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Access of adolescent sexual and reproductive health (ASRH) services in urban squatters of Kathmandu valley, Nepal

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ABSTRACT

Background

Initiation of early sexual activity and lack of adequate knowledge and skills for protection keeps adolescents at a higher risk of unwanted pregnancy, unsafe abortion and sexually transmitted infections including HIV/AIDS. High prevalence of early marriage and childbearing is associated with higher maternal mortality and morbidity.

Methods

This study aimed to explore access to adolescent sexual and reproductive health (ASRH) services among the adolescent urban squatters of Kathmandu Valley. This is a qualitative, non-intervention study. The findings are based on focus group discussions (FGDs) among male and female adolescents from squatter communities.

Results

School textbooks are the main source of ASRH information for adolescents. Government health service centres were not available within close distance of the squatters; however private pharmacies, private clinics and private hospitals were available. Adolescents wish to visit health facilities for contraceptives including the emergency contraceptive pill (ECR), safe motherhood, professional abortion and other reproductive health services but due to the lack of public health institutions near to squatter communities and the high cost of private health service providers, most of the economically poor adolescents were not easily able to access ASRH services.

Conclusion

Making government health institutions with quality services more accessible to urban squatter communities is the best option for ensuring easy access to ASRH services.

Keywords: Access, Adolescents, Sexual and Reproductive Health, Contraception, Safe Motherhood, Abortion

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INTRODUCTION

Adolescent sexual and reproductive health (ASRH) refers to the physical and emotional wellbeing of adolescents with regard to sexual activity and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and coercion.[1] There is widespread international agreement that adolescents have a right to access ASRH. The global community, first at the International Conference on Population and Development (ICPD) held in Cairo in 1994 and then at the Fourth International Conference on Women (ICW)

in Beijing in 1995, decided to protect and promote the rights of adolescents to access sexual and reproductive health information and services.[2,3]

Adolescents account for nearly one-fifth (18%) of the global population. In Nepal, adolescents comprise 24% of the total population. This group faces unique emotional, physical, sexual and reproductive health challenges.[4] The practice of early marriage is common in Nepal and is deeply rooted in the culture: Nepal has the third highest levels of child marriage globally. The legal age of marriage is 20 years but 17% of girls aged 15-19 years are already mothers or pregnant with their first child. Only 15% of currently married adolescents use a modern method of contraception. Furthermore, the Adolescent Fertility Rate (AFR) is increasing – from 81 per 1,000 women of 15-19 years in 2011 to 88 per 1,000 in 2016.[5]

Nepalese adolescents face a range of health and social challenges. For instance, initiation of early sexual activity without adequate knowledge and skills for protection keep adolescents at a higher risk of unwanted pregnancy, which could lead to unsafe abortion, and sexually transmitted infections including HIV/AIDS.[6] High prevalence of early marriage and childbearing is associated with higher maternal mortality and morbidity.[7] Adolescents are the most group most vulnerable to premarital sexual behavior. Unwanted pregnancy, teenage pregnancy, abortion, STIs, HIV/AIDS, regrets, guilt, loss of self-respect, depression, loss of family support, substance abuse and even suicide have all been recorded as health impacts of premarital sexual behaviour among adolescents in Nepal.[8]

Premarital sexual relationships are increasing among adolescents in Nepal. About 14% of in-school adolescents report having experienced premarital vaginal sexual intercourse, with the median age for first sexual experience reported as 16 years. Furthermore, 48% of adolescents who report ever having had sex report not using condoms during their first sexual intercourse; nor do 45% who report having multiple sexual partners.[9] Only one quarter of females and one third of males aged 15-24 had comprehensive knowledge of HIV/AIDS and STIs prevention.[10]

In this context, the Nepal government has made ASRH one of its priority programmes. To address the needs of emerging issues of adolescents, the National Adolescent Health and Development (NAHD) strategy was developed in 2000 and was revised in 2018.[11,12] A district level ASRH implementation guideline was developed in 2007 and Adolescent Friendly Services (AFS) were piloted in 26 health facilities (HF) across five districts. After piloting, the national ASRH programme has been scaled-up in 74 districts.[13] Awareness raising activities on ASRH has been carried out since the beginning of the programme under leadership of the National Health Education Information and Communication Center (NHEICC) and Family Welfare Division (FWD). Different approaches such as My First Baby (MFB), Partner Defined Quality for Youth (PDQY), and school health programmes have been applied to raise the awareness among adolescents and communities.[14]

It was expected that these myriad activities would help adolescents to understand the challenges associated with early sexual activity, become more familiar with how to mitigate the potential negative consequences and how to access the services available at health facilities (HFs) that increase the access to and availability of ASRH services. Despite the upgrading of health facilities to sites deemed to be adolescent-friendly, however, studies indicate low utilization of the available services. Limited access to ASRH services continues to contribute to poor sexual and reproductive health status among adolescents.[15] In this context, it is important to explore whether the adolescents of urban squatter communities are able access to ASRH services and what barriers to doing so they encounter.

METHODS AND MATERIALS

This was a qualitative, non-intervention study. The study finding is based on focus group discussions (FGDs) among male and female adolescents in the urban squatter communities of Kathmandu Valley, Nepal. In total, 12 FGDs were conducted in six different urban squat clusters. A survey by Lumanti Support Group (a national NGO) identified five riverside location squatter settlements, namely Bagmati, Bishnumati, Hanumante, Dhobikhola and

Tukucha in Kathmandu Valley. There were also some additional squatter settlements which were non-riverside. For this study, the urban squatter settlements were divided into six clusters: five riverside clusters and one non-riverside cluster.[16] Two FGDs were conducted in each cluster.

Out of 12 FGDs, three were conducted with male adolescents only and nine with female adolescents only. Each FGD consisted of 7-9 participants. Each participant was selected purposively – all the participants were school-going adolescents in reading grades 7-10. The age range of participants was 13-18 years. They were from different ethnic groups including Brahmin, Chhetri, Newar, Tamang, Rai, Limbu, Bhujel, Muslim and Dalit. As respondents were below 18 years of age, consent was taken from their parents as well as from the respondents themselves. Data was collected in December 2020. Before conducting the FGDs, verbal consent was taken from participants' parents and written consent was taken from the participants. An FGD guideline was developed that considered the objectives of the study. Before starting the discussion, participants were gathered in a separate room of the school building so as to maintain privacy. The study objectives were shared with the participants. Trained female moderators and female note keepers were involved for the FGDs with girl adolescents and male moderators were involved for discussion with male groups. Voice recorders were used to capture the discussions. The narrative analysis approach was used for qualitative data analysis. While performing the narrative analysis, transcribing was carried out with the raw field notes translated into well-organized sets of notes. The raw data were reviewed thoroughly and classified (coded) into themes. Data was checked for consistency, validity and reliability. Inferences were drawn on the basis of the identified themes and presented with results under each theme. From this, conclusions were made.

RESULTS

Nine main themes emerged from the coding: (1) access to ASHR information, education and communication; (2) availability of health facilities and ASHR services; (3) ASHR problems in squatter settlements; (4) questions regarding ASRH and how to access services; (5) availability and use of contraceptives (including emergency contraceptive pill, ECP); (6) access to abortion services; (7) availability and use of safe motherhood services; (8) barriers and challenges to accessing ASRH services; and (9) improving access to ASRH services.

Access to ASRH education and communication

School was the main source of ASRH information for adolescents. Almost all FGD participants said that they had received ASRH information from school and most had read a course book. Some mentioned that they also hear ASRH information from radio and television. Only a few participants mentioned the internet, printed media and family members as sources of information. Some female participants also reported that NGO staff occasionally visited their communities to teach about menstrual hygiene and the use of sanitary pads. Participants did not report health facilities or health workers being a common source of ASRH information.

Availability of health facility and ASRH services

During discussion regarding the availability of health facilities and ASRH services in the squatter settlements, almost all participants reported that there were private clinics, private pharmacies and private hospitals close to their community but only a few expressed nearby availability of public health facilities. Most were not aware of the types of ASRH services that exist in public or private health facilities.

A few mentioned that ASRH services such as information, family planning, antenatal care and treatment of STIs were available, particularly in the private health institutions, and some girl adolescents said that they could get a sanitary pad at school in emergencies. One adolescent girl expressed, *"there are no public health institutions in our community. There are private clinics, private pharmacies and private hospitals. The private sector health institutions provide the ASHR services but the cost is very high. Because of the high cost, most adolescents could not visit private health institutions for ASRH services, even in critical conditions. Because of the high cost, adolescents wish to visit public health institutions. Most of the time, the*

maternity hospital [government run] is the choice for ASRH service, which is not in close distance".

ASRH problems in squatter settlements

Discussion took place regarding whether adolescents were familiar with ASRH problems within their community. ASRH problems observed by the group included unhygienic menstrual practices, early initiation of sexual activities, unprotected sexual relationships, teenage pregnancy, teenage abortion, unsafe abortion, genital infections, STIs, rapes and gender-based violence. They stated that unhygienic menstrual practices, early initiation of sexual activities, and gender-based violence were the most common problems of those listed.

One adolescent girl stated, "*menstrual hygiene is not good among adolescent girls. Adolescent girls use a piece of clothes during menstrual period which is not safe, it may not be clean, it may cause infections. All the girls are not able to purchase the sanitary pads, so they use whatever piece of clothes they have in their home".* One adolescent boy reported, "*teenage marriage practice is high in our community. Because of early marriage, particularly adolescent girls are compelled to drop school, early marriage resulted in early pregnancy and early motherhood, they became mothers while they just crossed their childhood. Because of early marriage and early pregnancy, teenage maternal problems are also very common in our community".*

Questions regarding how to access ASRH services

Almost all of the respondents mentioned that they share their ASRH problems mostly with their mother and close friends. Adolescent girls felt it was easy to share their problems with their mother or sister while boys felt it easier to share mostly with their close friends. Regarding the ASRH service seeking behaviour, respondents felt that adolescents would like to visit health facilities if they have any problems.

A few respondents also mentioned that some adolescents visit faith healers or witch doctors in some cases. They reported that the cost of private health institutions was very high and that because of the cost of service, adolescents were disadvantaged. They opined that the best choice would be public health institutions, but these are not always in close proximity to their communities. When they do visit public health institutions, the quality of services is often very poor. Some added that adolescents are compelled to visit private pharmacies or private clinics to protect their privacy.

One male adolescent explained, "*Because of fear of disclosing the privacy and lack of public health facilities close to the squatter community, most of the adolescents are compelled to visit private clinics and private pharmacies, is very costly. Some are deprived of ASRH services due to poor economic conditions. Economically better off families do not have any problems, they can go elsewhere but economically poor families have no way. Even when visiting public health institutions, the service is very poor quality".*

Availability and use of contraceptives

All the participants opined that both married and unmarried adolescents need contraceptives to avoid teenage pregnancy; adolescents fall in love and initiate unprotected sexual relationships, and so risk teenage pregnancy. Some reported that teenage marriage was prevalent in their community and that some adolescents would have unwanted pregnancy which they would seek to abort. Most of the respondents stated that the use of contraceptives was vital to avoid abortion. Almost all the participants expressed that there was no public health facility close to the squatter settlement but that contraceptives were available in private clinics, pharmacies and hospitals close to their communities. A few respondents also mentioned that NGO clinics, such as the Family Planning Association, were available. Almost all the respondents stated that the private sector provides contraceptives but that they are very costly. They felt that cost and availability were the main factors determining the use of contraceptives.

One girl respondent expressed, "*Because of expensive private sector services, adolescents may have been deprived of using the contraceptives. Some adolescents are unaware of the availability of contraceptives, so they don't use them. Those who can afford it, they use contraceptives and those who are of low economic status don't use contraceptives. Adolescents wish to use*

contraceptives but to some extent because of shyness, cost and fear of disclosure of their privacy decide not to use contraceptives most of the time".

Around half of the respondents were not aware of the Emergency Contraceptive Pill (ECP). Those who knew about the ECP mentioned that it was available in the private pharmacies and clinics. They perceived the ECP as useful, particularly for unmarried adolescents who initiate sexual relationships. A few respondents also added that EPC was equally important to married adolescent couples. Regarding the cost of ECP, this was reported to be around 120 rupees for a single dose, which they viewed as very costly.

One male participant stated, "*ECP are necessary, particularly for unmarried adolescents. It is found in private medical shops which is costly i.e. 120 rupees per dose. Because of cost and shyness they do not share usages of ECP. Mainly the cost influences low use of ECP, even when it is well known. Most of the families earn around 6,000 rupees in a week, which is not enough for food and other expenses. Almost all adolescents do not have their own earnings because they are mostly students, so how could [they] manage the cost of EPC?*"

Access to abortion services

Most of the participants expressed that both married and unmarried adolescents seek abortion services in response to unwanted pregnancy. They viewed that because of early initiation of sexual activities there may be a chance of unwanted pregnancy; some added that most adolescents may not know how to prevent pregnancy. Even married adolescents may have unwanted pregnancy. They further added that abortion services were available in private clinics and private hospitals near to their communities. Participants knew of a few cases of abortion that were performed in private abortion clinics. They added that some adolescents may visit private abortion clinics but some do not because of high cost, poverty, social stigma, and fear of disclosure of their privacy.

One girl respondent mentioned "*I have noticed private abortion clinic in some locations and I have heard the abortion charge is costly. But adolescents with low economic families cannot afford high-cost services of private health facilities. Due to social stigma; fear of social blame, adolescents could not go openly for abortion. Adolescents don't have enough information related to the services as well. Because of lack of affordable cost and lack of free public safe abortion services and fear of society, the adolescents are compelled to have unsafe abortion".*

Availability and use of safe motherhood services

The adolescents viewed that safe motherhood services were necessary to adolescents because of the high levels of teenage marriage and teenage pregnancy present in their community. However, most of the participants stated that there were not available through government services in close distance of their community. They added that private clinics and private hospitals providing the services were expensive. Some respondents mentioned that because of the high cost charged by private providers, poor families were deprived of services. They opined that cost is the main determinant of service use.

One girl participant stated, "*The private clinics and private hospitals provide the antenatal care (ANC), delivery and postnatal care (PNC) services but are very costly. Because of high cost, most of the needy adolescents are unable to receive the ANC, delivery and PNC services. The economically well-off families go to the private providers and the poor families do not receive the services. Few of the needy adolescents visit the government hospital (Thapathali Prasuti Girha-maternity hospital) which is not in close distance".*

Barriers and challenges to accessing ASRH services

Frequent discussion with adolescents highlighted various barriers in accessing ASRH services. The FDGs identified some barriers from the provider's perspective and some from the receiver's perspective. Firstly, from the providers' side, the lack of government health services provided through the public sector to the squatter communities was identified as a major reason for adolescents from such communities not accessing ASRH services. Similarly, the few public health facilities in nearby areas were not considered to provide quality health services, including drugs and equipment. Likewise, the absence of ASRH information, education and counselling among the adolescents was another barrier

mentioned by the respondents. Services were available through private sector but these had high cost which was unaffordable for these adolescents.

In addition, the respondents also identified some barriers related to service receivers. Low economic status due to unemployment was one of the major barriers to accessing ASRH services. Adolescents often had little knowledge and/or feel shy about discussing sexual and reproductive health problems. A lack of family and social support added more challenges in accessing and using ASRH services.

Improving access to ASRH services

After discussing the barriers and challenges, further discussion with adolescents took place on ways forward to improve the accessibility of ASRH services in squatter settlements. The male and female respondents both gave opinions on how to improve access to ASRH services from service providers' and servicer receivers' perspective. Making public health facilities available locally with free and quality health services was recognized as the foremost option to promote ASRH services. Along with this, health services provided through the private sector, but at subsidized prices, would also support adolescents in availing such services. Similarly, the adolescents felt that providing family and social support to utilizing ASRH services when needed would also help in minimizing the challenges to some extent. Creating awareness among adolescents in a conducive environment through gender friendly counseling centers would also be helpful in helping them to access the services.

DISCUSSION

The most common source of ASRH information available to adolescents was school textbooks: ASRH information is available in the secondary level school curriculum. Around 90% of adolescents in Nepal complete primary education[17] but only 59% complete secondary level education. The 41% of adolescents who do not undertake secondary education cannot access ASRH information through school textbooks.

There were no public sector health facilities near the squatter community. Private pharmacies, private clinics and private hospitals were available but were often unaffordable. Thus, easily accessible information, education and communication activities under the health services system is virtually nonexistent in squatter settlements. Contraceptives are not easily accessible to adolescents from this community. Adolescents did express a wish to use contraceptives but shyness, the high cost of private providers and fear of disclosure of their privacy were barriers to accessing and using contraceptives most of the time. Adolescents also had poor access to professional abortion services. Private abortion clinics and private hospitals were providing abortion but due to high cost of services, fear of disclose privacy and social blame many were choosing less safe abortions. Around half of the adolescents were unaware of the Emergency Contraceptive Pill (ECP) and access was very low due to low awareness, cost and shyness. Lack of public health institutions close to the squatter settlements and high cost of private health institutions resulted in adolescents having overall poor access to safe motherhood services.

CONCLUSION

There was low access to ASRH services in the squatter community. The main barriers to services were lack of public health institutions, the poor quality of service in available facilities, low economic status and relatively high cost of private sector services. Private services were available but were unaffordable to most of the adolescents within these communities. Lack of awareness (linked low levels of secondary education),

lack of family support, lack of a social support system, and negative perceptions within society regarding ASRH issues were other barriers and challenges mentioned that impeded access to ASRH services.

To improve access to ASRH services in urban squatter communities, there is a need to make government health institutions with quality services more available and more easily accessible. Establishing functional urban clinics with quality ASRH services is an attractive option. Similarly, implementing outreach activities which create awareness and promote social support systems will also help to overcome barriers.

REFERENCES

1. UN. (1994). Report of the International Conference on Population and Development (ICPD), Cairo, 5-13 September, 1994
2. UN. (1995). Report of the Fourth World Conference on Women, Bejing, 4-15, September 1995
3. UNICEF. (2011). The state of the world's Children, Adolescence an age of opportunity
4. Ministry of Health and Population (MoHP) Nepal, New ERA. (2011). Demographic and Health Survey 2011
5. Ministry of Health and Population (MoHP) Nepal, Department of Health Services. (2019). Annual Report 2019
6. Family Health Division, Department of Health Services, Nepal. (2011). National Adolescent Sexual and Reproductive Health, Program Implementation Guide
7. WHO. (2020). An Overview – Adolescent Sexual and Reproductive Health: https://www.who.int/southeastasia/activities/adolescent-sexual-reproductive-health
8. Shrestha, R. (2019). Premarital Sexual Behavior and its Impact on Health among Adolescents. Journal of health promotion, vol 7, pp 43-52
9. Upreti, YR. Acharya, D. (2020). Premarital Sexual Behaviours among Secondary School Adolescents: A Cross-sectional Study in Kathmandu. Journal of Health Promotion, Vol.8, pp. 39-52
10. Ministry of Health and Population (MoHP) Nepal, New ERA. (2011). Demographic and Health Survey 2016
11. Ministry of Health and Population (MoHP) Nepal. (2000). National Adolescent Health and Development Strategy 2000
12. Ministry of Health and Population (MoHP) Nepal, Department of Health Services. Annual Report 2015
13. Ministry of Health and Population (MoHP) Nepal, Department of Health Services. Annual Report 2017
14. Ministry of Health and Population (MoHP) Nepal, Department of Health Services. Annual Report 2019
15. Napit K., Shretha, KB., Magar, S., Poudel, R., Dhakal, BR., Amatya, A. and Thapa, B. (2020). Factors associated with utilization of adolescent-friendly services in Bhaktapur district, Nepal. Journal of Health, Population and Nutrition, Vol.39, pp.1-9
16. Lumanti support group for shelter. (2008). Status of Squatter Communities along Bagmati River and its tributaries in Kathmandu Valley
17. NIRT & AIR. (2017). Nepal Education Sector Analysis, Kathmandu Nepal