

# Iranian adolescent girls' barriers in accessing sexual and reproductive health information and services: a qualitative study

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## ABSTRACT

**Introduction** Adolescence is a critical period of transition from childhood to adulthood. In today's world, to pass through this period successfully it is necessary to have adequate information and knowledge about sexual and reproductive health (SRH) issues. In Iran, it is crucial that special attention be paid to reproductive health services for adolescents, especially for girls.

**Purpose** This study aimed to explore the views and experiences of adolescent girls and key adults around the barriers to access of Iranian adolescent girls to SRH information and services.

**Methods** In this qualitative study, data were gathered through focus groups and semi-structured interviews with 247 adolescent girls and 71 key adults including mothers, teachers, health providers, governmental, nongovernmental and international managers of health programmes, health policymakers, sociologists and clergy in four Iranian cities. Data were coded and categorised using content analysis by MAXQDA10.

**Results** The main barriers identified were classified in four categories: (1) social and cultural barriers such as taboos; (2) structural and administrative barriers such as inappropriate structure of the health system; (3) political barriers such as lack of an adopted strategy by the government and (4) non-use of religious potential.

**Conclusions** Adolescent SRH in Iran should be firmly established as a priority for government leaders and policymakers. They should try to provide those services that are consistent with the community's cultural and religious values for adolescent girls.

## INTRODUCTION

Adolescence is a period when risks are taken, but it is also a formative period during which lifestyles are learned and

## Key message points

- ▶ Adolescents should have access to appropriate sexual and reproductive health services.
- ▶ The first necessary step in the process of developing national policy is political recognition that there is a problem.

established.<sup>1</sup> Many studies have shown that provision of sexual and reproductive health (SRH) information and services to adolescents can have positive reproductive health outcomes.<sup>2</sup> Of the Iranian population of over 75 million, more than 16% are between the ages of 10 and 19 years. Although the Iranian government has developed a number of educational programmes such as HIV/AIDS, puberty, family life, and life skills for unmarried adolescents,<sup>3</sup> these are short and fail to cover some important topics. School curricula do not include sex education. In Iran, as in most developing countries, sexuality issues are seen as taboo for adolescents and sex is often a topic only for the married. The concept of adolescent SRH (ASRH) services is not well understood and is controversial. The government provides SRH services within the Maternal and Child Health/Family Planning (MCH/FP) programmes and this has not been restricted to married couples, but adolescents tend to shy away from using the services because health providers do not have adequate skills to work with adolescents and they have judgmental attitudes towards them.

In Iran any premarital or extramarital sexual relationships are considered unlawful<sup>4</sup> but studies have shown that despite societal and religious disapproval, some Iranian adolescents initiate sex before marriage and may therefore be at risk of unwanted pregnancy and of acquiring sexually transmitted infections or HIV.<sup>5</sup> One Iranian study showed that of an initial sample of 1385 adolescent boys aged 15–18 years, approximately 28% reported any lifetime sexual experience and 68% of sexually experienced adolescents reported either having multiple sexual partners or non-use of condoms.<sup>6</sup>

The aim of this study was to explore the views and experiences of adolescent girls and key adults regarding factors that prevent adolescent girls accessing and utilising SRH information and services.

## METHODS

This qualitative descriptive study was conducted during the period February–November 2012. The participants were aged 14–57 years and were from different backgrounds and levels of expertise. Purposive sampling and snowball sampling methods were used for selection of key adults, and adolescents were selected by using a multi-stage cluster sampling method. Data to be collected were selected using World Health Organization (WHO) guidelines<sup>7</sup> and a review of related literature. Data were collected by carrying out focus group discussions (FGDs) with 247 adolescent girls and 26 of their mothers and also through semi-structured interviews with 45 key adults including 8 health policymakers, 14 governmental, nongovernmental and international managers of health programmes, 3 health care providers, 7 members of the clergy, 2 sociologists and 11 school counsellors in four Iranian cities (Tehran, Mashhad, Shahrud and Qom) using appropriate sets of interview guidelines. Eligible adolescent girls were 14–19 years old, never married and lived with their parents; they were in school grades 8–12 with different fields of study and diverse socioeconomic situations; therefore, there was heterogeneity between groups but homogeneity within groups (age, socioeconomic situation, grade and field of study). The sample of key adults was based on their practical experience with adolescents' health issues. All the interviews were conducted at the office room of the interviewees and the focus groups with 6–12 participants were conducted in schools. The interviews and focus groups were recorded on two digital recorders with the consent of the interviewees and were then transcribed and compared with handwritten notes for reliability of interpretation. Triangulation of information sources was used to improve the reliability of the collected data. The duration of an interview was 35–60 minutes; the duration of FGDs was on average 59 minutes. When no new information was obtained from interviewees

the sampling was stopped. The main foci of investigation are shown in Table 1.

The local ethics committee approved the study. The researcher informed participants about the study purpose and verbal consent was obtained from them; they were made aware that participation was voluntary and that they were free to end the interviews at any time. Full anonymity was also ensured during the FGDs and interviews. Data were analysed using qualitative content analysis by MAXQDA10 (VERBI GmbH, Berlin, Germany). Credibility of research findings was obtained with member checking and peer debriefing.

## RESULTS

The present study has identified the following barriers to Iranian adolescent girls accessing SRH information and services.

### Cultural and social barriers

This study showed that health care-seeking behaviour of adolescents is poor and many of them did not seek reproductive health services from public health centres due to negative attitudes of health providers, lack of confidentiality, lack of awareness of place of delivery of service and information, and sociocultural expectations.

*"If I go to the health centre for solving my problem, probably the health provider will inform my mother and I don't like this."* [Girl, 17 years]

*"Once I went to a health centre to ask questions about my sexual health concerns from a midwife, she thought I'm loose."* [Girl, 15 years]

*"In our culture, girls shouldn't show their sexual needs and capabilities; as a result, they feel that they have to shy away and not seek care even when they need services."* [Sociologist, 35 years]

The present study revealed that some adolescent girls do not want it to be known when they are seeking services due to sociocultural unacceptability.

*"I prefer to get the service from someone who doesn't know me."* [Girl, 18 years]

This study showed that some mothers traditionally withhold sexual information from adolescents until marriage and are opposed to adolescents' access to SRH information and services due to concerns about early sexual relations and dropping out of school. Some mothers believed that public high schools should include some aspects of sex education in their instructional programmes due to their own embarrassment and lack of adequate information and knowledge of adolescents' sexuality issues

*"Our information about adolescents' sexuality is low; it's better the necessary information is taught to them in school."* [Mother, 46 years]

**Table 1** Study participants and main foci of investigation

Study participants	Mean age (years)	Main foci of investigation
Government representatives International and NGO Health Programme Directors	47.4	<b>Adults</b>
Religious leaders	50.4	<ul style="list-style-type: none"> <li>▶ Extent and characteristics of risky sexual behaviour among adolescents</li> <li>▶ Existing policy and programme strategies to meet adolescents' needs</li> <li>▶ Access to the reproductive health care services for related problems</li> <li>▶ Constraints faced by officials in planning of programmes for adolescents</li> </ul>
Health service providers	52.8	<ul style="list-style-type: none"> <li>▶ Perspectives regarding future programmes and services and recommendations for improvement</li> </ul>
Mothers	40.3	<ul style="list-style-type: none"> <li>▶ Views of religion about ASRH information and services</li> </ul>
Teachers	40.4	<ul style="list-style-type: none"> <li>▶ Knowledge and attitudes about ASRH services</li> </ul>
Sociologists	39.5	<ul style="list-style-type: none"> <li>▶ Most common reproductive health problem of adolescents</li> <li>▶ Prevalence of risky sexual behaviour among adolescents</li> <li>▶ Involvement in health education in school</li> </ul>
Adolescents	16.1	<b>Adolescents</b>
		<ul style="list-style-type: none"> <li>▶ Most common reproductive health problems of adolescents</li> <li>▶ Discussion of sex-related matters with mother</li> <li>▶ Opinions about YFS and expanding ASRH services</li> <li>▶ Protective practices</li> <li>▶ Peer influences</li> <li>▶ Feelings about sex</li> <li>▶ School sex education</li> <li>▶ Sexual pressure</li> <li>▶ Talking about sex with friends</li> <li>▶ Main sources of information</li> <li>▶ Sexual risk-taking</li> </ul>

ASRH, adolescent sexual and reproductive health; NGO, non-governmental organisation; YFS, Youth Friendly Service.

Some policymakers of the Ministry of Health (MOH) expressed concerns that policymakers outside the MOH believed that if the MOH taught sexuality issues, this would promote promiscuity.

The culture of silence and lack of openness towards matters of sexuality, especially before marriage, makes adolescent girls unlikely to seek SRH information and services.

*"In our families we are comfortable to speak about honesty, integrity, humanity, and justice with daughters and sons, but parents are too embarrassed to discuss sexual issues with them."* [Policymaker, male, 47 years]

#### Structural and implementation barriers

There are no baseline data regarding the SRH status of adolescents in the Iranian health system.

*"Our information about the sexual and reproductive health status of adolescents is limited, data are incomplete. Behaviour studies are necessary in this age group."* [Policymaker, male, 46 years]

All government and nongovernmental organisation (NGO) health programme directors have perceived lack of a reproductive health policy for adolescents as a major obstacle

*"There aren't specific policies and guidelines for ASRH and they're included within policies regarding MCH/FP and HIV/AIDS prevention and adolescents aren't directly targeted."* [NGO Health Programme Director, male, 47 years]

This study also showed that health providers do not have specific skills and commitment to deal with adolescents.

*"We've received orders from the MOH to deliver reproductive health services to all clients regardless of age, gender or marital status but we haven't received training on how to provide services to adolescents."* [Health provider, 36 years]

Lack of coordination and collaboration between the various sectors is another administrative barrier for ASRH service provision to adolescent girls, and the various ministries that serve adolescents do not try to achieve coordination among themselves to package educational content for ASRH.

*"People of the health sector and people of departments of psychiatry and religion never sit to design a protocol on ASRH together, when each one of them designs a protocol to stand alone, it may be contested by another group."* [Policymaker, male, 48 years]

#### Political barriers

There is little commitment at the highest level due to fears of community opposition and lack of public support, and government leaders do not have a clear strategy on ASRH.

*"A major obstacle to implementing ASRH programmes is superstition and misunderstanding in public opinion. They think that we want to promote promiscuity."* [Policymaker, male, 51 years]

In this study the United Nations (UN) Health Programme Directors pointed out that lack of government cooperation is a major obstacle to the implementation of specific projects by them.

*“Our ASRH programs have been stopped for 2 years in Iran, because the government has no clear policies supporting the provision of SRH services to adolescents.”*  
[UN Health Programme Director, female, 53 years]

Some of the governmental health programme directors believed that ASRH issues should be managed by the relevant governmental ministries and they do not trust the UN agencies, so real cooperation between the agencies of the UN, NGOs and the MOH remains low.

*“WHO in other developing countries often plays a key role in developing ASRH services but we should realise our community situation, there are many beliefs and sensitivities in the community and we can't inject any programme to our system.”* [Policymaker, male, 37 years]

#### Non-use of potential help from religion

In the current study, not all clergymen were opposed to sexuality education in principle.

*“People who think that sex education isn't permitted in religion are completely wrong, but such knowledge should be taught in a way that informs adolescents about sexuality in a modest and moral manner.”*  
[Clergyman, 48 years]

*“It's important for all to know that sexuality education isn't a newly foreign phenomenon, since religion recognises the power of sexual need and has a lot of rules about many aspects of human sexuality.”* [Clergyman, 52 years]

*“We believe it's better to give the correct teaching to adolescents rather than leave this to chance and to incorrect sources.”* [Clergyman, 54 years]

The findings also showed that planners should use the capacity of religion for sex education.

*“The health directors should ask their questions on the religious perspective of the field of adolescents' sexuality education from religious leaders. They should have entered boldly into the arena and not be afraid of being stigmatised.”* [Clergyman, 57 years]

#### DISCUSSION

This study showed that health care-seeking behaviour of Iranian adolescent girls is poor for several reasons. The most common barriers for adolescent girls to obtain SRH services are cultural and social, in which social stigma is very dominant. Realistically in Iran ASRH is a sensitive and very controversial social matter and societal attitudes toward adolescent sex and sexuality often influence adolescents' behaviour, policymakers' priorities for sex education and policies

affecting adolescents' access to SRH information and services. This is consistent with other research.<sup>8–10</sup>

The findings of this study indicate that misconceptions about ASRH needs lead to stigmatisation of services and social exclusion of adolescents from such services. Some adults including parents believe that giving information on sexuality would lead to increased sexual activity, although a number of studies have shown this to be incorrect. On the contrary, some sexuality education programmes appear to have reinforced the belief that sexual activity should be within marriage.<sup>11–13</sup> Kirby *et al.*<sup>11</sup> reviewed 83 studies that measured the impact of sex and HIV education programmes on sexual behaviour among youth aged under 25 years around the world and underscored the fact that sex and AIDS education do not encourage sexual behaviour but, instead, that some programmes do seem to have had an effect on limiting sexual activity.

Evidence from the present study showed that in Iran open conversation about sex has long been a taboo and that parents do not feel comfortable discussing reproductive health-related issues with their adolescent offspring. This conservative culture and discomfort with open discussion of SRH issues with adolescents results in their lack of knowledge on SRH issues and of where to obtain information and services. Therefore adolescents are unable to access the knowledge and skills needed to make healthy decisions. This problem was addressed by previous investigators such as DeJong.<sup>14–16</sup> Some adolescent girls consider public health centres to be invaluable sources of SRH services, but the findings showed a lack of specific health care services for adolescents.

In Iran reproductive health and FP services are integrated into primary health services. Iran has had one of the most successful national FP programmes of developing countries. For example, the population growth rate decreased from 3.9% to 1.6% from 1988 to 2006 and maternal mortality decreased from 91 to 24.6 per 100 000 live births between 1988 and 2005. There was a decline in the married adolescent<sup>15–19</sup> fertility rate from 54 children per 1000 women in 1996 to 26.8 children per 1000 women in 2000.<sup>3 17</sup> But according to more recent studies, the general fertility rate of Iran has reduced to less than the net reproduction rate. The population policies have now been changed. Contraceptive methods have been given only to 'high-risk' groups including married women aged under 18 or over 35 years and those with four children, with children under the age of 3 years, a history of high-risk pregnancy, underlying diseases or congenital malformations. The health system in Iran does not offer clinical services tailored for adolescents and there are no explicit policies supporting the provision of SRH services for them. The services have always been tailored for married couples.<sup>8</sup>

The present study findings confirmed the lack of specific health care services for adolescents and reflected the unsuitable structure of the Iranian health system, with concerns regarding privacy and confidentiality, and access barriers for adolescents to SRH services. This finding is consistent with other research.<sup>2 15 18</sup> The present study has also demonstrated health providers' unpreparedness to discuss sexuality with adolescents, often because they feel uncomfortable or because they disapprove of unmarried adolescents who express an interest in sexuality, or because they have not received any training with regard to ASRH issues.

In a conservative country such as Iran with strong cultural influences on sexual behaviour, the creation of a supportive, receptive and enabling environment at both policy and community levels for adolescent girls, that acknowledges their evolving capacity to develop life skills and allows them to access information and services without embarrassment, is without doubt the most essential factor necessary to improve their SRH.<sup>19</sup> In view of this, it is recommended that the MOH should improve the structural setup of public health centres and ensure that the service environment promotes adolescents' confidentiality because protecting privacy and confidentiality is very important for unmarried adolescents.<sup>20</sup> The study findings showed the need to enhance interaction and positive attitudes between health care providers and adolescent girls. Health providers should be non-judgmental and friendly when working with adolescents. This attitude allows them to understand the problems of adolescents better and increases the willingness of adolescents to return to the facilities and share their sexual health concerns with them.<sup>21</sup> Warenius advises that it is important that adolescents should feel at ease in health centres and believe that they are accepted and respected.<sup>19</sup> Health care providers need to learn matters such as counselling, communication skills and ethical issues, especially regarding enhancing privacy and confidentiality. Also health care providers could enhance communication with adolescents by showing empathy when interacting with them.

Views obtained during the interviews showed that the Iranian government's view on ASRH is conservative and that there have been few efforts by them to promote provision of ASRH services because of the stigma attached to adolescent sexuality and fear of community opposition and lack of public support. The policymakers in the MOH should try to foster public support by diligently identifying key adults, especially parents and religious leaders, who support provision of SRH services to adolescents, by explanation of the advantages of proposed new services, according to the findings of research. This study also showed that in Iran, involvement of UN agencies and NGOs is limited, mainly due to mistrust by the government. International organisations such as UNICEF

have undertaken a number of activities aimed at addressing the reproductive health of adolescents but these were pilot efforts with limited impact. For example, the MOH partnered UNICEF in a project to pilot Adolescent Friendly Services (AFS) to the most at-risk adolescents for 5 years. The AFS project aimed to empower adolescents to protect themselves from HIV and related risk factors by providing information, education, counselling and referral services. That project has now ended however. The MOH should collaborate with international organisations, especially UNFPA and UNICEF, to learn from their experience and to use their technical support in the field of ASRH.

The study findings highlighted a lack of intersectoral collaboration on adolescent health matters and it seems that the MOH of Iran has made little effort to involve other ministries, such as the Ministry of Youth and Sport and especially the Ministry of Education, in discussions or activities on ASRH. In developing countries such as Iran, in which more than 85% of all adolescents are enrolled in school, well-designed in-school information and education programmes are among the most cost-effective investments in promotion of adolescents' health, and if sex education is integrated into school subjects this will help to minimise the possible sensitivity of the subject and the associated stigma in the community.<sup>22 23</sup>

This study explored the fact that against widely held belief, religion is not opposed to sex education, even for adolescents. Clergymen agree with sexuality education in principle.<sup>24</sup> In Iran religion plays a central and integral role in the cultural and social life of the people and has an important role in transmitting values, including those related to morals, families, sexuality and reproduction. Religious leaders are highly respected and their opinions are valued. They have the capacity and ability to advocate for ASRH programmes, therefore gaining their support is critical for the success of such interventions just as it was for FP programmes. Although in this study clergymen agreed with sex education for adolescents, its acceptance among them is not universal. Hence, the Iran MOH should provide appropriate and accurate information on SRH to adolescents with the help of skilful clergymen, consistent with religious values, thus gaining the support of the main religious leaders,<sup>24</sup> who are more likely to support the programme if they feel that their opinions have truly been taken into account. Then much can be done by mobilising their members towards supporting ASRH initiatives throughout the country.

In conclusion, the most important factors in the successful implementation of ASRH programmes in Iran are governmental political will and commitment to seriously address ASRH programmes, together with the creation of a supportive environment by key adults, especially parents and religious leaders. It is

clear that extensive efforts are needed to sensitise and motivate parents, policymakers and influential leaders regarding ASRH.

This study does have some limitations. In particular it is a qualitative study and focuses only on in-school and unmarried adolescent girls, so generalisation of findings is limited. However, a strength of the study is that it used the approach of including key adults in addition to adolescents in the main study population. Additional research is needed to understand how religion can potentially be used to encourage adolescents to use SRH information and services.

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