

Exploring barriers in accessing reproductive health services for adolescent married women: View health providers

Abstract

Introduction:

Access to reproductive health services is a fundamental human right, yet many young married women face obstacles in obtaining these services. Young married couples in lower- and middle-income countries face barriers to accessing quality reproductive health services.

Method:

This cross-sectional study examines the barriers to accessing reproductive health services for young married women in Shiraz, Iran. The research population comprises reproductive health providers working in health centers affiliated with Shiraz University of Medical Science. Data were collected using a structured questionnaire based on a literature review and expert opinions.

Result:

The study included 58% midwives and 42% physicians and family health care providers. Most providers (59.2%) stated that married teenagers face financial difficulties paying for reproductive health services. They also mentioned that married teenagers lack suitable transportation and may need permission from their husbands or mother-in-law to access health centers (27.7% and 69.7%, respectively). Additionally, 27.7% of providers reported that married teenage girls do not have insurance coverage. Providers generally agreed that structural factors were not barriers to accessing services. However, 20.6% of married adolescent women expressed dissatisfaction with the quality of services. Providers believed that consultations were compassionate, client problems were addressed (52.6%), and employees treated their patients well (57.9%). Regarding access to reproductive health services, providers stated that married teenagers do not have access to all services in their city and may need to go to another city or center to receive them (57.9%). There was also a lack of specialized staff to provide reproductive health services according to the needs of married teenagers, according to 58.2% of the providers. The study found that financial, structural, and geographical factors were related to access to reproductive health services, with percentages of 32%, 61% (structural factor 1), 82% (structural factor 2), and 88% (geographic factor), respectively.

Conclusion:

Based on all the information obtained from this research and related studies, there is a need to improve structural, financial, and geographical access for adolescent women to reproductive health services, as well as provide them with education on sexual skills, increasing their knowledge of sexual health and pre- and post-natal care, to improve the overall quality of pregnancy.

Keywords: Barriers, Access, Reproductive health services, adolescents, married women, Health providers

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Introduction

Globally, around 18 million women under the age of 20 give birth yearly, representing up to one-fifth of all births, with almost 95% occurring in developing countries (1). In general, reproductive health programs have traditionally focused on adult women. In recent years, they have expanded to include a focus on unmarried adolescents, and they have inadvertently neglected married young women despite their enormous need (2,3).

In many countries, the majority of adolescents are married before the age of 18, which adds to the problem of high maternal and neonatal morbidity and mortality (4). Reproductive health during youth is crucial. However, young people seldom utilize sexual and reproductive health services and subsequently suffer from poor outcomes in sexual and reproductive health. Access to reproductive health services is a fundamental human right, yet many young married women face obstacles in obtaining these services (5). The situation is

particularly challenging in developing countries, where most child marriages occur (6).

Adolescent girls who marry early often have limited access to education, health care, and social services, which can negatively impact their health and wellbeing and that of their families (7). Ensuring access to reproductive health services for young married women is essential to promoting their health and wellbeing. However, healthcare providers play a crucial role in delivering these services, and their attitudes and knowledge can significantly impact the quality of care provided (8,9). Young married couples in lower- and middle-income countries face barriers to accessing quality reproductive health services because policies either overlook them or are not reached by programs (10,11,12). Their age, lack of education, limited social agency, power imbalance, inadequate negotiation skills in their marital relationships, and economic dependence trap them in a cycle of poverty with rapid and repeated childbearing (13). While a substantial

proportion of pregnancy, childbearing, and parenthood occurs in women aged 15–24 years within the context of marriage, they are less knowledgeable about reproductive health and are less likely to use contraceptives and other maternal health services in comparison to women aged 25–29 years (14). Their age, lack of education, limited social agency, power imbalance, inadequate negotiation skills in their marital relationships, and economic dependence trap them in a cycle of poverty with rapid and repeated childbearing (15).

The issue of barriers to accessing reproductive health services for young married women is a complex one (16). Several factors contribute to this problem, including social norms and cultural beliefs, a lack of education and awareness, financial constraints, and the limited availability of services in certain areas. In many societies, young women are expected to get married and start a family at a relatively young age. This can create challenges when accessing reproductive health services, as these women may not have the knowledge or resources to seek care. Additionally, cultural beliefs about female sexuality and reproductive health can make it difficult for young women to discuss these issues with healthcare providers (17).

Financial constraints are also a major barrier to accessing reproductive health services. Many young women may not have the financial resources to pay for healthcare services or may not have insurance coverage that includes reproductive health services. This can result in delayed or inadequate care, seriously affecting their health and wellbeing (18). Finally, the limited availability of services in certain areas can also be a significant barrier for young women seeking reproductive health care. In some cases, there may not be any reproductive health clinics or providers in their community, which can make it difficult to access care (19).

Among the 1.15 billion adolescents worldwide, more than 700 million live in Asia (20). Youth (15–24 years) comprise about a third of the population in Asia. Globally, SRH problems are one of the main causes of high morbidity and mortality rates among young people (21). Aside from the contextual causes, young people's disproportionate burden of SRH issues is often aggravated by the lack of SRH knowledge and low availability and/or accessibility of SRH services (22). The accessibility of SRH services is influenced by a complex set of factors related to youth's SRH knowledge and awareness of services, sociocultural norms regarding the sexual activity of youth, availability of services, costs of using the services, and the quality of the services they provide (23).

Overall, these barriers can significantly impact the health and wellbeing of young married women. To address this issue, it is important to increase education and awareness about reproductive health, improve access to affordable care, and work to reduce cultural barriers that may prevent young women from seeking care (24). challenges young married

women face when accessing reproductive health services, as seen through the eyes of healthcare providers. The study found that traditional gender norms, limited education, and cultural beliefs were some of the key barriers to young women's access to reproductive health services. The authors highlight the importance of increasing awareness of reproductive health rights and improving access to accurate information and services. This study underscores the need for comprehensive sexual education programs and community-based interventions to address these barriers and empower young married women to make informed decisions about their reproductive health (25,26,27). The definitions and conceptual frameworks of the United Nations Committee on Economic, Social, and Cultural Rights were adapted to produce a merged conceptual model consisting of five key concepts: cognitive accessibility—the extent to which youth are aware of the existence of SRH services and their perceived SRH needs, including knowledge regarding contraceptive methods and risks for pregnancies and STIs when having sexual intercourse; psychosocial accessibility—the extent to which cultural and social norms influence youth to use SRH services and their perceived agency and autonomy to make decisions by themselves; geographic accessibility, the extent to which SRH services can be reached physically and the amount of time it takes; affordability, the perceived agency of youth to pay for reaching and using SRH services; and finally, quality of services, the extent to which the provided SRH services match with the perceived needs of youth: accessible, acceptable and appropriate (28-31).

Since the factors of access to health care services can be the biggest obstacles to receiving reproductive health services among married adolescent women This study aims to investigate the factors of access to reproductive health services with emphasis on the five dimensions of affordability, accessibility, availability, acceptability and appropriateness (adequacy) of services among young married women in Shiraz city and also with attention to the viewpoint of health care providers. This article explores the barriers healthcare providers face in delivering reproductive health services to young married women and identifies potential solutions to address these challenges. By examining the issue from the healthcare providers' perspective, we can better understand how to improve the quality of care and promote the right to reproductive health services for all women, regardless of their age or marital status. The results will help the policymakers prioritize interventions, formulate a comprehensive plan and allocate the necessary resources and budget to control and reduce negative effects and promote health. Conversely, attitudes of health providers and communities have been cited as important barriers to youth access to reproductive health information services.

Method:

This is a cross-sectional, descriptive, and analytical study. The research population consists of reproductive health providers with at least one year of work experience in reproductive health services. These providers work in health centers affiliated with the Shiraz University of Medical Science.

After receiving a list of comprehensive health centers, ten centers were randomly selected from each center. Then, reproductive health service providers who met the inclusion criteria were purposefully selected and sampled from each comprehensive center. Participants were selected from a list of eligible teenagers who had visited the center for reproductive health services.

The study objectives, potential risks, and benefits were explained to the participants, and their informed consent was obtained before data collection. Additionally, reproductive health service providers were invited to participate in the study if they met the inclusion criteria, and those who agreed were included. Data were collected using a structured questionnaire based on a literature review and expert opinions.

The questionnaire comprised questions related to demographic characteristics, barriers to accessing reproductive health services, and experiences with reproductive health services. Descriptive and inferential statistical methods were used for data analysis. Ethical considerations were considered throughout the study, and participant confidentiality was maintained.

The data collection tool used was a questionnaire designed by the researcher. The questionnaire included demographic characteristics such as age, work experience, and gender. It also included questions related to access to reproductive health services. It should also be noted that all the items in the questionnaire were extracted by reviewing previous studies. The validity and reliability of both questionnaires were confirmed during the pilot study.

To assess the reliability of the access to reproductive health services questionnaire, it was administered to 30 individuals from the target population after being reviewed by experts. The Cronbach's alpha coefficient was calculated using SPSS software. In addition to Cronbach's alpha coefficient, Test re test and ICC (internal correlation coefficient) were also used. The intragroup correlation coefficient for this questionnaire was 0.976. The Kappa coefficient for the first test ranged from 0.65 to 0.87, and for the test-retest, it ranged from 0.46 to 0.75. Face validity and content validity with CVI and CVR indices were used to validate the questionnaires used in this study. The questionnaires were presented to university professors and faculty members to identify any items with ambiguity or unclear understanding. Additionally, feedback on the comprehensiveness, completeness, and relevance of the

questionnaire to the test's purpose was gathered, and the questionnaire was modified accordingly based on their opinions. For the questionnaire on access to reproductive health services among married teenagers from the perspective of reproductive health service providers, $CVR=0.82$ and $CVI=0.85$ were calculated, confirming the validity of the questionnaire.

After obtaining the necessary permits from the research management of Shiraz University of Medical Sciences, the researcher collected and completed the questionnaire by personally visiting health centers affiliated with Shiraz University of Medical Sciences and contacting the center's referrers in person and online until the desired sample size was achieved.

After data collection, SPSS22 software was utilized for analysis. Mean (standard deviation) was used to describe quantitative data, while frequency (percentage) was used to describe qualitative data. To achieve the research objectives, the mean and standard deviation were used to describe the scores of accessibility, affordability, acceptability, appropriateness, and availability of reproductive health services. After verifying the normality of the data, parametric tests and equivalent non-parametric tests were used for inferential analysis.

Results:

The results showed that all the participants in the study were women; 58% were midwives, and 42% were physicians and family health care providers. The average age of the providers examined in the study was 34.89, with a standard deviation of 5; the average experience was 8.47, with a standard deviation of 5.

Most of the providers of reproductive health services stated that married teenagers face a problem paying for services after the initial visit and refuse to receive services because of the costs, which are significant and important (59.2%). And from the point of view of most of them (7.85%), married teenagers do not have a suitable vehicle or the ability to pay the agency fee to visit centers providing reproductive health services. 27.7% of service providers participating in the study stated that married teenage girls had no insurance coverage. 69.7% of the service providers stated that married teenagers need the permission of their husband or mother-in-law to go to comprehensive urban health centers, which is in line with the opinion of married teenagers, and such an issue reduces access. Also, 59.2 percent of the service providers disagreed with the statement, "Married teenagers go to comprehensive urban health centers to solve their problems and do not solve the problem by consulting family or friends and self-treatment." 75% of service providers were against the statement, "Married teenagers do not necessarily go to midwives or doctors and female staff to receive reproductive health services (they also

go to doctors and male staff);" according to them, the preference of married teenagers is female service providers. From the point of view of providers, structural factors in access to services are at an acceptable level and are not an obstacle to receiving services. 25% were very agreeable, and 63.2% agreed that "the environment of comprehensive urban health centers is clean and hygiene is observed." In the item "The structure of comprehensive urban health centers should be such that married teenagers can come every day of the week and at any hour of the day to receive reproductive health services and the services are available," 42.1% of people were very agreeable, and 27.6% were agreeable. In the item "in comprehensive urban health centers, the privacy of married adolescents is given full attention," 36.8% of people strongly agreed, and 63.2% agreed. No one objected to the lack of attention and respect for privacy. In the item "Employees of comprehensive urban health centers have necessary confidentiality while providing services," 65.8% of people were very agreeable, and 34.2% were agreeable. All the service providers stated that the service quality is good, but 20.6% of the married teenage women referring to the centers were not satisfied with the services provided. 52.6% were very agreeable, and 27.6% agreed that "consultations are done compassionately and clients' problems

are answered." 57.9% of people were very agreeable, and 13.2% agreed with the item "Employees of comprehensive urban health centers treat their patients well". 14.5% of the service providers participating in the study stated that the staff of comprehensive urban health centers do not behave appropriately towards the client. 57.9% of the people in the studied sample said that people do not need to go to a private clinic or center, 14.5% had no opinion, and 27.7% said that people in the public sector need reproductive health services. They do not receive and need to go to private centers and clinics. In their opinion, 57.9% of service providers stated that married teenagers do not have access to all reproductive health services and are forced to go to another city or center to receive services.

From the point of view of the service clients, it took less than 15 minutes to see a doctor or midwife (25.2%), more than an hour (8.4%), 45 minutes to one hour (5.3%), 30-45 minutes (16%), and 15-30 minutes for most people (45%). 58.2% of the service providers participating in the study stated that in the service provider center, there is no specialized staff to provide reproductive health services that can provide services according to the needs of married teenagers.

Table No. 1 - Description of the quality of access to services from the point of view of the providers

Access to a range of options	very well (percentage)	good	average	bad	very bad
How do you evaluate access to reproductive health services?	20 (26/3)	43 (56/6)	-	(17/1) 13	-

Table No. 2- The average indicators measured in the examined sample in reproductive health service providers

	average	standard deviation	maximum	minimum
acceptability score in access to reproductive health services	2/65	0/39	1/88	3/25
affordability score for reproductive health services	3/35	0/78	2/33	5
adequacy score in access to reproductive health services	1/81	0/53	1	2/7
availability score to reproductive health services	2/58	0/89	1/71	4/43
accessibility score to reproductive health services	2/76	1/12	1	4/5

The average score of acceptability in access to reproductive health services is 2.65 with a standard deviation of 0.39; the average score of affordability in access to reproductive health services is 3.35 with a standard deviation of 0.78; the average score of adequacy in access to reproductive health services is 1.81 with a standard deviation of 0.53; the average availability score for reproductive health services was 2.58 with a standard deviation of 0.89; and the average score for accessibility for reproductive health services was 2.76 with a standard deviation of 1.12.

Among the health providers participating in the study, there is a relationship between structural factors, financial, structural, and geographical factors, and access to reproductive health services. Among these dimensions, 32% of financial factors, 61% of structural factors 1, 82% of structural factors 2, and 88% of geographic factors were related to access to reproductive health services.

Discussion:

All health providers were female. 58% were midwives, and 42% were physicians and family health care providers. The

mean age of the participants was 34.89 with a standard deviation of 5, and the mean years of work experience were 8.47 with a standard deviation of 5.

According to health providers' views, the average score for accessibility to reproductive health services was 2.76, with a standard deviation of 12.1.

59.2% of health providers reported that married teenagers had to wait more than 45 minutes to receive fertility health services. 71% also stated that people had traveled a distance of more than two kilometers. Ali Moazem and colleagues' study (2008) also showed that various factors limit women's access to health services, including geographic distance and another shortage of ambulances, causing delays in transporting critically ill patients to centers and putting them at risk (32). Therefore, health centers should be located in suitable locations so that most people in the area have fair and easy access to these centers, and efforts should be made to improve transportation systems and reduce physical barriers to increase public access to health centers. Mohammad Shariati and colleagues' study (2014) showed that geographical access was not identified as a serious barrier. Instead, social and structural barriers were identified as the main obstacles (33).

For the examined health providers, the average score for availability regarding reproductive health services was 2.58 with a standard deviation of 0.089. No significant difference was observed in the availability score between the two groups under study.

57.9% of service providers stated that married adolescents have no access to fertility health services and are forced to go to another city or center to receive services. In comparison, 29% reported that essential medical facilities and equipment are unavailable in their center.

58.2% of health providers participating in the study stated that no specialized staff is available at the health center to provide fertility health services tailored to the needs of married adolescents. The results of Rita Moses's study (2012) also showed that a significant number of health centers lack staff who can provide specialized services related to reproductive and sexual health rights, which is consistent with the views of health providers in this study. Participants also expressed a need for services such as education, counseling, and testing, but due to the lack of privacy, staff confidentiality, inadequate equipment, and negative attitudes from health providers, these services were not available, which is inconsistent with the results of this study (34).

Health providers also reported that essential medical facilities and equipment are not available at the centers, and 58.2% of them stated that centers require specialized staff to provide fertility health services tailored to the needs of adolescents. Therefore, it is necessary to employ specialized staff, including senior reproductive and sexual health experts, and accurately

assess the centers' human resources, equipment, and facilities to meet the demand of the covered population for greater access to fertility health services.

Among service providers, the average financial access score for fertility health services was 3.35, with a standard deviation of 0.78. Most married adolescents receive healthcare coverage, but accessing fertility health services is difficult due to financial considerations, according to service providers. Additionally, many fertility health service providers reported that married adolescents have difficulty paying for services after the initial visit and refrain from receiving services due to high costs, which is a significant and important issue (2.59%), and, according to most of them (85.7%), married adolescents do not have appropriate transportation or the ability to pay agency fees to access fertility health centers.

According to the present study, 27.7% of health providers reported that married adolescent girls had no insurance coverage. A study by Zhou et al. (2015) showed that individuals with low incomes had less chance of receiving fertility health services, consistent with the present study (35). However, the results of a study by Najafi Sharjabad and Haghghatjo (2019) showed that social-cultural and structural barriers were the most significant challenges for Asian youth to access healthcare services, and financial issues were not an obstacle to receiving and accessing services, which does not align with the results of the present study (36). The results of a study by Gort Nalwadda et al. (2017) showed that healthcare providers considered eliminating misconceptions about family planning methods among adolescents as the most important barrier, followed by financial issues, which is not consistent with the results of the present study (37). This discrepancy may be due to differences in the society studied. In a study by Mohammad Shariati et al. (2014), financial obstacles were not identified as the main barrier, which is inconsistent with the results of the present study (33). The results of a study by Sekine and Carter (2019) also indicated that limited access to financial resources, limited decision-making power, social isolation, and the dominant power of husbands and mothers-in-law have negative effects on access to fertility health services, which is consistent with the results of the present study (38).

There needs to be a solution to stop these factors from restricting married adolescents' access to reproductive health services because research shows that they have trouble paying for post-initial visit services, may forego services due to cost, and some of them are still not covered by any insurance. This is an important issue that requires special attention from policymakers.

69.7/7% of health providers have stated that married adolescents need permission from their husbands or mothers-in-law to visit health centers, which can lead to reduced access

to services. Additionally, 59.2 % of health providers disagreed with the married adolescents seeking help from health centers to solve their problems. They do not try to solve them through consulting with family or friends or self-treatment.

%75 of health providers are opposed to the statement that married adolescents do not necessarily go to female midwives or physicians and staff for reproductive health services (they also go to male doctors and staff)", and in their opinion, married adolescents prefer female health providers. Another view among health providers is that married adolescent women need counseling to prevent or treat reproductive diseases. Additionally, due to the higher prevalence of reproductive diseases at younger ages and the problems that arise as a result of them, it is necessary to increase awareness and promote culture to encourage married adolescent women to use counseling services and increase their access to reproductive health services, so that obstacles such as ignorance, shame, lack of autonomy, and independence do not prevent them from accessing these services.

The study by Ali-Moazem and colleagues (2008) showed that various factors limit women's access to services, which are not available in most health centers. The absence of staff and geographic distance were among those factors. Health centers did not provide essential services on a 24.7 basis, which resulted in deprivation and put many people's lives at risk. Cultural norms dictated that women had to be examined by female doctors, and with a shortage of female doctors, these services became inaccessible, consistent with the present study (32). The results of the study by Sekine and Carter (2019) also showed that women's limited access to financial resources, limited decision-making power, social isolation, and the dominant power of husbands and mothers-in-law have negative effects on access to reproductive health services, which is consistent with the results of the current study (38).

The results of the study by Zanjani and Jazayeri (2015) also showed that, according to Spearman's correlation coefficient, there is a weak and inverse correlation between fertility health status and the age of the first pregnancy. Additionally, the correlation between fertility health and gender preference for children is weak and inverse, and its intensity is low. Fertility health for women living in cities was significantly higher than that of women in rural areas. Some cultural factors, such as preferring male infants due to increasing childbirths and reducing pregnancy intervals, decrease fertility health (39).

The results of the study by Sychareun and colleagues (2018) showed that the relationship between premarital sex, early marriage, and early pregnancy was normal in this study. Determining factors for adolescent pregnancy included liberal attitudes towards premarital sex, early marriage, early pregnancy, incomplete knowledge about reproductive and sexual health, and limited access to appropriate services. These

are multidimensional factors that require a spectrum of responses. Since some of these factors are deeply rooted in individual values and beliefs and are difficult to change, it is necessary to consider culturally appropriate mechanisms that can empower individuals to access health services (40).

Among the service providers, the average adequacy score for accessing reproductive health services was 1.81, with a standard deviation of 0.53. In fact, service providers expressed a lower score of adequacy in access, which may be due to married adolescent women's inadequate understanding or insufficient awareness of accessible services. From the perspective of service providers, 25% strongly agreed and 63.2% agreed with the statement, "The environment of health centers is clean, and hygiene is observed".

Among health providers participating in the study, there is a correlation between structural, financial, geographical, and access factors to reproductive health services. Among these dimensions, 32% of financial factors, 61% of structural factor 1, 82% of structural factors, and geographical factors had an 88% correlation with access to reproductive health services. The results of the study by Wilson and colleagues also showed that four factors, financial, structural, geographical, and individual, significantly impact people's access to services provided in health centers from the perspective of healthcare staff. These results are consistent with the present study (41). The study's findings showed that, according to health providers' opinions, there is a correlation between structural, financial, geographical, and access factors to reproductive health services.

The least received service by married adolescents was screening and diagnosis of diseases (% 0/8). Because early age and early onset of sexual activity are risk factors for many diseases, and due to the higher prevalence of cervical cancer in young people, this issue should be considered by managers and policymakers. Also, counseling for sexually transmitted infections was only 1.5 %, which managers should investigate due to the increased risk of HIV, AIDS, and STIs. Counseling and care before pregnancy and childbirth were also 1.5%, which should receive more attention due to the higher incidence of pregnancy and childbirth complications in this age group. Married adolescents need to receive counseling on various dimensions, such as nutritional problems, domestic violence, psychological disorders, depression, vaccination, genetic diseases, etc., to prevent these complications.

Conclusion

Access to reproductive health services is one of the most important factors in maternal and child health and also impacts society's overall health. Adolescent married women are more likely to be at risk of not having access to reproductive health services, highlighting the need for increased attention to this

issue. Based on all the information obtained from this research and related studies, there is a need to improve structural, financial, and geographical access for adolescent women to reproductive health services, as well as provide them with education on sexual skills, increasing their knowledge of sexual health and pre- and post-natal care, to improve the overall quality of pregnancy.

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