of discrimination and degrading treatment which occurred in Gaborone health facilities:

“One participant who is feminine presenting said he went to a clinic with general chest pains. As he was explaining to the attending nurse, she was looking at him strangely at first. She then called in another nurse and started talking rudely about him right there in his presence, laughing about his appearance and ‘gay’ behaviour; his health issue totally forgotten. He told them to mind their business and demanded treatment. She in turn became rude and rough with him. All the time while she was treating him she lectured about God and sin of Sodom.”

“I had a fight with my brother after he found out that I dated boys. He was hitting me and kicked me on the testicles so I had to go to the hospital when the pain wouldn’t go away. I explained to the doctor what had happened and as soon as I disclosed that the fight was over my sexual preference the doctor’s attitude changed. He stopped listening and started lecturing me, saying that I deserved the beating, that in fact my brother should have cut my testicles off. He stopped treating me right there and then and told me to leave him, telling me I deserved worse for doing ‘unnatural things’. I left and went to a pharmacy and was given painkillers.”

Globally, transgender persons are at high risk of HIV infection due to discrimination and societal marginalisation. Transgender and gender non-conforming persons experience extremely high levels of violence worldwide — between 21 and 68% of transgender women experience rape in their lifetime. While there is limited information concerning transgender and gender nonconforming persons in Botswana, it is estimated that at least 75% of HIV programmes and services for transgender persons are provided by civil society. Due to discrimination, transgender individuals often delay accessing health care, which can result in a number of negative health consequences, particularly in the context of HIV.

Transgender persons in Botswana are unable to access identity documents that reflect their gender identity which is a barrier to health services, including in the context of HIV. For example, if a transgender woman has an identity document that indicates she is male, she may be denied admission into a health facility. In one documented case, a transwoman’s identity card did not reflect her gender identity—her identity card photo indicated she was “male.” When she presented her identity card at a health facility, a health worker called the police who took her into custody. Identity card issues also lead to confusion and delays in access to HIV-related and other health services for transgender and gender non-conforming persons, which could be addressed by reviewing the relevant legislation. Additionally, intersex persons do not have a third gender option on identity documents (in addition to male or female).

Section 16 of the National Registration Act provides that a new identity card should be issued “[w]here the registrar is of the opinion that any change in the particulars relating to a registered person materially affects his registration.” Interpreting this provision to apply to transgender persons could help address these serious challenges facing them, including access to health services. Changes in this law could also have an impact on other legal and policy provisions.

**RECOMMENDATIONS: LGBTI People**

- It is recommended that laws that discriminate against LGBTI persons, including laws that criminalise consensual sexual relations between adults of the same sex are reviewed against international standards. In line with the recommendations of GCHL and the Human Rights Committee and to meet regional and international human rights obligations to prevent discrimination and abuse of LGBTI people and ensure access to HIV-related health services, repeal sections 164, 165 and 167 of the Penal Code.

- Review laws and regulations including “nuisance,” “public disorder,” “cross-dressing,” “impersonation” and similar offences, which are used to target, blackmail, harass, abuse, arrest and otherwise commit human rights abuses against LGBTI people and repeal or revise those that are used to target and victimise LGBTI persons and other vulnerable groups.

- Given the practical challenges and the risk of rights violations when individuals have identity documents “mismatched” with their gender identity, review section 16 of the National Registration Act with the aim of ensuring transgender and intersex persons are able to change the gender marker on their identity cards. If this law is changed, it would be beneficial to review additional legal provisions concerning gender identity to ensure harmonisation.

- Consider reviewing whether a third gender (in addition to male and female) should be an option on identity documents for intersex and other gender non-conforming persons who do not identify as male or female.

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**ARASA, Identifying Injustice: Law and Policy on Sexual Orientation, Gender Identity and HIV in Southern Africa, at 100 (2016).**
• Ensure that every case of violence, abuse against and victimisation of LGBTI persons is thoroughly investigated, and where appropriate, prosecuted.

• Ensure that effective legal mechanisms exist for victims, including LGBTI persons, to report cases of violence, abuse and victimisation committed by state actors, including law enforcement officers.

• Ensure that law enforcement officers, health workers and other government officials receive human rights trainings and information confirming the universal application of human rights, which are guaranteed to all persons including LGBTI persons, as well as specific training and information on the specific human rights issues facing LGBTI persons.

• It is recommended that steps be taken to prevent abuse, discrimination and breaches in confidentiality of LGBTI persons in health facilities, including by:
  o implementing human rights and ethical guidelines for health providers that protect and respect the rights of LGBTI persons, men who have sex with men and women who have sex with women;
  o facilitating human rights trainings which include information on sexual and gender diversity for health providers; and
  o ensuring that there are effective mechanisms in place for victims to report violations.

• Ensure there are adequate protective measures that guarantee the right to non-discriminatory access to quality HIV and TB-related and other health services for all persons, including LGBTI persons.

• Implementation of specific policies, plans and frameworks (within existing policy documents or in separate policy documents) that outline how the government will ensure that LGBTI people have comprehensive and non-discriminatory access to HIV and TB-related health services is recommended.

• Conduct public outreach and sensitisation on LGBTI rights issues and the impact of LGBTI-related discrimination on the HIV response and human rights implications.

**Laws Criminalising Aspects of Sex Work**

The United Nations Special Rapporteur on the Right to Health has expressed concern that criminalisation of sex work inhibits labour regulation, and access to police protection, health services, and legal remedies when rights violations occur:

“As with other criminalized practices, the sex-work sector invariably restructures itself so that those involved may evade punishment. In doing so, access to health services is impeded and occupational risk increases. Basic rights afforded to other workers are also denied to sex workers because of criminalization, as illegal work does not afford the protections that legal work requires, such as occupational health and safety standards.”
The Penal Code of Botswana criminalises acts associated with sex work including procurement, solicitation, living off the earnings of sex work, brothel keeping, idle or disorderly public conduct and ‘rogue and vagabond’ laws. Sex workers have also been arrested and detained under Section 176 of the Penal Code which broadly prohibits ‘common nuisance.’ While sex work itself is not illegal in Botswana, 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. Condoms are used as “evidence” against sex workers, thereby deterring sex workers from carrying them. In some cases, clients have abused sex workers and thereafter refused to pay them and left them in a remote area without clothing. There are documented cases of sex workers being killed and mutilated with impunity.

Sex workers are some of the most vulnerable members of society and are highly vulnerable to HIV due to the lack of adequate legal protections, lack of bargaining power and labour regulations, and discrimination in health and other public facilities. Indeed, the 2012 BBSS found that HIV prevalence amongst female sex workers is 61.9% and HIV incidence is 12.5% in the three districts surveyed. While limited data is available concerning TB prevalence among sex workers, high HIV prevalence and marginalisation mean that sex workers are at high risk of TB infection. Beyond the implications for sex workers and their clients, high HIV prevalence in this population has significant implications for the general population—because many clients of sex workers have wives and families, these clients serve as a bridge between female sex workers and the general population. While the NSF does identify female sex workers as a vulnerable population, it also indicates that the capacity to design prevention interventions for sex workers or to develop innovative and targeted initiatives is a critical gap in the national response.

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431 Penal Code, Section 149.
432 Id, Section 155.
433 Id, Section 158.
434 Id, Section 179.
435 Id, Section 182.
436 Sub-section 1 provides “(a) Any person 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.”
438 Focus Group Discussion, October 2016.
439 Id.
441 Id.
Another law contributing to discrimination against sex workers is the law providing that sex workers are considered undesirable immigrants in Botswana. Section 50 of the Immigration Act prohibits entry and presence of sex workers, persons who have knowingly lived off the earnings of sex work, and persons who have procured sex workers.\footnote{Botswana Immigration Act, No. 3 of 2011, Section 50(e).}

The Minister can issue a deportation order against undesirable immigrants and if they do not comply with a deportation order, undesirable immigrants are subject to involuntary removal.\footnote{Id, Section 50(2) and (3).}

Immigrant sex workers are at higher risk of HIV infection and poor health outcomes due to discrimination both as sex workers and often also on the basis of immigration status. Working in a criminalised labour sector exposes them to violence and abuse with impunity where they lack bargaining power to negotiate safe sex, while status as non-citizens precludes them from access to free HIV-related health services and further diminishes their agency and bargaining power. Approximately 75% of sex workers are locals while 25% are immigrants, though the two groups of sex workers share clients. Indeed, immigrant and local sex workers are at high risk of HIV infection. The BIAS IV found that HIV prevalence amongst Zimbabwean female sex workers is 69.5% and 57.7% amongst Batswana female sex workers.

In addition to lack of access to free HIV-related health services, due to immigration status, immigrant sex workers face challenges obtaining employment in the formal sector, and immigration status is likely to deter health-seeking behaviour and reporting of cases of violence and abuse to the authorities. Focus Group participants also reported that due to financial desperation (as they lack other sources of income), immigrant sex workers accept extremely small amounts of compensation for sex work and that immigrant sex workers (i) are even less likely to be able to negotiate condom use and (ii) are often willing to engage in sex work without a condom for more pay.\footnote{Focus Group Discussion, October 2016.}

Sex workers face significant challenges protecting themselves from HIV and other STIs. Prevalent violence and inadequate access to justice interferes with the rights of sex workers, contributes to high HIV infection rates, and further disempowers them, thereby increasing vulnerability to HIV and human rights violations. Due to the continued criminalisation of aspects of sex work, police officers and clients believe they can abuse them with impunity - a belief which is given credence when crimes committed against sex workers are not prosecuted or punished.
In line with the Focus Group discussion findings, the BBSS found that although sex workers reported a "widespread understanding of the importance of condom use in HIV prevention, they faced several obstacles to consistent condom use. These included clients paying more not to use condoms, clients forcing the sex workers not to use condoms, and regular experiences with condoms breaking." Focus Group participants reported that clients often refuse to use condoms "in an aggressive way" and refuse to pay sex workers. The continued criminalisation of aspects of sex work means there is no labour regulation or labour remedies for non-payment or abuse in the context of employment.

In health facilities, sex workers face discrimination and degrading treatment which interferes with medical ethics and discourages health-seeking behaviour. For instance, health workers have violated the confidentiality rights of sex workers, including disclosing HIV status and that individuals are sex workers. In Botswana, sex workers have also experienced harsh, abusive and discriminatory language, failures of health workers to accommodate ART needs, segregation of healthcare users and use of identifying practices, among others.

The Global Commission on HIV and the Law recommends that States:

- take legal measures to ensure safe working conditions for sex workers and
- repeal all laws criminalising sex work and aspects of sex work including laws that "prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against "immoral" earnings, "living off the earnings" of prostitution and brothel-keeping.

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Findings from sex worker focus group discussions:

- Because it is difficult to legally prove that sex workers are ‘living off the earnings’ of sex work or committing other sex work-specific offences, police will instead arrest sex workers for ‘loitering,’ ‘nuisance’ or other laws with broad application.
- The laws criminalising aspects of sex work are used to degrade and humiliate sex workers.
- Sex workers or persons perceived to be sex workers are often arrested arbitrarily, on the basis of hairstyle, make-up or being in a certain location or ‘hot spot’. It is difficult or impossible to challenge such cases.
- Police officers regularly detain sex workers and threaten to arrest them or take them to the police station if they do not have sex with them.
- Police officers frequent areas known for sex worker traffic and detain persons suspected of sex work or those said to be ‘loitering’. During such detentions, sex workers are often raped, sometimes by multiple police officers and sometimes perpetrators refuse to use condoms. In some cases, police will also blackmail sex workers for money. If sex workers cannot pay, they will be taken to the police station.
- Some police officers (some of whom are clients of sex workers) have been known to follow sex workers to their homes since they know where they live.
- Sex workers have reported many incidents of violence and abuse to the police stations, but typically there is no investigation conducted or any follow-up. Cases of violence against sex workers are ignored and almost always go unpunished.
- Sex workers have been denied access to post-exposure prophylaxis (PEP).
RECOMMENDATIONS: Sex Workers

• Review all penal and other laws that criminalise aspects of sex work or are otherwise used to arrest, harass and abuse sex workers including those prohibiting procurement, solicitation, living off the earnings of sex work, brothel keeping, idle or disorderly public conduct and ‘rogue and vagabond’ laws, ensuring alignment with international standards.

• Review laws, regulations and ordinances such as ‘nuisance,’ ‘loitering,’ ‘public order’ and any other similar laws which are used to target, blackmail, harass, abuse, arrest and otherwise commit human rights abuses against sex workers and repeal or revise those that are used to target and victimise sex workers and other vulnerable groups ensuring alignment with international standards.

• Ensure that every case of violence, abuse against and victimization of sex workers is thoroughly investigated, and where appropriate, prosecuted.

• Ensure that effective legal mechanisms exist for sex worker victims to report cases of violence, abuse and victimisation committed by state actors, including law enforcement officers.

• Ensure that law enforcement officers, health workers and other government officials receive human rights trainings and information confirming the universal application of human rights, which are guaranteed to all persons including sex workers, as well as specific training and information on the specific human rights issues facing sex workers.

• It is recommended that specific steps are taken to prevent abuse, discrimination and breaches in confidentiality of sex workers in health facilities, including:
  o implementing human rights and ethical guidelines for health providers that protect and respect the rights of sex workers;
  o facilitating human rights trainings for health providers; and
  o ensuring that there are effective mechanisms in place for victims to report violations.

• Ensure the provision of adequate protective measures that guarantee the right to non-discriminatory access to quality HIV and TB-related and other health services for all persons, including sex workers.

• Ensure implementation of specific policies, plans and frameworks (within existing policy documents or in separate policy documents) that outline how the government will ensure that sex workers have comprehensive and non-discriminatory access to HIV and TB-related health services.

Laws Criminalising Personal Drug Use and Harm Reduction

To ensure that people who use drugs are empowered to reduce their vulnerability to HIV and enforce their human rights, the Global Commission on HIV and the Law recommended that countries do the following, among others:

• Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence. Countries must:
  o Shut down all compulsory drug detention centres for people who use drugs and replace them with evidence-based, voluntary services for treating drug dependence.
  o Abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.
  o Repeal punitive conditions such as the United States government’s federal ban on funding of needle and syringe exchange programmes that inhibit access to HIV services for people who use drugs.
  o Decriminalize the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society.
In Botswana, the Drugs and Related Substances Act prohibits the use, possession and sale of “habit-forming” drugs. There is little information on the population or relevant health information of people who use drugs in Botswana. There is limited information concerning harm reduction programmes. According to Harm Reduction International, Botswana does not provide harm reduction services—including needle and syringe exchange programmes or opioid substitution therapy.

**RECOMMENDATIONS: People Who Use Drugs**

- Consider conducting a baseline study on people who use drugs and HIV and TB prevalence, risks and challenges, including to assess legal and other barriers to HIV and TB prevention and related health services.
- Consider reviewing existing legislation, with a view towards repealing laws inconsistent with a human rights-based approach to effectively addressing the needs of people who use drugs and consider enacting legal and policy provisions that allow for, facilitate and regulate, harm reduction strategies to prevent HIV infection and to safeguard the health rights of people who use drugs, in line with the recommendations of the Global Commission on HIV and the Law and international standards.

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450 Drugs and Related Substances Act, No. 18 of 1992, Section 16.
Employment and Labour

The International Guidelines on HIV/AIDS and Human Rights recognise that the right to work protects the right of every person to access to employment without any pre condition except the necessary occupational qualifications. Additionally, in recognition of the impact of HIV on society, economies and that the world of work (formal and informal) is part of the wider society, in June 2010, delegates to the International Labour Conference adopted HIV and AIDS Recommendation 2010 (No. 200). Recommendation 200 aims to strengthen universal access to HIV prevention, treatment, care and support by recognising that HIV is a workplace issue, containing preventative and anti-discrimination provisions aimed to address national issues in the context of the workplace.

In view of Recommendation 200, the Government of Botswana amended the Employment Act in 2010 to prohibit HIV-related discrimination with respect to termination of employment contracts. Employers are prohibited from terminating employees’ contracts based on an individual’s sexual orientation or HIV status. The Employment Amendment Act of 2010 prohibits dismissal based on “the employee’s race, tribe, place of origin, social origin, marital status, gender, sexual orientation, colour, creed, health status or disability.” Section 23 (e) also provides protection against discrimination for “any other reason which does not affect the employee’s ability to perform that employee’s duties under the contract of employment”. The Botswana courts have protected the rights of people living with HIV from unlawful HIV testing in the workplace in a number of instances. The Employment Act also requires 14 days of paid sick leave a year.

In addition to the amended Employment Act, the Government of Botswana, through the Ministry of Labour and Home Affairs, has drafted a national Employment Policy that guides the conduct of all parties to the employment relationship and to promote mutual understanding of all, including government, employers and employees in managing HIV and AIDS issues through the establishment of workplace programmes. The policy emphasises the need for all employers to create an environment that promotes the elimination of discrimination, stigma, ignorance and prejudice in the workplace. The policy, based on principles of shared responsibility and accountability, further promotes regular dialogue and HIV testing. Although the policy recognises HIV testing as a strong foundation for prevention, care, support and treatment services, it emphasises the need to conduct such testing in accordance with national protocols and informed consent of the workers. The legislative Employment Act does not provide protection on the basis of gender identity, or otherwise protect the rights of transgender or intersex persons in the context of employment.

In addition to the Employment Amendment Act and national employment policy, the Code of Good Practice: HIV/AIDS and Employment, 2002 (attached to the Trade Disputes Act 15 of 2004) also protects the rights of employees with HIV to non-discrimination, confidentiality, HIV testing only with voluntary and informed consent and to protection from unfair dismissals. Additionally, the Public Service Act of 2008 protects public service employees from discrimination on the grounds of sex, race, tribe, place of origin, national extraction, social origin, colour, creed, political opinion, marital status, health status, disability, pregnancy or other grounds.

452 Employment Amendment Act, No. 10 of 2010, Section 23(d)
454 Employment Act, No. 29 of 1982, Section 100.
Whilst key informants recognised that the Employment Act of 2010 provides protection from discrimination and termination of contracts on the basis of HIV status, they recommended a more comprehensive law that addresses issues of reasonable accommodation for those living with HIV and TB, ensuring they have a safe and supportive environment to access treatment, care and support. ILO Recommendation 200 provides guidance as to reasonable accommodation, which is defined as “any modification or adjustment to a job or to the workplace that is reasonably practicable and enables a person living with HIV or AIDS to have access to, or participate or advance in, employment.”

Key informants also identified the following challenges in addressing HIV in the context of employment:

- Despite the existence of protective employment laws and policies, and case law that has affirmed the prohibition of pre-employment HIV testing, some private and public sector employers test potential employees for HIV and subsequently disqualify them on the basis of being HIV positive;
- Due to living in remote locations, low income and/or poverty, farm employees (particularly migrant farm workers) are disproportionately affected by HIV;
- Due to the lack of awareness of HIV-related employment law protections, violations are not often challenged in the courts and as a result the protective rights were not enforced.

**RECOMMENDATIONS: Employment and Labour**

- Ensure full implementation, enforcement and awareness of the existing legal protections for people living with HIV and TB in the public and private sectors, including the Employment Amendment Act, the Public Service Act, court decisions upholding the rights of people living with HIV, and relevant policies through awareness trainings of employers and employees, provision of guidelines, and monitoring of employment practices.
- Review the existing employment laws and policies (including the Employment Act, the Public Service Act, and related policies) in line with ILO Recommendation 200;
- Consider amending the Employment Act or otherwise enact a law and policy that clearly provides for reasonable accommodation to ensure people living with HIV and TB have access to and are able to participate and advance in employment.
- Ensure that existing internal redress mechanism for labour discrimination adequately address workplace discrimination against people living with HIV, TB and key and vulnerable populations.

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456 Diau v. BBS, Industrial Court, Gaborone, No. 50 of 2003; Rapula Jimson v. BBS, Industrial Court, Gaborone, No. 35 of 2003.

457 See supra, Section on Migrant Workers.
Education and Information

Children, adolescents, youth and adults have the right to receive age-appropriate HIV-related information and education, particularly regarding prevention and treatment and access to information and education concerning HIV and TB is an essential life-saving component of an effective response. In the context of HIV, the right to education encompasses (i) the right of children and adults to receive HIV-related education, particularly regarding prevention and care, which is available in every culture and religion, both inside and outside schools; (ii) protection from discrimination in access to education on the basis of HIV status and (iii) states must promote understanding, respect, tolerance and non-discrimination in relation to persons living with HIV. Further, the right to access HIV-related information in their own language is particularly important to indigenous persons and minority groups.

While the existing Education Act does not address HIV, TB or comprehensive sexuality education, the Act is currently under review which provides an opportunity to include language to strengthen rights relevant to HIV and align the law with the HIV Policy, including the right to non-discrimination on the bases of HIV and health status and the right to comprehensive access to accurate and comprehensive HIV and TB-related education and information for all persons. The Botswana HIV and AIDS Policy specifies that people living with HIV have access to education without being subjected to any form of discrimination or stigma and states that to prevent the spread of HIV, the Government of Botswana “will ensure access to prevention information, techniques and services, to all persons.” However, while the school curriculum includes a life skills component, some sources indicate that there is inadequate provision of sexual and reproductive health information in schools and teachers are often not trained to provide comprehensive sexuality education. Key informants also expressed concern that there is inadequate provision of information on HIV and sexual and reproductive health both in schools and outside of schools. These and other educational gaps in schools result from inter alia (i) inadequate human resources; (ii) funding gaps; and (iii) inadequate commitment from management. Further barriers cited include (i) nurses or other school officials are unable to provide condoms or other commodities to students which would allow them to protect themselves from HIV; (ii) orphans, children living in child-headed households and other children are vulnerable to HIV and are not receiving information on HIV or SRHR from their guardians; (iii) due to lack of information on SRHR there are high rates of learner pregnancy which lead to drop-outs; (iv) due to child marriage, children are exposed to HIV and lack access to information on HIV and/or lack the ability to negotiate safe sex.

Similarly, a 2015 UNESCO report emphasised the importance of improving life skills education, recommending the following:

Teaching of life skills education programmes, possibly with peer-education mode of delivery, needed to be developed and introduced at all levels of schooling as a matter of priority. That was to be done after a series of public consultations and public debates were conducted on strategies that could be adopted. All sub-sectors of education needed to have an HIV/AIDS coordinating office and needed to adopt life skills programmes for a section of the population in that sub-sector.
A rapid assessment on adolescent pregnancy in Botswana conducted in 2016 by the Ministry of Basic Education\textsuperscript{466} found that fear of open discussion about sexual health between parents and adolescents continues to be a barrier to providing young people with accurate information on sexuality.

The 1994 Revised National Education policy does not address HIV or SRHR education. While the Botswana Education and Training Sector Strategic Plan does prioritise improved health and safety including HIV and AIDS care,\textsuperscript{467} it does not mention HIV or SRHR-related information or curriculum. To address access to information and policy framework gaps, in 2014, Botswana initiated the process of integrating comprehensive sexuality education into its primary and secondary school curricula. Botswana is in the process of reviewing relevant policy documents including the the Life Skills Framework, the Guidance and Counselling Policy, the School Health Policy, and the Adolescent Sexual and Reproductive Health training manual of 2012. Review of these policy documents provides an opportunity for review against international and regional standards pertinent to HIV and comprehensive sexuality education. The 1992 HIV policy for schools is outdated and does not adequately address current needs.

While the Botswana 2010 Life Skills Framework for pre-primary, primary and secondary level students\textsuperscript{468} curriculum is an important step, it has missing elements and major gaps including in areas pertaining to reproductive health and physiology, sexual relationships, contraception and adolescent pregnancy, and negotiation/decision making skills as they pertain to sexual relationships.

Further, though abstinence education and condoms are both presented in the new draft curriculum, it is unclear to what extent these are available in practice. Additionally, the Adolescent Sexual and Reproductive Health Strategy Implementation Plan drafted by the Botswana Ministry of Health (MOH) identifies deficiencies in monitoring and evaluation, poor integration of sexuality issues, including gender issues and abuse, and a lack of trained teachers as gaps that need to be addressed.\textsuperscript{469}

In addition to the inadequate provision of information contributing to high risk of HIV amongst youth, in Botswana, there has been a high rate of adolescent pregnancy after primary school which interferes with the rights to education, health and non-discrimination. According to the Botswana Vital Statistics\textsuperscript{470} report, teenage (13-19 years) live births accounted for about 9% of births that occurred in 2014 of which 0.07 percent were below the age of 15. In 2014, Botswana registered babies born to mothers as young as 12. Births to adolescent girls (aged 15–19 years) have heightened risk of morbidity and mortality and well as the highest risk of infant and child mortality.\textsuperscript{471}

\textsuperscript{466}Botswana Ministry of Basic Education, Rapid Assessment of Adolescent Pregnancy in Botswana (2016).
\textsuperscript{467}Botswana Education and Training Sector Strategic Plan, at 40 (2015-2020).
Although the rates of adolescent pregnancy in Botswana are lower than the regional figures, the increasing rate of adolescent pregnancies which leads to school dropouts is cause for concern. According to the Education Statistics Report,\textsuperscript{472} the 2011 drop out as percentage of 2010 enrolment for primary schools (331,196) was 0.9%. In 2012, 2.3% of primary school pupils dropped out of school due to pregnancy in North West, Central and Southern regions.

### Sexual Behaviour Statistics, Botswana Ministry of Basic Education

Second Botswana Youth Risk Behavioural and Biological Surveillance Survey Among 13-19 years old Students (2016)

- 22.3% of students had ever had sexual intercourse.
- 10.7% of students had sexual intercourse in the past 12 months prior to the survey
- Of the 22.3% sexually experienced students
  - 33.0% had sexual intercourse for the first time before age 13 years;
  - 69.0% used a condom the last time they had sexual intercourse;
  - 48.9% had sexual intercourse in the past 12 months;
  - 43.7% had sexual intercourse with two or more people in the past 12 months;
  - 13.4% of girls reported having been pregnant and 13.0% of boys reported having impregnated someone; and
  - 13.4% reported ever exchanging sex for money drugs or gifts.

The Sexual and Reproductive Health Policy Guidelines and Service Standards provide that information, education and communication on HIV and AIDS should be available in all health facilities and NGOs shall provide information to individuals, families and communities.\textsuperscript{473} The guidelines also provide that special considerations should be made for youth and adolescents. Some gaps identified include the following:

(i) Not enough IEC materials targeting the adolescents and youth;
(ii) Materials developed without consultation;
(iii) Environment not conducive to cater for adolescents and youth;
(iv) Attitudes/practices of health workers not conducive to adolescents and youth;
(v) Inadequate outlets/places offering services to adolescents and youth other than health facilities;
(vi) Services offered while some adolescents and youth are in school;
(vii) Correct information not reaching the adolescents and youth\textsuperscript{474}

While the Ministry of Education indicates that human rights education information is integrated into existing curriculum, it was suggested that provision of human rights information could be strengthened, including by ingraining human rights training into the national training curriculum for teachers and educational staff.

Several recent initiatives have sought to address gaps in access to information including a community awareness programme to discuss sexuality education with the community and a manual has been developed on parent/child communication and the Department is currently consulting with communities. The manual will address the challenge of parent to child communication concerning HIV and sexual health.

\textsuperscript{473} Botswana Ministry of Health, SRH Guidelines, at 45 (2015).
\textsuperscript{474} Id, at 46.
RECOMMENDATIONS: Education and Information

General

• During review of the Education Act and other legislative and policy review, consider provision in law for the right to non-discrimination in education on the basis of HIV and health status (as is provided in the HIV and AIDS policy).

• During review of the Education Act and other legislative and policy review, consider provision in law and policy guaranteeing access to accurate and comprehensive HIV and TB-related education and information for all persons with focus on vulnerable groups, including adolescents and youth, LGBTI persons, sex workers, prisoners, migrants, remote area dwellers and people with disabilities.

• Strengthen stigma and discrimination reduction campaigns amongst communities, service providers (e.g. health care workers) and law enforcement officials, to reduce HIV and TB-related discrimination and discrimination against vulnerable and key populations at higher risk of HIV exposure.

Comprehensive SRHR Education, Information and Commodities

• Since the Life Skills Framework, the Guidance and Counselling Policy, the School Health Policy, and the Adolescent Sexual and Reproductive Health training manual are under review, this is an opportunity to ensure that these and other policies and frameworks clearly set out the requirements of in school and out of school programmes on HIV-related information and education, including on safe sex and provide adequate guidance to teachers.

• Consider reviewing and updating the 1992 policy for schools on HIV to ensure it addresses the needs of students.

• Ensure full implementation of a comprehensive sexuality curriculum into primary and secondary schools which includes information on HIV, TB, reproductive health, rights and physiology, sexual relationships, contraception and adolescent pregnancy, and negotiation/decision making skills as they pertain to sexual relationships.

• Through policy and school curriculum, clearly provide for distribution of contraceptives in schools, including by school nurses or other appropriate school staff. Dialogue between health, education, parents, children to discuss provision of condoms is recommended, to ensure coherence amongst policies to provide ongoing support to adolescents beyond provision of condoms.

• Ensure that teachers are adequately trained and provide accurate information on HIV, TB and sexual and reproductive health and rights, including information on safe sex.

• Human rights education and training should be strengthened and further integrated into the school curricula through provision into existing frameworks (i.e. life skills and other) and programmes should be available for out-of-school children, adolescents and youth. Programmes should include age appropriate information about HIV, TB, stigma and discrimination and human rights which includes safe sex education at an early age. Such programmes should also be available in the health system, within the working environment and amongst law enforcement officials.
Awareness and Sensitisation

- Intensify community awareness and education campaigns on HIV, TB, law and human rights, including by monitoring, evaluating and continuing to support existing programmes and by developing media in local languages on HIV and human rights issues. Programmes should specifically target and include information on issues and laws relevant to all vulnerable and key populations and on existing protective laws and policies.

- Information and sensitisation campaigns should be introduced for judicial officers, to ensure on-going and updated information for all judicial officers on HIV and human rights issues.

- Information and sensitisation campaigns should be introduced for law and policy-makers, to support the efforts of all decision-makers to develop supportive and effective legal and regulatory frameworks for HIV, AIDS and TB.

- Awareness and education on HIV, AIDS and TB as well as training on reporting on HIV and TB specific issues for the media personnel.
Social Welfare

The Universal Declaration on Human Rights provides “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” The General Comment 19 of the Committee on the Economic, Social and Cultural Rights provides:

“The right to social security is the right to access and maintain benefits, whether in cash or in kind, without discrimination in order to secure protection, inter alia, from (a) lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) unaffordable access to health care; (c) insufficient family support, particularly for children and adult dependents.”

In the context of human rights, UN member states are expected to observe the following key elements:

- **Availability:** A scheme that ensures that benefits are provided for the relevant social risks and contingencies should be available;
- **Adequacy:** Member states should provide adequate benefits for everyone to realise his or her rights to family protection, assistance and access to health care;
- **Affordability:** Social security schemes must be affordable for all; and
- **Accessibility:** the most disadvantaged and marginalised groups should be covered by the social security system without discrimination.

Access to social welfare systems and support is essential for people living with and affected by HIV and TB to ensure their health, survival and well-being, as well as the well-being of their families. Adequate systems should be in place to ensure that individuals with HIV-related disabilities have access to social welfare and support. Botswana has implemented a complex social protection system to address economic and social challenges. Some social protection programmes include: community home-based care (CHBC), orphaned and vulnerable children programmes, primary and secondary school feeding, vulnerable group feeding, the destitute programme, state old age and war veterans pensions, the remote area dwellers programme and labour intensive public works (‘Ipelegeng’).

The Revised Policy on Destitute Persons provides for social assistance to persons who are unable to engage in sustainable economic activities due to disability or chronic health conditions and have insufficient income. The policy provides assistance in the form of food, finances, psychosocial support, and housing for ‘destitute persons.’ Assistance for people living with HIV may be provided under the above mentioned provisions if they meet the required criteria. Providing further support, the Pensions Act provides financial assistance to citizens over the age of 65, without a means determination.

The Social Development Policy Framework recognises the need to ensure adequate social welfare protection in Botswana. The Framework includes a strategy for making Botswana “a compassionate, just, and caring nation” and for fulfilling the third pillar of Vision 2016, which aims for a more equitable income distribution and the eradication of poverty in Botswana. Towards these aims, Vision 2016 and the Social Development Policy Framework recognise the need for a social safety net for the poor and vulnerable that can withstand unexpected disasters or crises.

**Recommendations: Social Welfare**

- Conduct research on the extent to which people with HIV and TB have meaningful access to social welfare and support systems. Address any gaps that would improve their health outcomes and the well-being of them and their families.
- Ensure that adequate systems are in place to provide adequate social welfare and support for individuals with HIV-related disabilities.
- Ensure that social welfare protections and programmes are available without discrimination to people living with HIV and TB.
PART IV: PROTECTION, ACCESS TO JUSTICE AND LAW ENFORCEMENT IN BOTSWANA

Strengthening access to justice and law enforcement is essential to the realisation of human rights in the contexts of HIV and TB. The Global Commission on HIV and the Law emphasises that States should enforce all existing protective laws, particularly in the context of sexual and other violence and that “effective legal aid can make justice and equality a reality for people living with HIV, and this can contribute to better health outcomes.”475

The UNAIDS International Guidelines on HIV/AIDS and Human Rights recommend the provision of legal support services, education and awareness and strengthening of monitoring and enforcement mechanisms.


Guideline 7: Legal Support Services
States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

Guideline 9:
States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

Guideline 11:
States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

The International Guidelines also recommend the following:

• Support for legal aid systems specialising in HIV casework, possibly involving community legal aid centres and/or legal service services based in AIDS service organisations.

• Support to private sector law firms to provide pro bono services to people living with HIV and affected populations.

• Support for programmes to educate and raise awareness of HIV law and human rights amongst affected populations, lawyers, legal support services and civil society organisations.

• Support for HIV legal services and protection through a variety of offices, such as Ministries of Justice, procurator and other legal offices, health complaint units, ombudspersons and human rights commissions.

• Support for stigma and discrimination reduction programmes to the broader public, within educational institutions, workplaces and for key leaders and service providers, to promote dignity and respect for people living with HIV and other key populations.

• Support monitoring and data collection on HIV and human rights including through the establishment of HIV focal points in relevant government branches, support to civil society organizations and through new or existing human rights commissions, national legal bodies and law reform commissions.

Awareness of HIV, Law and Human Rights and Legal Support

The Resolution adopted by the 99th Inter-Parliamentary Union (IPU) Conference in Windhoek, Namibia highlights the following recommendations related to the need for awareness creation:

• Taking a partnership approach by involving the widest possible range of concerned stakeholders, including people living with HIV and the community, in decision-making processes, as well as information sharing;
• Having targeted education and preventive measures as the key components of successful national AIDS strategies; and
• Establishing non-partisan parliamentary groups to ensure continuing dialogue, briefings and debate, as well as training activities, in order to deepen the understanding of the pandemic and promote a consensus on national policies.

Whilst Botswana has a number of laws and policies that protect the rights of all people from discrimination and promote access to health care and other services, key informants interviewed during the assessment indicated that many community members are not aware of the laws and policies that protect their rights. Inadequate access to information on the law hinders meaningful access to justice.

The establishment of the country’s first legal aid system in 2012 has increased access to justice in Botswana for those lacking adequate resources to obtain legal advice and representation. While prior to the legal aid system the Legal Practitioners Act obligated attorneys to undertake pro deo and pro bono work, in practice this did not give rise to an effective system of free legal representation. To date, for criminal matters including those with constitutional implications, pro deo counsel is to be made available. The extent to which these legal services are available is not clear.

The Legal Aid Act and the Legal Practitioners (Amendment) Act were enacted to facilitate the provision of legal aid. Legal aid now provides qualified representation in courts on civil matters including divorce, child custody, maintenance and protection from domestic violence. Legal representation in other matters, such as claims related to constitutional rights or discrimination may be provided upon authorisation on a case-by-case basis. Provision of legal services should be expanded to strengthen constitutional and other rights and ensure access to justice.

Another challenge is that legal aid only has offices in Gaborone, Francistown, and Maun, which may limit availability of legal aid outside of these areas. This is a particular challenge since those most in need who live in remote areas are unlikely able to afford transport to urban areas to seek legal advice. Key informants were also of the view that legal aid services are not accessible outside of urban areas and are overwhelmed, with few lawyers.

478 Key Informant Interview.
There are insufficient CSOs funded to provide information on law and human rights, legal advice and legal representation, particularly in the context of HIV, TB and on issues facing vulnerable and key populations. There are a small number of CSOs providing legal support services for HIV and human rights issues such as Botswana Network on Ethics, Law and HIV and AIDS (BONELA).

**RECOMMENDATIONS: Awareness of HIV, Law and Human Rights and Legal Support**

- Clarify, through law and policy, which matters qualify for legal aid with a view towards ensuring that matters concerning constitutional rights and discrimination qualify.
- Strengthen legal support services and mechanisms for enforcing HIV and TB-related human rights complaints and redress mechanisms, including by ensuring full accessibility and sufficient availability of resources, including in rural areas;
- Increase the capacity of legal support services to provide support services for HIV and TB-related human rights violations
  - Ensure that legal aid is available for individuals in all areas of the country to access legal representation and services.
  - Ensure meaningful access to legal aid for individuals living in remote areas;
- Conduct outreach and practical engagement to ensure those who can benefit from the legal aid are aware of its existence and scope.
- Ensure provision of support to CSOs who provide legal representation and advice on the law and human rights.
- Provision of law and human rights information, trainings and sensitisation on the law, human rights, HIV and TB; and
- Provision of education and training for all, including key populations and service providers such as health workers.

**Statutory Institutions**

**A) The Office of the Ombudsman**

In Botswana, there is neither a law commission nor a human rights commission. The Botswana Ombudsman was established by a 1995 Act of Parliament and started operating on 1 December 1997. The Ombudsman is an official who is appointed by the President in consultation with the Leader of the Opposition in Parliament. The powers and responsibilities of the Office of the Ombudsman are set forth in the Ombudsman Act.\(^{479}\) The Ombudsman may investigate any action taken by or on behalf of a Government department or other authority in exercise of administrative functions of that department or authority.\(^{480}\) Investigations can arise from:

(i) complaints by members of the public who claim to have sustained injustice;
(ii) where a complaint is referred to the Office of the Ombudsman with consent of the person who made it and consent of the President, a Minister, or a member of the National Assembly; or
(iii) in circumstances in which the Ombudsman considers it necessary to investigate an action where an individual has or may have sustained injustice.

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\(^{479}\) The Ombudsman Act, No. 5 of 1995.
\(^{480}\) Id, Section 3(1).
The Ombudsman is prohibited from investigating some types of actions including, for example, matters the President or a Minister certify affect the Government’s relations with other Governments or International Organisations and actions taken in respect of appointments to offices or other employment for the Government.\textsuperscript{481}

The Government is in the process of changing the structure so that the office also functions as a human rights commission.\textsuperscript{482} The Office of the Ombudsman produces an annual report which highlights which actions its office have taken. The 2012-2013 report (the most recent report available) does not include any actions taken in the context of HIV or health.\textsuperscript{483}

**Recommendations:**

- Increase the capacity of the Ombudsman and key government offices, and institutions to provide support services for HIV and TB-related human rights violations

**The Courts**

Section 10(9) of the Constitution provides that Courts and adjudicating authorities shall be independent and impartial and that proceedings shall be given fair hearing within a reasonable amount of time. Chapter IV of the Constitution and legislation establish the courts and provide a judiciary framework.

**A) Civil and Criminal Courts**

The Court of Appeal and the High Courts are established by the Constitution. The Court of Appeal is the highest and final court in Botswana.\textsuperscript{484} The Court of Appeal is headed by the President of the Court of Appeal who is appointed by the President of Botswana.\textsuperscript{485} There is a right of appeal to the Court of Appeal for any constitutional decision made by the High Court.\textsuperscript{486} The High Court has unlimited original jurisdiction to hear and determine any civil and criminal matter under any law.\textsuperscript{487} A legal matter concerning a constitutional issue can be referred to the High Court.\textsuperscript{488}

The Magistrates’ Court Act creates the Magistrate Courts and provides jurisdiction over civil and criminal matters.\textsuperscript{489} The High Courts have authority to review Magistrate Court decisions.\textsuperscript{490} There are additional courts such as the Industrial Courts which have jurisdiction over employment matters as well as Children’s Courts, established by the Children’s Act of 2009.

\textsuperscript{481} Id, Section 4.  
\textsuperscript{482} Key Informant Interview.  
\textsuperscript{485} Constitution of Botswana, Sections 99(2)(a) and 100(1).  
\textsuperscript{486} Id, Section 106.  
\textsuperscript{487} Constitution of Botswana, Section 95(1).  
\textsuperscript{488} Constitution of Botswana, Section 105.  
\textsuperscript{489} Botswana Magistrates’ Courts Act, Act No. 20 of 1974, Parts V and VI.  
B) Customary Courts

In addition to the civil court system, customary courts are provided for through legislation. Customary courts have civil and criminal jurisdiction, subject to the exclusions listed in Section 13 of the Customary Courts Act.\footnote{Customary Courts Act, No. 57 of 1968.}

Section 3 of the Customary Law Act provides:

The courts of Botswana shall, within the limits of their jurisdiction, apply customary law in all cases and proceedings in which, by virtue of the provisions of this Act or any other law, customary law is properly applied and where it is not properly applied such courts shall apply the common law.

The Customary Law Act further provides that customary law shall apply in all civil cases between tribal members unless the parties expressly agree otherwise or circumstances indicate their intention to determine the matter under common law.\footnote{Id, Section 4.} If one party to a case requests a transfer of a civil or criminal matter to another court, the court shall agree to the transfer if the transfer is, "in the interests of justice."\footnote{Id, Section 37.} Cases adjudicated in the Customary Court of Appeal are subject to appeal in the High Court.

Customary courts administer “customary law” defined as “in relation to any particular 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 or natural justice” and written laws that the courts have been specifically authorised to administer.\footnote{Id.} The definition may prevent potential conflicts between customary and other laws.

The Customary Courts Act defines the scope of civil and criminal jurisdiction therein. Customary courts only have criminal jurisdiction to the extent set out by warrant in connection with criminal charges that have taken place within the area of the court’s jurisdiction. The Act specifically excludes certain criminal cases from customary court jurisdiction. No customary court has jurisdiction to try cases in which the accused is charged with inter alia treason, murder and rape.\footnote{Id, Section 13.} The Act further provides that customary courts shall administer (i) customary law and (ii) provisions of other written law which the court is authorised to administer by any written law.\footnote{Id, Section 15.} Decisions made by Customary courts can be reviewed by the Customary Courts of Appeal.

In accordance with the principle of constitutional supremacy, the Court of Appeal has held that customary law is subject to, and must be applied and interpreted in accordance with, the Constitution:

“Custom and tradition have never been static. Even then, they have always yielded to express legislation. Custom and tradition must a fortiori ... yield to the Constitution. A constitutional guarantee cannot be overridden by custom. Of course, the custom will as far as possible be read so as to conform with the Constitution. But where this is impossible, it is custom not the Constitution which must go.”\footnote{Attorney General v. Dow, Court of Appeal, Botswana, 1992 BLR 219 (CA), 2 July 1992. See also, Mmusi and Others v. Ramantele and Another, Court of Appeal in Gaborone, High Court Case No. MAHLB-000836-10, paras. 86-88, (2012).}
C) The Impact of Customary Law on Gender Equality

As discussed above, the Constitution limits the right to non-discrimination and equality, including gender equality, in a number of contexts including in marriage, adoption and inheritance. While Courts have struck down some discriminatory provisions in such contexts as inconsistent with the Constitutional right to gender equality, in practice customary law remains a barrier to gender equality in Botswana.

Customary law and customary courts play a significant role in access to justice in Botswana—a 2013 report found that 75% of minor criminal matters and civil disputes such as property and inheritance claims and marital and child custody issues are dealt with in the customary system. There are a number of reasons that many prefer customary systems including: lower court costs; closer proximity to their homes which reduces transport time; customary courts are more familiar and therefore less intimidating; and preference for reconciliatory dispute resolution within the community and family (instead of adversarial).

However, in some customary systems, customary law is discriminatory in itself and/or interpreted in a discriminatory manner. Customary laws are not written, but instead are based on tradition and custom. Key informants cited several challenges in achieving gender equality in the context of customary law and courts including:

- Insufficient training on human rights and gender equality;
- Inadequate oversight of decisions;
- Exclusion from women as participants in some customary systems (both as litigants and as decision-makers in proceedings); and
- Women are not considered equal to men in some customary systems, regardless of constitutional and legislative protections guaranteeing the right to gender equality (for example, in some systems, women cannot make family decisions or are considered the property of their husbands).

Given the high proportion of cases decided within customary systems, gender equality can have a profound impact on the realisation of the right to gender equality. As seen in the Mmusi case, there are customary systems in Botswana which discriminate against women in the context of inheritance and property rights, as well as other rights. Not all cases reach the Customary Court of Appeal, let alone the High Court so it is difficult to estimate how many cases have gender equality implications. Key informants also indicated that not all customary court officials and judges have adequate legal training, which is essential in the context of human rights and gender issues. Additional research is needed ascertain the impact of the customary law system on the rights to non-discrimination and gender equality and access to justice for women in Botswana.

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499 Id.
Access to Justice

While many protective laws and legal mechanisms exist that guarantee the rights of people living with HIV, TB and those vulnerable to and disproportionately impacted by HIV and TB, there is a need to strengthen the enforcement mechanisms and access to justice. Access to justice and enforcement challenges in Botswana are well documented, including in the context of gender-based violence. Key informants reported a number of challenges in the justice system including the following: slow pace of litigation, high case backlogs, lack of legal knowledge and rights amongst the public, mistrust of the justice system amongst the general public, and inadequate monitoring and oversight of police officers, law enforcement and other government officials. Vulnerable populations and complainants report feeling intimidated by the justice system and in some cases have experienced discrimination, abusive treatment and harassment when seeking access to justice.

Illustrative of some of the challenges in access to justice in cases of gender-based violence, one study identified inter alia, the following barriers for survivors of domestic violence:

- When women seek to report incidents of intimate partner violence to the police, they are encouraged to go home and sort out the matter privately. Officials encourage women to ‘forgive and forget’ and reconcile;
- Particularly in rural areas, it is not uncommon for police officers to assume the role of arbitrators, insisting that women negotiate with their partner and involving the couple’s families in reconciliation attempts;
- Some magistrates consider cases of domestic violence to be trivial and that they should be resolved out of Court or dealt with at Customary Courts;
- Lack of or inadequate knowledge of existing protective laws, including the Domestic Violence Act;
- Failures to investigate and prosecute cases of domestic violence due to (i) assumptions that such violence is best resolved at home; (ii) failures to identify incidents of domestic violence as constituent parts of Penal Code offences requiring criminal investigation; (iii) insufficient training and information as to the nature of domestic violence crimes and the needs of survivors; (iv) a lack of prioritisation of domestic violence.

LGBTI persons, sex workers and other vulnerable populations also face challenges reporting cases of violence and other crimes committed against them and criminal cases against marginalized members of society are often not investigated, prosecuted or otherwise pursued.

RECOMMENDATIONS: The Courts

- Research the extent to which key and vulnerable populations have adequate legal protection through enforcement of existing criminal laws, including in the context of gender-based and other violence, as well as violence against LGBTI persons and sex workers. Address gaps and challenges through law, policy and monitoring and accountability.
- Ensure law enforcement officers are adequately trained on the law and sensitised to the needs of victims of gender-based and other violence.
- Research the extent to which the rights to gender equality and other HIV and TB-related human rights are enforced under customary law.
- Sensitise judiciary (including customary) on law and human rights issues affecting people living with HIV, TB and other vulnerable and key populations.
- Ensure that customary courts, traditional leaders and other relevant stakeholders are trained on the law and human rights relevant to HIV, TB and gender equality.
- Ensure, through legal provision and enforcement of the law and oversight, that customary courts are enforcing constitutional and other human rights, including the rights of people living with HIV, TB and the right to gender equality.

Access to Justice in the Context of Healthcare

A 2016 study done by the Southern Africa Litigation Centre looked at the extent to which there is accountability and redress for discrimination in healthcare in Botswana, as well as in Malawi and Zambia. The study found that while most respondents understood their options for redress as either facility-level complaints or seeking remedy through the courts, most viewed court proceedings as inaccessible and unaffordable. The report also looked at the effectiveness of other institutions where discrimination and other complaints can be lodged, including: the Botswana Health Professions Council (BHPC); the Nursing and Midwifery Council of Botswana (NMCB); the Office of People with Disability (OPD); and the Office of the Ombudsman.

Some of SALC’s findings concerning effectiveness, availability, sufficiency and safety of these mechanisms and institutions include the following:

- **NGO and CBO respondents and health professions bodies** described facility-level complaints as “seldom effective.” Facility-level processes have low levels of effectiveness due to the lack of clarity and guarantees in process. The efficiency, transparency and independence of the process is unstable and without guarantees.

- **The BHPC** is relatively effective because it ensures complainants the opportunity to make representations and decision-makers are independent. However, complaints can only be submitted in a limited manner and requiring complainants to present evidence and requiring that they are available for subpoena can compromise the safety of vulnerable complainants. An additional challenge is the limited scope of redress.

- **The NMCB** is relatively effective because it is independent and provides opportunities for complainants to be heard. However, the NMCB was rated low on availability and sufficiency, due to difficulty with enforcement and because it has no powers to order redress or to “meaningfully motivate structural changes.”

- **The OPD** was rated high on availability, as it offers diverse entry points, options for assistance of complainants and referrals and has no requirement for complainants to expose their identities. OPD was rated high in sufficiency of breadth of available interventions but was rated low in effectiveness due to unclear or unprescribed transparency, independence and efficiency.

- **The Office of the Ombudsman** was rated low for availability and effectiveness for healthcare complaints due to its narrow mandate—most healthcare complaints would not meet the jurisdiction requirements of this office. Further, the sufficiency of the office is limited since the Ombudsman’s recommendations are unenforceable.

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The Police Service

The Botswana Police Act sets forth the duties and functions of the Botswana Police Service who are obligated to "protect life and property, prevent and detect crime, repress internal disturbances, maintain security and public tranquillity, apprehend offenders, bring offenders to justice, duly enforce all written laws with which it is directly charged and generally maintain the peace." Criminal and punitive laws and law enforcements pertinent to HIV and vulnerable and key populations are addressed above.

RECOMMENDATIONS: The Police Service

• Key informants indicated that there is a need to provide training and sensitisation for police officers on human rights, the law and HIV-related issues, with a focus on gender, rape and gender-based violence; LGBTI rights and protection; and sex worker rights and protection. Issues and cases pertaining to these and other issues are not always handled properly and with sensitivity, hindering access to justice for victims. Trainings should include:
  o information on the universal application of constitutional and human rights, which are guaranteed to people living with HIV and TB and key and vulnerable populations;
  o specific training and information on the specific human rights issues facing people living with HIV, TB and key and vulnerable populations.
• Ensure that every case of violence, abuse against and victimisation, including those committed against key and vulnerable groups is thoroughly investigated, and where appropriate, prosecuted.
• To encourage reporting of rights violations and meaningful access to justice, steps should be taken to ensure that all law enforcement personnel perform their duties appropriately, with competency and in a non-discriminatory manner, including through use of internal regulatory and ethical boards and committees.
• Ensure that effective legal mechanisms exist for victims, to report cases of violence, abuse and victimisation committed by state actors, including law enforcement officers.

The Prisons Service

In Botswana, there are 23 prisons, including the centre for illegal immigrants; there are seven prison clinics and sixteen health posts, as well as two Infectious Disease Control Centres in the Francistown and Gaborone prison facilities and one ARV site in Mahalapye. The mission statement of the Botswana Prison Service is to "provide safe custodial care and correction to offenders through effective rehabilitation and reintegration programmes for the protection of the society." The prison service is regulated by the Prisons Act (Cap 21:03), Act 28 of 1979 and the Prison regulations. Prison law and policy regarding the care of all prisoners, including prisoners living with HIV and those at risk of HIV exposure, is addressed above.

Prison staff is provided with a basic initial warders' course prior to starting work in the prisons. Additionally, lectures are given to prison staff regularly by health care providers such as counsellors, social welfare officers and assistants' psychologists, and health care auxiliaries. The Botswana Prison Service also indicates that official visitors such as judges, magistrates, the Ombudsman and the International Red Cross also provide support and empower the staff and prisoners.

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503 Id, Section 6 (1).
RECOMMENDATIONS: The Prison Service

• To strengthen the existing legal protections for inmates in the context of TB, a specific policy or framework on TB prevention, testing and management in prisons would provide clarity on the rights of prisoners, the scope of TB-related prevention, treatment and management services available in prison, and ensure that medical officers and other prison staff have clear guidance that informs them of the scope of their duties and otherwise enables them to protect the rights of prisoners and ensure the provision of health and other services.

• Ensure provision of comprehensive trainings to prison staff on existing legal protections and the policy framework on HIV, TB and human rights in prisons, including on key population issues.

• Ensure that prisoners are able to meaningfully utilise existing legal mechanisms who are victims of violence, or other violations to report cases committed by fellow prisoners as well as state actors.

• Ensure that prison staff are trained to prevent sexual and other violence in prisons including by, in line with the International Guidelines, ensuring that all prisoners engaging in rape, violence and sexual coercion are subject to discipline, irrespective of HIV status.
PART V: RECOMMENDATIONS

Constitutional Review and Reform:

• Consider inclusion of the right to health in the constitution to strengthen the protection of this right.
• Consider prohibiting discrimination on the basis of HIV and health status in the Constitution to strengthen the legal protections of people living with HIV and TB.
• Consider inclusion of additional economic, social and cultural rights for all persons, some of which are especially relevant in the context of HIV, AIDS and TB including: the rights to education and information; the right to work; and the right to social welfare to strengthen the protection of these rights.
• Consider removing or amending the restrictive provisions of Section 15, including sub-section 4 which restricts, inter alia, the right to gender equality.

Human Rights Treaty Ratification

BOTSWANA SHOULD RATIFY:

• The Convention on the Rights of Persons with Disabilities;
• The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa;
• The International Covenant on Economic, Social and Cultural Rights (ICESCR); and
• The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

Health Laws, Policies and Plans Concerning HIV, TB, and Human Rights

General Recommendations

• Consider legal provision for the right of all people to available, accessible, appropriate, affordable and quality medicines, diagnostics and related technologies for HIV, AIDS, and TB without discrimination for prevention, treatment, care and support of HIV and AIDS;
• Consider legal provision for prioritisation of the HIV and TB-related needs of vulnerable and key populations in access to health care services, including HIV and TB-related health services;
• Consider provision in National Strategic Frameworks, policies and plans for needs-based HIV and TB-related services targeting key and vulnerable populations;
• Consider provision of a specific strategy or framework that addresses the HIV and TB-related needs of key and vulnerable populations;
• Ensure health care workers have training, including rights-based and sensitisation training, to adequately implement and provide non-discriminatory services to key and vulnerable populations;
• Consider provision in law or policy for clear definitions of ‘vulnerable populations,’ ‘key populations’ and ‘remote area dwellers,’ to facilitate the enactment and implementation of appropriate and evidence-informed policies and programmes.

Tuberculosis

• Ensure through provision in law and policy that there is access to high quality preventative TB medication, TB treatment (including MDR (multi-drug resistant) and XDR (extensively drug resistant)), diagnostics, care and support for all, including paediatric formulations of medication for children.

• Facilitate provision in law and policy that the needs of populations at high risk of tuberculosis (including prisoners, children, remote farming communities, mine workers, mining communities, asylum seekers, health workers, remote area dwellers, people living with HIV, pregnant women and Basarwa) are being adequately met including through provision of tuberculosis information, prevention, treatment, care and support, including in remote areas and in all appropriate languages and formats. Such legal and policy frameworks should address the specific occupational, practical and other risks, concerns and challenges faced by individual populations (i.e. such as prisoners, health workers and mine workers).
The Public Health Act:

It is recommended that provisions of the Public Health Act are reviewed to ensure that the legislation affirms and protects health rights in the context of HIV, AIDS, and TB consistent with the recommendations of the Global Commission on HIV and the Law – that is, that promotes protective, non-punitive and coercive responses to HIV, TB and those affected by HIV and TB. Specifically, the following sections and aspects of the Act should be revised to strengthen protections and ensure a human-rights based approach to HIV and TB:

• Consider expressly guaranteeing the right to non-discrimination in the provision of health services and access to health services for all, through an overarching non-discrimination provision in the Public Health Act. Such a provision could protect the right to non-discrimination in the context of health on the bases of inter alia, HIV, TB and health status, sex, gender; race, ethnicity, tribe, place of origin, political opinions, colour, creed, disability, citizenship, immigration status, sexual orientation and gender identity.

• Section 52: The Act may wish to clearly set out the purpose of notification of diseases. The detailed provision for the notification of HIV, AIDS and TB should be accompanied by clear provision for the confidentiality of personal information, according to the same standards as those provided for in the Ministry of Health Botswana National HTS Guidelines, 2016 for HIV testing. This detail may be provided for within the Integrated Disease Surveillance and Response Guidelines.

• Section 53: If the provision is to remain, consider limiting application to a list of specific communicable diseases.

• Section 57: Consider amendment of the section to:
  o Provide safeguards that ensure that isolation and detention are a measure of last resort to achieve the aim of limiting the spread of a disease, in line with the Siracusa Principles regarding reasonable and justifiable limitations of the rights to liberty, security of person and freedom of movement;
  o Allow for detention to be authorised by a court which should also set out specific conditions of detention, periods of detention, and for the appointment of legal representation for detainees;
  o At minimum, ensure (i) there are guidelines in place, including as to appropriate circumstances for and length of detention and (ii) there is an oversight mechanism in place to review decisions on isolation and detention; and
  o Provide for remedies in cases of unlawful detention; and
  o Include schedules to classify the different communicable diseases which emphasise the protection of the rights of patients.

• Section 104 (3)(b), Section 104(4), Section 105 (2)(b)
  o Review these provisions to promote voluntary HIV testing, with informed consent, patient confidentiality and the provision of counselling with testing.
  o Consider the inclusion of broad factors for the Director to consider before ordering a mandatory HIV test.
  o If the Director and the courts are provided with the power to order mandatory HIV testing, it is recommended that HIV testing (and any related disclosures) are reviewed against the international standards set out by the Siracusa Principles, to ensure that mandatory HIV testing is only permitted where it is a “justifiable and reasonable limitation” of the rights of the patient, in that it is strictly necessary to meet a specific aim, there are no less restrictive means to achieve the aim, and is not imposed arbitrarily.
  o If Section 104(4) is to remain, ensure that there is guidance and orientation for magistrates on the application of the provision in a manner consistent with public health and human rights standards.
  o It is recommended that the clause in Section 104(3)(b) that authorises testing of ‘categories of persons’ be removed.
  o If section 105(2)(b) is to remain, consider an amendment which requires that the test is clinically necessary AND desirable in the interests of the individual.
• Section 108: It is recommended that the section be reviewed and aligned with the National Guidelines on HIV testing which only allow for mandatory testing of persons convicted of rape by court order. Provision of conditions and guidelines as to application of Section 108 are also recommended, which would clarify and safeguard the rights of the victim and the convicted, including the purpose of the mandatory HIV test (i.e. sentencing) and to whom the test results will be available, ensuring that any limitations on rights are justifiable and reasonable and otherwise meet international standards.

• Sections 104(1)(a) and 105(b): Review these provisions to consider the possibility of lowering the age of consent for access to HIV testing and related sexual and reproductive health services, with due consideration for related ages of consent.

• Section 109(3): In the future, there may be a need for research to identify whether provision this provision is abused, including in terms of mandatory testing or refusal of services.

• Section 115(1): Section 15(1)(g) allows for broad disclosures and it is recommended that the provision should specify that a court must first hear an application for admission of such evidence.

• Section 116: Review the section against the SADC PF Model Law on HIV, the International Guidelines on HIV and AIDS and other international standards is recommended. Guideline 3(28)(g) of the International Guidelines on HIV/AIDS and Human Rights provides that disclosure of a person’s HIV status by a medical practitioner to a sexual partner “should only be made in accordance with the following criteria:
  • The HIV-positive person in question has been thoroughly counselled;
  • Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
  • The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
  • A real risk of HIV transmission to the partner(s) exists;
  • The HIV-positive person is given reasonable advance notice;
  • The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; follow-up is provided to ensure support to those involved, as necessary.”

• Section 116(1)(b): It is recommended that obligation to inform a caregiver of HIV status should be removed.

• Section 116(7): The provision of guidelines defining a ‘reasonable opportunity’ for disclosure would provide legal clarity. It is also recommended that the provision allow for screening of violence prior to making a decision on disclosure.

• Section 116(9): This section should be reviewed against international standards.

• Section 122(2): This section should be reviewed against international standards concerning the right to confidentiality.

• Section 117: This section should be reviewed against international standards given the potentially broad application, which could be applied in a discriminatory manner against vulnerable groups.

• Section 119: Review this section to consider whether home and/or self-testing should be available in Botswana and under which circumstances, taking into account ethical implications.

• Sections 136-138: Review these provisions since they provide for different treatment and standards of care for people with communicable and non-communicable diseases.
National HIV Policy:

The retention of the protective and rights-based provisions in the HIV policy is recommended. However, it is recommended that the policy also ensure the provision of HIV-related services to non-citizens and key and vulnerable populations and that the provisions allowing for and referring to mandatory testing be reviewed against international standards, to ensure that any proposed limitation of the right to testing with voluntary informed consent only takes place where it is reasonable and justifiable in the circumstances.

TRIPS Flexibility:

Ensure implementation of all recommendations of the Working Group and full implementation of the Industrial Property Act and other relevant legislation, as specified above. In particular repeal the TRIPS-plus measure which criminalises patent infringement.

- Consider amending the law to include IPR in the anti-competition legislation to prevent anti-competitive practices
- Consider amending the law to ensure that all patents are examinable by the regulator
- Consider making provision for and otherwise facilitate a procedure for filing patent grant oppositions.

The LEA process has identified several key issues that require intervention to enable Botswana to achieve a sustainable medicines provisions system:

- Ensuring Bilateral Trade Agreements do not hinder full exploitation of TRIPS flexibilities.
- Implementing the SADC Pooled Procurement Strategy to increase access.
- Strengthening Medicines Supply Chain System and Medicines Regulatory Authority. The technical and financial position of the Drugs Regulatory Unit (DRU) should be strengthened.
- Assist the Government in the process of granting the DRU autonomous status as a drugs regulatory authority, which can then raise its own income.
- Enhance the DRU’s collaboration with other regulators on the harmonisation of regulations at regional and continental levels.
- Take steps to harmonise the essential medicines’ list with the register maintained by the DRU.
- The DRU should take steps to provide guidelines for parallel imports of medicines.
- Increase the national and regional capacity for manufacturing generic pharmaceuticals and diagnostic tools.
Regulation of Health Centres and Health Providers:

- Ensure that ethical and other oversight of medical practitioners, nurses and midwives are effective in ensuring the rights of people living with HIV and TB and vulnerable and key populations to comprehensive and high quality health services.
- Key informants indicated that there is a need to provide training and sensitisation for health providers on human rights, the law and HIV and TB-related issues, particularly on LGBTI and sex worker rights and health-related issues. It is recommended that trainings include:
  - information on the universal application of constitutional and human rights, which are guaranteed to people living with HIV and TB and key and vulnerable populations;
  - information on the universal application of medical and professional ethics, which are essential to ensure access to quality health services for people living with HIV and TB and key and vulnerable populations;
  - specific training and information on the specific human rights issues facing people living with HIV, TB and key and vulnerable populations.
- Ensure that effective legal mechanisms exist for patients to report cases of abuse and degrading treatment committed by health professionals and practitioners.

RECOMMENDATIONS: Gender Equality and the Right to Non-Discrimination

- Review against international standards the restrictive provisions of Section 15, including sub-section 4 which restricts, inter alia, the right to gender equality.
- Ensure implementation and enforcement of court decisions that uphold and protect the rights to gender equality and non-discrimination, including in the context of customary law, including the case Mmusi and Others v Ramantele and Others.
- Conduct sensitisation and trainings on law and gender equality, including under customary law, with a focus on remote areas.
- It is recommended that all legal, policy and other necessary measures should be taken to strengthen access to justice for survivors of gender-based violence for crimes in the Penal Code and the Domestic Violence Act. In line with the recommendations of the Global Commission on HIV and the Law, it is recommended that Botswana take concrete steps to:
  - Enact and enforcing specific laws that prohibit marital rape.
  - Ensure that violence, rape and sexual assault is prohibited and there is meaningful access to justice whether perpetrated against females, males or transgender persons.
  - Take judicial or legislative steps to remove any immunity–or interpreted immunity–from prosecution for rape when the perpetrator is a married or unmarried partner. This may include abolishing common law ‘conjugal rights,’ and specifically criminalising marital rape in the criminal code and addressing any customary laws, policies or practices that permit marital rape.
  - Fully enforce existing laws meant to protect women and girls from violence, and prosecute perpetrators of violence against women and girls to the full extent of the law.
  - Formulate and implement comprehensive, fully resourced national strategies to eliminate violence against women and girls, which include robust mechanisms to prevent, investigate and punish violence.
  - Guarantee provision of health services, including post-exposure prophylaxis, legal services and social protection for survivors of violence.
• Ensure that the rights to equality and non-discrimination of all persons in Botswana are guaranteed in the context of marriage including by aligning the customary, Muslim, and Hindu and other marriage laws and regulations with rights applicable to civil marriages and in line with the Constitution, and regional and international treaty obligations and standards.
  o This includes ensuring the protections of the Marriage Act (including minimum age of marriage), the Abolition of Marital Powers Act and the Matrimonial Causes Act are applicable to all marriages, including customary, Muslim, Hindu and other religious marriages.
• Ensure that the law equally protects persons married out of community of property as those married in community of property in every respect.
• Ensure implementation of the National Sexual and Reproductive Health Programme Framework, Policy Guidelines and Service Standards on Sexual and Reproductive Health including access to:
  o comprehensive SRHR information, including on HIV prevention and pregnancy prevention;
  o contraceptives and family planning services for all sexually active persons, including adolescents and youth without requirements of parental, partner, or other third party consent; and
  o comprehensive information on safe, legal abortion and post-abortion care and non-discriminatory quality abortion and post-abortion care services.
• With the aim of reducing illegal and unsafe abortions which risk the lives, health and well-being of all women, with disproportionate impact on adolescents, re-consider the criminalisation provisions with a view toward broadening the categories of circumstances under which termination of pregnancy will be provided.
  o Ensure that those falling with categories of persons lawfully able to access abortion, are in fact able to access and enforce their rights, including by providing trainings to health care workers.

RECOMMENDATIONS: Children, Adolescents and Young People

• Ensure that penal code provisions prohibiting abuse, violence and other violations and the Children’s Act are fully implemented and enforced including by providing training and conducting sensitisation and outreach on the protective and other provisions of the Children’s Act, including the provisions prohibiting abuse and harmful practices, and those protecting children’s rights to inter alia, health, education and the right to participate in decision making.
  o Trainings and sensitisation should be conducted for law enforcement officers, health workers, educators and community members.
• Encourage reporting of cases of sexual and other violence by providing information (in pamphlets or in other forms), including how to report a case and relevant procedures.
• Ensure that every reported case of sexual and other violence, abuse and harmful practices is handled in a sensitive manner, thoroughly investigated, and where appropriate, prosecuted.
• Ensure that law enforcement officers are adequately trained to deal with issues of sexual and other violence and abuse, including through regular training and ensure adequate oversight.
• Conduct sensitisation on the law and children’s rights, including under customary law, with a focus on remote areas. In particular, provide information on the age of consent laws, the minimum age of marriage and the prohibition of abuse and harmful practices.
• Ensure that in and out-of-school children and adolescents and their parents and guardians are provided with information on their human rights under inter alia, the Children’s Act including the rights to health, education, participation in decision-making, and the right to protection from abuse, exploitation and harmful practices.
  o Ensure that in and out-of-school children and adolescents are provided with information on how to report a case of abuse or violence, including to a teacher, school counsellor, police officer, or another appropriate adult.
Sexual and Reproductive Health and Rights

• Through inter alia, provision in law and policy, trainings, sensitisation and oversight, including with service providers, young people and their parents and guardians, ensure that the Ministries of Health and Wellbeing and Education collaborate to provide adolescents and young people with access to comprehensive SRHR services without discrimination on the basis of inter alia, age including HIV testing as well as information on TB and those included in the SRH Guidelines:
  o IEC and advocacy to the general public
  o IEC and counselling on ASRH issues and for behaviour change
  o Provision of FP services
  o Provision of ANC and PMTCT, delivery and PNC
  o Provision of Post Abortion Care
  o Management of STIs, HIV and AIDS
  o Provision of HIV VCT (Pre and Post Test Counselling)
  o Family Life Education
  o Cervical cancer screening

• Ensure that all vulnerable groups, including those specified in the SRH Guidelines, have access to comprehensive SRHR services including through targeted programming, outreach and sensitisation.

Age of Consent Laws

• Review existing age of consent laws to ensure that they are in line with international and regional guidelines and to ensure legal harmonisation, clarity as well as harmonisation with enabling policies.
• In line with the SADC PF Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, amend the Marriage Act and take any other steps to effectively prohibit marriage for all persons under the age of 18 without exceptions and without discrimination. This includes cases where there is parental consent and civil, customary, Muslim, Hindu and other religious marriages.
• Clarification and harmonisation of the age of consent for accessing health care services, including medical treatment, contraceptives, harm reduction and drug treatment services and to participation in medical research is recommended.
• In light of evidence that persons below the age of 16 in Botswana are sexually active and are unable to access health services, including HIV-testing and treatment without parental consent, consider review of the age of consent laws to health care services, including medical treatment, HIV and TB testing and treatment, to allow access to services for persons younger than 16 without parental consent.
• Consider enacting a policy, frameworks, strategies and/or plans which provide for and facilitate support to promote child and adolescent adherence, including for those without adequate parental or other support.
• Ensure that adolescents and young people are provided with comprehensive HIV, TB and SRHR-related information (as set out in Education and Information Section below) and information on laws and policies that enable them to realise their human rights.
RECOMMENDATIONS: People with Disabilities

• Take concrete steps to enact into law the Bill on Disability.
  o Ensure that the law prohibits discrimination on the basis of disability.
  o Ensure that the legal framework (i) guarantees the rights of people with disabilities, in line with international standards, and (ii) addresses management of disability. The law should be evidence-informed, addressing human rights issues and practical issues facing people with disabilities. Enact policies, strategies and frameworks that facilitate implementation of the law, including the draft revised Policy on Disability. It is recommended that the law and policy:
    - Provides specific measures and programmes that ensure and facilitate access to health facilities for people with disabilities including for HIV and TB prevention, treatment, support and management for people with disabilities.
    - Provides specific measures and programmes to ensure access to education and information for people with disabilities, including on HIV, TB, SRHR and other health-related information.
    - Includes a complaint mechanism and procedures for people with disabilities to report violations of their rights.
• Signature and Ratification of the Convention on the Rights of Persons with Disabilities.
• In line with the Continental Plan of Action for the African Decade of Persons with Disabilities and other commitments, ensure that HIV, TB and SRHR-related information is available and delivered in appropriate and accessible formats (i.e. braille).
• Ensure that HIV, TB, health-related, and other relevant laws, policies, plans and programming address HIV prevention, testing and treatment meet the needs of people with disabilities, including through research, oversight and evaluation.
• Ensure that provisions of the current Policy on Disability and other existing policies and commitments that address disability are fully implemented including inter alia:
  o maintaining a system of care for people with disabilities;
  o ensuring that the welfare of people with disabilities is taken into account in educational, health and other programmes; and
  o ensuring that people with disabilities are not disadvantaged in securing employment.
  o Ensure all the provisions and strategies in the National Development Plan for 2009-2016 relevant to people with disabilities have been fully implemented including inter alia establishing a Centre for Disability and an assessment centre for children with disabilities.
  o Implementation of priority action items and other objectives of the Continental Plan of Action for the African Decade of Persons with Disabilities is recommended.
• Facilitate research on the health needs of people with disabilities in the context of health to ensure that policies and programmes are evidence-informed and effective.
  o It is recommended that research includes barriers to HIV and TB-related and other health services for people with disabilities and the extent to which people with disabilities have access to HIV-related health services.
  o The inclusion of people with disabilities is recommended, as well as the collection of information pertinent to people with disabilities in national surveys including BIAS, TB surveys and Demographic Health Surveys. The provision of disaggregated information on people with disabilities and the extent to which people with disabilities have access to HIV-related health services.
  o The inclusion of people with disabilities is recommended, as well as the collection of information pertinent to people with disabilities in national surveys including BIAS, TB surveys and Demographic Health Surveys. The provision of disaggregated information on people with disabilities would help ensure that their needs can be effectively addressed.
RECOMMENDATIONS: Migrants

• Signature and ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

• Ensure implementation of commitments under the 2011 and 2016 Political Declarations on HIV and AIDS, including to address through national legislation the vulnerabilities to HIV of migrant and mobile populations and support their access to HIV prevention, treatment, care and support and ensure financial resources are targeted to address the HIV-related needs of migrants, as well as TB-related needs of migrants.

• The inclusion of migrant and mobile populations in national policy documents including National Strategic Frameworks is recommended.

• Clarify which illnesses are ‘prescribed’ for purposes of immigration. Ensure that HIV and TB status are not a ground for prohibiting entry and presence in Botswana.

• Clear provision in law and policy that mandatory HIV tests, including for purposes of entry, are illegal and therefore not part of the medical examination requirement for university and other students and staff, is recommended.

• Ensure that refugees and those claiming asylum are not being detained or held in prisons with the general prison population. Review the law on refugees against international and regional standards.

• Clear provision in law and policy for access to comprehensive HIV and TB-related health services for refugees, including prevention, testing, treatment, care and support, is recommended.

• Ensure, through provision in law, that all migrants have access to HIV and TB-related health services, including free testing, treatment, care and support. In particular, ensure that the most vulnerable migrants including sex workers have access to such health services.

• Clarify, through law and policy, the rights of agricultural and other migrant workers including minimum monthly medical leave and paid benefits.

  o Ensure that migrant workers, including hourly workers, have adequate medical leave to access health facilities, including workers who must travel to receive HIV and TB treatment and other services.

  o The provision of medical leave payment would promote treatment retention and health-seeking behaviour.

  o Requiring employers, including farms and mines, in remote areas to provide for or help facilitate transportation to health facilities would increase access to health services for their employees.

  o In addition to ensuring adequate paid medical leave, through law, policy and programming, address HIV and TB risk factors of migrant workers including, inter alia, ensuring adequate home leave, the provision of HIV and TB-related information, prevention, testing, treatment and support.

• To ensure that continental and regional voluntary and forced migration practicalities are regulated and the human rights of migrants are protected, domesticate the African Union migration policy framework and SADC labour migration policy.

• To ensure that migrants in Botswana have access to social safeguards, align the national framework with the SADC Code on Social Security.

• To ensure accurate information is available, include migrants and gather information pertinent to migrants in national surveys including BIAS, TB surveys and Demographic Health Surveys. Provide disaggregated information on migrants to ensure that their needs can be effectively addressed.
RECOMMENDATIONS: Remote Area Dwellers

• In the post-2017 National Strategic Framework and other HIV and TB policy documents, consider inclusion of specific measures addressing the needs of all remote area dwellers as well as specific measures addressing the needs of indigenous persons in Botswana.

• Specific provisions through law and policy that protect the rights of remote area dwellers, including the right to non-discrimination and non-discriminatory access to health services, would strengthen their rights.

• Implementation of a specific multi-sectoral framework, policies and programmes (or otherwise incorporate into existing frameworks, policies and programmes) that address the health needs of remote area dwellers is recommended. It is further recommended that the process of developing frameworks, policies and programmes is participatory and consultative and that frameworks, policies and programmes address the specific needs of remote area dwellers including inter alia:
  o Specific measures to facilitate access to HIV and TB information, prevention, treatment, support and care for remote area dwellers (i.e. mobile clinics).
  o HIV, TB and SRHR-related information which is delivered in appropriate languages and formats, including for example, through audio-visual presentation for those who may not have had formal education or who are illiterate.
  o Frameworks, policies and programmes should take into account traditional preventative care, healing practices and medicines;

• Ensure that the law provides remote area dwellers, including hourly workers, with adequate paid medical leave to allow them to access health facilities, including those who must travel to receive HIV and TB treatment and other services. The law should require employers in remote areas to provide or facilitate transportation to health facilities.

• Inclusion of remote area dwellers and gather information pertinent to these groups in national surveys including BIAS, TB surveys and Demographic Health Surveys would ensure the availability of accurate information. Provide disaggregated information to ensure that their needs can be effectively addressed.

• Strengthen the (Revised) Remote Area Development Programme by ensuring the programme recognises the need to prioritise remote area dwellers as a vulnerable population, involves all relevant sectors, is fully implemented and available in all areas and to all persons without discrimination.
RECOMMENDATIONS: Criminalization of HIV and Communicable Disease Transmission and Exposure and Other Punitive Provisions

• Section 58 of the Public Health Act and Section 184 of the Penal Code should be reviewed, to ensure that they are not inappropriately applied to HIV and TB and are in line with recommendations of the Global Commission on HIV and the Law, UNAIDS and other international and regional standards. Guidance should be developed as to application. The Act should affirm and protect the right to health for all, including the rights of people living with HIV and/or TB.
• In line with the Global Commission on HIV and the Law recommendation, Botswana should ensure that prosecution for HIV transmission is only available in very limited circumstances, when transmission is actual and intentional and prosecutions are pursued with high levels of evidence. Additional safeguards should be implemented to ensure that prosecution does not infringe the right to privacy and other human rights, such as disclosure of HIV status.

RECOMMENDATIONS: LGBTI People

• It is recommended that laws that discriminate against LGBTI persons, including laws that criminalise consensual sexual relations between adults of the same sex are reviewed against international standards. In line with the recommendations of GCHL and the Human Rights Committee and to meet regional and international human rights obligations to prevent discrimination and abuse of LGBTI people and ensure access to HIV-related health services, repeal sections 164, 165 and 167 of the Penal Code.
• Review laws and regulations including “nuisance,” “public disorder,” “cross-dressing,” “impersonation” and similar offences, which are used to target, blackmail, harass, abuse, arrest and otherwise commit human rights abuses against LGBTI people and repeal or revise those that are used to target and victimise LGBTI persons and other vulnerable groups.
• Given the practical challenges and the risk of rights violations when individuals have identity documents “mismatched” with their gender identity, review section 16 of the National Registration Act with the aim of ensuring transgender and intersex persons are able to change the gender marker on their identity cards. If this law is changed, it would be beneficial to review additional legal provisions concerning gender identity to ensure harmonisation.
• Consider reviewing whether a third gender (in addition to male and female) should be an option on identity documents for intersex and other gender non-conforming persons who do not identify as male or female.
• Ensure that every case of violence, abuse against and victimisation of LGBTI persons is thoroughly investigated, and where appropriate, prosecuted.
• Ensure that effective legal mechanisms exist for victims, including LGBTI persons, to report cases of violence, abuse and victimisation committed by state actors, including law enforcement officers.
• Ensure that law enforcement officers, health workers and other government officials receive human rights trainings and information confirming the universal application of human rights, which are guaranteed to all persons including LGBTI persons, as well as specific training and information on the specific human rights issues facing LGBTI persons.
• It is recommended that steps be taken to prevent abuse, discrimination and breaches in confidentiality of LGBTI persons in health facilities, including by:
  o implementing human rights and ethical guidelines for health providers that protect and respect the rights of LGBTI persons, men who have sex with men and women who have sex with women;
  o facilitating human rights trainings which include information on sexual and gender diversity for health providers; and
  o ensuring that there are effective mechanisms in place for victims to report violations.
• Ensure there are adequate protective measures that guarantee the right to non-discriminatory access to quality HIV and TB-related and other health services for all persons, including LGBTI persons.
• Implementation of specific policies, plans and frameworks (within existing policy documents or in separate policy documents) that outline how the government will ensure that LGBTI people have comprehensive and non-discriminatory access to HIV and TB-related health services is recommended.
• Conduct public outreach and sensitisation on LGBTI rights issues and the impact of LGBTI-related discrimination on the HIV response and human rights implications.

RECOMMENDATIONS: Sex Workers

• Review all penal and other laws that criminalise aspects of sex work or are otherwise used to arrest, harass and abuse sex workers including those prohibiting procurement, solicitation, living off the earnings of sex work, brothel keeping, idle or disorderly public conduct and ‘rogue and vagabond’ laws, ensuring alignment with international standards.
• Review laws, regulations and ordinances such as ‘nuisance,’ ‘loitering,’ ‘public order’ and any other similar laws which are used to target, blackmail, harass, abuse, arrest and otherwise commit human rights abuses against sex workers and repeal or revise those that are used to target and victimise sex workers and other vulnerable groups ensuring alignment with international standards.
• Ensure that every case of violence, abuse against and victimization of sex workers is thoroughly investigated, and where appropriate, prosecuted.
• Ensure that effective legal mechanisms exist for sex worker victims to report cases of violence, abuse and victimisation committed by state actors, including law enforcement officers.
• Ensure that law enforcement officers, health workers and other government officials receive human rights trainings and information confirming the universal application of human rights, which are guaranteed to all persons including sex workers, as well as specific training and information on the specific human rights issues facing sex workers.
• It is recommended that specific steps are taken to prevent abuse, discrimination and breaches in confidentiality of sex workers in health facilities, including:
  o implementing human rights and ethical guidelines for health providers that protect and respect the rights of sex workers;
  o facilitating human rights trainings for health providers; and
  o ensuring that there are effective mechanisms in place for victims to report violations.
• Ensure the provision of adequate protective measures that guarantee the right to non-discriminatory access to quality HIV and TB-related and other health services for all persons, including sex workers.
• Ensure implementation of specific policies, plans and frameworks (within existing policy documents or in separate policy documents) that outline how the government will ensure that sex workers have comprehensive and non-discriminatory access to HIV and TB-related health services.
RECOMMENDATIONS: People Who Use Drugs

- Consider conducting a baseline study on people who use drugs and HIV and TB prevalence, risks and challenges, including to assess legal and other barriers to HIV and TB prevention and related health services.
- Consider reviewing existing legislation, with a view towards repealing laws inconsistent with a human rights-based approach to effectively addressing the needs of people who use drugs and consider enacting legal and policy provisions that allow for, facilitate and regulate, harm reduction strategies to prevent HIV infection and to safeguard the health rights of people who use drugs, in line with the recommendations of the Global Commission on HIV and the Law and international standards.

RECOMMENDATIONS: Employment and Labour

- Ensure full implementation, enforcement and awareness of the existing legal protections for people living with HIV and TB in the public and private sectors, including the Employment Amendment Act, the Public Service Act, court decisions upholding the rights of people living with HIV, and relevant policies through awareness trainings of employers and employees, provision of guidelines, and monitoring of employment practices.
- Review the existing employment laws and policies (including the Employment Act, the Public Service Act, and related policies) in line with ILO Recommendation 200;
- Consider amending the Employment Act or otherwise enact a law and policy that clearly provides for reasonable accommodation to ensure people living with HIV and TB have access to and are able to participate and advance in employment.
- Ensure that existing internal redress mechanism for labour discrimination adequately address workplace discrimination against people living with HIV, TB and key and vulnerable populations.

RECOMMENDATIONS: Education and Information

General

- During review of the Education Act and other legislative and policy review, consider provision in law for the right to non-discrimination in education on the basis of HIV and health status (as is provided in the HIV and AIDS policy).
- During review of the Education Act and other legislative and policy review, consider provision in law and policy guaranteeing access to accurate and comprehensive HIV and TB-related education and information for all persons with focus on vulnerable groups, including adolescents and youth, LGBTI persons, sex workers, prisoners, migrants, remote area dwellers and people with disabilities.
- Strengthen stigma and discrimination reduction campaigns amongst communities, service providers (e.g. health care workers) and law enforcement officials, to reduce HIV and TB-related discrimination and discrimination against vulnerable and key populations at higher risk of HIV exposure.
Comprehensive SRHR Education, Information and Commodities

• Since the Life Skills Framework, the Guidance and Counselling Policy, the School Health Policy, and the Adolescent Sexual and Reproductive Health training manual are under review, this is an opportunity to ensure that these and other policies and frameworks clearly set out the requirements of in school and out of school programmes on HIV-related information and education, including on safe sex and provide adequate guidance to teachers.
• Consider reviewing and updating the 1992 policy for schools on HIV to ensure it addresses the needs of students.
• Ensure full implementation of a comprehensive sexuality curriculum into primary and secondary schools which includes information on HIV, TB, reproductive health, rights and physiology, sexual relationships, contraception and adolescent pregnancy, and negotiation/decision making skills as they pertain to sexual relationships.
• Through policy and school curriculum, clearly provide for distribution of contraceptives in schools, including by school nurses or other appropriate school staff. Dialogue between health, education, parents, children to discuss provision of condoms is recommended, to ensure coherence amongst policies to provide ongoing support to adolescents beyond provision of condoms.
• Ensure that teachers are adequately trained and provide accurate information on HIV, TB and sexual and reproductive health and rights, including information on safe sex.
• Human rights education and training should be strengthened and further integrated into the school curricula through provision into existing frameworks (i.e. life skills and other) and programmes should be available for out-of-school children, adolescents and youth. Programmes should include age appropriate information about HIV, TB, stigma and discrimination and human rights which includes safe sex education at an early age. Such programmes should also be available in the health system, within the working environment and amongst law enforcement officials.

Awareness and Sensitisation

• Intensify community awareness and education campaigns on HIV, TB, law and human rights, including by monitoring, evaluating and continuing to support existing programmes and by developing media in local languages on HIV and human rights issues. Programmes should specifically target and include information on issues and laws relevant to all vulnerable and key populations and on existing protective laws and policies.
• Information and sensitisation campaigns should be introduced for judicial officers, to ensure on-going and updated information for all judicial officers on HIV and human rights issues.
• Information and sensitisation campaigns should be introduced for law and policy-makers, to support the efforts of all decision-makers to develop supportive and effective legal and regulatory frameworks for HIV, AIDS and TB.
• Awareness and education on HIV, AIDS and TB as well as training on reporting on HIV and TB specific issues for the media personnel.
RECOMMENDATIONS: Social Welfare

• Conduct research on the extent to which people with HIV and TB have meaningful access to social welfare and support systems. Address any gaps that would improve their health outcomes and the well-being of them and their families.
• Ensure that adequate systems are in place to provide adequate social welfare and support for individuals with HIV-related disabilities.
• Ensure that social welfare protections and programmes are available without discrimination to people living with HIV and TB.

RECOMMENDATIONS: Awareness of HIV, Law and Human Rights and Legal Support

• Clarify, through law and policy, which matters qualify for legal aid with a view towards ensuring that matters concerning constitutional rights and discrimination qualify.
• Strengthen legal support services and mechanisms for enforcing HIV and TB-related human rights complaints and redress mechanisms, including by ensuring full accessibility and sufficient availability of resources, including in rural areas;
• Increase the capacity of legal support services to provide support services for HIV and TB-related human rights violations
  o Ensure that legal aid is available for individuals in all areas of the country to access legal representation and services.
  o Ensure meaningful access to legal aid for individuals living in remote areas;
• Conduct outreach and practical engagement to ensure those who can benefit from the legal aid are aware of its existence and scope.
• Ensure provision of support to CSOs who provide legal representation and advice on the law and human rights.
• Provision of law and human rights information, trainings and sensitisation on the law, human rights, HIV and TB; and
• Provision of education and training for all, including key populations and service providers such as health workers.

RECOMMENDATIONS: The Office of the Ombudsman

• Increase the capacity of the Ombudsman and key government offices, and institutions to provide support services for HIV and TB-related human rights violations

RECOMMENDATIONS: The Courts

• Research the extent to which key and vulnerable populations have adequate legal protection through enforcement of existing criminal laws, including in the context of gender-based and other violence, as well as violence against LGBTI persons and sex workers. Address gaps and challenges through law, policy and monitoring and accountability.
• Ensure law enforcement officers are adequately trained on the law and sensitised to the needs of victims of gender-based and other violence.
• Research the extent to which the rights to gender equality and other HIV and TB-related human rights are enforced under customary law.
• Sensitise judiciary (including customary) on law and human rights issues affecting people living with HIV, TB and other vulnerable and key populations.
• Ensure that customary courts, traditional leaders and other relevant stakeholders are trained on the law and human rights relevant to HIV, TB and gender equality.
• Ensure, through legal provision and enforcement of the law and oversight, that customary courts are enforcing constitutional and other human rights, including the rights of people living with HIV, TB and the right to gender equality.
RECOMMENDATIONS: The Police Service

• Key informants indicated that there is a need to provide training and sensitisation for police officers on human rights, the law and HIV-related issues, with a focus on gender, rape and gender-based violence; LGBTI rights and protection; and sex worker rights and protection. Issues and cases pertaining to these and other issues are not always handled properly and with sensitivity, hindering access to justice for victims. Trainings should include:
  o information on the universal application of constitutional and human rights, which are guaranteed to people living with HIV and TB and key and vulnerable populations;
  o specific training and information on the specific human rights issues facing people living with HIV and key and vulnerable populations.
• Ensure that every case of violence, abuse against and victimisation, including those committed against key and vulnerable groups is thoroughly investigated, and where appropriate, prosecuted.
• To encourage reporting of rights violations and meaningful access to justice, steps should be taken to ensure that all law enforcement personnel perform their duties appropriately, with competency and in a non-discriminatory manner, including through use of internal regulatory and ethical boards and committees. Ensure that effective legal mechanisms exist for victims, to report cases of violence, abuse and victimisation committed by state actors, including law enforcement officers.