© Kamla-Raj 2011
J Soc Sci, 28(2): 137-143 (2011)
PRINT: ISSN 0971-8923 ONLINE: ISSN 2456-6756
DOI: 10.31901/24566756.2011/28.02.08

Youth's Perception towards Sexual and Reproductive Health Services at Family Welfare Association Centres in Botswana

C. Lesedi*, M. E. Hoque** and B. Ntuli-Ngcobo**

**P O Box 45287, Riverwalk, Gaborone, Botswana*
*** Department of Public Health, School of Health Care Sciences, University of Limpopo (Medunsa Campus), South Africa*

KEYWORDS Youth. Perception. Sexual and Reproductive Health Services. Botswana

ABSTRACT The objectives of the study were to determine the youth's perception regarding sexual and reproductive health services offered at family welfare association centres, and to determine the friendliness of health providers towards youth seeking sexual reproductive health services. This was a cross-sectional study in which 110 conveniently selected participants completed a self-administered questionnaire. The mean age of the participants was 22.08 (SD = 3.48) years. Overall, the participants had a positive perception about sexual reproductive health services. One- third (33%) of participants perceived the referral system as not being youth-friendly and/or not being adequate. Judgemental attitude and friendliness of the health providers were rated lowest (mean scores of 0.96 and 0.95 respectively). The referral system was perceived as a barrier, as 33% rated it as being unfriendly. Youth perceived sexual and reproductive health services positively and had positive expectations of health providers. There are some weaknesses that need to be strengthened, particularly respect for youth and the referral system.

INTRODUCTION

Promoting sexual and reproductive health and rights of young people remains a public health challenge. People under the age of 25 represent nearly half of the world's population, which means they have a powerful role to play in world reproductive health (Advocates for Youth 2005). The period between 10 and 29 years of age is a period of transition from childhood to adulthood and this phase is full of inconsistencies. It is a time when young people are vulnerable to health risks, particularly those related to sex and reproduction. Advocates for Youth (2005) reported that the lives of youth aged between 15 and 24 seems to be overshadowed by reproductive health issues, unintended pregnancy, HIV and other sexually transmitted infections (STIs). The same study indicated over 100 million new cases of STIs among young people each year and young women experience high rates of unintended pregnancy. For example, 40 percent of unintended pregnancy in Latin America and Caribbean, and in sub-Saharan Africa, the percentages varies from 11 to 77 percent (Advocates for Youth 2005).

Corresponding Author:
Mr. M. E. Hoque, MSc
Lecturer, Department of Public Health,
School of Health Care Sciences,
University of Limpopo (Medunsa Campus),
South Africa
Telephone: +27 012 5213093
E-mail: Muhammad_Hoque@embanet.com

Many governments in sub-Saharan Africa view the region's continued rapid population growth, high birth rates and escalating rate of HIV infection and unprotected adolescent sexual activity with concern, as these contribute significantly to the statistics (Advocates for Youth 2008). At least 80 percent of sub-Saharan Africa's youth are sexually experienced and the statistics on having had intercourse by the age of 20 are: 73 percent of Liberian women aged 15 to 19; 15 percent of Nigerian women; 49 percent of Ugandan women; and 32 percent of Batswana women (Advocates for Youth 2008). The United Nations Population Fund (UNFPA) Country Programme focuses on Adolescent Sexual Reproductive Health and one of the focus areas is to increase access to youth-friendly reproductive health services (Lawson 2001).

Young people face many challenges when they seek reproductive health services. Among the challenging variables are: policy constraints, operational barriers, lack of information, and a feeling of discomfort or embarrassment (Senderowitz 1999). Researchers have argued that young people encountered health providers who were judgmental, rude and who refused to provide services, especially at government-owned maternal and child health/family planning facilities (Erulkar et al. 2005).

Another study, conducted among British adolescents, reported that they do not seek help, even if they have a serious health concerns, including sexual health concerns (Booth et al.

2004). A study conducted in Uganda found that adolescents seek help from pharmacies and druggists without divulging the condition that requires treatment (Kibombo et al. 2008). Another study, conducted among youth in Tanzania, indicated that health providers shout at the youth or criticize them (for being sexually active) when they seek sexual reproductive health care (African Youth Alliance/Pathfinder 2003).

A study done in Uganda and Nigeria indicated that youth are not treated in the same way as are older people when they seek reproductive health care from health providers (Erulkar et al. 2005). One study reported that youth were impressed with the services they received, but 12 percent had a negative impression and some participants mentioned that they disliked the doctors (Geber 1997). According to a study conducted in Zambia, youth were satisfied with the attitude of health providers (Mmari and Magnani 2003).

In Botswana, adolescents and youth are at risk of substance abuse, delinquent behaviour, depression-suicide, sexual abuse and sexual risk-taking behaviour, resulting in unplanned pregnancy and the transmission of STIs, including HIV. Among adolescents and youth in Botswana: the average age of sexual intercourse is 17.5 years; the first birth is at 18.6 years; 24 percent are using contraceptives; and teenage pregnancy is approximately 16 percent (Ministry of Health 2005). This indicates a need for Adolescent Sexual and Reproductive Health counselling. HIV infection in Botswana is high and young people are mostly infected**.** Therefore the need for sexual and reproductive health services for young people is crucial. It must also be borne in mind that the adoption of a western culture has led to the abolition of initiation schools in Botswana (*bogwera* and *bojale*), that is, the rite of passage from childhood to adulthood, which practice includes guidance about adulthood and behaviour being imparted (including responsible sexual behaviour). Even though Botswana Family Welfare Association (BOFWA) has taken the initiative to provide youth-friendly services in Botswana, little has been done to assess the services offered.

The objectives of this study were: to determine the youth's perception towards sexual and reproductive health services offered at BOFWA facilities; and to determine the friendliness of the health providers towards youth seeking sexual reproductive health (SRH) services.

METHODOLOGY

Study Setting

There are three sites in the southern region of Botswana that offer youth-friendly health services. Two sites were randomly selected for the study: Gaborone and Kanye. Gaborone is the capital city of Botswana, situated in the south-eastern corner of Botswana and 15 km from the South African border. The city has a range of government health facilities, ranging from a referral hospital to clinics, a private health facility and one BOFWA centre that offers youth-friendly services. Kanye is located in the southern part of Botswana. It is a peri-urban village, which serves as the administrative and commercial centre of the Ngwaketse district. Kanye has a mission hospital that operates at a district level, clinics and a BOFWA centre solely for adolescents and youth. Areas in the Kanye/Moshupa district are catchment areas for Kanye health facilities, including the Kanye Youth-Friendly Clinic.

Study Design and Study Population

This was a descriptive cross-sectional study. The population of youth was adopted from the Central Statistics Office 2005 as the Population Projections for Botswana 2001-2031. It is divided into districts and sub-districts and Gaborone represents a district and Kanye/Moshupa a district that represents youth who utilize the Kanye Youth-Friendly Clinic. The projected youth population for Gaborone district in the year 2008 was 106,824, while that of Kanye/Moshupa district was 42,928. The study population is all the youth in the Gaborone district and Kanye/Moshupa district, that is, 106,824 and 42,928 respectively (Central Statistics Office 2005). The target population was youth who utilized the services at the two youth-friendly clinics during a one-year period, that is, 5200 used Gaborone Youth-friendly Clinic; and 4990 used Kanye Youth-Friendly Clinic. Young people aged 15 to 29 years were the target age group for participation in the survey.

Sample Size and Sampling Procedure

The minimum sample size for the study was calculated using the Epi-Info software program.

For Gaborone, the researcher considered: a proportion factor as 20 percent; the worst acceptable result as being 12.6 percent; and a 95 percent confidence level (given a sample size of 112). For Kanye/Moshupa, the researchers: took 8.6 percent as the proportion factor; considered the worst acceptable result to be 3.5 percent. At a 95 percent confidence level, the sample size was 116.

The researcher sampled for youth who had utilized the sexual and reproductive health services twice in order to obtain information about the services. Thus the convenient sampling method was used to recruit the participants for the study.

Exclusion and Inclusion Criteria

Young people aged below 15 years and first users were excluded from the study. Young people aged 15-29 years, who had visited the facilities more than once, were included in the study.

Ethical Consideration

Ethical clearance for the study was obtained from Medunsa Campus Research and Ethics Committee of the University of Limpopo (Medunsa Campus). Permission to conduct the study was granted by the Health Research Development Committee, Ministry of Health, Botswana. Permission to conduct the study and recruit participants was also obtained from the clinic facilities' headquarters (BOFWA) in Gaborone, Botswana. Informed written consent was obtained from Botswana. Confidentiality of participants was maintained at all times. To further maintain confidentiality no identifiers were included in the questionnaire. Participation was voluntary and participants were informed that they could withdraw from the study at any stage of the interview if they so desired and without any penalty.

Data Collection Tools and Procedures

A self-administered questionnaire was used to collect data. The questionnaire was self-developed and based on the characteristics of Youth Friendly Services adopted from Senderowitz et al. (2003) and A Mystery Client Interview Guide by African Youth Alliance-Botswana (2005) (Senderowitz et al. 2003; African Youth Alliance-Botswana 2005). The questionnaire had three sections. The first section was a demographic section; the second section dealt with the youth's perception of sexual and reproductive health services offered at BOFWA facilities; and the last section dealt with the friendliness of the health providers towards youth seeking SRH services. The last two sections used a 5-point Likert Scale question set. Data collection took a period of a month, including both sites.

The questionnaire was translated to the local Setswana language and was pre-tested using 10 patients in another health facility not included in the study; this to identify gaps and modify the questionnaire as required.

Data Analysis

Data were entered into a Microsoft Excel spreadsheet and exported into SPSS version 13.0 (SPSS Inc, Chicago) for analysis. For the closed questions in sections 2 and 3, the technique used for response was the 5 point Likert Scale; therefore, participants rated their level of agreement or disagreement with the statement. Possible responses ranged from strongly agree to strongly disagree. Each response was translated into a numerical value. Strongly agree was coded 2, if the statement was in a positive form, and strongly disagree was coded -2. The scale was revised for negatively worded questions.

The results were summarized using descriptive summary measures: expressed as mean (SD) for continuous variables and percent for categorical variables. Scoring the user-friendliness of each aspect of the service was based on a 5-point Likert Scale, with low points being assigned for weaker user-friendliness and higher points being assigned for stronger user-friendliness.

RESULTS

A total of 110 participants were enrolled into the study across two sites in Botswana. The mean age of the participants was 22.08 (SD = 3.48) years. More females (59%) utilized the services than males. Table 1 shows the summary of the socio-demographic characteristics. The results also suggested that over half of the participants (55%) had secondary education; almost all (97%) were single and most were unemployed (76%).

Table 1: Socio-demographic characteristics of the participants

Variable	*n*	*Percentage*
Age		
15 - 19	26	24
20 – 24	55	50
25 – 29	29	26
Average age (SD)	22.08(3.48)	
Sex		
Male	44	41
Female	63	59
Marital Status		
SingleMarried	1073	973
Education		
Primary	6	6
Secondary	59	55
Tertiary	42	39
Employment		
Unemployed	83	76
Employed	26	24

Youth's Perceptions of SRH Services

Participants were asked how they perceived the sexual and reproductive health services provided in the facilities. Table 2 summarizes the youth's perception of SRH services. Overall the participants had a positive perception of the SRH services (mean score of 1.29). The response variables issuing of contraceptives (including condoms) and recommending the facility to friends were rated highest, while the response variable referral to other health facilities for SRH services was rated lower (mean = 0.80). The responses were also analyzed dichotomously as youth-friendly (strongly agree and agree) and not youth-friendly (uncertain, disagree and strongly disagree). Most of the participants rated the services as youth-friendly. It was also noted that 33 percent of participants perceived the referral system as not youth-friendly and/or not adequate.

Health Providers' Attitude

Table 3 indicates the participants' rating of the health providers' attitudes. The lowest ratings were seen with judgmental attitudes and friendliness of the health providers: 0.96 and 0.95 respectively). Health providers' attitudes were also analyzed using a dichotomous question (Youth Friendly and Not Youth Friendly). Majority (92%) of participants indicated that health providers encourage youth to ask questions and over a quarter (26%) indicated that health providers have no respect for youth.

DISCUSSION

The study investigated the extent of the user-friendliness of sexual and reproductive health services offered at BOFWA centres at two sites in Botswana. There is a growing recognition world-wide that 'youth friendly' services are needed to ensure effective sexual and reproductive health services. The services must be able to attract and retain young people for continuing care and influence behavioural change among them and the community at large. The SRH services for youth need to continue to be assessed and evaluated periodically to ensure they continue to be relevant and achieve the intended outputs and impact.

The present study found that the overall perception of youth regarding the services was positive; however, certain variables were rated low. This included an inadequate referral service. Opening hours were not convenient for the youth because most of them are students. This means that regardless of how well designed the SRH programs are, social marketing and publicity is critical for uptake. In one study, researchers found that most adolescents from Kenya and

Table 2: Perceptions of youth about the SRH services offered

Statements	*Descriptive*		*Youth friendly (%)*	
	Mean	*SD*	*YF*	*Not YF*
I feel that SRH service are meant for me	1.45	0.89	92	8
Services offered are important for healthy individual development	1.48	0.81	93	7
I will recommend this facility to any of my friends	1.53	0.71	96	4
SRH information meets my needs	1.20	0.84	82	18
Counselling services meets my needs	1.20	0.82	85	15
Issuing of contraceptives meets my needs	1.53	0.88	91	9
Treatment of SRH problems met	1.38	0.77	90	10
Referral to other service met	0.80	1.07	67	33
I will visit the clinic more than once	1.04	0.90	78	22
Aggregate of perceptions	1.29	0.49	86	14

Table 3: Participants' rating for the health provider attitudes

Statements	*Descriptive*		*Youth friendly (%)*	
	Mean	*SD*	*YF*	*Not YF*
Health providers greet youth receiving sexual and reproductive health service in a polite manner	1.32	0.96	85	15
Health providers respect youth	1.04	1.18	74	26
Health providers assure confidentiality to youth	1.08	1.06	75	25
Health providers allocate enough time for youth interaction	1.01	1.05	73	27
Health providers are willing to listen	1.23	1.00	81	19
Health providers tell youth to return if they have concerns:	1.40	0.86	89	11
Health providers give relevant info top youth needs	1.22	0.92	87	13
We are encouraged to ask questions	1.48	0.80	92	8
Aggregate	1.17	1.02	80	20

Zimbabwe did not obtain reproductive health services because they did not know where to obtain such services (Erulkar et al. 2005). However, there were certain substantial differences on how the characteristics were rated for friendliness as far as the youth characteristic is concerned and such response variables were rated low, denoting weaker friendliness/ not youth-friendly.

Participants perceived the SRH services positively; they felt that SRH services are of paramount importance for their development as healthy individuals. In Botswana, as outlined in the Policy Guidelines and Service Standards: Sexual and Reproductive Health, all persons of reproductive age, regardless of age or marital status, shall have the fundamental right to determine for themselves how many children to have and when to have them (Ministry of Health 2005). This is practical in Botswana as evidenced by majority of participants from this study perceiving positively the supply of contraceptives, including condoms. In contrast, some researchers found that the perception of the youth was that they would be welcome when obtaining all SRH services, except family planning services (Mmari and Magnani 2003). In some countries, there are restrictions by law on the access of specific commodities, thus limiting youth's access to such services. Also another study pointed out that, in some African countries, health providers impose age restrictions into the provision of family planning methods, including condoms, even though such restrictions are medically unjustifiable (Erulkar et al. 2005).

At times, it is not possible to provide services that meet the needs of youth. In such situations, a referral system needs to function so that youth are referred to a service where they will be treated in a friendly manner. Nevertheless, participants' indicated that the referral system was negatively perceived by the majority of the participants, denoting a possible lack of friendliness regarding this particular service.

Poor referral systems can affect the perception of the friendliness of the service offered to youth in any given youth-friendly clinic and the findings of this study suggest that the referral system of youth-friendly clinics is poor.

Health Providers' Attitude

There is a need for specially trained staff to work proficiently and with sensitivity with youth, thus creating youth-friendly services. A study done in Zimbabwe found that youth services were made friendlier by training nurses and creating youth corners where youth could obtain information from peers concerning reproductive health issues (Mmari and Magnani 2003). In fact, this study found that the health provider's attitude is the most significant predictor of friendliness of services. A health provider's attitude can influence the youth accessing services that allow them to safely manage their sexual and reproductive health, and make informed decisions concerning their reproductive health (Senderowitz 1999). By and large, the results show that the youth have positive expectations regarding health providers.

Despite strong friendliness of health providers, there were some significant differences, that is, responses to certain variables. For example, some variables were perceived as a barrier to access services; these include, but are not limited to: health providers being friendly to youth; and health providers being judgemental.

Many studies have indicated that health providers have a negative attitude towards youth seeking sexual reproductive health services (African Youth Alliance-Botswana 2005; Biddlecom et al. 2007). Researchers have argue that young people experienced health provides who were judgmental, rude and who refused to provide services, especially at government-owned maternal and child health/family planning facilities (Erulkar et al. 2005). In another study, the youth indicated that health providers shouted at them or criticized them for being sexually active when they sought sexual reproductive health care (AYA/Pathfinder 2003). This was also evident in this study: health providers were rated at 27 percent, that is, as not being friendly to youth seeking SRH services. According to a study, some health care providers were biased against adolescent sexual activity or found it difficult to relate to adolescents in a respectful way (Senderowitz 1999).

Limitations of the Study

The non-probability sampling method was used to select participants to ensure no possibility of selection bias. Participants selected were those who often utilize the services and therefore there is a possibility of response bias. The results should only be interpreted for the catchment population.

CONCLUSION

The way participants perceive the SRH services provided at a clinic is influential into how they rate the friendliness of health providers. Even though the results indicated that youth have a positive expectation about services offered at the Youth-Friendly Clinics, the program design remains a barrier to access SRH services. There is a lack of publicity about the services and social marketing and publicity is critical for uptake. Even though the program for youth-friendly service is doing well in Botswana, there are some weaknesses that need to be strengthened.

RECOMMENDATIONS

SRH Services need to be assessed periodically to ensure that the standards of youth-friendly services are met. SRH services could be extended to secondary schools to increase accessibility by youth.

ACKNOWLEDGEMENT

The authors wish to thank: the clinics' management team for their support in conducting the study; and the youths who voluntarily took part in this study. No funding was received for the study and there is no conflict of interest in this study.

REFERENCES

Advocates for Youth 2005. Youth's Reproductive Health: Key to Achieving the Millennium Development Goals at the Country Level. Available at: <http://www.advocatesforyouth.org/Publications/iag/millenniumgoalscountry.pdf> (Retrieved March 20, 2008).

Advocates for Youth 2008. Adolescent Sexual and Reproductive Health in Sub-Sahara Africa. Available at: <http://www.advocatesforyouth.org/publicationsfactsheet/fssxrepr.htm> (Retrieved March 5, 2008).

African Youth Alliance/Pathfinder 2003. Youth-Friendly Sexual and Reproductive Health Services: An Assessment of Facilities. Available at: <http://www.pathfind.org/site/DocServer/Youth-friendly-Services-Summary_Assessment_Report-Tanzania.pdf?docID=4381> (Retrieved March 5, 2008).

African Youth Alliance-Botswana 2005. Youth-Friendly Services: Botswana End of Program Evaluation Report. Available at: <http://www.ayaonline.org/CDwebDocs/AYAResources/ToolboxEop_Reports/YFS/BT_YFS_FINAL.pdf> (Retrieved March 7, 2008).

Biddlecom AE, Munthali A, Singh S, Woog V 2007. Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *Afr J Reprod Health,* 11: 100-110.

Booth ML, Bernard D, Quine S, Kang MS, Usherwood T, Alperstein G, Bennett DL 2004. Access to Health Care Among Australian Adolescents - Young People's Perspectives and Their Socio Demographic Distribution. *J Adolesc Health,* 34: 98-103.

Central Statistics Office 2005. *Population Projections for Botswana 2001-2031.* Gaborone: printed by Department of Printing and Publishing Services.

Erulkar AS, Onoka CJ, Phiri A 2005. What is Youth-Friendly? Adolescents' Preferences for Reproductive Health Services in Kenya and Zimbabwe. *Afr J Reprod Health,* 9: 52-58.

Geber GM 1997. Barriers to Health Care for Street Youth. *J Adolesc Health,* 21: 287-290.

Kibombo R, Neema S, Moore AM, Ahmed H 2008. Adults' Perceptions of Adolescents' Sexual and Reproductive Health: Qualitative Evidence from Uganda. Available at: <http://www.guttmacher.org/pubs/2008/02/29/or35.pdf> (Retrieved August 8, 2008).

Lawson A 2001. UNFPA Botswana Representatives. Available at: <http://www.unbotswana.org.bw/unfpa.html> (Retrieved March 10, 2008).

Ministry of Health Botswana 2005. *Policy Guidelines and Service Standards: Sexual and Reproductive Health.* Gaborone: Family Health Division.

Mmari KN, Magnani RJ 2003. Does making clinic-based re-

productive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *J Adolesc Health,* 33:259-270.

Senderowitz J 1999. Making Reproductive Health Services Youth Friendly. Available at: <http://www.fhi.org/NR/rdonlyres/ek115zcld7fcs3zic4317vxbaokgvumttd6Fkg53h5nqurwcr71h4www4i3zFpqqelfwnyjbz3opjd/makingRltserviceyouthfriendly.pdf> (Retrieved March 5, 2008).

Senderowitz J, Hainsworth G, Solter C 2003. A Rapid Assessment of Youth Friendly Reproductive Health Services. Available at: <http://www.pathfinder.org/site/DocServer/YFS_TG_Final_web_version.pdf?docID=762> (Retrieved March 5, 2008).