Original Article

Perceived Barriers and Needs in Accessing Sexual Health Services for Iranian Couples: A Qualitative Research

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Abstract

Background: Sexual and Reproductive Health (SRH) and access to related services are the most important issues and are part of reproductive health rights. Therefore, this study was designed and conducted to explain the perceived barriers and needs in accessing sexual health services for Iranian couples. **Materials and Methods:** We conducted this study on 14 subjects at the Navab Health Center in Isfahan and Behsa Counseling Center in Tehran from November 2015 to December 2016 by common qualitative content analysis approach through semi-structured interviews. **Results:** The results show that sub-subcategories "Therapist's Individual Traits" and "Specialized Skills of Therapist" formed "Need for Access to a Professional Therapist" subcategory and sub-subcategories "Provide specialized problem-based treatments" and "Rapid and Timely Therapy of Sexual Problems" formed the "Need for Timely and Comprehensive Access" subcategory and these two subcategories formed the main category of "Need to access a specialized, comprehensive and timely sexual health services system." Furthermore, sub-subcategories of "Failure to Prioritize Sexual Matters" and "Lack of sexual awareness" formed the "Individual Challenges of Search for Sexual Health Services" subcategory, and sub-subcategories of "Sexual Problems are a Taboo" and "Lack of awareness of the existence of sex therapists and sexual health service centers" formed "Sociocultural Challenges to Access Sexual Health Services" subcategory. Two subcategories formed the main category of "Obstacles to Access Efficient and Proper Sexual Health Services." **Conclusions:** The explored couple's experiences demonstrated that the need to receive timely and comprehensive specialized sexual health services because of the obstacles to access is not provided.

Keywords: *Perception, couples therapy, sexual Health, qualitative Research*

Introduction

Sexual health is a state of physical, emotional, mental, and social well-being regarding sexuality.[1] Sexual health is one of the main aspects of social welfare that affects all persons of different ages at different stages of life.[2] Sexual and Reproductive Health (SRH) and access to efficient sexual health-based services is one of the most important issues and is a health right.[3] Based on the sustainable development goals (goals 3, 7), public access to SRH will have to be realized by 2030. Yet, knowledge of SRH benefiting from the services has continued limited in many lower- and middle-income countries) LMICs).[4]

Iran is among the countries benefiting from a relatively desirable health and medical care service-providing structure[5] and has achieved improvements in the maternal and child healthcare systems,[6] and in Iran's health and medical care services continuum, sexual health is focused on the prevention and treatment of such diseases as HIV.[7] Overall, the healthcare system has not paid enough attention to the sexual health needs of customers or provided sexual health services.[8] The various presuppositions for the missing sexual health services in the health and medical care system in Iran are debatable. One such importance is that it is a taboo subject.[9] Studies indicate that the fact that sexual subjects are taboo can cause a delay in people, especially women, in treating themselves, followed by negative health consequences.[10,11] The available evidence shows that although access to other health services and equality in providing health services crosses your mind when it comes to sexual health, the fact that sexuality is taboo shows itself off.[12] In Iran, like in many communities, sexuality is taboo.[9,13]

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The fact that it is a taboo is rooted in a complex of social factors.[13] In some Asian cultures, like China, sexuality is taboo.[14,15] A review study pointed out that people with a sexual performance disorder have no interest in seeking help from related specialists. Chinese suffering from a sexual performance disorder tends to attribute their problem to a physical source. They would prefer using the current pharmaceutical therapies to see a specialist or counselor about it.[15] The available evidence shows that traditional values and cultural problems limit people's access to sexual knowledge, and limited sexual behavior may influence sexuality by feeling guilt and shame. When people feel guilt, shame, or anxiety, discussion of religious matters may disclose contextual conflicts.[16]

Beliefs, attitudes, and values related to sexuality differ in various communities. The historical roots and philosophical traditions of family structure and the differences in interpersonal relations can lead to different beliefs about sexual activity. For example, in many Asian countries, sexuality is linked to reproduction, while in modern western communities, it is regarded as fun and for deriving pleasure. This broad difference can tell how the existing differences in the social structure can have significant consequences for the individual.[14]

A requirement for creating any health and medical care program is to precisely recognize the needs and expectations of the customers receiving services.[17] Moreover, health and medical care systems will be more successful if, apart from the customer's needs, they supposed a context-based program.[17] This rule will equally apply to the provision of sexual health services. Hence, understanding the needs and expectations of customers is essential. Therefore, this study was designed and conducted to explain the Perceived barriers and needs in accessing sexual health services for Iranian couples.

Materials and Methods

This study is a part of the results of the doctoral dissertation on reproductive health supported by the Isfahan University of Medical Sciences. We used content analysis to analyze the data using a systematic classification process based on the extraction of codes and identification of categories or patterns to explain the experiences of the Iranian couples in Navab Health Center in Isfahan and Behsa Psychology and Counseling Clinic in Tehran from November 2015 to December 2016. Psychologists and psychiatrists were extant at Navab Health Center in Isfahan, but there was no sex therapist. In addition to a psychologist and psychiatrist, sex therapists were also extant at Behsa Psychology and Counseling Clinic. The participants comprised 14 (seven married female and seven married male participants) of reproductive ages, proficient in Persian, capable of communicating with no difficulty, and residing in Tehran or Isfahan, Iran. The couples had a minimum of 1 year of legally married life, were interested in participating in the study, reporting their experiences, and had no chronic disease that would disrupt their sexual performance. We did sampling purposefully and continued with maximum variation until data saturation. Of the female participants, three suffered from a lack of sexual desire and one from anorgasmia. Of the male participants, one suffered from a lack of sexual desire and two from premature ejaculation. Before entering the study, all the participants were clinically verified for the disorders by the researcher. Three male participants and one female participant have histories of referrals to sexual therapists. As building confidence in sexual studies is important, the researcher arranged face-to-face meetings where she introduced herself, explained the aim and importance of the research to the couples, and set a time and place for the interview. Before the interview, we obtained both oral and written informed consent from the participants. Also, the researcher observed ethical principles in the research, such as confidentiality, anonymity, and the right to withdraw from the study if they will stop the interview.

First, we conducted 14 in-depth semi-structured interviews, and then, where needed, we reinterviewed the participants to complete the data obtained. Thus, 20 individual interviews were done and recorded using a digital recorder. The length of the interviews varied from 30 to 135 min, depending on the interest of the interviewee to respond to the questions. We conducted the interviews individually to allow people freely report on their experiences. They started with a general and open question ("Have you ever consulted a sex therapist or sexual health center to answer your sexual questions, concerns, and sexual problems?"). If the answer was yes, they would be asked about "their experiences when visiting a sex therapist and what they expect from a sex therapist." If the answer was no, the reason for not going to the sex therapist was asked and "what conditions should be provided for people to go to the sex therapist?" Data collection continued until no new data were added to the existing data; hence, data saturation.

Data analysis was conducted based on qualitative content analysis as suggested by Lindgren and Lundman.[18] First, upon completion of each interview, they were immediately listened to several times to find the general view, and then we wrote down the interview. Second, we read each transcript several times to obtain a sense of the data as a whole. The whole interview and observations of the couple's experiences and feelings about sex services were considered as a unit of analysis. The meaning unit was identified which included words, sentences, and paragraphs that were related in meaning or content. We put these units together according to their concept. In the next step (summarization), the size of the semantic units was reduced while preserving the original meaning, and an attempt was made to show both explicit and implicit content with a description that was close to the text, and they were coded in the next step. Various codes of couples' experiences with sexual services were compared

in terms of differences and similarities and were placed in the sub-subcategory and subcategory. And the categories created by the two researchers were discussed and pondered. Finally, by comparing the categories with each other and carefully considering the meaning, the content contained in the data emerged as a general category based on the interrelationships between the subcategories. At the time of data analysis, an attempt was made to avoid any hypothesis and to allow categories of data to appear.

To increase the validity of the research, the text of the interview and the extracted codes were checked by three members of the research team, and the accuracy of the codes and the naming of categories and similarities and differences were ensured. The credibility of data was established through prolonged engagement, immersion in the data, writing field notes, and member checking. For member checking, a summary of the researcher's interpretation was returned to the participants to confirm or correct the results. Also, participants with maximum variety and the data collection process to selected saturation in all categories and transferability of the data. The resulting codes and classes were made available and approved by two experts who were not involved in extracting the results for the dependability and reliability of the research.[19]

Ethical considerations

The authorization IR. MUI. REC.1394.3.488 was obtained from the Ethics Committee, Isfahan University of Medical Sciences. The researcher explained the objectives of the study to the participants. Written informed consent was obtained from them for the interview. They were informed that their participation in the research was optional and that they could withdraw from the study at any stage.

Results

There were 14 participants, seven male and seven female, who were qualified for the study, and their data are listed in Table 1. On analyzing the description of the participants, we extracted two main categories, four subcategories, and 16 sub-subcategories. Based on the description of the participants, first, each main category was introduced, and then, the sub-categories with their sub-subcategories were reported in detail regarding the items for the participants [Table 2]. Two main categories are "Need to access a specialized, comprehensive, and timely sexual health services system" and "Obstacles to Access Efficient and Proper Sexual Health Services."

1. Need to access a specialized, comprehensive, and timely sexual health services system

Analysis of the participant's views and expectations about sexual treatment leads to developing the category "Need to access a specialized, comprehensive and timely sexual health services system." The participant's views on the therapeutic dimensions were describable from two aspects "Need for Access to a Professional Therapist" and "Need for Timely and Comprehensive Access."

1.1. Need for Access to a Professional Therapist

Analysis of the participant's experiences indicated that the couples pointed out the individual traits of the therapist and their specialized skills in counseling and evaluation of sexual problems.

1.1.1. Therapist's Individual Traits

Most participants said the therapist should be perseverant, kind, patient, reasonable, flexible, reliable, privy, clean, and tidy. They should be a good listener with an attractive way of speaking. They should be capable of receiving and understanding customers without having a judgmental or critical attitude. The therapist should be able to create a comfortable and intimate environment for treatment so that people feel at home and be able to discuss their problems without getting embarrassed. A male participant preferred

Table 1: Details of participants

Participant Male=M Female=F		Age	Education	Job	Number of Children	Duration of marriage
M	1	52	High School Diploma	Nonemployee	2	27
F	2	50	High School Diploma	Housewife	2	27
M	3	33	Bachelor's Degree	Employee	0	8
F	4	28	Bachelor's Degree	Nonemployee	0	8
M	5	31	High School Diploma	Nonemployee	0	3
F	6	31	Bachelor's Degree	Nonemployee	0	3
M	7	38	Bachelor's Degree	Employee	0	12
F	8	37	PhD	Nonemployee	0	12
M	9	43	Bachelor's Degree	Employee	2	19
F	10	40	PhD	Employee	2	19
M	11	37	Under High School Diploma	Nonemployee	0	13
F	12	35	High School Diploma	Employee	0	13
M	13	25	Bachelor's Degree	Nonemployee	0	1
F	14	21	High School Diploma	Housewife		1

Table 2: Main categories, subcategories, and sub-subcategories, extracted from the participants' reports

Sub-subcategries	Subcategories	Categories
1.1.1. Therapist's Individual Traits	1.1. Need for Access to a Professional Therapist	1. Need to access a specialized, comprehensive, and timely sexual health services system
1.1.2 Specialized Skills of Therapist		
1.2.1. Provide specialized problem-based treatments	1.2. Need for Timely and Comprehensive Access	
1.2.2. Rapid and Timely Therapy of Sexual Problems		
2.1.1. Failure to Prioritize Sexual Matters	2.1. Individual Challenges of Search for Sexual Health Services	2. Obstacles to Access Efficient and Proper Sexual Health Services
2.1.2. Lack of sexual awareness		
2.2.1. Sexual Problems are a Taboo	2.2. Sociocultural Challenges to Access Sexual Health Services	
2.2.2. Lack of awareness of the existence of sex therapists and sexual health service centers		

discussing his own and his wife's private problems with a female therapist, but some other participants felt more at home discussing them with their same-sex therapist. Participant #13, a 25-year-old man said: *"I can never talk to a lady easily! Some ladies cannot easily talk to a gentleman! It is now five years that I haven't seen any therapist about them, because I used to see a female therapist who judge me without knowing me?"*

1.1.2 Specialized Skills of Therapist

According to most participants, the therapist should evaluate the couples properly to be able to identify their problems and offer them a good solution. The solution or treatment suggested should be needed by each individual based on the identification provided. While recording the history, the therapist should take into account the physiological problems, the growth bedrock of the people, childhood and adolescent problems, history of sexual abuse, family environment, relationships with the parents, the probability of extramarital relationships, and the background sexual experiences. The therapist should be familiar with the faith and cultural beliefs of the people and correct their misbeliefs. They should also be familiarized with the couple's views on and attitudes to therapy, for the people's acceptability of therapy will highly affect their treatment. The therapist should consider some individual traits and living conditions for treatment. Most participants said that the therapist should encourage people to be able to open up and relate their stories. The people's beliefs in the impact of treatment and their demands for improved sexual relations play an important and effective role in the treatment. Properly educated and well-informed, the therapist should step in to treat sexual problems, and by classifying and prioritizing the problems, they provide the proprietary treatment needed for each partner, pay due attention to the differences in the couple's responses to treatment, and avoid issuing the same prescription for both partners. Participant #10, a 40-year-old woman, said: *"Well, in my opinion, the therapist should first record an accurate history. That is, they should look at the history of the people, at what kind of bedrock they grew up on, and, generally, what view they have about sex."*

1.2. Need for Timely and Comprehensive Access

Analysis of the couple's experiences indicated that sexual problems call for rapid and timely treatment. Apart from the fact that treatment should be provided by a team, it should be multidimensional where training, pharmacotherapy, psychotherapy, cognitive-behavioral therapy, correcting faulty communication patterns, and the couple's emotional problems are resolved.

1.2.1. Provide specialized problem-based treatment

Some female participants said if the people needed a consultant, they would be referred to a counselor and correct the emotional and interpersonal problems of the couple. The partners must help to express their feelings and emotions, and in this regard, providing procedures for creating nonsexual romantic relationships can help. According to the participants, a healthy sexual relationship in a proper communication context is created. Therefore, an improvement in the interpersonal relationships of the couple should be one of the important dimensions of treatment.

Some participants pointed out the need for the diagnosis and treatment of psychological problems, noting that the individual and personality problems of the couples could be treated and their resistance to medications determined by using psychological medicine. Some participants said that sexual problems could be radically solved by making cognitive changes and providing the couples with applied procedures to make behavioral changes, and if the people want to experience sexual pleasure psychologically, their intellectual framework should change over time; otherwise, once the treatment process is complete, they will return to their previous state. Most of the participants pointed out the important role of training in preventing and treating sexual problems. They said that training should include the most elementary to the most complex sexual relationships.

Some participants pointed out that they were willing to use chemical and herbal medicine if they developed sexual disorders. Some participants referred to their sexual experiences, saying that they had improved their sexual performance by seeing a sex therapist and using medications to improve their depression and premature

ejaculation. Participant #11, the 37-year-old man said: *"Medication could help. Very seldom did I have sex with my wife. As the intervals were too long, I experienced an orgasm in 3-5 minutes and my wife suffered from it. I saw a doctor about it, discussing my problem. He administered medication. I take half a pill each day. With this medication, even if I haven't had sex with my partner for ten days, I can continue having sex for up to 20 minutes."*

1.2.2. Rapid and Timely Therapy of Sexual Problems

Some of the participants pointed out the need for a fast treatment possible for the sexual problems of the couple, believing that counseling and understanding the sexual problems should begin with premarital and post-marital counseling. Therapy should begin when the couple is young and in their early married life, for later therapy would improperly underpin the sexual relationships of the couples and reduce the effect of the therapy. Participant #2, a 50-year-old woman, said: *"As sexual relationships have a very important place in married life, for the sake of family stability, they should be worked on from the very first. If at all possible, therapy should start when the couples who have just gotten married and not yet started to live under the same roof."*

2. Obstacles to Access Efficient and Proper Sexual Health Services

Analysis of the participant's views about the reasons for not seeing a sexual therapist led to the formation of the category of obstacles to accessing efficient and proper sexual health services. Explanation of the views is debatable from two aspects: individual and socio-cultural.

2.1. Individual Challenges of Search for Sexual Health Services

Analysis of the participant's experiences revealed that some couples suffered from sexual ignorance, lack of sexual confidence, or the fact that sexual problems were not their priority.

2.1.1 Failure to Prioritize Sexual Matters

According to some female participants, sexual problems did not matter much and were their last priority. For these women, routine house chores such as preparing meals, housekeeping, and having peace at home were more important. For them, fulfilling the wishes of their husband and children had a higher priority, and it was enough for them only when the husband was satisfied with his sexual relationship. Some male and female participants pointed out that they did not care about their sexual problems. Consequently, they did not set aside time for solving their sexual problems. Although they had sexual problems with their husbands, they had no emotional problems and looked up to them. Participant #2, a 50-year-old woman, said: *"Although I was suffering from decreased sexual desire and lack of wetness, I had not thought about treating it until I talked to you, because, unlike my husband, this is my last priority."*

2.1.2. Lack of sexual awareness

According to some participants, their failure to see a therapist was because they were not sufficiently aware of their sexual problems.

People attributed the problem to their spouse even though they had the problem themselves, or they thought there was no solution to the problem, thinking it was due to stress and thought that there was no therapist to solve the problem. Some couples considered their sexual problem very rare and stated that there was no other way but to adapt to the problems. They pointed out that it is enough to have good sex from time to time, and that the quality of sex is not important. Their view of sex was a matter of satisfaction and fertility, and they had no idea of sexual pleasure. Participant No. 1, a 52-year-old man, says: "*Before talking to you, I did not think I would have premature ejaculation myself. My wife did not think that not enjoying it in a relationship is a disorder. I thought she could solve it herself, there is no need for treatment."*

2.2. Socio-cultural Challenges to Access Sexual Health Services

Analysis of the participant's experiences indicated that talking about their sexual problems in the community and seeing a sex therapist was a taboo subject and that couples complained about the limited access to experienced sex therapists.

2.2.1. Sexual Problems are Taboo

Some participants said that discussing sexual problems was taboo in their culture. Perhaps if there were no such cultural problems, the participants would feel more at home discussing their problems. They felt embarrassed about discussing their sexual problems and did not want anyone to invade their privacy and learn about it. The participants believed that the reason for their not seeing a sex therapist was shyness, escape from reality, and their disinclination to face the problem. They wanted it protected. The participants, especially men, were worried about others' judgments and changes of view. They said that the people around them believed that having sexual problems and seeing a therapist about it was a sign of mental problems and weakened manliness. Participant #9, a 43-year-old man, said: *"First, I believe that talking about sexual problems is taboo. Another problem is that men believe that weakness in sexual matters is weakness in manliness. They feel that it is very embarrassing, and as they do not discuss such matters, they think that they are the only men, or very few men, who have the problem."*

2.2.2. Lack of awareness of the existence of sex therapists and sexual health service centers

According to some participants, sex therapist is socially unknown and it is difficult for ordinary people to locate

them. In recent years, people did not even know that there were such specialists, and whenever they had a problem, they did not know which specialist to see about sexual problems. To solve their sexual problems, most women choose a midwife or a gynecologist, and most men choose a urologist about it, which did not often work for such specialists were not fully informed and experienced. Participant #10, a 40-year-old woman, said: *"Until three or four years ago, no one had heard of a sex therapist or sexologist. Even if there are such specialists, they are few in number and difficult to reach. Specialists reside in large cities and centers of provinces. There should be at least one such specialist well-known to people in each city."*

Discussion

According to the participant's experiences, the factors influencing receipt of sexual health services are presented in two categories: the need to access a specialized, comprehensive, and timely sexual health services system and obstacles to accessing efficient and proper sexual health services which we will discuss in this section.

The couple's views about the dimensions of therapy are explained in terms of the therapist and therapy. Analysis of the couple's experiences showed that the couple referred to the individual traits of the therapist and their specialized skills in counseling and assessment of sexual problems. The couples pointed out the need for a comprehensive and timely treatment of sexual problems, referring for this purpose to seeking specialized problem-based treatments.

The results of Helsinki's psychotherapeutic study indicated that the personal and professional traits of the therapist were effective in the prediction of therapeutic alliance and the results of a psychotherapist. It seems that the lack of skill of the therapist and the fact that the customer does not enjoy the therapy, especially in short-term therapies can be injurious, where confidence and the nature of communicating with the customer are important. In contrast, they will work with thoughtful and careful communication, free of compulsory inquiries.[16] Moors and Zech found that such traits as flexibility, honesty, respect, reliability, warmth, willingness, and receptivity had a positive role in establishing therapeutic alliances.[20] In another study, it has been pointed out that access to a comprehensive and multidisciplinary approach to the treatment of sexual disorders is a new global aim, and that organizations and researchers working in the field are committed to pursuing it.[21] In this study, in support of the previous studies, the participating couples acknowledged the need for accurate assessment and complete multidimensional treatment, pointing out many of the above items in the above stages.

Analysis of the participant's experiences indicated that the obstacles to accessing sexual health services were debatable from two aspects: individual and socio-cultural. The individual obstacles were the failure of the participant to see a sex therapist, shyness, escape from the reality, and lack of interest in facing the problem. Other studies reported that due to shyness, women experienced a delay in seeing a therapist, and given their cultural and religious conditions, were seeking a therapist of their same-sex.[11]

Evidence shows that conservative attitudes toward sexual relations, lack of concern for sexual problems in life, and failure to express sexual feelings will reduce marital satisfaction, especially in women. With sexual activity being an important part of women's life, it is estimated that 60% to 80% of women have a variety of sexual performance disorders that directly or indirectly affect many aspects of their life,[22] for suffering from sexual performance disorders increases the signs of low self-confidence, anxiety, improper self-control, and feeling of guilt in women,[23] and that lack of sexual knowledge will result in increased confrontation and sexual injuries in the couple, while efficient sexual knowledge will increase the probability of finding a logical solution to their conjugal problems. In reality, to have a healthy and happy life, the couple will need to have a collective knowledge of sexual problems and the sexual orientation of their partner.[22]

Available evidence shows that culture will influence not only sexual desire but also the expression of sexual performance disorder,[16] and having male and female roles, cultural beliefs, especially in the Iranian community play a major role in the sexual satisfaction of the couple, and that for men, the concept of manliness is entry and reproduction,[16] and that anxiety about sexual problems may be rooted in cultural beliefs.[16] Cultural sensitivity and awareness are important aspects of the physician–client relationship, and that treatment will be effective only when it is based on the client's culture.[11]

According to some participants, lack of access to a competent sexual therapist is a major problem in the community. The available evidence shows that most healthcare specialists, who often make up the first contact point with people with sexual health problems, have poor sexual counseling skills and lack sufficient training on sexual problems and how to cope with such people.[24] The main reason for the delay in receiving sexual health services is the unwillingness of specialists and healthcare providers to provide sexual counseling services, including sex therapy.[25] Given the nature of sexual issues, it was difficult to find couples who volunteered to express their expectations for receiving sexual health services. Besides, participants would not reveal some of their experiences and information to the researcher, but the researcher tried to gain as much trust as possible by communicating effectively. The present study is one of the first studies conducted in Iran in the field of sexual health, which aims to explain the perceived barriers and needs in accessing sexual health services for Iranian couples.

Conclusion

References were made to various obstacles to accessing sexual health services including the taboos on sexual problems and the lack of knowledge of and priority for sexual problems. The results explain the perceived needs of Iranian couples for receiving timely and comprehensive specialized sexual health services, which, due to obstacles, have not been adequately addressed. For this reason, it is suggested that efficient sexual health services are based on the socio-cultural structure integrated into health-medical care treatment.

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Conflicts of interest

Nothing to declare.

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