

Challenges of Poverty on Sexual Reproductive Health

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Abstract: This paper reflects on the challenges of poverty on sexual reproductive health in Botswana. It intends to stimulate discussions on issues surrounding poverty and sexual reproductive and how to alleviate such challenges. The challenges explored include: lack of information on Sexual Reproductive Health Rights (SRHR); poor access to SRHR; lack of negotiation skills for sexuality, and adolescents in poverty and SRHR. The paper starts with an overview of poverty in Botswana, then discusses the challenges of poverty on sexual and reproductive health rights and lastly, the recommendations that intend to address the challenges of poverty related to SRHR.

Keywords: Poverty; sexual and reproductive health; and Botswana

INTRODUCTION

Poverty is a socioeconomic and multidimensional occurrence which is common in Sub Saharan Africa (Meyer & Nishimwe-Niyimbanira, 2016). It exists in all countries and most significant in developing countries, Botswana included. Poverty exposes women and their future generations to serious sexual reproductive health complications. Women who live in poverty and are poorly educated have shorter lifespan, high rates of illness and death, and more limited access to health care services. Poverty is cyclical and deprives women and their generations to acquire literacy, good health and a long productive quality life. Poor women are unable to access family planning, cannot space their pregnancy, hence tend to have many and un spaced children. Poverty and wealth inequality have a direct and detrimental impact on educational outcomes, and vulnerability to HIV.

Roughly a third of Botswana's population lives below the national poverty line (Republic of Botswana & United Nations, 2010). Therefore, development experts have established family planning and reproductive health care programmes as fundamental mitigating factors for improving the wellbeing and social status of women. Countries have developed policies and strategies that aim to ensure access to sexual and reproductive health and rights services, empowering women, men and young people to exercise their rights to sexual and reproductive health. Access and empowerment are seen as driving factors for bringing development and ending poverty (Gibbs & Engebretson, 2013). Countries including Botswana have committed themselves and agreed during International forums such as the International Conference on Population development in Cairo (ICPD) in the 1990's to consider issues of reproductive health and family planning into their programmes and policies. World leaders agreed on a declaration that resulted in the formulation of eight Millennium Development Goals. These form a policy framework for alleviating poverty and enhancing wellbeing (Ministry of Health, 2008). Botswana like other countries in Africa has implemented policies to combat poverty. The poverty levels vary across regions and the levels of education. The country needs effective poverty reduction programmes with an in-depth understanding of changes in the country. The aim of this paper is to explore how poverty impacts upon SRHR, its challenges as well as to highlight recommendations that could combat the problem.

METHODS

The authors collaboratively performed desk review of the literature using key words such as poverty and sexual reproductive health in Botswana, poverty in Botswana and sexual reproductive health, challenges of poverty and sexual reproductive health. Data bases searched included EBSCOHOST, PUBMED, CINHAL, GOOGLE SCHOLAR, HINARI and Botswana Governments Websites. The authors also hand-picked some articles and examined grey literature and reports that were relevant to poverty and sexual reproductive health in Botswana. Furthermore, the authors made inferences to their own experiences as health care providers servicing sexual and reproductive health care system in Botswana.

Challenges of poverty on SRH

Over the years, the challenges of poverty have heightened among many countries. Challenges of poverty are multifaceted and spread across the health care systems within societies. Education has an important influence on the socio-economic status of individuals.



Women who have not completed at least high school are at risk for poor health (Gibbs & Engebretson, 2013). This paper focusses on the challenges of poverty in relation to sexual reproductive health and rights. Challenges addressed in this paper are: Lack of information on SRHR; poor access to sexual and reproductive health right services; lack of negotiation skills related to sexuality issues; poverty in adolescents as well as pregnancy.

Lack of information / knowledge on SRHR

Education plays a major role in decision making and being equipped with a wide range of information is a great benefit to an individual. Similarly, being knowledgeable about information related to SRHR is an advantage and an enabler to making rational and informed choices with regard to sexual and reproductive health matters. On the contrary, living in poverty deprives individuals to acquire information related to SRHR services that is equally obtainable by other people. SRHR services include family planning, ante natal, intrapartum, post-natal and neonatal care (Ministry of Health, 2008). As a result, people living in poverty lack information and understanding of SRHR services being offered.

Missing out on pertinent and crucial information needed for one's entire life concerning reproductive health results in either underutilization or non-utilization of services. Engaging in risky sexual behaviours without full understanding of the consequences of their commissions or omissions of their acts is a common observation among people living in poverty. For example, lack of information on the appropriate use of condoms increases the likelihood of its non-utilization. Failure to use condoms greatly increases the likelihood of acquiring sexually transmitted infections including HIV and AIDS which potentially increases the morbidity and mortality rates.

Poor access to sexual and reproductive health right services

Access to SRHR services by people living in poverty is very crucial. Accessibility is the availability of good health services within reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them (WHO,2015). People living in poverty hardly access SRHR services largely due to lack of knowledge on what is available, where and how to access such. Failure to access family planning services often results in too large families. The poor tend to have larger families than the rich, they are prone to illnesses, and insufficient utilisation of health care services, such as family planning and care during pregnancy (Izugbara and Ngilagwa, 2010). They also experience financial limitations. For instance, lack of resources to pay for transportation to reach the health facilities where they access quality care at critical moments (Roudi-Fahimi and Ashford, 2005). People living in poverty are also not likely to access screening services for cancer such as the 'see and treat' that are intended to reduce the morbidities and mortalities associated with cancer. Results of a study conducted in Egypt, reflect that the percentage of births attended by medically trained personnel were (31% in the poorest fifth, 61% in the middle fifth and 94% in the richest fifth. These results reflect that the poorest fifth were the lowest in attendance. Poverty hampers women's ability to use available maternal care services. (Roudi-Fahimi and Ashford, 2005).

Lack of negotiation skills related to sexuality issues

SRHR knowledge, negotiation skills and one's confidence are key in fruitful negotiations related to sexuality issues. Limitations in these aspects as often is the case in people living in poverty hinder them from engaging in discussions related to sexual reproductive health matters. The ability of poor women to negotiate for safer sex is limited, therefore, they are at risk of being overpowered by their male counter parts during SRHR discussions. This is most likely when they are economically dependent on their male partners. The end results of failed negotiations is the occurrence of unplanned and unwanted pregnancies. The unwanted pregnancies are most likely to induce stress among females which may ultimately lead to both ante and post-partum distress. Unplanned pregnancies increase the risks of depression among mothers and stress related to parenting (Bahk, et al, 2015)

Adolescents in poverty and sexual reproductive health

Adolescent's sexual reproductive health and poverty are still a public health challenge. In sub-Saharan Africa, Botswana inclusive, adolescents get married at a younger age that is as early as 16 years. In addition, adolescent childbearing, HIV transmission and low coverage of modern contraceptives are common factors affecting adolescents in sub-Saharan countries. According to Melesse et al 2020, adolescents do not have access to Sexual reproductive services as a result of lack of resources such as transportation and money. A lot of adolescents are not reached in terms of services. There are inequalities in adolescents by gender, education, urban rural residence and household wealth that is the poorest and the richest as this is persisting, and the issue need to be addressed. In



2015, a national survey by Wood et al 2015, looked at the use of SRH services among adolescent women in 70 Low Middle Income Countries. The report revealed that in almost all the Low Middle Countries evaluated, only 10% or fewer of all adolescent women had visited health facilities in the past 12 months and were informed about family planning (Wood et al., 2015). Teenage pregnancy is still a challenge globally particularly in low- and middle-income countries. Haberland & Rogow (2015) define teenage pregnancy as a situation of becoming pregnant among persons aged 13-19 years old. Sixteen million girls aged 15-19 around the world give birth each year. Zulu et al (2019) reveal that a proportion of the births occur in Low -Middle Income Countries. The highest teenage pregnancy is recorded in West Africa (115 per 1000) and Sub Saharan Africa as a result of factors such as rural residence, not attending school, no maternal education, no father's education, lack of parent to adolescent communication on sexual issues, and inaccessibility of SRH (Desiderio, 2014; Fatusi, 2016; et al., 2019). Botswana press agency [BOPA] (2017) reported that the adolescent fertility rate in Botswana was estimated at 51 births per 1000 women aged 15-19 years and that the trend continued to rise. According to the then Minister of Education Honorable – Fedelis Molao, findings of a study conducted by the Ministry of Health in collaboration UNFPA to determine the rate of school drop outs due to pregnancy and causes of such pregnancies indicated that for the year 2016 alone, there were 6 dropouts in pre-primary, 271 in primary school, 1 194 junior secondary and 477 in senior secondary (BOPA, 2017). Ramabu, (2020) also extracted data from Botswana statistics from 2013 and 2016. The data revealed that 901 children were reported to be pregnant in 2013.

Poverty and pregnancy

Other attributes have shown that poorer women have been depressed by lack of resources and resorted to the use of alcohol, tobacco, and other harmful substances. This led to higher risk for food insufficiency and insecurity and poor feeding practices and habits (Izugbara and Ngilagwa. 2010). Living in poverty has profound effects on the expectant woman and her family and it is likely to increase the risk of adverse pregnancy outcome (Kim et al, 2018). Poverty is associated with reduced financial independence of one's ability to sustain pregnancy needs especially in terms of food and nutrition. Malnutrition is one of the common conditions found among pregnant women living in poverty. Malnutrition is either a deficient or an excess of intake of nutrients which may result in undernutrition or overweight respectively (WHO, 2016).

Pregnant women living in poverty are also prone to developing nutrient deficiency related conditions such as anaemia. Anaemia in pregnancy, characterized by a decrease in the oxygen- carrying capacity of the blood due to dysfunctional red blood cells (Prakash & Yadav, 2015; Fraser & Cooper, 2004) and haemoglobin concentration of less than 110g/l (World Health Organization, 2018) and or approximately a haematocrit of less than 33% (Auerbach & Landy, 2020) increases the risk of maternal morbidity during pregnancy. A study conducted by Lin et al (2018) revealed that pregnant women with lower family per capita presented with anaemia more than those with the higher one and that anaemia was prevalent in women who were from rural areas. Melku et, al (2014) also in their institutional based cross sectional study on the prevalence and predictors of maternal anemia during pregnancy revealed that mothers with low monthly family income were three times more likely to be anemic as compared to those with high monthly income.

Anaemia during pregnancy increases the risk of postpartum haemorrhage, one of the leading causes of maternal mortality in Botswana (Statistics Botswana, 2018). These nutrients related problems often result in fetal deaths, premature births, pregnancy loss, and maternal mortality morbidity and deformity (WHO, UNICEF, 2015). Poverty primarily generates adverse maternal outcomes by exposing women to exceedingly poor health conditions. Women's health is key to affect children's survival, household wellbeing, and societal continuity. Women who have not completed at least high school are at risk for poor health. (Gibbs & Engebretson, 2013).

The greatest impact of malnutrition is mostly notable on the girl child. An undernourished growing girl child is at increased risk of developing stunted growth with a contracted pelvis. 2-15% of pregnancies are complicated by pelvic disproportion (Deepika et al, 2019). A contracted pelvis may interfere with progress of labour which may subsequently negatively affect her during childbirth process. The girl-child's role as caregiver also contributes to a large number of girls being absent from the natural science careers and being channeled into less-paying jobs (Tlou, 1999). This may result in high failure rates for girls, a phenomenon that exposes them to poverty and a low level of living. Education has an important influence on socioeconomic status.

Early marriages of girl children are exacerbated by among other things the low socio-economic position, traditional beliefs and cultural obligations of many families in Botswana (Rivers, 2000). A related issue is that men generally own more resources than women. As such some men have a tendency of enticing young girls to have sexual intercourse with them in exchange for money



and gifts. Men's use of money to get sexual favors from young girls is not peculiar to Botswana only, it is a phenomenon, which also exists in other countries (Fanning, 2001).

Although the above challenges exist in relation to poverty and SRHR in Botswana, it is important to highlight that the Botswana government has embarked on various poverty eradication programs. Some of the programs are meant to empower SRHR recipients with knowledge and skills to combat poverty, while others target other vulnerable populations. The latter include programs that equip mothers to be more competent in caring for their children and households, bear healthy children, and contribute positively to family upkeep and wellbeing. Poor maternal health in contrast and decreased family resources lead to deficient childcare and foster household poverty. It is not in dispute that healthy mothers and women contribute more positively to the community, and participate more in neighbourhood development and in civil society organization (Iugbara and Ngilagwa, 2010)

Implications for Sexual Reproductive Health and Rights Programs

This section highlights recommendations that could go a long way to address poverty-related challenges that are related to SRHR discussed above. Poverty must be recognized as a key hindrance to sexual and reproductive health in poor communities. In order to improve the health of the poor, the government must adopt a comprehensive plan that addresses socio-environmental and economic conditions that strengthen the health conditions of the poor in the vulnerable areas (UNFPA, 2010). Socio-economic empowerment activities should, therefore, be incorporated into programmes addressing health care services. Economic empowerment activities planned must be relevant to the status of the poor in both rural and urban communities and motivate all children to study up to tertiary levels, micro-credits programs, vocational skills training, and employment creation/business start-up grants (Izugbara, and Ngilagwa, 2010).

In order to address the impact of poverty and enhance quality of life need to embark on intervention strategy that takes a holistic approach to address structural poverty and poor SRH outcomes, should include access to education, economic asset building, delay of first pregnancy, support for safe birth, and prevention of violence against girls and women. Linking up of these pillars will have greater impact on young women's wellbeing. The programmes will enable women and girls to overcome the above risks and experience positive educational, health and socio-economic outcomes. If sustained and well implemented, the strategy has the potential to address the SRH&R burden among the poor.

Governments and development partners should consider priority areas and inclusiveness within rural and urban communities, including vulnerable children such as street children, those with disability internally-displaced persons, and cross-border migrants. It is important for reproductive health services to be offered freely or at an affordable cost to all especially those living in poverty. Mitigations to improve the health of the poor must adopt a comprehensive plan that addresses socio-environmental and economic conditions that strengthen the health conditions of the poor in the vulnerable areas (UNFPA, 2010). A holistic approach can enhance the quality of life, reduce negative impacts on the environment, improve the overall health of a population, and reduce the burden of investment in curative health and poverty alleviation. Poverty, in particular, must be recognized as a key hindrance to sexual and reproductive health in poor communities. Socio-economic empowerment activities should, therefore, be incorporated into programmes addressing health care services. Economic empowerment activities planned must be relevant to the status of the poor in both rural and urban communities and motivate all children to go to schools up to tertiary levels, micro-credits programs, vocational skills training, and employment creation/business start-up grants (Izugbara, and Ngilagwa, 2010)

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Implications for Research

Comprehensive efforts have been provided in research on SRH in Sub Saharan Africa, with the known history of Family Planning and SRH generally well documented. Therefore, a strategic focus on SRH in countries is critical to the development of healthy productive populations and, ultimately, the improvement of the quality of life for the rapidly increasing number of communities across the globe. To achieve improvements in SRH indicators in the communities, governments and development partners must develop an understanding of the dynamics of the living patterns of communities in rural and urban areas. Stakeholders need to



support and embark on high quality research that provides relevant evidence for policy and action on SRH in communities and institutions, particularly among vulnerable populations. The research agenda on SRH in communities also need to include efforts to establish the cost-effectiveness and feasibility of SRH interventions, such as government subsidies for services and supplies (UNFPA, 2015).

Implications for Public Education

Also, specific SRH health services for urban-based adolescents should be offered through a variety of non-traditional outlets including outreach camps, private provision of health services and in school health services, as well as door-to-door services. This, will ensure that all vulnerable youth in rural and urban areas are reached. Women are more disadvantaged regarding employment irrespective of similar educational achievements.

It is time for urgent action by our governments, young people and civil society to re-affirm the rights of young people to a better future. We have a duty to make good quality HIV and sexuality education and sexual and reproductive health services a reality for all. Family planning helps women to avoid unplanned pregnancies that pose a high risk for the health of the mothers and their babies. Studies have shown that there are linkages between wealth and Health.

Lastly, an innovative approach that creates awareness of sexual and reproductive health services, such as using mobile technology, should be further developed and adopted particularly for the hardest-to-reach among urban populations, such as women and youth in urban slums.

Comprehensive sexuality education (CSE) is widely documented to be the key component in efforts to improve sexual and reproductive outcomes for young people. Reproductive health problems such as HIV, unwanted pregnancy and unsafe abortion among adolescents are closely linked to insufficient knowledge about sexuality and reproduction, and lack of access to contraceptives (Zulu et al., 2019). WHO (2018) defined CSE as a curriculum-based process of teaching and learning about the cognitive, physical, and social aspects of sexuality. The good thing about CSE is that it gives students the knowledge, attitudes, skills, and values to make appropriate and healthy choices in their sexual lives (Williams et al., 2018). Moreover, an innovative approach that creates awareness of sexual and reproductive health services, such as using mobile technology, should be further developed and adopted particularly for the hardest-to-reach among urban populations, such as women and youth in urban slums.

Leadership skills and economic empowerment of adolescents

Adolescents, both girls and boys in Botswana have overflow potentials for becoming scientists, entrepreneurs, and other visionary change makers of the country. An organization 'Steppingstone international' in the country is working hard to empower adolescents (both in and out school). Steppingstone is located in Mochudi and have a branch in Gaborone too. However, most adolescents especially girls, still face arduous barriers preventing them from reaching their potentials. The 2017 report by UNICEF revealed that every 10 minutes, an adolescent girl dies as a result of violence worldwide, mostly in developing countries, including Botswana (UNICEF Botswana, 2017). A cohort of children and adolescents in Botswana are still overlaid by child labour, sexual abuse, trafficking, gender inequality, and even prostitution among some adolescents. In 2013, there was a high number of 1058 of children who stayed away from school

Although adolescents are overrepresented in discussions of SHR issues, stakeholders should not lose sight of aging populations. Consequently, aging populations should also be integrated into SRH programs in both rural and urban areas including, but not limited to, the provision of breast, cervical and prostate cancer screening.

CONCLUSION

Family planning on its own, as a single intervention will have minimal impact on the health of women and children, especially that of vulnerable groups. Integrated provision of family planning and maternal and child health services has implications for not only poverty reduction in resource poor settings, but significant declines in the maternal and child mortality rates (WHO, UNESCO, 2015). Finally, the significant role of poverty in the adverse SRH outcomes of the urban poor cannot be overlooked in policies and programs. The argument presented in this regard is that the SRH of the vulnerable group needs to be explored both from a development as well as a service delivery perspective. The need for multipronged approaches that include behavior change, job and wealth creation remains essential to addressing the SRH needs of the poor. Similarly, research efforts linking all these pillars, and documenting impacts, what works and identifying new and innovative approaches should be an important part of the process. Roudi-Fahimi and Ashford, (2005). It is time for urgent action by our governments, young people and civil society to re-affirm the rights



of young people to a better future. We are all responsible to make people living in poverty make use of sexual reproductive health and rights services a reality for them.

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