

## *Facilitators of Adolescent Girls' Access to Sexual and Reproductive Health Services in Iran: A Qualitative Study*

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### **Abstract**

**Background:** Investment in the adolescents' health is an effective way to improve the public health.

**Objectives:** This study aimed to explore the views and experiences of adolescent girls and key adults to identify the facilitators of access to sexual and reproductive health services among Iranian adolescent girls.

**Methods:** In this qualitative study, the data were gathered through focus groups and semi-structured interviews with 247 adolescent girls and 71 key adults in Iran. The collected data were coded and categorized using a content analysis method in MAXQDA v10.

**Results:** The main facilitators of Iranian adolescent girls' access to reproductive health services were classified into five categories: 1) Factors associated with policymaking, such as governmental support; 2) benefiting from the religion's potentials; 3) social and cultural factors, such as creating a supportive environment in the community; 4) public participation; and 5) factors associated with the methods of service delivery.

**Conclusion:** The governments' acceptance of sexual health education shortcomings is the most important factor affecting the successful implementation of reproductive health programs for Iranian adolescents. Overall, increasing public participation and intersectional collaboration, besides creating a supportive environment in the community, is the next step in improving sexual health education.

**Keywords:** *qualitative research, adolescent girls, sexual health, reproductive health, facilities*

### **Introduction**

Reproductive health is a key aspect of human development [1]. In Iran, approximately 25.1% of the population is aged between 15 and 29 years [2]. Sexuality is generally an important phenomenon, especially in this age group. Adolescents and young adults are exposed to sexual issues and activities through mass media, which lack accurate information about sex, fertility, and reproductive health [3]. The Global

Health Statistics 2014 showed that about 16 million girls, aged 15-19 years, and about one million girls under 15 years give birth every year, mostly in low- and middle-income countries. Also, complications during pregnancy and childbirth are the second cause of death in 15- to 19-year-old girls worldwide. Every year, about three million girls, aged 15-19 years, undergo unsafe abortions [4]. The onset of puberty in girls and boys has gradually declined around the world,

while the age of marriage has increased in most countries in the last decades, thereby increasing the likelihood of adolescents' engagement in premarital sexual activities [5].

One of the Sustainable Development Goals (SDG 3) is that by 2030, the world should ensure universal access to sexual and reproductive health services [6]. However, reproductive health for adolescents is neglected in most health systems of developing countries [7]. In Iran, the age range of most HIV-positive patients (40%) is 25-34 years, followed by 35-43 years. It is clear that a high percentage of HIV infections occur during adolescence or youth due to the long incubation period of the virus [8]. Evidence shows that a significant minority of girls and a relatively larger number of boys start sex before marriage, despite its unconventionality and legal or religious barriers [9,10]. In a previous study, more than 21% of boys and 5.5% of girls in the age group of 15-24 years had extramarital sex, and also, 27.6% of girls and 57.5% of boys had more than one sexual partner [11]. Although these figures are much lower than the global statistics, they are commonly lower than the actual values due to the sensitivity of sexual issues [12].

An adolescent's sexual and reproductive health is strongly associated with his/her social, cultural, and economic status. Access to sexual and reproductive health and sources of education, information, and support varies widely in different areas [13-15], and these variations demand country-level analyses of the patterns. In a systematic review of women's views and experiences of access to sexual and reproductive health in Australia, the main barriers/facilitators were personal experiences of access to health services, women's interactions with the healthcare system, and women's experiences of communication with healthcare providers [16]. In

a scoping review of the barriers and facilitators of sexual and reproductive health and the rights of young people in refugee contexts, 19 barrier subcategories and 14 facilitator subcategories were identified at the individual, social, institutional, health system, and structural levels [17]. In another study, facilitators of adolescents' access to sexual/reproductive health services were few and included prioritizing school-aged adolescents and creating an environment for partnership about adolescent health issues [18].

Generally, our understanding of the factors accelerating the use of reproductive health services by Iranian adolescent girls is very limited. Therefore, the present study aimed to identify the facilitators of access to reproductive health services in Iranian female adolescents.

### **Methods**

This qualitative research was carried out based on the attitudes and beliefs of eligible individuals, including adolescent girls and key adults (Table 1), from January to December 2015. The guidelines for conducting the interviews were set following a review of relevant publications, as well as guidelines developed by the World Health Organization (WHO) [19,20], consistent with the Iranian culture. Data were collected through focus-group discussions with 247 high-school girls and 26 mothers in one of the school classrooms by one of the researchers (second researcher), who was a reproductive health student and an assistant researcher. Also, individual, in-depth, semi-structured interviews were conducted with 45 key adults with different backgrounds and expertise in Tehran, Mashhad, Shahrud, and Qom, Iran, by one of the researchers (second researcher). If necessary, further exploration or note-taking was performed.

Table 1: The study participants and the main focus of investigations

Study participants	Number	Main focus of the investigation
Health policymakers	8	Adults
NGO and governmental or international directors of health programs	14	<ul style="list-style-type: none"> <li>▶ Extent and characteristics of risky sexual behaviors among adolescents</li> <li>▶ The most common reproductive health problems of adolescents</li> </ul>
Clergymen	7	<ul style="list-style-type: none"> <li>▶ The prevalence of risky sexual behaviors among adolescents</li> </ul>
Health service providers	3	<ul style="list-style-type: none"> <li>▶ The existing policymaking strategies and programs to meet the adolescents' needs</li> </ul>
Mothers	26	<ul style="list-style-type: none"> <li>▶ Access to reproductive health services for related problems</li> <li>▶ Perspectives about future programs, services, and recommendations for improvement</li> <li>▶ Religious views about the ASRH information and services</li> <li>▶ Knowledge of and attitudes toward ASRH services</li> <li>▶ Involvement in health education at schools</li> </ul>
Counseling teachers	11	
Sociologists	2	
<b>Adolescents</b>	<b>247</b>	Adolescents <ul style="list-style-type: none"> <li>▶ The most common reproductive health problems of the adolescents</li> <li>▶ Discussions about sexual issues with mothers</li> <li>▶ Opinions about YFS and expansion of ASRH services</li> <li>▶ Protective practices</li> <li>▶ Feelings about sex</li> <li>▶ School sex education</li> <li>▶ Main sources of information</li> <li>▶ Sexual risk-taking</li> </ul>

**ASRH, Adolescent Sexual and Reproductive Health; NGO, Non-Governmental Organization; YFS, Youth-Friendly Services.**

The focus-group discussions were conducted with only adolescents and their mothers separately. For forming the focus group, coordination was made with the school principals, who invited interested mothers to meetings at schools (where their daughters were studying) on a specific time and day. The researchers attempted to include mothers with different levels of education and socioeconomic status in one meeting; their common feature was having one or more teenage daughters studying at the schools. After the meeting, the researcher introduced herself and the assistant researcher to the mothers and explained the objectives of the meeting. The participants were then asked for their permission to record the sessions; they were also asked to introduce themselves briefly for familiarization.

The main researcher explained the rules of the session to the participants and allowed them to talk by asking simple and general questions. After the so-called "freezing of the session",

challenging questions were asked about the adolescent reproductive and sexual health. The meeting was led by the principal researcher; during discussions, attempts were made not to focus on a particular person and to involve everyone in the discussions. Moreover, the trained assistant researcher helped the main researcher to record the mothers' conversations throughout the session. At the end of the session, the principal investigator summarized the general opinions and sought the mothers' opinions for confirmation. The general principles for the adolescents' meetings were the same as those for the mothers; the meetings were held in the prayer hall of the school or one of the classrooms.

In this study, triangulation was used to increase the reliability of data. The adequacy of the sample size was based on the saturation of collected data. The number of participants in the focus-group discussions was 6-12. The length of discussions and interviews was on average 59 and 31-60

minutes, respectively. The inclusion criteria in this study were adolescent girls, aged 14-19 years, who were unmarried and lived with their parents. The girls were in grades 8-12 of high school from different disciplines and socioeconomic backgrounds. Although there was homogeneity within the groups, between-group heterogeneity was observed (age, academic grade, discipline, and socioeconomic status).

The qualified healthcare providers in this study had work experience in youth-friendly centers; others were selected if they had a history of work experience with adolescents. This study was approved by the Ethics Committee of Shahrud University of Medical Sciences, Shahrud, Iran (ethics code: 910/02). Participation in this study was completely voluntary. After the objectives of the study were explained to the participants, oral consent was obtained. The subjects were also informed that they could withdraw from the study at any time. Full anonymity during focus-group discussions and interviews was also observed. All interviews and focus-group discussions were recorded digitally after obtaining the interviewees' consent, and then, transcribed and compared with the manually written manuscript. For the content analysis, the data were coded and categorized using MAXQDA v10. For this

purpose, the researcher listened to all interviews and group discussions twice, transcribed them, and reviewed them several times to gain an overall view. First, the units of analysis, including all interviews and written notes, were determined, and then, semantic units, including paragraphs, statements, and meaningful words, were specified. The initial codes and abstract codes were extracted during the processes of reduction, compression, and summarization, and then, suitable labels were assigned. In the next step, the same codes were integrated, and codes with similar concepts were used to create the subcategories. The main categories with more general and abstract concepts were formed by continuing the inductive approach for the subcategories. To ensure the trustworthiness of the findings, member checking and peer debriefing were used.

### Results

According to the participants' perceptions and experiences, strategies were proposed to facilitate the adolescent girls' access to reproductive health services. These facilitators were classified into 1245 codes, five categories, and 12 subcategories (Table 2).

*Table 2: The main categories and subcategories*

Categories	Main categories	Subcategories
1	Factors associated with policymaking	- Governmental support - Prioritizing the health of adolescents
2	Benefiting from the religion's potentials	- Participation of clergymen in education - Use of religion as a facilitator for planning and implementation of programs
3	Social and cultural factors	- Improvement of the cultural context - Creating a supportive environment in the community
4	Public participation	- Intersectional cooperation - Collaboration and active participation of adolescents
5	Factors associated with the methods of service delivery	- Human factors - Physical factors - Technical factors - Motivational factors

#### **Category 1: Factors associated with policymaking**

Governmental policies regarding adolescent sexual health have both direct and indirect effects on facilitating the adolescents' access to reproductive health services:

“The first step is to consider the problem and identify its magnitude, since some Iranian adolescents are engaging in sexual activities before marriage...Everyone should know that we have this problem, and officials, managers, experts, decision-makers, as well as policymakers, need to accept and acknowledge it. As soon as the

extent of the problem is determined, we need to develop an appropriate strategy.” (policymaker, male, 47 years old)

Some governmental and non-governmental health managers and policymakers believed that the integration of reproductive health programs in the current healthcare system is essential for adolescents:

“There should be legal healthcare services for adolescents. We need to define these services in the system. We should monitor the puberty symptoms in adolescents as soon as they reach puberty the same way that we care for our children until they can walk on their own. When it comes to the risks of sexual intercourse, we must pay particular attention to these issues and talk to them; this breaks the ice...These measures allow us to understand and solve their problems.” (policymaker, male, 47 years old)

### **Category 2: Benefiting from the religion’s potentials**

In Islam, there are numerous sayings about sexual matters, and a strong emphasis has been placed on sex education in different stages of life, even for children and adolescents to pass this critical period:

“There are thousands of narratives about sexuality. Now, some people argue that sexuality should be hidden and overlooked, while we see that all Imams have talked about this issue.” (clergyman, 47 years old)

Some adults believed that models of religious education should be updated:

“Models of education and training in our religion should be modified and must be consistent with the actual needs of young people. Now, I think that clergymen are not doing anything special in this area.” (governmental health program director, male, 45 years old)

Given the public's trust and confidence in mosques, use of their capacity to provide information for the adolescents can act as a facilitator of access to reproductive health services:

“As a matter of fact, mosques can provide enough information in this area...The public trust these places. I mean if mosques start relevant activities, most people will allow their children to come and learn.” (clergyman, 52 years old)

### **Category 3: Social and cultural factors**

This category comprised of two subcategories, that is, development of cultural factors and creating a supportive environment in the community. To eradicate cultural taboos restricting the adolescent girls’ access to reproductive health services, an appropriate cultural background should be provided:

“I think we should start this education slowly and steadily...If we start with an infrastructure-oriented approach and teach the kids from an early age, for example from adolescence or even the end of primary school, based on their age, they will not face similar problems with their children in the future.” (counseling teacher, female, 43 years old)

“High-ranking officials, who are known by the society as religious, political, or scientific figures, must break this taboo. For example, if our religious leaders confirm that sexual issues do not conflict with religion, one cannot claim that they are against religion. I think this is the first and the most important step.” (policymaker, male, 51 years old)

“Regarding this issue, not only we should clarify that it is a necessity for human health, but also we must explain it as a necessity from a religious point of view. As explained, religious authorities inevitably seek to practice religion while considering these issues.” (clergyman, 47 years old)

“It is important where the services are delivered. It should not be a busy or scary environment or somewhere nobody trusts.” (adolescent girl, 17 years old)

“First, the parents must be aware of these issues so that they can inform their daughters and reduce high social sensitivities in this area. We should work more with the parents to reduce social sensitivities and stigmas.” (policymaker, female, 43 years old)

### **Category 4: Public participation**

Intersectional collaboration and active participation of adolescents are the subcategories related to the concept of public participation as one of the main facilitators of providing access to reproductive health services for adolescents:

“We trained some adolescents as peers. They acquired complete scientific knowledge about sexual issues. This information could be helpful, regardless of their education level, and could

indicate the importance of these issues.” (health service provider, female, 36 years old)

#### **Category 5: Factors associated with methods of service delivery**

This category included different subcategories, such as human, physical, technical, and motivational factors. Considering the characteristics and attitudes of adolescents, special methods need to be applied to provide reproductive health services:

“Keeping secrets is of utmost importance. Health providers should be able to talk privately with us. For example, if I am with my mother, they should not tell everything in front of her.” (adolescent girl, 18 years old)

“They should not be indifferent. Teenagers may feel uncomfortable or regretful, but the doctor should not disappoint them by their behavior. They should not behave in a way that makes us feel guilty or regret seeking help.” (adolescent girl, 17 years old)

“There should be a governmental center. When our parents think that the center is run by the government, they trust it and let us visit.” (adolescent girl, 14 years old)

“Sometimes some problems happen, and we cannot visit a healthcare center. It would be good if there was a phone number that we could call and work out our problems.” (adolescent girl, 19 years old)

“There should be a clean restroom, and the walls should have comforting and bright colors. The environment should not smell bad. When we enter such centers, they should not make us feel stressed and anxious. It is much better if the healthcare centers are solely dedicated to adolescents in the afternoons.” (adolescent girl, 16 years old)

#### **Discussion**

Governments, especially in developing countries, can develop effective and sustainable intervention programs for the reproductive health of adolescents. They also play a vital role in providing human and financial resources to overcome the obstacles of promoting adolescent sexual and reproductive health. Therefore, political support and governmental commitment can be utilized for the implementation and success of such programs [21,22]. In this regard, policymakers in the Ministry of Health and

Medical Education of Iran need to attract the public's support for the delivery of such services through continuous interactions with key adults, especially parents and religious scholars, and explain the benefits of evidence-based delivery of all reproductive health services to adolescents.

Based on the findings of this study, most mothers tend to collect the necessary information about the adolescent sexual and reproductive health in order to discuss it with their daughters; In this regard, Huston and colleagues argued that parents, participating in meetings and seminars on sex education, can talk with adolescents about sex easier [23]. Furthermore, the WHO has placed great emphasis on the necessity of parental discussions with children [24]. In a conservative country like Iran, where the culture has a significant impact on the individuals' sexual behaviors, the most important factor in the promotion of reproductive health in adolescent girls is creating a supportive, respectful, and empowering environment to help them use their potentials, master their skills, and access reproductive health information and services without embarrassment or guilt.

The Ministry of Health and Medical Education has recommended promoting the structure of all governmental healthcare centers to ensure the privacy of adolescents in service-delivery environments, because as mentioned earlier, maintaining the adolescents' privacy and information confidentiality is very important to encourage them to use reproductive health services. In this study, one of the proposed strategies to respect the students' privacy was setting specific hours for the delivery of services in the healthcare centers; these findings were consistent with the results of other studies in different contexts, such as Jordan and USA [15,18, 25].

The health needs of adolescents can be different from those of adults; therefore, healthcare professionals are required to have the knowledge and skills to provide services for the adolescents, particularly communication skills that are of great importance in interactions with adolescents. Based on the findings of this study, specific methods and trained personnel with adequate experience and familiarity with such interactions must provide services for the adolescents; these findings are in line with the results of a study by

Khalaf and Mengesha [15,16]. Moreover, the present findings indicated the need to increase positive interactions between professionals in charge of providing services and adolescent girls. These findings were consistent with the results of other studies in different contexts, such as Jordan, USA, and African countries [15,25-27]. According to the present findings, this need can be met by making the service providers sensitive to the necessity of reproductive health services for adolescents and building communication and counseling skills.

Research shows that young people require sexual and reproductive health services, depending on their biological, cognitive, and psychological characteristics, which determine their transition into adulthood [28]. In this study, adolescents preferred young service providers because they believed that these providers could better understand and respect them and avoid judgments; these findings were consistent with the results of other studies in different contexts, such as Nepal, UK, and African countries [13,27,28]. Furthermore, according to the results of this study, attention to the physical and technical characteristics of healthcare centers can be important for creating a sense of comfort in adolescents in service-providing centers. For example, the adolescents demanded in-person and phone-based counseling, attention to hygiene, and positive environments (e.g., suitable waiting rooms). These findings were consistent with the results of studies conducted in Jordan, Africa, and Lithuania [15,29,30].

The findings of this study also demonstrated that a safe environment for providing services is very important for adolescents. These findings were consistent with the results of a study by Khalaf . This study also indicated that motivational factors, such as providing popular services for adolescents (e.g., educational counseling along with reproductive health services), can be used to facilitate the access of adolescent girls to such services [31]. To provide effective reproductive health services for adolescents, not only service providers, but also users need to participate in the decision-making process and design of services; this ensures the suitability and relevance of specific programs [27,31]. These findings were consistent with the results of other studies in

different contexts, such as Jordan, Africa, and Bangladesh [15,27,31].

Based on the findings of the present study, if educational-informative programs are well-designed and implemented at schools in developing countries, such as Iran, where more than 85% of adolescents are studying at schools, interventions to promote adolescent health will be more cost-effective. If sex education programs, appropriate for the age and cultural/religious values of adolescents, are gradually incorporated into the school curricula, they can reduce sensitivities and stigmas at social levels. These findings were consistent with the results of another study conducted in a very different sociocultural context, that is, India [32].

According to the present study, Islam, contrary to the common belief, is not against sex education to adolescents, as all participating clergymen agreed with the basics of sex education [33-36]. On the other hand, in accordance with the findings of our study and research conducted in countries with different sociocultural backgrounds, Islam agrees with sex education to adolescents by specifying some boundaries. Since the objective of sex education according to Islamic and Western views is prompting a healthy perspective and providing sufficient information about sexual issues, sex education should involve training that can result in mental health and social compatibility. It also minimizes the consequences of social inconsistencies, behavioral disorders, and ethical issues [37,38]. Therefore, biological, psychological, moral, and cultural aspects should be considered in the context of sex education to provide an integrated approach and present adequate information about sexual issues.

In Iran, clergymen play a central role in the cultural and social lives of individuals. They also influence the value systems of communities in areas of morality, family, and reproductive health. Therefore, their support is critical for the success of interventions, considering its great impact on the successful experience of family planning programs. Although clergymen agreed with sex education for adolescents in this study, acceptance was not pervasive among them. In the present study, facilitating access to sexual and reproductive health services for adolescents was classified into five main categories. However, the type and extent of actions needed to operate these

facilitators vary in different countries with respect to their cultural, social, and religious backgrounds. For example, the actions of governments that accept premarital sex in adolescents can be very different from those of governments that consider it as a taboo. Overall, use of religion as a facilitator for planning and implementing adolescent sexual health programs in countries, such as Iran (where religion has a significant impact on the lives of individuals), is more effective than communities with different sociocultural contexts.

### Conclusion

In conclusion, according to the findings of the present study, the most important factor for the successful implementation of adolescent reproductive health programs in Iran is the government's acceptance of realities and political commitment to adolescent reproductive health programs in line with Iran's international obligations in the International Conference on Population and Development (ICPD). Investment in public participation can be made in the form of intersectional collaboration, particularly by incorporating the adolescents' participation in the design, implementation, monitoring, and evaluation of services and creating a supportive environment in the community. However, one of the limitations of this study was that the sample size was confined to adolescent girls who were single and studied at schools. It is recommended to conduct similar studies on adolescent boys in Iran.

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### Conflict of interest

None declared.

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