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Barriers to Reproductive Health Access for Adolescent Girls in Urban Slums: A Case Study of Korail, Dhaka

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Abstract

The study involved a cross sectional mixed method approach to identifying barriers and opportunities for reproductive health service utilization for adolescent girls in Korail slum, Dhaka. Structured questionnaires, interviews and focus group discussions were used to collect data from 120 girls aged 13–19 years. While 59.16% have no access to reproductive health services, 94.17% has heard of reproductive health. Limited awareness, parental disapproval, fear and stigma, cultural restrictions, financial constraints and limited service availability were key barriers. Also, 64.16% suffered mistreatment and/or discrimination. Mothers and women family members were relied upon sources of information. The majority of the respondents agreed with the reproductive health education in schools. The study suggests services that are accessible, comprehensive education, family engagement, and stigma-free policies.

Keywords: *Urban Slums, Adolescent SRHR, Reproductive Health Access, Adolescent Girls, Korail*

Introduction

Adolescent girls in urban slums face a greater risk of not receiving reproductive health treatments as a result of the complex social, cultural, and infrastructure barriers. Informal settlements have grown in Bangladesh with the rapid urbanization process, one of the largest and most densely populated informal settlements is Korail in Dhaka (Hasan et al., 2024). These environments characterized by poor sanitation, crowding, and limited access to formal health services have a negative effect on adolescent girls' reproductive health. Adolescents aged 10–19 years constitute a large proportion of the world's population, and their sexual and reproductive health and rights (SRHR) are often overlooked, particularly in cities that have limited resources (Wado et al., 2020). Unplanned births, early marriage and limited contraceptive and menstrual hygiene management (MHM) access are common among adolescent girls living in urban slums in Bangladesh (Lopez, 2023). These issues are made worse by cultural taboos, a paucity of programs geared at young people, and a fear of stigma (Rashid, 2006). There is a lack of basic information on reproductive health among adolescent girls living in Dhaka slum areas, and they often have to make reproductive choices within patriarchal family structures (Rashid, 2006; Billah et al., 2025). Poor health outcomes and fragmented service delivery have been caused by the lack of inclusive policy frameworks and focused interventions. In Korail, 30% of families are moderately vulnerable based on their socioeconomic and health conditions, and 9% are severely vulnerable (Hasan et al., 2024). The goal of this study is to understand the various structural, cultural and service barriers affecting adolescent girls' access to reproductive health services in Korail, Dhaka. The results will help to

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inform policy recommendations and programmatic approaches that offer equitable and rights-based reproductive health services for marginalized urban populations.

Although there has been a global movement on SRHR, adolescent girls in Korail Slum continue to experience a number of problems: poverty and overcrowding, lack of health care, early marriage, stigma and misinformation, lack of youth-friendly services. Current policies that don't include their needs. This study helps to fill gaps in evidence by identifying context-specific barriers and to help shape equitable, rights-based reproductive health policies and interventions.

Research Objectives

- To identify the socio-demographic factors;
- To assess knowledge of reproductive health;
- To assess the opportunity for accessing into reproductive health services; and
- To identify the barriers and prospects to get reproductive health services.

Research Questions

- What are socio-demographic factors?
- What is the knowledge of reproductive health?
- What are opportunities for accessing into reproductive health services? and
- What are the barriers that hindered to get reproductive health services?

Review of Literature

Barriers to Reproductive Health Access among Adolescent Girls in Urban Slums

Multiple structural and social disadvantages converge in an urban slum, making sexual and reproductive health (SRH) services a large public health problem for adolescent girls. Poverty, high population density, poor infrastructure and underdeveloped health systems are some of the factors that affect the availability of quality reproductive health services for adolescents living in informal settlements (McGranahan et al., 2021; Wado et al., 2020). Restrictive gender norms, cultural taboos on sexuality and social stigma hinder young women's access to reproductive healthcare, as well as their autonomy in making reproductive health choices (Haque et al., 2024; Tuhebwe et al., 2021). Adolescents' trust in accessing the available services is further undermined by institutional discrimination, judgmental attitudes by health care providers and gendered power dynamics (Dávila et al., 2025; Ndunguru et al., 2026). One of the key factors contributing to poor reproductive health access is lack of reproductive health knowledge.

Many adolescent girls lack formal education regarding menstruation, contraception, sexually transmitted infections (STIs) and reproductive physiology, and this makes them less likely to be able to identify health problems or seek timely healthcare (Acquah et al., 2023; Nasrun, 2026). Also, inadequate communication between health workers and adolescents and limited confidentiality and privacy in health facilities have an impact on adolescents' trust in formal health services (Janighorban et al., 2022; McGranahan et al., 2021). As a result, many adolescent excluded and marginalized continue to have unmet reproductive health needs because of lack of adolescent friendly, confidential and culturally sensitive health services (Nowshin et al., 2022; Santhya & Jejeebhoy, 2015). These pre-existing barriers were compounded by the COVID-19 pandemic which affected routine reproductive health care service delivery and financial risk in vulnerable households (Ssebunya et al., 2022). Reports indicated that access to maternal and reproductive

health services had been disrupted, access to menstrual products had been lowered, and the reliance on unsafe reproductive health practices had been increased due to the pandemic (Meherali et al., 2021). Financial difficulties and lack of documentation sometimes forced migrant and IDP adolescents to rely on informal networks within the communities they lived in instead of the formal healthcare system (Jahan et al., 2024).

Conventional service delivery methods were also unsuccessful in reaching adolescents' information and service needs, due to high residential mobility, overcrowding, and inadequate community outreach efforts (Billah et al., 2023). Additionally, there is some evidence that adolescents in resource-limited urban areas continue to have a high risk of reproductive health issues because of poor continuity of care, underdeveloped referral systems and poor delivery of health care (Hedayet et al., 2023). Youth continue to be discouraged from visiting clinical settings for important reproductive health care due to persistent provider bias, confidentiality concerns, and lack of youth-friendly clinical environments (Meyer et al., 2022). Additional vulnerabilities are exacerbated by humanitarian crises and public health emergencies, including unintended pregnancies and sexual violence, as well as disruptions to specialized reproductive health services (Desrosiers et al., 2020). There is growing advocacy for community-based and adolescent-sensitive strategies to enhance access to SRH services in recent literature.

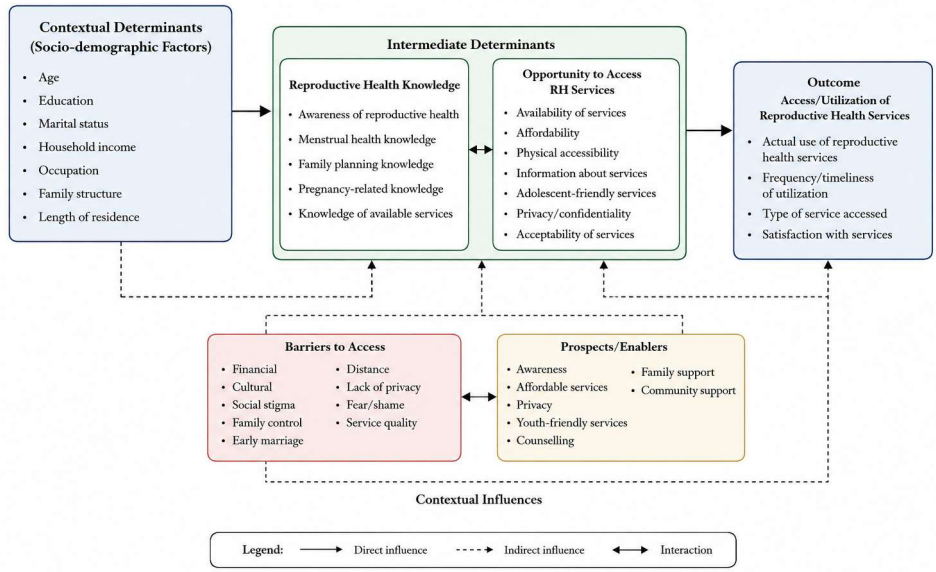
In recent years, the importance of community-based and adolescent-sensitive strategies to enhance access to SRH services is gaining increased voice in the literature. Community engagement, co-designed interventions, culturally appropriate health education, and enhanced outreach programmes have all shown promise for enhancing adolescent engagement with reproductive health care services (Castleton et al., 2025). However, the researchers call for disaggregated data for both age and sex to gain more understanding of the reproductive health needs of adolescents, which are diverse (Jennings et al., 2019). Moreover, geospatial mapping and local surveys have proven useful as tools to determine the population in need and inform targeted reproductive health interventions in high-density urban settlements (Chandra-Mouli et al., 2021).

Research Gap

Study on the adolescent reproductive health in the slums of urban areas, in particular Korail is still less in Bangladesh. Current research focuses on knowledge, contraceptives and maternal health, with a lack of attention to multi-faceted barriers of a socio-economic, cultural, gender, institutional and health-system nature. This mixed-methods study aims to fill these gaps, such as the lack of service continuity, confidentiality, trust of providers and access to services, to inform equitable interventions.

Conceptual Framework

Figure 1 Conceptual Framework



Conceptual framework depicting the link between socio-demographic characteristics, reproductive-health knowledge, opportunities, barriers, enabling factors and access to reproductive-health services for adolescent girls in Korail slum, Dhaka.

Materials and Methods

Study Area and Population

The study was undertaken in the most densely populated slum in Dhaka, Bangladesh-Korail slum-which is located in Mohakhali, has an average slum dwellers' family size of 3.8 persons, a poverty rate of 53%, and low quality sanitation, insecure housing, and healthcare services. The study population included adolescent girls ages 13-19, married and unmarried girls from a variety of educational, occupational and housing levels.

Sample Size and Sampling Procedure

For the quantitative survey 120 adolescent girls were purposively sampled. To further explore the experiences with reproductive health and service barriers, 3 in-depth interviews (IDIs) and 2 focus group discussions (FGDs) were conducted with purposively selected respondents.

Data Collection Instruments and Procedure

Expert-designed, pre-tested structured questionnaires were used to gather quantitative data, and semi-structured interviews were conducted to collect qualitative data on family influence, stigma, healthcare experiences and education needs. Trained female interviewers conducted Bangla face-

to-face interviews. The procedures of collecting data systematically and ethically were followed, and IDIs and FGDs were audio-recorded in private following informed consent.

Data Analysis

The quantitative data were analyzed by frequencies and percentages using a MS Excel and qualitative data were transcribed, translated and thematic analyzed. The five priority themes were family influence, informal sources of information, reproductive health stigma, discrimination in healthcare and educational needs. The data was merged into a convergent mixed methods approach to achieve complete understanding of the barriers to reproductive health.

Ethical Considerations

The relevant ethics committee approved the study. Consent (written informed consent) was obtained with those aged 18–19 and for those younger, with parental consent and adolescent assent. There was no coercion in the participation of the children and confidentiality and anonymity were ensured.

Results and Analysis

Quantitative Analysis

Socio-demographic Information

42.5% of respondents were in the age group of 13-15 years and 57.5% were aged 16-19 years. The level of educational attainment was not very good, with 40% having achieved upper secondary education, 49.16% having finished secondary education and 10.83% having only completed elementary education. The majority of respondents (65.83%) were unmarried and the other 30.83% were married, with 3.33% divorced, indicating early marriage and possible vulnerability. About 70% lived with parents, whereas 30% lived with spouses. Job-wise, domestic work was the major occupation (35.83%), followed by RMG job (26.66%) indicating economic vulnerability. Meanwhile, 18.33% were housewives, 13.33% were involved in tailoring and a small portion were engaged in beauty related or small scale business. In general, the results show that adolescent girls have various educational, marital, occupational and socio-economic statuses. Early marriage, domestic duties, job requirements, and weak career prospects can impact their independence, mobility, education, and information and services on reproductive health. Table 1.

Table 1. Socio-demographic information

Information category	Response Options	F (%)
Age	13-15 years	51 (42.5%)
	16-19 years	69 (57.5%)
Level of education	Primary	13 (10.83%)
	Secondary	59 (49.16%)
	Higher secondary	48 (40%)
Marital status	Unmarried	79 (65.83%)
	Married	37 (30.83%)
	Divorced	04 (3.33%)
Living arrangement	With parents	84 (70%)
	With spouse	36 (30%)
Occupation	Work at RMG	32 (26.66%)

	Domestic helper	43 (35.83%)
	Pretty business	07 (5.83%)
	Tailoring	16 (13.33%)
	Housewife	22 (18.33%)

Knowledge about Reproductive Health

A small proportion (5.83%) don't know what reproductive health means, suggesting that there may be scope for specific outreach work to bridge this gap. A very high proportion (94.17%) of respondents have heard the term, suggesting good overall awareness, which may be influenced by factors such as age, level of education and exposure to sources of information. The social media as the most popular source (57.5%) of information brings to the question the accuracy of the information, but also highlights the important role that social media plays in adolescent engagement. Family comes in second (40.83%), with high levels of trust, especially when it comes to topics that are sensitive, but can sometimes provide inaccurate or biased information. A significant contribution is also from friends (30.83%) indicating the potential for peer learning when peers are knowledgeable. Educational institutions raise awareness for 27.5% of respondents, which may signify that there are weaknesses in the curriculum or delivery in the educational institutions. Government healthcare personnel have the lowest level of activity (19.16%), indicating limited involvement in increasing awareness on reproductive health matters, while NGOs have the highest (24.16%), underscoring the importance of civil society in promoting awareness in the community. Table 2.

Table 2. Knowledge about reproductive health

Information category	Response Options	F (%)
Heard the term "reproductive health"	Yes	113 (94.17%)
	No	07 (5.83%)
Sources of information (Multiple responses)	Educational institute	33 (27.5%)
	Family	49 (40.83%)
	Friends	37 (30.83%)
	Govt. healthcare workers	23 (19.16%)
	Social media	69 (57.5%)
	NGOs	29 (24.16%)

Access to Reproductive Health Services

The statistics show that 40.14% have access to reproductive health care, which indicates that there are some services available, but there are significant sociocultural and institutional barriers as well. On the other hand, 59.16% of people do not have access, which emphasizes the critical need for focused actions to close these gaps. Several reasons for this limited access have been cited: 35.83% of teenagers report that they don't know about the services, even though they know about reproductive health; 32.5% say that parents are against it; 24.16% feel ashamed and afraid because of cultural taboos that prevent them from talking openly and asking for help; 19.16% of respondents report infrastructure/geographic constraints as a reason for lack of access to services, especially in underserved areas; and 14.16% report financial constraints as a reason for lack of access to services, although less severe than the other reasons cited above. Table 3.

Table 3. Access to Reproductive Health Services

Information category	Response Options	F (%)
Access to reproductive health	Yes	49 (40.14%)
	No	71 (59.16%)
Do not access to reproductive health (in case of 'no' of previous response) (Multiple responses)	Lack of awareness	43 (35.83%)
	Fear/shame	29 (24.16%)
	Financial barriers	17 (14.16%)
	Cultural restrictions	23 (19.16%)
	Parental disapproval	39 (32.5%)
	Service not available	(15.16%)

Barriers and Prospects

The results indicate high levels of reproductive health access issues for adolescent girls. Almost 2 thirds (64.16%) were mistreated or discriminated against, and 38.33% of them felt unsafe in the healthcare facilities. Respectful care was inconsistent-only 15% were always treated with respect while 28.33% were never treated with respect. These experiences highlight issues that affect service quality, privacy, communication and accountability, which can be barriers for future health service utilization. Although these are hurdles, strong interest and demand for reliable information was expressed as 90.83% endorsed the integration of reproductive health education into school curricula. Trust in mothers (74.16%) and trust in sisters or other female relatives (69.83%) was the highest and trust in peers (32.5%), health professionals (37.5%) and teachers (10%) and NGO workers (20.83%) was comparatively low. Increasing family and community participation in reproductive health issues, therefore, may lead to better reproductive health knowledge. Education of teachers, health care workers, and peer educators also is needed to improve trust and confidentiality, respectful care, and correct information. Generally, the vital institutional reforms and school-based education are needed to improve adolescents' reproductive health experiences and access. Table 4.

Table 4. Barriers and prospects

Information category	Response Options	F (%)
Have you ever sought reproductive health services and been subjected to mistreatment or discrimination?	Yes	77 (64.16%)
	No	43 (35.83%)
Do you feel secure and at ease going to nearby medical facilities?	Yes	74 (61.66%)
	No	46 (38.33%)
Do medical professionals treat you with dignity and consider your needs?	Always	18 (15%)

	Sometimes	39 (32.5%)
	Rarely	34 (28.33%)
	Never	29 (24.16%)
Do you believe that school's curriculum should include instruction on reproductive health?	Yes	109 (90.83%)
	No	11 (9.16%)
Who do you most trust for advice or information about reproductive health? (Multiple response)	Mother	89 (74.16%)
	Sister/Female Relative	73 (69.83%)
	Peer	39 (32.5%)
	Teacher	12 (10%)
	Health Worker	45 (37.5%)
	NGO Staff	25 (20.83%)

Qualitative Analysis

Persistent Influence of Family Structures

The reproductive health decision making autonomy and freedom of the adolescent girls in Korail Slum is restricted with strong family control. Parents, especially mothers, are a great source of learning and guidance, but they can also hinder access to healthcare. Families' decisions on early marriage restrict girls' education, development, and reproductive health service access as well as their ability to make decisions.

Informal Channels as Primary Information Sources

Social media, the family and peers were cited by respondents as the most important places to get knowledge on reproductive health. Many mentioned that they did not feel confident in approaching instructors or works of NGOs because of fear of being judged or being dismissed from their job. This reliance on unofficial sources may result in false or inaccurate information, knowledge gaps and misrepresentation.

Stigma and Silence Surrounding Reproductive Health

The taboos surrounding talking about reproductive health kept coming up. People reported experiences of shame, fear or discomfort seeking help or asking questions. A few said they were prevented from using the most basic services due to social barriers and/or dissuaded by relatives.

Disrespect and Discrimination at Health Facilities

Numerous adolescent girls spoke about the mistreatment they had suffered by health care providers or the lack of interest in them, especially during seeking reproductive services. Some said they were deterred from going back because they felt ignored or criticized by the medical professionals. The situations in which residents were close to services created a lack of trust and anxiety, since services were not consistently courteous.

Demand for Safe and Structured Education

Adolescent girls have a strong desire for reproductive health education in schools as it is a trusted and safe source of information. They supposed that the curricula of the various subjects were not appropriate and that trained teachers could provide a reliable assistance. Result indicates that there are institutional, family and cultural barriers which need to be addressed through compassionate, youth friendly and community sensitive approaches to reproductive health interventions.

Discussion

Socio-demographic Characteristics and Reproductive Health Vulnerability

Adolescent girls are particularly vulnerable to reproductive health risks because of their gender inequalities and socioeconomic deprivation in Korail. Nearly a third of the people responding to the survey experience early marriage, which restricts their educational and autonomous opportunities and access to health care. Many are domestic or RMG workers, which is a sign of economic hardship and financial responsibilities, with work schedules that are a limitation on education, healthcare and wellbeing. Moreover, the cultural norms around marriage that expect young women to settle down and conceive soon after marriage compound these vulnerabilities by discouraging young women from accessing prenatal care actively (Haque et al., 2024). Household relations and family strife tend to exacerbate the situation, and make young brides feel obligated to pursue childbearing over their own physical or emotional maturity (Rashid, 2006). All of these institutional and interpersonal challenges ultimately contribute to a cycle of adverse health outcomes, such as preterm delivery and the complications of adolescent childbearing (Huda et al., 2014). Likewise, the combination of restricted formal education and economic need can further create structural barriers that impede young women from navigating reproductive health systems in an effective manner (Nasrin, 2012; Rahman, 2017).

Knowledge Does Not Guarantee Access to Services

While 94% of women were aware of reproductive health, almost 60% had no access to services, suggesting that there is a disparity between knowledge and utilization. Behaviours related to seeking health care are limited by structural, cultural and institutional factors. Social media is the primary source of information, with a rise in misinformation dangers. Providing accurate, age appropriate reproductive health education and services in school and healthcare provision facilities. In addition, teachers are not well-trained and there are not enough instructional resources to help adolescents deal with their complicated reproductive health issues (Chavula et al., 2022). Combating these gaps, interactive digital health platforms and the incorporation of health professionals into the development of digital content can make sure that adolescents have access to verified, evidence-based counseling (Sawedi, 2025). Furthermore, having a dedicated youth friendly service corner has the potential to improve the adoption of services by youth if it creates supportive environments that will help them build self-efficacy and increase their capacity to utilize services (Agbenu et al., 2024; Abdurahman et al., 2022). The high costs of contraceptives and negative attitudes of providers are also important to addressing to remove the administrative and economic barriers that currently discourage youth engagement (Acquah et al., 2023; Ninsiima et al., 2021).

Socio-cultural and Institutional Barriers to Healthcare Access

Adolescent girls in Korail encounter several overlapping challenges when accessing reproductive health services, such as low awareness, disapproval from parents, stigma, cultural constraints,

financial problems and low access to services. The decisions are heavily swayed by family authority and conservative norms discourage the open discussion. These are all the results that underscore the combined effect of social norms, gender inequalities, and health-system barriers to access to reproductive health services. Moreover, such systemic issues are frequently exacerbated by the lack of youth-friendly policies and the attitudes of service providers who seem to have an attitude of apathy to youth (Lang'at et al., 2024; Nmadu et al., 2020). This structural and normative barrier thus contributes to the vulnerability of young age groups to sexually transmitted infections and unwanted pregnancies (Acquah et al., 2023). However, these socio-cultural and systemic factors will need to be addressed through holistic, youth-sensitive health services that include legal assistance and/or policy change (Janighorban et al., 2022; Ndunguru et al., 2026). These interventions need to specifically acknowledge the ongoing role of gendered ideologies and moral discourses that continue to marginalize adolescent health needs (Pandey et al., 2019).

Healthcare Experiences and Trust in Service Providers

Adolescent girls are less likely to use health facilities due to mistreatment and discrimination. Almost two thirds felt unsociable service, judgemental attitudes, lack of communication and lack of privacy in formal service, undermining their trust in formal services. This means that the families are more important to girls than professionals. Rebuilding trust depends on enhanced provider training, confidentiality, privacy, and respectful communications, as well as adolescent-friendly policies. In addition to structural changes, improving the professional skills of clinicians in terms of their communication and sensitivity is important to bridge the gap between the need of the children and the requirements at the clinic (Kigongo et al., 2025; Patton et al., 2016). To make the health system more accessible to unmarried adolescent girls and boys, addressing these behavioral and structural barriers will require consistent provider sensitization on the specific SRH needs of unmarried adolescent girls and boys, and maintaining strict confidentiality, so as not to stigmatize or cause further consequences (Okyere et al., 2024; Pandey et al., 2019). Furthermore, embedding SRH skills into pre-service preparation of medical officers and nurses is crucial to sustaining improvements in clinical attitudes and services provision in the long-term (Kennedy et al., 2013).

Conclusion

The study shows that although adolescent girls have relatively high awareness, there are significant challenges for them to access reproductive health services in the Korail Slum context. Socio-economic disadvantage, early marriage, parental control, cultural stigma, financial factors and limited adolescent-friendly services all limit access to health services. There is low trust and slow health-seeking due to discrimination, disrespectful treatment and lack of confidentiality. There is a need for collaboration between the health, education, family and community sectors to solve these problems. Reproductive health education should be comprehensive and age-appropriate and be included in the school curriculum. Healthcare providers are expected to ensure privacy, confidentiality, respect, affordable services and non-judgemental counselling. Healthcare personnel must be trained to deliver adolescent friendly health services, be sensitive to gender, communicate and practice ethical care. To minimize stigma, engagement of families and communities, especially female guardians and parents, is needed. Schools, government and civil society organization outreach can help raise awareness and combat misinformation. The reproductive health inequities need to be addressed by providing better access to young-friendly clinics and services in slums, actively implementing youth health policies, monitoring, and conducting additional research.

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