

# The Stigma of Reproductive Health Services Utilization by Unmarried Women

Fatemeh Mohammadi,<sup>1</sup> Shahnaz Kohan,<sup>2,\*</sup> Firoozeh Mostafavi,<sup>3</sup> and Ali Gholami<sup>4</sup>

<sup>1</sup>Student Research Center, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, IR Iran

<sup>2</sup>Nursing and Midwifery Care Research Center, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, IR Iran

<sup>3</sup>Department of Health Education and Promotion, Faculty of Health, Isfahan University of Medical Sciences, Isfahan, IR Iran

<sup>4</sup>Department of Islamic Sciences, Isfahan University of Medical Sciences, Isfahan, IR Iran

\*Corresponding Author: Shahnaz Kohan, Nursing and Midwifery Care Research Center, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, IR Iran. Tel: +98-3136687140, Fax: +98-3136699398, E-mail: kohan@nm.mui.ac.ir

Received 2014 October 4; Revised 2014 October 28; Accepted 2014 November 23.

## Abstract

**Background:** Fear of the stigma associated with reproductive health services has always been one of the reasons why youth and unmarried individuals avoid making use of such services. This stigma imposes a great deal of mental stress, fear, and depression on patients and causes delays in the diagnosis and treatment of their conditions.

**Objectives:** This paper explores the concept of stigma in the context of the utilization of reproductive health services by unmarried women.

**Patients and Methods:** This study is qualitative in nature. Purposive sampling was employed, and semi-structured interviews were conducted with 16 unmarried women, five midwives, and two physicians. The data were analyzed using the conventional content analysis method.

**Results:** Four main categories constituted the general concept concerning the stigma suffered by unmarried women for using reproductive health services, i.e., prevalent stereotypical thinking patterns in society, the fear of being judged and labeled by others, discrimination, and feeling ashamed of seeking reproductive health services.

**Conclusions:** The findings indicated that society associates reproductive health issues with sexual relations, which in turn shapes the stigma and places limitations on unmarried women for using reproductive health services. Thus, while reproductive health services are planned and provided to unmarried women, strategies are demanded for overcoming this stigma.

**Keywords:** Social Stigma, Reproductive Health Services, Single Person

## 1. Background

According to the International conference on population and development's operational program, reproductive health services have been included in the service programs of most countries since 1994. These services aim not only to provide consultation and treatment for reproductive health and sexually-related issues, but also to improve quality of life and inter-personal relations (1). Although all age and population groups were taken into consideration for these services, the use of these services by specific sub-groups, such as teenagers and unmarried individuals, has been impacted by various factors (2). The cultural context of communities plays an important role in individuals' use of these services. This factor affects not only unmarried individuals' approach when searching for these services, but also medical professionals' approach when providing these services (3, 4). Studies have highlighted the effect of socio-demographic and cultural factors, such as the approach of individuals and service providers, individuals' age, marital status, income, where

they live, and their lack of independence in mobility, particularly in the case of unmarried women, as reasons for shunning these services (5-7). In many communities, the youth and unmarried individuals also stated non-reliance as well as shame and the fear of stigma as impediments to using reproductive health services (8-10). In Iran, the fear of stigma is the main impediment to using reproductive health services (11).

"Stigma is a mark or sign of disgrace usually eliciting negative attitudes to its bearer" (12). Different categories, such as perceived stigma, self-stigma, and enacted stigma, have been defined as the most common types of stigma (13), and stereotypes, prejudice, and discrimination were mentioned as the three main components of any type of stigma (14). What makes stigma noticeable in the realm of health is the fact that it imposes a great deal of mental stress, fear, depression, and constraints on patients and results in delayed diagnosis and treatment of their conditions (13). Any type of stigma triggered by any

possible cause can have these consequences. The presence of certain presumptions within society creates fear about the disclosure of stigmatized individuals' particular traits. Thus, such patients tend to hide these traits and shun healthcare services to avoid social reactions (15).

Unmarried patients' concerns about receiving reproductive health services are generally viewed as being caused by embarrassment and fear of stigma; however, the true nature of this stigma is not yet clear. It appears that stigma needs to be justified before designing any interventions to improve patients' approach to receiving these services.

## 2. Objectives

The authors of this paper aimed to justify, through a qualitative approach, the stigma suffered by unmarried women for using reproductive health services.

## 3. Patients and Methods

The current research employed a quantitative approach with a naturalistic paradigm and a conventional content analysis approach to justify the stigma experienced by participants with reproductive health services.

### 3.1. Participants and Data Gathering

Purposive sampling was employed for this study. All women between 25 and 60 years of age, who were not customary or legally married and living in Isfahan, as well as reproductive health professionals in the governmental and private sectors, constituted the population of the research. Participants were sampled with maximal variation (age, educational level, and social and economic status) from families referred to healthcare, educational, and cultural centers in Isfahan. Healthcare professionals were also sampled. Inclusion criteria were a willingness to participate in the study and no history of mental illness (according to self-report). Not wanting to continue working in every phase of the study was considered the exclusion criterion.

Sampling was done at healthcare, educational, and cultural centers by soliciting the employees to receive a call number from clients who have a single girl with the eligibility criteria in their family. The researcher contacted the participants and introduced herself, before explaining the objective of the research to the participants. The interview venue as selected based on the preferences of participants. Twenty-three individuals participated in the research and consisted of 16 unmarried women, five midwives (two midwives had their own offices and three worked in governmental centers) and two gynecologists. Data were gathered using in-depth, semi-structured interviews, and several sample questions were employed to guide and direct the interviews. Participants were asked what measures they took when they needed reproductive health services, what obstacles they faced when receiving the services, and what experiences they gained upon using reproductive health services. Each interview lasted for 15 to 65 minutes, depending on how participants an-

swered the questions. Interviews were continued until the data saturation point.

### 3.2. Data Analysis

Data analysis was carried out in parallel with data gathering and through conventional content analysis. This method is suitable for conditions where the information about the subject under-study is limited. Using this method, researchers allow codes and categories to emerge from the research results instead of using previously defined theories and categories (16). In this way, all interview recordings were transcribed verbatim. Then, they were read aloud after an initial review and extraction of the general idea. Units of meaning were then determined, meaning units were condensed, and the codes were extracted. Following extraction of the initial codes and the reduction of data by removing duplicate codes, subcategories and the main categories emerged from the code categorization.

To ensure the rigor in this qualitative research, we used four suggested criteria: credibility, dependability, transferability, and confirmability. Credibility was ensured in the present study by conducting in-depth interviews at different times and locations, revising preliminary encodings by the participants, and ensuring maximum variation among participants. Dependability was confirmed with the review of results and process of analysis by external supervisors. Transferability was checked via the review of results by individuals who had similar characteristics as study participants, and peer reviews were done for ensuring confirmability.

This study is part of a reproductive health Ph.D. thesis, and ethical considerations were confirmed by the ethical committee of Isfahan university of medical sciences prior to the commencement of data gathering. All ethical considerations, such as introducing the researcher, explaining the study goals to participants, keeping participants' information confidential, permitting the participants to leave the study at any time and to determine the time and location of interviews, and referring participants who needed or requested services, were respected. All participants provided their informed consent, orally and in written form, for participating in the study and for the recording of their interviews.

### 3.3. Research Location

This research was conducted in Isfahan, one of the central cities of Iran. In 2002, Isfahan had a population of 1,796,000 (17), among whom 11,000 constituted the population of unmarried women above 25 years of age. Regarding the cultural-religious background of the population, 99 percent are Muslims (18). In Isfahan, like many other cities of Iran, reproductive health services are provided by governmental and private centers. These services are provided through healthcare clinics in state-run centers and through midwifery experts, gynecologists, and general physicians in the private sector (19, 20).

## 4. Results

Sixteen unmarried women, ranging in ages from 27 to 53, participated in the research. Their education level ranged from elementary to master's levels (Table 1). The healthcare professionals participating in the research included five midwives and two gynecologists with an average experience of 15.3 and seven years, respectively (Table 2).

The analysis of the data pertaining to the stigma suf-

fered by unmarried women for using reproductive health services yielded four main categories, i.e., prevalent stereotypical thinking patterns in society, the fear of being judged and labeled by others, discrimination, and feeling ashamed of seeking out reproductive health services. Each main category included several subcategories (Table 3).

**Table 1.** The Profile of Research Participants (Unmarried Women)

Occupation	Education	Age	Number of Participants
Employed	University Education	33	P1
Unemployed	University Education	29	P2
Employed	University Education	31	P3
Employed	University Education	28	P4
Unemployed	University Education	29	P5
Unemployed	University Education	35	P6
Employed	University Education	33	P7
Employed	Diploma	38	P8
Unemployed	Guidance School	53	P9
Employed	Diploma	40	P10
Employed	University Education	30	P11
Employed	University Education	32	P12
Employed	University Education	31	P13
Employed	University Education	38	P14
Employed	University Education	42	P15
Unemployed	Primary School	27	P16

**Table 2.** The Profile of Research Participants (Healthcare Professionals)

Number of Participants	Age	Education and Profession	Occupation	Years of Work Experience
P1	31	Msc of midwifery	Personal office	7
P2	40	Bsc of midwifery	Health center	15
P3	41	Bsc of midwifery	Health center	17
P4	42	Bsc of midwifery	Health center	19.5
P5	41	Bsc of midwifery	Personal office	18
P6	39	Specialty of Obstetrics and Gynecology	Personal office/hospital	10
P7	37	Specialty of Obstetrics and Gynecology	Personal office/hospital	4

**Table 3.** Categories and Sub-Categories Resulting From the Analysis of Interviews With Unmarried Women and Healthcare Professionals Providing Reproductive Health Services to Explore the Concept of Reproductive Health Services Utilization Stigma Among Unmarried Women

Main Category/Sub-Category	Values <sup>a</sup>
<b>Prevalent stereotypical thinking patterns in society</b>	
Unmarried women unlikely to have reproductive health-related issues	3 (13)
Unmarried women not needing reproductive health services	13 (56.5)
<b>Fear of being judged and labeled by others</b>	
Fear of being labeled for having sexual intercourse	17 (73.9)
Fear of being labeled as a flawed woman	7 (30.4)
<b>Discrimination</b>	
Families forbidding access to health services-	5 (21.7)
Overlooking stated reproductive health-related problems	6 (26)
<b>Feeling ashamed of seeking out reproductive health services</b>	
Feeling ashamed of receiving services commonly used by married individuals	19 (82.6)
Delaying their referral until their condition gets serious	13 (56.5)
Taking no measures for receiving services and information	7 (30.4)

<sup>a</sup>Data are presented as No. (%).

#### 4.1. Prevalent Stereotypical Thinking Patterns in Society

The analysis of participants' statements showed that stereotypical thinking was prevalent in society with regard to reproductive health services for unmarried women. This category had two subcategories: "unmarried women unlikely to have reproductive health-related issues" and "unmarried women not needing reproductive health services."

##### 4.1.1. Unmarried Women Unlikely to Have Reproductive Health-Related Issues

Ruling out the possibility that unmarried women may have reproductive health-related diseases appears to be rooted in our thinking. A 31-year-old unmarried woman remarked on this subject, "Regardless of your marital status, you may suffer from gynecological disorders like other diseases. Society does not yet realize that all ... unmarried women may ... have gynecological diseases and may need to refer to a gynecologist."

In other words, it is commonly believed that reproductive health-related diseases are mainly caused by genital infections, which in turn are caused by sexual intercourse. A midwife working in a healthcare center stated, "It has been established in our country that infections and gynecological problems occur after marriage. That is, an unmarried woman cannot have such issues."

##### 4.1.2. Unmarried Women not Needing Reproductive Health Services

When society rules out the possibility of gynecological diseases among unmarried women, this population group's need for these services and for information on these services is overlooked. In addition, unmarried women are not considered by society among the target groups for such services. On the other hand, families deem it unnecessary to provide any information on this subject to unmarried women. A 38-year-old unmarried woman stated, "I don't know anything about menstruation, how pregnancy occurs and other related issues, but I have always wanted to know more about these topics. But my family believes I don't need to know about these subjects, as I am unmarried." In this situation, services provided by governmental and private sectors appear to be specifically targeted at married women only and not available to unmarried women. A midwife who runs her own office stated, "People must be taught to change their views. Married as well as unmarried women must be referred to related centers to have breast-screening tests. Most people think the healthcare system is there only for married women and that only married women should use these centers."

#### 4.2. Fear of Being Judged and Labeled by Others

One of the concerns of unmarried women when referring to reproductive health centers is the fear of being

judged and labeled by others. This concern comprises two notions of fear, i.e., being labeled for having premarital sexual intercourse and being labeled a flawed woman.

##### 4.2.1. Fear of Being Labeled for Having Sexual Intercourse

This fear was rooted in the cultural-religious backgrounds of participants' communities, which banned premarital sexual relations. The women were concerned about being negatively labeled for having premarital sexual relations upon making use of reproductive healthcare services. A 29-year-old unmarried woman stated, "If one is unmarried and has a gynecological problem, others will think that this individual has certainly had immoral sexual relations and is probably suffering from a serious disease." One of the midwives who has her own office stated, "The unmarried women who refer to my office try to avoid being seen by their relatives and acquaintances, as they are concerned about others thinking that they have been referred for a hymen check-up."

The other issue that worries unmarried women in this context is their fear of having their virginal status impaired during a gynecologist's inspection, as intact virginity indicates not having had sexual relations. This issue makes women not seek out these types of services. A 41-year-old unmarried woman stated, "Unmarried women don't refer to gynecologists because they are afraid of losing their virginity during inspection." A midwife who ran her own office stated with regard to the concerns of mother, "Mothers accompany their unmarried girls to the gynecologist's office to avoid the inspection, hurting their daughter's virginity and thereby avoiding future problems."

##### 4.2.2. Fear of Being Labeled a Flawed Woman

Unmarried women's fear of others knowing about their gynecological health was significantly emphasized by participants. It was revealed that others would view them as flawed women if they had these types of health issues. This could also affect their marriage in the future. A midwife who had her own office stated, "There must be places where ... unmarried women can go and talk about their problems. It is important for unmarried individuals to have someone they can trust, someone who respects their confidentiality. They are afraid to disclose their issues and as a result, their future lives and married lives are hurt by this."

This cultural background context, like that of other communities, considers childbearing the most significant function of women that can affect their married status in the future. For this reason, women hide their reproductive health problems to avoid being considered flawed. A 41-year-old unmarried woman stated, "The girls do not refer to gynecologists because they think someone may find out about their problem and then they will not be able to marry or they may be stigmatized. For in-



stance, others may say such a woman is sick and unable to have a child.”

### 4.3. Discrimination

Participants stated that some families behaved toward unmarried girls' reproductive health-related issues with bias and discrimination, that is, unmarried women are faced either with families forbidding them from receiving these services or overlooking stated reproductive health-related problems.

#### 4.3.1. Families Forbidding Women From Receiving Health Services

In Isfahan, most women live with their families until they are married and are mostly dependent on their family for reproductive health services. This stereotypical way of thinking at a societal level, as well as women's fear of being negatively labeled, have caused unmarried women to not refer to healthcare professionals upon experiencing gynecological issues and due to constraints imposed by their family. A 38-year-old unmarried woman stated, “I get annoyed by my delayed periods. My family tells me that, as I am not yet married, I don't need to worry or take any measures.” Furthermore, a 33-year-old unmarried woman stated, “I know some families who do not pay much attention to their daughters' diseases and do not accompany them to the gynecologist's office. They also tell them that they don't need to refer to health services as they are still unmarried.”

#### 4.3.2. Overlooking Stated Reproductive Health-Related Problems

The participating unmarried women stated that whenever they had shared their reproductive health-related problems with their families, no advice had been provided to them. A 29-year-old unmarried woman stated, “Once, I talked to my mother and explained an infection I had. However, I think she never took this seriously. She was a good listener but never provided good advice. She did not even suggest that I refer to a doctor.” A 28-year-old unmarried woman further added, “If I have a problem, I tell my mother about it ... I told her about my infection and she just listened and took no measures against it.”

### 4.4. Feeling Ashamed of Seeking out Reproductive Health Services

The shame unmarried women experience as a result of receiving reproductive health services is part of the stigma associated with seeking out these services. This category has three sub-categories: “feeling ashamed of receiving services commonly used by married individuals,” “delaying referral until the condition gets serious,” and “taking no measures for receiving services and information.”

#### 4.4.1. Feeling Ashamed of Receiving Services Commonly Used by Married Individuals

Participants stated that, as it was not customary in their society for unmarried individuals to seek out reproductive health services, they felt ashamed upon referring to pharmacies, medical centers, and gynecologist offices, and thus avoid these centers. A 28-year-old unmarried woman stated, “I used to feel annoyed when I referred to a gynecologist's office, as other patients there were married. I felt ashamed because I was not married.”

A 29-year-old unmarried woman stated, “I once accompanied one of my friends to a gynecologist's office. I saw that all the other patients were married. Despite the fact that I needed to talk with the gynecologist, it was difficult for me and I could not accept it. During the time I was there, I hoped that all the other patients knew I was simply accompanying my friend.”

These women hid their marital status (being unmarried) from service providers upon referring to reproductive health centers. A midwife stated in this regard, “We ask the patients about their marital status. Unmarried women do not answer this question and try to hide the reason for their referral from the secretary and others and say that they have a question and have been referred to the office for a consultation.”

#### 4.4.2. Delaying Their Referral to the Point Where Their Condition Gets Serious

The shame and stigma that unmarried women experience cause them to delay referring to reproductive health centers upon occurrence of reproductive health issues until symptoms become unbearable. As such, they sometimes refer to centers with a deteriorated condition due to too much procrastination. A 35-year-old unmarried woman stated, “I was in so much pain due to my menstrual periods, but I did not refer to the gynecologist. It was so difficult for me to refer to a physician for these issues. I wouldn't do anything until my pain was severely aggravated and then I had to refer to the emergency with my mother. The doctor used to ask me why I had not visited earlier so she could prescribe me some medicine. But I always felt ashamed of doing so.”

#### 4.4.3. Taking no Measures for Receiving Services and Information

The participants, most of whom suffered from unresolved reproductive health-related issues, took no measures for receiving information and services when the symptoms were bearable. A 42-year-old unmarried woman stated, “I get worried when my menstrual periods become irregular or when I have another problem. I don't like to refer to clinics for treatment. I don't know why but I don't really like to refer to doctors.”

A 29-year-old unmarried woman added, “My period was delayed for some months when I began exercising.

I didn't talk to anyone about this. I just told my exercise trainer that I had been hit in the stomach and that's why it was sore. It took three months for my menstrual period to resume. I didn't share this with anyone and simply waited for it to return to normal."

## 5. Discussion

The findings of this research showed that, altogether, the stereotypical thinking patterns, the fear of being labeled, discrimination, and feeling ashamed of receiving reproductive health services constituted the stigma attributed to unmarried women using reproductive health services. In some countries, for example, South Asian countries, where premarital sexual relations are banned (21) and a woman's pre-marriage virginal status is highly valued, the provision of reproductive health services to unmarried women has been significantly influenced by the cultures of these countries (8, 22). Although it seems that these cultures bring about stigma and shame for receiving these services (23), a girl is stigmatized and rejected by society if it is believed that her problem might be caused by sexual relations (24). Stereotypical thinking patterns and presumptions about this issue have led to the stigma attached to it and have made it very difficult for unmarried individuals to access reproductive health services (2). Other studies that have confirming the results obtained by the present research have shown that unmarried teenagers and young individuals are afraid of being labeled and stigmatized for using these services. These individuals state that it is this fear that causes them to avoid using these services (25, 26).

According to the obtained results for the present study, the fear of being labeled as a flawed woman is among the concerns of most women who access reproductive health services. Abdoli et al. also showed that when a woman is stigmatized by an illness and when her childbearing ability is doubted, she will not be chosen for marriage (27). In Iran, like many other communities, to ensure that no future limitations are placed on childbearing, choosing a healthy wife is preferred. In fact, good health is one of the main characteristics sought in a woman to be successful in the role of mother and wife (28, 29).

Participants stated that unmarried women faced many constraints from their families when in need of using reproductive health services for possible health concerns. Similarly, adults, parents, and even teachers in many other countries tend to control their children/students with regard to reproductive health-related issues. This issue can lead to limited access to reproductive health information and services. As such, it appears that women are more controlled than men in terms of following existing norms (11).

The customary reactions of the unmarried women participating in the study to reproductive health-related issues were shame and the avoidance of receiving these services. Dinos et al. Thornicroft and Fortenberry et al.

showed in their studies that stigmatized people tend not to request or receive such services to avoid the stigma attached to these circumstances. Instead, they attempt to hide their condition by delaying their referral to reproductive health clinics (30-32). The enforcement of norms and directing individuals to situations that might carry some stigma generally causes youth and unmarried individuals to hide their conditions to avoid using the available services (11). Studies have shown that changing the social approach to this issue can be one of the solutions for helping these individuals (33). Thus, it appears that alongside the provision of reproductive health services, de-stigmatization should also be taken into consideration in this context. This is because the social acceptance of reproductive health services for special groups significantly affects the behavior of these groups and their approach to seeking out and using these services. Even in communities where reproductive health services are officially provided to unmarried individuals and youth, it has sometimes been seen that cultural sensitivities and social reluctance can continue to affect people's willingness to access these services (34, 35).

Considering the fact that the stigma attributed to reproductive health services used by unmarried women is rooted in stereotypical thinking patterns, it appears that in addition to a socialist approach that employs extensive training to change the public approach to reproductive healthcare services and establish the probability that all unmarried women may struggle with gynecological issues in the future, the provision of reproductive healthcare services is the first step toward resolving this issue. Society, families, and unmarried women themselves need to understand that sexual and reproductive health is an important part of a woman's entire lifecycle. It needs to be understood that reproductive health-related conditions do not necessarily point to the conclusion that an individual has engaged in sexual intercourse. The strength of this study was that it included the maximum variance in samples, including from women with different age, educational level, social, and economic status referring to health and educational centers in different areas. The limitations were the unavailability of the population of unmarried women who were older, their mothers or their family members did not go to healthcare or educational centers, and there was no possibility of interviewing them. Another limitation was the high dependency of the results on a specific cultural context, which reduces the ability to generalize the results. Therefore, it is recommended that further research be conducted in various communities and cultures.

## Footnotes

**Authors' Contribution:** Study concept and design: Fatemah Mohammadi, Shahnaz Kohan; acquisition of data: Fatemeh Mohammadi, Shahnaz Kohan, and Firoozeh Mostafavi; analysis and interpretation of data:

Fatemeh Mohammadi, Shahnaz Kohan, Firoozeh Mostafavi, and Ali Gholami; drafting of the manuscript: Fatemeh Mohammadi, and Shahnaz Kohan; analysis: Fatemeh Mohammadi, Shahnaz Kohan, and Firoozeh Mostafavi; study supervision: Fatemeh Mohammadi, Shahnaz Kohan, Firoozeh Mostafavi, and Ali Gholami.

**Funding/Support:** This study was funded and supported by the Department of Research and Technology, Isfahan University of Medical Sciences.

## References

1. UNFPA. *International-Conference-on-Population-and-Development*. 1994. Available from: <http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development>.
2. DeJong J, Shepard B, Roudi-Fahimi F, Ashford L. Young people's sexual and reproductive health in the Middle East and North Africa. *reproductive health*. 2007;**14**(78):8.
3. Bhandari MN, Kannan S. Untreated reproductive morbidities among ever married women of slums of Rajkot City, Gujarat: the role of class, distance, provider attitudes, and perceived quality of care. *J Urban Health*. 2010;**87**(2):254-63. doi: 10.1007/s11524-009-9423-y. [PubMed: 20108049]
4. Braeken D, Rondinelli I. Sexual and reproductive health needs of young people: matching needs with systems. *Int J Gynaecol Obstet*. 2012;**119** Suppl 1:S60-3. doi: 10.1016/j.ijgo.2012.03.019. [PubMed: 22884824]
5. Sabarwal S, Santhya KG. Treatment-seeking for symptoms of reproductive tract infections among young women in India. *Int Perspect Sex Reprod Health*. 2012;**38**(2):90-8. doi: 10.1363/3809012. [PubMed: 22832149]
6. Hall KS, Moreau C, Trussell J. Continuing social disparities despite upward trends in sexual and reproductive health service use among young women in the United States. *Contraception*. 2012;**86**(6):681-6. doi: 10.1016/j.contraception.2012.05.013. [PubMed: 22762707]
7. DeJong J, Jawad R, Mortagy I, Shepard B. The sexual and reproductive health of young people in the Arab countries and Iran. *Reprod Health Matters*. 2005;**13**(25):49-59. [PubMed: 16035597]
8. Sychareun V. Meeting the contraceptive needs of unmarried young people: attitudes of formal and informal sector providers in Vientiane Municipality, Lao PDR. *Reprod Health Matters*. 2004;**12**(23):155-65. [PubMed: 15242224]
9. Lindberg C, Lewis-Spruill C, Crownover R. Barriers to sexual and reproductive health care: urban male adolescents speak out. *Issues Compr Pediatr Nurs*. 2006;**29**(2):73-88. doi: 10.1080/01460860600677577. [PubMed: 16772237]
10. Mosavi SA, Babazadeh R, Najmabadi KM, Shariati M. Assessing Iranian adolescent girls' needs for sexual and reproductive health information. *J Adolesc Health*. 2014;**55**(1):107-13. doi: 10.1016/j.jadohealth.2013.11.029. [PubMed: 24560307]
11. Abedian K, Shahhosseini Z. University students' point of views to facilitators and barriers to sexual and reproductive health services. *Int J Adolesc Med Health*. 2014;**26**(3):387-92. doi: 10.1515/ijamh-2013-0316. [PubMed: 24243747]
12. Thornicroft G, Rose D, Kassam A, Sartorius N. Stigma: ignorance, prejudice or discrimination? *Br J Psychiatry*. 2007;**190**:192-3. doi: 10.1192/bjp.bp.106.025791. [PubMed: 17329736]
13. Van Brakel WH. Measuring health-related stigma—a literature review. *Psychol Health Med*. 2006;**11**(3):307-34. doi: 10.1080/13548500600595160. [PubMed: 17130068]
14. Corrigan PW. On the Stigma of Mental Illness: Practical Strategies for Research and Social Change. American Psychological Association. 2005.
15. Goffman E. *Stigma: Notes on the management of spoiled identity*. Simon and Schuster; 2009.
16. Golestannezhad A. *Statistics Book of Isfahan City*. Isfahan: Isfahan Municipality. Vice-chancellor of Planning, Research and Technology Information; 2012.
17. Governor of Isfahan. *Office of Statistics & Information*. 2002. Available from: <http://statistics.ostan-es.ir/>.
18. Naeli J, Moghimi D. *Policy Document to Promote Primary Health Care*. Ministry of Health and Medical Education of Iran. 2008. Available from: <http://www.behdasht.gov.ir>.
19. Davari M, Kohan S, Enjezab B, Javadnoori M. Promoting the Efficient Use of Human Resources in Reproductive Health Services in Iran: A Cost-Service Analysis. *Director General*. 2012;**8**(7)
20. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;**15**(9):1277-88. doi: 10.1177/1049732305276687. [PubMed: 16204405]
21. Wellings K, Collumbien M, Slaymaker E, Singh S, Hodges Z, Patel D, et al. Sexual behaviour in context: a global perspective. *Lancet*. 2006;**368**(9548):1706-28. doi: 10.1016/S0140-6736(06)69479-8. [PubMed: 17098090]
22. Jejeebhoy S, Shah I, Puri C. *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*. Geneva; World Health Organization. 2003.
23. Latifnejad Roudsari R, Javadnoori M, Hasanpour M, Hazavehei SM, Taghipour A. Socio-cultural challenges to sexual health education for female adolescents in Iran. *Iran J Reprod Med*. 2013;**11**(2):101-10. [PubMed: 24639734]
24. Bennett LR. *Women, Islam and modernity: single women, sexuality and reproductive health in contemporary Indonesia*. New York: Routledge; 2005.
25. DeJong J, El-Khoury G. Reproductive health of Arab young people. *BMJ*. 2006;**333**(7573):849-51. doi: 10.1136/bmj.33993.460197.68. [PubMed: 17053245]
26. Biddlecom AE, Munthali A, Singh S, Woog V. Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *Afr J Reprod Health*. 2007;**11**(3):99-110. [PubMed: 18458737]
27. Abdoli S, Abazari P, Mardanian L. Exploring diabetes type 1-related stigma. *Iran J Nurs Midwifery Res*. 2013;**18**(1):65-70. [PubMed: 23983731]
28. Goenka N, Dobson L, Patel V, O'Hare P. Cultural barriers to diabetes care in South Asians: arranged marriage—arranged complications? *Pract Diabetes Int*. 2004;**21**(4):154-6. doi: 10.1002/pdi.624.
29. Abdoli S, Mardanian L, Mirzaei M. How public perceive diabetes: A qualitative study. *Iran J Nurs Midwifery Res*. 2012;**17**(5):370-4. [PubMed: 23853650]
30. Dinos S, Stevens S, Serfaty M, Weich S, King M. Stigma: the feelings and experiences of 46 people with mental illness. Qualitative study. *Br J Psychiatry*. 2004;**184**:176-81. [PubMed: 14754832]
31. Thornicroft G. Stigma and discrimination limit access to mental health care. *Epidemiol Psychiatr Soc*. 2008;**17**(1):14-9. [PubMed: 18444452]
32. Fortenberry JD. The effects of stigma on genital herpes care-seeking behaviours. *Herpes*. 2004;**11**(1):8-11. [PubMed: 15115631]
33. Brown L, Macintyre K, Trujillo L. Interventions to reduce HIV/AIDS stigma: what have we learned? *AIDS Educ Prev*. 2003;**15**(1):49-69. [PubMed: 12627743]
34. Mmari KN, Magnani RJ. Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *J Adolesc Health*. 2003;**33**(4):259-70. [PubMed: 14519567]
35. Oraby DM. Sexual and reproductive health among young people in Egypt: the role and contribution of youth-friendly services. *Sex Educ*. 2013;**13**(4):470-7. doi: 10.1080/14681811.2012.756810.