Immigrants' and refugees' unmet reproductive health demands in Botswana: Perceptions of public healthcare providers

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Abstract

Background: The healthcare of Batswana (citizens of Botswana) as indicated in the country's Vision 2016 is one of the top priorities of the government of Botswana, yet Botswana's National Health Policy, the Immigration Policy and the National Sexual and Reproductive Health Programme Framework all are silent on the obligations of the government to provide health services to the immigrant and refugee population. In view of the high prevalence of HIV/AIDS in Botswana, South Africa and other sub-Saharan countries, it is critical that reproductive health services be as affordable and accessible for the immigrants and refugees as they are for other residents in Botswana.

This study measured the views of the primary healthcare providers in Botswana on the perceived reproductive health needs of immigrants and refugees and the availability and accessibility of reproductive healthcare services to the immigrant and refugee populations in the country. This information will be important for policy makers, the government of Botswana and the private sector to shape intervention measures to assist immigrants and refugees in seeking and accessing the desired reproductive health services.

Methods: The study targeted all 4 667 medical doctors and nurses who were serving in various hospitals and clinics in 23 health districts of Botswana as at June 2005 when this study was conducted. Using NCS Pearson statistical software, the sample size for the study was determined to be 851. This 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 healthcare providers to be interviewed from each health district were selected randomly and in proportion to the number of doctors and nurses in each district.

Questionnaires were administered to these healthcare providers by research assistants, who explained the purpose of the study and obtained informed consent. The questionnaires were coded to ensure the anonymity of the respondents. It contained questions about the healthcare providers' demographic characteristics, their opinions on the reproductive health needs of immigrants and refugees, and their views on factors that influence the accessibility of these services to immigrants and refugees. Data were collected from 678 doctors and nurses (about 80% of the targeted sample).

Results: The majority of the healthcare providers indicated that the most important reproductive health needs of the immigrants and refugees, namely pregnancy-related services (prenatal, obstetrics, postnatal conditions), treatment for sexually transmitted infections (STIs), HIV/AIDS treatment and counselling and family planning were not different from those of the locals. However, some major differences noted between the local population and the foreigners were (i) that antiretroviral (ARV) treatment and prevention of mother-to-child-transmission (PMTCT) programmes were never accessible to the non-citizens; and (ii) that while treatments and other health services were free to Batswana, a fee was charged to non-citizens. Although 86% of the 21 studied reproductive health services were available in the healthcare system more than 50% of the time, only 62% of them were accessible to the immigrants and refugees 50% of the time. The major reasons for inability to access these services were: (i) The immigrants and refugees have to pay higher fees to access the reproductive health services; (ii) Once an immigrant or refugee is identified as HIV positive, there are no further follow-ups on the patient such as detecting the immune status using a CD4 count or testing the viral load; (iii) The immigrants and refugees do not have referral rights to referral clinics/hospitals for follow-ups in case of certain health conditions; and (iv) The immigrants and refugees are required to join a medical aid scheme to help offset part of the costs for the desired services.

Conclusions: The study recommended that the government of Botswana should improve the availability of reproductive health services to immigrants and refugees, and expunge those laws and practices that make it difficult for immigrants and refugees to access the available reproductive health services.

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Introduction

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 living in 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 % over the country's population from the 1971 census figure.[1] The legal immigrants consist primarily of permanent or temporary workers and their families,[2] while the refugees consist of those who are fleeing from regional/national political or social problems from the nearby countries like Namibia, Angola, and the 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. While some of the immigrants are employed and may be financially able to afford health services, these services are usually difficult to access. On the other hand, most of the refugees are destitute and only qualified for temporary and low-paying jobs, such that health services are not affordable even if these services are identified.[3,4]

Botswana's National Health Policy, the Immigration Policy, and the National Sexual and Reproductive Health Programme Framework are silent on the obligations of the government to provide health services to the immigrant and refugee population. In view of the high prevalence of HIV/AIDS in Botswana, South Africa and other sub-Saharan countries (see Table I), it is critical that reproductive health services be as affordable and accessible for this population as they are for citizens of Botswana.

Table I: HIV/AIDS prevalence rate for selected countries

Country	HIV/AIDS prevalence rate (%) (2007)	HIV/AIDS prevalence based on antenatal clinics attendees (%) – 2006
Botswana	17.1	32.0
Zimbabwe	18.0	18.0
South Africa	18.3	29.0
Namibia	20.0	20.0
Zambia	17.0	25.0
Swaziland	26.0	26.0

Source: UNAIDS (2007): 2007 AIDS epidemic update – sub-Saharan Africa

The primary healthcare providers in Botswana are the doctors and nurses who are employed in the hospitals and clinics throughout the country. They are conversant with the facilities and infrastructure for the provision of healthcare to the inhabitants of any country, including patients who make use of these facilities. The perceptions of these healthcare providers reflect the true reproductive health attitudes of the immigrants and refugees and the extent of availability and accessibility of these services to them. In addition, the opinions of the healthcare providers can help inform policies aimed at improving healthcare delivery in Botswana. This study documented the views of these primary healthcare providers in Botswana on the perceived reproductive health needs of immigrants and refugees as well as the availability and accessibility of reproductive healthcare services to the immigrant and refugee population in the country. This information will be necessary for policy makers, the government of Botswana and the private sector to shape intervention measures to assist immigrants and refugees to seek and access the desired reproductive health services.

Availability of reproductive health services in Botswana's health system

Immigrants and refugees in Botswana seek reproductive health services from all the available sources in the country, namely central and local government hospitals and clinics, private hospitals/clinics and pharmacies. But how many of these services the immigrants and refugees can access depends to a large extent on the availability of the reproductive health services in the healthcare system. A survey carried out in 1999 to examine the distribution of selected reproductive health services across the country and at different levels of healthcare provision indicated an unfair distribution of resources for reproductive health at different levels of facilities. This was largely because while hospitals were well equipped with adequate infrastructure and supplied with drugs, the clinics and health posts lacked these provisions. The survey found a relatively equitable distribution of reproductive health services between the districts.[6] The government of Botswana invests a substantial proportion of its annual budget in the provision of health facilities, including reproductive health services, for Batswana. The extent to which these services are available to the immigrants and refugees is not known, and formed the focus of this study. The availability of reproductive health services in this study was measured by the physical presence of the desired services and the presence of qualified, non-discriminatory healthcare providers at the service points.

Accessibility of reproductive healthcare services

Access to reproductive healthcare is a multidimensional concept with several determinants, which include availability, affordability, acceptability, appropriateness and quality.[7] The United Kingdom's Department of International Development indicated that for reproductive health services to perform well, they should be appropriate to local needs; acceptable to poor women, men, young people and specific vulnerable groups (such as sex workers and immigrants and refugees); affordable; and physically accessible (in terms of location and opening times).[8] In this study the accessibility of reproductive health services in Botswana's healthcare system to the immigrants and refugees was measured by its affordability and closeness of the service points to the immigrants and refugees.[9,10]

This study analysed the healthcare providers' responses to four main issues: legally resident immigrants' and refugees' reproductive health demands; the availability of reproductive health services in the Botswana healthcare system; the accessibility of the available reproductive health services to the immigrants and refugees; and factors which, in the view of the healthcare providers, influenced the accessibility of reproductive health services to the immigrants and refugees in the country.

Throughout this study the term 'immigrant' was adopted generally without invoking statuses such as 'permanent' or 'temporary' and used simply to denote those who are not Batswana by either birth or citizenship and who moved to the country voluntarily, unlike refugees who had been forced by circumstances to do so. The focus of the study was on legal immigrants, who are documented and have been authorised to stay in the country, and refugees.

Methodology

The study targeted all 4 667 medical doctors and nurses who were serving in various hospitals and clinics in 23 health districts of Botswana, as at June 2005 when this study was conducted. Using NCS Pearson[11]

and allowing for a 99% confidence (and an error of 4%), which posits that the response from the sampled population would be the same as that of the entire population, the estimated sample size for the study was 851. This 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 healthcare providers to be interviewed from each health district were selected randomly and in proportion to the number of doctors and nurses in each district.

Questionnaires were administered to these health professionals by research assistants, who explained the purpose of the study and obtained informed consent. The questionnaires were coded to ensure the anonymity of the respondents. Most questionnaires were completed in the presence of the research assistants, while some were completed by participants at a more convenient time and returned to the research assistants within one to three days. The questionnaire contained questions about the healthcare providers' demographic characteristics, their opinions on the reproductive health needs of immigrants and refugees, their views on the availability and accessibility of reproductive health services to immigrants and refugees, and factors that influence the accessibility of these services to immigrants and refugees. The questions were open-ended and the healthcare providers could further provide information to clarify their responses on the plight of the immigrants and refugees in seeking reproductive healthcare services.

The healthcare providers were asked to focus on two issues: (i) the physical availability of the reproductive health services at the service points, whenever those services were needed; and (ii) the presence of qualified service providers at the service points to serve clients without any discrimination and stigmatisation. Answers were provided on a five-point Likert scale, namely 1 = never (it is not available at all); 2 = sparingly (it is available 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); and 5 = all the time (it is available 100% of the time). In the case of accessibility, the five-point Likert scale used was 1 = never (it is not accessible at all); 2 = to some extent (it is accessible 1% but below 20% of the time); 3 = to a reasonable extent (it is accessible 20 to 50% of the time); 4 = to a great extent (it is accessible over 50 to 90% of the time); and 5 = to a very great extent (it is accessible over 90% of the time).

Reliability of the study was limited by three factors. First, approximately 23% of the respondents were expatriates, whose life experiences may have resulted in different service expectations than those of native Batswana. Second, the study population consisted entirely of government employees (84%), who may have felt that negative responses would affect their careers in government service. Third, eight of the twenty research assistants were expatriates, and the local healthcare providers may have been unwilling to discuss Botswana's healthcare system problems with foreigners.

Data were collected from 678 doctors and nurses (about 80% of the targeted sample). This response rate compared favourably with previous research on immigrants in Botswana,[12,13] where the response rates were much lower.

Results

The study population of 678 individuals consisted of 15% doctors, 82% nurses and 3% others who did not specify their profession.

Perceptions of immigrants' and refugees' reproductive health needs

The healthcare providers' views about the need for reproductive healthcare services for immigrants and refugees show that the most important needs were in four of the six categories studied, namely pregnancy-related services, STI treatment, HIV/AIDS treatment and counselling, and family planning (see Table II). In all cases the percentage of doctors that had these perceptions was always greater than those of the nurses, although the differences were not significant (p-value > 0.05) except in the case of HIV/AIDS treatment and counselling (p-value < 0.05).

Table II: Doctors' and nurses' response on reproductive health needs of immigrants and refugees

Reproductive health needs of immigrants and refugees	Professional category		(n = 627) Total %	Sig t-test for difference in proportion of nurses and doctors
	(n = 95) Doctor %	(n = 516) Nurse %		
Pregnancy (prenatal, obstetrics, postnatal conditions)	84.2	79.1	79.3	ns
Decisions on whether to use contraceptives	50.5	49.2	48.8	ns
Decisions on which contraceptive to use	54.7	50.4	50.6	ns
STI treatment	76.8	73.4	73.2	ns
HIV/AIDS treatment and counselling	85.3	70.3	73.0	s
Family planning	69.5	67.1	67.3	ns

ns = not significant at 5%; s = significant at 5%.
The category 'Other' (n = 16 responses) for professional category was omitted in the above comparison since it was not known whether they were doctors or nurses.

Reproductive health needs of locals versus immigrants and refugees

In order to determine differences in the reproductive health needs of the local population and those of immigrants and refugees in Botswana, the healthcare providers were asked to indicate whether the reproductive health needs of immigrants and refugees in Botswana were different from those of the local population. Only 10% of the healthcare providers indicated that the reproductive health needs of immigrants and refugees were different from those of the local population, while an overwhelming majority (77%) contended that there were no differences. In addition, about the same percentage of the doctors (78%) and nurses (77%) stated that there were no differences between the reproductive health needs of the immigrants and refugees and those of the local population (see Figure 1).

When the healthcare providers who said that there were differences between the locals and foreigners were asked to specify the differences in reproductive health needs, they cited access to reproductive health services. One difference noted was that ARV treatments and PMTCT programmes were never accessible to the non-citizens; others were that treatments and other health services were free to Batswana, while a fee was charged for non-citizens (see Table III).

Availability of reproductive health services to immigrants and refugees

The percentage responses of the healthcare providers to reproductive health service availability of 21 services (see Figure 2) show that there

Figure 1: Percent of healthcare providers' responses on whether the reproductive health needs of immigrants and refugees are different from those of the local population

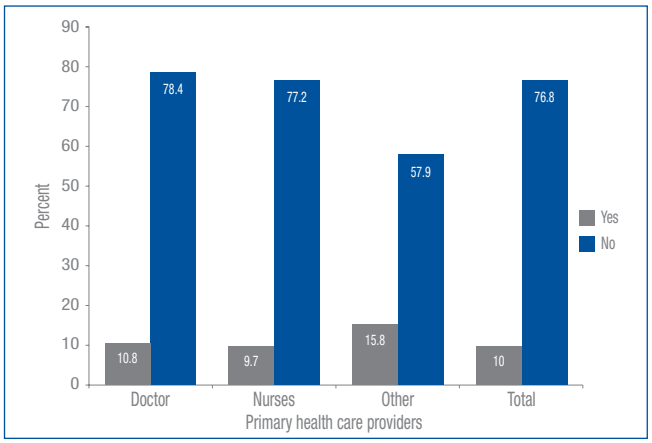


Table III: Healthcare providers' indication of differences between immigrants and refugees and the local population (based on 'yes' response only)

Difference between locals and foreigners	Professional category						Total	
	Doctor		Nurse		Other			
	Count	%	Count	%	Count	%	Count	%
Foreigners have no access to ARV treatment and PMTCT programmes	8	100.0	36	76.6	3	100.0	47	81.0
Foreigners get treatment only after they pay for it	0	0.0	20	42.6	0	0.0	20	34.5
The locals have access to ARV treatment	6	75.0	30	63.8	2	66.7	38	65.5
The locals get free medical services	1	12.5	21	44.7	0	0.0	22	37.9
Total yes responses	8	100.0	47	100.0	3	100.0	58	100.0

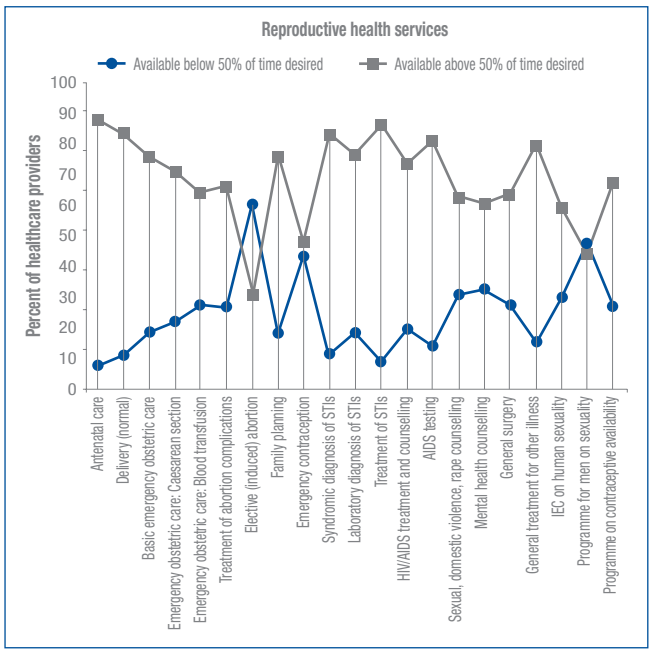
are two services that are believed by the majority to be available less than half of the time. These are elective (induced) abortions (60%) and programmes involving men in sexual reproductive health (47%). All the other services are available over half of the time that the immigrants and refugees desired them. Whereas two-thirds of the healthcare providers considered services for the treatment of abortion complications to be available all the time, only half of them indicated that the services for elective (induced) abortions were never available or available only sparingly.

Accessibility of reproductive health services to immigrants and refugees

The analysis in the previous section has revealed that Botswana's healthcare system has adequate reproductive health services, which theoretically should be accessible to those who need them, whether local or foreigner. To determine the extent of accessibility of these available reproductive health services to the immigrants and refugees when needed, the study sought the opinions of the healthcare providers using a five-point scale.

The majority of healthcare providers (between 50 and 68%) responded that 13 out of the 21 available reproductive services were accessible

Figure 2: Percent of healthcare providers who indicated that reproductive health services were available to the immigrants and refugees in the Botswana healthcare system



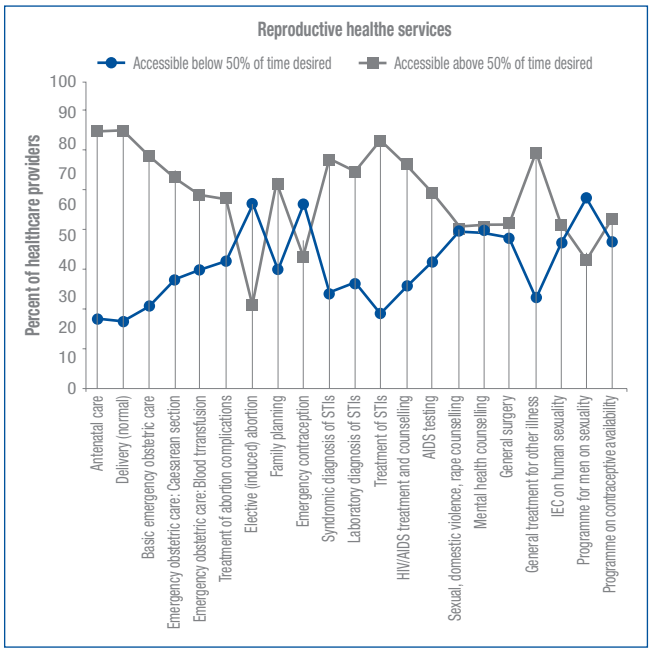
to the immigrants and refugees over half the time (see Figure 3). These reproductive health services are antenatal care, delivery (normal), basic emergency obstetric care and comprehensive emergency obstetric care (Caesarean section), comprehensive emergency obstetric care (blood transfusion), treatment of abortion complications, family planning, syndromic diagnosis of STIs, laboratory diagnosis of STIs, treatment of STIs, HIV/AIDS treatment/counselling, AIDS testing and general treatment for other illnesses.

A little over three in every five healthcare providers and about half of them, respectively, believed that services for elective (induced) abortions and programmes involving men in sexual and reproductive health were hardly ever accessible to the immigrants and refugees.

When asked whether there were limitations to the accessibility of reproductive healthcare services to immigrants and refugees, over four in every five doctors and three in every four nurses believed that there were limitations. These limitations are identified in Table IV and include the following: (i) The immigrants and refugees have to pay higher fees to access the reproductive health services; (ii) Once an immigrant or refugee is identified as HIV positive, there are no further follow-ups on the patient such as detecting the immune status using a CD4 count or testing the viral load; (iii) The immigrants and refugees do not have referral rights to referral clinics/hospitals for follow-ups in case of certain health conditions; and (iv) The immigrants and refugees are required to enlist in medical aid schemes to help offset part of the costs for the desired services.

A high percentage of immigrants and refugees in Botswana come from neighbouring countries with an equally high prevalence of HIV.[14] The regular interactions that sometimes culminate in sexual relations between these immigrants, refugees and the local population can be detrimental to the national health policies and projections if the health needs of any of the groups are neglected. Without effective treatment and follow-up, these individuals already infected with HIV/AIDS can potentially infect the Batswana. Against this background, the healthcare providers were asked

Figure 3: Percent of healthcare providers indicating the extent of accessibility of reproductive health services to the immigrants and refugees in Botswana



to state what they did when an immigrant or refugee tested positive to HIV (Table V). The respondents in this study indicated that in only 13% of cases do they personally follow up these patients, and in 39% of the cases do they provide counselling. However, in 36% of the cases the patients are referred to private clinics or hospitals. However, the doctors and nurses overwhelmingly (79%) believed that these practices portend a health danger to Batswana.

Discussion and conclusion

This study has greatly revealed the views of healthcare providers (doctors and nurses) on the perceived reproductive health needs of immigrants and refugees residing in Botswana, the availability of reproductive health services in the Botswana healthcare system and the accessibility of these services to the immigrants and refugees.

The results of the study showed that the major reproductive health needs of immigrants and refugees, although not different from the needs of the local population, are pregnancy-related services (prenatal, obstetrics and postnatal), HIV/AIDS treatment and counselling, STI treatment and family planning. This result is in line with that of Allotey et al,[4] who identified the major reproductive health issues of immigrants and refugees as problems with maternity and obstetric services. The finding that the reproductive health needs of the local population are not different from those of immigrants and refugees stems from the fact that the majority of the immigrants and refugees were from the South African Development Community (SADC), and with identical cultural backgrounds.[15]

A wide range of reproductive health services are available in the Botswana healthcare system, corroborating the findings of Purdin et al[16] that a wide range of refugee and conflict-affected sites provide reproductive health services. The availability of a wide range of reproductive health services within Botswana's healthcare system demonstrates Botswana's compliance with the Millennium Development Goals through the provision of healthcare services to reduce child mortality, improve maternal health and ensure the availability of skilled health personnel to provide healthcare.

Table IV: Healthcare providers' views on the factors affecting immigrants' and refugees' access to reproductive health services (based on 'yes' response only)

Limitations to accessing reproductive health services	Professional category						Total	
	Doctor		Nurse		Other			
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
They have to pay higher fees	73	88.0	360	87.8	14	93.3	447	88.0
They do not have referral rights to referral clinics/hospitals for follow-ups in case of certain health conditions	19	22.9	45	11.0	5	33.3	69	13.6
They are restricted to conditions as per their medical aids	18	21.7	39	9.5	3	20.0	60	11.8
They are to be given reduced dosages of a ny treatments different from those of the local population	3	3.6	8	2.0	0	0.0	11	2.2
Once an immigrant or refugee is identified as HIV positive, there are no further follow-ups on the patient such as detecting the immune status using CD4 or testing the viral load	51	61.4	218	53.2	10	66.7	279	54.9
The current ARV therapy is for Batswana only; immigrants and refugees can only get their treatment in private sectors	6	7.2	14	3.4	0	0.0	20	3.9
There is a tendency to harass and an unwillingness to assist non-citizens	4	4.8	10	2.4	0	0.0	14	2.8
Most of them do not have a medical aid scheme	4	4.8	9	2.2	0	0.0	13	2.6
Total	83	100.0	410	100.0	15	100.0	508	100.0

Table V: Healthcare providers' response to immigrants and refugees who test positive to HIV

If an immigrant or refugee is tested positive to HIV, what do you usually do?	Professional Category						Total	
	Doctor		Nurse		Other			
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Follow him/ her up with CD4 or test the viral load	12	(11.8)	72	(12.9)	1	(5.3)	85	(12.5)
Recommend him/her to private clinic/hospital	47	(46.1)	188	(33.8)	9	(47.4)	244	(36.0)
Counsel him/her	31	(30.4)	227	(40.8)	7	(36.8)	265	(39.1)
Send him/ her away without any advice	1	(1.0)	2	(0.4)	0	(0.0)	3	(0.4)
Any other	2	(2.0)	6	(1.1)	0	(0.0)	8	(1.2)
Not stated	9	(8.8)	62	(11.1)	2	(10.5)	73	(10.8)

The result of the study that over half of the available reproductive health services were accessible to immigrants and refugees over half of the time corroborates only partially the opinion of female immigrants and refugees, 25–40% of whom acknowledged that these services were accessible to them half of the time.[15] Unfortunately, three important factors tended to limit immigrants and refugees from accessing the desired reproductive health services: high fees that they are charged for the services; policy that prohibits the healthcare providers from following up HIV-positive immigrants and refugees and to detect their immune status and test their viral load; and the requirement that immigrants and refugees must join a medical aid scheme to insure their reproductive health problems.

Resources to pay for reproductive health services have been known to be a major hindrance to women accessing healthcare. As many immigrants and refugees were either unemployed or employed in very low-paying jobs, they were unable to join any medical aid schemes.[3,4,15] Nanda[17] determined that a lack of access to resources and inequitable decision-making power can deprive poor women from seeking healthcare as the cost of care may become out of reach.[18] The Centre for Women in Government and Civil Society and Family Planning Advocates of New York State[19] cited a lack of health insurance among other factors that inhibit immigrant women from accessing their reproductive health needs and a lack of funds as a major barrier to service provision, as cited by family planning providers. In a situation like Botswana's where most immigrant women are unemployed spouses, access to any form of health services is highly restricted. The government of Botswana needs to facilitate the employment of immigrants and refugees, especially where they possess the requisite qualifications, as this would improve women's access to desired reproductive health services. The unemployed immigrants and refugees should be allowed, like the local population, to access the desired reproductive health services free of charge. The lack of hard evidence on the impact of the lack of resources on reproductive health utilisation calls for an immediate need to examine how the immigrant and refugee women cope with healthcare costs and how they are able to pay for healthcare.

The fact that immigrants and refugees who qualify to receive ARV treatment and to join PMTCT programmes were denied these reproductive health services speaks volumes of the shortcomings of Botswana's healthcare system. In a democratic system where no restriction is placed on social relationships, some of which result in sexual relations between Batswana and immigrants or refugees, these policies and practices invalidate the philosophy of the country's National Health Policy and Vision 2016, which aims to completely eliminate the incidence of HIV by 2016.[20] It is therefore important to redress these policies on both humanitarian grounds as well as in compliance with Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which guarantees to immigrants and refugees rights to medical care, including reproductive healthcare.

The study's findings that a minority of the healthcare providers (39%) counselled immigrants or refugees who tested positive to HIV while 36% of them advised those affected to obtain assistance from a private clinic or hospital and that a small percentage of the healthcare providers (13%) followed up the affected persons by testing their CD4 count or the viral load corroborate the earlier finding that immigrants and refugees are unable to meet their reproductive health needs. A number of issues emerge, that although 79% of the healthcare providers consider that immigrants and refugees can constitute a serious health risk to themselves and to the local population when their reproductive health demands (including HIV/AIDS) are not being addressed, all they could do is advise the foreigners as they have no power to influence existing policy. Clearly, regarding the implementation of health programmes, the healthcare providers are guided by existing policies, laws and practices governing the provision of health services in the country. Therefore, their responses are consistent with existing policies, laws and practices, which need to be addressed if the country's health goal of providing good health to all Batswana is to be attained.

More light is shed on the healthcare providers' views on the availability and accessibility of the services for syndromic diagnosis of STIs, laboratory diagnosis of STIs and treatment of STIs to immigrants and refugees. The treatment of STIs in Botswana is given high priority because of its close association with HIV; STIs are known to cause the weakness of the cell integrity, facilitating HIV infection.[21] The Botswana health system ensures that these services are available all the time in all the health facilities and can be accessed by those who desire them all the time, but in the case of immigrants and refugees they are accessible only after due payment of the prescribed fees.

The study's findings that the treatment of abortion complications was available all the time, whereas the services for elective (induced) abortions were only available sparingly, are by no means surprising because Botswana, like most sub-Saharan African countries, criminalises abortion, hence the minimal or non-existent infrastructure for executing abortions. In addition, the fact that the healthcare providers were convinced that elective (induced) abortions were accessible to the immigrants and refugees less than 20% of the time whenever they needed the service is consistent with the Botswana government's legal position regarding abortion. The country's 1991 Penal Code Act allows abortion only in "exceptional circumstances such as rape, defilement or incest or at the request of the victim or her next of kin or guardian. There must be evidence that the continuance of the pregnancy would risk the life of the pregnant woman or it is established that if the child is born, it would suffer or later develop serious physical or mental abnormality or disease. [22] The maximum punishment for executing abortions is seven years[22]– a drastic legal position, which explains why abortion services are seldom accessible to potential users in Botswana. Permissible abortions must, however, be carried out within the first 16 weeks of the pregnancy. The fact that 28% of the healthcare providers considered that abortion services were accessible more than 50% of the time reflects minimal use of abortion facilities in the hospitals and clinics.

Recommendations

In view of the findings from this study, the following are recommended:

1. The government of Botswana should facilitate the employment of immigrants and refugees, especially where they possess the requisite qualifications, as this would improve women's access to desired reproductive health services. The unemployed immigrants and refugees should be allowed, like the local population, to access the desired reproductive health services free of charge.
2. It is important for the government of Botswana to redress those policies that prohibit immigrants and refugees who qualify to receive ARV treatment and to join PMTCT programmes, and deny the immigrants and refugees access to the desired reproductive health services. The existence of such policies are not in compliance

with Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which guarantees to immigrants and refugees rights to medical care, including reproductive healthcare and HIV/AIDS treatment.

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