

Sexual and Reproductive Health Services: Utilization Pattern of Adolescents in Nepal

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Abstract

This paper explores sexual and reproductive health service utilization pattern of adolescents in Nepal, adopting both quantitative and qualitative methods. The study shows that socio-cultural constructions of sexual health and psychological interpretation influence the ways in which Nepalese adolescents experience sexual and reproductive health and utilize the services. Hence, sexual and reproductive health should be regarded as a biosocial and psychosomatic process and sexual reproductive health needs and problem requires understanding of biological, psychological and socio-cultural variations.

Keywords: Marital Communication, Interpretive Approach, Trepidation

Introduction

Medical anthropological lenses acknowledge, understand, and question the socio-cultural norms and beliefs embedded with health, illness and health behaviors. These socio-cultural norms and beliefs entrenched to human cultural discourses and institutions are expressed through diverse taboos and activities that shape how people perceive health and disease. As the interdisciplinary branch of anthropology, medical anthropology deals with aspects of health, illness, and disease, physical and mental addressing both theoretical and applied problems - portraying a bi-polar process whose one pole is biological and another is socio-cultural (Freidson, 1970). Medical anthropology examines the ways in which culture and society are organized or influenced by issues of health, healthcare and related issues of children, adolescents and adults.

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Adolescent (between 10-19 years of age) is an intermediary stage of physical and psychological development occurring during the period from puberty to adulthood. About one quarter (26%) of the world's population is between the age of 10 and 24 and one-fifth (18%) of the world's population is between 10 and 19, with vast majority living in developing countries (UN, 2011). About one fourth (24%) of the total population of Nepal is adolescents, about one third (32.5 percent) is young (10-24) indicating a high number of young people in Nepal's population composition (MoHP, 2011). According to *Population Monograph of Nepal* (2014), Nepal's child population of age 14 and below constitutes 34.9% of the total population. Children aged 16 years and below make up 39.8% of the population; those below 19 years old constitute 44.4% of the population. Adolescents, the young population of 10- 19 years, make up 24.2% of the population and youth of the age group (15-24) years make up almost 20% of the total population of Nepal.

Despite a huge population of adolescents, there are numerous social, community and individual level relationship barriers to adolescents accessing correct information or services on sexual and reproductive health in Nepal. Very few adolescents utilize health services from any kind of health facility in Nepal due to socio-cultural taboos on sex. Adolescents are usually shy; have incomplete knowledge about pubertal changes (including emotional and physical changes due to puberty) and HIV, AIDS and Sexually Transmitted Infection (NDHS, 2013). Similarly, Nepalese adolescent girls have unsanitary menstrual hygiene practice, unhealthy and poor food habit. Fifty percent of pregnant Nepalese adolescent girls (age 15-19) do not seek Antenatal care (NDHS, 2013). In order to tackle these issues, a rigorous effort is needed to reach adolescents with the information and skill they need to live healthy and full lives. Abbey & Halman (1991) argue that sexual functioning and dissatisfaction, marital communication and adjustment problems, interpersonal relationship difficulties, and emotional and psychological distress are vital in determining sexual and reproductive health of adolescents in Nepal.

Realizing the complexity of adolescent sexual health problems in differential socio-cultural, religious and gender practices, The World Health Report (2011) has reiterated vulnerabilities and risks associated with sexual and reproductive health practices of adolescents in Nepal. There are different age and gender-related sexual health risks and opportunities in Nepalese families, communities and societies. Pathak and Pokharal (2012) argue that

apart from physiological transition, a natural process, adolescents and youth in Nepal are passing through socio-cultural and ideational transition. They are fighting the traditional norms, practices and values of sexuality and facing different barriers to access sexual and reproductive health facilities. The contraceptive prevalence rate (CPR) among currently married 15-19 years old is 14% which is extremely low. Comprehensive knowledge of HIV and AIDS is uncommon among male and female adolescents. Testing for HIV is quite rare among adolescents and youth. Many sexually active adolescents (15-19) have unmet need for contraception (41.5 %). Fifty percent of the pregnant adolescents do not go to health centers for delivery (NDHS, 2013). Adolescents are vulnerable to numerous sexual and reproductive health problems, ranging from early and unwanted pregnancies to sexually transmitted infections including HIV. This has left them at risk of exclusion from family system, social structure and policy and program responses. The individual coping strategies are not sufficiently strong for many young people. As a result they are unable to resist the peer pressures and demonstration effects on sexual relations.

With an aim to make sexual and reproductive services more effective and adolescent-friendly, in 2011, Ministry of Health and Population, Department of Health Services, Family Health Division, Nepal, developed a National Adolescent Sexual and Reproductive Health Program package (MoHP, Annual Report, 2013). This programme has at its core the introduction of Adolescent-friendly Services (AFS) aimed to improve existing clinical services such as safe abortion, family planning, maternal and child health care, and HIV and STI prevention and treatment, with a view to make them accessible and utilizable to adolescent. Keeping in view the core of this program, the prime objective of this paper is to explore the adolescent-friendly sexual and reproductive health services access and utilization pattern by Nepalese adolescent students. The specific objective is to find out impediments in the process of service utilization.

The study location is sited in Pyuthan district of mid-western Nepal. This district has a total population of 228,102, female 128049 (56.13%) and male 100053 (43.86%) (CBS, 2011). Pyuthan district is one of the backward and less developed districts of Nepal in terms of human development indicators and ranks as 53rd (out of 75 districts of Nepal) in National Human Development Index, and has HDI of 0.426 compared to Nepal's global rank 145 in HDI, with a score of 0.548. The district has a literacy rate (above five years) of 67.01%, malnutrition rate of 42.5%, Infant Mortality Rate

(IMR) 54/1000, family with access to drinking water 78.28%, and poverty rate of 32.2 (NHDR, 2015). The district is inhabited by diverse caste/ethnic groups. Ethnic Magars are dominant ethnic group followed by high caste Hindus viz. chhetri, brahmin, sanyasi and low caste dalit (CBS, 2011). Major religions in the district are Hindu (96.6%) followed by Buddhist 2.81% (CBS, 2011). District headquarters Pyuthan Municipality is the recently declared municipality which consists of former seven Village Development Committees (VDCs).

Pyuthan Municipality of Pyuthan district was selected as study site because the sexual and reproductive health service related data of Pyuthan is very little. In Pyuthan district, the institutional deliveries were only 28% and Contraceptive Prevalence Rate among married women of reproductive age group was 41% (DHO, 2014). Considering the prevalence of child marriage (below age 18) as high as 33%, the prevalence highest among female (DHO, 2014), it was expected that the proportion of adolescents using reproductive health service might also be large. As adolescent friendly health service has been implemented in Pyuthan since 2012, it is possible to study the service utilization pattern and impediments at different levels.

World Health Report (1986)'s categorizes adolescence as young people between 10-19 years of age as adolescence. But in this study, students in their pubescent age 12 -19 are regarded as adolescence or pubescent. The stage begins with the onset of physiologically normal puberty, and ends when an adult identity and behavior are accepted socially. This period of development corresponds roughly to the period between the ages of 10 and 19 years. Early adolescence prevails during 10-14 years and late adolescence stretches up to 15-19 years.

According to the Pyuthan District Health Office Report, 2015, there were altogether 11 government schools in Pyuthan Municipality with 3656 students (1851 male students and 1805 female students) from grade (class) 6 to 12. In Nepal, grade six to eight are regarded as lower secondary, grade nine and ten called secondary and grade eleven and twelve as higher secondary. These students are accessing sexual and reproductive health facilities from government's seven Adolescent Sexual and Reproductive Health services centers located in Pyuthan Municipality.

The universe of this study was adolescent students from 12 to 19 years, studying at different government schools in Pyuthan Municipality. The proportion of male and female students in three stratum, grade 6-8, 9-

10 and 11-12 was calculated from three selected schools. In total, 412 (82.4%) students, 208 male and 204 female were selected randomly as the final sample from randomly selected three schools. The schools were selected on the criteria that these three schools were the leading schools in Pyuthan Municipality in terms of student number. Students over 19 years of age were excluded from the study. Adolescent students of age 12 to 19 years were the only source of primary data.

Quantitative and qualitative, as well as primary and secondary data were used in this study. Primary data was collected from the field and secondary data were collected from various sources viz. library, brochures, reports and websites. Primary data was collected from the field during December 1-29, 2015. Three types of techniques: Self Administered Questionnaire, Interview and Observation were used. Data was collected from the field using anonymous self-administered questionnaires. Questions were raised to respondents using an unstructured interview schedule. The measure of reliability was obtained by administering the same test twice over a period of time to the respondents. The scores from Time 1 and Time 2 were correlated in order to evaluate the test for stability over time. Validity was ensured that the measure is actually measured what is intended to measure.

The accessibility of the researcher to the field was difficult and in a region where talking about sex is a taboo, there were various difficulties in carrying out interviews on sexual and reproductive health service utilization pattern. The first challenge was to face and accept this *new* reality. Researcher then focused on detailing the way he organized his fieldwork. Four local youth assistants (two female and two male) were chosen for collecting field data. There were different gender related challenges involved in carrying out fieldwork. Only few girls were ready to speak on sexual and reproductive health owing to traditional cultural norms of regarding sexual issues as proscribed. These norms proved to be a barrier in interacting with teen girls. Due to such norms, girls virtually pulled out from interview sessions at first, but they were convinced by female field assistants. Understanding the local language was not a problem because all can understand Nepali lingo in this region. Ethical approval in verbal consent was obtained from each respondent before administering the interview and each respondent was convinced that the confidentiality of the information would be maintained.

Conceptual Framework

Drawing on Anderson and Newman's Framework (1973) of health service utilization, the conceptual framework of the paper illustrates the relationship between various domains (factors) and discover the underlying conditions that either impede or facilitate the use of adolescent-friendly sexual and reproductive health services by adolescents. It emphasizes the importance of three major domains: (1) Individual determinants of utilization (2) Characteristics of the health service delivery system, and (3) Socio-cultural beliefs and practices of families and communities related to sexual and reproductive health. These three factors are specified within the context of their impact on the access and utilization of sexual health care services by adolescent.

Social and Demographic Profile of Adolescent

The social and demographic profile of 412 adolescent was analyzed. Among the 412 respondents, majority respondents were of age 16 (24.8%) followed by age 15 (24.3%). The mean age of the respondents was 15.89.

Age of the respondents	Number (n=412)	Percent
12	5	1.2
13	6	1.5
14	59	14.3
15	100	24.3
16	102	24.8
17	80	19.4
18	48	11.7
19	12	2.9
Total	412	100

Source: Field Study, 2015

Majority of adolescents in the sample, about 59 percent, were from so called Hindu higher castes - brahmin, chhetri, followed by ethnic group students (30.3%) and the low caste dalit students' percent is only 10.7%. The low number of dalit students was due to their low enrollment and high school dropout which is evident from the data provided by District Education Office (DEO, 2014). Owing to socio-economic and caste based social stratification; lower caste dalit people are usually disadvantaged and have

lower level of awareness as well as low access to education, health and economic resources.

Adolescent Sexual and Reproductive Health services are available free of cost to all adolescents (both married and unmarried), however, in a traditional Nepali socio-cultural environment where sexual and reproductive health service utilization practices are welcomed and acceptable only after the marriage; the marital data provides clues on understanding the proportion of population that mostly need sexual and reproductive health services. Most of the adolescent students (96.3%) were unmarried. Only few (3.7%) were married. Among them, 2.7% were living together as spouse and the rest were divorced. Among the total ever married respondents, only 12 of them revealed their age at marriage. The mean age at marriage was 16.3.

Gap in Sexual and Reproductive Health (SRH) Services

Adolescents were using multiple sources of information while collecting information on Sexual and Reproductive Health (SRH). School course curriculum was the major source. Not less than one third of the students were using various sources of available information such as school curriculum, radio and television, teachers and health workers as day to day sources of information on sexual and reproductive health. One-fourth of the students get sexual reproductive health related messages through peers. But, the access of students to sources such, as newspaper and internet (using mobile phone) for health information is very low which is due to low access of these facilities in this part of the country.

Only about three fifths have adequate knowledge on the availability of different services from adolescent friendly services. Over one third of the respondents have only partial knowledge on the targeted sexual and reproductive health service components of the adolescent friendly service package offered to the adolescents. Still, many adolescents have no proper information, and have many misconceptions or incorrect knowledge regarding the appropriate site of service delivery. They have no access to information on the availability of services, various service components and correct knowledge about the place of service delivery.

Sexual and Reproductive Health Service Utilization and Impediments

Human health is closely linked to the culture and the interpretation of the people. How the people and their culture interpret health and illness is fundamental. Kleinman (1978) argue that illness is not an entity but an

explanatory interpretative model. Health and illness, in this perspective, belongs to culture. Culture is essential not only a means of representing disease, but also for very constitution of human understanding of health and using health facilities. The interpretive activities involve interaction of biology, social practices and culturally constituted frames of meanings, through which clinical realities are constructed. Interpretive tradition in medical anthropology examines the construction of interpretations in different social contexts. That is: how meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of health trajectories.

The experiences of adolescent related sexual and reproductive health services utilization can be linked with the interpretive theoretical orientation that helps in understanding how adolescent interpret and use sexual and reproductive health services. There were different reasons for the use and non-use of sexual and reproductive health services by both married and unmarried adolescents. 231 adolescents (56%) revealed that they did not feel any sexual and reproductive health related problem that needed counseling and treatment from health facility; hence they did not go to health facility. Only 181 adolescents (44%) had felt need and they visited the health services, but they felt shy and awkward to interpret and share such issues to health workers. They were not comfortable of others' knowing their sexual problems. Financial problems (lack of bus fare to go to nearby centre), inaccessibility of health facilities due to distance and lack of information etc., also stood as obstacles in availing the health facilities.

As regards the type of sexual reproductive health services used, respondents had been to adolescent sexual and reproductive health centre for treatment and counseling services, taking treatment services for infections on genital parts, and menstrual problems related counseling and treatment. Also widely utilized services were the collection of adolescent health learning information and materials followed by general health check up and counseling.

Eighty three percent of respondents expressed satisfaction to the service they had received. They felt they got the desired services from the health facility and felt the behaviour of health workers in the health facility as friendly. However, about 17% of them did not find the available service as per their expectations. They felt lack of privacy and many other reasons for dissatisfaction in health facility while receiving the service. They felt

the unavailability of health workers and were unable to get required medicines and supplies. Also, they do not perceive the behaviour of health workers good and felt humiliated. Similarly, some felt that health workers were not interpreting their problems properly or taking adolescents' issues seriously and not providing the required health information. Other hindrances were gender norms. Female students felt embarrassed to express their sexual health problems to male health workers. They felt that male workers were not interpreting their problems sincerely. Male students also felt awkward to express their sexual and reproductive health problems to female health workers. Lack of confidentiality, fear, difficulty to open up and long waiting hours in health facility were the reasons for not using sexual and reproductive health services. In other words these reasons were working as impediments in sexual and reproductive health service utilization.

Sharing Sexual and Reproductive Health Related Problems in Family

Adolescence and youth is a period defined by certain biological and physiological changes (Khan & Mishra, 2008; The World Bank, 2004) followed by experimental behaviors and imaging self. Such an image of self largely depends on the existing socio-cultural and family norms and generally, produces different images between male and female adolescent that starts with the interaction between the family members. Such *self image* created through socialization experiences in the family, help in building confidence level of adolescent and enables them to interact with the family members on different issues. As sexual and reproductive health related matter is a taboo in traditional Nepali family structure, individuals, families and societies are socialized to proscribe talking openly to one another on such matters. Such issues are not encouraged to be shared with one another and also not given priority. Of the 181 adolescent (44%) who felt need to visit the health services for sexual and reproductive health related problems, less than half i.e. 80 (43.8%) shared their sexual and reproductive health related problems with their families especially with parents (girls with their mothers/ elder sisters and boys with fathers/elder brothers). Majority 101 (56.2%) did not share their sexual and reproductive health problems with their family and directly visited the health services. Many adolescent find it at ease sharing their sexual health problems with already acquainted community health volunteers and health workers who are not the part of sexual and reproductive health service centers.

Even though the proportion of population who shared their sexual and reproductive health related problems with family was low, but the

encouraging trend was that those who shared, they directly shared their problems with their parents and immediate kin. However, as adolescence is a transitional vulnerable period with multiple risk behaviour, not sharing sexual problems with family signifies that there was lack of proper guidance and support from family in the matters of sexual health. Such practice can create future risk of negative sexual and reproductive health behaviour.

Majority of adolescents not sharing their problems with families is due to socialized traditional cultural norms and misconceptions existing in Nepali families where issues related to sex are unthinkable and disgraceful to be discussed. Hence, adolescents were expressively depressed to share their sexual health problem with the family members. The major barriers to share their problem with family were of psychological nature, especially inability to express the sexual and reproductive health issues due to shyness and feeling awkward. Families were also hesitant to openly converse on such issues with their children. The reasons were factors such as socio-cultural taboos regarding sexual issues, nervousness to share and friends being the easier option to talk on sexual and reproductive health. Parents also find it difficult and awkward to discuss sexual and reproductive health issues with their child which is due to their own socialization training that regards discussing sexual and reproductive health issues as a misdemeanor of traditional culture.

There is wide gap between parents and children regarding interpretation and sharing of knowledge and perception on sexual and reproductive health. This gap has remained the major barrier in sharing sexual/reproductive concerns in the family. Lack of sexual and reproductive

health problem sharing culture between Nepalese parents and children is a vital trepidation. Even in 21st century, Nepalese parents hesitate and psychologically depressed to inform as well as counsel their children on sex issues due to the deeply rooted cultural norms and values that regard sex as a taboo socialized from childhood.

Conclusion

Culture and health relations are embedded in human cultural discourses and institutions that are expressed through diverse social and cultural veracities, taboos and norms that shape how people perceive and interpret health, sexual and reproductive issues. Conventionally socialized cultural beliefs, norms and taboos are entrenched in human psychology. Factors related with societal determinants such as social customs, belief systems, gender norms, socialization process, family discernment towards sexual health are deeply correlated with sexual and reproductive health service utilization pattern of Nepalese adolescents. Absence of practice of sharing sexual health problems within family, familial support and involvement in the counseling and treatment process are intricately linked with sexual and reproductive health service utilization pattern. There is complicated interplay of psychological problems (such as fear, hesitation, shyness and difficulties) in the communication of the sexual health problems.

Factors related with individual determinants such as perceived need for service by adolescents, their health beliefs including knowledge towards sexual and reproductive health services are associated with sexual health service utilization. Cultural constructions of sexual and reproductive health behavior shape the ways in which adolescents experience and interpret their sexual health. Gender norms are responsible for feeling embarrassed to share sexual health problems with health workers of opposite sex. It is complicated for girls to persuade health professionals to take their sexual problems seriously — which, in turn, makes adolescent girls diffident to speak up about their sexual health concerns in the first place, for fear of being rebuked that they're exaggerating. The complicated interplay between gender roles and the health care system may put female sexual health at hazard. There is a need for gender friendly sexual and reproductive health services with specific provisions of female health service providers as counselors, as health educators as well as sex health providers. There is an urgent need for making arrangements for regular health education classes in school, providing health education and trainings to community people, expanding adolescent targeted

health services and information centers, and providing services of health educators and change agents.

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