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# Designing and Implementing a Program Education for Enhancing Sexual Function Among Married Women in Ilam, Iran (Policy Brief)

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**A B S T R A C T**

**Introduction**: The sexual dysfunction is one of the most common public health issues and can have negative effects on the health and life of women. This study aimed to compare the effect of a sexual health education programme based on a structured curriculum on improvement of sexual function and attitude in women during reproductive period.

**Materials & Methods:** In a field experiment 103 women were randomly selected to the control and intervention groups at health centers in the west of Iran. The intervention group was provided with structured sexual health education which included biological and psychological basics and communication skills in couples. Pre and post evaluation of the Female Sexual Function Index (FSFI) and sexual attitude was done.

**Conclusions:** The intervention group showed significant improvement in overall sexual function scores compared to the control group on the FSFI after intervention ($P<0.01$) particularly in the desire, arousal, orgasm, satisfaction and pain domains. The two groups did not significantly differ on the sexual attitude post intervention, however, the intervention group demonstrated significant improvements in sexual attitude after the education.

**Conclusions and Recommendations:** There was an improvement in women's sexual function and attitudes, which was achieved through structured sexual health education. Based on the above, an effective step towards preventing female sexual disorder can be taken by health policymakers by increasing similar educational programs both in primary health care systems and in educational systems and schools. Although the results are encouraging, further research is needed into alternative ways of teaching and learning as well as more accurate assessment instruments, especially for sexual attitudes.

**Keywords**: sexual health, reproductive health, sexual function, sexual health program, sexual attitude

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## Introduction

Sexual health relates to health and it affects the quality of life, marital satisfaction, self-esteem, psychological health and family stability. Sexual health is a part of reproductive health and a critical factor in the health of every person, according to the World Health Organization (WHO). Although it is important, sexual health is not sufficiently discussed in primary healthcare systems in many situations including Iran, where cultural and social taboos are still restricting access to structured sexual health education and counselling services, and to interventions that integrate sexual health education into existing healthcare programs (1, 2).

Sexual function is an important aspect of sexual health, and is one of the most prevalent sexual health issues in women. With evidence from Iran, it is estimated that one-third to two-third of women have an extent of sexual dysfunction, implying that there is a considerable public health burden (3, 4). There are many potential consequences of female sexual dysfunction which include marital dissatisfaction, diminished quality of life, psychological distress and family instability, all of which highlight the need for effective culturally appropriate intervention strategies (5, 6).

The results are that there is growing evidence that structured sexual health education makes a significant difference in women's sexual knowledge, attitudes, satisfaction and sexual functioning. Randomized controlled trials have shown that culturally adapted educational interventions have a positive impact on women's sexual health, such as the Sexual Health Model (SHM) (7-9).

In compliance with this, our study revealed that married women who received two group-based educational sessions in health centers had a sex attitude improvement as well as a sex function improvement. The findings suggest that both the effectiveness of these low-cost, culturally appropriate, short-term education programs and the need to address this important (but under-researched) element of women's health can be achieved. Incorporating systematic sexual health education into primary healthcare and reproductive health services could thus be an effective and scalable approach to enhancing sexual health and family life in Iran for women.

When it is not solved, and it is still a problem, it has the following implications:

An increase in the number of divorces, as well as divorce rates, among married couples.

Increase in number and percentage of divorcees among the population of couples.

Women's dissatisfaction with their marriages might arise and worsen, leading to poor mental health in women and poor quality of life for couples.

Increased consumption of sedative medications, and inadequate counseling.

Difficulty with social, marital, maternal and parenting functioning.

More access to non-standard and/or possibly harmful educational material instead of sexual education.

## Materials and methods

This policy brief is based on evidence obtained from a randomized controlled trial (RCT) carried out with the married women who visited comprehensive health centers in the Ilam district of western Iran. A total of 101 women who were eligible were randomly assigned to a group to participate in a culturally adapted sexual health education program or a routine-care group (control group). The educational intervention comprised four group based sessions related to sexual and reproductive health, sexual relationships, communication skills and correcting common sexual misconceptions. Results of 103 participants who completed the study were used for the final analysis.

At baseline and 1 month post-intervention, the Women's Sexual Performance Index (FSFI) was used

to assess sexual attitudes and sexual performance, in addition to a researcher-developed questionnaire.

The study protocol was approved by the Ethics Committee of Ilam University of Medical Sciences (IR.MEDILAM.REC.1398.209), and written informed consent was obtained from all participants.

## Results

A total of 110 women were enrolled in the study of which 103 were completed and included in the final analysis. There were no differences between the intervention and control groups at baseline.

Overall, women's sexual health outcomes were significantly improved as a result of the sexual health education program. In the intervention group, the percentage of people with sexual dysfunction dropped from 47.1% before the intervention to 11.8% one month later, whereas there was little change in the control group. Sexual function and sexual attitudes also significantly improved among participants receiving the intervention, but not among women receiving routine care.

Review of implementation of past policies. Review of past policy implementation.

The country had been limitedly addressing sexual education in the past, where pre-marital counseling and certain family planning courses were the main courses being taught, and no formal and systematic approach to addressing sexual education in primary healthcare services existed. Comprehensive health centre level sustainable and evaluated programs were not available. The majority of educational material has been translated and may be culturally inappropriate. Majority of midwives working in these centres reported that they lacked skills to provide sexual education to the couples, and couples reported the lack of knowledge and awareness about sexual health services and solving sexual health issues.

Proposed Policy Options

2. Obtaining funding for sexual health education in primary healthcare services.

Sexual health education should be delivered as part of the normal reproductive and primary health care, offered via comprehensive health centres. Attending to women's sexual knowledge, attitudes and sexual function during routine health care encounters can enhance culturally appropriate sexual education and efficiently leverage existing health care infrastructure.

2. Building capacity of mental health professionals and midwives

Midwives, psychologists and family counsellors should be able to receive standardised training to increase their capacity in the areas of sexual health education and counselling. A train-the-trainer approach may enhance service quality and increase access to professional sexual health services.

The development and dissemination of culturally adapted educational resources.

Evidence-based educational materials such as booklets, videos and electronic resources should be created to deliver accurate and culturally appropriate sexual health information. Resources should be differentiated for various levels of literacy in order to provide maximum access and effectiveness.

4. Pilot testing before National scale-up.

It is recommended that sexual health education be piloted in some provinces before it is rolled out at the national level. Feasibility, acceptability and effectiveness assessments under routine service conditions can facilitate further policy decisions and aid in successful national implementation.

### The requirements and barriers to implementation of proposed policy options

***Requirements:***

Structural support of the developed sexual education programmes from the Deputy of Health and the

Deputy of Education of the University of Medical Sciences.

Funding to print simple and comprehensible educational packages to be distributed at comprehensive health centers, suitable for public understanding and distribution.

Competent personnel training and development to provide the appropriate sexual education in health centers.

Collaboration with cultural and religious groups to highlight the importance of raising awareness among couples, especially women, on sexual health.

***Barriers***:

Cultural resistance at the family level and among some groups of people.

Lack of trained midwives with sexual health and sexual functioning skills.

Inadequate resources to print educational materials, provide training and track implementation.

***Proposed Solutions:***

Pilot to 2-3 health centers in Ilam County and scale up to provincial level.

Ensure that trained women are actively engaged as facilitators to respond to existing challenges.

Seek endorsement of the education material from religious/cultural authorities.

***Potential Barriers***

Cultural stigma associated with conversations about sexual health, lack of acceptance of sexual health education in some communities, lack of training of health care providers, lack of culturally diverse sexual health education materials and limited organizational support to introducing sexual health education into routine primary care services all present potential barriers to implementing sexual health education.

Strategies to overcome or reduce barriers that may be proposed to address the issue. Strategies that may be suggested to overcome or reduce barriers.

These barriers can be overcome by implementing educational programs for women, families and health care providers on the importance of sexual health and optimal sexual function; strengthening the capacity of midwives and counselors through standardized training and development; creating culturally appropriate educational materials; and promoting the integration of reproductive health units, health care facilities, and academic institutions. It can also help with successful uptake and sustainability of the programme by piloting the programme in selected provinces before it is rolled out nationally.

The research project is aimed at a target audience. The Research project has a target audience.

This policy brief is targeted to health policy makers in the Ministry of Health, senior health managers, provincial health managers, reproductive health programme planners, and health care providers in comprehensive health facilities. Secondary audiences include universities and research institutions, professional associations of midwives and psychologists, and organizations that promote the health and welfare of the family and women.

## Acknowledgements

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## Ethics approval

Ethics approval for this study was obtained from the Research Ethics Council of the Vice-Chancellor for Research, Ilam University of Medical Sciences with the tracking code (IR.MEDILAM.REC.1398.209).

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## Conflict of interest

The authors declare that there are no conflicts of interest.

## Authors' contributions

NR and N Sh performed data collection, analysis and interpretation of data, as well as literature review. The manuscript was drafted by ST and MK. All authors read, revised, and approved the final version of the manuscript.

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