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The Effects of a Culture-Based Sexual Health Training Course on Knowledge, Attitude, Performance, and Self-Efficacy of Midwives in Providing Sexual Health Services

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Quantitative Study

Abstract

Background: Sexual health is one of the major aspects of health that is formed under the influence of various biological, social, psychological, and cultural factors. This study was conducted with the aim to determine the effects of a culture-based sexual health training course on the knowledge, attitude, performance, and self-efficacy of midwives in providing sexual health services.

Methods: The present study was performed with a pretest-posttest design and follow-up. In total, 32 midwives were included in the online sexual health training course via the census sampling method. Accordingly, the knowledge, attitude, performance, and self-efficacy of the midwives were assessed using a researcher-made questionnaire before, immediately after, and 4 weeks after the intervention. Moreover, repeated measures ANOVA was used to determine the effects of the intervention.

Results: Comparing the results of pretest and posttest indicated that the training course significantly increased the midwives' mean scores of knowledge (from 17.12 to 23.87), attitude (from 39.40 to 50.18), performance (from 36.18 to 46.15), and self-efficacy (from 27.31 to 39.28)..

Conclusion: This study indicated that running a culture-based training course on sexual health would be likely to improve professional capacity building in providing sexual health services. Given the importance of cultural and social issues in sexual health education, this course could play an effective role in helping midwives face and solve their clients' problems.

Keywords: Transcranial direct current stimulation; Craving; Overweight

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Introduction

Sexual health is a major aspect of individual health and a basic component of human life. In fact, it is formed under the influence of various biological, social, psychological, cultural, economic, political, moral, legal, historical, and spiritual factors passed down from generation to generation (Evangelista, Moreira, Freitas, Val, Diniz, & Azevedo, 2019; World Health Organization, 2010). Providing counseling on sexual health and improving clients' quality of life (QOL) through promoting sexual health (Sung, Huang, & Lin, 2015) are among the major roles of healthcare professionals. However, few of them play this role correctly in clinical environments (Bal & Sahiner, 2015; Dyer & das Nair, 2013; Jaarsma et al., 2010; Oren, Zengin, Yazici, & Akinci, 2018).

In most cases, sexual health services and sexual counseling are not provided as expected due to various organizational and structural factors (Bal & Sahiner, 2015; Baker-Green, 2017, Grewal et al., 2014) and factors related to personal characteristics of staff and clients (Bal & Sahiner, 2015, Grewal et al., 2014; Papaharitou, Nakopoulou, Moraitou, Tsimtsiou, Konstantinidou, & Hatzichristou, 2008; Percat & Elmerstig, 2017; Rostamkhani, Jafari, Ozgoli, & Shakeri, 2015). However, evidence suggests that one of the main reasons for shortcomings in this field is the lack of correct training in sexual health for health workers, which necessitates specialized training in this field (Bal & Sahiner, 2015; Jaarsma et al., 2010; Percat & Elmerstig, 2017; Magnan, Reynolds, & Galvin, 2005; Nakopoulou, Papaharitou, & Hatzichristou, 2009; Sung, Jiang, Chen, & Chao, 2016). In many cases, despite the patient's willingness to talk in this regard, the staff are not capable of giving due attention to their clients' sexual health for various reasons, including discomfort, time limitations, fear of insufficient personal knowledge and skills, lack of adequate knowledge of treatment, and in general lack of training in this field (Sung et al., 2016; Ford, Barnes, Rompalo, & Hook, 2013) Accordingly, they avoid talking about and addressing their clients' sexual issues.

Talking about sexual issues is a taboo in many countries, including Iran (Rostamkhani et al., 2015; Çuhadaroðlu, 2017). These factors cause sexual problems to remain unresolved despite their prevalence and considerable importance (Rostamkhani et al., 2015). All societies need culture-sensitive sex education, of which Iran is no exception. No doubt, there is a great need for the development of sexual health training courses based on the Iranian culture in the education curricula (Karimian et al., 2018). Due to the sensitivity of sexual issues, cultural training of health care professionals is important.

Since most reproductive and sexual health services and sexual counseling in Iran are provided by midwives at comprehensive health service centers, they play a significant role in this regard. Midwives are at the front line of providing counseling on sexual problems, and provide easy and cost-effective access to such services (Farnam, Janghorbani, Raisi, & Merghati-Khoei, 2014; Karimian, 2016; Khadivzadeh, Ardaghi, Mirzaii, & Mazloum, 2016). However, according to previous researches, lack of education and self-confidence are often the main barriers to the initiation of sexual discussions and provision of sexual health services by midwives (Jaarsma et al., 2010; Percat & Elmerstig, 2017; Rostamkhani et al., 2015; Khadivzadeh, Ghazanfarpour, & Latifnejad, 2018). Despite being faced with numerous sexual questions and concerns in various areas of their career, midwives are not adequately skilled in this field (Percat & Elmerstig, 2017; Karimian, 2016; Khadivzadeh et al.,

2016; Evcili & Demirel, 2018; Walker & Davis, 2014). Therefore, to promote the professional capacity of health care providers, a culturally adaptive course with clear and valid content seems to be necessary.

Training midwives in a sociocultural manner can play an effective role in enabling them to address sexual health challenges, with this training being regarded as a key step in providing appropriate and accessible sexual health services to all women. In view of the foregoing, the present study was conducted with the aim to examine the effects of a sexual health training course on knowledge, attitude, performance, and self-efficacy of midwives in providing sexual health services.

Methods

This interventional study had a pretest-posttest and follow-up design. The participants of this study were all midwives (34 people) of comprehensive health service centers in Rafsanjan County, Iran. They entered the present study via a census. The inclusion criteria were having a bachelor's degree or higher and at least 1 year of work experience. Unwillingness to complete the training course for any reasons and attending another training program on sexual health were the exclusion criteria. In total, 32 midwives participated in the present study. The initial training course was designed to be face-to-face, yet due to the COVID-19 pandemic, the 4 training program sessions were held online in 3-hour sessions over 2 weeks (2 days per week). The content of the sexual health training course was designed based on the review of previous studies, the structure of the modules presented by Karimian (2016), as well as educational need assessment results of midwives. The intervention included teaching communication skills, principles of sexual counseling, principles of obtaining a sexual history, understanding cultural beliefs and values about sexual issues and concepts, sexual dysfunctions in women, and the way to evaluate such disorders. To this end, the educational content was reviewed and verified by 10 faculty members of medical universities. Online training sessions were held through Skyroom and Adobe Connect in the form of lectures, questions and answers, brainstorming, and case reports. At the end of each session, 15 minutes was allocated to answering questions. Before running the training course, a short 2-hour face-to-face session was held to explain the objectives and method of the training course, and to perform the pretest in accordance with health protocols upon the permission of Rafsanjan University of Medical Sciences, Iran. To this end, data collection was performed using a researcher-made questionnaire. After passing the online training course, the participants received the data collected at the posttest and follow-up (4 weeks) via email.

To evaluate the effects of sexual education on the knowledge, attitude, performance, and self-efficacy of midwives in providing sexual health services, a researcher-made questionnaire was used, which was based on the content of the culture-based sexual education course and created by reviewing previous texts and researches (Sung et al., 2016; Karimian, 2016; Sung & Lin, 2013). The questionnaire includes 60 questions in 5 sections. Section 1 covers demographic characteristics, including age, marital status, work experience, place of work, level of academic education in sexual health, self-assessment of one's level of general information about sexual counseling, and availability of suitable conditions for providing sexual health services to clients at the health centers. Section 2 consists of questions about sexual knowledge, including 25 questions about midwives' knowledge of appropriate communication with clients, counseling principles, principles of obtaining a sexual

history, and evaluation of women's sexual disorders and their treatment. These questions were designed as true/false questions (true: score 1; false or I do not know: score 0), with the total score of each section ranging from 0 to 25. Section 3 includes 13 questions regarding attitude. This section includes cultural aspects of the midwives' attitudes toward the importance of sexuality, comfort in sexual counseling, job roles and responsibilities, and providing sexual health services to clients. To avoid bias, questions 2, 5, 6, 8, and 10 are reverse scored. Moreover, the questions are scored on a 5-point Likert scale ranging from strongly agree (5) to strongly disagree (1). Higher scores indicate a better attitude. Section 4 is related to the midwives' performance in terms of providing sexual healthcare services, and includes 12 questions. Similarly, these questions are scored on a 5-point Likert scale ranging from always (5) to never (1). Section 5 of the questionnaire is related to the self-efficacy of the midwives in providing sexual services. Accordingly, this section measures their ability to provide services with 10 questions scores on a 5-point Likert scale ranging from strongly agree (5) to strongly disagree (1).

The validity of the questionnaire was verified using the quantitative and qualitative content validity methods. To control the validity of the qualitative content, the questionnaire was reviewed by 10 experts and revised based on their corrective and supplementary opinions. In terms of quantitative content validity, the content validity ratio (CVR) and the content validity index (CVI) were measured. Furthermore, to determine the reliability of the questionnaire, a test-retest method was used. Accordingly, the questionnaire was completed by 15 midwives other than those working at the comprehensive health service centers. The Cronbach's alpha coefficient values of the attitude, performance, and self-efficacy subscales were 0.72, 0.75, and 0.88, respectively. In addition, the Kuder-Richardson reliability coefficient of the knowledge subscale was 0.76. Additionally, the stability coefficient [intra-class correlation (ICC)] for 2 replications was 0.85, 0.86, and 0.83 for the attitude, performance, and self-efficacy subscales, respectively, and 0.93 for the knowledge subscale. Data were analyzed using SPSS software (version 22.0; IBM Corp., Armonk, NY, USA). Moreover, data were evaluated using descriptive tests and repeated measures ANOVA. The significance level of the study was set at 0.05 ($P < 0.05$).

Ethical considerations: To perform the study, the code of ethics was received from the Ethics Committee of Shahid Beheshti University of Medical Sciences, Iran. In addition, the necessary permissions were obtained from Rafsanjan University of Medical Sciences. Before the intervention, the participants were briefed on the objectives and process of the study. Next, Written informed consent was obtained from all participants for participation in the study. Moreover, they were assured that their information would be kept confidential. Additionally, adequate explanations were given about the possibility of withdrawal from the study at any stage of the research.

Results

Based on the results, the midwives in the present study were 27-53 years old with a mean age of 38.47 ± 7.13 years. In addition, their work experience varied from 1 to 30 years with an average of 12.56 ± 8.22 years (Table 1). As many as 23 midwives (71.9%) stated that little or very little attention had been paid to sexual health in their academic midwifery trainings. A total of 17 midwives (53.1%) considered their own level of knowledge of sexual health and sexual counseling low or very low, especially in terms of its sociocultural aspects.

Only 14 midwives (43.8%) stated that they had moderate knowledge in this field.

Table 1. The demographic characteristics of midwives (N = 32)

Variable		n (%)
Age (year)	25-34	14 (43.8)
	35-44	10 (31.3)
	45-54	8 (25.0)
Work experience (year)	1-10	19 (59.4)
	11-20	7 (21.9)
	21-30	6 (18.8)
Education	BSc	29 (90.63)
	MSc	3 (9.37)
Marital status	Married	25 (78.13)
	Single	7 (21.87)

Moreover, a total of 19 midwives (59.4%) announced that they had frequently or very frequently met clients with sexual concerns and problems in the workplace. In addition, as many as 27 midwives (84.4%) admitted that there were no suitable conditions for providing sexual health services to their clients in the workplace.

The Kolmogorov-Smirnov test was used to control the normality, which showed the variables had a normal distribution ($P > 0.05$). Mauchly's test of sphericity showed that the assumption of homogeneity is also valid ($P > 0.05$) (Table 2). Table 3 presents the mean scores of knowledge, attitude, performance, and self-efficacy among the midwives in providing sexual health services. According to table 4, the results of the Bonferroni post hoc test and the pairwise comparison of knowledge, attitude, performance, and self-efficacy scores at different times showed a significant difference between the scores before and after the educational intervention ($P < 0.01$); however, there was no difference between the posttest and follow-up (1 month after the intervention) scores. Thus, it can be concluded that the provided training played a significant role in increasing knowledge and improving attitude, performance, and self-efficacy among the midwives in providing the required sexual health services.

Discussion

Sex has often been one of the most sensitive topics for discussion in most countries where sexual education in schools and universities either does not exist, or its content is not satisfactory (Tabatabaie, 2015).

According to the results of the present study, the majority of midwives stated that they had acquired little knowledge of sexual health during their academic studies. These results indicate that the inadequacy of sexual courses during midwifery education and the lack of in-service training courses in this field have led to a lack of knowledge and information about sexual issues among the midwives. In their study, Oren, Zengin, Yazici, and Akinci (2018) reported that although midwifery students were aware of the significance of sexual counseling, they were not educated in this regard, and over half of them, at best, had moderate knowledge of sexual counseling (Jaarsma et al., 2010).

Table 2. Results of repeated measures analysis of variance and Mauchly's test of Sphericity

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	P*	Parameters		
					Mean Square	F	P**
Knowledge	0.872	3.758	2	.171	429.510	109.898	< 0.001
Attitude	0.886	3.639	2	.162	1258.073	38.835	< 0.001
Performance	0.923	3.138	2	.188	1545.969	31.378	< 0.001
Self-efficacy	0.963	1.137	2	.566	1474.198	68.571	< 0.001

df: Degree of freedom

Table 3. Mean scores of knowledge, attitude, performance, and self-efficacy among the midwives in providing sexual health services over time

Dependent variable	Pretest (Mean ± SD)	Posttest (Mean ± SD)	Follow-up (Mean ± SD)	P*
Knowledge (0-25)	17.12 ± 2.83	23.87 ± 1.45	22.96 ± 1.78	< 0.001
Attitude (13-65)	39.40 ± 6.81	50.18 ± 5.22	50.34 ± 5.64	< 0.001
Performance (12-60)	36.18 ± 4.72	46.15 ± 5.19	49.56 ± 10.59	< 0.001
Self-efficacy (10-50)	27.31 ± 3.30	39.28 ± 5.86	38.84 ±4.75	< 0.001

*Repeated measures ANOVA

In the same vein, in another study by Karimian (2016), midwives provided unprincipled counseling or used their own personal experiences in providing counseling due to their lack of sufficient skills and training in this field. The results of the study by McIntosh, Fraser, Stephen, and Avis (2013) showed that there was an inconsistency between what midwifery students thought they needed to know to act as a confident midwife and what they were taught at the university. Moreover, these results were in line with several other studies stating that healthcare providers lack the required knowledge and skills to face sexual problems, and this prevents them from performing sexual assessments in practice (Sung et al., 2016; McIntosh et al., 2013; Helland, Garratt, Kjeken, Kvien, & Dagfinrud, 2013).

The results of this study indicated that the culture-based sexual health training program was associated with a significant improvement in the midwives' knowledge and awareness of sexual health. One of the reasons for the significant effect of the training program could be the large number of the midwives' clients in this field and their essential needs. Accordingly, over half of the midwives (59.4%) admitted that they would deal with numerous clients with sexual concerns and problems in their clinical environments. In a study conducted by Walker and Davis (2014), midwives with clinical work experience were more likely to express their need for training in this field. These findings were in line with those of the studies by Sung et al. (2016), Sung and Lin (2013), and Nicolai et al. (2013).

As sexual issues are a taboo in Iran (Rostamkhani et al., 2015), a sociocultural change of midwives' attitudes toward providing desirable sexual health services is very important and effective. As Arab and Jannati, 2016 stated sexual counseling in the social, cultural, and religious context in health centers is necessary. Our culture-based training improved midwives' attitudes toward providing sexual health.

Table 4. Changes in knowledge, attitude, performance, and self-efficacy of midwives (pairwise comparison) over time

Dependent variable	Time	Mean score	SE	P* (Pairwise comparison)
Knowledge	pretest and posttest	-6.75	0.58	< 0.001
	pretest and follow-up	-5.84	0.51	< 0.001
	posttest and follow-up	0.91	0.37	0.062
Attitude	pretest and posttest	-10.78	1.65	< 0.001
	pretest and follow-up	-10.94	1.31	< 0.001
	posttest and follow-up	-0.16	1.28	0.99
Performance	pretest and posttest	-9.97	1.21	< 0.001
	pretest and follow-up	-13.38	1.98	< 0.001
	posttest and follow-up	-3.41	1.96	0.278
Self-efficacy	pretest and posttest	-11.97	1.24	< 0.001
	pretest and follow-up	-11.53	1.05	< 0.001
	posttest and follow-up	0.44	1.19	0.99

* Bonferroni post-hoc test
SE: Standard error

Quinn and Happell (2013) reported that, after a brief educational intervention using

the BETTER Model as a guide to action, all healthcare professionals were willing to address patients' sexual issues. However, most of the studies stress that the knowledge of sexual health significantly improves attitudes towards sexual issues, thereby resulting in a higher level of confidence in discussing sexual care and providing the related information. Some studies indicate that the effect of increased knowledge on attitude improvement is exaggerated (Evangelista et al., 2019).

Moreover, the results of the present study were in line with those of other studies indicating the effectiveness of educational programs in improving the self-efficacy and performance of midwives and other healthcare providers in providing sexual health services (Sung et al., 2016; Khadivzadeh et al., 2016; Sung & Lin, 2013; Quinn & Happell, 2013; Pieters, Kedde, & Bender, 2018). However, in the study conducted by Sung et al. (2016), although self-efficacy in providing sexual healthcare services improved over time in the intervention group, it was not significantly different from that in the control group. In this study, comparing the results obtained immediately after the training course with those obtained 1 month after the intervention showed the durability of the training effect. Other studies reported similar results (Sung et al., 2016; Sung & Lin, 2013; Pieters et al., 2018), yet due to the short duration of the follow-up assessment, the effect of time on the durability of the training effect might not have been demonstrated well. However, as shown in many studies on health behavior change, it would be difficult to predict if this behavior persists over time. This is mainly owing to the fact that different clinical environments result in different experiences of the provision of sexual health services to individuals (Tugut & Golbasi, 2017). The main strengths of the present study included the extensive dimensions of sexual health issues and the consistency of the training with the midwives' needs. The present interventional study was conducted on all midwives working at comprehensive health service centers in Rafsanjan County, which covered our target community in the best way possible. In addition, it was helpful in proving the effectiveness of online in-service training that has been very common during the COVID-19 pandemic. The limitations of the present study included the small number of the samples and the absence of a control group. Another limitation was that the study was conducted in a small town, in which due to the taboo nature of sexuality, sexual health training was inevitably affected by sociocultural issues. It is suggested that further research be conducted with a larger sample size, a control group, and a longer follow-up period.

Conclusion

The present study showed that culture-based sexual health training programs could have positive effects on increasing midwives' knowledge and awareness in the field of sexual healthcare. Moreover, it helped change their sociocultural attitudes, increased their willingness to actively address patients' sexual concerns, and positively affected their performance and self-efficacy in providing sexual health services to their clients. Accordingly, midwifery managers and planners are expected to pay due attention to this field in educational planning and policymaking so that midwifery staff can play an effective role in promoting their clients' sexual health status.

Conflict of Interests

Authors have no conflict of interests.

Acknowledgments

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