

Call for submissions

Women's and girls' sexual and reproductive health and rights in situations of crisis

The Working Group on discrimination against women and girls will present a thematic report on women's and girls' sexual and reproductive health and rights¹ (SRHR) in situations of crisis to the 47th session of the Human Rights Council in June 2021. The report will examine women's and girls' SRHR within an overarching framework of reasserting gender equality and countering roll-backs.

The Working Group will take a broad approach to crisis. In doing so, it intends not only to look at humanitarian crises, typically understood as encompassing international and non-international conflicts and occupied territories, natural disasters, man-made disasters, famine and pandemics, but it will also examine long-standing situations of crisis resulting from structural discrimination deeply embedded in histories of patriarchy, colonization, conquest and marginalization (such as in the case, for example, of indigenous women, Roma women and women of African descent), as well as other types of crisis based on the lived experiences of women, such as those induced by environmental factors, including the toxification of the planet, land grabbing, political, social and economic crises, including the impact of austerity measures, refugee and migrant crises, displacement crises, and gang-related violence, among others. The Working Group will examine how existing laws, policies, and practices can contribute to negative reproductive health outcomes for women and girls in situations of crisis and restrictions on their autonomy during their life-cycle, using an intersectional approach.

In order to inform the preparation of this report and in line with its mandate to maintain a constructive dialogue with States and other stakeholders to address discrimination against women and girls, the Working Group would like to seek inputs from all stakeholders. Submissions should be sent **by 31 August 2020** to wgdiscriminationwomen@ohchr.org and will be made public on the Working Group's web page, unless otherwise requested. The Working Group is particularly interested in receiving information about challenges faced in ensuring that women's and girls' sexual and reproductive rights are respected, protected and fulfilled in times of crisis, and are adequately prioritized, as well as examples of good practices.

Questionnaire

Concept/definition of crisis

1. Please provide information on the legal and policy framework used by your State to manage situations of crisis and on how the concept of "crisis" has been defined or framed.

¹ SRHR include women's right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health, as well as entitlements to unhindered access to a whole range of health facilities, goods, services and information on sexual and reproductive health, such as maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancer. Women's right to sexual and reproductive health further encompasses the "underlying determinants" of sexual and reproductive health, including access to safe and potable water, adequate sanitation, adequate food and nutrition, and adequate housing, among others, and effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health. Moreover, it covers social determinants, notably social inequalities in society, poverty, unequal distribution of power based on gender, ethnic origin, age, disability and other factors, systemic discrimination, and marginalisation, which affect people's patterns of sexual and reproductive health.

The State of Emergency regulations often articulate, as per Presidential prerogative and with Parliament's permission, what would be deemed a crisis in Botswana. This would include response and policy interventions gazetted under State of Emergency. The COVID-19 crisis response has largely been complimented by the Public Health Act, where the Director for Health Services can enforce regulations. The National Disaster Risk Management Plan (NDRMP) could be argued as a standing framework for crises. It guides all sectors and stakeholders on Disaster Risk Reduction implementation and Emergency Management plans. These however, apply to natural and man-made hazards.²

2. Please list the type of situations that would fit the concept of "crisis" in your State and indicate what situations are excluded.

Botswana has not ratified or domesticated international instrument on Disaster Risk Management. There is no National Disaster Risk Management legislation; regulation of international disaster assistance.³ Thus, articulating a crisis within Botswana's context depends on government leadership. Legislative progress has been made in establishing the National Disaster Management Office to create countrywide systems and coordination. Thus, it would present natural or man-made crises including fires, drought and floods.⁴ COVID-19 has been deemed a crisis as it is wide reaching, unpredictable and invoked a six month state of emergency since April 2020.

3. What institutional mechanisms are in place for managing a crisis and how are priorities determined?

Aside from the National Disaster framework articulated in previous responses, there is a presidential task force established in response to the COVID-19 crisis. All crises include collaborations with government, few civil society and private companies. More notably, the shadow pandemic of domestic violence has resulted in concerted collaborative effort among all stakeholders.⁵

Challenges and good practices

4. Please highlight any challenges faced in the provision of SRH services and good practices in ensuring women's and girls' SRHR in situations of crisis, including, for example, measures concerning timely access to the the following types of services and aspects of care:
 - a. Access to non-biased and scientifically accurate information about sexual and reproductive health matters and services;

² Office of the President (2009) Botswana: National disaster risk management plan *Government of Botswana* <https://www.preventionweb.net/english/professional/policies/v.php?id=21556>

³ O. Boti (2013) Botswana exposed to disaster management clumsiness *Sunday Standard*

<https://www.sundaystandard.info/botswana-exposed-to-disaster-management-clumsiness-report/>

⁴ Botswana Youth (2020) The Functions Of NATIONAL DISASTER MANAGEMENT OFFICE (NDMO) *Botswana Youth* <https://www.botswanayouth.com/national-disaster-management-office-ndmo/>

⁵ L. Nchunga (2019) Botswana's Limited Capacity In Responding To Gender-Based Violence *Mmegi online* <https://www.mmegi.bw/index.php?aid=83016&dir=2019/october/08>

Most of the contraceptive information is not specific to young people in Botswana. Information is based on the options available; condoms, pills and injectables, other options are under explored because of high levels of stigma.⁶

- b. Access to medical professionals and health service providers, including traditional birth attendants, with adequate provision for their training and safety including personal protective equipment;

Medical care in Botswana is easily accessible without considerations for related costs and distance. There are various sectors to access healthcare; traditional, public and private sectors.⁷ Provisions have been made through the COVID-19 response to provide training and safety for healthcare providers in the public health system.

- c. Access to essential medicines as prescribed by the WHO, equipment and technologies essential for the quality provision of sexual and reproductive health services;

Costs are a challenges to access. This includes travel and related expenditure. Botswana imports most medicines. Thus, more generic and not patented medicines are procured by the government.⁸ This does not mean medicines were easily available as many individuals did not have the means to access them. Primarily because travel needed permits and there was no public transport available during lockdowns.

- d. Prevention of HIV transmission, post-exposure prophylaxis and treatment for HIV/AIDS as well as the prevention and treatment of sexually transmissible infections;

These were available, although not all community referral systems were fully functioning due to COVID-19 regulations. CSOs were not considered essential services. Notably, under normal circumstances, over 90% of pregnant women living with HIV have access to antiretroviral medicines in Botswana. This has resulted in a 41% reduction in new HIV infections among children. These are attributed to political leadership, rapid policy adoption and concerted efforts by all stakeholders⁹ Thus, within the context of COVID-19, only the first two attributes were effected.

- e. Pregnancy-related health services, including pre- and post-natal care, assistance during child-birth, and emergency obstetric care

Only emergencies were communicated as essential. Thus monthly check ups were limited or inaccessible for women that did not have private cars or means to access public health facilities. However, pregnancy related complications are always treated with urgency.¹⁰

⁶ Mazur, A., Brindis, C.D. & Decker, M.J. (2018) Assessing youth-friendly sexual and reproductive health services: a systematic review. *BMC Health Serv Res* 18, 216). <https://doi.org/10.1186/s12913-018-2982-4>

⁷ Your Botswana(2017) Healthcare in Botswana *Your Botswana*
<https://yourbotswana.com/2017/03/26/healthcare-in-botswana/>

⁸ World Health Organisation (2017) Essential medicines and health products *World Health Organisation*
https://www.who.int/medicines/areas/policy/wto_trips/en/

⁹ UNAIDS (2020) Despite great progress since the early days, the HIV response is still failing children *UNAIDS*
<https://www.unaids.org/en/keywords/preventing-mother-child-transmission>

¹⁰ W. Peters(2019) Harvard Medical School Center for Global Health Delivery *Harvard medical insititute*
https://ghd-dubai.hms.harvard.edu/files/ghd_dubai/files/nsoap-2019-1.pdf

- f. The full range of modern contraceptive information and services, including emergency contraception, as well as family planning information and services related to the number, timing and spacing of pregnancies and infertility treatments;

During hard lockdowns, access was limited to emergencies. Even then, it depended on whether individuals had the means (private car or walking proximity) after securing a travel permit. Notably, contraceptive methods available at the health facilities are the pill, male condom, female condom, injectable (Depo-Provera), intrauterine device (Copper T), male sterilization, and female sterilization. The last two are only offered in hospitals. However, implants have not been approved for use.¹¹

- g. Safe abortion services including surgical and non-surgical methods of termination of pregnancy and humane post-abortion care, regardless of the legal status of abortion;

During hard lockdowns, access was limited to emergencies. Even then, it depended on whether individuals had the means (private car or walking proximity) after securing a travel permit. This made it difficult for any one seeking an informal or formal/legally permissible abortion. There are significant personal, financial, and health costs for women seeking informal abortion, including crossing national borders.¹² This was not possible under lockdown.

- h. Treatment for pregnancy-related morbidities such as obstetric fistula and uterine prolapse, among others;

Treatment depended on whether individuals had the means (private car or walking proximity) after securing a travel permit. However, under normal circumstances women are encouraged to go for monthly obstetric check ups.¹³

- i. Screenings and treatment for reproductive cancers;

During hard lockdowns, access was limited to emergencies. Even then, it depended on whether individuals had the means (private car or walking proximity) after securing a travel permit. No readily available data suggests that this was possible. There are gaps in health seeking behaviour even under normal circumstances. Women who have received initial screening may lose follow up or future screening opportunities if there is no targeted communication interventions on cervical cancer, including stressing the importance of regular screening. Notably for women living with HIV, structured and variant health seeking behavioural communications are needed for anti-retroviral

¹¹ S. Mokgweetsinyana (2018) The Contribution of the Botswana Family Planning Program to the Largest Fertility Decline in Sub-Saharan Africa *Government of Botswana*
http://fpconference.org/2009/media/DIR_169701/15f1ae857ca97193ffff8363ffffd524.pdf

¹² N. Nassali (2018) Management of post abortion complications in Botswana -The need for a standardized approach *plos one* <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192438>

¹³ The University of Nottingham (2019) Prenatal care utilization and infant health in Botswana *ECONSTOR*
<https://www.econstor.eu/bitstream/10419/210860/1/1677829605.pdf>

drug (ARV) refills and being assisted by trained community workers to review cervical cancer risks during a crisis.¹⁴

- j. Menstrual hygiene products, menstrual pain management and menstrual regulation;

During hard lockdowns, access was limited to emergencies. Even then, it depended on whether individuals had the means (private car or walking proximity) after securing a travel permit. No readily available data suggests that this was possible, except for a select few CSOs that were allowed to operate. There are no dedicated SDG targets or indicators against which to gauge progress on special attention being given to women and girls.¹⁵ Thus, the same is reflected at state, district and municipal level in Botswana.

- k. Prevention, investigation and punishment of all forms of gender-based violence, and access to timely and comprehensive medical interventions, mental health care, and psychosocial support for victims and survivors;

This did not happen. The administrative and bureaucratic burden of seeking assistance from police, along with difficulties of limited movement for everyone compounded vulnerabilities. There were significant challenges in prevention, investigation and punishment. Of the three hard lockdowns, there was always a surge in reports post-lockdown. Over two thirds of women in Botswana (67%) have experienced some form of gender violence in their lifetime including partner and non-partner violence. Only 1.2% of Botswana women reported cases of GBV to the police. The levels of GBV are far higher than those recorded in official statistics and that women have lost faith in the very systems that should protect them and offer remedy.¹⁶

- l. Measures to prevent and prohibit practices such as female genital mutilation and child, early and forced marriage;

Botswana has committed to eliminate child, early and forced marriage by 2030 in line with target 5.3 of the Sustainable Development Goals. It also co-sponsored the 2017 Human Rights Council resolution recognising the need to address child, early and forced marriage in humanitarian contexts. However, the government did not provide an update on progress towards this target during its Voluntary National Review at the 2017 High Level Political Forum.¹⁷ Thus, the lack of focus on preventing and harmful practices (even where law provides, implementation in rural and traditional settings remains a gap) on young women and girls pre-dates the COVID-19 crisis.

¹⁴ Barchi *et al.* (2019). Adherence to screening appointments in a cervical cancer clinic serving HIV-positive women in Botswana. *BMC Public Health* <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6638-z>

¹⁵ L. Hall (2019) Menstrual Hygiene Efforts to Provide Dignity for Girls *institute of international affairs* <http://www.internationalaffairs.org.au/australianoutlook/menstrual-hygiene-efforts-to-provide-dignity-for-girls-and-women-in-remote-australia/>

¹⁶ Government of Botswana (2016) GBV National Report *Gender Affairs* [file:///C:/Users/USER/Desktop/outputs/something%20else/GBV%20Indicators%20Botswana%20report%20\(1\).pdf](file:///C:/Users/USER/Desktop/outputs/something%20else/GBV%20Indicators%20Botswana%20report%20(1).pdf)

¹⁷ The Voice of Africa (2018) *Girls Not Brides* <https://www.girlsnotbrides.org/child-marriage/botswana/>

- m. Legal and policy safeguards against abuses and delays in the provision of SRH services for example in relation to confidentiality, referrals, informed consent, conscientious objection, and third party consent requirements;

No readily available data on this. Adolescent and sexual and reproductive health issues will only be addressed in next National Development Plan II.¹⁸

- n. The affordability of SRH services especially for those in situations of vulnerability; and

No readily available data on this. Social determinants remain a challenge, as detailed in other responses above.

- o. Other pertinent information that may affect the availability accessibility, affordability, acceptability and quality of SRH services and information.

There are limitations in legal and policy frameworks for safe abortion. Thus, unsafe abortions remain costly in many ways.¹⁹

Experiences of crisis

- 5. Please list the situations of crisis experienced by your State in the last five years.

Aside from impacts of climate change, where droughts and floods have led to municipal level crises, the COVID-19 crisis is most notable. Along with the shadow pandemic of domestic violence²⁰

- 6. What was the impact of those crises on women and girls? Please provide information in particular on the following aspects:
 - a. Which groups of women and girls were most affected and how, taking into account different factors, such as age, geographic location (including urban and rural areas), ethnic and social origin, disability, marital status, migratory status, citizenship status or other status?

All women and girls were affected. Care work is not recognised, further exasperated by high levels of unemployment and poverty. Most notably in rural or remote locations where travel was not possible, even in instances where a permit was secured.

¹⁸ SYP (2016) Safe Guarding young people *United Nations* <https://esaro.unfpa.org/sites/default/files/pub-pdf/SYPReport-FinalDigital.pdf>

¹⁹ Smith, Stephanie. (2013). The challenges procuring of safe abortion care in Botswana. *African journal of reproductive health*. https://www.researchgate.net/publication/260372691_The_challenges_procuring_of_safe_abortion_care_in_Botswana/

²⁰ OECD (2020) The territorial impact of COVID-19: Managing the crisis across levels of government *OECD* <https://www.oecd.org/coronavirus/policy-responses/the-territorial-impact-of-covid-19-managing-the-crisis-across-levels-of-government-d3e314e1/>

- b. What was the impact on their SRHR? Were any specific risk factors and needs identified? Do you have data and/or qualitative information disaggregated by the factors listed under question 6(a)? If not, please explain why.

Affordability, other social determinants and lack of readily available information. CSOs are not resourced to document and systemically review these kinds of challenges. There is limited resourcing and capacity.

- c. What were the main obstacles encountered by the State, if any, in identifying and addressing the impact of the crisis on women's and girls' SRHR?

The state did not even recognise SRHR as an issue to be addressed. Still doesn't.

- d. What measures were adopted during and after the crisis to ensure women and girls' access to sexual and reproductive health services? Please indicate which SRHR services are recognized as essential services in the health policy or laws of your State and are funded through the health system. What steps were taken to ensure the continuity of services and access during the crisis?

None.

- e. What other protocols or systems were put in place to prevent adverse reproductive and sexual health outcomes due to the common risks triggered by crisis including, for example, gender-based violence and child marriage? Were any special measures adopted for specific groups of women and girls?

None.

- f. Were women's rights organizations²¹ involved in the needs and impact assessments and the recovery policies? If not, please indicate why.

None. Only violence prevention and mitigation organisations were resourced. SRHR was and is not a priority for the state.

- g. Which actors or institutions played a role in the provision of emergency responses? Please describe their role and explain what roles were played, if any, by national women's rights or human rights mechanisms, or other similar bodies as well as civil society organisations.

Too few, elite CSOs were included or in the least, marginally resourced and enabled to contribute/compliment the response and recovery efforts.

- h. How were the emergency responses funded and to what extent did they rely on foreign aid or assistance, if any? Please also indicate how in your State adequate financing of women's sexual and reproductive health is ensured more generally on an ongoing basis.

²¹ The expression women's rights organizations should be understood as encompassing organizations of women of different ages, backgrounds and identities.

No readily available data on this. However, there were select media reports of in kind donations and international donor funding (US Government, EU, etc).

- i. What obstacles have civil society organisations encountered in their efforts to deliver sexual and reproductive services?

No readily available data on this. However, no resourcing, no travel or essential service permits. Limited to no engagement from the task force.

7. Could you identify any lessons learned? Please indicate if and how these lessons have been applied in preparedness strategies or in subsequent situations of crisis.

These are detailed [here](#).

8. If your State has humanitarian aid programmes, please indicate whether SRHR are explicitly covered in the humanitarian aid strategy and how priorities on SRHR are set.

No readily available data.

9. Please indicate the main challenges, if any, encountered by women and girls to access justice and obtain reparations for violations of their SRHR, including any procedural barriers, and the types of assistance available to access legal and other remedies. Please also indicate the groups of women and girls most affected. Where applicable, please indicate the role played by a national truth and reconciliation commission (or a similar body) in ensuring the recognition of human rights violations in relation to women's and girls' SRHR and reparations.

No readily available data specific to COVID-19 crisis.

Preparedness, recovery and resilience

10. Is there any preparedness or risk management strategy/plan/policy in your State? If so, please provide information on the following aspects:

Yes. The National Disaster Risk Management Plan (NDRMP).

- a. To what crisis does it apply? What situations are excluded?

All situations are considered/included.

- b. Does it contain a definition of crisis? If so, please indicate the definition used.

No.

- c. Does it include measures concerning women and girls' SRHR? If so, please describe the measures included and any special measures envisaged and/or adopted for specific groups of women and girls concerning both preparedness and recovery.

No.

- d. How were the risks related to women and girls' sexual and reproductive health and rights, in urban and rural areas, identified and assessed?

No readily available data.

- e. Were women's rights organizations involved in: i) the development of the strategy/plan/policy; ii) assessment of the risks concerning SRHR; iii) the design of the measures implemented; and iv) the monitoring of the strategy/plan/policy? Please indicate the steps taken to ensure their participation and to include a gender-perspective in crisis preparedness, management and recovery.

No. Also, no readily available data on monitoring or steps to ensure participation.

- f. Please indicate if the strategy/plan/policy has undergone any assessments to date. If so, what were the main findings and recommendations concerning women's and girls' SRHR?

N/A.

- 11. If your State does not have a plan that can immediately go into effect in a time of crisis, please explain why it is so.

N/A.

- 12. Are there specific ways in which international human rights mechanisms can support States in their efforts to address a crisis?

Advocate for the inclusion of all CSOs, particularly the underserved and underresourced. Provide measures for cost efficient reporting mechanisms and evidence building for future feedback.