

REVIEW ARTICLE

Reproductive Health and the Question of Abortion in Botswana: A Review

Stephanie S. Smith

10 The crescent, Horsley Woodhouse, Ilkeston, Derby, DE76BJ, UK.

*For correspondence: E-mail: smith.s.stephanie@gmail.com; Phone: 07808 668493

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 fetus to term and abandon the infant at birth. I conducted research into perceptions of abortion in urban Botswana in order 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 constitutes 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. My findings however, 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 grossesse 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 2,065,398². The 2001 census showed 72% of Batswana identified themselves as Christian, less than one percent was Muslim, and 21% stated no religious affiliation¹.

I lived in Botswana's capital, Gaborone, working as a volunteer teacher for 16 months in 2010-2011. During that time I witnessed indicators

of problems for women's reproductive choice, which appeared out of alignment with a rapidly modernising society. I met women who had been compelled to surrender their personal aspirations because they were unable to terminate an unwanted pregnancy either as a result 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 numerous newspaper reports about women being prosecuted for involvement in abortion; the suicides of pregnant teenagers; deaths caused by dangerous 'backyard' abortions; and babies and fetuses being found abandoned or buried³⁻⁷. 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 in order 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 notion of submissive obedience for women has permeated socialisation to the extent that it can be difficult to recognise⁹⁻¹⁰. In the gender-related development index Botswana ranks 109 out of 157, illustrating that gender inequalities remain an issue¹¹. Whilst some women have begun to live relatively independent lives, they 'continue to negotiate their gender identities against a background of internalised cultural values'¹².

Many women in Botswana today live simultaneously modern and traditional lifestyles. They share their time between their rural homes and their city workplaces, increasing their independence and yet continuing to operate 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 independence¹³. The boundaries of patriarchy in Botswana are becoming increasingly fluid as women begin to move away from their traditional gender roles¹⁴.

Traditionally, the *lobola* (bride price) system represented the purchase of a woman's reproductive function, moving it from her family to her husband's family. Having paid this, the new husband was entitled to total sexual and physical control over his wife under customary law¹⁵⁻¹⁶. Customary law operates alongside common law today, but is ring-fenced and thus not subject to constitutional obligations that protect women's rights. The historical practice of *lobola* persists. Women's ability to resist a situation where they have little or no bodily autonomy continues to be undermined by their economic dependence on men¹⁷. Whilst employment in the formal sector is beginning to open up for women, it is limited and positions reserved for women are low-paid; most women are low-income domestic workers¹⁷. This situation supports the continuation of unequal marriages, and pushes unmarried women into exploitative interactions with older men who can supply them with the goods and services they require. Within these relationships women's reproductive decision-making powers are likely to be compromised by their subordinate position, which is both culturally perpetuated and economically necessary for their material survival¹⁷.

Gendered rules of behaviour mean that if a woman is raped she was 'asking for it' by acting inappropriately¹⁸. STDs are generally perceived to be women's diseases; some believe HIV can only be contracted from a woman¹⁷. 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 behaviour⁸. 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 men¹², and there is no space for women to participate genuinely and effectively in law or politics¹⁹. Botswana's system is inherently contradictory; a modern, democratic state, proclaiming the equal rights of all citizens; it is still fundamentally patriarchal¹⁹. 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 rights¹⁰. 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 reforms¹⁰⁻²⁰. Despite this impressive inventory of programmes aimed at eradicating gender inequality and advocating 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 autonomy²¹.

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 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 discriminatory²². 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 system¹. The country has witnessed rapid fertility decline, from 7.1 in 1981 to 2.9 in 2007¹¹ and 2.5 in 2011 at the time of my research². 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 accessible¹. 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 hospital²³. 94% of women received antenatal care at the time of writing (2011)¹¹.

Despite improvements in reproductive health, maternal mortality remains very high and its causes must be addressed²⁴. 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 measurement²¹, 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 21²⁶. Set against this goal, even the lowest figures for maternal mortality 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 families²⁷. 3,700 women were officially treated for complications of unsafe abortion in 1992³, which amounts to around 3% of the 1992 population. In 2007, 16% of maternal deaths were attributed to septic abortion²³. 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 total annual cost of post-abortion care in sub-Saharan Africa is between \$80m and \$145m, and this would be at least doubled if all the women who needed such care actually received it²⁸. The psychological and personal costs for women are great. Confusion, guilt and depression often follow abortion²⁹. Suicide associated with the turmoil of unwanted pregnancy and abortion is yet another cost²⁹. Vlassoff et al call attention to indirect costs to households and society³⁰. Inter-generational productivity is affected by maternal deaths or morbidity in the family and this has repercussions for the economy.

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 fetal impairment. The UN warns that despite this liberalisation of the abortion law, dangerous and illegal procedures

occur regularly in Botswana³¹. 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/or quality aftercare is usually restricted to women who have access to funds. Those without such means become the victims of dangerous clandestine procedures²⁸. This is applicable to Botswana where those with sufficient finances 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 requiring abortions are restricted to 'backyard' services.

While police and newspaper reports must be treated with caution, they do suggest that 'backyard abortion', 'fetus-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. Fetus-dumping refers to the concealment of a fetus 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 important that this effect of criminalising abortion is acknowledged and monitored as far as possible. It is likely that incidences of baby-dumping would be dramatically reduced if abortion was legal and accessible.

The 'pro-life' (anti-abortion) argument is commonly grounded in the idea that termination of the fetus is tantamount to murder. The debate surrounding the Penal Code (Amendment) Bill gave voice to vigorous disagreement from the Botswana Christian Council who took this approach³³. However, the Penal Code states, 'a child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother.' Thus, Botswana's law does not have any legitimate base in the pro-life paradigm, and the government's pro-active approach to revising gender-discriminatory laws implies that it is not simply an outdated piece of colonial legislation. Rather, there are contemporary grounds for denying abortion on demand. In the context of Botswana's notable democratic record it is reasonable to expect that its laws reflect the values of its society. This prompted me to explore attitudes to abortion, in order to find out if there are socio-cultural explanations for the criminal status of 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 vital indicator of womanhood. This has not diminished with modernisation. Childless women are treated with suspicion and suffer harsh consequences^{17,34}. Schapera emphasises how having and raising children is the cornerstone of the family and society in Tswana culture¹⁵. 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 ties¹⁹. 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 abortion¹⁵. Today it is still

widely considered that a man cannot be infertile; the responsibility for childlessness must fall upon the woman³⁵. Women have deployed covert devices to negotiate problems arising from uncertain fecundity in their husband. Narratives of 'sleeping fetuses' to explain how a woman became pregnant while her migrant worker husband was away, are just one example³⁵. 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 perceptions of motherhood; to terminate a pregnancy is to deny childbirth.

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 problem of abortion, and to its impact on women and the country as a whole. Such factors include the cultural challenges that are presented by a culture that defines women as subservient, and the impact of rapid developmental changes on traditional gendered roles. The effect of this situation is reflected in the complex dynamics of previous abortion law reform. 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 as a result of pressure from the medical profession seeking to protect themselves from the law, rather than from public demand for women's rights³³. Mogwe challenges the extent to which abortion law reform has actually increased women's bodily autonomy in Botswana; she 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 policy-making provide some useful information on women's reproductive health and rights.

Researchers have extensively 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 given the customary-law practice of *lobola* ('bride price') substantial attention¹⁵⁻¹⁶, as it underscores women's situation with regards to their 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 women¹². However, the belief that 'motherhood is rather a mandate and not an option' prevails³⁷, 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. Contributing to my understanding of motherhood in Botswana, Mogobe details the multiple ways in which being perceived as infertile can destroy a woman's social standing and identity³⁷. Peters calls for further investigation into interactions between women and men in the context of developmental changes³⁹; my research into the socio-cultural aspects of abortion in urban Botswana will add to this. To some extent, inferences about the socio-cultural aspects of abortion 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 called for qualitative work that addresses the absence of socio-cultural research focusing specifically on abortion^{28,29,40}. NGO Emang Basadi has called for studies that investigate the beliefs and attitudes of men and women in regard to family planning²⁵.

A number of 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 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. This compromises the efficacy of this grouping for discussion of sexual and reproductive health matters.

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 on the procedure serve to create a market for unsafe, clandestine services, increasing the risk of complications and resulting maternal deaths. Hord and Wolf discuss how dangerous problems such as infection, haemorrhage, perforation, infertility and pelvic inflammatory disease are almost totally preventable if procedures are done safely, and yet resources directed at reducing complications from unsafe abortion are too minimal to be effective⁴⁴. 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, sexual and reproductive services are supplied free in government clinics and hospitals, and yet alarming maternal mortality levels persist⁴⁷. In agreement with Hord and Wolf, they attribute the high number of abortion-related deaths to the 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 official 'Policy on Women in Development' declares the State's dedication to promoting reproductive health rights²⁴. We see this pledge repeated in multiple reports and publications. In these papers, discussions of rape, contraception, family planning, teenage pregnancy, HIV/AIDS, maternal mortality and other related issues are extensive. Abortion is given only a cursory mention as one cause of maternal mortality and is not investigated further. The government of Botswana and UNICEF acknowledged the tragic consequences of an increase in backstreet abortion in the late 1980s⁴⁸, yet only six lines are reserved for this issue within a 253-page publication. The government has continued to confirm that illegal, unsafe abortion is a regular occurrence in Botswana⁴⁹.

The way forward

Official reports outline the country's goals, achievements and strategies in the arena of women's health and rights. This allows me to gauge the extent to which abortion-related concerns support or contradict the perceived stage

of development in these issues. However, they are limited in that they only state what ought to be happening, what improvements have been attempted and the statistical impact of these changes. They cannot be said to represent lived experience or attitudes; people's voices are not heard through numerical data. It is imperative that investigations of beliefs and knowledge are carried out so that we can gain an understanding of the context of unsafe abortion, which may help pave the way for a thorough investigation of the problem.

Only a small number of studies have been based on the voices of the Botswana rather than on statistical data^{10,35,47,50}. Datta's research on gender and development involved interviews being conducted with official representatives in government and NGOs, as well as focus group discussions with groups of men¹⁰. Ritsema's illuminating study on HIV/AIDS in the context of rapid urban growth in Botswana presents a similar methodological framework as my own research, in that it is comprised of opportunistic selection of interview respondents⁵⁰. Mogobe's study of infertility was based on interviews with people living in Gaborone and encompassing a range of demographic attributes³⁷.

Given the legal and socio-cultural constraints on abortion in Botswana, it is not possible to estimate the true extent of the issue. However, the problem clearly has an impact on women's health, and is inextricable from the wider issue of women's reproductive rights, their bodily autonomy, and their position in a rapidly-developing nation.

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