Research Article

SEXUAL AND REPRODUCTIVE HEALTH PROBLEM IN YOUNG PEOPLE: STIGMA

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Abstract

Aim: This analytical study was conducted to determine young people's sexual and reproductive health-related stigma level.

Method: The data were collected online between May 2022 and July 2022 using the "Participant Information Form" and the "Young Women Sexual and Reproductive Health Stigma Scale (YWSRHSS)". The sample consisted of 275 young women.

Findings: Of them, 51.3% were in the age group of 18-20 years, 47.3% were in the second year of university, 60.4% had an income equal to their expenses, and 46.5% lived in the dormitory. The mean scores they obtained from the overall YWSRHSS and its External Stigma, Unreal Stigma Attitudes and Internal Stigma sub-dimensions were 8.06±4.12, 4.02±1.87, 1.87±1.82, and 2.16±1.56 respectively. These results suggest that the participants' mean scores were low, indicating that their levels of stigmatization attitudes were also low. Moreover a significant and negative relationship between the economic status variable and the mean score for the external stigma sub-dimension ($p<0.05$).

Results: In order for young people to access accurate information constantly without stigma and judgment, the society's awareness should be raised, cooperation should be established between sectors, and legal changes should be made.

Keywords: Midwifery, Sexual health, Reproductive health, Young people, Stigma

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Gençlerde Cinsel Sağlık ve Üreme Sağlığı Sorunu: Damgalama

Öz

Amaç: Bu analitik çalışma, gençlerin cinsel sağlık ve üreme sağlığı ile ilgili damgalanma düzeyini belirlemek amacıyla yapılmıştır.

Yöntem: Veriler Mayıs 2022-Temmuz 2022 tarihleri arasında "Katılımcı Bilgi Formu" ve "Genç Kadın Cinsel ve Üreme Sağlığı Damgalanma Ölçeği (YWSRHSS)" kullanılarak çevrimiçi olarak toplanmıştır. Örneklemi 275 genç kadın oluşturmuştur.

Bulgular: Bireylerin %51,3'ü 18-20 yaş grubunda, %47,3'ü üniversite ikinci sınıfta, %60,4'ünün gelirinin-giderine denk olduğu, %46,5'inin yurtta yaşadığı belirlenmiştir. YWSRHSS genel ölçeğinden ve Dışsal Damgalanma, Gerçek Dışı Damgalanma Tutumları ve İçsel Damgalanma alt boyutlarından aldıkları puan ortalamaları sırasıyla 8,06+4,12, 4,02+1,87, 1,87+1,82 ve 2,16+1,56'dır. Bu sonuçlar katılımcıların ortalama puanlarının düşük olduğunu, dolayısıyla damgalama tutum düzeylerinin de düşük olduğunu göstermektedir. Ayrıca ekonomik durum değişkeni ile dışsal damgalanma alt boyutu puan ortalaması arasında anlamlı ve negatif bir ilişki bulunmaktadır ($p<0,05$).

Sonuç: Gençlerin damgalanmadan ve yargılamadan doğru bilgiye sürekli ulaşabilmeleri için toplumun farkındalığının artırılması, sektörler arası işbirliğinin kurulması ve yasal değişiklikler yapılması gerekmektedir.

Anahtar Kelimeler: Ebelik, Cinsel sağlık, Üreme Sağlığı, Gençler, Damgalama

1. INTRODUCTION

The World Health Organization defines the age range of 10-19 as the adolescence and the age range of 15-24 as youth (WHO, 2022). Youth is a period when health habits and sexual behaviors begin to take shape, and issues related to sexual and reproductive health (SRH) should be addressed with priority (Bakir et al., 2021; Koluacik et al., 2010). Adolescents 90% of whom live in low- and middle-income countries constitute 1/6 of the world's population, which is approximately 1.2 billion. In Turkey, adolescents (10-19) constitute 16% of the entire population (TDHS, 2018).

In our country, Turkey, as in the other countries of the world, adolescents and young people have difficulties in accessing SRH services due to economic and physical conditions. In addition, social situations such as fear, embarrassment, false beliefs, lack of knowledge, exclusion, stigma, and health professionals' judgmental, disrespectful attitudes and behaviors, lack of knowledge and ignoring the needs of young people pose obstacles preventing them from receiving such services (Ogul, 2021).

In our society, families pressure and social environment dictate concepts such as premarital sexual intercourse and virginity as taboos for young people, which negatively affects their future lives. Parents do not inform their children for such reasons as embarrassment or loss of authority, which causes young people to resort to resources other than families. Attitudes like neglect and stigmatization of young people can cause problems in the short and long term. Not using family planning methods, one of these problems, leads to problems such as adolescent pregnancies, sexually transmitted infections and curettage (Gaur et al., 2022; Hall et al., 2018; Zeren & Gursoy, 2018). Health professionals and educators assume important responsibilities for informing young people on these issues. Providing young people with effective counseling within this context can protect them from potential problems at an early stage.

Sexuality is one of the basic needs of human life. Sexuality is a concept that starts before birth and continues throughout life, and reflects not only the reproductive organs of individuals, but also all aspects they have as human beings. Sexual life and sexual health are accepted to improve the general condition, well-being and quality of life of individuals (Zeren & Gursoy, 2018). Sexuality is a positive force that not only motivates people to survive in balance and to socialize, but also ensures the continuity of the family lineage (Evcili & Golbasi, 2017). The concept of "Reproductive Health" was first defined internationally at the Conference on Population and Development in Cairo. Reproductive health not only refers to the health of the reproductive system but also defends people's right to have satisfactory and safe sexual activities and to exercise their reproductive abilities independently whenever and as often as they want (Kocak & Buyukkayaci Duman, 2019).

As a result of not getting enough information and counseling, risky situations may be encountered in terms of reproductive and sexual health. Adolescence and youth are considered as risky periods not only due to reproductive health problems but also for these reasons as the proliferation of sexually transmitted infections, unwanted pregnancies and complications related to such pregnancies, illegal abortions, sexual abuse and violence, and adolescent marriages (Bakir et al., 2021). Although the public is very curious about sexuality, it is a topic rarely talked about. People feel ashamed when they talk about it but, conversely, they brag about their sexual experiences, and it seems complicated because it is a basic need regardless of the person's sex (Karabulutlu & Yilmaz, 2018). During youth, many changes, values and approaches affect life, sexuality is perceived as a taboo and talking about it is regarded as a shame (Aksoy Derya et al., 2017). All these cause unmarried adolescents' SRH needs to be overlooked, prevent them from accessing accurate and reliable information due to reasons such as exclusion, rejection, and labeling, and cause them to tend to develop risky behaviors and to be exposed to stigma (Citak, 2021).

Stigmatization refers to exclusion of a person or group from the society because of perceiving them as a source of shame when they go outside the boundaries considered normal by the society. Social stigma can make the stigmatized person lose his or her value beyond consideration. As a result of stigma, social class distinction emerges between those who are considered normal and those who are stigmatized, and young people hide their sexuality due to the fear of being excluded (Ozmen & Erdem, 2018). Maintenance of healthy sexuality without discrimination is of great importance. Factors such as cultural pressure, stigma, harassment at school, home or social environments, and physical and sexual violence adversely affect young people's lives. These situations are of importance because young people who have different sexual tendencies and choices experience problems such as substance use, abnormal life style and suicidal tendencies over time (Bakir et al., 2021). This analytical study was conducted to determine the levels of sexual and reproductive health-related stigma among young people.

1.1 Research Questions

Question 1. What is the level of sexual and reproductive health stigmatization among young people?

Question 2. What is the effect of sociodemographic characteristics on the level of sexual and reproductive health stigma in young people?

2. METHODS

Type of study: The study is descriptive and cross-sectional.

Population and Sample of the Study

The population of the study comprised women in the age group of 18-24 years in Turkey. Of them, those who accepted to participate in the study between May 12, 2022 and July 12, 2022 and filled in the online research questionnaire completely (n=275) formed the sample of the study.

Population and Sample of the Study

The population of the study comprised women in the age group of 18-24 years in a province of Turkey and snowball sampling was preferred as the sampling method. The number of people to be sampled was taken as 50% with the sampling technique of uncertain population and calculated with a 90% confidence interval (α=0.05) using the EpiInfo 2022 program, and in this case, a total of 270 young women were planned to be included in the study. Of them, those who accepted to participate in the study between May 12, 2022 and July 12, 2022 and filled in the online research questionnaire completely young women formed the sample of the study. The study was completed with 275 people.

Inclusion Criteria:

- Volunteering to participate in the study
- Being a woman in the age group of 18-24 years
- Having no mental problems
- Not having communication, hearing or vision problems preventing her from filling in the questionnaire

Exclusion criteria

- Those who have trouble filling the link link
- Verbal, mental etc. those with disabilities

Dependent variable: Young Women Sexual and Reproductive Health Stigma Scale score

Independent variables: Socio-demographic characteristics such as age, educational status, economic status, educational status of parents, employment status of parents, place of residence, the person(s) she lives with

2.1. Data Collection Tools

The data were collected using the forms below.

1-Participant Information Form: The form prepared by the researchers in line with the literature consists of 11 items questioning the participants' socio-demographic characteristics (Bayrakceken & Eryilmaz, 2021).

2. Young Women Sexual and Reproductive Health Stigma Scale (YWSRHSS): The YWSRHSS is the Turkish version of the Adolescent Sexual and Reproductive Health Stigma Scale developed by Hall et al. in 2017 to determine sexual and reproductive health-related stigma in women aged 15–24 years. The validity and reliability study of the Turkish version of the Adolescent Sexual and Reproductive Health Stigma Scale (**YWSRHSS)** was performed by Bayrakceken and Eryilmaz in 2021. The YWSRHSS has 20 items and the following 3 dimensions: external stigma (items 1, 2, 3, 4, 5 and 6), unreal stigma attitudes (items 7, 8, 9, 10, 14, 15, 16, 19 and 20) and internal stigma (items 11, 12, 13, 17 and 18). The minimum and maximum possible scores to be obtained from the scale are 0 and 20 respectively. Responses given to the items are scored as follows: 0 = Disagree, 0 = Neutral and 1 = Agree. The higher the score obtained from the scale is the higher the level of stigmatization attitude is (Bayrakceken & Eryilmaz, 2021; Hall et al., 2018). The Cronbach's alpha coefficient was calculated as 0.83 in the Turkish validity and reliability study of the scale and 0.82 in the present study.

Data Collection

The present study was conducted between May 2022 and July 2022 using web-based data collection method (Google Forms). The questions included in the Participant Information Form, and Young Women Sexual and Reproductive Health Stigma Scale were transferred to the "Google Forms", a shareable link was created and this link was sent to the participants online. The individuals included in the study were evaluated based on the data collected through the questionnaires filled in online. The participants were also provided with necessary guiding, informative explanations on "Google Forms" and those who want to participate in the study marked the checkbox.

2.2. Analysis of the Data

The analysis of the data obtained from the research was performed using the SPSS 26.0 (Statistical Package for Social Science). Descriptive information about the participants was given as numbers, percentage distributions and arithmetic mean and standard deviation. In all the analyses, $p<0.05$ was accepted as the threshold level of statistical significance Kolmogorov Smirnov test was used to find out whether the variables were distributed normally. In the non-parametric analyses, while the Kruskal Wallis test was used to determine the significance of the difference between the means of three or more groups, the Mann Whitney U test was used to compare the means of two independent groups, and of the Post-hoc tests, the Kruskal-Wallis H test with Bonferroni correction was used to determine from which groups the significant difference originated.

2.3. Research Ethics

Before the study was conducted, approval was obtained from the Ethics Committee of Sakarya University, Social and Human Sciences Faculty (decision number: 45/17, decision date: May 11, 2022). In addition, the consent of the participants was obtained.

3. FINDINGS

The comparison of the mean scores the participants obtained from the overall YWSRHSS and its sub-dimensions in terms of their socio-demographic characteristics was given in Table 1. of the participants, 51.3% were in the age group of 18-20 years, 47.3% were in the second year of university, 74.5% had primary school graduate mothers, 46.9% had primary school graduate fathers, and 80% had non-working mothers, 32.7% had fathers who were workers, 60.4% an income equal to their expenses, 58.5% lived in a province, 45.8% lived in a district, 46.5% stayed in the dormitory, and 39.6% live with their parents. Their average allowance per month was $60.

Table 1. Comparison of Socio-Demographical Characteristics and Total Mean Scores of the Sexual Health Reproductive Health Stigma Scale and its Sub-Dimensions in Young Women

Introductory Features (n=275)	**N**	**%**	**External Stigma**	**Unreal Stigma Attitudes**	**Internal Stigma**	**YWSRHSS Total**
Age Group						
18–20	141	51,3	4,07±1,84	2,00±1,90	2,15±1,55	8,23±4,14
21–24	134	48,7	3,97±1,92	1,74±1,73	2,16±1,58	7,88±4,11
***U**			-0,28	-1,11	-0,05	-0,44
p			0,77	0,26	0,95	0,65
Education Status						
College Preparatory Class	16	5,8	3,93±1,91	2,31±2,38	2,81±1,83	9,06±4,65
University first year	71	25,8	4,22±1,84	2,01±1,85	2,26±1,54	8,50±4,25
University 2nd year	130	47,3	4,00±1,83	1,79±1,82	2,03±1,53	7,82±4,06
University 3rd year	30	10,9	4,06±2,04	1,83±1,59	2,13±1,69	8,03±4,08
University 4th year	6	2,2	4,50±1,04	3,33±1,96	3,50±1,37	11,33±3,26
Bachelor's Degree	22	8,0	3,45±2,17	1,27±1,31	1,77±1,23	6,50±3,52

****Z**			2,98	8,17	8,80	9,53
p			0,70	0,14	0,11	0,09
Mother's Education						
Primary School	205	74,5	4,00±1,85	1,89±1,93	2,24±1,61	8,13±4,32
High School	43	15,6	4,04±2,09	1,90±1,61	2,02±1,51	7,97±3,76
High Education	27	9.8	4,22±1,76	1,70±1,13	1,74±1,12	7,66±3,18
****Z**			0,50	0,30	2,33	0,14
p			0,77	0,85	0,31	0,92
Father's Education						
İlköğretim	129	46,9	3,90±2,06	1,97±1,99	2,24±1,60	8,12±4,62
High School	96	34,9	4,12±1,75	1,65±1,69	2,07±1,59	7,85±3,88
High Education	50	18,2	4,16±1,58	2,04±1,57	2,12±1,39	8,32±3,18
****Z**			0,09	2,71	0,64	0,64
p			0,95	0,25	0,72	0,72
Mother's Employment Status						
Working	55	20,0	4,10±2,04	1,69±1,26	2,00±1,52	7,80±3,64
Non-Working	220	80,0	4,00±1,84	1,92±1,93	2,20±1,57	8,13±4,24
***U**			-0,85	-0,02	-0,80	-0,22
p			0,39	0,98	0,42	0,82
Father's Employment Status						
Officer	43	15,6	4,09±1,72	2,18±1,84	2,25±1,46	8,53±3,73
Employee	90	32,7	4,08±1,92	1,78±1,69	2,28±1,53	8,16±3,91
Self-Employment	88	32,0	3,92±1,94	1,61±1,82	1,86±1,57	7,39±4,27
Other	54	19,6	4,05±1,85	2,20±1,96	2,35±1,63	8,61±4,48
****Z**			0,48	6,88	4,71	4,11
p			0,92	0,07	0,19	0,25

Economical Situation						
Income More than Expenses	87	31,6	3,31±1,83	1,81±1,99	1,77±1,84	6,90±4,33
Income Equal to their Expenses	166	60,4	3,99±1,84	1,71±1,70	2,07±1,56	7,78±4,01
Income Less than Expenses	22	8,0	4,27±1,92	2,19±1,97	2,42±1,45	8,89±4,18
****Z**			6,68	3,40	4,85	4,60
p			**0,03**	0,18	0,08	0,10
Currently Living Place						
Province	20	7,3	4,09±1,75	1,89±1,76	2,16±+1,56	8,15±3,89
District	94	34,2	3,77±2,03	1,71±1,77	2,04±1,52	7,53±4,32
Village/Town	161	58,5	4,70±1,92	2,50±2,35	2,65±1,75	9,85±4,65
****Z**			5,47	2,33	2,13	4,09
p			0,06	0,31	0,34	0,12
Family Living Place						
Province	48	17,5	4,21±1,65	2,00±1,90	2,23±1,57	8,45±3,92
District	126	45,8	3,92±1,96	1,62±1,53	2,00±1,45	7,55±3,97
Village/Town	101	36,7	3,91±2,08	2,27±2,23	2,39±1,80	8,58±4,83
****Z**			0,68	3,25	2,02	1,60
p			0,70	0,19	0,36	0,44
Who Lives with						
Live with their Parents	109	39,6	3,94±1,88	1,81±1,96	2,15±1,47	7,91±4,16
Dormitory	128	46,5	4,10±1,78	1,99±1,75	2,24±1,62	8,34±4,19
Other (Mother / Father / Elder / Close Relative / Own House)	38	13,8	4,00±2,18	1,65±1,61	1,89±1,60	7,55±3,80
****Z**			0,49	2,33	1,55	2,07
p			0,78	0,31	0,46	0,35
TOTAL	**275**	**100**				

No statistically significant relationship was determined between the scores the participants obtained from the YWSRHSS and its sub-dimensions and their socio-demographic characteristics such as age, education level, mother's education level, father's education level, mother's and father's employment status, the current place of residence and the place where their family lived, and who they lived with ($p>0.05$).) However, there was a negative relationship between the variables such as age group and the mother's employment status, and the mean scores for the overall YWSRHSS and its sub-dimensions.

There was a statistically significant relationship between the participants' economic status and the mean score they obtained from the External Stigma sub-dimension of the YWSRHSS ($p<0.05$). According to the results of the regression analysis, their economic status affected the mean score they obtained from the External Stigma sub-dimension negatively and significantly. Of the participants, those whose income was less than their expenses obtained higher scores from the YWSRHSS and its sub-dimensions.

The mean scores the participants obtained from the Young Women Sexual and Reproductive Health Stigma Scale and its sub-dimensions are shown in Table 2. Their mean scores were as follows: 4.02±1.87 (min-max: 0-6) for the External Stigma sub-dimension, 1.87+1.82 (min-max: 0-9) for the Unreal Stigma Attitudes sub-dimension, 2.16+1.56 (min-max: 0-5) for the Internal Stigma sub-dimension and 8.06+4.12 (min-max: 2-20) for the overall YWSRHSS (Table 2).

Table 2. Total Mean Scores of the Sexual Health Reproductive Health Stigma Scale and its Sub-Dimensions in Young Women

YWSRHSS and Sub-Dimensions	$\bar{X}$ ± SS	Min-Max
External Stigma	4,02±1,87	0-6
Unreal Stigma Attitudes	1,87±1,82	0-9
Internal Stigma	2,16±1,56	0-5
YWSRHSS Total	8,06±4,12	2-20

4. DISCUSSION

Stigma imposes an embarrassing characteristic on the individual and causes separation and exclusion from other people. It also poses a potential risk for adolescents and young people in terms of SRH. (Bakir et al., 2021; Yildiz et al., 2020; Ozmen & Erdem, 2018).

External or social stigma is the situation in which negative attitudes and behaviors are displayed towards a person by the society, and the person is perceived as an unwanted person. The deficiencies,

and different thoughts and behaviors of individuals are perceived as a reason for stigmatizing, and cause social inequalities. On the other hand, internal stigma is the situation in which an individual imposes negative judgments and emotions on himself or herself, experiences a decrease in self-esteem, and isolates himself or herself due to thoughts such as shame. Individuals who internalize this situation show the same reactions to themselves by supporting the norms stereotyped by the society (Bayrakceken & Eryilmaz, 2021; Pescosolido, 2013; Corrigan, 2007).

The mean scores the participants obtained from the overall YWSRHSS and its External Stigma, Unreal Stigma Attitudes, Internal Stigma sub-dimensions were attitude levels were low. The mean score obtained from the overall YWSRHSS was 9.96±4.50 in Bayrakceken and Eryilmaz's study (2021), 8.26±3.84 in Bakir et al.'s study (2021) and 8.00+6.00 in Yildiz et al.'s study (2020). These results in the literature are consistent with our results.

No statistically significant relationship was determined between the scores the participants obtained from the YWSRHSS and its sub-dimensions and their socio-demographic characteristics such as age, education level, mother's education level, father's education level, mother's and father's employment status, the current place of residence and the place where their family lived, and who they lived with ($p>0.05$).

Of the participants those who were in the age group of 21-24 years, had a bachelor's degree, lived in a district, lived with a relative or in their own house obtained lower scores from the overall YWSRHSS, which indicates that their stigmatization levels were low.

Of the participants, those whose income was less than their expenses obtained higher scores from the overall YWSRHSS and its sub-dimensions. There was a statistically significant relationship between the participants' economic status and the mean score they obtained from the External Stigma sub-dimension of the YWSRHSS ($p<0.05$). In addition, it was determined that the economic status affected the External Stigma sub-dimension mean score negatively and significantly.

While External Stigma and Unreal Stigma Attitudes sub-dimensions of the YWSRHSS included items on having sexual intercourse, experiencing abortion, family planning methods, getting pregnant and sexuality, the Internal Stigma sub-dimension included items on having sexual intercourse, getting pregnant, undergoing curettage and the effect of the media. At this point, although the difference between the mean scores the participants obtained from the sub-dimensions of the YWSRHSS was not significant, the mean scores the participants obtained from the External Stigma sub-dimension scores were higher.

In their studies, Bakir et al. (2021) and Yildiz et al. (2020) stated that the level of stigmatization differed according to the participants' income level, and that those whose family income status was

medium and low obtained a statistically significantly higher mean score from the scale than did the participants whose family income level was good. These results in the literature are consistent with our results.

Today, sexuality is perceived as a phenomenon that must be kept under control and is difficult to accept, and emerges as a social obstacle in cases such as the prevention, treatment and access to care of sexually transmitted diseases. In order to prevent these obstacles, it is important to provide accurate information, and to motivate and talk to the person about sexuality (Ogul, 2021).

In studies conducted in Europe, New Zealand, North and South America and Asia, it is reported that young people regretted their first sexual experience or wanted to have sexual experience at a later age due to gender norms and expectations. It is reported that young people in the 15-19 age group have sexual experience earlier than do young people in the 20-24 age group, and the rate of having difficulty in the first sexual intercourse is high in both age groups. They are also more likely to be with a high-risk partner and less likely to have their partner use condoms during the first sexual intercourse. Therefore, it is important to organize programs to delay the age of onset of first sexual experience and to support this process (Appollis et al., 2021).

In several studies, it has been reported that adolescent girls in low and middle-income countries receive health care services disproportionately and in poor conditions due to lack of knowledge, lack of perceived needs, shyness and not having the freedom to make decisions. Unsupportive society and family structure, stigma, prejudices, lack of communication, being obliged to obtain permission from the family in matters, and gender inequality constitute other problems that affect access to services. In addition, problems such as inadequate SRH education, healthcare facilities' being far away, healthcare personnel's and teachers' lack of knowledge, inability to access family planning and abortion services adversely affect SRH services.

In several Asian countries, low socio-economic status, inability to use family planning methods, lack of knowledge and education, sexual taboos and stigma cause adolescent pregnancies. As is reported in Nepal, only 15% of married women aged 15-19 years use modern family planning methods (Tiwari et al., 2022; Pandey et al., 2019).

Evidence suggests that although a significant proportion of young people aged 15-24 years are sexually active, their awareness level of SRH is low. In many recent studies, it is reported that girls are unprepared for menarche and experience this process in fear and panic. Inaccurate and incomplete

knowledge increases the risk of pregnancy, reproductive system infections and sexually transmitted diseases (Khanna et al., 2022; Mukherjee et al., 2020).

In their study conducted in 2019, Pandey et al. stated that it was easier for the participants to talk to their peers about SRH, and that older people treated them like children and did not understand their needs. The participant in the study stated the following:

"Health workers are as old as our mothers. We don't know much about this issue. They should understand our issues and give appropriate advice, but they are trying to teach" (an adolescent boy) (Pandey et al., 2019).

In their qualitative study conducted on SRH in 2022, Tiwari et al. stated that the participants lacked knowledge on family planning and that they needed information. At the end of the interview, the participant in their study stated the following:

"In Nepal, women (have no right to make decisions, and early marriage practice is common here. As soon as they get married, they give birth to children. If they were able decide, they wouldn't get pregnant" (an 18-year-old single adolescent).

It has been reported that adolescent girls internalize negative attitudes towards SRH services, feel ashamed to learn about these issues, experience menstruation-related stigma, and that there is a concept that girls should not need family planning services before marriage. Some of the participant stated the following:

"I was hesitant to talk about birth control pills. Hearing this for the first time was bothersome. I used to think 'why do they talk about such disgusting things'" (an 18-year-old single adolescent) (Tiwari et al., 2022).

Many participants stated that adolescent girls should get permission from their parents, partners or other family members to access SRH services, otherwise they might have problems such as gossip, conflicts and revenge, and that there are different gender norms in the society regarding premarital sexuality. Statements of some of the participant in the study were as follows:

*"I can't go to hospital alone. If girls go to hospital alone, people gossip about them. They may think that I go there for abortion… So before we go to hospital we should ask our mothers to get their permission" (*a 16-year-old single adolescent*).*

The fear of being stigmatized by the society causes adolescent girls to have difficulties in accessing family planning methods and especially in accessing abortion services. Some girls stated that they bought abortion pills on their own to avoid stigma. Statements of some of the participants in the study were as follows:

*"If a girl accidentally gets pregnant, the first thing they feel is embarrassment… Girls are afraid people will find out that they are pregnant, so they don't go to a health center (*a 17-year-old single adolescent*).*

In their study (2022), Khanna et al. reported that most of the married women were not knowledgeable about sexual intercourse before marriage, that they did not talk to anyone about the first night of marriage, that they were nervous and that they even had an unintended pregnancy for this reason. A participant in their study stated the following:

"I didn't even know we had to sleep in the same room when we got married" (Khanna et al., 2022).

Unmet need for family planning is a major cause of unwanted pregnancies, self-induced abortions and the increased rate of abortions. In their study, Gau et al. (2022) reported that in women who had abortion in a health institution, the rate of using permanent family planning methods was high, and that the rate of using any family planning method in women who had abortion in the second or third trimester was half as much as those who had abortion in the first trimester (Gaur et al., 2022).

In low- and middle-income countries, the number of adolescent pregnancies is approximately 21 million, and 10 million of these pregnancies are unwanted pregnancies. Of the unwanted pregnancies, 5.7 million end in abortion, most of which occur in unsafe conditions (United Nations Population Fund - UNFPA, 2022). Adolescent pregnancies, which are an individual, social and universal public health problem, are more common in underdeveloped countries where the level of socio-economic status and education is low (Ogul, 2021). The country with the highest adolescent (15-19 age) fertility rate in 2020 was Bulgaria with 38‰ whereas the country with the lowest adolescent fertility rate was Holland and Denmark with 2‰. The adolescent fertility rate in Turkey was 13‰ (TSI, 2022).

Among the leading causes of death in adolescents and young people are complications occurring during pregnancy and childbirth (WHO, 2022). In addition, while the risk of pregnancy complications is twice as high in adolescents, the risk of preterm birth, eclampsia, endometritis and infection is higher than is that in women aged 20-24 years. It is reported that the rate of unintended pregnancies due to sexual abuse and violence among adolescents living in developing countries is 49% and that

half of them are terminated by curettage. By preventing adolescent marriages with laws and sanctions, maternal mortality rate will decrease (Gaur et al., 2022; Ogul, 2021).

Although gender discrimination, sexual violence, and menstrual stigma have a negative effect on attitudes and behaviors that support sexual and reproductive health rights, they may cause embarrassment during menstruation, and prevent from managing the process, and meeting information and hygiene needs. Although sexuality constitutes the basis of SRH in adolescents, it also brings many risky behaviors such as early sexual experience, presence of multiple partners, frequent sexual intercourse, consistency in condom use, and substance use. In addition, pornography watching rate is reported to be high in adolescents who have problems in family relations or who have weak family ties. In Koletić's study (2017), pornography is stated to affect sexual behavior, norms, attitudes, sexual satisfaction and self-esteem negatively (Ogul, 2021; Koletić, 2017).

It is of great importance for midwives and health professionals who play a key role in the society to inform the society and parents about the protection of sexual health and the prevention of violence, and to integrate the accurate information and practices into the culture. Midwives and all healthcare professionals should pay attention to the SRH-related privacy of people, and provide a safe and successful service through peer education, and adolescent-friendly and non-judgmental approaches. Women should not be perceived only as "mothers of the future"; they should be provided with accurate and effective services on education, health promotion, general health, family planning and maternity, safe abortion, school health education and the management of gender-based violence (Khanna et al., 2022; Tiwari et al., 2022; Maas et al., 2022; Pandey et al., 2019).

5. LIMITATIONS

That the present study included only young women in the age group of 18-24 years but not women in the age group of 15-17 years and men is the limitation of the study.

6. CONCLUSION

Although it was observed that the stigmatization attitudes of the individuals participating in the study were low, it was determined that the stigmatization levels of the individuals living in their own home, graduates and those with a higher age group were found to be low.

However, it was determined that the scale and scale sub-dimension total score averages of individuals with less income than their expenses were higher and there was a significant difference between the external stigma scale average.

Although many factors affect the sexual and reproductive health of adolescents and young people, all these factors should be evaluated separately and resolved correctly. The health of adolescents and young people concerns the whole society and affects the health of the country. Midwives who assume significant responsibilities in public health should plan training to address difficulties and obstacles faced by adolescents and young people in the society, provide accurate and comprehensive information on the risks related to SRH and contribute to an effective and efficient process via peer education. Adolescents and young people who have problems related to the use of family planning methods, adolescent pregnancy, curettage, anemia, HIV and other sexually transmitted infections should also be provided with preventive and therapeutic special care services.

If the provision and maintenance of such services are to be ensured, accomplishment of inter-sectoral cooperation and political and legal changes is of importance. Therefore, SRH education should be provided in schools, counseling units should be established, easy access to family planning methods should be ensured, and the society' awareness of the issue should be raised. All these will ensure the protection of the health of adolescents and young people, their access to SRH-related information without stigmatization and judgment, and prevention of early pregnancies and possible risky situations.

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Conflict of Interest

The authors reported no conflict of interest.

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