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Impact of Agency on Iranian Women's Access to and Utilisation of Reproductive Healthcare Services: A Qualitative Study

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Abstract

Introduction Agency, as the ability to identify one's goals and act upon them, has been recognised as a prominent strategy to achieve universal access to sexual and reproductive healthcare services (SRHS). This study explored Iranian women's agency in accessing and using SRHS and how agency at various individual, relational, and collective levels, is constructed, constrained, and facilitated.

Methods A qualitative inductive thematic analysis using in-depth, semi-structured, individual face-to-face interviews was conducted with 52 participants across three categories: women of reproductive age (18–49 years), experts and healthcare providers, and policymakers in Iran in 2021.

Results Iranian women exercise their agency to uptake SRHS by relying on their individual capacities, financial autonomy, and social media as a source of sexual and reproductive knowledge in a culture that is largely silent on sexual and reproductive health matters. Women's agency at the familial level is limited because of the exclusion of men from SRHS and reproductive education. At the structural level, sociocultural norms and expectations, patriarchal gender norms, lack of political will and legal support, and lack of appropriate policies to meet the sexual and reproductive needs of all populations restrict access to SRHS. Marginalising people who act outside the traditional sociocultural norms and legal framework made accessing and using SRHS difficult because healthcare services and policies do not recognise these groups.

Conclusion This study provides unique insights into how Iranian women face limitations to exercise agency but can, at times, negotiate and enact agency to access and use SRHS.

Policy Implications Essential requirements to improve Iranian women's agency in accessing and using SRHS require a strong political commitment to evaluate and eliminate the social, legal, policy, administrative, and healthcare-level barriers.

Keywords Health services · Reproductive health services · Women's agency · Empowerment

Introduction

Universal access to sexual and reproductive healthcare services (SRHS), which also includes access to sexual and reproductive health information and education, is critical not only for achieving Sustainable Development Goals (SDGs) but also for addressing human and reproductive rights (Temmerman et al., 2014). SRHS encompass a broad range of services, including maternal care, family planning, safe abortion, sexual health and safe sex, and prevention and treatment of sexually transmitted infections (STIs) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (Germain et al., 2015).

The 1994 United Nations International Conference on Population and Development called for a global commitment to improving women's access to SRHS by centralising women's agency within reproductive health research and

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programs (Bhan et al., 2022). Agency—defined as the ability to identify one's goals and act upon them—has been recognised as a prominent strategy to achieve universal access to SRHS (Plouffe et al., 2020). Specific to access to SRHS, women's agency has three key dimensions: decision-making power, the vocalisation of gender-equitable attitudes, and freedom of movement. In fact, it might be expected that women who are able to have meaningful involvement in decision-making over their health and control and access financial resources to spend on their health, freedom of movement to cover the distance to go to healthcare centres, and more equitable gender attitudes may exercise a higher ability to negotiate their sexual and reproductive choices and rights (James-Hawkins et al., 2018). It also improves women's negotiating power in sexual relationships and safe sex practices with their partners (James-Hawkins et al., 2018; Karp et al., 2020).

While the terminology may vary, agency is generally conceptualised as the result of the interaction between individual and structural factors (Burke et al., 2022). As a context-specific and multidimensional construct, agency is exercised at three different levels: individual—women's ability to have meaningful involvement in the decision-making process; relational—related to their romantic/marital partners, family members, and peers; and collective—in relation to a broader societal context (Edmeades et al., 2018; Samari, 2017). Moreover, at each level, individuals draw on resources such as sexual and reproductive knowledge and healthcare services to promote their agency within the specific context in which they live (Burke et al., 2022).

Nonetheless, research on SRHS has largely neglected women's agency in exercising choice and making decisions to access and use these services (UNFPA, 2019). This is particularly important in contexts like Iran, where power imbalances, inequitable gender norms, and sociocultural beliefs maintain men's power and silence women's voices, leaving women with limited power to negotiate sexual and reproductive rights and preferences (Ouahid et al., 2023a, b). It is crucial to explore women's access to SRHS from an agentic perspective to understand their opportunities and needs in relation to the specific context in which they live. Understanding women's opportunities to enact agency in accessing and using SRHS can inform healthcare systems to provide sexual and health services and achieve universal coverage of SRHS.

Study Context

In Iran, many efforts have been made to provide an equitable distribution of SRHS to all people. In so doing, SRHS are embedded in primary healthcare through an extensive primary healthcare network and secondary and tertiary care through public and private healthcare centres. In addition to the public healthcare services provided by the government, Iran's healthcare system is also equipped with a well-developed private health sector, providing more than 80% of outpatient services but mainly in cities (Sajadi et al., 2022). Nonetheless, under this healthcare structure, access to healthcare services in urban and rural areas is unequal; in rural areas, more services are delivered by general practitioners via primary healthcare services, while in urban areas, specialist and subspecialist service utilisation is more common and easier to access (Danaei et al., 2019; Sajadi et al., 2022).

Currently, almost 90% of Iranians have some kind of health insurance, either public or private (Danaei et al., 2019). However, the extensive multilateral sanctions against Iran that began in 2012 have resulted in an economic downturn leading to an 87% annual inflation rate with a 45% inflation rate in the cost of healthcare services. This economic hardship drastically reduced people's spending ability, including spending on healthcare (Kokabisaghi, 2018a, b). In 2019, Iran spent 6.7% of its gross domestic product (GDP) on health, with a share of OOP expenditure of 39.5% (Doshmangir et al., 2021). The high out-of-pocket expenditure might be deemed as a deterrent for Iranian women seeking SRHS, especially when women may have limited agency in negotiating how they wish to spend money on their health in some circumstances.

In Iran, there are 15.8 doctors and 20.8 nurses and midwives for every 10,000 head of population. Almost 99% of births are attended by skilled healthcare personnel. The maternal mortality ratio was 16 per 100,000 live births in 2021. A total of 57% of women of reproductive age use modern contraceptive methods (World Health Organization, 2021). There are also a limited number of "Centers for Behavioral Diseases" that provide confidential, free testing and treatment for STIs and HIV/AIDS. However, these facilities are not publicly advertised and are primarily used by "high-risk" groups, including drug users and sex workers (Sheikhansari et al., 2021).

Sexual and reproductive health in Iran, a predominantly Muslim country, is a culturally conservative issue, with premarital sex being strictly forbidden by laws and traditions, particularly for women (Farahani, 2020). Accordingly, SRHS are mainly prioritised for married women, further limiting unmarried women's access to these services (Motamedi et al., 2021). Sexual and reproductive health issues are associated with secrecy and silence, with public discussion of these issues described in terms of cultural taboo and disrespect (Khalili et al., 2020). Shame, secrecy, and silence have implications for reproductive-related knowledge acquisition and practices (Ussher et al., 2017), as Iran does not have any formal education for either youth or adults on sexual and reproductive health, including safe sex practices (Alimoradi et al., 2017).

Moreover, a husband's consent is compulsory for many reproductive healthcare practices, such as surgery, legal abortion, and tubal ligation (Kokabisaghi, 2018a, b). In such a prevailing male-dominated context, the expansion of women's agency to make strategic sexual and reproductive health choices may be influenced by household composition, spouse relationships, and sociocultural norms.

On the other hand, in recent years, Iran has experienced a number of demographic, social, and cultural changes due to globalisation, urbanisation, the rising age at marriage, increasing women's participation in work markets and society, widespread access to global media (e.g. internet, satellite television, social media), significant improvement in women's education level, greater preference for higher education and frequent socialisation with male peers and premarital heterosexual friendships (Farahani, 2020). These cultural shifts have caused early sexual awakening, resulting in an increased rate of premarital sex among the younger generation (Farahani, 2020).

Nonetheless, Iranian society, including healthcare authorities, policymakers, and legislators, are ambivalent to these changes, locking policies, and programmes into place that create a vicious cycle in which these groups' reproductive healthcare needs are not addressed (Motamedi et al., 2021). This context perpetuates violations of sexual and reproductive rights, stigmatisation of reproductive health issues, and marginalisation of population groups who lack a voice in society, as they act outside accepted norms, for example, those who have premarital sexual relationships (Khalili et al., 2020).

Although a growing number of studies in Iran have been conducted to evaluate women's access to SRHS (Alimoradi et al., 2017; Kokabisaghi, 2018a, b), no study has assessed the impact of women's agency in accessing and using these services. In light of social and cultural transitions in Iran and its unique context, women's agency remains a novel aspect of SRHS. In addition to the availability and accessibility of SRHS, studies highlighted that the sociocultural and legal barriers prohibit universal access to SRHS for all people in Iran (Sheikhansari et al., 2021). Public health programs often define women's reproductive choices based on specific indicators, such as the availability and uptake of services. However, availability and uptake do not necessarily indicate agency and choice, nor do they ensure that choice leads to agency (Bhan & Raj, 2021). For this purpose, agency has been a central refrain in calls for access to universal RHCS (Starrs et al., 2018). Together with other factors, such as the availability and accessibility to high-quality RHCS, agency could determine a woman's capacity to use these services (Bhan & Raj, 2021).

Therefore, this qualitative study was undertaken to fill a gap in the knowledge base about Iranian women's agency in accessing and using SRHS. As agency is exercised in different ways and aspects (Logie & Daniel, 2016), the central research questions, derived from a multi-level model of agency (Edmeades et al., 2018), were 1) 'How do Iranian women enact agency to shape and determine their sexual and reproductive choices, and by so doing, improve their access to, and utilisation of, SRHS? 2) How is Iranian women's agency constructed, facilitated, or/and constrained?'.

Methods

A qualitative thematic analysis was performed to gain an in-depth understanding of participants' perceptions and experiences regarding women's agency in accessing and using SRHS. As women's agency is subject to personal experience, it would not have been possible to gauge the answers to these nuanced and complex questions through quantitative research techniques. The qualitative approach is best suited to uncovering women's agency in contexts in which it is often hidden from the public view.

The study was conducted between March and July 2021 in Tehran, the capital of Iran. Tehran has a population greater than 10 million people and is housing the central governing organisation of major policymakers and the Ministry of Health.

Participants

Participants comprised three categories of key informants, all women, including (1) women of reproductive age (18–49 years), (2) experts in women's rights, gender equality, and women's studies and healthcare providers representing diverse sectors and years of experience in the field of SRHS and women's health, (hereafter, experts), and (3) policymakers at Iran's Ministry of Health who were involved in the formulation of policies related to SRHS.

Participant Recruitment

To ensure the transferability of findings, the study was designed to recruit a sample of women of broad and varied experience and backgrounds. Therefore, women of reproductive age were purposively selected (Palinkas et al., 2015) according to age, education, occupation, marital status, location, and economic status. Inclusion criteria were women between 18 and 49 years of age and those who are able to voluntarily participate and openly discuss their reproductive health issues. Women outside this age range, those who were unable to understand the questions or share their experiences and opinions, or those who were not comfortable talking about their reproductive health, were excluded from the study. The potential participants were approached in various settings, including public and private healthcare centres,

universities, workplaces, and public places such as shopping centres, subways, and parks.

In the expert/healthcare provider and policymaker cohorts, potential participants were included if they were involved in sexual and reproductive health delivery or women's health and rights. They were recruited from a range of disciplines and professional groups through a mix of purposive and snowball sampling methods (Kirchherr & Charles, 2018). Several ways were used to approach them, including searching in the list of researchers and faculty members across universities; accessing researchers' profiles on Google Scholar for those who are working in the field of reproductive health; non-governmental organisations (NGOs) working in this field; women's rights organisations; and the professional networks.

The first author contacted the potential participants via telephone, email, or in person and provided them with the patient information and consent form (PICF), which included details on the study purpose and the right of participants to withdraw at any time if they so wished, assurances that confidentiality would be safeguarded by replacing any personal identifier in data collected with a number code. The researcher provided these potential participants with contact details to enable women to ask further questions about the study and to organise interviews, including a time and place according to participant preference.

Thirty women of reproductive age were contacted alongside 27 experts and healthcare providers and six policymakers, of which 23 (77%) women of reproductive age, 24 (84%) experts and healthcare providers, and five (87%) policymakers agreed to participate. The main reason given by policymakers and experts for not participating was time constraints. The reasons for not participating of women of reproductive age were unclear as women simply did not attend the pre-arranged time for the interview ($n=4$) and postponed the interview twice but still did not attend ($n=3$).

Interviews were conducted either in the participants' workplaces ($n=35$ interviews), in healthcare centres ($n=10$ interviews), or in the researcher's workplace ($n=7$ interviews), in a private room, so participants felt free and comfortable talking about the sensitive issues and expressing their honest opinions. All participants from the policymaker's cohort were working in the Ministry of Health. Participants in the expert cohort mainly worked at public hospitals or healthcare centres and universities with some working in the private healthcare system.

Data Collection

A semi-structured interview schedule with open-ended questions was developed by the research team based on an extensive literature review (e.g. Edmeades et al., 2018; Hinson et al., 2019; Upadhyay et al., 2014; Vizheh et al., 2021). The research guide steered the discussion and covered topics including how agency is constructed, constrained, and facilitated. It also explored women's personal experiences of accessing and using SRHS and the roles played by their partners, friends, family, and broader socioeconomic and political structures. Broad topics of interest were covered while allowing flexibility for probing questions in response to information offered by participants. A similar question framework was used for all three cohorts (see Supplementary file).

The interview schedule was piloted before the data collection, with two women, one healthcare provider, and one woman of reproductive age. These pilot exercises were critical in identifying shortcomings in the initial interview schedule (Lune & Berg, 2017). Modifications were made according to these pilots to ensure question clarity and ease of understanding. Individual, face-to-face interviews were conducted in Persian, the official Iranian language. All interviews were recorded using two digital recorders. The length of interviews ranged from 35 to 60 min for women of reproductive age and 45 to 70 min for experts/healthcare providers and policymakers.

Interviews were continued until "data saturation" often defined as "information redundancy", was achieved (Guba & Lincoln, 1989; Thorogood & Green, 2018). This was the point where no new information, codes, or themes emerged from data to embellish findings or shed light on issues raised by participants (Braun & Clarke, 2021b).

Data Analysis

All recorded interviews were transcribed verbatim, de-identified, and then translated into English by the first author. We undertook a thematic analysis based on the methods described by Braun and Clark using an inductive approach. Data analysis was performed manually to ensure an ongoing understanding of emergent findings. This enabled continual contact with the dataset and recognition and familiarity with data content and allowed a number of analysts to return to the data repeatedly as themes and concepts emerged to immerse themselves in the data (Braun & Clarke, 2021a; Peterson, 2019). Two researchers (MV and FR) read each anonymised transcript several times and then coded data, independently. Any discrepancies were discussed with other research members (YZ and JB) in the study team until a consensus was reached on codes and their meaning.

Following the generation of open codes, the research team discussed and agreed on a list of sub-themes grouped into themes, indicating the most important findings. The themes were evaluated to understand how they contributed to answering the research questions (Braun & Clarke, 2021a). The quotes were selected from the coded portion of

the transcripts that represented each sub-theme while ensuring that the selected quotes represented the key issues discussed within each sub-theme. The quotes were also selected to demonstrate how the findings and interpretations have arisen from the data (Eldh et al., 2020).

In this research, several techniques and approaches were applied to improve the rigour of data collection and analysis and the reliability and validity of findings. Triangulation of researchers' opinions and codes was considered a central approach to ensure the quality of the analysis (Bierbaum et al., 2020). Providing thick and rich descriptions was another strategy used to achieve data credibility and obtain transferability (Hadi & José Closs, 2016; Lincoln & Guba, 1985). Researchers attempted to provide sufficient and in-depth details of study settings, inclusion/exclusion criteria, participants' characteristics, data collection, and analysis methods, so readers of the research could subsequently consider the extent to which the conclusions were appropriate and potentially transferable to other settings and populations (Hadi & José Closs, 2016). Moreover, member checking was performed by sending the transcripts to five participants, two women of reproductive age and three experts/healthcare providers (Creswell & Poth, 2016; Patton, 2014). This approach demonstrated that participants' perception was similar to those of the researchers, thereby strengthening the validity of data interpretation (Motulsky, 2021). All illustrative quotes in this paper are identified by a code that denotes the participant number, age, and speciality or occupation (e.g. P.29, 54 years, specialist in community medicine).

Ethical Considerations and Consent

This study was approved by the ethics committee of the Tehran University of Medical Sciences with the ethics code: IR.TUMS.FNM.REC.1397.214. Before starting the interview, written and verbal consent was acquired from all participants. Participants were assured they could refuse to answer any question if they wished and could discontinue the interview at any time.

Results

Fifty-two women participated in this study from three cohorts: women of reproductive age, experts and healthcare providers, and policymakers. Table 1 presents the main demographic characteristics of the participants.

Overview of the Qualitative Results

There was extensive overlap across all three cohorts of participants in the information and opinions provided during interviews. However, women of reproductive age most emphatically emphasised relational agency, conceptualised as their ability to pursue and achieve their sexual and reproductive goals within the context of their personal relationships with members of their own household, including their husbands. This was followed by individual agency, including opinions and experiences of women's individual actions decided and undertaken according to their everyday lives, options, and priorities to act on their own choices. Few women of reproductive age mentioned collective agency and structural factors such as societal expectations and practices or the expectations of their social circles, healthcare systems, or the legal system in improving or reducing agency in using SRHS. On the other hand, participants in the expert/healthcare provider and policymaker cohorts spoke of agency in the context of collective and relational agency. They recognised the constraints of social, institutional, and political blockages and unequal familial relations on influencing and shaping women's individual actions. The findings reported here are the results of the triangulation of responses in these three cohorts.

Thematic Examination

Participants across three groups discussed the process of individual, relational, and collective agency in accessing and using SRHS. Findings show that participants exercise agency by relying on their individual capacities, financial autonomy, and social media as a source of sexual and reproductive knowledge in a culture of silence and ignorance of vulnerable and marginalised groups in SRHS and policy directives. The lack of involvement or active exclusion of men in sexual and reproductive knowledge and SRHS was highlighted as problematic, especially in a gender-inequitable society (Fig. 1).

Individual Agency

- Recognition of Individual Capacities

Participants in this study stated that the ability to exercise agency is derived from individual aspirations, motivations, and capabilities to define reproductive goals and act upon them. Individual capacity remains an important source of power for women to challenge the limitations they face in accessing and using SRHS. Women discussed how individual capacity improves their negotiating strategies with their male partners and how to assert power in sexual and reproductive decisions confidently.

An expert stated: "I can say that a woman can achieve her desired sexual and reproductive health that is psychologically, physically, economically, and socially self-sufficient and able to pursue her needs and interests by appealing to her abilities. Self-confidence and self-esteem are essential

Table 1 Socio-demographic characteristics of participants in three cohorts

Participants	Women of reproductive age (number = 23)	Experts and healthcare providers (number = 24)	Policymakers (number = 5)
Characteristics	**Number (percent)**	**Number (percent)**	**Number (percent)**
Age (years)			
18–28	7 (30.4%)	0	0
29–39	12 (52.2%)	6 (25%)	0
40–49	4 (17.4%)	6 (25%)	1 (20%)
50–59	NA*	7 (29.2%)	3 (60%)
60–69	NA	5 (20.8%)	1 (20%)
Relationship status			
Single	4 (17.4%)	4 (16.8%)	1 (20%)
Married	16 (69.6%)	18 (75%)	4 (80%)
Divorced	1 (4.3%)	1 (4.1%)	0
Widowed	2 (8.7%)	1 (4.1%)	0
Highest educational level			
Medical Doctor	0	4 (16.7%)	4 (80%)
Postgraduate (Master or PhD)	2 (8.7%)	17 (70.8%)	1 (20%)
Bachelor's degree	7 (30.4%)	3 (12.5%)	0
High school	9 (39.1%)	0	0
Secondary school	5 (21.7%)	0	0
Employment			
Employed	10 (43.5%)	24 (100%)	5 (100%)
Unemployed	10 (43.5%)	0	0
University student	3 (13%)	0	0
Have children	19 (82.6%)	19 (79.2%)	4 (80%)
Self-rated economic status			
Poor	6 (26.1%)	0	0
Moderate	14 (60.9%)	11 (45.8%)	0
Good	3(13%)	13 (54.2%)	5 (100%)

**NA* not applicable

to have a satisfactory sexual life. Women with higher self-confidence are more likely to discuss their sexual and reproductive requests with their partners. Self-confidence gives them the power of negotiation" (P.7, 57 years, cultural anthropologist).

One woman of reproductive age corroborated this: "women should have skills to provide their sexual and reproductive needs and fulfil their reproductive goals through discussing with their partners and healthcare providers, finding the appropriate health service, and taking care of their health with considering healthy behaviours which enable them to achieve their sexual and reproductive desires" (P.39, 36 years, tailor).

- Social Media as a Means to Counteract the Prevailing Silence

In the conservative context of Iran, where sexual and reproductive health is silent, not being discussed in society, and no formal education about sexual and reproductive health is available, women's resistance to silencing and secrecy about women's health issues and SRHS is facilitated by social media, which is used to navigate and contribute to and share the knowledge about SRHS, reproductive health, and rights.

As one young participant commented: "social media is very effective. They introduced the world to us. I know women's rights in other countries, so our thinking style is far better than our previous generations. Moreover, my friends and I always search for any question about sexual and reproductive health on the internet" (P.31, 20 years, student).

Social media enables new opportunities to break the silence and taboo and to discuss sexual and reproductive health more openly while covering a wide range of audiences. Although at the same time, participants were concerned and unsure about the correctness of information disseminated through social media, especially among youth.

One expert articulated: "even though social media includes wrong information, we should not see just the

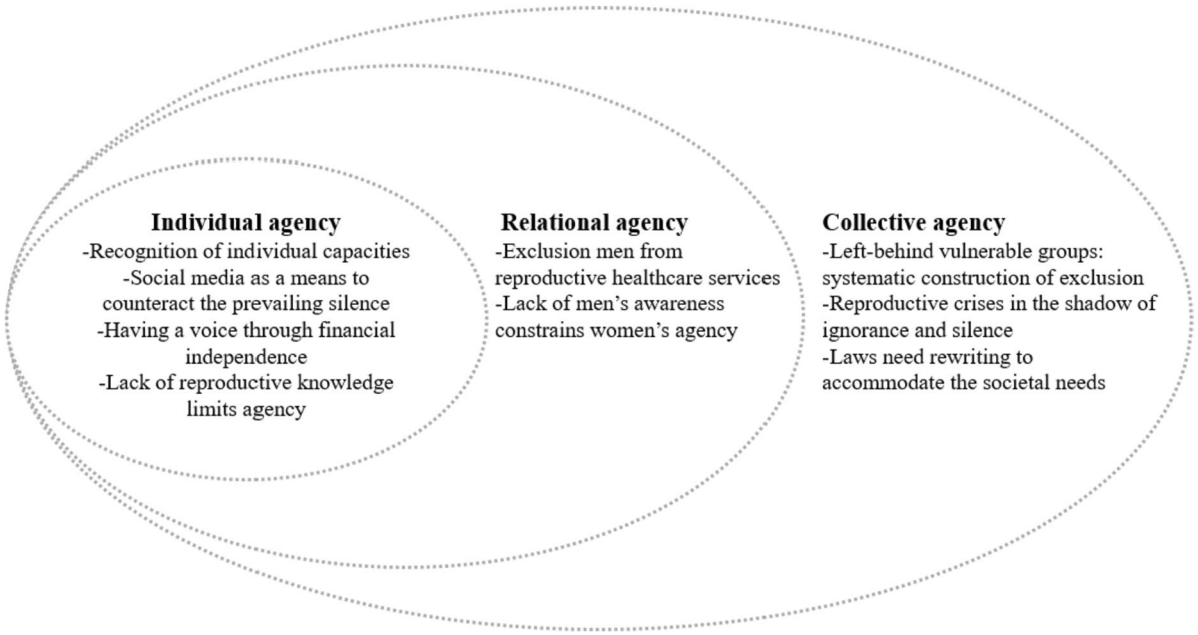

Fig. 1 Main themes and sub-themes extracted from the narratives of participants regarding Iranian women's agency in accessing and using sexual and reproductive healthcare services

negative side of it. Social media has an incredible role in promoting women's awareness and knowledge of sexual and reproductive health, rights, and services, particularly in the specific context of our country. Most of the [sexual and reproductive] issues are taboos, and we cannot talk about them; however, they are easily disseminated in social media" (P.26, 66 years, specialist in health services management).

- Having a Voice Through Financial Independence

Unequal levels of control over and access to financial resources may hinder women from obtaining needed SRHS. Exercising agency for many participants, therefore, began with financial autonomy. Having access to money gave women more power and a voice to mediate the power imbalance between spouses. As women experience financial autonomy, they are able to step out of restricted gender scripts that place women in inferior positions compared to their male partners. Participants perceived access to SRHS as a financial decision and a key component of exercising agency.

One expert said: "Economic independence changes the balance of power drastically. This allows a woman to represent herself. Economically independent women have more negotiating power to use SRHS when they want or need" (P.9, 36 years, member of an NGO helping vulnerable women).

Women's financial dependence on men was said to have the effect of silencing their power, holding them back from achieving desirable reproductive goals, and constraining their agency over their sexual and reproductive choices. The narratives about financial independence were quite consistent across the participant groups.

A woman of reproductive age added: "when a woman has her money, she does not have to wait for her husband's money to receive SRHS. Frequently, women ignore their reproductive health, because their husbands, [as the main breadwinner], avoid providing them with the needed money to use the SRHS" (P.41, 32 years, housewife).

- Lack of Reproductive Knowledge Limits Agency

For all cohorts of participants, agency involved access to valid sources of sexual and reproductive information for not only women but also men. As a result of the culturally sanctioned secrecy and silence around the topic, none of the women involved in this study reported ever receiving formal information about sexual and reproductive health. This unawareness limits their ability to enact agency. This is even more important for unmarried women, as they may experience more distress when they have concerns or symptoms associated with sexual and reproductive health. For these women, acquiring reliable information and advice to understand symptoms, build knowledge in this area, and navigate SRHS when they need it promotes informed decisions about their sexual and reproductive health matters. However, women also expressed

uncertainty about information accessed online and having no means of checking the validity of that information.

One young woman said: "We have no valid resource to acquire information about sexual and reproductive health such as menstrual health, sexual practices, and many other questions. We do not know when we should refer to a reproductive service. Most of us receive this information from our peers or mostly from the internet. We judge their validity based on our senses. There is no choice!" (P.42, 18 years, student).

Several experts argued that sexual and reproductive knowledge and information should be "culturally sensitive, but direct and explicit".

One expert articulated: "We do not have any systematic sexual and reproductive health education. Our women have the minimum knowledge about the most vital reproductive matters. This is even worse for adolescents, as they do not know about STIs, HIV, and contraceptives. So, this jeopardises their health. sexual and reproductive health education should be comprehensive and fundamental, starting from families and continuing by the educational sector and universities." (P.11, 55 years, working in family planning services).

Relational agency

- Exclusion of Men from Reproductive Healthcare Services

Most participants acknowledged that SRHS is not available to men, their access to these services is limited, and this is the root of many problems restricting women's ability to persuade their husbands about their sexual and reproductive needs. Participants' narratives reflected that in the Iranian context, men are culturally dominant. Therefore, if they see sexual and reproductive health as important, they can influence their wives' ability to access SRHS. Participants believed that men have a right to receive sexual and reproductive information and services that affect their own health and will enable them to avoid behaviours that may pose a risk to the health of their female partners.

One expert stated: "Our health clinics are gender-based. Most of the time, men are not allowed or comfortable to company their wives in health facilities. This is a source of many problems. Sometimes, even doctors or midwives prevent males' presence in their offices because they are uncomfortable discussing sexual and reproductive health matters in the presence of a man. If we want real progress, the couple-based health care system should be established" (P.6, 39 years, working in women's health policy organisation).

One woman of reproductive age also stated: "I have four children, two of them were unwanted. I did not use any modern contraceptives because my husband disagreed. I asked him to come to the health centre to talk directly with the doctor, but he felt embarrassed. He said these places are for women. Nevertheless, I am sure if he came, the doctor could justify using effective contraceptives, and now I would not have two unwanted pregnancies" (P.44, 39 years, housewife).

- Lack of Men's Awareness Constrains Women's Agency

Participants in this study stated that improving women's awareness to decide on their sexual and reproductive health cannot necessarily lead to agency; instead, it may even be harmful. To achieve greater agency, there is a need to promote men's awareness and knowledge of sexual and reproductive health and rights and involve them in SRHS, as well. However, excluding men from SRHS due to social norms and expectations is a massive barrier. The participants' narratives reflected that all women, especially in family structures, deal with men that impact their decisions over a wide range of sexual and reproductive issues. Hence, unaware men can hinder women from achieving their goals.

One expert said: "Incidentally, we must have an equal view to both men and women in sexual and reproductive health and rights. Any efforts to improve women's awareness of their sexual and reproductive rights should engage men, too. Otherwise, we push these women toward divorce. Because this woman is now familiar with her sexual and reproductive rights, however, her husband has not changed correspondingly" (P.15, 41 years, midwife).

Many women of reproductive age gave accounts of having little agency regarding access to SRHS, feeling unable to decide on their sexual and reproductive health freely. However, when they fought against this, exercising agency came at a cost. Several women talked of the need to either sacrifice their sexual and reproductive desires or endure conflict or challenges with their husbands and family-in-law.

This is illustrated by one woman who said: "in our country, men decide on everything. I did not want to have a second pregnancy, but my husband forced me. He did not know this is a woman's right to decide on pregnancies. First, I disagreed, but after lots of conflicts, I had to accept" (P.47, 30 years, housewife).

Collective Agency

- Left-Behind, Vulnerable Groups: Systematic Construction of Exclusion

While in Iran, premarital sexual relationships are strictly stigmatised, being unmarried does not necessarily preclude many young women from engaging in sexual activity. However, because in this context, there is neither recognition nor acknowledgement that this occurs; access to SRHS, particularly contraceptive and maternal healthcare services, is limited for such women. Living in rural areas and being poor

adds another layer of restrictions to access. Participants discussed how these women are marginalised, and they further articulated that SRHS should evolve and adapt to embrace cultural changes and transitions.

One expert said: "unmarried and adolescents are lost rings in this [SRHS] system and related policies. Our health system has been developed one-dimensionally. Regarding maternal and child health, it is excellent and active. Nevertheless, it has eminent faults. It does not recognise other groups' rights. Providing more expanded services to include unmarried, adolescents, people with STIs, HIV/AIDS, and empowering health staff on sexual and reproductive health issues is vital" (P.29, 54 years, specialist in community medicine).

As the preceding quotation highlights, although Iran is in the phase of cultural transition, its SRHS is not compatible with new societal changes. Most experts were quick to point out the sociocultural norms and values that dissuade authorities from acknowledging that there are vulnerable groups and that sexual encounters do occur outside of marriage, underlying a culture of silence that prevails among policymakers. This leaves vulnerable groups unrecognised, with their SRHS needs unmet and therefore at risk of poor health outcomes.

A policymaker stated, "there is not much willingness to improve various target groups' access to diverse SRHS. This is because of some reasons, such as fear of being judged by upper-hand managers or religious leaders, which might lead to losing their jobs or being punished. Consequently, most policymakers tend to take steps in a very limited scope, such as maternal and child health, which is completely acceptable by the societal norms" (P.28, 40 years, Specialist in maternal health).

The recent launch of the new policy in Iran to increase the fertility rate that led to the suspension of providing family planning methods in governmental centres (Erfani et al., 2019) was a main concern pointed out by all policymakers and several healthcare providers.

Accordingly, one healthcare provider argued that: "we successfully provided all [married] women with free, available, and accessible family planning methods. However, this new policy to restrict women's access to contraceptives in order to increase the fertility rate is the main challenge to Iranian women's access to SRHS. This policy decreases the free services transferred to women, especially for rural and poor women, who could not provide family planning methods from private healthcare system due to financial constraints" (P.14, 36 years, midwife).

A woman of reproductive age also echoed: "the society does not recognise the young women and men who have relationship out of marriage. Incidentally, they need more information and education, but they are ignored" (P.32, 46 years, clerk).

- Reproductive Crises in the Shadow of Ignorance and Silence

There were several concerns voiced about the sharp increase in the rate of STIs/HIV, unsafe abortion, unintended pregnancy, unmet needs of contraceptives, sexual dissatisfaction between couples, infertility, and gynaecological cancers. However, silence, secrecy, denial, and ignorance of these challenges were frequently discussed by participants.

"The rate of STI, HIV/AIDS is increasing sharply, and this jeopardises our women's health, especially adolescents. They do not know where they should refer. This hurts them mentally, too" (P.29, 54 years, specialist in infectious diseases).

In the policy arena, these issues are considered culturally sensitive or unacceptable for many sections of society; therefore, these issues are not addressed in policy. Policymakers refuse to acknowledge the existence and prevalence of these sexual crises. All of these factors compromise women's reproductive health and leave them, especially young women, at a greater risk of adverse reproductive outcomes.

One expert remarked: "sexual immorality of both women and men are hidden in the underground. But soon, they will be exposed. We face sexual crises. It is the time to intervene; otherwise, we all regret it" (P.1, 55 years, specialist in reproductive health).

This issue has also attracted the attention of women of reproductive age. For example, one participant commented: "many young women engage in sexual relationships without knowing how to prevent pregnancy or sexual diseases. I think these women are at a high risk of infertility and gynaecological cancers. However, nobody cares!"(P.49, 25 years, clerk).

- Laws Need Rewriting to Accommodate the Societal Needs

As a product of sociocultural beliefs, Iran's legal system endorses a culture of silence and secrecy, failing to acknowledge all women's rights in equal access to SRHS. Experts and policymakers believed that education or changing culture and social attitudes is time-consuming and needs years and even decades to achieve. Participants also considered legislation as the best way to provide all women with equal access to SRHS.

A policymaker stated: "the most vital obstacle in our country is laws. We are very successful in every aspect accepted with laws such as maternal and child health. Nevertheless, issues that are out of the legal framework are excluded. For example, since the law stemmed from the sociocultural norms stating that sexual relationships should be confined to marriage, sexual healthcare is unnecessary for adolescents and unmarried people. These target groups

are deliberately ignored. We need to reconsider our laws to be more compatible with the actual situation of our society" (P.24, 48 years, demographer).

One expert also cited sociocultural norms as the main reason for the legal system's failure to support women's sexual and reproductive health and rights.

She said: "most of our legislators were born and have grown in this patriarchal society. Consciously or unconsciously, they often object to policies that oppose the traditional views they have lived with them. We need empowered politicians too" (P.2, 51 years, specialist in maternal and child health).

A woman of reproductive age added: "we should admit that our society has changed significantly. Now, my daughter does not adhere to values that were important to me. So, the authorities should consider these changes" (P.36, 40 years, housewife).

Discussion

Societal changes in Iran, in line with its specific sociocultural context, call for evidence to inform health systems on how Iranian women enact their agency to fulfil their sexual and reproductive healthcare needs. This study makes a unique contribution to evidence about Iranian women's agency in accessing and using SRHS that could be used to inform much-needed improvements in equitable access to SRHS.

Summary of Findings

Findings showed that the circumstances in which agency was negotiated and enacted were fraught with power imbalances and legal obstacles upheld by traditional, conservative sociocultural norms and values. Women participating in this study expressed concerns about limited agency among Iranian women. However, through individual capacity, financial autonomy, and the use of social media to acquire sexual and reproductive knowledge and information, women appeared to be attempting to gain some control over their sexual and reproductive lives. These findings suggest that despite social changes and cultural transitions in Iran, reproductive health policy and services have not changed or adapted correspondingly. This causes obstacles to agentic opportunities that enable women to make informed and free decisions about their sexual and reproductive health.

Worldwide priorities in reproductive health have been shifting from a narrow focus on maternal and child health to a broader comprehensive concept of reproductive health and women's rights over their life course (Langer et al., 2015). Nonetheless, it seems that Iran's reproductive healthcare system still prioritises maternal health for married women and neglects other components of SRHS and other groups of women. This highlights a major fault in the system while alarmingly rising rates of HIV in Iran signal an impending crisis (SeyedAlinaghi et al., 2021).

A desire for establishing comprehensive sexual and reproductive education for all population groups, including men, was emphasised by all participants. Being equipped with accurate sexual and reproductive knowledge can improve women's agency and ability to make responsible and informed decisions on sexual and reproductive health needs (Miedema et al., 2020). Education should be gender-sensitive, available, and appropriate for men as well. Improving men's knowledge could be considered a means to hold them equally responsible and accountable for sexual and reproductive health and its outcomes (Jordal et al., 2013).

The multi-level model of agency employed in this study was helpful to better understand the construction of agency by Iranian women and the application of agency to access and use SRHS. Women of reproductive age insisted on the importance of the role their husbands play in obstructing their efforts to exercise agency in achieving their reproductive goals. They affirmed a bottom-up approach to enact agency in uptaking SRHS. On the other hand, experts/healthcare providers and policymakers considered a top-down approach to give maximum weight to sociocultural and legal structures. The top-down approach conceives agency in a deterministic form, while the bottom-up approach admits the free will of individuals in sexual and reproductive choices and asks for individual self-determination and free choice (Riga, 2020). This observation could further highlight that for women of reproductive age, these societal-level influences are enacted and experienced via their interpersonal relationships. This further characterises men's influences on women's access to SRHS. Patriarchal power structures and men's domination which is often institutionalised on multiple levels, for example, on broader societal factors, cultural beliefs, legal and political systems restrict women's agency and their access to SRHS (Namasasu et al., 2016; Ouahid et al., 2023a, b). These findings are consistent with other studies performed in Iran, where lack of the political commitment of the government to improve marginal groups' access to SRHS; lack of policymakers' knowledge on sexual and reproductive health; low public awareness of sexual and reproductive health; emerging risky sexual behaviours; a fear of losing managerial jobs among healthcare policymakers to expand the scope of delivered services especially in public healthcare system were cited as barriers in Iranian women's access to SRHS (Damari & Akrami, 2021; Motamedi et al., 2016). Furthermore, lack of access to valid sources of sexual and reproductive education and the use of informal sources of information, including social media, by Iranian women were echoed in other studies, too (Sheikhansari et al., 2021).

Practical Implication and Prospect of the Results

To promote Iranian women's agency in access to SRHS, changes should occur at the individual, household, community, and national levels simultaneously (Plouffe et al., 2020). Far from being an individual process, women's agency in reproductive health is shaped by the mutual influence and interplay of these levels (Paul et al., 2017; Price & Hawkins, 2007). For the individual agency to be enacted, three main processes are needed. Firstly, women need to define goals in line with their values. These goals are driven by motivations regulated or endorsed by the self, guided by fear of coercion or retribution by others such as husbands, or conditioned by internalised social norms (Donald et al., 2020). Accordingly, findings show that gender norms, stigma, taboos, and lack of knowledge hinder women, especially young and unmarried women, from enacting agency, limiting their access to SRHS. Secondly, individuals need to perceive a sense of ability to define their own goals and act on them. Women need to believe that they can achieve their goals (Donald et al., 2020). However, a lack of knowledge about sexual and reproductive health and available services, especially among marginal groups such as adolescents, restricts women's agency from accessing these services. Thirdly, individuals need to act on their goals. Whereas the first two dimensions are guided internally, acting on goals is a relational process strongly influenced by gendered power relations (Donald et al., 2020).

At the relational level, the importance of involving men in sexual and reproductive healthcare and education was emphasised by almost all participants. There has been a growing worldwide recognition of involving men in sexual and reproductive healthcare (Davis et al., 2016). Male partners' engagement in discussions around sexual and reproductive health is crucial to ensure that women can communicate their preferences and negotiate their rights to exercise their choices. Evidence has shown that to achieve greater agency, strategies to challenge harmful gender norms should address both men and women. Working with women alone is ineffective; increasing women's capacity to resist gender norms might generate a backlash and even greater oppression (Cislaghi, 2018). Working with men alone, on the other hand, is similarly ineffective, as it might reduce the symptoms of gender inequality, for instance, violence against women, but it cannot eradicate the root causes of this problem. However, providing both men and women, especially from childhood, with comprehensive education from a human rights lens improves renegotiating the inequitable gender norms that restrict women's agency (Cislaghi, 2018).

At the structural level, the findings highlight the course of action that should go beyond individual agency to improve women's agency as a whole regarding SRHS. To achieve the SDGs and universal access to SRHS, it is critical to expand universal access to neglected populations, including adolescents, unmarried, and rural women (Tiwari et al., 2021). It is also necessary to place sexual and reproductive rights, including access to high-quality SRHS, comprehensive sexual and reproductive education, gender equality, and the ability to make decisions about one's own body at the centre of this endeavour (Amroussia et al., 2016; Tiwari et al., 2021).

Implications for Policy and Practice

In the Iranian context, women's agency requires the government to adopt effective interventions and policies to improve gender equality and human rights and enact policies for promoting all women's access to SRHS, regardless of age or marital status (Erfani et al., 2019). The legal system should guarantee the availability, accessibility, and quality of SRHS and sexual and reproductive information for all. These legal actions especially should protect the sexual and reproductive health of marginalised target groups (Amroussia et al., 2016). Kismödi et al. (2015) emphasised that to advance reproductive health, countries should have an obligation to set their laws in line with international human and reproductive rights. These rights-based legal guarantees, although insufficient alone, are critical to accountable SRHS, improved sexual and reproductive health outcomes, and the protection of human rights (Kismödi et al., 2015).

Strengths and Limitations

Involving various groups of key informants produced a variety of rich data sets. A strength of this study was the use of several approaches to improve the reliability and validity of data, including purposive sampling, the inclusion of participants from diverse backgrounds, disciplines, and socioeconomic status, checking transcripts against audio recordings and field notes, the triangulation of data by a group of researchers, and consensus-driven discussion. Finally, a strength of this study was participant feedback which added veracity to the findings and emphasised the rigour of the data collected.

The limitation of this study is that results are not generalisable beyond the immediate context. Nevertheless, these findings are unique and contribute to the body of evidence on the subject and capture the complexity of Iranian women's agency regarding the uptake of SRHS. A further limitation is the absence of men's views about women's agency and SRHS. Further research is needed to address this important limitation. Although there was an effort to include diverse participants, it is acknowledged that several groups, including adolescents, women older than 49 years, illiterate women, and other marginalised groups (e.g. sex

workers, transgenders) who may have different needs and experience different constraints are missing from this study. Future studies are needed to explore agency among marginalised women, including sex workers, illicit drug users, and those with HIV/AIDS and STIs.

Conclusion

In conclusion, this study demonstrated the salience of individual capacity, financial autonomy, and knowledge acquisition through social media in shaping Iranian women's individual agency to access and use SRHS. Yet, agency, at the relational level, is limited because of the exclusion of men from the sexual and reproductive healthcare system and education. At the structural level, a culture of silence, lack of support from the legal system and lack of appropriate policies to meet the sexual and reproductive needs of all populations, with marginalising people who act outside the traditional sociocultural norms and legal framework, significantly restricts Iranian women's agency in accessing SRHS.

In light of these results, essential requirements to improve Iranian women's agency regarding access to SRHS should include providing all social groups with valid, direct, and explicit information on sexual and reproductive health. This should be provided through formal and informal education from childhood for both men and women. Progress towards quality SRHS, reproductive information, and rights protections, particularly for disadvantaged and marginalised women and girls of all ages regardless of marital status, requires a strong political commitment to evaluate and eliminate the legal, policy, administrative, and healthcare-level barriers.

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Declarations

Conflict of Interest The authors declare no competing interests.

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