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ORIGINAL RESEARCH – QUANTITATIVE

A clinical trial of the effect of sexual health education on the quality of life of married Muslim women in Iran

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ABSTRACT

Background: Marital satisfaction is one of the key factors affecting women's holistic health.
Aim: The present study was conducted to evaluate the effect of sexual health education on the quality of life in married women.
Methods: The present controlled clinical trial was conducted with a pretest–posttest design on a study population of 60 women (aged 20–45) admitted to select health centres affiliated to Tehran University of Medical Sciences. Samples were selected through convenience sampling and randomly allocated to an intervention group ($n = 30$) and a control group ($n = 30$). The data collection tool was the WHOQOL completed by participants first in the pretest and then in the follow-up posttest (after 2 months). The intervention group received sexual health education, while no interventions were provided to the control group. Data were analysed in SPSS-16 using the paired *t*-test and the independent *t*-test.
Findings: Participants were matched in the two groups in terms of demographic variables such as age, occupation, age at marriage, duration of marriage, residential status and income level. At the baseline, no significant differences were observed between the intervention group (77.35 ± 9.36) and the control group (75.64 ± 8.32) in terms of the quality of life score ($P = 0.26$). After the intervention, the quality of life score was 94.3 ± 6.54 in the intervention group and 74.2 ± 7.33 in the control group, making for a significant difference ($P < 0.01$).
Conclusion: Based on the findings, sexual health education can help women improve their sexual health through promoting sexual and marital satisfaction and consequently improve their quality of life.
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1. Introduction

Quality of life is defined as a certain degree of satisfaction and achievement of needs in physical, social, psychological, and behavioural domains, and more importantly as feeling well.[1,2] The World Health Organization has defined the quality of life as "an individual's perception of their life status in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". This definition covers physical and psychological domains, level of independence, social relationships, environment and personal beliefs.[3,4]

Marital satisfaction is one of the most important factors affecting women's health and life satisfaction index.[4,5] Couples who are compatible and satisfied with their marriage tend to agree with each other extensively, be satisfied with the type and level of their relationship, be satisfied with the type and quality of their leisure time and to also plan their time and work on their financial issues.[5–7] Sexuality is one of the main issues affecting people's personal and social life.[8] Sexual satisfaction is the individual's judgement that their sexual activity is pleasant and satisfying to them.[9,10] Sexual problems or concerns form the major challenges of marriage, with the different levels of libido in men and women being the main cause of marital unhappiness.[11]

According to the World Health Organization, sexual health is an adaptation of physical, emotional, mental and social aspects of sexuality so that it will promote the character, relationships and love.[12] Adult sexual health is defined by Iranian experts as experiencing satisfying relationship within a socially supported relationship with someone of the opposite sex.[13] In this study,

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sexual health is a broad term encompassing a positive attitude towards sexuality and is seen as a kind of enrichment in life and in interpersonal relationships; it is not limited to fertility counselling and care and sexual diseases.[7,14,15] For some women residing in Iran, the realization that sexual health – as defined here – allows for living a life respectful of one's personal and social ethics while also enjoying sexual activity is a new and liberating idea. Sexual health education also involves the fertility control and the avoidance of factors that inhibit the sexual response and cause sexual dysfunction: e.g. ignorance, fear, misconceptions, shame, guilt, sexual diseases, physical disorders and deficiencies interfering with fertility and sexual functioning.[15,16] Sexual health is an individual's ability to express their sexuality within the value system of the society, laws, beliefs and current culture, without fear of sexually transmitted infections, unwanted pregnancy, coercion, violence and discrimination.[17,18] Sexual health means the ability to have a conscious, pleasurable and safe sexual life based on positive expression of sexual characteristics and mutual respect in sexual relationships. In this case, not only is sexual health enjoyable, but it also strengthens communication and interpersonal relationships.[17,19]

Common causes of sexual dysfunction include marital disagreements or communication problems within the marriage.[11,20] New marital problems often emerge if there are sexual problems in the relationship.[8,21] Marital satisfaction is significantly associated with sexual pleasure and more sexual satisfaction will result in higher marital satisfaction.[18,22] According to the International Conference on Population and Development in Cairo, one of the principal human rights is to attain the highest standard of sexual information and health.[23,24] Some researchers believe that sexual dissatisfaction among couples is the main reason for 80% of marital conflicts.[1,20] However, 40% of couples satisfied with their marital life have some impaired sexual relationships or relative dissatisfaction with sexual relationship.[8,9] In a study on sexual and marital satisfaction in Chinese families, it was found that sexual satisfaction has a remarkable effect on marital satisfaction.[7] The Iranian community is rooted in an Islamic and traditional context and has its own distinct ideas of sexual health that urge action for more extensive training in this area. Sexual health spreads across the community without any organized education and is typically passed within families to their next generations; nevertheless, families do not provide sexual education to their children. The role of sexual education is such that more attention should be paid to it at a particular point in life, because although the traditional course of training is conducted through the family, unfortunately there are lots of gaps in the field of sexual health education and sexual education in the society. In Iran there is no formal sexual health education such as those incorporated into the school curriculum. The only formal sex education is the one provided to couples before marriage. These pre-marriage education classes emphasize contraceptive methods rather than sexual health as a more broad concept. Sexual health education programmes should therefore be designed in the country at different levels to provide individuals and couples with one of the skills integral to life, so that sexual disorders and marital unhappiness can be prevented in the years to come.[3,7,18,25] Given that sexual health education in Iran has always been a social taboo and also due to poor quality of pre-marriage education, we decided to conduct this study to assess the effect of sexual health education on the quality of life in women attending health centres.

Null hypothesis: The study hypothesis was a sexual health education programme will have no effect on quality of life of married Muslim women when compared with no educational intervention.

2. Participants and ethics

The study was approved by the research committee of Tehran University of Medical Sciences. The Institutional Review Board and the Ethics Committee of Tehran University of Medical Sciences approved the study. The study was then registered at the Iranian Registry of Clinical Trials under the number IRCT2013011912188N1. A written informed consent was obtained from all the study participants.

Before recruiting participants, permission was obtained from the relevant authorities and after a full explanation of the purpose of the research, possible benefits including increased sexual satisfaction and quality of life and possible problems such as the time needed to participate, a written consent was obtained from them.

The present study analysed the data of a sample of married Muslim women admitted to select health centres affiliated to Tehran University of Medical Sciences. The target population included 20–45 year-old women who met the inclusion criterion of having no mental diseases and being literate. The women were encouraged to participate in the study by a female researcher who provided them with explanations about the study objectives and methods using an appropriate language and ensured them of the confidentiality of their participation in the sexual education class, the voluntary nature of participation, their preservation of the right to withdraw from the study at any point in time, their getting a small reimbursement from the research team and their being given the opportunity to take advantage of extra training on the subject. The study exclusion criteria consisted of having a drug addiction, drinking alcohol, not being Muslim, having participated in similar training programmes and having certain diseases such as heart disease, arthritis, diabetes, emphysema and cancer and having undergone ostomy, mastectomy and hysterectomy. Based on the sample size formula and a delta of 1.4, a Cronbach's alpha of 0.05 and a power of 0.80, sample size was determined as 30 in each group.

3. Research design

The present single-blind randomized controlled trial allocated its participants to two groups using a balanced block randomization method. Block randomizations work by randomizing participants within blocks so that an equal number of participants are assigned to each treatment. An important advantage of blocked randomization is that the treatment groups formed will be equal in size and tend to be uniformly distributed in terms of the main outcome-related characteristics.[26]

4. The educational intervention

The sexual health education programme was conducted by a knowledgeable and trained female expert who was also a member of the research team. There were three 45-min sessions. The curriculum included sexual health (human sexual anatomy, sexual reproduction, reproductive health and sexual activity), how to make a better relationship with one's husband (emotional, mental and sexual). Promoting sexual and marital satisfaction (positive and respectful approach to sexual relationship in marriage). In training sessions, an educational pamphlet and a PowerPoint presentation were used, in addition to lectures, for better explanation of the subject. We emphasized that the participants in both groups do not participate in another similar training session, and return after 2 months for the post-test. Fortunately, there was no sample loss during three months. Furthermore, to ensure no sample loss and avoid its consequent decrease in efficiency of the study and given the importance of participating in the study, an extra training course (e.g. contraception methods)

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