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## International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo



## CLINICAL ARTICLE

## Barriers to sexual and reproductive health care among widows in Nepal



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## ARTICLE INFO

## Article history:

Received 14 July 2013

Received in revised form 21 October 2013

Accepted 26 January 2014

## Keywords:

Health services accessibility

Healthcare disparities

Nepal

Reproductive health

Social stigma

Widowhood

Women's health

## ABSTRACT

**Objective:** To investigate how the social status of high-caste Nepali widows of reproductive age impacts their sexual and reproductive health care. **Methods:** Twenty-one in-depth interviews and 1 focus group (n = 6) were conducted between September and November 2012 in the Kathmandu, Kavre, and Chitwan districts of Nepal. Participants were members of Women for Human Rights, Single Women Group. Interviews and the focus group with widows followed a semi-structured interview guide designed to elicit information on sexual and reproductive health problems, knowledge about them, and barriers to care. Two researchers used inductive and deductive coding to analyze transcripts for themes using ATLAS.ti. **Results:** Widows reported facing substantial obstacles to accessing sexual and reproductive health care. Widows suspected of having sexual and reproductive health problems, or who discussed or tried to access these services, could be ostracized by their families and experience severe economic and psychological consequences. Additionally, widows feared discrimination, lack of confidentiality, and sexual harassment by male providers if their status was known. These barriers appeared to stem from the perception that sexual relationships are necessary for widows to require care for gynecologic problems. **Conclusion:** Widows expressed a need for sexual and reproductive health care and described cultural and systematic barriers to accessing this care; these barriers need to be addressed.

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## 1. Introduction

In many low-resource countries, widowhood is highly stigmatized and widows' lives are strictly scripted by cultural norms [1,3]. With the loss of a husband comes loss of identity, exclusion from community events [2,4], and socially sanctioned restrictions on movement and access to services [4,5]. Despite estimates that many of the 245 million widows worldwide are of reproductive age [4,6], little research has been conducted on widows' sexual and reproductive health.

Widows' issues are particularly salient in Nepal, where there are an estimated 498 606 widows [7], many of whom are young because they were widowed in the recent civil war, which ended in 2006. In Hindu society, women who break traditional rules governing sexuality are perceived as dishonoring their families and the larger society [8,9]. Because widows in South Asia are expected to abstain from sex following their husbands' deaths, their sexual and reproductive health is often ignored [2]. While many widows may not be engaged in sexual relationships, they still experience sexual and reproductive health problems such as

HIV and other sexually transmitted infections [4,10]. Widows are also at increased risk of sexual violence because of their marginalized social status [2,4,5]. Additionally, widows of reproductive age are still in need of sexual and reproductive health care for problems that all women can experience, such as uterine prolapse and uterine fibroids. Thus, there exists a critical need to understand sexual and reproductive health care for this vulnerable population.

Despite legal assurances under the interim constitution of women's rights to reproductive health [11], it is unclear to what degree Nepali widows receive care for their sexual and reproductive health; furthermore, if they do not receive this essential care, it is not clear which barriers prevent them from doing so. The aim of the present qualitative study was to provide a preliminary understanding of these issues.

## 2. Materials and methods

Nepal ranks among the world's poorest countries, with an annual gross domestic product per capita of US \$619 [12]. Despite an ethnically diverse population, women's social norms are largely dictated by the Hindu belief system [13,14]. Furthermore, patriarchal social practices persist across ethnic and caste lines [8,13].

The present study was conducted in partnership with Women for Human Rights, Single Women Group (WHR), which is a Nepali

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nongovernmental organization focusing on widows' issues. Widows older than 16 years of age who were members of WHR and who had been widowed for at least 1 year were eligible to participate. Given that high-caste Nepali widows face greater restrictions from social norms [8,13], we focused on widows of reproductive age from 2 major caste groups locally identified as "high caste" (Nepali: *thulo jaat*): Brahmin and Chhetri. Newar high-caste women were also included. Traditionally, high-caste Brahmin, Chhetri, and Newar have dominated the major institutions of religious, political, and economic power in Nepal [15]. Three widows over the age of 45 years were included in order to compare experiences of sexual and reproductive health problems among older widows. The study took place in the Kathmandu, Kavre, and Chitwan districts of Nepal, facilitating exploration of widows' experiences in both rural and urban settings. Approval was provided by the Nepal Health Research Council and Johns Hopkins Bloomberg School of Public Health institutional review board.

Data collection took place between September 25 and November 8, 2012. One focus group discussion with widows was held prior to the individual interviews to identify key themes and content for the semi-structured interview guide. The duration of the focus group discussion was 60 minutes, and demographic information on the participants was not collected. Following this focus group discussion, widows were invited by WHR staff members to be interviewed. All agreed to participate. Three, 10, and 8 interviews were conducted in Kavre, Chitwan, and Kathmandu, respectively. Interviews followed a semi-structured guide of open-ended questions covering topics including widows' problems related to sexual and reproductive health; perceptions of how widows' sexual and reproductive health differed from that of coupled women; barriers to accessing care; and knowledge about sexual and reproductive health. All questions in the guide were open-ended (e.g. "What are some of the challenges single women face in accessing modern methods of contraception?") and interviews were structured as conversations. This made it possible for interviewees to probe each participant to elaborate on their unique experiences. Following the interview, closed-ended sociodemographic questions were asked (e.g. "How old are you?" and "How did your husband die?"). The average interview duration was 90 minutes.

Participants were reimbursed 200 Nepal rupees (US \$3.64) for their transportation. Verbal informed consent was obtained before each interview. Interviews were audio recorded and transcribed verbatim in Nepali.

Analysis of the data was conducted using an adapted grounded theory approach [16,17]. Deductive codes were determined based on participants' responses during the first several interviews. Codes were then revised and built-upon during the process of data analysis, and new codes and subcodes were reapplied to previous transcripts, as needed, using an iterative approach [18]. All transcripts were independently coded by 2 members of the research team (M.J.H. and A.S.) using ATLAS.ti version 6.0 (Atlas.ti, Berlin, Germany), after which discrepancies and differences in interpretation were discussed.

### 3. Results

Twenty-one in-depth interviews were conducted. Consistent with the sampling objectives, the majority of participants were of reproductive age (18 of 21 [86%]) and high caste (21 of 21 [100%]) (Table 1). The length of widowhood varied (3, 6, and 8 women had been widowed for 1–5, 6–10, and 11 years, respectively).

Three key themes emerged regarding barriers to widows accessing care for their sexual and reproductive health: fear of being suspected of having a sexual relationship; the consequences if family/community discovered that a widow had sought care; and fear of provider discrimination, lack of confidentiality, and maltreatment.

The results indicated that a barrier to health seeking was linked to the belief that sexual intercourse is a prerequisite for having a gynecologic problem. This perception made it challenging for widows to

discuss issues of sexual and reproductive health or to seek medical treatment. Participants explained that married women were able to access care for their gynecologic problems because they were able to share their problems with their husbands, who would then relay the information to a healthcare provider. Widows, however, were unable to speak about their gynecologic problems with others because they feared being suspected of having a sexual relationship (Table 2, quotation 1).

The findings indicate that the fear of being suspected of having a sexual relationship was particularly salient for widows who wanted to access family-planning services. Participants explained that they were expected to be abstinent, and therefore to not require contraception. One participant recollected that, when she suggested to her friends that she take injectable contraceptives to gain weight as they had, her friends accused her of wanting to engage in a sexual relationship (Table 2, quotation 2). Another participant explained that, if a widow wanted to undergo tubal ligation, the community would talk about how she wanted to do so in order to engage in a sexual relationship (Table 2, quotation 5). One widow stated that community members were quick to suspect a widow of accessing family-planning services (Table 2, quotation 6), even when she lied about the procedure she had undergone.

These findings indicate that widows worried that others might assume that widows who had gynecologic problems or who wanted to access other sexual and reproductive health services such as contraception were engaging in sexual relationships and, thus, defying traditional norms. This fear of suspicion was pervasive and served as a powerful barrier to discussing sexual and reproductive health concerns with healthcare providers, family members, friends, and even other widows (Table 2, quotations 3 and 4).

The participants described severe repercussions for having—or being suspected of having—a sexual relationship, including stigmatization, verbal and physical harassment, being ostracized by their families, and having their businesses boycotted (Table 3, quotation 1). The women explained that this fear of family and community maltreatment was especially a concern for widows who tried to access family-planning services. Participants said that their actions were carefully watched by their families and communities and that, if their families discovered that they had accessed family-planning services, they could be ostracized from the community (Table 3, quotations 2 and 3). One participant explained that no-one would speak up for a widow if it was discovered that she was accessing contraceptive services and that, therefore, she would be completely isolated in her community (Table 3, quotation 3). Because widows are highly dependent on their families and communities for economic and social support, the fear of being cut-off from their families and communities can have a tremendous impact on a widow's decision to seek care for her sexual and reproductive health.

Another set of barriers preventing widows from accessing care for their sexual and reproductive health related to widows' experiences with healthcare providers. Many of the widows were worried that they would be taken advantage of by hospital staff and be given inferior treatment. Participants explained that this discrimination would be worse if the providers discovered that the widow was not abstinent (Table 4, quotations 1 and 2).

The discriminatory treatment extended to the provision of family-planning services. Participants said that, for family-planning services, providers would most likely not give widows the contraceptives they asked for, if they knew their status as widows (Table 4, quotation 3). One participant said that, if a widow did want to access contraception, she would have to either lie about her marital status to the provider or refuse to tell the provider why she wanted contraception (Table 4, quotation 2). In rural communities in which providers were likely to know both the widow and her family, participants explained that it was unlikely that a widow would even have the opportunity to exercise either of these options.

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