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Barriers to Accessing Healthcare Services among Urban Squatter Communities in Kathmandu Valley, Nepal: A Qualitative Study of Providers' Perspectives

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ABSTRACT

The purpose of this study was to explore the barriers to accessing healthcare services among marginalized individuals in urban squatter communities of Kathmandu Valley. A qualitative approach was used for the study. The squatter communities were divided into six clusters, and healthcare providers working in government-run local health institutions in the periphery of the urban squatters of Kathmandu Valley were approached for an interview. Thematic analysis was used to identify the barriers. Different barriers to accessing healthcare services among the squatter communities were identified, related to the supply and demand of healthcare services.

Keywords: Access, Barriers, Health Care Services, Healthcare Providers, Urban Squatters

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INTRODUCTION

Universal Health Coverage (UHC) is when every individual has access to the full range of high-quality healthcare services they require, at the appropriate time and location, and without facing financial hardship and includes all aspects of essential health services from promotive, preventive, treatment, rehabilitative and palliative care throughout the life course (World Health Organization: WHO, 2023). The Government of Nepal (GoN) is committed to achieving UHC, which is a part of Sustainable Development Goals (SDGs) and consisting of two major indicators: Essential Health Service Coverage and Financial Protection (Nepal Health Research Council: NHRC, 2022). Essential health service coverage includes 16 indicators in four areas of reproductive, maternal, newborn and child health; infectious diseases; communicable disease and service capacity, access, and health security. Similarly, the financial protection is measured through impoverishment and catastrophic health expenditure (World Health Organization Southeast-Asian Region: WHO SEAR, 2019).

Access to healthcare means that people, regardless of differences in race, sex, language, religion, economy, or social status have physical access to health commodities, and services. Access to health services is considered as the right to health (Huls, 2004). Barriers to healthcare are factors that restrict the use of health services by making it more difficult for individuals. Barriers to accessing health services can be viewed as demand and supply side factors. Demand side barriers are factors influencing the ability to use health services at individual or community level, while supply side barriers are aspects inherent to the health system that hinder service uptake by individuals or community (Jacobs et al., 2011).

Access is conceptualized in various ways and has different dimensions such as availability, accessibility, affordability, and acceptability. Access to health service also can be viewed as supply and demand factors. The supply side factors consist of location, availability, cost, quality, and appropriateness of services. The demand side factors consist of knowledge, attitudes, skills, self-care practices and ability to pay (Jacobs et al., 2011). This is in line with the notions of predisposing factors to utilize on one side and enabling and health system factors on the other. Predisposing factors include an individual's perception of an illness, as well as population specific cultural, social, and epidemiological factors. Enabling factors include the means available to individuals for using health services. Health system factors comprise resources, structures, institutions, procedures, and regulations through which health services are delivered (Levesque et al., 2013).

Over 50% of the world's population currently resides in urban areas and this

is increasing over time. Rapid urbanization frequently has detrimental effects like environmental degradation, increased health services costs, swelling property, increasing the likelihood of disease outbreaks, expensive transportation and increase in criminal activities, which are made worse by both the individual residents' behavioral patterns and the absence of public services (World Health Organization: WHO & UN-HABITAT, 2010). Squatter settlements are increasing due to rapid urbanization, especially in developing nations. Squatter colonies are contributing to the unfavorable aspects of urbanization. These squatters have fostered violent and destructive behaviors as well as crime, juvenile delinquency, and prostitution (Adhikari, 2016).

The squatters are the 'dumping ground' for unwanted aspects of urban life and the recipients of the city's exteriority; waste materials, crime, social dysfunction, and fragile or polluted environment. Because of unhealthy, crowded and often hazardous environments, serious health risks, normally associated with poor sanitation, lack of waste disposal facilities, presence of vermin, and poor water quality. However, access to healthcare services for slum and squatter people is limited and their ability to utilize health service depends on various factors (Firdaus, 2012).

The urban squatter residents of Kathmandu Valley are most vulnerable poorest social group (Shrestha et al., 2020). They are the most vulnerable to preventable communicable and non-communicable diseases and have high rates of mortality because of lack of access to clean drinking water, sanitation, and hygiene (The New Humanitarian, 2007). Similarly, they are living with unhealthy and degraded environment, which leads to the emergence of various diseases. They are also socio-economically vulnerable due to lack of employment, low income, poor housing conditions which creates many socio-economic crises in the squatters (Marasini & Chidi, 2021). In addition, the children from the poorest wealth quintile, particularly in urban squatter areas are 4.5 times more likely to die before the age of five than those of the wealthiest urban quintile (Ministry of Health and Population: MoHP, 2016).

Access barrier to health care is an international phenomenon. Poverty has been identified as a critical component of low access across low-income countries (Santalahti et al., 2020). In many cities, the urban poor who live in slums and squatters face challenges in accessing health services due to their inability to pay out-of-pocket expenses for high-cost health services (World Health Organization: WHO & UN-HABITAT, 2010).

It is estimated that at least half of the people in the world do not receive the health services they need. Similarly, in the western pacific region nearly 60% people had lack of access to essential health services. In Southeast Asia, more than 130 million people were not in access to essential healthcare services (WHO, 2020). In Nepal, the largest source of funding for health services is out-of-pocket expenditure with 49% source of funding, which is one of the

most unjust and regressive methods of doing so. Thus, when seeking care, citizens face unjust prices, as well as inappropriate, insufficient, and unnecessary care due to the lack of comprehensive regulatory fee structure. The heavy out-of-pocket payment increases financial barriers to poverty and causes further poverty (Ministry of Health and Population: MoHP, 2015). Around 43% of the poorest Nepalese did not seek care for their last illnesses in 2012 due to heavy out-of-pocket expenses (Dahal et al., 2017).

Government of Nepal has endorsed different strategies for universal coverage of health services. The Constitution of Nepal, 2016 states that every citizen should have the right to free basic health services from the state, no one should be deprived of health services and every citizen have equal access to health service (Constitution of Nepal, 2016). The National Health Policy, 2019 has emphasized universal access of comprehensive quality services with special focus to marginalized, dalit, Indigenous community and the urban poor (Department of Health Services: DoHS, 2019). Similarly, Nepal Health Sector Strategy (2015-2020) focused on strengthening service delivery access and demand generation to underserved population (Ministry of Health and Population: MoHP, 2015).

People living in squatter and slum areas were the most vulnerable to preventable communicable and non-communicable diseases but had low access of healthcare services (Ministry of Health and Population: MoHP & Ministry of Local Development: MoLD, 2010). Most of the urban areas were rapidly turning into slums and squatters due to shortcomings in the provision of infrastructure and services. More than 10% of the urban population of Kathmandu valley lives in informal settlements such as urban squatters and slums. However, they have limited access to health services because of various limitations (Ministry of Urban Development: MoUD, 2016).

The utilization of health services among the urban poor women particularly in the urban squatters is extremely low. For example, the utilization of antenatal care services among urban women is 72% but it is 38% among urban poor women residing in squatter settlements. Similarly, 85% urban women have childbirth with the assistance of skilled providers, and 90% urban children receive vaccinations while it is 45% and 77% respectively among the urban poor women (Ministry of Health and Population: MoHP, 2016). Through this, it is clear that there are high unmet needs of maternal health care services to women living in the squatters of Nepal (Ranabhat et al., 2021).

Likewise, utilization of Basic Primary Health Care services among urban poor, particularly in slums and squatter settlements is also extremely low (Ministry of Health and Population: MoHP, 2015). It is assumed that many Nepalese citizens are facing several barriers such as financial, socio cultural, geographical, and institutional in accessing quality healthcare services. There may be wide variations in health service availability, utilization and health status

across different socio-economic and geographic populations indicating the challenges to access quality health services. The urban poor like squatter residents are more sufferers with limited access to healthcare (Ministry of Health and Population: MoHP, 2015).

However, there is not enough information regarding the access barriers to health care services among squatter residents but it is particularly important to understand the issue. Therefore, this study aimed to explore the barriers of health services among the urban squatters communities of Kathmandu valley. The study findings are applicable to health policy makers, planners, implementers, and academicians involving in the health sector fields.

METHODS AND MATERIALS

This is a qualitative, non-intervention study. The study is based on Key Informants Interview (KIIs) with healthcare providers working in government run local health institutions in the periphery of urban squatter communities of Kathmandu valley.

The Lumanti Support Group, a national NGO, identified five riversides located squatter settlements clusters, namely Bagmati, Bishnumati, Hanumante, Dhobikhola and Tukucha in Kathmandu valley. There was also one additional cluster with non-riverside squatter settlements. (Lumanti, 2008). The same clusters still existed today and hence, in this study the same clusters were used. The study represents all six clusters i.e., five riverside clusters and one non-riverside cluster.

For data collection, the health centers located at the periphery of each six clusters were identified. One health center representing each cluster within the nearest proximity was selected for data collection. Health workers working in the respective centers were approached for KII. From each cluster, three interviews were conducted among the health workers. Thus, a total of 18 KIIs were conducted. Each participant was selected purposively visiting the local health facilities around the location of squatter communities. Written consent was received from each respondent. Data was collected in December 2020 using KII guidelines. The study objectives was shared with the participants. Trained moderator was responsible for facilitating the interview while a note taker was used for note keeping. In-depth discussion was done to explore respondent's perception on the barriers to access health service among the urban squatter settlements. Voice recorder was also used to capture the discussions.

Narrative approaches were used for data analysis. The collected data was transcribed and translated into English, verified through the raw field notes. The transcribed data and the raw field notes were reviewed thoroughly to develop a coding framework to identify the barriers to accessing healthcare services among urban slum communities, comprising a list of themes. The transcribed data and

the field notes were studied carefully, and the data was classified and coded into various themes based on the coding framework. Consensus was developed among the researchers to identify the most appropriate codes based on the data analyzed. Inferences were drawn on the basis of the identified themes and presented with the results under each theme. Conclusions were made from the identified themes.

FINDINGS

Of the total 18 healthcare providers, eight were males and ten were females having work experiences ranging from 6-17 years. Two major themes were identified from the analysis. The identified themes included supply side barriers and demand side barriers. Demand-side barriers are defined as individual, household or community characteristics that influence the demand for health services whereas supply side barriers are those characteristics of health system that exists beyond the control of potential health service users, such as health physical facilities, drugs, cost of services, not availability of services, poor quality of services (Bezabih et al., 2018). Seven barriers from supply side and five barriers from demand side were identified from the analysis.

Supply Side Barriers

Lack of Physical Facilities

Almost all the healthcare providers mentioned that inadequate physical facilities were one of the major barriers of health service access in the urban squatters. They stated that almost all health facilities had inadequate physical facilities. As stated by the respondents, almost health facilities were operated in rented houses or old buildings provided by the local authorities which were very congested, without adequate rooms for services, no waiting spaces, inadequate furniture, and lack of water supply and toilets.

One of the in-charge of health post (HP) explained *"My HP is very congested; we have only two rooms for services. We don't have separate rooms for family planning (FP), antenatal care (ANC), postnatal care (PNC), health education and counseling services. We do not have sufficient space for patients waiting. We have only one toilet, not enough water; we purchase jar water for drinking. So how could we provide quality services to the community with better access in this situation?"*

Similarly, a senior Auxiliary Nurse Midwife (ANM) expressed *"The physical facilities are the most vital part for quality and access to health services. We do not have own building and there is not sufficient spaces. This rented building is very congested. We provide multiple services from a single room. We*

cannot organize regular health education activities. Also, maintaining privacy for FP, ANC and PNC and reproductive health services is difficult."

Inadequate Human Resources and Training

Most of the respondents stated that current number of health workers could not meet the increasing demand of public. They opined that addition healthcare providers was necessary. They added that for a long time they had not received any in-service training for updating knowledge and skill to tackle the emerging health problems. Healthcare providers viewed that technically competent, motivated, and socially responsible staff could make better access to services.

A senior nurse stated *"We do not have enough staff in our Primary Health Care Center (PHCC) as per sanctioned posts. We have shortage of 4 paramedical and 2 nursing staffs. The workload is high, and we cannot provide effective services. Because of lack of trained nurses, we could not provide long-acting contraceptives like Intrauterine Devices (IUD) and Implants. Adequate number of staff is essential for making the health services access to the community."*

One of the ANM mentioned "*I have not received training for IUD and Implant services. People seek delivery services, but we do not have a birth center and none of us have received Skilled Birth Attendant (SBA) training. If we provide IUDs, Implants, and delivery services to the people, particularly the poor would have more access to FP and safe motherhood services."*

Lack of Availability of Health Services

All the respondents explained that local health institutions were very limited-service components, but people expected more services. They added that people also expected laboratory services, child birthing facilities, long-acting contraceptives, and other specialty health services. Respondents further added that people also demanded for the treatment of heart and kidney problems, diabetes, arthritis, Chronic Obstructive Pulmonary Diseases (COPD), Alzheimer's disease etc. They opined that local health institutions were not able to provide all kinds of services, but they suggested adding some basic services such as laboratory facilities; delivery services; medical abortion; long-acting contraceptives and Adolescent Sexual and Reproductive Health (ASRH) services.

One HP in-charge mentioned *"People demand all kind of services but our health facilities provide extremely limited services. People's demands are increasing day by day. People expect laboratory services, birthing facilities, and treatment of special cases like heart and kidney problems, diabetes, arthritis, COPD, Alzheimer's disease etc. We have limitation but better to add some*

components like birthing centers, basic laboratory facility and addition of some first level of antihypertensive, anti-diabetic and other relevant drugs."

A Nurse added *"We refer the patients to hospitals for basic laboratory services; ASRH services; FP methods like IUD and Implants; and for normal childbirth. These are important basic health services, but we don't have them here. Hospital does not provide free services, private hospitals charge extremely high, and the poor people cannot afford for the services."*

Poor Information and Communication

Most of the healthcare providers believed that poor information and communication reduced the choices and access to health services. Because of congested spaces and inadequate rooms, almost health facilities had not implemented the planned regular health communication activities, but it was optional at the individual level. They stated that because of poor health communication some people were unaware of the particular health services and information on preventing diseases and promoting health.

One Nurse stated "*Appropriate information, education, and counseling activities promote the healthy behavior, prevent disease, and make individuals aware of the availability of health services. We do not conduct regular health education sessions because of inadequate rooms and spaces. Some women are not aware about the kinds of contraceptives and maternal health services that are available. People are unaware about the particular services that we have here."*

Inadequate Free Essential Drugs

Almost all healthcare providers viewed that inadequate free essential drugs reduces the access to health services. They stated that current provision of free essential drugs of 35 items for HP and 58 items for PHCC was not enough for both in number of items and quantity. Because of inadequate drugs some time they could not manage even simple health problems. Most of the healthcare providers stated that they advised the people to purchase drugs in the private pharmacies, but the poor people cannot afford the cost of medicines.

One nurse stated *"Current provision of free essential drugs is not enough both in number of items and quantity supplied. In the HP level, the provision of essential drugs items is only 35 and it is 58 for PHCC. It does not cover the drugs for the most basic health problems as well. The quantity supplied is also not enough. People demand all kind of drugs, but we only have limited drugs.*

One HP in-charge explained *"Some time we could not manage even simple health problems because of lack of free essential drugs. We prescribe medicines and advise to purchase them from the local pharmacies, but the poor people*

could not purchase them. So, the poor people particularly in the squatter community are deprived of even the basic health services."

Poor Quality Services

Healthcare providers expressed that congested space, limited rooms, lack of waiting spaces, lack of effective health communication, inadequate drugs, less competent providers, inadequate service components, poor physical facilities were hindering the quality of local health institutions.
One of the nurses pointed *"We are facing difficulties because of lack of sufficient rooms and space for services and other physical facilities such as toilets, water supply, inadequate drugs etc. There is no separate space for health education, FP, ANC, PNC services and patients waiting. These situations create poor quality making less access to health services."*

High Cost of Health Services

All healthcare providers perceived that costs determine the access to health services. They further added that local level health institutions provide basic health services free of cost to all, but they do not cover even the most basic services. Their limitation was that even for the simple health problems, patients were advised to buy drugs, but the poor could not afford the cost. For the higher-level problems, patients were referred to hospitals, but the poor could not access the hospital services even in the government hospital due to the costs.

One of the HP in-charge expressed *"the poor people are deprived of even basic health services because of high cost. We have limited health services here. We don't have laboratory services, or sufficient medicines. More often, patients are advised to purchase drugs, but the poor people could not afford the cost. We refer patients to hospitals frequently even for basic health services. Patients need to pay hospital charges, but the poor could not even pay for it."*

Demand Side Barriers

Poverty

Almost all the respondents opined that poverty was main hindrance of health service access. The free basic health services of local health institutions were limited in terms of coverage and pattern of diseases, but the poor people required more and more frequent services because of their vulnerability. Public demand could not be met by local health institutions. Respondents further mentioned that even the local level free health services were also less access to poor because of their outing for daily earning rather than visiting health facilities.

A senior AHW mentioned *"The poor people hardly earn Rs.700-800 per day. they cannot save money because they had to feed their children. The medical cost is remarkably high; even for a simple case patient needs to pay about Rs. 3000-4000 or even more. The cost would be extremely high in case of hospitalization or for surgery. The cost is beyond the capacity of poor people."*

Low level of Awareness

All the healthcare providers expressed that people particularly in squatter community were unaware of the health issues. People are unaware about preventing, promoting, and protecting their health. Respondents added that people of squatter communities were vulnerable to different diseases because of their poor living conditions; poor practice of waste disposal; poor personal hygiene; unhygienic food practices etc. Respondents further reported that the utilization of FP services, ANC, PNC, child immunization and other general health services was low in the squatter community because of poor awareness.

A senior AHW responded *"The poor people particularly squatter communities often practice unhealthy behavior such as poor personal hygiene, eating stale food, unhygienic food practices, unhygienic surrounding environment, lack of household sanitation, unhygienic disposal of waste etc. These activities promotes disease conditions like diarrhea, jaundice, intestinal worms, typhoid fever, and skin infections. Most of the people in squatter have lack of knowledge on health issues."*

One of the ANM stated *"Because of lack of awareness, the utilization of health services by squatter community is low. They have low utilization of FP services, ANC and PNC services and child immunization. For other general health problems also they seek less services, may be due to less concern on health issues or lacking time to visit health facilities.*"

Gender Discrimination

Most of the health care providers expressed that gender discrimination was also, a barrier of health services particularly among the poor women. They added that there was discrimination to female particularly in low socioeconomic status family. Most of the respondents expressed that female could not decide to seek health services like FP, safe abortion, and maternal health services without permission of husbands.

A senior nurse mentioned *"In the poor family like squatter community, there is discrimination to the female. Females cannot decide for themselves. Without husband's permission female cannot use FP services, reproductive health, ANC, and PNC services. For other general services too female need to take permission."*

Lack of Social Support

Most of the health care providers responded that lack of social support system makes less access of health services particularly among the poor. They added that that there was no established social support system in squatter settlements, however, people support each other only if they have close relationship. Respondents opined that during sickness the poor family required funds for medical costs and other help. But most often the poor could not get any such support.

An in-charge of HP expressed *"Community support system is lacking in urban squatters. Lack of support does not affect the wealthy families, but the poor families are affected more. The poor needs money and other help during sickness. If their society does not help, the poor cannot get services easily."*

Lack of Community Participation

Most of the healthcare providers believed that lack of community involvement was also a barrier to access healthcare services. Respondents added that there was no community support to improve local health system. They added that people come for services and receive health services whatever available. Sometime people blame the health facility for not having enough drugs and services. Healthcare providers viewed that people could strengthen local health services by supporting physical facilities and engaging in health facilities management.

A senior Health Assistant (HA) viewed *"Local people's participation for There is almost nothing to support better health services. People are not concerned about the health facility, its operation, the activities being conducted, the problems being faced by the health facilities and how they can support. They do not take part in any activities. Health services would be more accessible if community takes part for managing the local health facility."*

DISCUSSIONS

This study aimed to explore the barriers of health services access among the urban squatters. While analysis the information various barriers related to supply and demand sides were explored.

Inadequate Physical Facilities

Inadequate physical facilities were one of the demand side barriers to access health services. Because of lack of sufficient spaces, physical facilities and infrastructure health facilities were facing difficulties for operating various

activities such as FP, ANC, PNC, and health education services. A study by Luxon, 2015 also stated that inadequate physical infrastructure reduces the access and standards of healthcare services for all patients (Luxon, 2015).

Inadequate Human Resources

Inadequate and less competent human resources were hindering health service access particularly to the poor people. Current structure of human resources was not sufficient so they could not serve effective services. Lack of public health-oriented personnel had limited the preventive activities. Because of long time lacking in-services, training was creating less competent healthcare providers. A study explored that adequate and competent human resources management should be strategic priority to achieve better access and outcomes of healthcare (Kabene et al., 2006).

Lack of Availability of Services

The lack of availability of comprehensive basic health services was another barrier to access for the poor people of squatter settlements. Almost all the local health institutions had lacked
even some basic health services like long-acting contraceptives; normal delivery of child, ASRH friendly services, safe abortion, regular health education, basic laboratory facilities. For these services, people had to visit hospitals, but the poor could not the pay the hospital services.

Poor Health Communication

Health communication plays a vital role for making access services through creating awareness on service availability and option for choice. Health education also makes aware on disease prevention and health promotion. Health communication was just in optional basis in all the health institutions. People were deprived of their right to health information which might have reduced the access of services. Public health experts recognized similar facts that health education was the vital for disease prevention, health promotion and quality of life with accessing the health services (Tulane University, 2020).

Inadequate Free Essential Drugs

Inadequate free essential drugs were the main demand side barriers to access health services for the poor and squatter communities. Almost all the local health institutions had inadequate free essential drugs. Even for the basic health problems people had to purchase the medicines but the poor people who earn

daily could not afford the cost. The poor could not manage even two meals. There are nearly 2 billion people who had no access to basic medicines, causing a cascade of preventable misery and suffering with no access to health services (World Health Organization: WHO, 2017a).

Low Quality of Services

The low quality of health services was another barrier to access. The congested working space, limited number of rooms, lack of waiting spaces, lack of effective health communication, inadequate drugs, technically less competencies, inadequate service component, poor physical facilities all were creating low quality health services, consequently hindering the access of services. In 2018, WHO also mentioned that inaccurate diagnosis; medication errors, inappropriate treatment, unsafe clinical practices, or providers who lack adequate training existed in all countries which contributing barriers of health services (WHO, 2018).

Cost of Health Services

The cost of health services was one of the most hindering factors of health services access. The local level health institutions had even lacked many basic health services components including free essential medicines. The choice of people was to seek hospital services but was not free of cost. Furthermore, private hospitals charged extremely highly. This was beyond the capacity of many poor people. The cost was also barriers to other countries too. In 2015, 16% of Australians people had forgone healthcare due to cost of health services (Corscadden et al., 2016). Similarly, in 2014, 18% households and 32% disabled people of Finland had experienced cost-related barrier (Aaltonen et al., 2014).

Poverty

The poverty was one of the demand side barriers of health service particularly to urban squatters. The poor people those who earn Rs. 700-800 daily were unable to get hospital services because of high cost. The free basic health services of local health institutions were limited. Government did not provide hospital service free of cost. The cost of private sector was unacceptably high for almost people. The World Bank, 2014 also mentioned that poverty was a major cause of ill health and a barrier to accessing healthcare and stated further that poor people could not purchase things needed for good health including medicines (World Bank Group, 2022). Similarly, a report from the World Bank and WHO in 2017 reported that at least half of the world's population could not obtain essential health services because of poverty and added that each year,

large numbers of households were being pushed into poverty because of paying for health care out of their own pockets (World Health Organization: WHO, 2017).

Lack of Awareness

Lack of awareness was another demand side barrier to access health services. Particularly, the poor people like the squatter community were unaware for the promotion of their health and to protect them from disease risk factors. They were vulnerable to many diseases because of poor living conditions; unhygienic food practices, poor personal hygiene, and bad household sanitation. Due to lack of awareness the poor ignored health services. The squatter community people were also unaware of the types of services available in their communities.

Gender Discrimination

Women had less access to health services because they could not use FP, safe abortion and maternal health services without husband's permission. Similar situation was in other countries too. In 2020, about 32% women of Central Malawian reported that they had barriers to healthcare because of traditional gender roles (Azad et al., 2020). Similarly, in Nigeria, 60% providers reported that women could not choose FP services without consent of husbands (Oduenyi et al., 2021).

Lack of Social Support

The lack of social support can also be considered a barrier**.** Because of lack of social support networks, most families could not get funds and other support while they got sick. Lack of funds and other support of their society during sickness contributed to poor access to the poor people.

Poor Community Support

The nature of community was more demanding rather than supporting for supporting the local health services. Local support could contribute for improving physical facilities, available of essential drugs and engaging in management that eventually could improve the access of services.

CONCLUSIONS

The study explored that the people of urban squatters had different barriers to access healthcare services. The barriers were related to supply side as well as demand side. The supply side barriers were lack of physical facilities; inadequate human resources; lack of availability of services; poor health communication; inadequate essential drugs; poor quality of services and cost of services. Similarly, the demand side barriers were poverty; poor awareness; gender discrimination; lack of social support system and poor community support.

Improving the access to health services in urban squatter government need to strengthen the local health institutions with providing adequate physical facilities; adding competent healthcare providers; adding basic health service components; strengthening health communication activities; supplying adequate essential drugs; enhancing quality of services; and increasing the universal free health coverage. Similarly, the local government needs to implement different socio-economic activities such as income generating, skill training, employment, awareness creation, women empowerment, and community involvement for managing local health institutions.

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