REVIEW ARTICLE

Reproductive health and the question of abortion in Botswana: A review

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Abstract

The complications of unsafe, illegal abortions are a significant cause of maternal mortality in Botswana. The stigma attached to abortion leads some women to seek clandestine procedures, or alternatively, to carry the foetus to term and abandon the infant at birth. I conducted research into perceptions of abortion in urban Botswana to understand the social and cultural obstacles to women's reproductive autonomy, focusing particularly on attitudes to terminating a pregnancy. I carried out 21 interviews with female and male urban adult Batswana. This article provides a review of the abortion issue in Botswana based on my research. Restrictive laws must eventually be abolished to allow women access to safe, timely abortions. However, my findings suggest that socio-cultural factors, not punitive laws, present the greatest barriers to women seeking to terminate an unwanted pregnancy. These factors must be addressed so that effective local solutions to unsafe abortion can be generated. *(Afr J Reprod Health 2013; 17[4]: 26-34).*

Keywords: Abortion, Botswana, maternal mortality, Africa, women.

Résumé

Les complications de l'avortement dangereux et illégales, constituent une cause importante de la mortalité maternelle au Botswana. La stigmatisation liée à l'avortement conduit certaines femmes à avoir recours à des procédures clandestines, ou encore, à mener le fœtus à terme et à abandonner l'enfant à la naissance. Nous avons effectué des recherches sur la perception de l'avortement en milieu urbain au Botswana afin de comprendre les obstacles sociaux et culturels à l'autonomie de la reproduction chez les femmes. Nous avons mis l'accent surtout sur les attitudes permettant d'interrompre une grossesse. Nous avons recueilli 21 entrevues auprès des femmes et des hommes adultes du milieu urbain au Botswana. Cet article constitue un examen de la question de l'avortement au Botswana d'après mes recherches. Il faut, en fin de compte, supprimer les lois restrictives pour permettre l'accès des femmes à l'avortement en temps opportun sûr. Les résultats suggèrent cependant que les facteurs socioculturels, des lois non punitives, constituent les plus grands obstacles pour les femmes qui cherchent à interrompre une Fgrossesse non désirée. Il faut aborder ces facteurs afin de trouver des solutions locales efficaces aux avortements dangereux. *(Afr J Reprod Health 2013; 17[4]: 26-34).*

Mots clés: avortement, Botswana, mortalité maternelle, Afrique, femmes

Introduction

Botswana is a sub-Saharan African country bordered by Namibia, Angola, South Africa, Zambia and Zimbabwe. It has maintained a multi-party democracy since independence in 1966 and has remained politically stable. The economy has experienced rapid growth since the discovery of mineral deposits in 1967. Botswana is the only African country deemed one of the world's 13 'economic miracles'[1]. It has invested its diamond wealth in education, health, employment and infrastructure with notable results. The national language is Setswana and the official language is English. People from Botswana are collectively referred to as *Batswana*, and individually as *Motswana.* The population estimate for 2011 was 2,065,398[2]. The 2001 census showed 72% of Batswana identified themselves as Christian, under one percent were Muslim, and 21% stated no religious affiliation[1].

I lived in Botswana's capital, Gaborone, working as a volunteer teacher for 16 months in

2010-2011. During that time, I observed obstacles to women's reproductive choice, which appeared out of alignment with a rapidly modernizing society. I met women who had felt compelled to surrender their personal aspirations because they were unable to terminate an unwanted pregnancy either because of social or familial pressures, or because abortion on request was not available in Botswana. I encountered a small number of women who were being forced to track down clandestine providers, and many more who had made the expensive and time-consuming journey to South Africa to procure an abortion in a legal setting. I read newspaper reports about women being prosecuted for involvement in abortion; the suicides of pregnant teenagers; deaths caused by dangerous 'backyard' abortions; and babies and foetuses being found abandoned or buried[3-7]. I was struck by the implication of these incidents; that there is an unmet need for safe, legal and accessible abortion in Botswana.

Women's position in Botswana today

The situation of women in Botswana must be appreciated to understand the problem of unsafe abortion. There is notable tension between traditional culture and the new values accompanying development. 'Cultures resistant to women's equality with men have unselfconsciously perpetuated women's subordination and powerlessness as a "natural" condition of family life and social order so profoundly as often to render women's disadvantage invisible'[8]. This quote is pertinent in the case of Botswana where the norm of submissive female obedience has permeated socialization to the extent that it can be difficult to recognise[9-10]. In the gender-related development index Botswana ranks 109 out of 157, illustrating that gender inequalities remain an issue[11]. While most women live autonomously in many respects, they 'continue to negotiate their gender identities against a background of internalized cultural values'[12].

Women often manage simultaneously modern and traditional lifestyles, sharing their time between their rural homes and their city workplaces, valuing their independence while operating within the customary patriarchal system. An NGO study found that young people in Botswana expect women in rural communities to be subservient, yet view women in the city as determined to seize their independence[13]. The boundaries of patriarchy in Botswana are becoming increasingly fluid as women begin to move away from conventional gender roles[14].

Traditionally, the *lobola* (bride price) system represented the purchase of a woman's reproductive function, shifting 'ownership' from her family to her husband's family. Having paid *lobola,* the new husband was entitled to total sexual and physical control over his wife under customary law[15-16]. Customary law operates alongside common law today but is ring-fenced and thus not subject to constitutional obligations that protect women's rights, and the historical practice of *lobola* persists.

Women's bodily autonomy continues to be undermined by such practices, and by their economic dependence on men. Although employment opportunities in the formal sector are growing, the positions available to women are limited and poorly paid. Many women are either unemployed or engaged in unstable domestic work, leaving them vulnerable to exploitative interactions with men who can provide financial support. In such relationships, a woman's reproductive decision-making power is often compromised due to her subordinate position.[17].

Gendered rules of behaviour mean that if a woman is raped, she was 'asking for it' by acting inappropriately[18]. STDs are generally perceived to be women's diseases, some believe HIV can only be contracted from a woman[17]. This belief system extends to holding women culpable for unintended pregnancies, it is thought that they risk pregnancy by choosing to have sexual intercourse. To have an abortion is hence viewed as avoidance of responsibility, the woman must bear a child as punishment for her lascivious behaviour[8]. In a nation where men generally dominate sexual decision-making, this punitive approach has especially damaging consequences for women's health rights.

Botswana has seen great social change since independence, although the benefits of modernisation have unevenly favoured men. The unemployment rate for women is consistently higher than that for men[12], and there is no space for

women to participate genuinely and effectively in law or politics[19]. Botswana's system is inherently contradictory, a modern, democratic state, proclaiming the equal rights of all citizens, it is still fundamentally patriarchal[19]. Current restrictive abortion laws, high levels of domestic violence against women, and increasing incidence of rape would suggest that society's gravitation towards individualistic, autonomous lifestyles has not extended into the realm of women's bodily autonomy.

The government and women's rights

The government of Botswana, aided by NGOs and donor agencies, has made some important commitments to establishing women's rights[10]. These include the formation of the Women's Affairs Division and the accompanying National Gender Framework; Vision 2016, which is rooted in national principles of democracy, equality and autonomy; the Platform for Action following the 1995 Beijing World Conference on Women; the signing of international instruments for gender equality, including the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Southern African Development Community (SADC) Declaration on Gender and Development and the Protocol to the African Charter on the Rights of Women; Millennium Development Goals (MDG); the Declaration of the International Conference on Population and Development; the Constitution; National Development Plan 9 (NDP9); and the instigation of a comprehensive review of gender-discriminatory laws, which has resulted in numerous reforms[10-20].

Despite this impressive inventory of programmes aimed at eradicating gender inequality and advancing women's health rights, women continue to be socialised into subservient, dependent roles, unable to participate in sexual decision making and thus made vulnerable to rape, forced pregnancy and unsafe abortion. 'Tradition' is invoked all too often as a defence against the gendered roles that hinder women's autonomy[21].

The government claims it is committed to revising all discriminatory laws and altering the damaging cultural attitudes that currently prevent women from making full use of healthcare and family planning resources. Botswana is a signatory to international instruments that specify the importance of women's sexual and reproductive health and rights. This includes CEDAW, which states that withholding medical services needed only by women, such as abortion, is discriminatory[22]. Yet, the Abortion Act has not been included in the State's otherwise extensive legal reforms. Failure to acknowledge that a restrictive abortion law damages women's health contradicts the government's pledge to address gender equality within the law.

Reproductive health versus maternal mortality

Botswana's healthcare system is funded by 18% of the total budget and resources are distributed throughout rural areas via an outreach system[1]. The country has witnessed rapid fertility decline, from 7.1 in 1981 to 2.9 in 2007[11] and 2.5 in 2011[2]. Fertility according to education level shows marked disparity. The fertility rate for women with no formal education is 5.8. For university-educated women it is 2.7. The fertility transition is partially a result of the family planning programme in Botswana. Deemed the most effective in Africa, it is incorporated into maternal and child health services and is free and accessible[1]. By 2007, 95% of the population lived within 8km of a healthcare facility and 90-99% of births were assisted by skilled birth attendants. In 2010 only 1% of births did not take place in a clinic or hospital[23], and 94% of women received antenatal care[11].

Despite improvements in reproductive health, maternal mortality remains very high, and its causes must be addressed[24]. MDG target 5a is a reduction of the maternal mortality ratio by three quarters between 1990 and 2015. A lack of baseline data has resulted in imprecise measurement[21], although varying data sources give an impression of the situation. Figures vary from 163 to 800, although 200 to 300 is the most frequently cited range[2,11,23,25]. Botswana's MDG target for 2015 is 21[26]. Set against this goal, even the lowest figures suggest inadequate progress. A significant cause of maternal mortality in Botswana is unsafe, illegal abortion. This seems to have been increasing since the 1990s, which could be a result of the

desire for smaller families[27]. 3,700 women were officially treated for complications of unsafe abortion in 1992[3]. In 2007, 16% of maternal deaths were attributed to septic abortion[23]. In 2010, deaths from abortion complications were the leading cause of maternal mortality at 13.4%. After abortion-related deaths, the biggest known causes were respiratory diseases 11%, HIV-related causes 9.8%, protozoal diseases 8.6% and eclampsia 7.3%[23]. It must be noted that some women suffering from the medical consequences of unsafe abortion may present with miscarriages or unknown causes to protect themselves from the law, many more women will not receive treatment at all. Under-reporting is the likely result.

The issue of abortion in Botswana

Abortion was illegal in Botswana until 1991, when amendments were made under the Penal Code (Amendment) Bill. Pregnancy could be legally terminated within 16 weeks of conception under the following conditions: if the pregnancy was caused by rape or incest, to save the life of the mother, or in the instance of foetal impairment. The UN warns that despite this liberalisation of the abortion law, dangerous and illegal procedures occur regularly in Botswana[31]. Bureaucratic delays; lack of clearly defined protocol; negative attitudes of health facility staff; shortage of sites where the procedure may be carried out; shortage of doctors and women's lack of knowledge of their rights under the law, all contribute to denying access to the procedure even where it would be legal.

Abortion outside of the permitted circumstances is illegal. The sentence for aiding an abortion carries a maximum of seven years imprisonment. A woman who attempts the procedure herself is liable to three years imprisonment. Criminalising abortion contributes to economic injustice in developing countries[28,32]. Access to safe abortion and quality aftercare is restricted to women with resources, while those with limited means become the victims of dangerous clandestine procedures[28]. This is applicable to Botswana where those with sufficient funds and freedom of movement can procure safer illegal services from a qualified practitioner, or travel to neighbouring South Africa to access legal abortion. However, most women are restricted to 'backyard' services.

Police reports suggest that 'backyard abortion', 'foetus-dumping' and 'baby-dumping' occur regularly. In the local context, backyard abortion is a common term for unsafe abortion. This is defined by the WHO as a 'procedure for terminating an unwanted pregnancy done by persons who may lack the necessary skills or conducted in an environment that lacks the minimal medical standards, or both'[32]. Foetus-dumping refers to the concealment of a foetus following an abortion, usually through burial in pit-latrines or flushing down toilets. Baby-dumping is closely linked with infanticide, and involves the abandonment of a new-born child. In some cases the child is killed and the body is hidden, in others the child is left alive in a public place such as a hospital. It is not unreasonable to anticipate that incidences of baby-dumping would be reduced if abortion was legal and accessible.

The 'pro-life' argument – centred on the belief that abortion is equivalent to taking a human life – is arguably the most common anti-abortion position globally. It is certainly prevalent in Botswana. The Botswana Christian Council vociferously relies on such rhetoric to oppose abortion. However, this does not appear to be the basis for the legal restrictions: the Penal Code states that 'a child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother.' The law does not support the view that abortion is equivalent to murder. Accordingly, it is necessary to examine additional factors contributing to the legal prohibition and social taboo around abortion.

What it means to be a mother

I argue that the interpretation of motherhood in Botswana is important in understanding the way abortion is perceived. Motherhood is rooted in traditional culture as a signifier of womanhood. This has not diminished with modernisation. Childless women are treated with suspicion and suffer harsh consequences[17,34]. Schapera emphasises childbearing as the cornerstone of the family and society in Tswana culture[15]. Sexual and social practices are deliberately created to maximise

reproductivity. The primary reason for marriage is the production of offspring. Children are seen as key sources of labour, and they help strengthen important family ties[19]. A woman becomes an adult on becoming a mother, women are re-named in relation to their first child (for example '*Mma* Kgosi', meaning 'Mother of Kgosi').

Being able to bear children continues to be central to women's identity, and a point of great personal pride. To be perceived as infertile 'is to risk characterisation as an individual who is not seen as a Motswana'[35]. Traditionally, the blame for infertility was placed on witchcraft or a past abortion[15]. Today it is still widely considered that a man cannot be infertile, the responsibility for childlessness must fall upon the woman[35]. Women have deployed covert devices to negotiate problems arising from uncertain fecundity in their husband. Narratives of 'sleeping foetuses' to explain how a woman became pregnant while her migrant worker husband was away, are just one example[35]. Despite such evidence of women's agency, the literature is weighted towards the devastating impact of infertility on women. In this context, perceptions of abortion are inextricable from notions of fertility, motherhood, and identity.

Contextualising the abortion issue in Botswana – previous research

As discussed above, the cultural significance of motherhood curtails women's reproductive choice. However, there are further factors that contribute to the abortion issue, and to its impact on women and the community. For example, the challenges presented by a culture that defines women as subservient, and the impact of rapid developmental changes on traditional gendered roles. Central to the problem of understanding abortion is the lack of research that is specific to Botswana. The following section considers the above-mentioned issues in the wider context of women's reproductive health in Africa, and is based on prior research that has been conducted in the area.

Mogwe outlines the key points of debate that surrounded the Penal Code (Amendment) Bill of 1991. The Catholic Church, backed by the leading opposition party, actively resisted the reforms. The bill was finally passed because of pressure from the medical profession seeking to protect themselves from the law, rather than because of public demand for women's rights[33]. Mogwe argues that the extent to which the law enables women to procure abortions is dubious, particularly as they must secure a conviction through the courts to receive an abortion on grounds of rape or incest.

Notwithstanding Mogwe's article, there is little academic work that discusses abortion specifically in the context of Botswana. I have been able to gain a limited understanding of the situation by reading more widely around issues of women's health in Africa. The literature on aspects of Botswana's culture, society and history has helped me to situate my own research in a wider context. In addition, official publications from the government of Botswana and its partners in policymaking provide some useful information on women's reproductive health and rights.

Researchers have explored the position of women in traditional Tswana culture[9,15]. They highlight the gender imbalances created by a patriarchal socialisation process. Women are expected to be subservient not only to their husbands and fathers, but to all men. Schapera and Maharaj have examined the customary law practice of *lobola*[15-16], showing how it undermines women's bodily autonomy. Understanding the dynamics of *lobola* is useful for investigating contemporary issues of sexual and reproductive choice, potentially illuminating perceptions of abortion.

The capital Gaborone is beginning to witness changing norms in family structure, including increases in cohabitation and extra-marital pregnancy. Mookodi attributes this to a greater desire for autonomy in the face of new education and employment opportunities for women[12]. However, the belief that 'motherhood is rather a mandate and not an option' prevails[37], severely limiting women's prospects for control over reproductive decisions. Researchers have explored the meaning of motherhood in Tswana culture[15,17,19,34-35,37-38], emphasizing that bearing a child is tantamount to womanhood. Mogobe details the multiple ways in which being perceived as infertile can destroy a woman's social standing and identity[37].

Peters calls for further investigation into the interactions between women and men in the context

of developmental changes, my research into the socio-cultural aspects of abortion in urban Botswana will contribute to this. To some extent, inferences can be drawn from literature that explores identity, family planning, motherhood, teenage pregnancy, infertility, HIV/AIDS, rape, domestic violence, and the status of women in Botswana. However, researchers have emphasized the need for qualitative work that addresses the lack of socio-cultural research specifically focusing on abortion. Additionally, the NGO Emang Basadi demands studies that investigate the beliefs and attitudes of men and women regarding family planning.

Researchers have examined the costs of unsafe abortion[26,28,30,40-44]. They focus heavily on health-care system costs. Whilst the cost of illegal abortion is a strong argument to present to policymakers in a campaign for law reform, it is not my key focus. Rights to bodily integrity are of equal importance and my analysis will be weighted towards this paradigm. Teklehaimanot, Sai, and Benson have discussed the possibilities for a human rights approach to abortion law reform, emphasizing that reproductive autonomy is a basic right, regardless of the legal context[32,43,45]. However, until we begin to develop a localised understanding of how unsafe abortion is constructed and dealt with, attempts at generating effective human rights-based solutions will be limited.

Researchers have discussed abortion in the wider African context[26,29,30,32,41,43-44]. Where Botswana is mentioned it tends to be grouped with the sub-Saharan region as a whole. These studies shed light on the general dynamics of abortion, but merging one nation into a regional compound is problematic. Countries in sub-Saharan Africa differ significantly from one another in terms of their culture, political stability, economy and social structure, and do not share a common history. However, there may be illuminating points of contrast and comparison.

Unsafe abortion

The literature on unsafe abortion in developing countries focuses on maternal mortality and morbidity. It emphasizes that 'it is the number of maternal deaths, not abortions, that is most affected by legal codes'[28]. This signifies that, rather than reducing the number of abortions taking place, legal restrictions create a market for unsafe, clandestine services, increasing the risk of complications and maternal deaths. Hord and Wolf discuss how dangerous problems such as infection, haemorrhage, perforation, infertility and pelvic inflammatory disease are often preventable if procedures are carried out safely. Yet resources directed at reducing complications from unsafe abortion are too minimal to be effective[44]. They blame this situation on the stigma surrounding sexual and reproductive concerns in Africa, which my interviews suggest is a legitimate claim in the case of Botswana.

Mogobe et al examine the situation in Botswana, where sexual and reproductive services are supplied free in government clinics and hospitals, and yet alarming maternal mortality levels persist[47]. In agreement with Hord and Wolf, they attribute the high number of abortion-related deaths to cultural stigma, which prevents women from seeking medical attention for complications of unsafe procedures, and to Botswana's restrictive law pushing women to clandestine providers.

The 'Policy on Women in Development' declares the State's dedication to promoting reproductive health rights[24]. This pledge is reiterated in multiple reports and publications. In these documents, discussions of rape, contraception, family planning, teenage pregnancy, HIV/AIDS, maternal mortality and other related issues are extensive. However, abortion is given only a cursory mention as one cause of maternal mortality. The government has repeatedly confirmed that illegal, unsafe abortion is common in Botswana[49]. In a 253-page publication from the late 1980s, the government of Botswana and UNICEF acknowledged the tragic consequences of increased backstreet abortions, yet only six lines were dedicated to the issue.

The way forward

Official reports outline the country's goals, achievements, and strategies in the realm of women's health and rights. However, they are limited as they only state what *should* be

happening, what improvements have been attempted, and the statistical impact of these changes. They do not represent lived experiences or attitudes, and people's voices are not conveyed through numerical data. It is imperative to conduct investigations into beliefs and knowledge to gain a deeper understanding of the context of unsafe abortion, which may pave the way for a thorough examination of the issue.

Only a small number of studies have been based on the voices of Batswana rather than on statistical data[10,35,47,50]. Datta's research on gender and development involves interviews with official representatives in government and NGOs, as well as focus group discussions with groups of men[10]. Ritsema's illuminating study on HIV/AIDS in the context of rapid urban growth in Botswana is based on interviews[50], and Mogobe's study of infertility involves a wide range of people living in Gaborone[37].

The complex socio-cultural context to abortion in Botswana, coupled with the scarcity of research, present a multifaceted problem. The issue clearly impacts women's health and is inextricably linked to broader issues of women's reproductive rights, their bodily autonomy, and their position in a rapidly changing nation.

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