

Challenges faced by older women in Botswana in accessing services that address sexual and reproductive health, and family planning needs, in Botswana

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Abstract

Objective: This study explored the challenges that older women from selected sites in Botswana face in accessing services that address sexual and reproductive health (SRH) and family planning (FP) needs.

Design, setting and subjects: Two rural and two urban health districts were randomly selected for the study. A statistically determined sample of 454 older women was allocated to the different districts (strata), using probability proportional to size.

Outcome measures: The study estimated the percentage use of sexual and reproductive health services (including family planning services), unmet need for family planning and factors inhibiting use of these services.

Results: The study revealed that 25% of the older women used some type of FP method. Of this number, 67.9% were aged 50-59 years, 17.4% 60-69 years, 10.1% 70-79 years, and 72% had unmet needs for FP. The older women used natural FP methods mainly. The main SRH services used by them were screening for human immunodeficiency virus/acquired immune deficiency syndrome, sexually transmitted infections and cervical cancer. Obstacles to accessing SRH and FP services were found to include illiteracy, lack of education, financial constraints, a perception that healthcare planners limited SRH needs to antenatal and obstetrical services, a cultural reluctance to discuss SRH in public and domestic issues.

Conclusion: The study recommends comprehensive public health education for older women on human sexuality and fertility, contraceptive use, access to services, effective training programmes for healthcare providers on how to deal with older women's issues and better access to STI and cervical cancer screening services.

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Introduction

Reproductive health has been defined as a state of complete physical, mental and social well-being in all matters relating to the reproductive system and its functions, and not merely the absence of disease or infirmity. Therefore, reproductive health implies that people are able to have a satisfying and safe sex life, and have the capability to reproduce with the freedom to decide if, when and how often to do so.¹ The provision of adequate sexual and reproductive health (SRH) care includes ongoing improvement of antenatal, perinatal, postpartum and neonatal care, and providing high-quality family planning (FP) services, including fertility services. It also extends to eliminating unsafe abortion, combating sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), reproductive tract infections,

cervical cancer and other gynaecological morbidities, as well as promoting healthy sexuality.¹

Access to SRH/FP services is an essential component of integrated health care in addressing HIV/acquired immune deficiency syndrome (AIDS) and reducing the burden of disease globally. It is the basic right of all couples and individuals to attain the highest standard of SRH, to decide freely and responsibly on the number, spacing and timing of their children, and to have the information and means to do so. This basic right includes the right to make decisions on reproduction free of discrimination, coercion and violence, as expressed in human rights documents.²

Family planning is critical in preventing unwanted pregnancies and unsafe abortion, reducing poverty and maternal and child mortality, and also empowering women

to choose when and with whom to have children. FP programmes have been successful in developed countries and in most of Latin America and Asia, including Bangladesh and Nepal.³⁻⁴ Globally, 380 women will conceive each minute. Of this number, 190 are unplanned or unwanted pregnancies, 110 women experience a pregnancy-related complication, 40 have an unsafe abortion, one dies from a pregnancy-related cause, 650 people are infected with a curable STI, and 10 people are infected with HIV/AIDS.⁵

Many of the SRH/FP services target women of childbearing age (15-49 years) and to a lesser extent, men. Very few special programmes or interventions target the needs of older or vulnerable women (50 years and older). These women have serious SRH health needs. Well over half the women over 60 years of age live in developing countries.⁶⁻⁷

Studies that have been carried out in developing countries report that women suffer from gynaecological problems throughout their reproductive years and beyond, partially because of limited maternity and obstetrical services, combined with high parity.⁸ With progression to menopause and old age, women are at risk of symptoms associated with hormonal changes, cardiovascular disease, gynaecological malignancies and various genitourinary conditions.⁹⁻¹⁰ At this stage, their health depends on their health status prior to menopause to a large extent. Some of them are still sexually active and risk having unwanted and undesired pregnancies. SRH services that prevent recurrent unwanted pregnancies in older women contribute to improved perimenopausal health status. The women need the protection of condoms against HIV/AIDS and other sexually transmitted diseases. Factors such as lack of access to health facilities, disability-related technical and human support, stigma and discrimination (which affect older women's access to SRH services, including FP), need to be addressed by public health providers.

Botswana's economy is better than most neighbouring countries. The country has relatively good roads, a solid communications network, and 24-hour hospital services that are fairly well distributed throughout the country. However, there are serious barriers to access to comprehensive SRH care and FP services.¹¹ In spite of the free SRH/FP services, STI treatment, prenatal care, obstetrical care, and post-abortion care provided by maternity care providers, hospitals and government clinics, the health indicators, such as maternal mortality, HIV and contraceptive prevalence, do not reflect a healthcare system that meets the needs of its population.¹¹ Contraceptive prevalence in Botswana remains at 48%.¹²

Approximately 90% of people in Botswana are known to live within 15 km of a healthcare centre, yet use of these centres for SRH services is very low, especially among young people and older women. The availability of SRH services

does not necessarily translate to accessibility, particularly for older citizens. Young people have indicated that they are discouraged from utilising the services because of inconvenient hours, poor information on provided services and the unwelcoming attitudes of service providers towards them.¹³ Nevertheless, not much is known on why older women do not utilise these services.

Despite the clear need to focus resources on women of reproductive age, the public health services also need to ensure that the health needs of older women, including their reproductive and sexual health needs, are adequately addressed. According to a study that was carried out by Senanayake in 2000, roughly 31% of postmenopausal women have obstetric-related gynaecological diseases.¹⁰ Older women suffer from the lifelong effects of sexual bias and low social status, which can be burdensome. They bear emotional and economic burdens associated with their responsibility as family caregivers: looking after ageing parents, older husbands and orphaned or abandoned grandchildren.⁹ Little information on the SRH needs of older women is available. An example of this is Sri Lanka, where the Ministry of Health's routine Maternal and Child Health/FP information system does not collect data relating to older women. The Sri Lanka Demographic and Health Survey 2000 only collected information on fertility, FP and other selected reproductive health issues of ever-married women aged 15-49 years. Researchers rely mostly on clinical impressions and experience of older women's health profiles.¹⁴

To the best of our knowledge, information on programmes or interventions that target older women in Botswana is not available. Healthcare providers have limited information on the physical, psychological and social problems of older women. These women seldom seek care, often because they accept the physical discomfort associated with gynaecological problems, menopause and ageing as being natural.¹⁵ According to a study that was carried out in Botswana in 2009, 48% of older women could not access health care because of long distances from the services, while 62% of respondents indicated that lack of transport was an issue. They had to walk to attend a healthcare service.¹⁶

This paper explores the challenges faced by older women who are 50 years of age and older, from selected sites in Botswana, in accessing healthcare services needed to meet their SRH/FP needs. The study was conducted by the authors between February and October 2011 on a sample of older women who did not have any physical disabilities such as blindness, lameness, hearing defects or dumbness.

Older women provide most of the care to orphans and patients who are afflicted and affected by HIV/AIDS in Botswana.¹⁶ Therefore, it is particularly imperative that they

should remain in good health. Their health needs should be assessed to assist SRH programme designers in addressing issues that might improve their quality of life. Public health departments in Botswana should develop interventions to improve access to available SRH and FP services to meet those needs in older women.

Objectives

The objectives of the study were the following:

- To understand the demographic characteristics of older women.
- To determine the availability and accessibility of SRH/FP services to older women, and their utilisation thereof.
- To determine barriers encountered by older women in accessing basic SRH/FP services in selected sites in Botswana, and to elicit the opinions of older women on how these challenges could be overcome.
- To determine any policy implications that relate to the findings, and to make proposals.

Setting and sample

The study, funded by the University of Botswana, was conducted between February and October 2011. Four health districts of Botswana were included in the study: Gaborone, Kweneng East, Selibe Phikwe and Barolong. The 2011 population projection of women aged 50 years and older was 139 915 women, comprising 15.2% of the total female population and 12.1% of the total country's population.¹⁷ The estimated sample size for the study was calculated as 454, using the sample size calculator programme¹⁸ that allows for 95% confidence (and an error margin of 5%), and that posits that the sampled population's response should be the same as that of the entire population. This number was allocated to the four sampled districts, using probability proportional to size, where the size is the number of older women aged 50 years and older from each district.¹⁷ The snowball technique, a nonprobability sampling method, was used to identify older women from each of the districts because of the sparse nature of the population and the difficulty in obtaining an updated sampling frame of such women. The snowball technique was considered to be preferable to the house-to-house survey as the latter is associated with a largely quantitative tradition of measuring the rare event that is often affected by a lack of response thereto, whereas snowball sampling involves locating the household with the rare event through the key informant approach. Snowball sampling was found to be economical, efficient and effective for the purposes of this study.¹⁹⁻²⁰

Instruments used for the study and data collection

A questionnaire that covered demographic characteristics, the sexual activities and needs of older women; and the

needs, limitations, biases and stigma that relate to access to SRH/FP services was developed as the research instrument. The questionnaire was of mixed method. Some responses were provided on a five-point Likert scale, while open-ended questions gave the older women an opportunity to express their own opinion on the issues under investigation.

Trained research assistants administered the questionnaires to the participants in their homes or at their workplaces. In some cases, when the respondent did not have time for a face-to-face interview, the questionnaire was self-administered and collected at a convenient agreed-upon time. The participants were assured of confidentiality. The purpose of the study was explained. There was no financial incentive. Participation was voluntary. Participants were not obliged to answer all of the questions and could terminate the interview at any time. Participants signed an informed consent form prior to participation, but the questionnaire was completed anonymously.

Ethics consideration

Experts in public health and ageing reviewed the questionnaire prior to submission to the ethics committee of the University of Botswana. The ethics committee of the Ministry of Health Research also provided approval for the study. District health management teams gave permission to conduct the study in each of the health districts. Research assistants were trained during a two-day training workshop on the content and administration of the research instrument, as well as on the principles of attitude and behaviour towards older participants.

The study excluded older women who had physical or mental disabilities, such as blindness, lameness, hearing defects, dumbness or any form of mental ill health. This was because of inherent practical difficulties associated with the need to provide special equipment, such as facilities for the hearing-impaired (signage and loops), the preparation of large-print material for participants with visual impairments, the provision of material in easy-to-read format for participants with intellectual disabilities, and also the need to offer disability awareness training for interviewers.

Data analysis

The SPSS[®] computer programme was used to capture the data. All variables, including responses to the open-ended questions, were coded before being captured. Data were analysed using descriptive measures, such as percentages, means and standard deviation. Inferential statistics, such as the t-test, were employed to determine if there were significant differences in the mean proportion of older women's access to SRH services and the availability thereof. Results were illustrated graphically. The results of the study were disseminated through departmental seminars.

Results

A total of 444 older women completed the questionnaire. This was an approximate 98% response rate.

Demographic characteristics

Age

The majority of the women (53.2%) were aged 50-59 years; 27% 60-69; 13.5% 70-79, while 0.9% were 90 years of age and older.

Educational qualifications

The majority (42.8%) had no education, while 26.4% had obtained a primary school certificate. Only 6.3% had attempted secondary school, while 9% had been awarded with a secondary school certificate. Only 1.4% had tried to obtain a university degree, of whom 4.3% were successful.

Employment status

The majority (35.1%) of participants were unemployed and not seeking employment, 32% were employed, and 9.2% were unemployed and seeking employment. There were 13.7% housewives.

Marital status

The majority (32.9%) were married, while 27.9% were single (never married), 24.1% were widowed, 6.3% were cohabitating and 8.6% were divorced.

Figure 1 shows the demographic characteristics of the older women.

Sexual and reproductive health, including family planning needs

Table I summarises participants' responses to two questions: "Do you still desire to have any children?" and "Are you using any family planning method?" There was a significant positive relationship between the desire to have

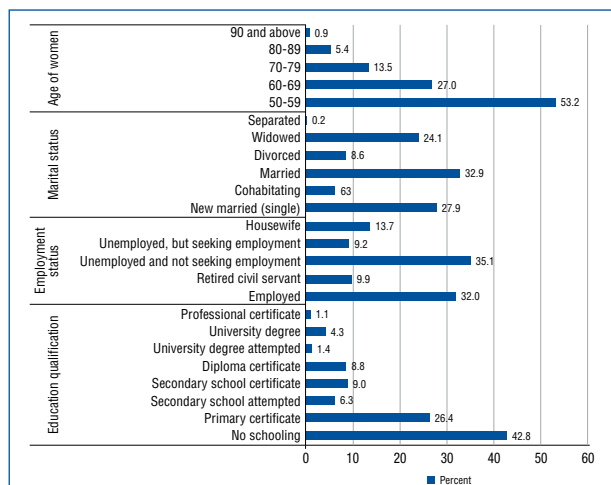


Figure 1: Demographic characteristics of the older women (n = 444)

another child and the use of a method to prevent future pregnancy (contingency coefficient, $r = 0.437$, p -value < 0.01).

Only 2% of the women wanted another child. Twenty-five per cent used some FP method to prevent a future pregnancy. Twenty-four per cent used FP methods, although they didn't want another child. Seventy-two per cent had an unmet need for FP, i.e. while they would prefer to avoid falling pregnant, they weren't using any FP method or contraception.

Table I: Desire for children and use of family planning methods (n = 427)

| Using family planning methods | Want to have another child (number) % | | | |
|-------------------------------|---------------------------------------|----------|------------|-----------|
| | Yes | No | Don't know | Total |
| Yes | (7) 1 | (101) 24 | (0) 0 | (108) 25 |
| No | (4) 1 | (309) 72 | (1) 0 | (314) 73 |
| Don't know | (0) 0 | (3) 1 | (2) 1 | (5) 2 |
| Total | (11) 2 | (413) 97 | (3) 1 | (427) 100 |

When the two variables, namely the older women's desire for another child, and the use of FP methods, were analysed according to age group, the results showed that 5.5% of older women aged 50-59 years (n = 223), 15.8% of those between 60 and 69 (n = 112), and 0% aged 70-79 (n = 58), 80-89 (n = 24) and 90 years of age and older (n = 4) still wanted to have children and were using a FP method.

Availability of and accessibility to sexual and reproductive health and family planning services

Availability of SRH/FP services in the healthcare service was measured by the older women's knowledge of whether or not the services existed in the hospitals and clinics, while accessibility was measured by their awareness of the proximity of healthcare facilities to their homes, mindfulness of the affordability of the services, whether or not the healthcare services were sensitive to social and cultural considerations such as gender, language and religion, and attentiveness to the quality of the services.²¹

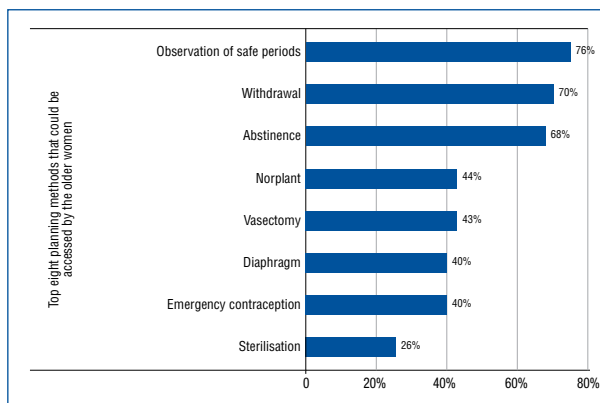


Figure 2: Family planning methods that were available to the older women (n = 376)

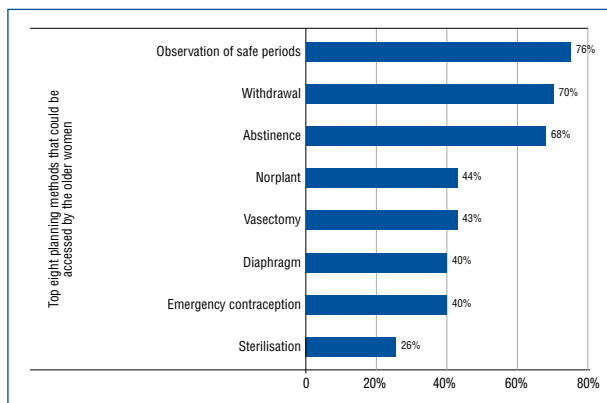


Figure 3: Family planning methods that were accessible to the older women (n = 361)

Participants were asked to indicate which FP methods were available and accessible to them. Figure 2 shows that the most available FP methods were observation of safe periods (78%), withdrawal (72%) and abstinence (69%).

When asked which of the methods were most accessible to them, the results showed that observation of safe periods (76%), withdrawal (70%) and abstinence (68%) were the top three (Figure 3). Therefore, the natural FP methods that were available to the older women were also the most accessible.

Use of SRH/FP services depended to a large extent on their availability and accessibility. The older women were also asked to indicate if the SRH services were available and accessible. The results in Table II indicate the percentage of older women who reported that the SRH services supplied by the hospitals and clinics were available and accessible to them. Antenatal care, postnatal care and screening for HIV/AIDS were the most accessible and available SRH services.

Table II: Percentages of sexual and reproductive health services available to and accessible to the older women

| Type of services | Availability (%) | Accessibility (%) |
|-------------------------------|------------------|-------------------|
| Antenatal care | 89 | 86 |
| Postnatal care | 87 | 84 |
| Screening for HIV/AIDS | 83 | 73 |
| Safe delivery | 72 | 68 |
| Family planning | 70 | 62 |
| Screening for STIs | 69 | 63 |
| Treatment for HIV/AIDS | 67 | 59 |
| PMTCT | 65 | 59 |
| Screening for cervical cancer | 61 | 56 |
| Treatment for STIs | 59 | 52 |
| Supply of contraceptives | 58 | 52 |

HIV/AIDS: human immunodeficiency virus/acquired immune deficiency syndrome, STIs: sexually transmitted infections, PMTCT: prevention of mother-to-child transmission

Accessibility to the SRH services supplied by the hospitals and clinics depended on the availability of the services. The data in Table II show that accessibility to the SRH services

by the older women correlated highly with the availability of the former ($r = 0.968$). A regression equation of SRH services accessibility (y) on availability (x) gave the following predictive model:

$$y = 1.0063x - 6.704$$

with coefficient of multiple determination, $R^2 = 0.937$. Thus, 93.7% the older women's access to the healthcare systems' SRH services can be explained by the availability of the healthcare facilities (Table II). Other factors such as proximity to the home, the financial ability to pay for the services, the attitude of the healthcare providers and information on the available services (all of which affect accessibility to the SRH services), only explain approximately 6.3% of the variation in accessibility to the services.

Sexual and reproductive health and family planning services needs

In this study, the need for SRH/FP services was measured by current or previous use of these services. The older women were asked to indicate the type of FP method that was being used by them at present. The results are depicted in Figure 4. Current FP methods that were used the most by the older women were abstinence (55%), condoms (41%), breastfeeding (10%), observation methods (5%) and withdrawal (5%). However, before attaining the age of 50 years, the methods that were mainly used were breastfeeding (56%), condoms (54%), abstinence (51%) and combined oral contraception (23%) (Figure 5). The majority of the older women (60%) utilised HIV/AIDS services, while a substantial proportion underwent screening for STIs (32%) and cervical cancer (29%).

According to the results, the subjects relied on natural FP methods in general, as they were the most available and accessible. Very few older women under the age of 50 used other FP methods. There was a high positive correlation ($n = 17$, $r = 0.78$) between the percentage of older women using FP methods currently and those who did so previously. Furthermore, there was a decrease in the percentage of older women using FP methods currently, compared with those who did so previously, but the results of the analysis (t-test) indicated that there was no significant difference in the percentage of older women using the methods currently, and those who did so previously ($n = 17$, $t = 1.697$, $p\text{-value} > 0.05$). However, the percentage using abstinence as a method of control had increased from those who did this previously.

Challenges in addressing the sexual and reproductive health and family planning needs of older women (n = 378)

Lack of knowledge (45%) was the most predominant reason given by the older women for not meeting their SRH/FP

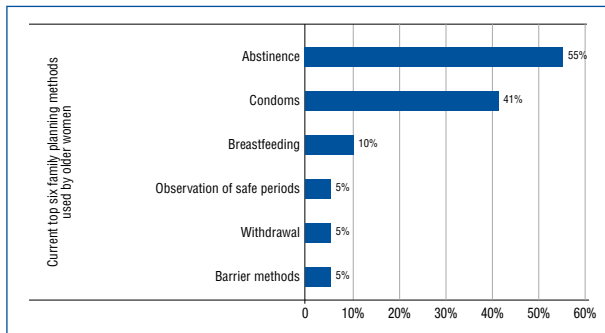


Figure 4: Currently family planning methods (n = 204)

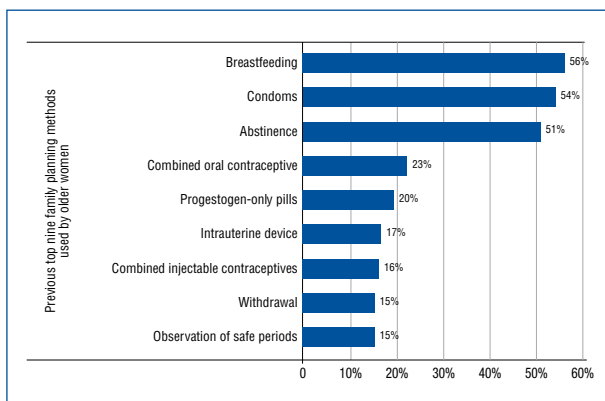


Figure 5: Previous top nine family planning methods used by the older women (n = 369)

needs. Other reasons included lack of financial resources (7%), the negative and unfriendly attitudes of healthcare providers (7%), a lack of interest (6%) and illiteracy (6%).

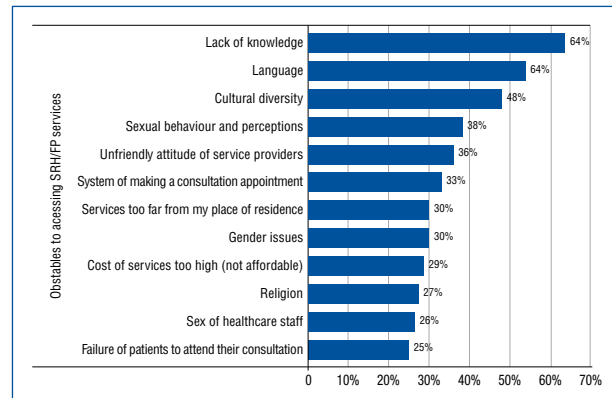
Obstacles to addressing the sexual and reproductive health and family planning needs of older women (n = 341)

The main identified obstacles by the older women that barred them from their SRH/FP services needs being met were lack of knowledge about contraception use or availability (64%), language (54%), cultural diversity (48%) and sexual behaviour and perceptions (38%).

Knowledge of SRH/FP is key to usage of the services. Results have shown that lack of knowledge features prominently as a major challenge and obstacle to the use of SRH and FP methods. The absence of knowledge on which contraceptives to use and associated risks means that most of the older women may not have known about the available FP methods at the healthcare facilities. Therefore, they would not have been able to use them.

Figure 6 details the obstacles that were encountered by the older women in addressing their SRH/FP needs through lack of access to the healthcare systems in Botswana.

Illiteracy, leading to inadequate knowledge about human sexuality and fertility (61%); lack of education, measured in terms of a lack of educational qualification which restricts the type of association and invariably affects level of



SRH: sexual and reproductive health, FP: family planning

Figure 6: Obstacles to addressing sexual and reproductive health and family planning needs through access to the healthcare systems in Botswana

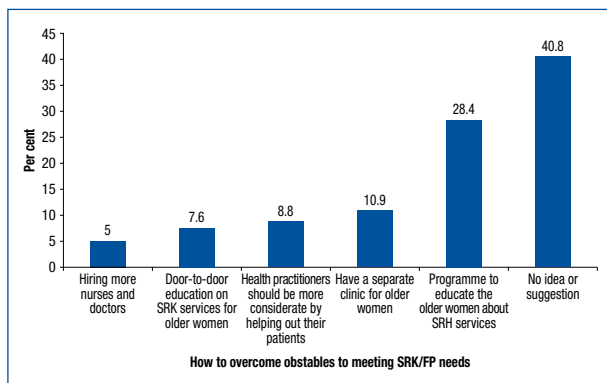
income, social status and decision-making ability (60%); health planners' perceptions of SRH, as women's health mostly relates to pregnancy and childbirth (35%); and lack of money to pay for SRH/FP services (34%), were top on the list of identified social obstacles. Early marriage (22%), and silence and shame surrounding pregnancy and childbirth (20%) were some of the identified, but less important, social barriers to accessing SRH/FP services. Cultural barriers included prohibition of public discussions about sex (75%), reluctance by people to discuss domestic situations (57%), and cultural restrictions placed on people with regard to talking about SRH issues (53%). Other cultural barriers were traditional attitudes and discrimination which discouraged women from working outside the home (48%), husbands' reluctance to discuss matters relating to sexuality with their wives and unwillingness to admit that they lacked knowledge on issues of sexuality (31%), and the prioritisation given to educating boys, rather than girls (30%).

Suggested methods to overcome obstacles to meet sexual and reproductive health and family planning needs (n = 341)

When asked to state how the obstacles of meeting SRH/FP needs could be overcome, the majority of respondents (40.8%) had no idea, while 28.4% of them believed that programmes would be helpful in educating them about the availability, accessibility and utility of SRH/FP services (Figure 7). Other suggestions included separate clinics for older women (10.9%), training health practitioners to be more considerate towards older women (8.8%), door-to-door education on SRH/FP services (7.6%), and hiring more doctors and nurses (5%).

Discussion

This study was based on information provided by older women from Gaborone, Selibe Phikwe, Kgatleng East and



SRH: sexual and reproductive health

Figure 7: Suggested measures to overcome obstacles to meet sexual health and reproduction and family planning needs

Barolong health districts, on encountered challenges in meeting their SRH/FP service needs within the Botswana healthcare system. The study revealed that contraceptive use was low (25%), while an unmet need (percentage of older women who were not using any FP method to prevent pregnancy, and yet who did not want to have any more children) for FP was very high (72%), in comparison to the results of similar studies that were carried out in Cambodia, Nepal, Pakistan and Yemen, where unmet needs were reported to be approximately 30%, escalating to 40% in Haiti.^{22, 23} It is likely that a majority of the unmet need must have been for births to be limited since the results of the analysis show that the older women did not want to have another child.

The results of this study, which indicated the high unmet need for FP services (72%), pose a challenge to policymakers and programme planners, but could also assist them in better understanding the needs and encountered challenges of older women, and in aiding them in improve services.

This study revealed that SRH and FP services were readily available and accessible in hospitals and clinics, yet the older women mostly relied on natural FP methods, and screening services for HIV/AIDS, STIs and cervical cancer. The sudden drop in numbers of those who previously used SRH services is a cause of concern. Reference is made to antenatal services, postnatal care and safe delivery, especially since a good proportion of the older women indicated that they wanted another child.

There is a need for increased access to and use of SRH services in order to offer older women more control over their reproductive lives, and to safeguard and enhance the fertility of those who still wish to bear children. Increased access to SRH services would also offer major public health benefits regarding maternal and infant morbidity and mortality, particularly for women of childbearing age.

Programme managers need to address a range of barriers to access to SHR and FP services that were highlighted by the older women and to effect an increase in the utilisation of those services. Public awareness and health promotion

campaigns can help overcome some of these barriers. Outreach programmes and community-based activities, such as support groups, and use of volunteer health promoters could mobilise and motivate the older and the wider community towards optimum resource utilisation. The major challenge facing older women in accessing SRH/FP services was lack of knowledge. This finding is in agreement with that of Ashford.²⁴

Lack of knowledge about SRH/FP services was cited in this study by 45% of older women as a major challenge in meeting their SRH/FP needs. Effective FP programmes could promote wider knowledge about a range of contraceptive methods and their proper use. The proportion of women who cite lack of knowledge as a barrier to contraceptive use is substantially lower in countries where education programmes are most active. In this study, the fact that approximately 69% of older women either had no education (42.8%) or primary school certificate (26.4%), highlights the need for intensive education programmes at all levels to create awareness of and knowledge about available SRH and FP services, and how to use them. Lack of education meant that this group of older women was unable to read and understand written material that explained the relevance and risks pertaining to SRH services. This might explain the large number of participants who used natural FP methods in this study. The authors recommend further investigations to determine factors which account for overdependence on natural FP methods by older women.

Effective training of healthcare workers on how to meet the SRH/FP needs of older women is also advised. Reproductive health programmes for women in their childbearing years are equally appropriate for women approaching menopause and beyond, and can ensure that they have access to appropriate contraceptive methods during the perimenopausal period. The programmes should emphasise meonopause symptoms, as well as the elements of a healthy lifestyle, such as diet and exercise, and include public awareness campaigns on the use of SRH services, including FP.

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