ACCESS TO REPRODUCTIVE HEALTH SERVICES AMONG IMMIGRANTS AND REFUGEES IN BOTSWANA

NJOKU O. AMA AND JOHN O. OUCHO

INTRODUCTION

Reproductive health has been defined by Kulier and Campana[1] as a state of physical and social well-being in all matters relating to the reproductive system at all stages of life. Good reproductive health implies that people (including immigrants and refugees) are able to have a satisfying and safe sex life and that they have capability to reproduce and the freedom to decide if, when and how often to do so. Reproductive health entails more than just issues pertaining to reproductive organs; it embraces how social and sexual behaviours and relationships affect and create ill-health.[2] The Programme of Action[3] adopted at the International Conference on Population and Development (ICPDA/PA), held in Cairo in 1994 defined reproductive health as:

> "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and process"

It defined reproductive care as:

> "the constellation of methods, techniques and services that contribute to reproductive and sexual health and well-being by preventing and solving reproductive health problems, which also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases".

Immigrants and refugees, like most other people and particularly, because of their own peculiar circumstances are very vulnerable to reproductive ill-health as a result of: (a) restrictions on information about sexuality, contraception, disease

Njoku O. Ama, Department of Statistics, University of Botswana, Gaborone, Botswana and John O. Oucho, Centre for Research in Ethnic Relations, University of Warwick, United Kingdom.

prevention, condoms and health care; (b)harmful traditions such as the ritual of a woman having intercourse with a male relative after death of her husband, female genital mutilation, ritual scarification, tattooing and bloodletting (c) early marriage; (d) inability to negotiate safe sexual practices and rape; (d) discrimination against women in education, employment and social status; (e) laws that reinforce women's economic dependence on men and reliance on prostitution, including child prostitution for economic survival; and f) anomalous circumstances occasioned by war, famine, natural disasters, political oppression, poverty and displacement.[2]

Separation of immigrants and refugees from members of their family render them susceptible to infectious and communicable diseases including STDs and HIV/AIDS. Having left their home countries, and left behind relatives, friends, possessions, traditional routines and value systems and abandoned conventional ways of behaving in their home countries, immigrants and refugees face a number of problems in the host country. They include inaccessibility of health care services (including reproductive health care), adaptation to poor ecological problems, and job insecurity despite their level of education and work skills, learning the language of the host country, and not knowing where to seek reproductive health care services.[4-6] These circumstances call for comprehensive reproductive care services to be availed by immigrants and refugees, other displaced persons or populations affected by conflict on grounds of equity, justice and human rights.

The situation of ethnic minorities in the United Kingdom verifies this. For instance, babies born to Asian women in the United Kingdom are known to have lower birthweight than other babies and prenatal and postnatal mortality rates are generally higher among Pakistani and the Caribbean-born immigrants than in the general population. In the European Union, difficult pregnancies and pregnancy related illnesses are common problems among migrant women.[4] Yet these health concerns are hardly addressed in the host countries, subjecting the immigrants therein to face further health risks. The same situation exists in Mauritius,[5] generally in Latin America[6] and often faces immigrants and refugees in different settings.[9]

As provided in the international conventions – notably The Universal Declaration of Human Rights (UDHR) of 1948, the International Covenant on Economic, Social and Cultural Rights (ICESR) adopted in 1966, the International Covenant on Civil and Political Right (ICCPR), and also adopted in 1966 and the UN Convention on Migrant Workers and Members of their Families (CMWMF), operational from 1990 – immigrants and refugees are entitled to the same treatment as that of citizens of their countries of immigration. To amplify, Articles 5, 13 and 14 of the United National Universal Declaration of Human Rights, stipulate that they have the right to freedom from inhuman or degrading treatment and the right to seek and enjoy asylum in other countries. Both the ICCPR and the ICESR touch on the rights of immigrants and refugees that are often infringed in the host countries; and the CMWMF targets especially immigrant workers and members of their families who constitute the vast majority of foreigners in Botswana. A number of countries including Botswana might be among them, sign but thereafter fail to ratify these international instruments of human rights; and even when they ratify the instruments and pass national legislation, they do not enforce them. There exists, therefore, tension between international laws to protect human rights and national laws and countries' promotion of only the rights

and welfare of their citizens. Botswana, a democratic country that has no overt spurts of violation of human rights is expected to conform to these international instruments of human rights, in particular the CMWMF, given its heavy dependence on immigrant workers who of necessity must be accompanied by members of their families.

Other studies stress that expansion of the types and places where clients can obtain reproductive health services, namely public hospitals, clinics and health posts, private medical facilities, pharmacies, convenience stores, malls and markets, as well as diversifying methods and reducing cost of the service enhance access to these services. As found in Thailand, a woman who has reached the desired family size is more likely to use contraception if an outlet providing services is nearby than if the outlet is some distance away; thus close proximity of a family planning outlet brings a difference in contraceptive prevalence of about 27 percent.[13]

Department of International Development (DFID) of the United Kingdom[14] has indicated that for reproductive health services to perform well, they should be: (a) responsive and accountable to poor and vulnerable people; (b) appropriate to local needs; (c) acceptable to poor women, men, young people and specific vulnerable groups (such as sex workers and the immigrants and refugees); (d) affordable; (e) physically accessible (in terms of location and opening time); (f) of high quality (client-focused, well-managed with skilled, equipment and supplies needed to offer best practice); and (g) non-discriminatory and non-stigmatising, for example the health providers do not discriminate the poor and vulnerable people.

Other studies have identified barriers to accessing reproductive health services by immigrant women to include: (i) lack of community education about available services; (ii) lack of linguistically-competent reproductive health services; (iii) use of male relatives as interpreters; (iv) male domination and lack of personal decision-making power; (v) intersection of domestic violence and gender power imbalance with access to reproductive health services; (vi) fear of deportation and detention; (vii) lack of health insurance; (viii) inflexible health clinic hours; and (ix) lack of culturally sensitive services, negative attitudes of front-line health workers and insensitivity to the unique challenges facing immigrant women.[12,15] A study of health providers revealed language, lack of funds, lack of interpreters and cost in providing language interpretation, in that order, as the barriers to service provision.[15]

The theoretical framework of this study is premised on the happening in the international scene, including the international instruments for human rights that have been highlighted earlier. At a meeting in December 1998, UNAIDS[16] underlined the need to review restrictive immigration laws which in their view limit effective AIDS prevention, care and support, as well as the need to review human rights violations (such as discriminatory policies associated with HIV screening) which contribute to immigrants' and refugees' vulnerability to HIV infection. The HIV/AIDS agency contended that failure to respect immigrants' human rights such as freedom of movement, asylum, and being accompanied by family members, may have unanticipated effects on the health of immigrants and the public health in general. Immigrants, particularly refugees and 'undocumented immigrants' are often vulnerable to reproductive ill-health, including HIV/AIDS and other sexually transmitted diseases.[17] Even the achievement of three of the eight Millennium Development Goals (MDGs), namely reduction of child mortality and

of maternal mortality, combating HIV/AIDS, malaria and other diseases by 2015 is doubtful unless both the local population and the two groups of foreigners receive the same level of health care service.

If neglect to access reproductive services persists, it would constitute a major obstacle to attainment of the MDGs. It has also been identified that access to reproductive health services influences global security, reduces reproductive illnesses and unintended pregnancies in both the teenage girls and adult women, reduces maternal mortality, and gives the woman an opportunity to determine the number and spacing of her children, thereby making it possible for her to participate in work force and contribute to the development of the economy.[18]

The ICPDA/PA (United Nations, 1996, para. 4.4)[3] makes an even more telling statement: "Countries should act to empower women and should take steps to eliminate inequalities between men and women .... by: .... eliminating all practices that discriminate against women, assisting women to establish and realize their rights, including those that relate to reproductive and sexual health; ....eliminating violence against women; .... eliminating discriminatory practices by employers against women such as those based on proof of contraceptive use or pregnancy status.....".

It recognizes the importance of improving the status of women; thereby enhancing their decision-making capacity at all levels in the sphere of life, and especially in the area of sexuality and reproduction.

As detailed in the international instruments on human rights, immigrants and refugees, being part of the societies in which they live should not be excluded from these forms of empowerments. Their access to reproductive health is a fundamental human right which should never be denied to them irrespective of their immigration status.

While the immigrants and refugees, being foreigners, share a lot in common, they have minor differences. The 1951 Refugee Convention and its 1967 Protocol restricts the definition of a refugee to:

> *"a person who is outside his own country, who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion and who as a result of that fear is unable or unwilling to return to this country or to avail himself to its protection"* (1951 Refugee Convention, Article IA (2)).

With the establishment of the Organisation of African Unity (OAU), a new definition that captures the regional conditions became necessary. Thus, the 1969 OAU Refugee Convention extended the definition to cover:

> *"every person, who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality".*

Immigrants, on the other hand, are those who move partly (and like the refugees) due to fear of persecution, wars or conflicts; political repression, generally directed at particular groups; environmental hazards (such as drought, flooding or other natural disasters) and partly because of lack of employment opportunities and rampant unemployment as well as underemployment in their countries. They migrate to the countries where employment opportunities are perceived to exist, while refugees are forced by circumstances beyond their control to move to the same destinations. Thus, for immigrants economic reasons

usually tend to outweigh other reasons for migration.[19]

Background

Botswana has a history of unique political stability in comparison to other sub-Saharan African countries. This has resulted in a high rate of legal immigrants and refugees into the country during the past two decades. The Botswana Population and Housing Census of 2001 reported 60,716 immigrants and refugees, which represents approximately 3% of the population of the country, an increase of 1.2% from the 1971 census figure (Republic of Botswana, 2003).[20] The legal immigrants consist primarily of permanent or temporary workers and their families,[21] while the refugees consist of those who are fleeing from regional/national while political or social problems from the nearby countries, Namibia, Angola, and Democratic Republic of Congo (DRC). The majority of the refugees are held in the Dukwi Refugee Camp, located 130 km from Francistown, Botswana's second largest city. Their movements are highly restricted for security reasons, which limit their interaction with the local population. While some of the immigrants have employment, and may be able to afford health services, although these services can be difficult to locate, most of refugees are destitute and qualified only for temporary and low-paying jobs, so health services are not affordable even if it can be identified.[4,23]

There is no mention of obligations of the government for providing health services for the immigrant and refugees population in the Botswana's National Health Policy, the Immigration Policy, and the National Sexual and Reproductive Health Programme Framework. In view of the high prevalence of HIV/AIDS in Botswana, South Africa and other sub-Saharan countries,[2] it is critical that reproductive health services be as affordable and accessible for this population as it is for others in Botswana.

The tension analysed in this study is the conflict between availability of reproductive health services in Botswana's health system and the failure of immigrants and refugees in the country to access it. This is anomalous from the theoretical standpoint as eligible clients often make full use of the available reproductive health services unless they lack knowledge of it or issues such as cost of transport and timing. This study aims at: (a) assessing the extent of availability of reproductive health services in Botswana's Health system to immigrants and refugees; (b) assessing the extent to which reproductive health services that are available in Botswana's Health system are accessible to immigrants and refugees in the country; and (c) assessing whether there are differences in availability and accessibility of reproductive health services to immigrants and refugees in their home countries and in Botswana.

Methodology

This is a cross-sectional study using both qualitative and quantitative methods in seeking the views of immigrants and refugees on accessibility of reproductive health care services from the Botswana health care systems. The population of immigrants and refugees was stratified by 23 health districts. The estimated sample size was allocated to the 23 health districts (strata) using probability proportional to size (PPS). Having obtained the sample size for each district, the immigrants and refugees to be interviewed from each health district were selected randomly until the allocated sample size was attained.

The study answered the following questions: (i) To what extent are reproductive health services available in the Botswana's health care system? (ii)

How accessible are the available reproductive health services to immigrants and refugees? (iii) How do availability and accessibility of reproductive health services in Botswana compare with those in the immigrants' and refugees' home countries?

The survey targeted 60,716 legal immigrants and refugees residing in the 23 health districts of Botswana. In order to determine an appropriate sample size for the study, the Creative Research Systems (2003),[25] a sample size calculator computer package was used. The programme showed that for a population of 60,716 legal immigrants and refugees, and with 95% confidence (allowing an error of plus or minus 3%), that the response of the immigrants and refugees sampled will be the same as that from the entire population, a sample size of 1049 legal immigrants and refugees would be required for the study. An additional 15% of this statistically generated sample was included to cater for those who in the original sample may not be located or who might decline to participate in the study, bringing the sample size to 1205. This measure is appropriate to ensure that at no time will be study sample be less than the statistically generated sample size for the study.

The instrument used in this study was a questionnaire. The questionnaire contained questions on the demographic and socio-economic characteristics as well as availability and accessibility of reproductive health services by the immigrants and refugees. Trained Research Assistants appointed for fieldwork and under supervision contacted respondents either at their home or at the workplace. They explained the purpose and nature of the study to give the respondents an opportunity to either accept or decline participation in the study. For those who consented, the Research Assistants administered the English language questionnaire. Code numbers were assigned to each questionnaire as a way of ensuring confidentiality. However, in cases where the respondents complained of not having time to sit with the Research Assistant to complete the questionnaires, the questionnaires were self-administered and collected later as mutually agreed by the particular respondent and Research Assistant. The total number of immigrants and refugees that responded was 1,188 (652 male and 536 female immigrants and refugees) giving a response rate of 98.6%. This paper is based on the responses from the 1188 immigrants and refugees.

The questionnaire for the study was tested on a sample of 30 immigrants from the University of Botswana for its content validity and later reviewed by scholars. The reliability was measured and found to be adequate (Cranach's alpha = 0.89). respondents included in the pre-test of the questionnaire were excluded from the final sample for the study.

The data analysis consists of two parts: Cross-tabulation of the socio-economic and demographic, availability and accessibility variables with immigration status. The chi-square test and correlation analysis were used to test for dependence of the criteria of classification.

Results

Background characteristics

The respondents were classified according to three demographic characteristics, namely, gender (male and female), educational attainment and marital status, some of the factors that affect access to reproductive health services.

A total of 652 (54.9%) male immigrants and refugees and 536 (45.1%) female counterparts participated in the study. Out of these, two-thirds (67%) were immigrants while slightly less than one-fourth (24%)

were refugees. Only about nine per cent of the respondents, including students, did not disclose their immigration status, a proportion small enough to be ignored in the data analysis.

A phenomenal 94.8 per cent of the immigrants and refugees had some education ranging from primary to university, while a lower proportion (45.1%) of the immigrants and refugees had post secondary education. Only 3.6 per cent had no formal schooling. Very few of the immigrants and refugees (6.2%) had no educational qualifications, while 28.8 per cent had a degree.

Most of the immigrants and refugees (61%) were either married or in some consensual union while only one-third of them were single. The dominance of married or in consensual union immigrants' and refugees' implies greater demand for reproductive services.

Availability of reproductive health services

Accessibility of the reproductive health services (including STDs and HIV/AIDS) depends primarily on their availability, mediated, of course, by national policies, laws and practices. The immigrants and refugees were asked to indicate the extent of their awareness of the availability of reproductive health services in the Botswana health system responding on a five-point scale: 1=never (it is not available at all); 2=sparingly (it is available from 1% but below 20% of the time); 3=sometimes (it is available from 20% to 50% of the time); 4=most of the time (it is available over 50% to 99% of the time); 5=all the time (it is available 100% of the time). Table 1 summarises the percentage responses of the immigrants and refugees for the two extreme positions, namely, most / all the time and never/sparingly. The results show that between 25 per cent and 45 per cent of the immigrants were aware, 81 per cent of the studied reproductive health services were available over 50 per cent of the time whereas the same percentage of the refugees were only aware that services for antenatal, treatment of STDs, AIDS counseling, AIDS testing and programme on contraceptive availability and use (representing 24% of the studied reproductive health services) were available over 50% of the time. Over one-fifth of the refugees were aware that most (62%) of the reproductive health services were never available.

Application of chi-square test suggests that there is a significant association between the immigrants' and refugees' responses on the extent of availability of reproductive health care services and reproductive health services ($p<0.05$). Immigrants and refugees were significantly and moderately positively correlated ($r=0.469$, $p<0.05$, $n=21$) in their opinions on availability of reproductive health services most or all the time, and substantially positively correlated in their view that reproductive health services were never available or available sparingly ($r=0.552$, $p<0.05$, $n=21$). In order to measure internal consistencies in the opinions of the sampled groups, most or all the time were correlated with those who indicated that the services were never or sparingly available. Similar measure of internal consistency was calculated for the refugees. The results show substantially negative correlation ($r=-0.574$; $p<0.05$, $n=21$) for the immigrant opinions and negatively low correlation among the refugee respondents ($r=-0.188$; $p<0.05$, $n=21$). Thus, while the two groups, immigrants and refugees tend to agree on the availability of reproductive health services in Botswana's health system, within each group there is some measure of disagreement and this, of course, is expected.

TABLE 1

Awareness of availability of reproductive health services in the Botswana health system among immigrants and refugees

Awareness on type of service available	Immigrants		Refugees	
	Most/all the time	Never/ sparingly	Most/all the time	Never/ sparingly
	%	%	%	%
Antenatal care	36.0	6.4	33.9	9.7
Delivery (normal)	37.4	12.3	2.9	10.0
Basic emergency obstetric care	26.7	13.2	12.8	25.6
Emergency: caesarean section	24.6	11.3	13.1	9.3
Emergency: blood transfusion	19.6	14.0	7.3	26.6
Treatment of abortion complication	18.1	20.4	12.4	25.6
Elective (induced) abortion	16.6	14.7	11.4	11.8
Family planning	25.0	6.6	24.2	8.0
Emergency contraception	26.7	11.3	15.9	21.1
Syndromic diagnosis of STDs	27.5	13.2	12.5	22.8
Laboratory diagnosis of STDs	30.5	11.0	13.8	22.8
Treatment of STDs	35.6	8.0	34.6	11.8
AIDS counseling	45.5	8.0	34.6	22.5
AIDS testing	37.0	13.9	32.9	23.5
Sexual/domestic violence/rape counseling	28.3	15.3	15.9	14.5
Mental health counseling	22.8	19.1	6.9	27.7
General surgery	31.5	10.9	12.4	24.9
General treatment for other illnesses (men, women, children)	29.4	10.8	14.5	22.8
IEC on human sexuality	29.4	13.9	9.7	26.0
Programme involving men in sexuality and reproductive health	30.9	14.4	16.3	24.2
Programmes on contraceptive availability and use	31.4	9.5	29.4	9.7

Accessibility of reproductive health services

Against the backdrop of the availability of reproductive health services in the Botswana's health system, immigrants and refugees were asked to state the extent to which the services were accessible to them whenever desired. Their responses were based on five-point scale: 1=never (it is not accessible at all); 2=to some extent (it is accessible between 1% and 20% of the time); 3=to a reasonable extent (it is accessible over 20% but less than 50% of the time); 4=to a great extent (it is accessible over 50% but less than 90% of the time); and 5=to a very great extent (it is accessible 90% or more of the time).

Table 2 shows that 38 per cent of all the available reproductive health services were accessible over 50% of the time to a little over 30 per cent of the immigrants, while only services in antenatal care, AIDS counseling and AIDS testing (14% of available reproductive health services) were accessible to more than 30 per cent of the refugees over 50% of the time when they desired them. Over one in every five refugees affirmed that services on

information education and communication (IEC) on human sexuality, programmes involving men on sexual and reproductive health, general treatment for other illnesses and blood transfusion were never accessible or were accessible to them only to some extent.

There was a very strong agreement among the immigrants and refugees ($r=0.892$, $p<0.05$, $n=21$) on the accessibility of the reproductive health services to a great or very great extent and substantial association ($r=0.582$, $p<0.05$, $n=21$) on whether the reproductive health services

TABLE 2

Accessibility of reproductive health services of Botswana health system among immigrants and refugees

Type of service accessible	Immigrants		Refugees		Others	
	To a great or very great extent	Never or to some extent	To a great or very great extent	Never or to some extent	To a great or very great extent	Never or to some extent
Antenatal care	38.4	6.3	31.5	7.6	26.6	13.0
Delivery (normal)	37.8	6.0	27.7	5.9	32.1	9.1
Basic emergency obstetric care	25.1	13.8	10.7	23.5	15.6	23.4
Comprehensive emergency obstetric care: caesarean section	22.1	12.8	8.7	10.4	16.4	16.5
Comprehensive emergency obstetric care: blood transfusion	16.8	17.8	5.9	27.3	9.7	24.0
Treatment of abortion complication	15.2	19.3	3.5	22.8	13.6	25.3
Elective (induced) abortion	12.4	20.0	5.5	10.0	10.4	26.6
Family planning	34.0	10.5	27.3	6.9	28.1	11.0
Emergency contraception	23.2	12.7	7.3	11.1	18.2	15.6
Syndromic diagnosis of STDs	25.1	9.9	7.3	11.1	18.8	15.6
Laboratory diagnosis of STDs	30.6	11.5	20.1	12.1	17.5	20.8
Treatment of STDs	30.4	11.8	13.5	25.3	20.8	13.0
AIDS counselling	43.4	12.3	33.1	21.0	40.3	11.0
AIDS testing	40.7	13.4	33.2	20.1	40.9	12.3
Sexual/domestic violence/rape counselling	25.1	10.4	13.8	8.0	24.0	13.6
Mental health counselling	22.2	18.2	5.2	15.2	18.8	20.1
General surgery	26.6	11.7	4.8	11.1	22.1	18.2
General treatment for other illnesses (men, women, children)	32.6	12.7	10.7	24.6	26.0	11.7
IEC on human sexuality	25.8	17.3	8.0	27.3	17.5	22.1
Programme involving men in sexuality and reproductive health	24.5	19.1	13.5	23.5	17.5	22.7
Programmes on contraceptive availability and use	25.1	15.7	12.5	22.8	17.4	19.5

were never accessible or were accessible to some extent.

Factors affecting inaccessibility of reproductive health services

The previous section has underscored the finding that some immigrants and refugees are unable to access the desired reproductive services. To explore the issue further, the study sought to know from the immigrants and refugees the reasons for inability to access the reproductive health services. A little over two in every five refugees indicated their inability to pay for the services due to lack of funds as their reason compared to about one in every ten immigrants who cited the same reason. Other reasons given for not being able to access reproductive health services, in descending order, included unavailability of the services at the clinics or hospitals whenever needed; reservation of the services for the local population; and meeting the cost of the services being viewed as an individual immigrant's or refugee's concern.

Reproductive health services in Botswana and home country

To determine how changes in the immigrants' and refugees' social and economic environment may have affected their reproductive health demand and acquisition, they were asked to compare availability as well as accessibility of reproductive health services in Botswana with those in their home countries. The responses were based on "yes", "no", "don't know", and "not applicable".

Table 3 summarises the two definitive responses with higher percentage of immigrants than refugees affirming that reproductive health services were more available and accessible in their home countries than in Botswana. A correlation of the opinions of immigrants and refugees showed that there was very little agreement between them ($r=0.273$; $n=21$). This is also supported by an analysis of variance (ANOVA) test which shows significant differences in the responses of the immigrants and refugees ($p<0.000$).

Discussion and Conclusions

This study examined the extent of access to reproductive health services by immigrants and refugees in Botswana against the recognition of the fact that access to reproductive health services, including contraception as well as care in pregnancy and childbirth can lead to: (i) reduction in a woman's exposure to fatal obstetric complications; (ii) reduction in the incidence of HIV/AIDS and other sexually transmitted diseases; (iii) empowerment of women to make informed choices and decisions that affect their lives; and (iv) it portends dangerous circumstances for Botswana when a resident in the country, in this study immigrants and refugees, fail to access these services.

The findings of the study confirm that while immigrants are aware of the availability of most reproductive health services in the Botswana health care system, the refugees are only aware of services in antenatal care, normal delivery, treatment of STDs, AIDS counseling and HIV testing and programme on contraceptive availability. This finding is in contrast to those of Purdin et al,[25] that a wide range of refugee and conflict-affected sites provide reproductive health services. Surprisingly too, IEC programme on human sexuality is hardly available to the immigrants and refugees. Unlike the majority of immigrants, refugees fled their home country due to unbearable socio-political circumstances and are more vulnerable to circumstances in Botswana about which they can do little to redress; they need information on reproductive health services available in the health care system in Botswana through an IEC programme that is tailored to their needs.

TABLE 3

Comparison of reproductive services in Botswana and the home country of immigrants and refugees

Type of service accessible	Response	Immigrants	Refugees	Others
		%	%	%
Antenatal care	Yes	29.6	17.7	24.5
	No	14.9	25.3	18.6
Delivery (normal)	Yes	27.6	17.3	25.5
	No	15.6	12.8	16.7
Basic emergency obstetric care	Yes	21.0	14.5	21.6
	No	16.6	24.9	17.7
Comprehensive emergency obstetric care: caesarean section	Yes	22.2	13.2	21.6
	No	15.8	27.7	19.6
Comprehensive emergency obstetric care: blood transfusion	Yes	21.7	26.6	21.6
	No	16.7	13.2	16.7
Treatment of abortion complication	Yes	21.2	6.9	16.7
	No	17.1	40.1	21.6
Elective (induced) abortion	Yes	20.8	13.8	20.6
	No	15.3	28.4	17.7
Family planning	Yes	22.0	14.2	21.6
	No	15.4	28.7	15.7
Emergency contraception	Yes	20.2	3.8	22.6
	No	16.9	38.1	16.7
Syndromic diagnosis of STDs	Yes	21.5	13.8	18.6
	No	17.4	29.8	19.6
Laboratory diagnosis of STDs	Yes	20.8	18.3	17.7
	No	18.6	30.8	20.6
Treatment of STDs	Yes	19.3	14.5	20.6
	No	20.2	31.1	20.6
AIDS counselling	Yes	22.1	16.3	25.5
	No	19.3	32.5	20.6
AIDS testing	Yes	22.7	17.0	25.5
	No	18.6	34.3	19.6
Sexual/domestic violence/rape counselling	Yes	22.6	21.1	25.5
	No	18.1	30.8	16.7
Mental health counselling	Yes	23.2	6.9	21.6
	No	16.8	40.1	14.7
General surgery	Yes	24.3	19.4	25.5
	No	15.1	28.4	12.8
General treatment for other illnesses (men, women, children)	Yes	22.6	15.9	21.6
	No	16.9	22.5	16.7
IEC on human sexuality	Yes	19.6	19.4	22.6
	No	16.8	30.8	14.7
Programme involving men in sexuality and reproductive health	Yes	22.1	16.6	23.5
	No	15.7	29.8	13.7
Programmes on contraceptive availability and use	Yes	19.8	4.5	24.5
	No	17.7	41.9	15.7

"Not applicable" and "Don't know" responses have been omitted for.

The revelation from the study that while over 30 per cent of the immigrants have access to about 38 per cent of the reproductive health services available in the Botswana's health care system, only 14 per cent of the available reproductive health services can be accessed by the same percentage of refugees, does not augur well for the foreigners. Indeed, confinement of most refugees in Dukwi refugee camp far away from both Francistown and Gaborone, where the services are more readily available, compromises their access to these services. Such a large concentration of foreigners from different countries and in the country due to different circumstances perhaps need better access to services than immigrants, some of whom can even afford to pay for the services. Expansion of different health-delivery points in the health system hierarchy, where users or clients can obtain the services and diversification of the services and reduction in cost of these services is likely to improve access to these services in the country. There is, therefore, a need to increase access to reproductive health services both at the Dukwi camp and in the neighbouring villages where refugees interact with other people-immigrants and the locals.

The study also has shown that a significant majority of the refugees and a lesser proportion of the immigrants were unable to access services to meet their reproductive health needs due to lack of funds to meet the cost of the services. This result corroborates that of a previous sudy.[15] Oucho and Ama[19] found that over 41 per cent of the immigrants and refugees were unemployed while some others who were employed had taken up poorer paying jobs that the locals shunned. The foreigners' meager earnings incapacitated them from meeting the cost of reproductive health needs.[19] On another plane, as refugees in the camp are usually not allowed to seek employment or leave the camps for security reasons, they have no opportunity to engage in paid employment, hence they exclusively rely on the only reproductive health services extended to them in the camp.

The findings that availability and accessibility of reproductive health services were better in the immigrant and worse in refugee home country than in Botswana questions the policy stance of the country of migration, which is known to have better services than most of the immigrants' countries of origin. This finding is not surprising because most of the refugees live on camps where reproductive health services are made more readily available and provided through the joint Government/UNHCR health programme. Thus, while refugees are served collectively given their status, immigrants have to fend for themselves. It is time that the immigrants and refugees exert their rights which is enshrined in the international instrument of human rights, which Botswana has signed and ratified. Perhaps this is also an issue that should be incorporated in Botswana's international relations agreements with the immigrant and refugee country of immigration. As immigrants provide invaluable service in diverse areas of development in Botswana, they deserve benevolence from the country of their service to the country's democracy and its ability to sustain its health system.

The findings indicate low accessibility of elective (induced) abortion which reflects Botswana's view on abortion as illegal and the services can only be availed in the case where pregnancy would involve risk to life of the pregnant woman or there is substantial risk of serious mental or physical abnormality to the child.

This article has shown that inspite of Botswana's huge investments in the health care programmes, only the citizens have benefited from it as foreigners become increasingly marginalized, despite their

inability to meet their desired reproductive health needs. The findings call attention to the Government of Botswana to factor in the national health policy and programme the shortcomings of immigrants and refugees not accessing the available reproductive health services in the country. Social and economic changes and changes in sexual behaviour due to relocation and social status affect reproductive health in general, and especially among women.[22] Since cost of obtaining reproductive health services seems to be a major hindrance to immigrants and refugees accessing their desired services, the Government of Botswana could introduce a reasonably subsidized health provision to immigrants and refugees. In addition, the Government of Botswana should prevail on the private sector, which the vast majority of serving immigrant workers to complement the provision of these services through tax rebates and other incentives thereby reducing the cost and enabling the service consumers to have better access.[27,28]

The study has also noted that refugees are more disadvantaged than immigrants, although they of necessity, require services given their traumatized background in the countries of origin and their vulnerability to reproductive health problems in the camp. It may be advisable for the Government of Botswana to expand access to reproductive health services through well-equipped outlets where the immigrants and refugees live; that could be a priority area for the Government of Botswana-UNHCR collaboration in the near future. Another service requiring expansion and intensification is the IEC programmes tailored to meet the reproductive needs of immigrants and refugees.

Legally and to underscore its adherence to international instruments of human and minority rights that it has signed and probably ratified, the Government of Botswana needs to have immigrants' and refugees' reproductive services embedded in the national health system. Numerous interactions between locals and foreigners in the country, which give rise to intimate sexual relationships, pregnancies and intermarriages, interrogate the wisdom of partial provision of services to citizens, rather than to the two interacting groups. It compromises the desire to contain reproductive health challenges such as HIV/AIDS, which threaten to radically alter the country's demographic future and constrain its socio-economic development, including the possibility of denying the country the realization of the principal objectives of Vision 2016 and the MDGs. For a country which has been receiving increasing numbers of immigrants and refugees, among them sex workers, provision of reproductive health services to locals only does not augur well for the health status of all inhabitants of the country. Its admission of immigrants and refugees has to take due cognizance of the international instruments governing human rights in general, the rights of immigrants and their families and refugees, and those in refugee-like circumstances.

That the international community has identified sexual and reproductive health as a component of the MDGs to be achieved by 2015 underscores the need for the findings of this study to be accorded attention in various circles within Botswana and in the country relations with other countries as well as development partners. The Millennium Project (MP) Task Force on Child Health and Maternal Health submission calls for universal access to reproductive and sexual services through the primary health care systems. A denial of access to reproductive health services of any group of people, particularly immigrants and refugees, violates the above recommendations, the Delhi Declaration on Maternal and Child Health (2005)[29] and The ICPD World Leaders Statement (2005)[30] to which

Botswana has acceded. Clearly, an expanded access to reproductive health programmes in Botswana both by the local population and by immigrants and refugees will play a more critical role in improving the quality of life for individuals and their entire communities.

Acknowledgement

The authors are most grateful to the John D. and Catherine T. MacArthur Foundation for Grant No. 04-83070-000-GSS which funded the initial study on which this article is based.

References

1. Kuller, R. and Campana, A. 2004. Reproductive health research challenges. Reproductive Health. Geneva Foundation for Medical Education and Research, Geneva, Switzerland. Vol. 1:2

2. WHO. 2000. Reproductive health during conflict and displacement. WHO/R/RHP/00.13. Available at: http//www.who.int/reproductive-health/publications/RHR_00_13_RH_conflict_and_disp. Accessed 16/10/2004

3. United Nations. 1996. Programme of Action adopted at the International Conference of Population and Development, Cairo, 5-13 September 1994. New York.

4. Carballo, M. and Nerukar, A. 2001. Migration, refugees, and health risks. Emerging Infectious Diseases: 7(3), Supplement, June.

5. DFID. 2004. Sexual and reproductive health and rights: A position paper. Department for International Development, UK.

6. Harris, N. 1997. Making decisions about reproductive health needs of immigrants and refugees. Personal Communications, John Snow, Inc.

7. Budory, B. 1996. Family planning for migrant workers in Mauritius. Personal Communication. Mauritius Family Planning Association

8. Di Blassi, F. 1996 Reproductive health services for immigrants in Latin America and the Caribbean. Personnal Communications. IPPF

9. Sachs, L. 1996. Availability of information on reproductive health and characteristics of immigrants and refugees. Personal Communication, Marie Stopes International, May 15.

10. The World Bank Group. 1994. Family planning: A development success story. Washington DC. (Based on the World Bank Publication: Effective Family Planning Programmes, Washington D.C.)

11. Lech MM. 2004. Contraception in Europe: accessibility and availability. Journal of Family Planning and Reproductive Health Care, 30(3): 151-153.

12. Outlook. 2004. Increasing access to reproductive health through pharmacists. Outlook, Vol.21(2). Available at http://www.path.org/files/FOL_21_2_Sept04.pdf

13. Entwisle, B., Hermalin, A.I., Kamnuansilpa, P., and Chamratrithirong, A. 1984. A multi-level model of family planning availability and contraceptive use in rural Thailand. Demography, 21(4):559-574.

14. DFID. 2004. Sexual and reproductive health and rights: A Position Paper. Department for International Development, UK.

15. Centre for Women in Government and Civil Society and Family Planning Advocates of New York State. 2002 Working together to increase immigrant women's access to reproductive health care. Office of Minority Health and The Bureau of Women's Health, New York State Department of Health, USA

16. UNAIDS. 1998. Migration and HIV/AIDS. UNAIDS Programme Coordination Board Paper presented at the Second Ad Hoc Thematic meeting, New Delhi, December, 9-11.

17. De Haan, A. 2000. Immigrants, livelihood, and rights: The relevance of migration in development policies. Social Development Working Paper No. 4. Social Development Department.

18. Population Action International. 2005. How access to sexual and reproductive health services is key to Millennium Development Goals. Available at: http://www.population.org/resources/factsheets/factsheet_11.htm Accessed 13/03/07

19. Ouche, J.O. and Ama, N.O. 2006. The impact of migration policy on the reproductive health of

immigrants and refugees: A case study of Botswana. A research report, submitted to the John D. and Catherine, T. Mac Arthur Foundation, February.

20. Republic of Botswana. 2003. 2001 Population and housing Census. The Government Printer, Gaborone.

21. Campbell, E.K. 2003. Attitudes of Botswana citizens towards immigrants: Signs of xenophobia? International Migration; Vol. 41(4):71-109

22. Carballo, M. and Nerukar, A. 2001. Migration, refugees and health risks. Emerging Infections Diseases, 7(3), Supplement, June.

23. Allotey P, Manderson L, Baho S, Demian L. 2004. Reproductive health for resettling refugee and migrant women. Health Issues, 78:12-17

24. UNAIDS. 2007. AIDS epidemic update: Sub-Saharan Africa-Regional Summary. World Health Organization (WHO) 2005. Measuring access to reproductive health services: Report of WHO/UNFPA Technical Consultation, 2-3 December 2003, Department of Reproductive Health and Research, World Health Organization, Switzerland.

25. Purdin, S., Casey, S., and McGinn, T. (n.d) Evaluation of coverage of reproductive health services for refugees and internally displaced persons, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University. Available at http://www.iinhcr.Org/home/PUBL/41 c847652.pdf. Accessed 26/04/07

26. Penal Code (Amendment) Act, 1991. Botswana Penal Code Amendment Act, 1991 of 11 October 1991. Government Gazette, Suppl. A, pp.A55-6

27. Oucho, J. 2000. Botswana: Migration overview. In: Oucho, J., Campbell, E., and E. Mukamaambo (eds), Botswana: Migration Perspective and Prospects, South African Migration Project, Migration Policy Series, No. 19, Capetown: IDS A and Canada: Queen's University, 2000, pp.6-21

28. Oucho, J.O. 2004. Skilled immigrants in Botswana: A stable but temporary work force, in: Oucho, J., Campbell, E. and E. Mukamaambo (eds.). Botswana: Migration Perspectives and Prospects. Southern African Migration Project Policy Series No. 19, Cape Town: IDS A and Canada: Queen's University, pp. 6-21.

29. The Delhi Declaration on maternal and child health. 2005. Lives in the balance. The New Partnership New Delhi, April.

30. ICPD World Leaders Conference. 2005. World Summit commits to universal access to reproductive health by 2015.