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Intervention-based Puberty Program: A Study on the Tendency of *Afghan female youths* to Engage in High-risk Behaviours in Iran

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Abstract: Risky behaviours are one of the major problems for adolescents. These behaviours are rooted in physical, sexual, mental, and social changes. This study aims at designing a puberty training program for Afghan female youths in Iran and assesses its effectiveness in reducing their tendency to high-risk behaviour. The aim of this study is in line with the fifth goal of Sustainable Development Goals which is "Gender equality". This study provides Afghan girls with easy access to information on puberty and its issues. Forty-three Afghan adolescent girls were selected through a random sampling method and organized into three intervention groups. The participants were given trainings on the physical symptoms of puberty, early/late puberty, genital anatomy, menstruation and hygiene, psychological changes symptoms, sexual relationships, sexually transmitted diseases, peer pressure, and addiction. The intervention consisted of seven sessions. Thirty-eight participants in the control group received no intervention. The Iranian adolescents' risk-taking scale was used to measure the dependent variable at baseline and completion of the program. The results showed that there were significant decreases in the tendency to smoke, substance abuse, alcohol consumption, and unprotected sexual relationships in the intervention groups ($P < 0.01$). However, the tendency to violence had no significant differences among the control nor in the intervention groups. This study provides evidence on the effectiveness of puberty training among Afghan adolescent girls with a tendency to engage in high-risk behaviours. Further research on the the immigrant adolescent's tendency towards violence are recommended. Longitudinal follow-ups are suggested to support the generalization of these kinds of interventions.

Keywords: Afghan Female, High-risk Behaviour, Intervention, Puberty, Iran

1. Introduction

Due to the common border, culture, language, religion, and forty-year war in Afghanistan, Iran is one of the destinations for Afghan migration [1]. Around 780,000 registered Afghan refugees and between 2.1 to 2.5 million undocumented Afghans live in Iran [2]. Having assets, bank account, health insurance, driver's license, domestic travel, registration in state schools are all challenging for Afghans living in Iran. Most of them are refugees and work in construction, agriculture, garbage collection, and cleaning [1]. This situation can have devastating effects on the quality of life of adolescent Afghan girls. There had been 83,179, 15–19-year-old Afghan female youths in Iran by the end of 2016 [3].

Adolescence is the period of transition between childhood and adulthood, emphasizing the period from 15 to 19 years old that identity formation begins [4, 5]. Identity is seen as a

dynamic, self-constructed, and internal set that includes individual desires, goals, abilities, and beliefs. One of the most important ways for adolescent identity formation is through peers [5]. Afghan teenagers are humiliated in their daily dealing with Iranians; they are disrespected, beaten, harmed, and their identities are insulted [6]. These experiences have destructive impacts on the Afghan juvenile's identity. Adolescents with a well-developed identity, have higher commitment and skills to adapt to different situations and have less tendency to high-risk behaviours [7].

Risky behaviours are any consciously or unconsciously controlled behaviours with a perceived uncertainty about their consequences, i.e., the advantages and disadvantages of the outcomes [8]. Risky behaviours include unsafe sex, violence, smoking, alcohol consumption, and substance abuse [9]. There are no statistics on the high-risk behaviours of Afghan adolescents, especially Afghan girls, in Iran. Alternatively, the statistics on the high-risk behaviours of Iranian adolescents, -which is the most like target population of the current study in terms of age and cultural characteristics- or the existing statistics published in Afghanistan.

1.1. Unsafe Sex

Unsafe sex is having condomless vaginal, or anal intercourse, multiple sex partners, a risky partner who has unsafe sex, and starting sexual activity at a young age. High-risk sex is a forced or voluntary sexual relationship within or outside the family. This situation can lead to sexually transmitted diseases, unwanted pregnancies, and abortion. Evidence illustrates that the prevalence of sexual relationships between teenage boys and girls has been reported from 12.8% to 20% [10]. There are different and sometimes contradictory estimates in Iran. Based on a recent meta-analysis 24 to 60.5% of Iranian adolescents experienced their first sexual relationship before the age of 15 [11]. Sex education is considered a Taboo both in Iran and Afghanistan. The knowledge around sex often spreads across the community without any organized education. Even it is not properly taught within the families [12]. According to the findings of a survey on sexual attitudes and behaviours of Afghan youths, most Afghan teens and adolescents do not have information about healthy sexual relationships. 90% of the participants of the mentioned survey admitted that talking about sexual attitudes and behaviours in public and families remain a cultural and social taboo in Afghanistan [13].

1.2. Violence

Violence is any behaviour that hurts others physically, mentally, and emotionally. Often it happens in different forms including (cyber) bullying, homicide, physical, sexual, verbal, and gang violence. The prevalence rate of verbal aggression ranges from 40 to 89%. Most studies of violence focus on men and boys because a higher percentage of them tend to engage in violent behaviour than women [14]. Violence tendency in this study means to engage in one of the mentioned violent behaviours, with friends, family members, and strangers, with or without reason. The prevalence of peer violence among school children in Afghanistan is reported around 50% among boys and 43% among girls. Food insecurity, witnessing family violence, and children's experiences of physical violence at home and corporal punishments at schools were among known reasons for peer violence among children [15]. Eventhough the search for literature on the violent behaviours of Afghan refugee youth living in Iran was inconclusive, prevalence rates of violent behaviours among Iranian adolescents ranged from 30% to 65.5% -in which males were 2½ times more affected than females- [16].

1.3. Smoking, Substance Abuse, and Alcohol Consumption

Adolescence is an important period in terms of starting to smoke. Preventing smoking by teens can help prevent other high-risk behaviours, such as alcohol use, unsafe sex, and drug use [17]. Adolescents engaged in several high-risk behaviours simultaneously. It has been reported that alcohol consumption or drug abuse by adolescents does not occur alone [18]. Limited evidence exists on the prevalence and social determinants of tobacco use in Afghanistan. Based on the estimations of one study, the prevalence rate of cigarette smoking was 3.4% for women in Afghanistan. They found that tobacco use was inversely associated with education [19]. As mentioned, prevalence rates of various drug consumptions among Afghan refugees in Iran were none-existent. Alcohol consumption among Iranian adolescents varied from 4.3% in Shiraz in 2003 to 37.7% in Kerman in 2010. Tramadol addiction was reported from 4.7% to 36% among Iranian students. 7% and 17% of the students in Tehran had experienced drug abuse and smoking, respectively [20]. Alcohol, opium, and marijuana were the first, second, and third most common among students in Tehran, respectively [21].

This study aims at designing a puberty training package for Afghan female youth in Iran to assess its effectiveness on decreasing the tendency to high-risk behaviour. The target group is among the most vulnerable minorities living in Iran. Adolescence experiences affect the future and adolescent girls rarely have decision-making authority and limited access to information resources and services [22]. Recognizing the impact of a well-developed identity on the future lives of adolescents, and due to the personal experience of working in various non-governmental organizations, the need for developing ways to empower Afghan female youths in Iran was felt strongly. The dearth of literature on such important issues was the next stimuli for the researchers to start the work. The aim of this study is in line with the fifth goal of Sustainable Development Goals, which is Gender equality. The main goal of the Afghan Female Puberty Training Program (AFPTP) is to provide Afghan girls with easy access to information about puberty and related issues, which ultimately leads to gender equality [23].

1.4. Objectives

The objectives of this research are:

1. Designing a puberty program package for Afghan female youths.
2. Assessing the impacts of AFPTP on the tendency to unsafe sex among Afghan female youths in Iran.
3. Assessing the impacts of AFPTP on the tendency to violence among Afghan female youths in Iran.
4. Evaluating the impacts of AFPTP on the tendency to smoking among Afghan female youths in Iran.
5. Evaluating the impacts of AFPTP on the tendency to substance abuse among Afghan female youths in Iran.
6. Assessing the impacts of AFPTP on the tendency to alcohol consumption among Afghan female youths in Iran.

2. Methods

2.1. Design

A two-arm intervention-control group was conducted to examine the effectiveness of AFPTP on the tendency to risky behaviour in Afghan female youths who were living in Iran. The intervention group received AFPTP two weeks after randomisation and the control group around eight weeks later. In this period, both groups had access to services as usual. Assessments took place two times: pre-test (before the AFPTP was started) and post-test (about nine weeks later than the pre-test). Figure 1 illustrates the process of AFPTP implementation.

AFPTP was conducted in four NGOs across Tehran. NGOs that had services for refugees. Their services included educational, medical, counseling, and entertainment services.

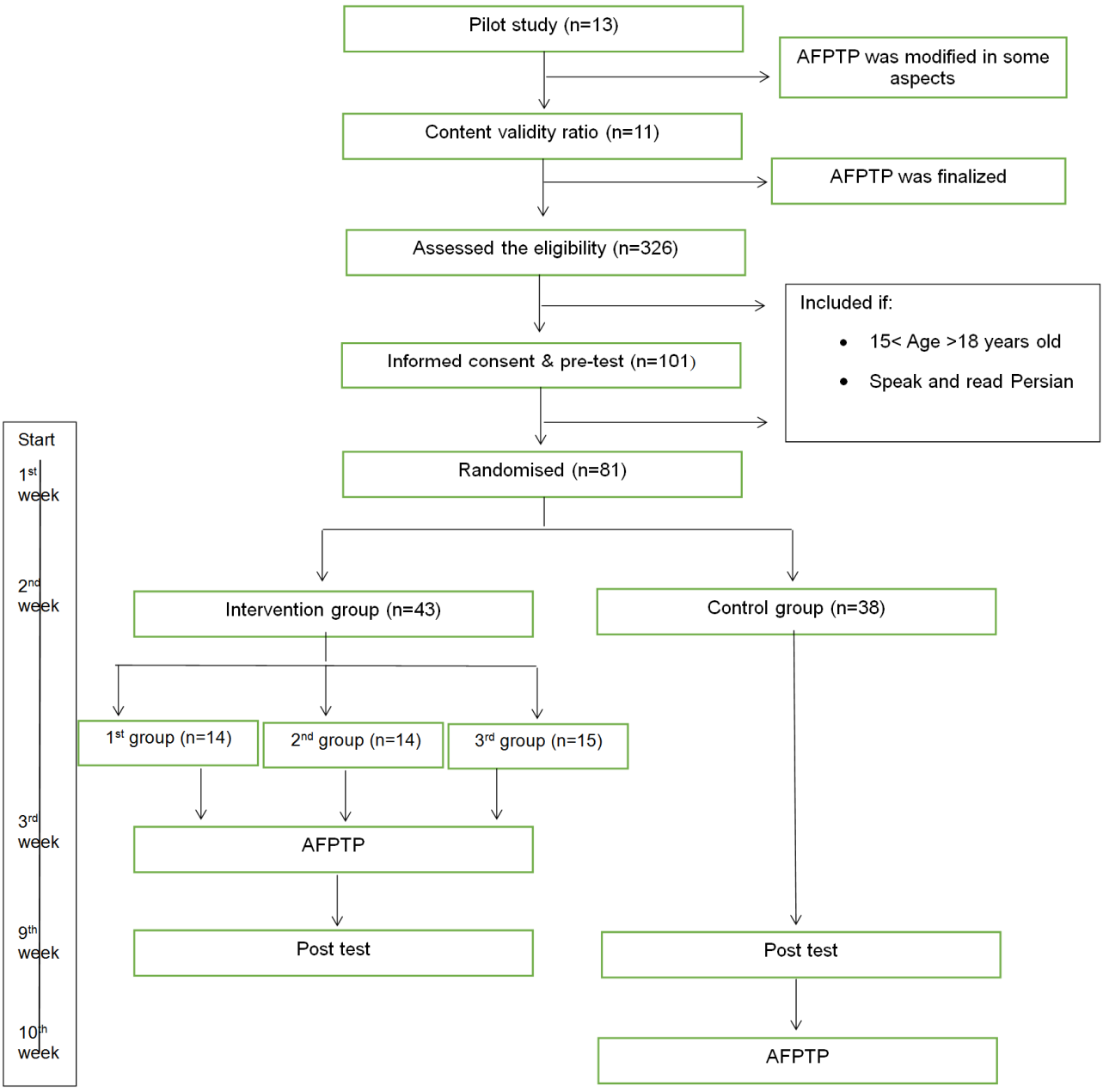

Figure 1. *Process of AFPTP implementation.*

2.2. Participants and Recruitment

Afghan female youths were eligible to participate if they included all of the following criteria:

1. Aged 15 to 18 years old.
2. Could speak and read Persian.

The NGOs' social workers referred all eligible individuals who had the initial desire to participate in the AFPTP program. Individuals could also self-refer. Afghan female youths who met the inclusion criteria were invited to an 'information and consent form' meeting individually. They received all the information about the study including the aims, outcomes, anonymity, possible risks, and if interested to partake in the program, they were given a consent form. Written informed consent was collected at this meeting or later on in another specified time if the potential participant needed more time to think and make a decision.

2.3. Sample Size

Although the NGOs had 326 Afghan female youth who were less than 18 years of age, only 101 of them were eligible to participate in the study. 81 girls signed the consent form and participated in the research. They were randomly assigned to the intervention and control groups. A total of 43 girls were selected for the intervention group and the others for the control group.

2.4. Control Group

Although the control group, which had 38 participants, did not receive AFPTP during the research interval, they received services from NGOs as usual. Since the objective of this intervention was to assess whether AFPTP provides additional strength. After completing AFPTP for the intervention group and performing the post-test for both groups, the control group received AFPTP.

2.5. Intervention Group

The intervention group was divided into three groups of 14, 14, and 15 participants, each of whom received AFPTP separately. Usual services also were available. AFPTP consisted of seven sessions on physical, sexual, mental, and social aspects, and the sessions were implemented in seven consecutive weeks. Each session was about 120 minutes. The first session was allocated to breaking the ice and laying down the rules for sessions. In the second session, the physical symptoms of puberty along with early/late puberty were explained through painting, group work, and discussion. The facilitator drew a girl on the board, showed the changes that take place in the body, and tried to decrease the participants' resistance regarding taboo subjects. In the third session, the anatomy of genital area and menstruation and hygiene during this period were explained through painting and discussions. Psychological issues during puberty, its symptoms such as the desire to be alone, the feeling of not being understood by the family and not participating in family gatherings, and ways to deal with negative symptoms were discussed at the fourth session. The next two sessions were about social puberty with topics such as peer pressure, addiction, unsafe sex, and sexually transmitted diseases. The last session was also about the conclusions, evaluation, and final discussions. Table 1 shows the details of AFPTP briefly.

Table 1. *AFPTP sessions.*

Session	Topic	Subjects	How
1	Getting to know each other	1. Introducing 2. Laying down rules	1. Ice-breaking method 2. participants collaboration
2	Physical puberty	1. Physical symptoms of puberty 2. Early/late puberty	1. Group work 2. Painting 3. Discussion
3	Sexual puberty	1. Genital area anatomy 2. Menstruation 3. Hygiene during menstruation	1. Painting 2. Discussion
4	Mental puberty	1. Psychological changes and its symptoms 2. How to deal with symptoms	1. Group work 2. Discussion
5	Social puberty	1. Peer pressure 2. Addiction	1. Group work 2. Discussion
6	Social puberty	1. Unsafe sex 2. Sexually transmitted diseases	1. Group work 2. Discussion
7	Conclusion	1. Conclusion 2. Final discussion	1. Discussion 2. Q&A

2.6. Validity and Reliability of AFPTP

The pilot studies have significance in culturally competent research. Because a learning program for Afghan female youths was designed in this research, a pilot study was necessary to find the obstacles and issues of AFPTP, modify the time and content of AFPTP, and engage the researcher in a culturally appropriate way [24].

AFPTP was conducted in four consecutive weeks. 13 Afghan female youths, who were 15-18 years old, participated in the pilot study. After finishing the pilot study, session time increased from 90 minutes to 120 minutes. Painting was added to the physical and sexual puberty sessions. Since they learned better about the physical

symptoms and genital anatomy by painting than discussion. Because many Afghan female youths did not talk to anyone before this study about topics such as smoking desire, increased sexual desire in adolescence, and menstrual problems, the pilot study illustrated that asking questions and answering participants' questions should receive more attention. Researchers found out how to engage in AFPTP in a culturally appropriate way.

After modifying AFPTP, it was sent to 11 experts, including 5 university professors in the field of intervention work, 2 facilitators of adolescent workshops, and 4 child and adolescent counselors. They reviewed the AFPTP to assess content validity ratio (CVR). The CVR for the physical, sexual, mental, and social aspects were 96%, 92%, 71%, and 84%, respectively.

2.7. Outcome Measure

2.7.1. Iranian Adolescents Risk-taking Scale (IARS)

This study measured changes in Afghan female youth's tendency towards risky behaviours. IARS assesses the tendency of adolescents to engage in risky behaviours and consists of 38 questions. Exploratory factor analysis indicated that IARS is a six-dimensional scale: the tendency to substance use, cigarette consumption, alcohol consumption, violence, and sexual relationships. The Cronbach's alpha values for the subscales were 0.9, 0.93, 0.90, 0.78, and 0.87 respectively [9].

2.7.2. Demographic Questionnaire

This study used brief demographic questions to gather the demographic information about the participant and her family. The demographic questionnaire consisted of variables such as the status of participant's education, parent's education, and parent's job. Demographic data was used to describe the samples' status.

2.8. Data Collection and Analysis

The pre-test was implemented after signing the consent form and before the first session of AFPTP in summer 2018. Post-test was administered nine weeks after pre-test in autumn 2018. After collecting data, an analysis of covariance (ANCOVA) was used to assess the impact of AFPTP on the variables.

2.9. Ethics

This research involved human participants and was approved by the Human Research Ethics Committee of the Social Welfare and Rehabilitation Sciences University (number: IR.USWR.REC.1395.2393).

Participants received all the information individually, and they signed the consent form. They were asked about their independence in participation. They were given more time if they needed someone else's permission or for pondering more upon their participation. Participants were fully informed that the study was based on voluntary participation, and they could withdraw their consent at any time without any negative consequences.

3. Results

The tendency to risky behaviours was assessed in 81 adolescents (43 girls in the intervention group and 38 girls in the control group). 63% of participants in each group were students and most participants' parents were workers (37% in the intervention group and 34% in the control group) and housewives (49% in the intervention group and 42% in the control group) respectively. More than 60% of parents did not have a high school degree. The demographic characteristics are shown in table 2.

Table 2. *Demographic characteristics of the intervention and control groups.*

Demographic characteristic		Intervention Group		Control Group	
		Prevalence	%	Prevalence	%
Education	Student	27	62.79	24	63.16
	Leaving School	16	37.21	14	36.84
Father's Job	Worker	16	37.21	13	34.21
	Freelancer	10	23.26	8	21.05
	Clerk	3	6.97	5	13.16
	Unemployed	14	32.56	12	31.58
Mother's Job	Housewife	21	48.84	16	42.11
	Work at home	14	32.56	14	36.84
	Worker	5	11.63	5	13.16
	Freelancer	3	6.97	3	7.89
Father's Education	Lower than High School	29	67.44	25	65.79
	High School & Bachelor's	10	23.26	9	23.68
	Above Bachelor's	4	9.3	4	10.53
Mother's Education	Lower the High School	26	60.47	22	57.89
	High School & Bachelor's	13	30.23	13	34.22
	Above Bachelor's	4	9.3	3	7.89

The mean and standard deviation are given in terms of the intervention and control groups. According to Table 2, the tendency to smoking, substance use, alcohol consumption, and sexual relationships altered dramatically, but the tendency to violence did not change much (Table 3).

Table 3. *Mean and standard deviation of the variables pre- and post-test for the study and control groups.*

Variables	Intervention group		Control group	
	Pre-test	Post-test	pre-test	Post-test
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Tendency to violence	14.63 (2.47)	13.98 (1.98)	14.42 (1.93)	14.34 (1.94)
Tendency to cigarette consumption	15.23 (2.44)	10.56 (1.71)	14.50 (2.18)	14.24 (2.36)
Tendency to Substance use	22.77 (3.70)	15.58 (2.93)	21.97 (3.14)	21.55 (3.00)
Tendency to alcohol consumption	13.95 (2.69)	9.65 (2.10)	13.71 (2.46)	13.53 (2.46)
Tendency to sexual relationship	10.84 (1.89)	7.21 (1.57)	10.37 (1.81)	11.24 (1.63)

Results of the ANCOVA test showed that there were significant differences between the intervention and control groups for the post-test, after eliminating the effect of the pre-test for most subscales of the tendency to risky behaviours ($P < 0.01$) among the participants. Although the tendency to violence ($P = 0.109$) did not alter significantly, the tendency to engage in the other mentioned high-risk behaviours among the target group did show a significant reduction (Table 4).

Table 4. *Results of ANCOVA test.*

	Source	Sum of squares	Degrees if freedom	Mean squares	F	Significance	Partial η^2
Tendency to substance use	Group	833.947	1	833.947	204.063	0.000	0.623
	Pre	375.097	1	375.097	91.785	0.000	0.541
	Error	318.763	78	4.087			
	Total	28785.000	81				
Tendency to alcohol consumption	Group	330.539	1	330.539	201.060	0.000	0.610
	Pre	281.011	1	281.011	170.933	0.000	0.587
	Error	128.231	78	1.644			
	Total	11367.000	81				
Tendency to cigarette consumption	Group	325.536	1	325.536	121.242	0.000	0.609
	Pre	120.043	1	120.043	44.709	0.000	0.364
	Error	209.430	78	2.685			
	Total	12825.000	81				
Tendency to violence	Group	4.949	1	4.949	2.627	0.109	0.033
	Pre	156.570	1	156.570	83.101	0.000	0.516
	Error	146.959	78	1.884			
	Total	16520.000	81				
Tendency to sexual relationships	Group	363.820	1	363.820	237.271	0.000	0.653
	Pre	82.383	1	82.383	53.728	0.000	0.408
	Error	119.601	78	1.533			
	Total	7235.000	81				

4. Discussion

This research aimed at assessing the effectiveness of puberty training on risky behaviours, including the tendency towards smoking, drug abuse, alcohol consumption, violence, and unsafe sex among Afghan female youths living in Iran. Although this intervention had a significant effect on the tendency to engage in high-risk behaviours, the tendency to violence did not change significantly. The results indicate that the intervention had a positive effect on substance abuse. This finding is confirmed by some other studies. Harm reduction training can lead to a decline in substance abuse [25]. Cognitive-behavioural intervention with parents at their home played a significant role in reducing their children's substance abuse [26]. One study in Iran showed the beneficial influence of life skills training on addicts' self-esteem and mental health. Self-esteem and mental health had an indirect effect on the tendency towards substance abuse [27].

In terms of alcohol consumption, a significant effect which was in line with an Iranian study was found, suggesting that a package of life skills with a prevention approach can play a beneficial role in adolescents' tendency to alcohol consumption [27]. Training via the internet can lead to a reduction in alcohol drinking among adolescents [28]. Another study showed that adolescents who could not watch movies that were not suitable for their age were less motivated to consume alcohol than their peers [29]. An attitude alteration approach can be effective to mitigate the tendency to alcohol consumption, although only for a short period; after a while, there was a return to the original level [30].

The other variable investigated in this study was smoking habits. Results revealed that the puberty hygiene intervention had a positive effect on smoking habits. Some community-oriented interventions accomplished with the families, school, and recreational centres had a significant effect on the tendency to smoke among 10 to 14-year-old students [31]. Adjusting prohibition rules for smoking and increasing the price of cigarettes has a decreasing effect on the smoking tendency [32]. In Iran, studies have indicated that all interventions that improved adolescents' information and attitudes had an indirect relationship with this variable [33].

There was no effect on the tendency to violence. Some studies have reported the opposite results. One study revealed that social-emotional skills training could lead to anger management [34]. Another study indicated that behaviour management training for parents had a significant impact on the anger of teenage bullies [35]. However, some studies indicated that interventions did not have long-term impacts, and adolescents were not successful in controlling their anger [36, 37]. It seems that this issue needs some long-term interventions.

The last variable examined in the current study was the tendency to unsafe sexual relationships. The intervention had a significant impact on this activity. Various studies noted that safe sex training could lead to a reduction in unsafe sex and HIV infection [38, 39]. There is a comparison among two methods regarding effective education on sexual relationships: (a) comprehensive training and (b) prohibition. The first target group had fewer tendencies to vaginal relationships than the second group. Prohibition without any education did not have any impact on the age of initiation of sexual relationships [40].

The findings of this study showed that preventive interventions enabled adolescents to reduce risky behaviours by enhancing protective factors based on training. Understanding the different developmental aspects of adolescence, and focusing on their needs is significant for professionals working with youths. During the intervention, adolescents were empowered through training. Empowerment "seeks to help clients gain the power of decision and action over their own lives" [41]. Payne indicated that through empowerment, clients try to decrease the negative effects of social or personal behaviour. In AFPTP, participants learned about puberty and its different dimensions (physical, sexual, mental, and social aspects). This knowledge helped the participants to manage their lives during puberty. Also, their knowledge and self-confidence in terms of peer pressure, unsafe sex, and sexually transmitted diseases increased.

5. Conclusion

Puberty training has a significant impact on adolescents' lives if they are well trained and aware of risky behaviours. This can help to improve the quality of life, which requires social planning. Testing the current intervention with a larger target group is suggested. Some programs can be considered for the adolescent population, such as periodic training in life skills, harm reduction, or a puberty hygiene intervention for Afghan female youths and their parents simultaneously, Further research in this area can assess the effects of social networks and social support on Afghan female youth's tendency to risky behaviours.

6. Limitation

The study was conducted in Tehran and girls who were in other cities were not included in the study. Many girls were eager to participate in the study, but their parents did not allow them to participate in the program, and several participants were missed. Although legal residency was not an inclusion criterion for participation, all participants had legal residency. This indicates that there is not easy access to illegal refugees, and this was one of the limitations of the study.

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