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Iranian key informants' perspectives towards gender sensitive STIs/HIV/AIDS prevention service delivery

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ABSTRACT

More than 340 million new cases of sexually transmitted infections occur throughout the world every year. The average annual ***STIs*** *growth rate was 17%from 1998 to 2006 in Iran. As this epidemic has progressed, relevant literatures shown that, gender has a critical element in implementation and impact of these programs. Most reproductive health programs haven't integrated gender mainstreaming to their service deliveries. In order to explore key informants perspectives towards gender sensitive STIs/HIV/AIDS prevention service delivery, this study was done. Participants including health managers, health policy makers and reproductive health providers were selected purposefully and continued by snow ball sampling. 43 semi-structured in depth interviews with 37 key informants analyzed according to content analysis. Main categories were generated after processing and organizing the codes. Key informants clearly explained the gender sensitive STIs/HIV/AIDS prevention structure in three domains: training gender sensitive providers, facilities and management. In our country, transforming gender neural to more complete gender sensitive STIs/HIV/AIDS prevention services needs structural reforms that make these interventions more effective.*

Key words: gender sensitive service delivery, prevention, STIs/HIV/AIDS

INTRODUCTION

Worldwide, Sexually Transmitted Infections are among the most prevalent infections that impose significant morbidity on people all over the world. The relationship between HIV infection, and STIs attaches greater importance to such a scourge. Globally, about 2.9 million deaths (5.2% of total) are attributable to unsafe sex.[1] According to a survey conducted by World Health Organization (WHO) in 2007, more than 340 million new cases of sexually transmitted infections occur throughout the world every year. Worldwide, gonococcal and chlamydial infections cause 4000 newborn babies blindness and up to 40% of infertilities every year. In addition, Hepatitis B virus, which may be transmitted sexually results in an estimated 350 million cases of chronic hepatitis.[2] A study in Tanzania revealed that 74% of HIV infections in men and 22% in women could be attributable to the presence of herpes simplex virus type 2.[3]

At the end of 2010, some 34 million people were suffering from HIV, of which women constituted 50% to 64% of the adults bearing HIV.[4] In America from1993 to 2003, HIV infection rate raised 15% in women but 1% in men.[5] While HIV prevalence had higher rate in high risk groups. A Vietnamese meta-analysis finding showed the increased rate of infection in low risks women from 19% in 2005 to 35% in 2008[6] and in the same period in china HIV infected women became doubled. [7]

The annual number of symptomatic reported cases has 8 times increase from 1998 to 2006 reaching about 1.6 incident cases in one-hundred populations. The average annual growth rate in last 6 years was 17%.Disaggregating by sex shows that although the number of reported male cases increased more than four times, the overall female incidence pattern mimics the trend of STIs among males.[8] More recently, there has been some evidence of the growing role of sexual transmission in the spread of HIV in Iran.[9] Gender norms affect both women's and men's sexual behavior,[10] power dynamics between them and inequity to access to test, care and treatment of STIs/HIV.[11] Relevant literature indicates that the incorporation of strategies to address gender inequality can lead to improved health and program outcomes.[2, 12] Traditional programs which neglected environmental norms encouraged high risk behavior, inequity to access to reproductive health services; gender related power dynamic imbalances and accountability to unmet needs have been failed. Nowadays, health organizations and services haven't integrated gender mainstreaming to their interventions and programs.[13]

A few studies consider gender sensitive reproductive health. Nicaraguan project has used the weekly drama TV series and focused groups discussion aimed at promoting young men and women empowerment of by gender transformation. It found that men with greater exposure to the intervention had a 56 percent greater probability of condomuse.[14] Cambodian adolescent reproductive health project incorporated concepts of gender equality and human rights into young men activities. The project used male peers as a way to engage young men with information about HIV/STIs and to change their behavior. It led to the conclusion that such projects can help men to promote gender equality and respect for women rights.[15] The results of an Iranian qualitative study showed gender norms and unsupportive roles of husbands were condom use obstacles at HIV risks women.[16] While the role of gender based power in sexual relationships has in recent years been acknowledged, the understanding has largely lacked practical considerations in the STIs/HIV/AIDS prevention fields. This study aims to explore gender sensitive STIs/HIV/AIDS prevention services concepts and dimensions. Our governmental reproductive health services have been delivered as a 'one size fits all' model, and mainstream health policy, the design and delivery of programs and services are not gender sensitive.

MATERIALS AND METHODS

This qualitative study is the part of an explorative sequential qualitative–quantitative study. Participants were selected purposefully and continued by snow ball sampling. Thirty seven key informants were interviewed (13 male, 24 female), including policymakers, program managers, university staff members, and health care providers in the reproductive health fields such as safe motherhood, family planning, youth and adolescence health, premarriage counseling and STIs/HIV/AIDS prevention services. Individuals worked at a local level in Shiraz and national level in ministry of health in Tehran. By permission of Shahid Beheshti Medical Science University, We conducted the interviews in the state clinics and the managers' offices in Shiraz and Tehran.

Data collected by using semi-structured in depth interview. The validity of interview guide questions was confirmed by three experts of reproductive health. All participants were provided with written informed consent. Interviews were face-to-face and audio-recorded. Each interview took 60 to 90 minutes. Sometimes supplementary interview was needed to explore complete perception. Interviews continued till data saturation. Finally 43 interviews were done.The data analyzed according to content analysis.

All interviews recorded, typed and coded in the same day. The second interview was done only after coding the first one. Before coding the data, the researchers read the typed interview transcripts and field notes line by line and word by word. Initial coding was done by Straus and Corbin[17] method according to concepts of data. In consideration to cultural diversity and specify of gender concept, the main messages of interviews were explored by reading and re-reading the meaning units. Then similar or related codes were classified to a particular group and subcategories and categories were emerged.

The credibility of the study was promoted by showing codes to participants to be assured about correct perception of their views, appropriate communication between researcher and participants, using various participants with substantial experience and expertise from among health care providers, staff members and medical managers, and also to maximize variability in terms of sex, age, and working experience. Transferability was increased by clear and distinct description of selection and characteristics of participants, data collection and process of analysis. To

facilitate conformability, voice files, coded printed interviews, notes, analysis and trustworthiness process of the study were documented. The data and records were revised by two reproductive health expert researchers to justify about similarities of results. In more than 90% of findings, similarities acquired.

RESULTS

37 participants in this study included STIs/HIV/AIDS prevention managers and providers. Their mean age was 43/1 and mean years of expertise was 16/2(Table 1)

Table 1: The characteristics of participations

Number	gender	Age	Years expertise In Field:	Specialty:	Responsibility:
1	Male	47	8	General practitioner	High Risk Behavior Prevention Center-Manager
2	Female	40	16	General practitioner	Regional Family Health Manager
3	Male	60	40	Public Health(Ms)	High Risk Behavior Prevention Center-Provider
4	Female	40	14	General practitioner	Regional Health Education-Manager
5	Female	50	25	Midwife(Bs)	Family Health-Provider
6	Female	40	15	Midwife(Bs)	Family Health-Provider
7	Male	47	21	General practitioner	Health Policy Center-Manager
8	Male	47	20	Internal Specialist	Previous Minister Of Health
9	Female	40	14	Mph Reproductive Health	Men Health Project Manager
10	Female	42	22	Midwife(Ms)	Faculty Of Nursing And Midwifery
11	Female	52	25	Public Health(Bs)	Rural Health House Manager (Regional)
12	Female	40	10	General practitioner	National Youth Health Manager
13	Female	36	15	Public Health(Bs)	Youth Health Provider
14	Female	36	5	Midwife(Bs)	Premarital Class Trainer
15	Male	50	5	General practitioner	Premarital Class Trainer
16	Male	46	17	General practitioner	Family Health –National Office
17	Female	49	15	General practitioner r	Family Health--Manager(Regional)
18	Female	48	22	Midwife(Bs)	Faculty Of Nursing And Midwifery
19	Female	45	15	Nurse(Ms)	Faculty Of Nursing And Midwifery
20	Female	43	8	General practitioner	High Risk Behavior Prevention Center-Physician
21	Female	40	14	General practitioner	Regional Youth Health Manager
22	Male	42	8	Diploma	HighRiskBehaviorPreventionCenter--Provider
23	Male	49	11	General practitioner	Head Of Regional Vasectomy Services
24	Male	53	6	General practitioner	Premarital Class Trainer
25	Female	39	14	Midwife(Bs)	Family Health-Provider
26	Male	47	24	Public Health(Bs)	Std Prevention Manager(Regional)
27	Female	45	20	Midwife(Ms)	Faculty Of Nursing And Midwifery
28	Male	49	17	Nurse(Ms)	Reproductive Health Manager
29	Female	47	14	Midwife(Ms)	Voluntary Health Trainer(Regional)
30	Female	36	13	Midwife	Family Health-Provider
31	Female	38	12	General practitioner	Regional Youth Health Manager
32	Female	41	16	Midwife(Bs)	Family Health-Provider
33	Female	33	10	Midwife(Bs)	Family Health-Provider
34	Female	33	34	Midwife(Bs)	Family Planning Office Provider(Regional)
35	Male	57	34	Health Education-PhD	Health Office Manager
36	Male	46	16	Health Education-PhD	Adolescent Reproductive Health Clinic Manager
37	Female	38	14	Midwife(Bs)	Family Health-Provider

Three main categories were formed as: Training gender sensitive STIs/HIV/AIDS prevention providers, Facilities to provide gender sensitive STIs/HIV/AIDS program and Gender sensitive STIs/HIV/AIDS program management (Table 2).

Table (2): Theme, categories and codes delivered from reproductive health managers and providers perception to gender sensitive STIs/HIV/AIDS prevention services

Theme	sub categories	CODES
Gender sensitive STIs/HIV/AIDS prevention services structure	**Training gender sensitive STIs/HIV/AIDS prevention providers**	Training of men providers to include men's STIs counseling, diagnosis and care services
		Provider's orientation of women's protection rights
		Modifying provider's beliefs in terms of offering services to both genders not just females
		Raising awareness of adolescent's risk reduction strategy
		Raising awareness of religious perception against reproductive rights and enabling them to overcome taboo
		Raising awareness of men and women reproductive rights in temporary marriage (Nikāh al-Mutah)
		Raising awareness of men and women reproductive rights
		Raising awareness of legal laws for protection of women's reproductive rights
		Raising awareness of the relationship between new sexual behavior patterns and STIs spreading
		empowering to provide services to opposite sex clients
		The empowerment of providers' sexual counseling
		Impartiality of provider in offering STIs prevention services
	Facilities to provide gender sensitive STIs/HIV/AIDS program	Introducing facilities to provide STIs/HIV/AIDS counseling, diagnosis and care for men.
		Introducing suitable places for adolescents with high risk behaviors
		creating environment of privacy and respect for STIs risk assessment
		providing facilities for pre marriage STIs screening
	Gender sensitive STIs/HIV/AIDS program management	preparing adolescents' high risk behaviors statistics
		supporting providers who protect women's reproductive rights
		Solving professional problems existing in offering men's STIs services

1- **Training gender sensitive STIs/HIV/AIDS prevention providers.**

1-1: Training of men providers to include men's STIs counseling, diagnosis and care services:

The need for skilled men staff emphasized by most participants interviewed:

"In order to offer services the need for male staff is obvious. Unfortunately, we lack such skilled manpower at present"(health policy maker with 34 years expertise).

An expert participant explained:

"Nowadays, a few male clients refer to the governmental STIs clinics. It is because the clients have to be examined by female physicians .Even if male clients talk openly about their STIs problems the physicians have gender related barriers to counseling and examination"(family health provider with 14 years expertise).

Some of providers added:

"In most male schools, puberty health education is not being fulfilled , because all trainers are from among female staff. They are not practically capable of offering services and examinations to male clients "(faculty member with 15 years expertise).

The majority of providers are female midwife. They stated:

"We have been trained just for routine tasks such as STIs screening and routines in women, number of women to be covered and reporting our daily work. We have not received any specific education or discussion for the men sexual health"(faculty member with 15 years expertise).

1-2- Provider's orientation of women's protection rights:

The majority of participants focused on provisions and measurements protecting women in high risk situations:

"I should tell her how she can avoid STIs complications, but the question is that, how I can help her when her husband denies using condom? Furthermore, I am not educated about alternative methods, consequently, I prefer not to intervene in her private life"(men's health manager with 15 years expertise).

1-3-Modifying provider's beliefs in terms of offering services to both genders not just females

The necessity of changing providers' beliefs was highlighted by many participants:

"Frankly speaking, we are still captured with taboos. As health care providers we forbid attendance of male clients into the clinics. We continue to live with such taboos. They are deeply embedded into our culture. Providers' thoughts and attitudes should be modified. Otherwise, they are embarrassed interacting with male clients, because they are grown up with the same taboos "(family health manager with 14 years expertise).

1-4- Raising awareness of adolescent's risk reduction strategy
Disability to educate risk reduction strategy(such as: decreasing sexual partner, reduce sexual relations and use contraceptives were mentioned as most participants' opinion:
"Our services for adolescents are limited to distribute condom. We lack any kind of sexual behavior monitoring or counseling, we didn't have any specific training on risk reduction strategies for them"(youth health manager with 14 years expertise).

A few instances thought otherwise:
"I disagree with talking about protection in sexual relation; I think teens should delay their sexual activity" (family health manager with 14 years expertise).

1-5- Raising awareness of religious perception against reproductive rights and enabling them to overcome taboo
One of the expert health manager mentioned the significant roles of health system in removing religious wrong concepts:
"nowadays, women's health especially in high risk sexual situations are exposed to dangers and their rights are rubbed merely because of a misconception about the so- called term " obedience"(tamkin). In order to eliminate such wrong conceptions, health providers should be taught for religious concepts related to reproductive health rights"(health policy maker with 34 years expertise).

1-6- Raising awareness of men and women reproductive rights in temporary marriage (Nikāh al-Mutah) :
The relationship between temporary marriage (Nikāh al-Mutah) and STIs spreading stressed by most participants:
"Certain groups of men and women welcome temporary marriage for specific purposes .Such commitments can lead to expansion of STIs, while none of them are aware of their rights or complications of such marriage. This type of marriage have been missed in our health intervention. In order to make sexual partners aware of the complications, specific health strategy and appropriate facilities should be provided"(health policy maker with 34 years expertise).

1-7- Raising awareness of men and women reproductive rights:
In favor of necessity of providers awareness of reproductive health rights the majority of participants said:
"We have a littlie back ground and knowledge about reproductive rights, and we will first need to acquaint ourselves with reproductive health rights. so we have little to say about partners rights in STIs or sexual dissatisfaction cases, we fear that our interventions make situation worsen "(men's health manager with 14 years expertise).

Some participants disagreed, one of them said:
"We are so overburdened with our work, that we do not have time to help men and women reaching their reproductive health rights, in addition when people know their rights without knowing ways to reach them, absolving problems remain beyond"(family health manager with 15 years expertise).

1-8-Raising awareness of legal laws for protection of women's reproductive rights.
Almost all participants ascertained that legal instruction related to reproductive health rights protect women's health:
We lack any protocols related to reproductive rights education, and there is no related interdisciplinary subjects in guidelines, published by ministry of health. Men's risky sexuality affects women's health, but we don't have any right-based intervention instruction"(health education manager with 15 years expertise).

Another opinion emerged in interviewees:
"Women reproductive rights protection is not our priority. We should manage other important problems. We can't intervene when man doesn't seek health behavior in sexual relation"(family health manager with 17 years expertise).

1-9- Raising awareness of the relationship between new sexual behavior patterns and STIs spreading.
The majority of participants recognized thenecessity for clarifying popular sexual behavior**:**
"Movies, magazines and models can also become powerful tools for giving sexual practice patterns more times harmful practices. Health system doesn't address these patterns so our prevention programs will not need-based and effective"(family health manager with 16 years expertise).

1-10-empowering to provide services to opposite sex clients:
All of our research participants had the same idea of female staff disability to manage men's reproductive health needs:

"It is very difficult for me to raise the reproductive and sexual issues with men especially young ones. I prefer to refer them to other clinics or private centers, thereby the following up of the results is disrupted"(family health manager with 16 years expertise).

A family health worker added:
"Our sexual and reproductive health training is limited on women's needs there is no similar training on addressing men's STIs and sexual needs. I think, it is midwifery education and health system fault"(family health provider with 15 years expertise).

1-11-The empowerment of providers' sexual counseling skills:
Promoting provider sexual counseling skills was mentioned by most participants:
"Continues education on a sexual counseling skill was ignored in our training programs. Even if we participate at sexual education class, our trainers can't speak openly so s/he teaches burden and stereotyping lessons. I haven't learned anything in these classes"(family health provider with 14 years expertise).

1-12-Impartiality of provider in offering STIs prevention services.
Many participants mentioned that providers' feelings and values affect their ability to provide certain services:
"In fact, I know some health care providers who feel negativity and ambivalence about providing reproductive health services to unmarried men or women……...we don't provide such services with traditional personnel "(family health manager with 16 years expertise).

An expert health policy maker explained his opinion:
"Special approach to the diseases made by sexual behavior is needed. The core of reproductive health program is family health. Services for high risk sexual groups should not integrate to family health, if we do so it will be failed. In some countries this integration occurred but in our country with special culture, it doesn't work"(National health policy maker with 16 years expertise).

2- Facilities to provide gender sensitive STIs/HIV/AIDS program.
Participants described gender sensitive facilities as follow:
2-1-Introducing facilities to provide STIs/HIV/AIDS counseling, diagnosis and care for men.
All participants emphasized on special facilities:
"There are no suitable places in governmental clinics that provide men's sexual counseling or care. I know that men may face barriers that cause them to feel they had no reason to be there"(faculty member with 20 years expertise).

2-2-Introducing suitable places for adolescents with high risk behaviors
The necessity for such centers was mentioned as an all participant's opinion:
"Unmarried girls referring to Specific HIV prevention centers for high risk population, face to wrong judgment, injustice and accusation, while boys refer to this clinic more freely. These clinics follow up HIV positive people, they don't monitor or treat other STIs "(STIs prevention manager with 8 years expertise).

2-3-creating environment of privacy and respect for STIs risk assessment.
All participants agreed that Lack of suitable places for women STIs/HIV risk assessment resulted in missing high risk groups especially in pregnant women:
"The pregnant woman feels that if she talks about her husband sexual risk factors, this may be heard by neighbors, friends, husband relatives or other staff who are attending there , so she refrain to speak honestly with us"(family health provider with 25 years expertise).

2-4- providing facilities for pre marriage STIs screening:
"Most participants agreed with providing pre marital STIs screening facilities:
Today the marriage age in Iran for girls and boys has increased considerably. This gives them sufficient time to engage in pre-marital affairs. We know most infected women get infection via marital sex. We need screen and treat who seek care but we have only screened syphilis"(pre marital service provider with 6 years expertise).

3-Gender sensitive STIs program management.
3-1-preparing adolescents' high risk behaviors statistics.
one of participants stressed the significance of relating statistics and said:
"within the adolescents health risks indicators, there aren't any sexual behavior related indicators. we don't know how early sexual activity either hetero or homosexual shaped . We can't estimate the weight of these problems. Adolescents afraid of reporting these sexual practices and we afraid of knowing these facts too"(adolescents health manager with 12 years expertise).

3-2-supporting providers who protect women's reproductive rights.
The majority of participants expressed worry about challenges for professional duties and providers' supportive laws:
*"STIs counseling may require disclosures concerning men's high risk sexual relationships outside marriage that would hurt women's health. How can we help the women? Is it any supportive system for providers? Do we have supportive system for protecting women's sexual health? Aren't we remonstrated or threatened to sue by the officials? There are many unanswered questions for providers"***(**STIs prevention manager with 25 years expertise).

3-3-Solving professional problems existing in offering men's STIs services
Most of the participants reported the need for solving practical problems in men's STIs services:
"Men are not our health intervention target groups. There are no definite indicators that measure information and practices of married men. We are not responsive to single young men and adolescents covered by the center. Hence, how should men's reproductive risk assessment be addressed and thereby planning prevention program for them? our health system neglects its responsibility against boys. How should be addressed men's reproductive risk assessment and then planned prevention program for them? "(Family health provider with 25 years expertise).

DISCUSSION

This is the first in-depth study, as far as we are aware, that set out to explore explicitly health care provider and managers' perception to gender sensitive STIs/HIV/AIDS prevention services.

This study took into account some structural design suitable for providing gender sensitive services such as, training of sophisticated manpower, facilities and gender sensitive management. In terms of sophisticated trainers, the participants proposed the significance of an appropriate education for the service providers and also continual updating and improvement of the very education. Our findings were similar to the studies done in terms of the effect of beliefs, knowledge, skills and values of the providers in presenting gender-sensitive services.[18-20] Significant effects of sexual counseling-skills training on promotion of men, women and youth reproductive health shown in our study similarly were confirmed by other studies.[21, 22]

The necessity of adequate training of service providers on protection of reproductive health rights via gender sensitive STIs/ HIV particularly women rights against men risky sexual behavior, reproductive health aspects in temporary marriage and awareness of adolescents risk reduction strategies was explained. Several studies have revealed that reproductive rights are significantly related to reproductive health.[23-25]

The required facilities regarding to the society's gender norms for STIs such as protecting private boundary, the existence of specialized centers and suitable capabilities which were similar to other findings.[26, 27] The role of management in empowering personnel defending the rights of women, the goodness of fit indicators and guidelines of health system assuring legal immunities were confirmed in similar studies.[28, 29]

CONCLUSION

In order to providing gender sensitive STIs/HIV/AIDS prevention services, appropriate training of providers, facilities, programs management should be designed, implemented and evaluated.

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