Youths' Perceptions Regarding Access to Sexual and Reproductive Health Services

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Abstract: Sexual and reproductive health services in Thailand have been provided in accordance with a national policy and strategic plan, but youths' sexual and reproductive health problems remain relatively high. A significant problem is youths' low access to appropriate services. This paper reports the first qualitative descriptive phase of participatory action research project, which aimed to develop a model for improving access to sexual and reproductive health services among youths. The study's purpose was to explore perceptions of youths regarding access to sexual and reproductive health services in northern Thailand. Qualitative data were collected from September 2019 to March 2020 through focus group discussions with 59 youths aged 15-24 years and in-depth interviews with four youths who had experienced an adolescent pregnancy. All participants were purposively recruited and volunteered. The data were recorded, transcribed verbatim, and analyzed using content analysis.

Reflecting factors emerged from youths' needs and contexts toward access to sexual and reproductive health services. Five categories were classified: 1) inaccessibility to existing services, 2) unacceptability of available services, 3) unaware of access to effective information, 4) community's negative attitude toward youths accessing services, and 5) availability of other convenience services. These findings provide useful information for healthcare providers, particularly nurses and other stakeholders to better understand the perspectives of youths, enhance awareness of collaboration, and promote participation among youths in the development of intervention and strategies to improve access to sexual and reproductive health services.

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Introduction

Youths are persons aged between 15-24 years with an estimated population of 1.21 billion worldwide, accounting for 15.5% of the global population,[1,2] and who are characterized by physical, psychological, emotional, and social changes. These adjustments are frequently predisposed to sexual and reproductive health (SRH) issues, including increased pregnancy among those aged 15-19 years old,[3,4] 41% of which

were unintentional, and led to abortion (56%).[3] The rates of STIs and HIV among youths increased more than other groups.[5] Moreover, SRH problems are main causes of high morbidity and mortality rates among youths.[3,4] In Thailand, the birth rate in adolescents aged 15-19 years during 2017-2019 decreased from 39.6 to 31.3 births per 1,000 persons. STIs and HIV rates among youths aged 15-24 years increased rapidly from 143.4 to 175.3 during 2016-2019.[6] In Chiang Mai, a province in northern Thailand, youths tend to have their first sexual intercourse earlier at average age of 15-16 years[7] and the birth rate among pregnant adolescents aged 15-24 years was 31.5 per 1,000 in 2019, which was slightly higher than the national rate.[6] Despite a slight decrease in birth rates among adolescents, adolescent pregnancy is considered a crucial problem due to its detrimental effects on physical and psychological well-being particularly depression,[8] social components of the family, and the national economy and society.[3]

In response to issues regarding sexual and reproductive health, the WHO launched a policy encouraging the provision of youth-friendly health services (YFHS),[9] and members adopted it to provide YFHS alone and integrated with other interventions such as programs of school-based, clinical service-based, community-based, technology-based, and evidence-based management.[10] These multi-dimensional provisions are effective in increasing access to services and reducing SRH problems.[11] Nonetheless, very high costs of implementation and the lack of facilities and infrastructures are the key barriers among developing countries and low-income countries[12] where, despite efforts to provide various services, youths' access to these services remains remarkably low.[11,13,14,19]

Thailand has adopted and integrated the provisions of YFHS under the National Policy and Strategy on Prevention and Solution to Adolescent Pregnancy Problems 2017-2026 [15] that emphasizes improving access to services among youths. Additionally, for the prevention and solution of teenage pregnancy by the mechanism of the District Health Board (DHB), a national project was organized with several organizations and provided along with YFHS. However, initiatives were confronted with barriers such as constraints of staff, inadequate competency to work with adolescents, lack of budget support, inadequate infrastructure, and lack of cooperation from adolescents who concealed information because they distrusted the staff.[16] As a result, there is a need to improve the promotion of youths' participation and cooperation in the processes of SRH services.[17,18] Consequently, youths' perceptions that represent their voices, regardless of their prior experience in accessing SRH services, need clarification to obtain a better insight into how they perceive the access to SRH services and to raise awareness of participation in enabling interventions to tailor services to meet youths' needs and increase their access to SRH services.

This paper illustrates the findings of a qualitative study as part of a participatory action research project on the development of a model for improving access to SRH services among youths. Data were collected to explore youths' perceptions regarding access to SRH services.

Review of literature

Youth is a period from adolescence to early adulthood,[1] which affects sexual development and sexuality. Effective access to SRH services is necessary for enhancing youths' ability to seek and obtain information, knowledge, counseling, and treatment[14] with accessibility, acceptability, availability, appropriate quality, and affordability.[9] The services comprise contraceptive services, SRH well-being services, adolescent pregnancy and unsafe abortion prevention, mother and child care, screening and treatment of STIs, and information and counseling services.[1,3] However, some youths were aware of their health risks but were concerned about the sensitivity of SRH problems, particularly in social and psychological aspects. Many were reluctant to seek health services, contributing to low access to them, despite the fact that they would like to receive the services to solve these problems.[14,20]

Several factors in the literature are described as contributing to youths' access to SRH services, namely unprotected sex causing fear of pregnancy and fear of contracting STIs, SRH problems (e.g., late menstruation and abnormal symptoms from sex hormone disorders that need consultation, and receiving contraceptive pills, implants, and condoms).[19,20,21] In contrast, many barriers influence youths' reluctance to seek healthcare, including low SRH information and knowledge,[14,22] and financial limitations.[23,24] The geographic access and distance from service settings are also barriers to youths' receiving the services.[23,25,26] Youths also complain about inconvenient service hours overlapping school hours[14,17,23,27] and long waiting times.[17,20,25] Another crucial factor of youths' access to SRH services was service providers' attitudes, especially negative attitudes and perceptions that the youths who received the services were troubled children.[14,20,21,28] Some studies reported that youths themselves were uninterested in accessing information and services, causing them to confront SRH problems.[14,17,23] Many youths did not want to obtain the services due to fear of their parents knowing[17,24,27,32] and a lack of trust in service confidentiality.[21,24,25,28,32] Previous findings provide some understanding of youths' perceived access to SRH services. However, each area has specific individual contexts and different factors influencing youths' perceptions that should be explored to solve each problem properly and provide services that meet youths' needs.

Thailand, a member of the WHO, has established national policies, strategies, and guidelines based on the elements of the YFHS and assigned local health services to design prevention and management of youths' health problems. In the past, local SRH services were provided as general health services. Condoms and birth control pills were available to general recipients without specialized youth services. Most youths obtained services for general health problems but were less likely to access SRH services.[17,18,28,32] To date, only some issues related to youths' access to SRH services have been identified, such as not knowing about service information,[17,33] being anxious about providers' reactions, and not having time to obtain services.[17,28,32] Thus, Thailand still has insufficient information for a comprehensive understanding of youths' perceptions regarding access to SRH services, indicating that rich information is required. The findings of this study will be useful for developing an intervention that successfully promotes access to SRH services among youths.

Study Aim

To explore the perceptions of Thai youths regarding access to SRH services

Methods

Study Design: This paper reports the findings of a qualitative descriptive approach conducted in a situation assessment phase, and is part of a larger participatory action research (PAR) project. The writing of this report adhered to the criteria for reporting qualitative studies (COREQ).[34]

Study setting and participants: The informants of this study were recruited from three sub-districts of semi-rural districts in Chiang Mai Province, northern Thailand, from September 2019 to March 2020. The research area has one district hospital and three health-promoting hospitals from three sub-districts that provide health services, including SRH services for youths. In total, 63 youths were purposively selected by the core working group in the PAR approach to be participants representing the youths in local communities from five schools, including a secondary school, a technical college, and three non-formal education schools in the three sub-districts.

The participants' inclusion criteria were: aged 15-24 years, living in the research area community, speaking and understanding Thai, and willing to be participants. In FGD, participants were grouped, respective of gender, age range, school, and education level, but irrespective of whether they had prior experience in accessing SRH services or not. For in-depth interviews,

participants were youths who had experienced pregnancy. Regarding the qualitative paradigm, the sample size of the participants was based on gathering adequate data to answer research questions until data saturation was achieved.

Ethical Considerations: Approval for conducting this study was obtained from the Ethics Committee of the Faculty of Nursing, Chiang Mai, Thailand (Study code: 2562 - FULL 025). All participants were informed about their rights as participants, potential risks and benefits, and confidentiality. They could withdraw from the study at any time, or refuse to answer, and had opportunities to ask questions. All youth participants under eighteen years old were asked to gain permission from their parents or guardians, and both youths and parents signed the consent forms. In addition, all participants were asked for permission before audio-recording to collect data during each session. Pseudonyms were assigned to each participant and used in field notes and transcripts. The documents and recordings were kept in a safe place and destroyed after completing the study.

Data Collection: This was done by co-researchers trained by the primary researcher, who acted as a facilitator throughout the data collection process to advocate and assist the co-researchers in clearly defining the problems and assuring the completion of data. Fifty-nine participants were divided into 13 FGDs (seven male groups and six female groups) based on the homogeneity of FGDs and similar backgrounds of participants in each group, such as gender, age range, education level and school. Each FGD included 4-6 participants and lasted approximately 60-90 minutes. Additionally, four voluntary participants who had an experience with unintended pregnancy were recruited for in-depth interviews that took approximately 60-90 minutes to gather their opinions and experiences related to accessing SRH services without telling their personal stories that could cause discomfort. All data collection approaches were conducted in a private room. Before beginning data collection, the ground rules of the focus group were agreed on in terms of respecting each other's views and confidentiality. Semi-structured guidelines for FGD and in-depth interviews were applied to obtain the youths' perspectives regarding access to SRH services. "What do you think about access to sexual and reproductive health services among youth?" and "Why?" were the principal open-ended questions for data collection.

Data Analysis: Content analysis following Stringer's method was employed in qualitative data analysis.[35] First, the research team repeatedly read all transcripts from FGDs and in-depth interviews to familiarize themselves with the data. Categorizing and coding were adopted to identify youths' perceptions. Identifying the categories, sub-categories, and excerpts were performed by the principal researcher and subsequently verified by the research team. Eventually, the co-authors discussed major categories, sub-categories, and key findings until a consensus was achieved.

Rigor and Trustworthiness: The strategies for ensuring this study's rigor adhered to the principles of trustworthiness by Lincoln and Guba.[36] Credibility was verified through member checking with 15 participants. Dependability was achieved by enhancing the co-researchers' capability to independently analyze the data. After that, the initial findings were compared and contrasted to accomplish consensus and to clarify the local context. The data were then evaluated and approved by the research advisory committee. Confirmability was ensured through an audit trail based on verbatim transcription and data interpretations. Then, the research team examined the findings, and the advisory committee evaluated the process and approved the accuracy of data interpretation.

Findings

A total of 63 youths participated in the study, 59 participants were recruited into FGDs, as presented in **Table 1**, and four youths who experienced adolescent pregnancy received in-depth interviews, as shown in **Table 2**.

Table 1. Focus group discussion (FGD) participants' characteristics (N = 59)

Characteristics	Male (N)	Female (N)
Gender	32	27
Age (years) (mean = 17.31)	(mean=17.25)	(mean=17.37)
15-17	22	14
18-20	9	13
21-24	1	-
School/ Education level		
Secondary school (N = 26)		
Grade 10	6	5
Grade 11	6	5
Grade 12	-	4
Technical college (N = 20)		
Year 1	5	4
Year 3	6	5
Non-formal school (N = 13)		
Junior high school	4	-
Senior high school	5	4
Current relationship status		
Single	5	6
Married	1	2
In a committed dating relationship	26	19
Have had sexual intercourse (N = 38)	21	17
Have received SRH information/ knowledge		
- Training by healthcare providers at school	13	16
- Sex education at school	14	18
Have experience in accessing SRH services at health services* (N = 4)		
- Receiving condom	2	1
- Sexually transmitted infection screening	1	-
Have experience in accessing SRH services at school		
- Receiving condom (from teacher)	10	-
Have experience in accessing services at private sector*		
- Buy condom (convenience stores/ drugstores/ online)	20	-
- Buy contraceptive pills	-	12

* More than one answer is possible.

Table 2. In-depth interview participants' characteristics (N = 4)

Characteristics	Female (N)
Gender	4
Age (years) (mean = 19.25)	
17	1
18	1
21	2
Non-formal school (N = 4)	
Senior high school	4

Table 2. In-depth interview participants' characteristics (N = 4) (Cont.)

Characteristics	Female (N)
Current relationship status	
Divorced	2
Married	2
Age when having adolescent pregnancy (years)	
16	2
18	2
Number of children	
1	4
Have received SRH information/ knowledge	
- Training by healthcare providers at school	1
- Sex education at school	1
Have experience in accessing SRH services at health services* (N = 4)	
- Maternal and child care	4
- Sexually transmitted infection screening	1
- Implant	3
- Contraceptive pills	1
- SRH counselling	4
Have experience in accessing services at private sector*	
- STIs treatment private clinic	1
- Buy contraceptive pills at pharmacies	4

* More than one answer is possible.

The youth perception findings from FGDs and in-depth interviews were categorized into five categories as follows:

Category 1: Inaccessibility to existing services

The youths expressed that they could not access SRH services as much as they wanted because they did not know information about available services and their rights, had complicated access to the services, and could not obtain reliable sources of SRH information. This category comprised three sub-categories:

1.1 Not knowing available service information. Most of the youths indicated that they were not informed about existing SRH services for youth in the community. They did not know what services were available, where they could receive the services, who the providers were, and what time they could obtain the services. More importantly, they did not know their right to access SRH services under their health coverage schemes:

"Now I don't have any clear information about what services they offer, where to receive services, and more importantly, who I have to contact if I had some information, I would directly contact the persons responsible for the services." (FGMY6)

"What time we can get the contraceptive pills...if we want to consult after school, can it be done? We don't know so nobody goes to receive the services." (FGMY2)

"I don't know that youths have the right to get free contraceptives pills, I thought we had to be married first so we can have the right to get free." (FGFY5)

1.2 Difficulty accessing service. The youths perceived that accessing services was difficult due to complicated steps and a lack of pre-service appointments.

As well as having a large number of clients during the service period, there was increased waiting time in queues. Moreover, the current service hours were inconvenient for youths as they overlapped with youths' study and work time:

> *"I don't want to go to the hospital. There are several complicated steps, I have to register and wait for the provider to call me, take blood pressure, and wait in the queue. It takes a long time because of many patients..."* (FGFY1)

> *"There are no appointments before going to the hospital, especially online appointments. If so, I would make an appointment before coming in, it would be easy and convenient...I have classes during services hours, so I prefer to come outside regular hours like after school in the evening or on weekends but they were closed...."* (FGMY4)

> *"...I'm studying at a non-formal school so the service hours are my work time so, not convenient...."* (FGMY5)

1.3 Unable to access reliable information. The youths pointed out that they could not differentiate the credibility of SRH information from online sources and ensure that the information provided was reliable and accurate:

> *"I searched information in general websites because I don't know which website is doctor websites...So, I'm not sure if I can trust all the answers...."* (FGFY2)

> *"...when I type emergency contraceptive pills, there are many websites showing up but I don't know which website is believable...It does not show who the writer is, a doctor or not, so I can't trust all of it."* (FGFY6)

Category 2: Unacceptability of available services

The youths did not utilize existing services because they were dissatisfied with the existing contraceptive services. They also felt no privacy and confidentiality of the services and lacked confidence in the provider's ability to maintain confidentiality. Additionally, they believed that providers had negative attitudes towards youths requiring SRH services. This category comprised four subcategories:

Dissatisfaction with existing services. The youths expressed that they were not satisfied with the existing contraceptive services. The condom size did not match their size and was not ensured regarding condom quality. In addition, there were no alternative types of contraceptive pills, and pills had several side effects. As a result, some youths used inappropriate preventive measures:

> *"The condoms they give away were only 49, 52, which was not my size. It was too small and it would hurt...so, I take a risk by pulling out before ejaculation and was always afraid of getting my girlfriend pregnant."* (FGMY6)

> *"...I am 50% confident in the condom quality because sometimes it's almost expired and it can leak easily...On the package, ... I am unsure of expire date so don't dare to use it..."* (FGFY6)

> *"...My friends got the contraceptive pill from sub-district hospital that has available only one type of it and made them fat, some-one had melasma, and some got dizzy and nauseous. I didn't get it there because I was afraid of side effects..."* (FGFY4)

2.2 Lack of privacy and confidentiality. The youths mentioned that they had to receive the services and wait for the investigation and treatment together with other adult patients. There were no particular youth services, no antenatal room or consultation room which led them to hesitate to seek confidential consultation:

> *"I had abdominal pain....and waited for best test in the same room with other pregnancy clients. Someone asked me whether I was pregnant*

and how many months pregnant...I was afraid to meet someone I know and might mistakenly think I was a pregnant teenager and gossip or tell my parents. That hospital visit made me feel bad..." (FGFY2)

"When I waited to receive antenatal care among other patients, they had an insulting look, seemed like they were gossiping that I am a teenage pregnancy...Some people asked me where the baby's father was...This made me feel bad." (InFY1)

"I had received antenatal care among many other clients and many staff in this room...I wanted to ask about vaginal discharge as it was itchy, but I was afraid someone might hear because there were no specific rooms for consultation..." (InFY3)

2.3 Distrust in service providers' confidentiality. The youths expressed that they were afraid the healthcare providers would disclose their information to their parents and others. Some healthcare providers were community dwellers, well known, and familiar with people in the community including youths' parents. As the result, the youths were embarrassed and thought they would be scolded by their parents. Therefore, they avoided obtaining the services at health services:

"...I won't go to the sub-district hospital because the providers know my mother. If I come to get condoms or contraceptives, the providers will tell my mother. I'm afraid my parent will scold me..." (FGFY4)

"...There are people who live in the same village working at the sub-district health promoting hospital. Sometimes there are healthcare volunteers. I am afraid they will reveal my secret and gossip to others. It makes me embarrassed...." (FGFY3)

2.4 Negative attitudes of service providers. The youths expressed that the negative attitudes of providers towards youth accessing SRH services was a crucial reason for low access to the services. Some youths were confronted with healthcare providers' reactions to illustrate that youth obtaining contraceptives, STIs examination and treatments, and consultation was a troubled child or having SRH problems.

"I feel that the staff in front of the examination room looked at me like I was a bad girl or AIDS-infected teenager even though I came to have an examination for vaginal discharge... I feel bad and don't want to go there for any examination." (InFY1)

"My friend and I went to get condoms at sub-district hospital. The staff gave us a very serious look and asked us why we needed them. I was stunned and did not know how to answer, so we grabbed the condoms quickly and left... they might have thought of us badly and prepared the condom for having sex or just asked to make us feel embarrassed...Then I never go there again." (FGFY5)

Category 3: Unaware of access to effective information

The youths perceived that they lacked awareness to obtain SRH services information because the providers provided the information without interesting means. They also were not interested in receiving the information, therefore unable to apply when confronted with risks or problems. This category comprised two sub-categories:

3.1 Unattractive methods of information provision. Some youths pointed out that they have been to receive SRH information, but the session had a large number of participants, which was difficult to control participants' attention. Additionally, uninteresting topics, unattractive teaching techniques or patterns, and not using modern media tools caused the youths had received insufficient information for implementation.

"The last two years, the healthcare providers provided information at my school...There are 200 students in attendance who talked loudly and disturbed those who were paying attention... The speaker could not manage them to keep interested or be quiet..." (FGFY3)

"...I have obtained the information in the classroom, my teacher just complained about teenage pregnancy's effects and reminded us to use condoms...she didn't show how to put on a condom or how to get the services, and never used models or other interesting presentations... so, I have rarely useful information for real-life..." (FGMY6)

3.2 Inattention to obtain SRH knowledge. The youths perceived that they did not pay attention to receiving SRH information due to uninteresting topics unrelated to them. Some youth identified as knowledgeable and experienced, particularly condom use led to neglect of receiving information services. As a result, the information was insufficient for practical use:

"While the teacher was teaching, I didn't intend to listen, it didn't involve me...but when my girlfriend wanted to take the emergency contraceptive pills I couldn't advise anything even though my teacher has already taught this..." (FGMY4)

"... While the teacher was teaching, my classmates were talking, playing games, and using their mobile phones, for me, I had already known and often use condoms. I think my friends as well. So, it's not our interesting topic...." (FGMY6)

Category 4. Community's negative attitudes toward youths accessing services

The youths perceived that the community held negative views of the youths who obtained SRH services by considering these youths as troubled children and judging their parents as not carrying out good parenting roles.

4.1 Being troubled children. Youths indicated that community people considered youths who accessed SRH services as bad children because they were not self-reserved (ไม่รักนวลสงวนตัว), had premature or premarital sex, were pregnant during adolescence, and had STIs due to a lack of protection.

"I don't want to receive contraceptive pills at the hospital because if the people in my community saw me and my boyfriend, they'd think of me negatively as a bad girl who's not self-reserved and had premature sex ...these people think premarital sex is inappropriate..." (FGFY3)

"My girlfriend had a stomachache and was examined...I saw my neighbors and they insulted us, stared at us, and gossiped. I think they suspected that my girlfriend was pregnant or had STIs. So, I don't dare to get the services...." (FGMY6)

4.2 Having neglectful parents. Youths expressed that the community was negative and blamed the parents of youths obtaining SRH services for ignoring childcare and not teaching about protected sex.

"I got pregnant while I was a student...My mother took me to receive antenatal care and we met someone we know. I heard them gossip that my parents should've known I liked to go out, blaming them for not reminding me to reserve myself or teach me about protection...I feel sorry for causing my parents to be criticized as bad parents, not taking good care of me..." (InFY3)

"People in my community think that children should not have premature sex. If they find children obtaining contraceptives. They may think of premarital sex. Parents are seen as neglecting their children, especially when their children are pregnant in adolescence...So children are afraid to receive services." (FGFY5)

Category 5: Availability of other convenient services

The youth perceived that they could easily purchase contraceptive devices and medicines from several private sources. They also could select SRH services from private healthcare in accordance with their needs. This category consists of two subcategories:

5.1 Easy access to private-sector sources. The youth indicated that they found it easy to access medical devices and medicine from several private sources such as pharmacies and convenience stores located in every district and even in local areas, including easily accessible many online shops:

> *"... Nowadays, if I want to take a pregnancy test, I can buy the strip test at pharmacies in my hometown. I also often buy contraceptive pills here. It easier to buy and do it by myself..."* (FGMY6)

> *"...I see my friends buy condoms at 7/11, it's easier to get it, and there are many convenience stores and drugstores in this district and nearby..."* (FGFY4)

> *"I buy condoms online...many online shops for selecting and very convenient to buy it and just wait at home around two to four days..."* (FGMY4)

5.2 Able to access on-demand services. The youths perceived that they could access different kinds and characteristics of contraceptive services, STIs investigations and treatments, and consultation at private clinics and hospitals because of more convenience; shorter wait times, youths service hours, and satisfaction of services despite having to pay fees:

> *"I prefer to buy contraceptive pills online shops because of many types and I chose one that has no side effects, especially fat...bought condoms online because have the size and many characteristics and cheaper than store.* (FgFY6)

> *"I went to a private clinic for a contraceptive injection...after school that was convenient and timelier...It did not have many people, so I can get an injection right upon arriving there...I also had a consultation and examination due to vaginal discharge and the doctor prescribed some medicines.... faster and more convenient... but I had to pay 300-500 baht instead of getting free services in government hospitals..."* (FGFY5)

Discussion

This study's findings illustrated youths' perceptions regarding access to SRH services. Youths perceived that they were unable to access existing services because they lacked information about the available SRH services and their rights. They simply knew that access to the services was difficult and complicated, and they were unable to obtain trustworthy information.

The lack of knowledge among adolescents about SRH services, which constitutes a significant barrier to poor access to the services among youths, is consistent with findings from earlier studies.[17,19,22,38] In this study, youths indicated that they did not know what services were offered or where they could be obtained. This concurs with research on how adolescents perceived the availability of reproductive healthcare facilities in Thailand's rural eastern and northern regions, reporting that adolescents did not know what services were offered (60.6%) or where to obtain the services (74%), and they had little knowledge of the services that were already in place (70%).[17] Additionally, Thai adolescents had little knowledge of their rights to SRH services, which affected their decisions to access such services. [32, 33]

Youths also complained that the access to services was rather difficult because of the complex procedures and the lack of a pre-service appointment system. This finding concurs with other studies that reported adolescents' difficulty in obtaining services

due to the complicated procedure,[19,21,32] too many patients during regular service hours, and a lack of availability and lengthy waiting time.[19,27] SRH services were available from Monday to Friday from 8 am to 4 pm, and usually closed on Saturdays and Sundays, which youths perceived to interfere with their school time.[17,19,33] Consequently, they could not receive the services because they needed to seek teachers' official permission. They were available to obtain services in the evening after work but sub-district hospitals were closed. Although some sub-districts hospital provided services during extra hours on Saturdays from 8 am to 4 pm, they had to study at non-formal education schools. Consequently, the available service hours and the addition of more on-demand pre-service appointments for youths may improve their access to the services.

The youths echoed that they could not access reliable sources of SRH information because they did not know who the information provider was and whether this person was reliable or not. Consistent with a study on the situation of adolescents' access to health services in Thailand, most teenagers searched for information by themselves on the internet or talked to friends.[29,37] The majority were afraid to use the service at hospitals and chose to consult with friends, but friends did not have enough information to give appropriate advice.[28,32]

Additionally, the youths expressed that they did not accept the available SRH services due to dissatisfaction with existing medical supply services. There was a lack of medical supplies that met youths' needs, such as inadequate options for condom size, limited features of the condoms provided, and limited kinds of contraceptive pills that had some side effects. Some youths mentioned they were unsure about the quality of both condoms and contraceptive pills, including implants. Currently, condoms provided free of charge at the health service system are supplied by the Ministry of Public Health and distributed to all hospitals. In the research areas, condoms are sometimes distributed to teachers at schools, especially in non-formal education, but the condoms are limited in size, therefore, available only to certain groups. There was only one type of condom available and some youths found that the condom broke easily. Therefore, they did not trust the condom quality. Additionally, the availability of free oral contraceptives in the public health system is limited. The types of contraceptives and hormonal forms could not be chosen, and there were potential side effects of both oral contraceptives and implants. This caused youths to become dissatisfied and did not want to receive existing services.[17,23,31]

Another reason for youths' not accepting existing services was a lack of privacy and confidentiality. The youths complained about having no specific zones for youth services. They had to receive the services together with all other patients. There was no counseling room for a private consultation to maintain confidentiality. This was congruent with the perceptions of barriers to accessing SRH services among Laotian youths who are culturally similar to Thai youths.[23] The lack of privacy and confidentiality was a crucial barrier to youths' access to SRH services reported worldwide.[13,17,23,27,21,25,31,38] Female youths in Ethiopia often visited traditional health providers due to no specific service areas, leading to fear of being seen at healthcare services.[27]

Youths distrusted providers in keeping their data confidential.[17] Thai youths perceived that healthcare providers in health facilities, particularly sub-district hospitals, were acquainted with their parents, and some staff were living in the same community, causing youths to feel insecure about data confidentiality that might be compromised by humiliating gossip. Thus, the youths did not receive local healthcare services. Consistent with several previous studies, youths were not confident whether health providers could keep secrets.[13,14,23,25,27] Some participants expressed fear of punishment from their parents if the information was revealed.[24] Hence, the lack of trust in keeping confidentiality among providers is an important obstacle to accessing the services.[14,23,27]

Moreover, youths admitted to confronting the negative attitude of service providers.[21,23,25] This concurs with several studies on the crucial barriers to youths accessing SRH services.[19,20,38] Most youths in Egypt (88.5%) perceived healthcare providers' attitudes as the major barrier to accessing SRH services.[20,38] Similarly, adolescents who experienced access to SRH services in Nigeria reported poor or unfriendly health providers' attitudes, such as keeping adolescents waiting, spending little time with them during consultations, judgmental attitudes, and lack of confidentiality in service provision.[20,25,38] Healthcare providers' negative attitudes concerning youth SRH services affect youth's access to services practically worldwide. According to reports of adolescents' access to healthcare in various regions of Thailand, one of the reasons adolescents were nervous to receive treatment was their embarrassment and fear of healthcare providers, and worries of being judged as troubled adolescents. Additionally, the adolescents who had been pregnant and received SRH services admitted feeling hesitant to ask healthcare providers questions, believing they would be perceived negatively by the providers. These factors contribute to feeling stressed, anxious, and ashamed,[32] especially in those with unintended pregnancies.[28,29]

Thailand has included SRH education in the curriculum in secondary schools, and some schools had extra activities to provide SRH knowledge from healthcare providers. However, youths still mentioned having insufficient SRH knowledge and service information due to unawareness of access to effective information services from inappropriate education that contributed to inattention to obtain class and training among youths. More than half of the participants had sex education and training in their school, but they mentioned not feeling inclined to obtain efficient information services because healthcare providers and teachers provided SRH information with uninteresting methods, such as lectures without proper training materials or attractive learning media to encourage effective learning.

This study found that the design of teaching, especially in non-formal education where there was no specific sex education subject, and one teacher taught all subjects, might therefore lead to insufficient expertise in sex education. For technical college students, there were health education-related subjects without clearly separating the subjects or topics. Youths felt disinterested and bored, and had poor knowledge regarding sexual health that was not applicable in real life. Inappropriate sex education was a barrier to sufficient knowledge and information.[23,13,26] Therefore, teacher-inspired teaching strategies are important, as they can impart SRH knowledge and skills through engaging teaching strategies that combine examples and expertise. Males and females should be learning together to exchange information and experiences.[29,37] As a result, learning only in class is not comprehensive, and training should be provided by healthcare providers.

Nowadays, even though more people seem to open their minds about premature sex and premarital sex, this study found that youths also complained that community people maintained a negative attitude toward adolescents who accessed SRH services. Community people considered it inappropriate to have sexual intercourse before marriage, become pregnant at school age or have STIs because teenagers were expected to pay attention to their studies. Sometimes, the community people labelled youths as bad children who were sexually active when they saw them take oral contraceptives, even though it was for treatment purposes. Such negativity discouraged youths from utilizing the services. In addition, it was often judged that parents did not teach youths to be modest and abstain from premature sex. Community people blamed the parents for not taking good care of their children, resulting in youths fearing that their parents would be reprimanded, or sometimes that the parents also had a negative attitude toward access to services.[17,32,38] Parenting styles, and parental and community opinions about sexual accessibility were significantly associated with adolescent sexual experiences. This affects access to SRH services as

well.[30,38] Therefore, adjusting the attitudes of parents and people in the community by sharing their opinions and suggestions, especially through participating in the development of SRH service arrangements, is a promising way to achieve greater understanding and promotion of youth access to services.

From the last finding, youths perceived various convenient SRH services that could be easily accessed nowadays, such as private-sector sources, including drugstores, convenience stores, and other private clinics. In Thailand, many drugstores, convenience stores, private clinics, and hospitals are widely distributed. These participants indicated that they often bought condoms at convenience stores, particularly 7-Eleven stores that are available everywhere in Thailand, even in rural areas. However, some participants, especially boys, talked about online shopping in the private sector, which was a confidential and easy way to access satisfying services on-demand, such as contraceptives and condoms that were available in various types and features. The variety of types, features, quality, and cost of contraceptive supplies were the choices for youths' satisfaction. The female youths often mentioned the side effects of available contraceptive pills in government hospitals, especially affecting their body images, such as gaining weight and causing the melasma, acne, and darker skin. Thus, they preferred contraceptive pills sold in drugstores, even at their own expense.

Additionally, the private sector offered the availability of appointments, shorter waiting time, privacy, and convenient service hours for youths who preferred to avoid overlapping school time and work, which were all the reasons for youths' decision to select satisfying options.[26,27] Similarly, a previous study in Laos reported that youths got self-treatment for STIs, contraceptives, and emergency contraceptive pills at drugstores due to easier access, anonymity, convenient service hours, and availability in the urban area despite limited suggestions or no counseling.[23] However, youths' access to SRH services for information and other services from both public and private sectors would contribute to the prevention and management of youths' SRH problems.

The study findings not only concur with previous studies on some issues but also highlight new information to understand youths' perception toward access to SRH services that is less often explored in Thailand. The findings contribute to promoting SRH knowledge and offer information to provide SRH services that suit youths' needs and context.

Limitations

This study had some limitations in that the perceptions regarding SRH services belonged only to youths in a province in northern Thailand. This may have a specific cultural context influencing their perceptions, and cannot capture all cultural diversity of general youths in Thailand. Additionally, the youths participating in this study were volunteers from both formal schools (high school and technical college) and non-formal schools. However, we were unable to reach youths living in the community who were not studying at any institution and may have specific or different perceptions from the youths included in this study.

Conclusions and Implications for Nursing Practice

The findings provide information about youths' perceptions regarding access to SRH services. Youths perceived that they did not access available services since existing services were unacceptable due to a lack of privacy and confidentiality of services and healthcare providers, including providers' attitudes. Youths lacked awareness of obtaining effective information and mentioned that private sector services were conveniently accessible. Additionally, negative community attitudes affected youths' access to services.

The study findings offer useful information for healthcare providers and other stakeholders to understand youths' perceptions toward available services and

their needs. An effective intervention to increase the accessibility of youths to reliable information, knowledge, and services, including the acceptability of appropriate services in accordance with youths' needs is necessary for reducing SRH risks and problems. However, raising providers' awareness is crucial, particularly for nurses whose roles involve providing almost all SRH services to enhance awareness and competencies among all stakeholders, including healthcare providers, schools, local administrator organizations, parents, and especially youths, to participate and collaborate to design effective SRH services. The stakeholders can apply the findings to develop a model for improving access to SRH services among youths that are consistent and appropriate to youths' needs and local contexts in further study. Importantly the study raised ethical issues about confidentiality for nurses regarding participants feeling they could not trust healthcare providers not to inform their parents or gossip about their situation. This needs careful reflection and remediation in practice.

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References

1. United Nations. Word youth report: youth social entrepreneurship and the 2030 agenda. New York: United Nations Publication; 2020.
2. United Nations. Department of Economic and Social Affairs, Population Division. World Population Prospects, Demographic Profiles. 2019; 2.
3. Taft AJ, Shankar M, Black KI, Mazza D, Hussainy S, Lucke JC. Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes. Med J Aust. 2018;209(9):407-8. doi: 10.5694/mja17.01094.
4. Gronvik T, Sandoy IF. Complications associated with adolescent childbearing in Sub-Saharan Africa: a systematic literature review and meta-analysis. PLoS One. 2018;13(9): e0204327. doi: 10.1371/journal.pone.0204327.
5. Shannon CL, Klausner JD. The growing epidemic of sexually transmitted infections in adolescents: a neglected population. Curr Opin Pediatr. 2018;30(1):137-43. doi: 10.1097/MOP.0000000000000578.
6. Department of Health, Ministry of Public health. Annual report of the department of health 2020 [Internet]. Nonthaburi: Ministry of Public health; 2020 [cited 2021 Dec 15]. Available from: https://rh.anamai.moph.go.th/th/cms-of-/download/?did=207028&id=80543&reload= pdf
7. Settheekul S, Fongkaew W, Viseskul N, Boonchieng W, Voss JG. Factors influencing sexual risk behaviors among adolescents: a community-based participatory study. Nurs Health Sci. 2019;21(2):186-97. doi: 10.1111/nhs.12580.
8. Elnagar MA, Ashour E, Shahin MA, Emam AMM. Perceived, psychological impact of teenage pregnancy among students. Am J Nurs. 2018;6(2):54-8. doi:10.12691/ajnr-6-2-3.
9. World Health Organization. Global accelerated action for the health of adolescents (AA-HA!) guidance to support country implementation. Geneva; 2017 [cited 2019 Oct 20]. Available from: file:///C:/Users/Acer/Downloads/WHO-FWC-MCA-17.05-eng.pdf
10. Mazur A, Brindis CD, Deckeret MJ. Assessing youth-friendly sexual and reproductive health services: a systematic review. BMC Health Serv Res. 2018;18(1):1-12. doi.org/10.1186/s12913-018-2982-4.
11. Salam RA, Faqqah A, Sajjad N, Lassi ZS, Das,JK, Kaufman M, Bhutta ZA. Improving adolescent sexual and reproductive health: a systematic review of potential interventions. J Adolesc Health. 2016;59(4): S11-28. doi: 10.1016/j.jadohealth.2016.05.022.

12. Hadley A, Ingham R. Teenage pregnancy and young parenthood: effective policy and practice. Adolescent and societies series, New York; Routledge. 2018;35-51. doi: 10.4324/9781315516615.
13. Ndayishimiye P, Uwase R, Kubwimana I, Niyonzima JdlC, Dzekem Dine R, Nyandwi JB, et al. Availability, accessibility, and quality of adolescent sexual and reproductive health (SRH) services in urban health facilities of Rwanda: a survey among social and healthcare providers. BMC Health Serv Res. 2020;20(1):1-11. doi:10.21203/rs.3.rs-17230/v2.
14. Onukwugha FI, Hayter M, Magadi MA. Views of service providers and adolescents on use of sexual and reproductive health services by adolescents: a systematic review. Afr J Reprod Health. 2019;23(2):134-47. doi: 10.29063/ajrh2019/v23i2.13.
15. Department of Health, Ministry of Public health. Action plan of the national strategy on prevention and solution of adolescent pregnancy problem B.E. 2560-2569 (2017-2026) of act for prevention and solution of adolescent pregnancy problem, B.E. 2559 (2016)[Internet]. Nonthaburi: Ministry of Public Health; 2017 [cited 2020 Apr 15]. Available from: http://rh.anamai.moph.go.th/download/all_file/index/actionplan_tp/the-National-Strategy-on-Prevention-and-Solution-of-Adolescent-Pregnancy-B.E. 2560-2569(2017-2026).pdf
16. Chooset P, Sara N, Tangdee O. A study of preventive implementation and probing the teenage pregnancy problems of District Health Board (DHB). AJCPH. 2020;6(4):39-50 (in Thai).
17. Sridawruang C. Youth friendly health services for rural Thai teenagers. Int J Humanit Soc Sci. 2016;10(6):2029-32.
18. Phromprapat P. The development of health services model for non-certified YFHS hospitals. J Health Ed. 2018;41(2): 128-40 (in Thai).
19. Nmadu AG, Mohammed S, Usman NO. Barriers to adolescents' access and utilization of reproductive health services in a community in north-western Nigeria: a qualitative exploratory study in primary care. Afr J Prim Health Care Fam Med. 2020;12(1):1-8. doi: 10.4102/phcfm.v12i1.2307.
20. Mohammed MM, Elgelany S, Goma K, Hassan H. Perceived barriers to accessing sexual and reproductive health services among educated young women in Egypt. Evid Based Women's Health J. 2020;10(4):324-32. doi: 10.21608/EBWHJ.2020.42332.1106.
21. Abubakari SW, Abu M, Yidana Z, Apraku AE, Mutaru GI, Badasu DM. Young people's experiences in accessing sexual and reproductive health services in subSaharan Africa from 1994 to 2019 - A content analysis. Int J Sex Reprod Health Care. 2020;3(1):017-26. doi:10.17352/ijsrhc.000011.
22. Adan FI, Githae MN. Factors influencing access to reproductive health information services among young aged 15-24 in Garissa Municipality, Kenya. Int J Contemp Res Rev. 2018;9(08):20537-74. https://doi.org/10.15520/ijcrr/2018/9/08/574.
23. Thongmixay S, Essink DR, Greeuw Td, Vongxay V, Sychareun V, Broerse JE. Perceived barriers in accessing sexual and reproductive health services for youth in Lao People's Democratic Republic. PLoS One. 2019;14(10): e0218296. doi:10.1371/journal.pone.0218296.
24. Erasmus MO, Knight L, Dutton J. Barriers to accessing maternal health care amongst pregnant adolescents in South Africa: a qualitative study. Int J Public Health. 2020;65(4): 469-76. doi: 10.1007/s00038-020-01374-7.
25. Onokerhoraye AG, Dudu JE. Perception of adolescents on the attitudes of providers on their access and use of reproductive health services in Delta State, Nigeria. Health. 2017;9(1): 88-105. doi: 10.4236/health.2017.91007.
26. Pandey PL, Seale H, Razee H. Exploring the factors impacting on access and acceptance of sexual and reproductive health services provided by adolescent-friendly health services in Nepal. PLoS One. 2019;14(8): e0220855. doi:10.1371/journal.pone.0220855.
27. Birhanu Z, Tushune K, Jebena MG. Sexual and reproductive health services use, perceptions, and barriers among young people in southwest Oromia, Ethiopia. Ethiop J Health Sci. 2018;28(1):37-48. doi: 10.4314/ejhs.v28i1.6.
28. Noinam S, Siripul P, Rojjanasrirat W. The early pregnancy in adolescents: adolescent's perspective. JNSH. 2018; 41(1):117-28. Available from: https://he01.tci-thaijo.org/index.php/nah/article/view/114350 (in Thai)
29. Buaboon N, Kongvattananon P. Teenagers' experiences in using a youth friendly health service: a descriptive qualitative research. J Royal Thai Army Nurses [Internet]. 2021Dec 29 [cited 2022 Oct 23];22(3):209-18. Available from: https://he01.tci-thaijo.org/index.php/JRTAN/article/view/241959 (in Thai)

30. Srijaiwong S, Sindhu S, Ratinthorn A, Viwatwongkasem C. Factors influencing sexual behaviors among Thai adolescents. JPSS. 2017;25(3): 171-93.
31. Nkosi B, Seeley J, Ngwenya N, Mchunu SL, Gumede D, Ferguson J, et al. Exploring adolescents and young people's candidacy for utilising health services in a rural district, South Africa. BMC Health Serv Res. 2019;19(1):1-12. doi:10.1186/s12913-019-3960-1.
32. Chomnirat W, Kanrussamee P, Chaiyapoom N, Jaitieng A. Health service and access to health service of teenage in Muang District, Khon Kaen Province. J Nurs Health Care. 2019;37(3):240-8 (in Thai).
33. Jensarikorn P, Phlainoi S, Phlainoi N, Saejeng K. Accessibility to reproductive health rights among adolescents in three provinces of Thailand. J Health Res. 2019;33(1):35-42. doi:10.1108/JHR-07-2018-0058.
34. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007; 19(6):349-57. https://doi.org/10.1093/intqhc/mzm042
35. Stringer ET. Action research. 4th ed. Thousand Oaks, CA: Sage; 2014.
36. Lincoln YS, Guba EG. Naturalistic inquiry. London: Sage; 1985.
37. Mutea L, Ontiri S, Kadiri F, Michielesen K, Gichangi P. Access to information and use of adolescent sexual reproductive health services: qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. PLoS One. 2020; 15(11): e0241985. doi:10.1371/journal.pone.0241985.
38. Muanda FM, Gahungu NP, Wood F, Bertrand JT. Attitudes toward sexual and reproductive health among adolescents and young people in urban and rural DR Congo. Reprod Health. 2018;15(1):1-14.

การรับรู้ของเยาวชนต่อการเข้าถึงบริการสุขภาพทางเพศและอนามัยเจริญพันธุ์

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บทคัดย่อ: บริการสุขภาพทางเพศและอนามัยเจริญพันธุ์ในประเทศไทย มีการจัดบริการตามนโยบายระดับชาติและแผนยุทธศาสตร์ แต่ยังมีปัญหาสุขภาพทางเพศของเยาวชนค่อนข้างสูง ปัญหาสำคัญคือเยาวชนเข้าถึงบริการต่ำ การศึกษาครั้งนี้ เป็นการรายงานข้อมูลพรรณนาเชิงคุณภาพในระยะแรกของการวิจัยเชิงปฏิบัติการแบบมีส่วนร่วม เพื่อพัฒนารูปแบบในการปรับปรุงการเข้าถึงบริการสุขภาพทางเพศและอนามัยเจริญพันธุ์ในกลุ่มเยาวชน การศึกษานี้มีวัตถุประสงค์เพื่อ ศึกษาการรับรู้ของเยาวชนเกี่ยวกับการเข้าถึงบริการสุขภาพทางเพศและอนามัยเจริญพันธุ์ ในเขตภาคเหนือของประเทศไทย รวบรวมข้อมูลเชิงคุณภาพตั้งแต่ เดือนกันยายน พ.ศ. 2562 ถึง เดือนมีนาคม พ.ศ. 2563 โดยใช้วิธีการสนทนากลุ่มย่อยกับเยาวชนที่มีอายุ 15-24 ปี จำนวน 59 คน และสัมภาษณ์เชิงลึกกับเยาวชนที่เคยตั้งครรภ์ไม่พึงประสงค์จำนวน 4 คน ผู้ให้ข้อมูลทุกคนได้รับการเลือกแบบเฉพาะเจาะจง และสมัครใจเข้าร่วมการวิจัย บันทึกข้อมูลถอดเสียงแบบคำต่อคำ และวิเคราะห์ข้อมูลโดยวิธีวิเคราะห์เชิงเนื้อหา

ผลการศึกษาพบปัจจัยสะท้อนความต้องการและบริบทของเยาวชนต่อการเข้าถึงบริการสุขภาพทางเพศและอนามัยเจริญพันธุ์ สามารถจำแนกได้ 5 ประเด็น ดังนี้ 1) ไม่สามารถเข้าถึงบริการที่มีอยู่ 2) ขาดการยอมรับในบริการที่มีอยู่ 3) ไม่ตระหนักในการเข้าถึงข้อมูลที่มีประสิทธิภาพ 4) ชุมชนมีทัศนคติด้านลบต่อเยาวชนที่ใช้บริการ และ 5) มีบริการที่สะดวกอื่น ๆ ผลการศึกษาครั้งนี้ให้ข้อมูลที่เป็นประโยชน์แก่ผู้ให้บริการสุขภาพ โดยเฉพาะพยาบาลและผู้มีส่วนได้ส่วนเสียอื่นที่เกี่ยวข้อง เพื่อให้เข้าใจมุมมองของเยาวชนมากขึ้น เพิ่มความตระหนักในการทำงานร่วมกัน และส่งเสริมการมีส่วนร่วมของกลุ่มเยาวชนในการพัฒนากิจกรรมและกลยุทธ์เพื่อปรับปรุงการเข้าถึงบริการสุขภาพทางเพศและอนามัยเจริญพันธุ์

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คำสำคัญ: เยาวชน การรับรู้ บริการสุขภาพทางเพศและอนามัยการเจริญพันธุ์ การศึกษาเชิงคุณภาพ ประเทศไทย

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