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OF SEXUALITY

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RAYMOND J. NOONAN, PH.D., CCIES WEBSITE EDITOR

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CONTINUUM *Complete*
International
ENCYCLOPEDIA
OF SEXUALITY

Updated, with More Countries

2004

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Botswana

Godisang Mookodi, Oleosi Ntshebe, and Ian Taylor, Ph.D.*

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Demographics and a Brief Historical Perspective

ROBERT T. FRANCOEUR

A. Demographics

Botswana is located in southern Africa, just north of South Africa, with Angola to the northwest, Zambia to the northeast, Zimbabwe to the east, and Namibia to the west. With a total area of 231,800 square miles (600,370 km²), Botswana is slightly smaller than the state of Texas. In the southwest, the Kalahari Desert supports nomadic San Bushmen and wildlife. In the north, farming is carried on amid salt lakes and swamplands. Livestock graze on the rolling plains in the east. The climate is semiarid, with warm winters and hot summers.

In July 2002, Botswana had an estimated population of 1.59 million. These estimates take into account the effects of excess mortality because of AIDS. This can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of the population by age and sex than would otherwise be expected. (All data are from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: 0-14 years: 40% with 1.01 male(s) per female (sex ratio); 15-64 years: 55.8% with 0.93 male(s) per female; 65 years and over: 4.2% with 0.68 male(s) per female; Total population sex ratio: 0.95 male(s) to 1 female

Life Expectancy at Birth: Total Population: 35.29 years; male: 35.15 years; female: 35.43 years

Urban/Rural Distribution: 63% to 37%

Ethnic Distribution: Tswana: 79%; Kalanga: 11%; Basarwa: 3%; others, including Kgalagadi and white: 7%. Note that these are mere estimates, as the government does not carry out ethnic censuses.

Religious Distribution: Indigenous religions: 85%; Christian: 15%

Birth Rate: 28.04 births per 1,000 population

Death Rate: 26.26 per 1,000 population

Infant Mortality Rate: 64.72 deaths per 1,000 live births



(CIA 2002)

Net Migration Rate: -0.24 migrant(s) per 1,000 population

Total Fertility Rate: 3.6 children born per woman

Population Growth Rate: 0.18%

HIV/AIDS (1999 est.): Adult prevalence: 35.8%; Persons living with HIV/AIDS: 290,000; Deaths: 24,000. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (defined as those age 15 and over who can read and write): 70%

Per Capita Gross Domestic Product (purchasing power parity): \$7,800; Inflation: 6.6%; Unemployment: 40% (the official rate is 21%); Living below the poverty line: 47% (2001 est.)

B. A Brief Historical Perspective

The earliest known inhabitants of the region were the San, who were followed by the Tswana. Today, over three quarters of the population are ethnic Tswana. The terms for the country's people, Motswana (*sing.*) and Botswana (*pl.*), refer to their national rather than ethnic identities. Encroachment by the Zulus in the 1820s, and by the Boers from Transvaal in the 1870s and 1880s, threatened the peace in the region. In 1885, Britain established a protectorate, known as Bechuanaland. In 1961, Britain granted a constitution to the country. Self-government began in 1965 and the country became independent the next year. Botswana is Africa's oldest democracy.

In its early years, Botswana maintained good relations with its white-ruled neighbors, but that changed in later decades as the government harbored rebel groups from Rhodesia and South Africa. Although Botswana is rich in diamonds, it has a high unemployment rate and stratified socioeconomic classes. In 1999, the nation suffered its first budget deficit in 16 years, because of a slump in the international diamond market. Nevertheless, the nation remains one of Africa's wealthiest and most stable countries.

1. Basic Sexological Premises

A. Character of Gender Roles

In Botswana, patriarchal sex/gender systems relegate males to positions of power and women to subordinate po-

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sitions within the context of cultural beliefs and practices. Patriarchal beliefs are based in cultural beliefs. Tswana culture makes a clear division between the public-political and the private-domestic spheres—women are largely relegated to domestic activities of childcare, and home maintenance. Men continue to dominate the arena of political decision-making within traditional political forums, such as the ‘kgotla,’ the house of chiefs and parliament. While women form a significant proportion of the electorate, they hold very few political positions.

Gender differences occur in the education of females and males. While there are equal enrollment rates for females and males in the first nine years of schooling, the enrollment figures for males outnumber those of females in higher levels of education, including vocational training schools. Enrollment rates at the only university in Botswana, the University of Botswana, show that the highest gender discrepancies are in the fields of engineering and technology, as well as the Faculty of Science, where the ratios of males to females are approximately 8:1 and 3:1, respectively.

B. Sociolegal Status of Males and Females

Botswana operates a dual legal system that consists of two ‘legal’ systems that are expected to operate side by side. On the one hand, there is what is known as Customary Law—which basically consists of laws based on the different customs and traditions of various ethnic groups. The second system is that of the General Law that is an adaptation of Roman and Dutch Law that was imposed during the colonial period from 1889 to 1966.

While the constitution of Botswana stipulates that there shall be no discrimination on the basis of sex, both legal systems reflect the strong influence of patriarchy. There are no clear distinctions between female and male children according to the laws. The distinctions begin at adolescence, largely in the area of punishment. In the context of customary law, corporal punishment is used within the context of ‘minor’ crimes, such as petty theft, and in minor civil offenses, such as indecent exposure and the use of insulting language. While both sexes may be sentenced to corporal punishment, it is largely practiced on male adolescents and adults.

There are certain aspects of the employment act that discriminate against women. The employment act prohibits the employment of women as soldiers in the army, as well as miners working underground.

C. General Concepts and Constructs of Sexuality, Love, Marriage, and Family

It is difficult to generalize concepts and constructs of sexuality and love, as there have been very few context-based studies on these concepts and constructs from which one can draw conclusions. Worth noting, however, is the influential work of anthropologist Isaac Schapera, who documented the customs and practices of Tswana groups in present-day Botswana and South Africa during the early part of the 20th century.

Tswana groups had gender-specific rites of passage that served to prepare young persons for adulthood and to control premarital fertility. Young adolescent males would undergo *bogwera*, which included circumcision and seclusion in the wild, during which time they would be taught survival tactics, as well as tribal laws and customs. Pubescent girls would undergo *bojale* in the village, through which they received formal instruction preparing them for the assumption of domestic and agricultural chores, as well as appropriate sexual behavior upon marriage.

Marriage in traditional pre-colonial Tswana groups was a lengthy multistage affair arranged through families, rather than by individuals. Individuals typically married soon after undergoing initiation rites. Marriage negotiations were initiated by a group comprised of the groom’s ‘key’ male relatives: his paternal uncles and male representatives from his mother’s family. These representatives of the groom’s family initiated the process by meeting with representatives from the prospective bride’s kinship group. After a period of time, the groom’s family would offer a formal betrothal. The formal betrothal (*patlo*) included the provision of gifts to the woman’s family, such as a cow, and a blanket for the paternal aunt of the woman (Schapera 1966).

The effects of socioeconomic changes and cultural diffusion are evident in present-day Botswana popular culture.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

A. Source and Character of Religious Values

According to *The World Factbook 2002* (CIA 2002) about 85% of the people of Botswana hold to indigenous religions and only 15% are affiliated with Christian denominations. However, in our view, the predominant religious beliefs in Botswana can best be described as “modified Christian.” For the larger part of the 20th century, the religious institutions that were given legitimacy in Botswana were those from Western countries. These included: the Roman Catholic Church, the Anglican Church, the London Missionary Society, the Dutch Reformed Church, and others.

While traditional indigenous religious rites, such as ancestor rituals, were largely outlawed during the colonial era, many of these indigenous beliefs have been integrated with Christian doctrine in the new “spiritual” churches. Many of the “new” churches follow a Christian dogma that integrates aspects of traditional cultural practices—some of which have been outlawed. One example is the practice of polygamy, which was outlawed before independence. Polygamy is practiced under customary traditions among the Mazeduru; however, it is practiced “informally” within the context of some religious movements.

B. Source and Character of Ethnic Values

Botswana is a country that is characterized by ethnocultural heterogeneity. The nation is essentially composed of a number of ethnic groups, each of which has their own languages—some of which are variations of dialects. These ethnic groups have their own peculiar customs and beliefs.

The ethnic groups can generally be divided into two main categories: Setswana-speaking and non-Setswana-speaking groups. The main Setswana-speaking groups include the Bakwena, Bangwaketse, Bangwato, Bakgatla, Barolong, Bamalete, Batawana, and Batlokwa. The common feature among these groups is that they all share Setswana as a common language. They do, however, use different dialects of Setswana. The non-Setswana-speaking groups include the Basarwa (San or Bushmen), Bakalanga, Baherero, Bayei, Bambukushu, Basubia, as well as people of European, Asian, and African origin.

It must be noted that Setswana is the official language. This is justified on the basis that most of the citizens of Botswana are Setswana-speaking groups. This integration of other ethnic groups has many implications for the interpretation of culture and tradition, and perhaps explains why there is a scarcity of information on sexuality within the context of cultural diversity.

3. Knowledge and Education about Sexuality

A. Government Policies and Programs

Botswana has no policy on sex education. Issues of sexuality are highlighted in the National Population Policy, and are discussed under Reproductive Health. The school curricula offer adolescent and sexual reproductive health through Guidance and Counseling. Other school subjects, such as science, also subscribe to the idea of Sexual and Reproductive Health. This is reflected by the topics that are integrated into the school curricula: personal guidance, social guidance, sexuality and HIV/AIDS, family life education, teenage pregnancy and HIV/AIDS, sexually transmissible infections and HIV/AIDS, as well as HIV/AIDS care and support. Topics are more comprehensive and detailed for secondary-school level than they are for primary-school level.

B. Informal Sources of Sexual Knowledge

There exists among the Tswana the tradition of reticence on sexual matters between parents and young people. Young people are more comfortable discussing sexuality with their friends and other members of the extended family than they are with their parents. Studies done in the country show that parents are uncomfortable talking about sexuality with their children, but for others, it may be just lack of access to sexual health information and services.

It is also evident that sexual norms have changed over time in Botswana, and parents feel they can no longer exercise control over their children as compared to the past, where relationships between young people were governed by strong societal norms that protected them. These norms also encouraged their respect for elders. However, in spite of little contribution by parents as a source of sex education, there seems to be a considerable amount of information about AIDS and increasing condom use among the youths. The sexual attitudes of youth are positive about condom use, and they are more likely to be engaged in safer sexual practices now than in the 1990s, even though their sexual behaviors are still risky.

4. Autoerotic Behaviors and Patterns

Most people in Botswana do not feel very comfortable talking about their own sexuality, and autoeroticism is no exception. However, negative attitudes towards such behavior appear prevalent in Botswana. As one sex education magazine put it, "masturbation has always been associated with trashy magazines and males especially 'bo-sacmen.' Society has come to define it in an extremely narrow minded manner" (University of Botswana 2001, 10).

5. Interpersonal Heterosexual Behaviors

A. Adolescents

Puberty Rituals and Premarital Sexual Relationships

Anthropologist Isaac Schapera (1970) documented the customs and practices of Tswana groups in Botswana and South Africa during the early part of the 20th century.

Tswana groups had gender-specific rites of passage that served to prepare young persons for adulthood and to control premarital fertility. Young adolescent males would undergo *bogwera*, which included circumcision and seclusion, during which time they would be taught survival tactics as well as tribal laws and customs. Pubescent girls would undergo *bojale* in the village, through which they received formal instruction that prepared them for the as-

sumption of domestic and agricultural chores, as well as what was deemed as appropriate sexual behavior upon marriage. Current indications are that these rites of passage are no longer being practiced among different ethnic groups. These processes are now mostly left to individual parents and educational institutions.

Over the years, much debate (within civil society and in certain government sectors) has focused on adolescent sexual activities. One of the key concerns has been the relatively high rate of teenage pregnancy in Botswana. Botswana Health Surveys consistently indicate that the average age at first birth for women in Botswana is 18 years. Data from the United Nations Development Programme rates teenage pregnancy at 19%. Teenage pregnancies are cited as a problem because they contribute to girls dropping out of school. Studies conducted on sexual behavior among adolescents point to the high rates at which young persons are engaging in sexual activities. While most of the sexual relationships are between young persons in the same age cohorts, indications are that many young women are engaging in sexual relationships with older men, who are often referred to as "sugar daddies" for financial reasons.

The discussion of teenage sexual relationships has been largely limited to 'problem' areas, such as teenage pregnancy and the spread of HIV/AIDS. This is partly because of the ambivalence in larger society about being seen to 'legitimate' premarital sexual relations. The HIV/AIDS prevalence rates point to the fact that up to 15% of all HIV-infected persons are in the age cohort 15 to 19 years. As a result, more attention is turning to understanding the challenges faced by young people, both females and males, in a rapidly changing environment. Within that context, the National AIDS Coordinating Agency (NACA) and the government AIDS/STD Unit are working with various nongovernmental organizations to assess youth sexuality, as well as developing appropriate measures to raise awareness and empower young people to negotiate safe sex or abstain.

C. Adults

Premarital Relations, Courtship, and Dating

See Section 1C, Basic Sexological Premises, General Concepts and Constructs of Sexuality, Love, Marriage, and Family.

Sexual Behavior and Relationships of Single Adults

When Botswana attained her independence from Britain in 1966, more than 80% of the population resided in the rural areas, depending on family-based subsistence agriculture for survival. In some instances, family incomes were supplemented with remittances from migrant workers in South Africa. Statistics from the 1991 census indicate that 45% of the population of Botswana currently resides in towns or 'urban villages.' The urban villages are primarily those in which the majority of the population does not rely on agriculture as their main source of livelihood. The rate of rural-urban migration is high, with both women and men leaving the rural areas in search of a 'better life.' These changes have had profound impact on individuals as well as family forms in Botswana. While gaining their independence from parents and extended family influences on the one hand, the lives of young adults in Botswana are embedded in a juxtaposition of traditional culture and the trappings of modernity.

Sexual behavior and relationships of single adults should be seen within the context of rapid socioeconomic

change, gender identities, and unequal power relations between women and men. Men are traditionally expected to initiate and control sexual activity. This places women in a subordinate position with regard to the negotiation of safe sex, particularly with regard to the use of condoms.

Marriage and Family: Structures and Patterns

Table 1 presents data on marital status by sex for the three census periods 1971, 1981, and 1991. The figures on marital status reveal a significant decline in the proportion married (by over 14%) between 1971 and 1991. While the mean age at marriage for men used to be significantly higher than that for women, the gap has been closing steadily over the years. There are significant gender differences in the categories separated/divorced and widowed, with more than 50% of the female population over 65 years being widowed compared to only 10% of men. This gender difference can be attributed to the tendency for men to remarry, or establish new co-residential consensual relationships following the deaths of their spouses, while women remain single.

A study conducted by the Women and Law in Southern Africa Research Trust (WLSA) in 1996 reflected a range of family forms that reflect the rapidly changing nature of social relations. While the conventional, male-headed family form based on marriage remains common, there is evidence that a large proportion of families consist of mother-child dyads, as well as cohabitants, both forms of which are on the increase. The study observed that while the interests of the collective remained paramount, individuals who are part of the societal collective articulate their interests and needs through a constant negotiation of cultural practices and individual autonomy. While families vary in form and content, the pursuit of material and emotional support continue to be of paramount importance in determining family membership.

6. Homoerotic, Homosexual, and Bisexual Behaviors

Homosexuality is a taboo subject in Botswana, and this is generally reflected in the attitudes of the officials and the society at large. People very rarely come out publicly to declare that they are homosexuals. The homosexual community as a whole is rejected, victimized, and sometimes blackmailed. This is because of societal myths, and because homosexuality is a forbidden subject in Botswana culture. Homosexuals face stigmatization and prejudice from family members, friends, and society in general. Indeed, same-sex activity between males and females is illegal in Botswana. The Botswana Penal Code makes those

found guilty of 'carnal knowledge of any person against the order of nature'; 'carnal knowledge of an animal'; or 'permits a male person to have carnal knowledge of him or her against the order of nature,' is liable to imprisonment for a term not exceeding seven years (Republic of Botswana 1986).

Thus, the social status of homosexual, lesbian, and bisexual couples is legally illicit and there are no legal provisions providing for equality with heterosexual couples. The Lesbians, Gays and Bisexuals of Botswana (LEGABIBO) Charter was drafted in response to those amendments to the Botswana Penal Code, which came into effect on April 30, 1998, and extended the seven-year maximum penalty for men caught engaging in same-sex sexual relations to women as well. The Charter emerged at a workshop on Lesbian and Gay Rights on May 2-3, 1998, hosted by Ditshwanelo—The Botswana Centre for Human Rights. The government has so far refused to register LEGABIBO as a nongovernmental organization. Because homosexuality itself is illegal in Botswana, LEGABIBO is in an awkward position. A spokesman from the organization claimed that "the government has stated that it will refuse to register our organization because to do so would be tantamount to registering an organization of criminals. Thus we can't raise funds to do our work" (*Sunday Independent* [Johannesburg], September 26, 1999). Homosexuals have no social or legal protection available for these experiencing prejudice or discrimination, and LEGABIBO has urged its constituency to choose very carefully those to whom they tell about their sexuality.

Prosecutions for homosexual activity are, however, rare. The last known case was the high-profile example in 2001 where a Botswana resident, who was accused of engaging in sexual relations with another man, filed an application in the country's High Court challenging the state's "unnatural sexual liaisons" laws. The fact remains though that homosexual liaisons are conducted furtively and there is no "out" community of any note.

In fact, the depth of opposition to homosexual behavior in Botswana runs deep. For instance, in 1999, the Botswana Christian Council called for a relaxation of social and legal prohibitions against homosexuality and organized a seminar at the University of Botswana. However, the overwhelmingly youthful student audience rejected such calls out of hand, with one youth leader quoted as saying the majority of Botswana's people are "traumatized by homosexuality" and "other ideas from overseas and (European and American) donors." It is very common for homosexuality to be dismissed as a "Western" disease and "un-African," even though there are numerous indigenous societies in Africa where same-sex relations are common.

7. Gender Diversity and Transgender Issues

The status of transvestites, transgenderists, and transsexuals in Botswana is not a topic of discussion in Botswana, simply because such behavior would be seen as being extremely strange and unusual. There are reports, however, that a handful of transvestites (less than ten) meet occasionally in a bar in central Gaborone. With regard to transgenderists or transsexuals in Botswana, there is no information on such people, and it is so far unheard of.

Table 1

Percentage of Population by Marital Status and Gender of Persons Aged 15 and Older in 1971, 1981, and 1991

Marital Status (%)	1971		1981		1991	
	Male	Female	Male	Female	Male	Female
Never Married	44	37	51.7	44.5	54.8	49.5
Married	47.1	42.9	44.4	41.5	29	27.2
Cohabiting	n/a	n/a	n/a	n/a	12.2	12
Separated/Divorced	5	6.6	2.1	3.3	1.7	2
Widowed	2.1	11.9	1.8	11	1.5	8.5
Mean Age at Marriage	29.4	24	30.8	26	30.8	28

(Source: Mukamaambo 1995, 58)
n/a: not covered by the census

8. Significant Unconventional Sexual Behaviors

A. Coercive Sexual Behaviors

Child Sexual Abuse, Incest, and Pedophilia

Child sexual abuse in Botswana occurs against the background of age and gender-based hierarchies that subordinate the status of children, particularly girl-children to adult authority. Much of the child sexual abuse takes place within homes and is perpetrated by male family members.

Sexual Harassment

The Botswana legal system is silent on the issue of sexual harassment. The University of Botswana is one of the few organizations that have a policy on sexual harassment. The policy defines sexual harassment as: any unwanted, unsolicited, and/or repeated sexually discriminatory remarks made which are offensive and objectionable to the recipient, or which cause the recipient discomfort and humiliation, or which the recipient believes interfere with the performance of his or her job or study, undermine job security or prospects, or create a threatening or intimidating work or study environment. Sexual harassment continues to be shrouded in secrecy in Botswana, and the absence of legislation contributes to the reluctance of victims to report it.

Rape

Police statistics in Botswana point to a recent increase in the frequency of rape. In a study conducted among 25 police stations comparing, among other things, the number of reported cases of rape and defilement of girls under 16 years between the years of 1995 and 1998 rose by 18.3% between 1996 and 1998, while reported cases of defilement rose by an alarming 65%. During those years, almost 58% of the victims were in the age category 16 to 30 years; those under 16 years constituted 27%. The majority of the suspects/perpetrators were between the age of 18 and 32 years. The Police Study on Rape, as well as the Study on Violence on Women, indicated that more than two-thirds of all rapes are committed by men known to their victims.

“Dry Sex” or “Wet Sex”

[*Comment 2003*: As noted in Section 8D, Significant Unconventional Sexual Behaviors, Female Genital Mutilation and Other Harmful Practices, of the Nigerian chapter, sexual relations in subequatorial Africa are male-dominated, with the male initiating coitus and dictating its style and pace. Female response and satisfaction are not considered important. Coitus usually takes place with no foreplay. The male-above position is standard, and marital coitus is for procreation, not for pleasure. Women in many African cultures do not even know what female orgasm is, and may have never experienced it. In describing mating customs in the chapter on Ghana, Augustine Ankoma reports that penile-vaginal penetrative sex with little foreplay is the normal sexual style. Although among the well-educated youth some forms of foreplay are gaining a foothold, fellatio and cunnilingus are abhorrent. Genital manipulation is hardly accepted, and, traditionally, women feel shy to touch the penis, and most men are not interested in having their genitals manipulated.

[These male-oriented cultural values underlie what is appropriately termed “dry sex,” a common practice throughout sub-Saharan Africa. The “dry sex” mating behavior fits comfortably with the male distaste for vaginal secretions and foreplay, and disinterest in female sexual arousal and orgasm. In this setting, males quickly reach orgasm and satisfaction. Women are left with painful intercourse, no arousal, and no orgasm.

[In many African cultures, women prepare themselves to pleasure their husbands with a dry vagina by mixing the powdered stem and leaf of the Mugugudhu tree with water, wrapped in a bit of nylon stocking and inserted in vagina for 10 to 15 minutes before intercourse. Other women use Mutendo wegudo, soil mixed with baboon urine, which they obtain from traditional healers. Still others use detergents, salt, cotton, or shredded newspaper. These swell the vaginal tissue, make it hot, and dry it out. The women admit that sexual intercourse is “very painful, but our African husbands enjoy sex with a dry vagina” (Schoofs 2000).

[The inevitable results of “dry sex” include increased friction, vaginal lacerations, suppression of the vagina’s natural bacteria, and torn condoms (when these are used). All these consequences increase a woman’s risk of STD and HIV infections. Fortunately, the tradition of “dry sex” is waning among the educated urban young, but any change in this traditional mating behavior is also resisted because of rejection of Western gender roles (Stellwaggon 2001).

[“Dry sex” is a well-established and more-or-less widespread practice in various subequatorial African cultures. It is very common in Southern Africa, particularly in Zimbabwe, Zambia, Malawi, some parts of Nigeria, some parts of Uganda, Southern Sudan, and even in Kenya and Botswana. The only difference is in what these women use for drying up their vaginas.

[In the northwest part of Tanzania and neighboring regions, “wet sex” is widely known and practiced. “Wet sex” consists of foreplay where there is intense stimulation by the male partner on the woman’s labia and clitoral regions. This stimulation results in copious production of secretions (thought to come from Bartholin’s glands). People talk about it openly, sometimes mixed with a sense of humor and intertribe jokes. Some researchers have blamed this practice for the high incidence and prevalence of HIV and STDs. The implications of this kind of information for action plans (resource inputs and sociocultural issues) are enormous. Now that these behaviors have been brought into public attention, a well-thought-out survey that is representative of different segments of the populations becomes essential for an effective public health policy (Tanzania, personal communication 2003). In March 2003, when the editor of this encyclopedia inquired whether “dry sex” was observed in Botswana, Dr. Ian Taylor replied: “‘Dry sex’ is common in Botswana as well and leads to vaginal tears and lesions which help spread HIV/AIDS, it is true.” (*End of comment by B. Opiyo-Omolola*)

B. Prostitution

While prostitution is outlawed by the Penal Code, it is widely practiced in Botswana, predominantly by women. The different types of prostitution include ‘streetwalkers’ and individuals who frequent establishments where alcohol is sold. In addition, there are an increasing number of prostitutes who focus specifically on long-distance drivers. While little is known about the incidence of child prostitution, girls and young women may engage in sex for financial and material gains from older men.

9. Contraception, Abortion, and Population Planning

Botswana has made remarkable progress in the provision and delivery of health facilities and services, but in spite of these improvements, aspects of reproductive health relating to abortion, teenage pregnancies, and HIV/AIDS remain issues of concern. The increase in HIV/AIDS and sexually transmitted diseases has emphasized the demands for distribution of condoms in the country.

A. Contraception

The current use of contraception in Botswana has been reported by 44% of women aged 15 to 49 years (Central Statistics Office 2001). Majelantle and Letamo (1999) further show that 61% of women attending antenatal clinics in the country have used contraceptive methods.

The most popular method used by women is the pill, followed by condom, injection, intrauterine device, and female sterilization. Condom use is, however, low among women aged 35 years and above, despite its widespread distribution as a strategy to curb the spread of HIV/AIDS. Traditional practices of breastfeeding and postpartum abstinence continue to be important among rural women and are less favorable among urban women.

Teenagers are far less likely to use contraception than older women; however, virtually all of the sexually active youths aged 15 to 24 years had used a condom at least once. There is also high awareness of condoms, high condom use, and consistency, as well as delayed onset of sexual activity among the youth. Condom knowledge and its role in STD/AIDS prevention have been reported at 100% among urban adolescents (10 to 19 years). Attitudes towards condom use are also positive among the young people in Botswana, but the problem is still with embarrassment and the purchasing of condoms.

Women's education level has been found to correspond positively with contraceptive prevalence, and male partners still play a role in the decision of a woman to use contraceptives.

B. Teenage (Unmarried) Pregnancies

There is a high incidence of teenage pregnancy in Botswana, and this is indicative of unprotected sex and, therefore, has serious implications for the spread of HIV infection as well as other STDs. The rate of teenage pregnancy is one in every three women aged 15 to 49 who attend antenatal clinics. The majority of these teenage women are single and their pregnancies take place outside marriage.

Teenage childbearing also poses social, economic, and reproductive health risks to the young women. These include social and economic problems, such as dropping out of school, rejection by their families and community, and unemployment, and health risks, such as low birth weight, unsafe abortions, incidence of still births, and implications for the spread of STDs, specifically HIV.

The mean age at first sexual intercourse for teenagers is 17.5 years and the mean age at first birth is 18.6 years.

C. Abortion

There is very little information available in Botswana on abortion. This could be because of the fact that abortion is treated as a sensitive topic and is highly stigmatized in Tswana society.

Abortion is illegal in Botswana. It is only permitted within the first 16 weeks of pregnancy under the following conditions: when the pregnancy is a result of rape, defilement, or incest; when the pregnancy poses a physical or mental health risk to the pregnant woman, and finally, when the unborn child would suffer from or later develop serious physical or mental abnormalities or disease. These conditions are observed only when a medical doctor from a government or registered private hospital or clinic approved by the Director of Health Services confirms in writing that the continuation of the pregnancy would risk the life of either the mother or child.

Even though abortion is illegal, it is apparent that a substantial number of women in Botswana resort to illegally induced abortion (Majelantle & Letamo 1999). These in-

duced abortions are done under unhygienic conditions and are performed by untrained persons, who use dangerous instruments and abortifacients.

With abortion being illegal, educated and wealthy women are reported to obtain their abortion services from South Africa, because in Botswana, induced abortions are only provided for certain medical conditions. Majelantle and Letamo (1999) show that women aged 35 years and above have had multiple abortions.

In its attempts to reduce maternal mortality, the Government of Botswana is aiming to reduce the mortality rate, estimated between 200 and 300 deaths per 100,000 live births in 1991, by at least 50% in 2011. Government hospitals and clinics also provide post-abortion counseling.

D. Population Control Efforts

Botswana has one of the highest population-growth rates in Africa, at 3.5% per year between 1981 and 1991. If, however, the population continues to grow at this rate, it will make it difficult for the economy to support gains achieved over a long period of time. Thus, the challenge the country faces is to reduce the growth rate of the population and increase the growth rate of the economy.

The young age structure of the population will persist for several years into the future as young women enter the reproductive age. The rapid population growth also places a burden on national and international efforts aimed at reducing poverty and improving the well-being of the population.

Efforts made to control the population growth include the provision of reproductive health and family planning services, counseling, and promoting modern methods of contraception, especially the condom, at all government hospitals and clinics.

The main emphasis is on human development and welfare dimensions in order to enhance the quality of population and improve the living standards, and as a result, the National Population Policy contains explicit and comprehensive strategies to influence population trends in a manner conducive to the attainment of sustainable human development. The Ministry of Finance and Development Planning is responsible for ensuring the integration of population factors in national plans and strategies for sustainable development at all levels.

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

Sexually transmitted diseases found in Botswana include genital warts, herpes simplex type 2, gonorrhea, and syphilis. These STDs may be the major determinants of the HIV epidemic in Botswana, as a relationship has been established between STDs and HIV transmission in the country. STDs present the third most common cause of attendance at public health facilities (NACA 2002, 30).

According to the National AIDS Coordinating Agency (2002), the prevalence of STDs in the country appears to be declining among women using family planning methods for the years 1993, 1997, and 2002. This pattern is the same for syphilis, gonorrhea, and *Trichomonas vaginalis*, but it is accelerating for *Chlamydia trachomatis* and herpes simplex type 2. The incidence of STDs among adolescents is higher as compared to women aged 35 and above. This is attributed to the low attendance of teenagers at antenatal clinics, and has worsened with the spread of the HIV/AIDS epidemic. Since STDs facilitate the transmission of HIV, and HIV prolongs the duration of symptoms, the prevention and management of STDs and HIV/AIDS has been made the highest priority in the National Sexual

Reproductive Health Programme. In addition to the prevention strategies in Botswana, data on STDs are routinely collected through the epidemiological reporting system.

However, there is still little data in the country on STD surveillance, making it difficult to give an exact picture of the magnitude of STDs in Botswana. Certain factors have been identified to influence this inability to accurately estimate STDs in the country, and include the asymptomatic nature of STDs among women, and the fact that some people with symptomatic STDs do not seek treatment from public health facilities or seek treatment at all.

Control of STDs in Botswana is considered as one of the main prevention strategies for HIV transmission, and according to the Ministry of Health (1998), STD control in Botswana encompasses a comprehensive program based on effective case management of symptomatic STDs in health-care facilities. This strategy calls for sound diagnosis, effective antibiotic treatment, preventive efforts that entail patient education on risk reduction, condom use, and the referral of sexual partners.

B. HIV/AIDS

Botswana's 1.7 million population has the highest HIV/AIDS infection rate in the world, and HIV/AIDS affects both urban and rural areas with the same intensity. In the early stages of the epidemic, prevalence was higher in urban areas than rural, but the clear distinction does not exist anymore.

AIDS in Botswana is spreading mainly by the heterosexual route (Macdonald 1996, 1325), and several factors may have contributed to the rapid spread of HIV/AIDS in the country, among these are social/sexual factors:

- Relative gender inequality: the position of women in the society, particularly their lack of power in negotiating sexual relationships.
- High levels of STDs: The presence of STDs has been shown to facilitate transmission and acquiring of HIV infection.
- Social migration patterns: Botswana has one of the most mobile populations in the world, and for years, Botswana have had to be mobile and live regularly in two to four different abodes, on a cattle post, in farmlands, a village, and towns). Circulating often between these areas for extended periods, especially during long weekends, has proved to be one of the driving forces of the epidemic in Botswana.
- Disintegration of traditional family patterns: Most of the pregnant women in Botswana are single, and sentinel surveys done in the country show a high HIV prevalence among single mothers who attend antenatal clinics as compared to married mothers. This is also an indication that many Botswana engage in short-term relationships and have other sexual partners subsequently.
- Lack of recreation facilities in the country and lenient law enforcement on the sale of alcohol to minors also make it easy for the youth to engage in risky sexual behaviors.

Given the current infection rates, the infant-mortality rate is expected to increase from 57 to 60 per 1,000 live births by the year 2005 (National AIDS Coordinating Agency 2002, ii). The population of orphans is predicted to increase from 139,000 to 214,000 by the year 2010. As the figures indicate, many children have been orphaned, and before the introduction of the prevention of mother-to-child HIV-transmission program, many babies were born infected with the HIV virus. Other age groups are not spared. It is estimated that in 2002, about 258,000 persons aged 15 to 49 years

were infected with HIV. However, the HIV prevalence in age groups 15 to 19 and 20 to 24 years has remained fairly stable in the last three years, indicating that the rate of new infections is not increasing as it was in the last ten years. This pattern could be attributed to high condom use, a relatively high awareness level, reduced numbers of sexual partners, declining STD incidence, and delayed onset of sexual activity among the youth (Ministry of Health 2001, 3; NACA 2002, 44).

A sentinel survey done in 2002 showed the HIV infection rate to be nine times higher in females aged 15 to 19 years than in males. Higher rates in females in young age groups are attributed to behavioral data. It has been shown that condom use is higher among males than females; girls engage in sexual relationships earlier than boys. Girls also engage in sexual relationships with older men for economic reasons. The prevalence of HIV in pregnant women aged 15 to 49 and women aged 15 to 19 years is outlined in Table 2 for the years indicated.

With the first tentative HIV/AIDS case reported in 1985, there is still no preventive vaccine or cure against HIV. However, the government of Botswana has various initiatives to address the HIV/AIDS epidemic. This is evidenced by the huge political commitment, the increase in resource mobilization and utilization, and the multisectorial collaboration and cooperation at all levels. The president of Botswana, H. E. Festus Mogae, has recognized HIV/AIDS as "the greatest challenge Botswana has faced" and has warned his nation that HIV/AIDS "threatens the country with annihilation." The president even chairs the National AIDS Council, the government structure that coordinates all HIV/AIDS-related activities in the country.

The Government of Botswana pays for at least 80% of all HIV/AIDS activities in the country. Other achievements made in the combat against HIV/AIDS in Botswana include the provision of highly active antiretroviral therapy (HAART) to the public at no cost, vaccine development, the Voluntary Counselling and Testing Programmes, the Community Home Based Care, the orphan and vulnerable children program, as well as the nationwide Prevention of Mother to Child Transmission (PMTCT) program to all public health facilities. Prevention and treatment of opportunistic infections is also provided at all public health facilities in the country.

Despite the achievements, there is still no provision made in terms of the distribution of condoms or safer sex education to the homosexual community. Consensual same-sex sexual intercourse remains illegal in Botswana. [Comment 2003: The practice of "dry sex," as noted earlier, is also a factor in HIV transmission. (End of comment by R. T. Francoeur)]

[Update 2002: UNAIDS Epidemiological Assessment: HIV sentinel surveillance among antenatal clinic attendees began in Botswana in 1990. In 2001, median HIV prevalence among antenatal clinic attendees tested in Botswana

Table 2

Percentage Distribution of HIV Prevalence among Women by Age and Year

Year	15-19 years	15-49 years
1992	16.4	18.1
1998	28.6	35.7
2000	—	38.5
2001	24.1	36.2
2002	—	35.4

(Source: The National AIDS Coordinating Agency, 2002, 20)

in 22 health districts (190 sites) was 36.3% with a range of 25.8 to 55.8%; 12 districts had rates between 30% and 40% and 7 districts had rates above 40%. HIV prevalence among antenatal clinic attendees in Botswana increased rapidly from 18.1% in 1992 to 32.4% in 1995, 38.5% in 2000, and 36.3% in 2001.

[Major urban areas in Botswana include Gaborone, Francistown, and Selebi-Phikwe. In Gaborone, HIV prevalence increased from 14.9% in 1992 to 39.1% in 2001, while in Francistown, the increase was from 23.7% in 1992 to 44.9% in 2001. In Selebi-Phikwe, HIV prevalence doubled from 27% in 1994 to 55.6% in 2001. Sites outside the major urban areas are also experiencing increasing HIV infection trends. In 2001, median HIV prevalence in areas outside the major urban areas was 38.6%, with rates ranging from 26.4% to 50.9%. The 15-to-19 and 20-to-24 age groups exhibit high and increasing HIV infection trends. HIV prevalence among the 15-to-19 year olds at all sites increased from 16.4% in 1992 to 24.1% in 2001. Among the 20-to-24 year olds, the increase was from 20.5% in 1992 to 39.5% in 2001. Peak HIV prevalence rates were observed among the 25-to-29-year-old antenatal clinic attendees; rates in this age group were 50.4% and 48.4% in 2000 and 2001, respectively.

[There is no information available on HIV prevalence among sex workers in Botswana. HIV prevalence among STD patients shows an upward trend. In Gaborone, HIV prevalence among male STD clinic attendees increased from 22% in 1992 to 44.1% in 1996, and then to 48.2% in 2000. Similarly in Francistown, HIV prevalence among male STD clinic patients increased from 29.7% in 1994 to 60% in 1997 and has remained around that figure since then. Outside Gaborone and Francistown, HIV prevalence among male STD clinic patients tested in six sites increased from no evidence of HIV infection in 1985 to 1987 to a median of 53% in 1998; in 1999, HIV prevalence among male STD clinic patients tested at these sites ranged from 44.2% to 62%.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	300,000 (rate: 38.8%)
Women ages 15-49:	170,000
Children ages 0-15:	28,000

[An estimated 26,000 adults and children died of AIDS during 2001.

[At the end of 2001, an estimated 69,000 Batswana children under age 15 were living without one or both parents who had died of AIDS. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

There is no information or data available.

12. Sex Research and Advanced Professional Education

The Directorate of Research and Development at the University of Botswana is the first point of contact for all stakeholders interested in conducting or sponsoring research and development in Botswana. This office works with all University of Botswana faculties, departments, schools, centers, associated institutes, affiliated institutes, and together with the Government of Botswana and nongovernmental organizations (NGOs) to facilitate and coordinate quality research in the country. This office also advises the Office of the President on applications made by researchers. Research on sexual and reproductive health matters is done through the Ministry of Health, Family Health Division. The National AIDS Coordinating Agency is responsible for coordinating all research on HIV/AIDS in Botswana.

There are, however, no programs or NGOs which specifically deal with issues of human sexuality; instead, issues of human sexuality are often incorporated into mandates of the different NGOs. There is also no association for sexologists or journals on sexuality in Botswana.

Information on sexual and reproductive health can be obtained from the Ministry of Health, Family Health Division. The University of Botswana, Department of Nursing Education offers courses, some at the undergraduate and postgraduate levels.

13. Significant Ethnic Minorities

Sexual Attitudes and Behaviors among the Basarwa/San

The Basarwa (or San) are hunters and gatherers who live in Southern Africa below the Congo-Zambezi watershed. The Republic of Botswana is home to over half (approximately 42,000) of all the San in the region. This indigenous group is distinct culturally, and their way of life is different, from other ethnic groups in Botswana. Basarwa are mostly found in the remote areas, and the population has high illiteracy levels. The Basarwa's way of life has adapted over the generations as they lived in contact with other ethnic groups; as a result, their way of life today can take the form of a sedentary villager, part- or full-time unskilled laborer, and squatters in freehold farms as herders and hunters. All these socioeconomic and cultural changes have had an impact on their sexual lifestyles. However, some of their cultural practices still hold to this day.

Basarwa culture is permissive to sexual activity at very early ages, often prior to puberty. This is because of the relative openness and acceptance of adult sexuality. Prepuberty marriages also exist. Traditional initiation customs encourage safer sex practices among the youths, and prohibit sexual intercourse outside marriage. Thus, in the Basarwa tradition, one sex partner is preferred. However, with modernization and urbanization, the traditional controls over sexuality have lapsed and the youth are now having multiple sexual partners.

Marriage relations among the Basarwa have no legal procedures, apart from gaining the mutual agreement of the spouses involved and their respective families (Guenther 1986). The majority of the marriages are monogamous, but this trait is slowly eroding as the Basarwa now live and mix with other ethnic tribes in Botswana. Marriages are within the same age group, as compared with other tribes in the country where intergenerational relationships and marriages are permissible.

Early marriages are, however, often sought for young people if they are maturing quickly to prevent the possibility of premarital pregnancies, and this contributes to nearly all children knowing their parents. Failure to marry is rare among the Basarwa, and this is in contrast to other tribes in Botswana where a lot of families are female-headed.

The use of modern contraceptives among the Basarwa is very low. This is because they live in rural areas, and their access to health facilities and services are limited in terms of distance, affordability, and acceptability. Attitudes towards condom use are positive among school-going adolescents, even though their parents do not favor modern contraceptives. Most Basarwa adults rely on traditional medicine, and this is because it is part of their culture and their primary accessible choice.

Most Basarwa children in the school-going-age group live in a boarding school, away from their parents for extended periods of time, and they miss out on their parental

guidance, chaperoning on matters of sexuality, as well as on traditional education and initiation that is conducted at puberty.

Incidence of HIV/AIDS is still quite low among the Basarwa, between 3 and 6% as compared with national averages of 20 to 35% (Lee & Susser 2002). This incidence is, however, enviable in this era, because they are found in the heart of the world region worst hit by the epidemic. Basarwa girls and women now engage in materially motivated sexual relationships with "rich" men from other ethnic groups. This, however, makes them vulnerable to reproductive health problems related to sexual debut and teenage childbearing.

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