Original Article

Factors Affecting the Providing of Sexual Health Services by Midwives: A Qualitative Research in Iran

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Abstract

Background: Sexual health is one of the most important aspects of health. In Iran, most services associated with reproductive and sexual health are provided by midwives at health centers. As different factors are effective in providing care services associated with sexual health, the present study aims to investigate the factors affecting the provision of sexual health services by midwives. **Materials and Methods:** In this qualitative content analysis study, data were collected by conducting in-depth interviews with 16 midwives, 7 key informants, and 6 stakeholders. Besides, the sampling method was purposeful, and data analysis was conducted using conventional content analysis and MAXQDA software. **Results:** After analyzing the content of the qualitative data, two themes were extracted, which included facilitators of and barriers to providing sexual health services by midwives. **Conclusions:** By modifying educational curricula, providing in-service training, and adopting appropriate policies, barriers for providing accessible sexual health services by midwives can be reduced.

Keywords: *Iran, Midwifery, Qualitative research, Sexual health*

Introduction

Sexual health, as an important aspect of health and sexual relations, is regarded as a fundamental component of human life.[1] Despite the significant importance of sexual health, issues related to sexual health are not often considered in routine care services provided by healthcare providers.[2] Sexual counseling is one of the most important roles defined for healthcare workers. However, few healthcare providers are capable of playing this role properly in the clinical environment.[3] This is due to various reasons, including religious beliefs, morals, embarrassment or discomfort, time constraints, fear of insufficient personal knowledge and skills, lack of adequate treatment, as well as a lack of education in general.[4] In addition, talking about sexual issues is regarded as taboo in many countries, including Iran.[5,6] Moreover, some clients refuse to discuss their sexual problems for different reasons, such as shame and embarrassment.[6,7] Accordingly, sexual problems remain unsolved despite their prevalence (approximately 31–51% of women in Iran[6]) and significant importance, which can lead to a reduced quality of life.[8-11]

In Iran, midwives provide various educational, supportive care, and counseling services to women at health centers. Research studies show that midwives play a critical role in providing sexual counseling to individuals, because of their close relationship with patients[12,13] and they possess actual abilities and potential capabilities, with the strengthening of which they can be used as frontline treatment forces, especially in promoting sexual health among women.[14,15] Thus, the elevation of the professional capacity of midwives and the use of this capacity are the key steps in providing appropriate and accessible sexual healthcare services to all women. By identifying relevant factors in this field, healthcare policymakers and providers can better help solve sexual problems among the clients and increase their quality of life. Since few studies have been conducted in Iran on the dimensions and factors affecting this issue, the present study tries to explain the factors affecting the provision of sexual healthcare services by midwives.

How to cite this article: Mohseni M, Riazi H, Karimian Z, Kariman N, Nasiri M. Factors affecting the providing of sexual health services by midwives: A qualitative research in Iran. Iranian J Nursing Midwifery Res 2023;28:47-52.

Submitted: 01-May-2021. **Revised:** 07-Jul-2021. **Accepted:** 17-Oct-2022. **Published:** 27-Jan-2023.

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Access this article online

Website: www.ijnmrjournal.net

DOI: 10.4103/ijnmr.ijnmr_157_21

Quick Response Code:

Materials and Methods

The present qualitative content analysis study was extracted from a Ph.D. thesis on reproductive health. The participants were selected through purposive sampling from November 2018 to June 2019 in Rafsanjan, Iran. Information sources included midwives, key informants (faculty members of a university of medical sciences, reproductive and sexual health specialists, the health department deputy, and health department experts), as well as stakeholders (women referring to health centers) who were willing to participate in the study and share their experiences. The inclusion criteria included no suffering from known mental illnesses and willingness to express one's experiences. Concerning the midwives, two more inclusion criteria were considered, which were having a bachelor's degree or higher and having at least one year of midwifery experience. Lack of willingness to keep participating in the study was the only exclusion criterion in the present study.

The data were collected by conducting in-depth and semi-structured interviews with the participants using open-ended questions. To achieve better results and to use a variety of methods, the interviews were conducted with both individuals and focus groups. The maximum variation was observed in terms of job position, workplace, organizational category, managerial position, educational level, and work experience. Besides, as many as eight individual interviews and three focus groups were conducted (two groups of key informants and midwives, and one group of stakeholders). All individual interviews were conducted in the counseling rooms of health centers in a quiet, secluded place with adequate mental peace for the participants. In addition, interviews of the focus groups were conducted in a university meeting room. In the interviews with midwives and key informants, the interview started with a general question such as "What work experiences have you had in terms of sexual health issues?" "How do you assess midwives' ability to provide sexual health services?" and "What are the strengths and weaknesses of midwives in providing sexual health services?," and "What are the challenges or problems in educating midwives in the field of sexual health care?" Similarly, in the focus group of stakeholders, some questions were asked, including "What are your experiences of referring to midwives for sexual problems?" and "What problems do you face when referring to midwives for sexual problems?" Besides, the interview was guided by exploratory questions or follow-up phrases, such as "Could you explain it further?" or "When you say. what do you mean by that?" All interviews were recorded, fully transcribed, and analyzed. The duration of each individual interview ranged from 35 to 105 min, and that of the focus groups ranged from 70 to 100 min. At the end, data saturation was obtained from interviews with 29 people. In addition, data analysis was conducted according to the steps proposed by Graneheim and Lundman[16] via conventional content analysis. For this purpose, the text of the interviews was entered into MAXQDA v10 for storage, retrieval, and analysis. Before starting the coding process, the contents were read several times so that the researcher would be fully informed about the data and obtain a general understanding of the data. Next, the main sentences and concepts of each line or paragraph were identified and coded. Besides, the codes were summarized and classified, with the themes extracted.

The Guba and Lincoln criteria were used for the rigor of the findings.[17] All interviews were conducted by the main researcher, who is a PhD candidate in Reproductive Health and has a background in qualitative research. Accordingly, to confirm credibility, the long-term involvement of the researcher and the allocation of sufficient time to data collection resulted in trust among the participants and the acquisition of more dependable data. The findings were reviewed and approved by the participants (member check). In addition, faculty members' reviews (peer check) were obtained, with the codes and classifications approved and corrected by professors and faculty members. To determine confirmability, several interview texts, the coding process, and the theme extraction process were provided to other professors of qualitative research so that they would investigate them and give their opinions. Moreover, the researcher carefully documented all the research steps and allowed external auditors to investigate all of them. To ensure the dependability of the data, external checking was used. In order to examine data transferability, the midwives who differed in terms of job position, workplace, organizational category, managerial position, educational level, and work experience were interviewed, and data collection methods (individual and focus group) were combined to ensure that sufficient information was used.

Ethical considerations

The present study was approved by the Ethics Committee of Shahid Beheshti University of Medical Sciences (IR.SBMU.REC.1397.055). Informed consent was also obtained from the participants for their participation in the study and for recording the interviews. The participants were assured that their audio files would be kept confidential. Besides, adequate explanations were given about the voluntary nature of the participation and the possibility of withdrawal from the study at any stage of the study.

Results

From among the 29 participants of the study, as many as 16 were midwives; there were 7 key informants, as well as 6 stakeholders. The demographic characteristics of participants are given in Tables 1 and 2. The results of data analysis performed through the conventional content analysis method yielded the two main themes of "facilitators of providing sexual services by midwives" with two categories and "barriers to providing sexual health services by midwives" with four categories [Table 3]. These

Table 1: The demographic characteristics of midwives (*n*=16)

No.	Age (year)	Work experience (year)	Work place	Education	Marriage status	Interview method
1	48	23	Health center	B.Sc*.	Married	Individual interview
2	49	21	Marriage counseling center	B.Sc.	Married	Individual interview
3	50	22	Health center	B.Sc.	Married	Individual interview
4	52	28	Health center	B.Sc.	Married	Individual interview
5	49	27	maternity ward	B.Sc.	Married	Focus group
6	34	9	Health center	B.Sc.	Married	Focus group
7	36	11	Health center	B.Sc.	Married	Focus group
8	38	15	Health center	B.Sc.	Married	Focus group
9	31	9	maternity ward	M.Sc**.	Married	Focus group
10	32	8	Health center	B.Sc.	Single	Focus group
11	33	5	Health center	B.Sc.	Married	Focus group
12	39	6	Health center	B.Sc.	Married	Focus group
13	32	5	Health center	B.Sc.	Single	Focus group
14	46	24	maternity ward	B.Sc.	Married	Focus group
15	33	4	Health center	B.Sc.	Single	Focus group
16	29	6	Clinic	B.Sc.	Married	Focus group

*Bachelor of Science. **Master of Science

Table 2: The demographic characteristics of key informants and stakeholders (*n*=13)

No	Age (year)	Education	Work experience (year)	Occupation	Workplace	Role	Interview method
17	50	Ph.D.*	26	Reproductive health specialists, faculty members	Nursing and midwifery faculty	key informants	Individual interview
18	54	M.Sc.**	30	Faculty members	Nursing and midwifery faculty	key informants	Individual interview
19	46	M.Sc.	22	Faculty members	Nursing and midwifery faculty	key informants	Individual interview
20	49	M.D.***	24	Health deputy	Health Department of RUMS*****	key informants	Individual interview
21	43	B.Sc.****	19	Midwife-health deputy expert	Health Department of RUMS	key informants	Focus group
22	44	B.Sc.	22	Midwife-health deputy expert	Health Department of RUMS	key informants	Focus group
23	47	B.Sc.	25	Midwife-treatment deputy expert	Health Department of RUMS	key informants	Focus group
24	47	High school diploma	-	Housewife	Client	Stakeholders	Focus group
25	33	B.Sc.	-	Coach of a sports	Client	Stakeholders	Focus group
26	32	High school diploma	-	Housewife	Client	Stakeholders	Focus group
27	34	High school diploma	-	Housewife	Client	Stakeholders	Focus group
28	24	Primary education	-	Housewife	Client	Stakeholders	Focus group
29	50	M.Sc.	-	Social activist	Client	Stakeholders	Focus group

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themes formed the basis of the present study. Besides, they explained the professional ability of the midwives to provide sexual health services as well as the factors effective in this field. The results of the present study are discussed through the following key themes:

Facilitators of providing sexual services by midwives

This concept was formed based on three categories: the high cost-effectiveness and cost-benefit ratio, professional competence in midwifery, and midwives' capacity for providing sexual health services. According to the participants of this study, some factors and conditions associated with the field and work environment of midwifery were regarded as the job capacity and professional competence of midwives for providing sexual health services.

1-1: High cost-effectiveness

Table 3: Themes, categories, and subcategories of the factors effective in providing sexual health services by midwives

Themes	Category	Subcategory
Facilitators of providing sexual health services by midwives	High cost-effectiveness	Being economical
		Clients' easy access to midwives
		The extent to which people refer to midwives
	Professional competence in midwifery	Being part of one's own job description
		The relationship between midwifery and sexual health
		Intimate and constant communication between midwives and clients
		suitable environment
		The possibility of referring
		Sexual counseling during midwifery care
		Brief sexual assessments at the health center system
		Providing services at marriage counseling centers
Barriers to providing sexual health services by midwives	Poor sexual education in midwives	Lack of adequate sexual health education in college
		Lack of in-service training
	Policymakers' approach and attitude	Attitudes present in macro policymaking
		Ignoring sexual health at the health center
	Time and source limitation	Lack of time and the large number of clients
		Improper environment for providing sexual counseling
		Restrictions on providing sexual health services to women
		Inefficiency of the referral system
	Cultural issues	Taboo nature of sexual issues
		Lack of cultural promotion and public education about sexual health
		Lack of localization in the field of sex education
		Client attitudes toward sexual issues
		Ignoring the impact of sexual problems on people's lives

Being economical of providing sexual services by midwives, clients' ease of access to midwives, and the extent of referral by people to midwives are among the factors that save both time and money and lead to providing sexual health services on a large scale. In other words, these factors result in both accessibility and convenience in providing services and increase the cost-effectiveness and cost-benefit ratio of the services provided. According to some of the participants: "*The health center provides free health services or very little cost. This is very beneficial. Most people do not have enough money to visit a doctor or a specialist in sex*" (P26, FG3).

"*This center covers all groups. People of the lower strata of the society do not visit a psychologist, a sexologist, etc., for such problems*" (P19).

1-2. Professional competence in midwifery

The capability and nature of midwifery, its association with the genital system and sexual issues, as well as midwives' responsibilities in this regard have turned sexual health and related care services into an integral part of midwifery. Accordingly, midwives' constant and sincere communication with clients, their interest in sexual health education, and the use of the referral system after initial counseling provide favorable conditions that pave the way for midwives in providing more sexual health services.

"*A midwife is quite familiar with female genitals and the genital system, especially with hormonal status, being their strong point. No one is as familiar with the genital system as a midwife working at a health center*" (P20).

"*Since women visit health centers very frequently, they are taken care of regularly and have an intimate relationship with midwives*" (P6, FG1).

However, while providing midwifery care services, assessments of the health center system, marriage counseling, and sexual counseling are made by midwives. This indicates their potential capability in this field. "*In the SIB system (Integrated health system), we ask clients 30 years old and even older about satisfaction with sexual performance and problems they have during sexual intercourse*" (P22, FG1).

"*If they face a problem, they will come back for marriage counseling. If we can answer their questions, we will do so. If we cannot, we will at least refer them to the suitable specialist*" (P2).

Barriers to providing sexual health services by midwives

This concept consists of four categories, including poor sexual education among midwives, policymakers' approach and attitude, time and source limitations, and cultural issues.

2-1. Poor sexual education in midwives

The most important problem that most of the participants somehow mentioned was the lack of adequate training in sexual health for midwives, which had turned into a barrier in providing services. In fact, due to shortages in this field, they would avoid posing or even addressing problems: "*Our midwives have not received trainings required in dealing with sexual problems of people, yet they make statements based on their attitudes, beliefs, life experiences, and religious beliefs*" (P17).

"*Although we passed a course on sexual dysfunction during our college years, it was not adequate for us*" (P16, FG2).

2-2. Policymakers' approach and attitude

In some cases, planning and policymaking are performed in such a way that they provide no assistance in sexual services at health centers, but instead become obstacles to providing these services. For example, in the fields of policymaking and planning for the health system, no attention has been paid to sexual health. Moreover, policymakers have not addressed midwives' capacity for providing sexual services. This was confirmed by the statements of some of the participants as follows: "*The health system is not adequate and has never raised questions about sexual problems. Besides, it has numerous limitations for the youth, and the elderly*." (P4).

"*When midwives decide to provide sexual health services to individuals, the major weakness is that, they didn't have education in mental health. In my opinion, sexual health is nothing without mental health*" (P20).

2-3. Time and source limitation

According to the participants, there were some problems that prevented midwives from providing sexual health services to clients at health centers. These problems included the lack of time, the large number of clients, the inadequate environment for providing sexual counseling, limitations on the provision of sexual health services to women, and the inefficiency of the referral system, which have been part of the organizational and systemic issues. "*There is a large number of clients, and we do not have enough time*." (P3, FG 1).

"*Our room is a public room and crowded. I cannot lock the door for anyone to provide counseling services*""(P1).

2-4. Cultural issues:

There are some cultural factors affecting sexual issues, which include the taboo nature of sexual issues in society, lack of cultural promotion, lack of sexual training based on cultural, national, and religious principles, especially for young people and teenagers, clients' incorrect attitude toward some sexual issues, and lack of due attention to the impact of sexual problems on people's lives. These factors have caused numerous problems in providing sexual health services to women. "*People feel very embarrassed at talking about sexual issues because they are considered taboo. They rarely refer to a health center for such problems*" (P4).

"*To some women, sexual issues are regarded as 'the last straw'. When sexual problems become highly annoying to them, they visit health centers and specialists*" (P17).

Discussion

The two themes of "facilitators of providing sexual services by midwives" and "barriers to proving sexual health services by midwives" were the main concepts derived from the findings of the present study. According to our results, the extent of referral to midwives, ease of access, as well as continuous and intimate communication with clients, are the most important capacities of midwifery in providing sexual health services at health centers. These results are in line with the findings of a study conducted by Karimian *et al*.[15] on the strong points of providing sexual health services by midwives. Besides, the results of the present study are consistent with those of the study conducted by Viveiros and Darling[18] that showed, midwives' knowledge and experience, continuity of care, scope and generality of care, and support by midwives were facilitators of access to midwifery care. Similarly, the findings of the present study were consistent with those of the study conducted by Mansour and Mohamed. Accordingly, they reported that the availability of a private environment, the relationship between the patients and the caregiver, good communication skills, and the provision of sex-related training for caregivers are among the facilitators of providing sexual healthcare services.[19]

In the present study, the most important barrier to providing sexual health services by midwives was the lack of adequate training for midwives in sexual health. Different studies have identified different barriers to providing sexual health services. However, the lack of adequate training and confidence, as well as the feeling of shame, were the main barriers to starting a sexual discussion.[2,6,7,20,21] However, according to the participants of the study conducted by Karimian *et al*.,[15] the most important barriers included performing multiple tasks by midwives as well as the lack of time, an appropriate physical environment, and motivation. Their results were not in line with those of the present study, in which most of the participants referred to the lack of required knowledge and training. The aforementioned factors are the major reasons for the avoidance of clients' sexual issues by midwives. Moreover, in the statements made by the participants, they referred to other barriers, such as the lack of time, the large number of clients, and an inappropriate environment. These were in line with the findings of other studies that referred to heavy workloads, lack of personnel, lack of resources (such as time) and lack of a private environment as barriers to talking to clients about sexual issues.[19,22,23] In addition to barriers, such as lack of time and personnel, Percat and Elmerstig referred to the lack of encouragement from managers and the lack of counseling tools as the existing barriers. In addition, they maintained that education alone would not help change attitudes toward addressing sexual issues

among patients. Organizational and managerial support, along with education about sexual issues, are essential.[21] According to research, sexual healthcare services have not been duly considered by policymakers.[22] Besides, the existing programs of the health system have failed to meet the sexual health needs of their clients.[24,25] This fact was also observed in the findings of the present study. Besides, the policymakers' attitude toward the way of providing sexual health services was the most significant barrier. The taboo nature of sexual issues and the lack of public education about sexual health were other barriers identified in the present study. These findings were in line with those of the studies conducted by Çuhadaroğlu and Khadivzadeh *et al*.[5,7] Moreover, the findings of the present study confirmed the results of the study conducted by Tabatabai, indicating that sexual issues are among the most difficult topics to discuss in conservative societies as well as in most Muslim countries. Besides, sex education in schools and universities is either unavailable, inadequate, or unsatisfactory contents.[26]

The limitation of the present study was that it was conducted in a small town, which was inevitably influenced by cultural and social issues due to the nature of sexual issues and taboos in general. Due to the great impact of cultural, social, and religious beliefs on sexual issues, it is recommended that this study be conducted on a larger scale in different cultural and social contexts.

Conclusion

By strengthening the facilitators and reducing barriers, the professional potential and abilities of midwives can be used to provide accessible, widespread, and cost-effective sexual health services at health centers.

Acknowledgments

The present study was a part of the Ph.D. thesis of the first author (Approved project no: 14804). The authors would like to extend their gratitude to all participants who assisted with this research.

Financial support and sponsorship

Shahid Beheshti University of Medical Sciences

Conflicts of interest

Nothing to declare.

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