

Nurses' Attitude Towered Communicating Female Sexuality issues: A Road-Map for Better Communication in Nursing Practice

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Abstract: Background: Nursing as a holistic practice, discuss all dimension of human health including sexuality to identify any alteration of health. **Aim:** This study aims to explore nurse's attitude towered communicate female sexuality issues. **Subjects and Methods:** A descriptive correctional research design was used to achieve the aim of the study. **Sample:** A purposive sample of 200 nurses working in different setting at teaching hospital affiliated to Cairo University was participated in this study. **Tools:** Data were collected through utilizing structured interviewing questionnaire tool and sexuality attitudes and beliefs Survey (SABS) tool. **Results:** The age range of the study samples ranged from < 30 and > 50 years (75 %) were diploma nurses. (50 %) have more than nine years' experience, (65 %) were married, (81 %) was staff nurse, The mean SABS scores varied from (3.14 to 4.70); 77.7% of the study sample viewed that sexuality as too private issue to discuss, 65.8 % agreed that they do not make time to discuss sexual issues, 63.4% of them assume that most hospitalized patients are too sick to be interested. Moreover, 74.8% reported work place limitation (72.8%) or sexuality care not being part of nursing routine work (68.3%). Years of experience, type of setting, educational level and marital status were statistically significant factors affecting communicating female sexuality issues in practice ($p = < 0.05$). **Conclusion and recommendation:** Sexuality is a basic human right and fundamental part for quality of life and there are certain beliefs and attitude can affects nurses to communicate sexual issues in nursing practice so, Sexual education is needed in basic nursing education to equip nurses with the relevant knowledge and competent to discuss sexuality issues for women.

Key Words: Nurses, Attitude, Communication, obstacle, improvement

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I. Introduction

Sexuality is a basic human right and a fundamental part of a healthy life (Verschuren, Enzlin, Dijkstra, Geertzen & Dekker, 2010). Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity (World Health Organization, 2013). Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as, the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (Miller, , Cottingham Kismödi and Gruskin ,2015).

Despite the international emphasis on sexual health, not enough progress has been made in developing countries including Egypt due to lack of access to information, education, health care services, taboos surrounding discussion of sexuality, and service providers' lack of knowledge to deal with sexual issues (Ferreira, Gozzo, Panobianco, Santos & Almeida, 2015).

There are diseases and conditions that may affects female sexuality such as impact of cervical cancer on women's sexual function (Bodurka & Sun ,2006) ,the study showed that 57% of the women experienced altered or limited sexuality after chemotherapy and/or radiotherapy; Moreover, Tierney (2008) mentioned that, woman suffering from gynecological cancer face numerous challenges to sexuality including threats to their body image, alter sexual response (interest, function and satisfaction) as well as, distorted sexual role and relationships. Also, a qualitative study among woman who had been treated for cervical and endometrial cancer, the study sample mentioned that at treatment initiation, they wanted more information from the health care providers about long term physical, emotional effects of treatment on their sexual functioning as well as reassurance about safety of sexual activity (Stead, Brown, Fallow field & Selby, 2013).

In addition, Price, (2009) reported that 54.4 % of diabetic women have sexual dysfunction. Also, studies conducted by Bispo, Lima Lopes & Barros (2013) showed that acute myocardial infarction and chronic cardiovascular diseases exert a negative impact on the sexual activity of men and women. It is known that individuals with coronary disease experience sexual dysfunction due to fear of having MI again and effect of

drugs. Moreover, El Miedany, El Gaafary, El Aroussy, Youssef & Ahmed (2012) reported that 45 % of women and 53 % of men with rheumatoid arthritis have sexual dysfunction.

There are various reasons causing patients' sexuality concerns to be overlooked by healthcare providers. One of these reasons may be the myths among nurses that patients diagnosed with cancers being too ill and interested in sex or sexual issues (Arikan, Meydanlioglu, Ozcan & Ozer, 2014). Other myths indicated that nurses may avoid discussing sexual issues with their patients because they believe that dealing with patients sexual issues is not within their professional responsibility (Nakopoulou, 2009), and they are afraid of offending patient's privacy (Katz, 2005). In addition, some nurses feel that they are not adequately prepared with relevant knowledge and skills to discuss issues of sexuality with their patients (Stilos, Doyle & Daines, 2008). Moreover, beliefs that patients do not expect to discuss their sexuality concerns with nurses (Magnan & Reynolds, 2006), lack of referral resources, unsuitable environment to discuss sexual concerns with woman (Yildiz, 2012), shorter stays in hospital and multiple care providers, all of these barriers limited opportunities to address sexual concerns with woman .

Nurses do not attempt to offer sexual training and consultancy services due to factors such as feeling ashamed, social taboos, underestimating sexuality and believing that they do not have sufficient information for guiding patients. In addition, Akinci, Yildiz & Zengin (2011) mentioned that conservative attitude of nurses, their prejudices towards patients and their lack of adequate training on sexuality are cited as other causes of the lack of routine sexuality care in nursing practices. Although nurses consider evaluation of sexual health and offering consultancy on the issue as part of their professional nursing roles, they can not reflect this awareness to patient care in practice (Fairchild, Haefner and, Berger, 2016).

Although studies highlighted the difficulties in communication related to the subject of sexuality in the nursing practice, gaps remain in the knowledge regarding the barriers which impede the topic's inclusion in the nursing care. A broader focus on this problem is needed, so that the experiences and meanings of these women can be valued and considered in nursing care practices because the concept of sexuality cannot be separated from health, and intimacy-related issues are fundamental to maintaining the well-being and self-esteem of women. However, In Egypt, few studies have explored attitude of nurses toward communicating sexuality issues in practice. Therefore; this study was carried out to assess nurses' attitude to communicating female sexuality issues.

Significance of the study

Sexual health is as important as any other facet of health and should receive the same level of attention. The opportunity for women to freely and fully discuss their sexual health needs, concerns, and potential treatment options with a trusted HCP is critical for improving sexual health outcomes. Despite the role of sexual health as a vital sign for overall health and quality of life, the topic is unfortunately too often left unaddressed by both HCPs and female patients. Women during their life cycle may have numerous sexuality concerns and therefore it is important for nurses and other health care providers in Egypt to discuss sexuality issues in practice. Findings from this study will provide a better understanding of nurses who work with women in non-acute care settings to address and meeting the sexual health needs of their women. The knowledge gain can inform nursing and midwifery educational curricula to meet the goals of healthcare reform by providing quality cost-effective care to women. Unfortunately, the current nursing curriculum in Egypt rarely includes information related to human sexuality. This deficit should be addressed and new teaching strategies should be integrated to help nurses to integrate sexuality care in their clinical practice. Also, this study will contribute to improve the nursing practice especially in relation to women follow up and monitor for early detection of any problems that may predispose to female sexual dysfunction. Since nurses are considered a member in health care team and work in a variety of settings, they have unique opportunities to address client sexuality during a routine health care that might help the women to understand how sexual feelings may be affected by illness, childbirth, and treatments.

Aim of the Study

The aim of this study was to explore nurse's attitude toward communicating female sexual issues .

Research questions:

To fulfill the aim of this study, the following research questions are formulated:

- 1- What are the nurses' attitudes toward communicating female sexual issues?
- 2- What are the factors that might affect nurses from communicating female sexuality issues in practice?

Operational Definition

Sexual issues: It refers to all aspects of women life's concern or themes that can threaten her sexuality such as disease, surgical operations, drugs, aging, as well as gynecological problems as measured by Sexuality Attitudes and Beliefs Survey (SABS) scale .

Subjects and Methods

The aim of the present study was to explore nurse's attitude toward communicating female sexual issues.

Research design:

Descriptive correlational research design was used to achieve the aim of the study.

Sample:

A purposive sample of 200 nurses working in teaching hospital affiliated to Cairo University according to the following criteria: Female nurses only, not less than one year of experience and working with female clients.

Setting:

The study was conducted at obstetric and gynecological inpatient departments and outpatient clinics, medical inpatient departments and outpatient clinics, surgical inpatient departments, oncology inpatient departments and outpatient clinics at teaching hospital affiliated to Cairo University.

Tools for data collection:

Data were collected through utilizing the following tools:

I- Structured interviewing questionnaire tool developed by the research investigator which included three parts:-

a- The first part included the demographic characteristic of the nurses, such as age, level of education, marital status, years of experience, work setting.

b- The second part included nurse's previous educational background, experience and training related to female sexual health.

c- Nurse's knowledge regarding issues affecting female sexual function

II- Sexuality Attitudes and Beliefs Survey (SABS) tool: This tool adopted from (Reynolds & Magnan, 2006) it measures individuals' attitudes and beliefs about "personal comfort, confidence, meeting patient expectations, and making time to address patient sexuality concerns". The SABS consists of 12 items in a Likert type scale ranged from 1 to 5. The percentage of disagreement or agreement was undertaken by dichotomizing item response options: those who chose options 1-3 (strongly disagreed, disagreed and no opinion) and 4-5 (agreed and strongly agreed) were classified as being disagreement and agreement respectively. The range of scores for the SABS is 12 to 60, where higher scores indicate negative attitude to addressing patients' sexuality in nursing practice.

Tool validity and reliability:

Tool was submitted to a panel of three medical and nursing experts in the field of obstetrics and gynecology nursing and medicine to test the content validity modifications were carried out according to the panel judgment on clarity of sentences and the appropriateness of content. Internal consistency was done by Cronbach alphas of .75 .

Ethical consideration:

An official permission was obtained from hospitals administrators to collect data from nurses working in different previous setting. Written informed consent was obtained from each participant in the study after clarification of the nature and aim of the study. The research investigator emphasized that participants in the study is entirely voluntary and can withdraw at any time. Anonymity and confidentiality were assured.

Pilot study:

A pilot study were conducted among (10%) of the sample to ensure the clarity, feasibility and validity of the tool. The pilot study lasted one week and modifications in some questions not appropriate with Egyptian culture were done based on the pilot results. Also, the sample included in the pilot study was excluded from the total sample.

Procedure:

Data of the current study were collected through a period of six months from January to June 2018. The researcher introduced herself to the study sample to discuss the purpose from the study and obtain their acceptance to be recruited in the study. The sample was interviewed individually and self administer questionnaire were plotted by the study sample through the three different shifts (morning, afternoon). For study sample working at afternoon shifts, the researcher admitted at 6pm to 10pm to meet the nurses during these shifts. For the study sample working at morning shift, the researcher was admitted to the previous setting at 10am to collect the required data. The researcher collected the data 2 days / week (Saturday, Sunday,). The time consumed to fulfill the questionnaire ranged from 25 - 30 minutes.

Statistical Design:

Statistical package for social science (SPSS) program version 20. Descriptive and inferential statistical tests were applied (e.g. mean, stander deviation, frequency and percentage). As well as, Fisher test. The level of significance was set at 0.05 %.

II. Results

The age range of the study samples ranged from < 30 and > 50 years, more than one third of the samples (43.5 %) their age under 30 years old; (75 %) were diploma nurses. (50 %) have more than nine years' experience, (65 %) were married, (81 %) was staff nurse, (32.5 %) of the study samples work in medical outpatient and inpatient departments as well as 22.5% work in oncology department.

More than three quarters of the study sample 91.5% didn't receive any educational background and training related to female sexual issues in their curriculum compared to 8.5% had received this type of education or training. Some of the nurses who received this education or training n= 17 , 82.5 % didn't apply this information in their practice, either due to patient not concerned with this sensitive issue , not required in clinical training or feeling of embarrassment (57.5%,21.5% and 14% respectively). (Table, 1)

Table (1): Nurse's previous education and training related to female sexual issues.

Variable	n=200	%
Previous educational background or training on sexual health		
- Yes	17	8.5
- No	183	91.5
Application in clinical practice		
- Yes	3	17.5
- No	14	82.5
Reasons:		
-Not required in clinical training	3	21.5
-Feeling of embarrassment	2	14
-Women didn't ask	1	7
-Women not concerned with this sensitive issues	8	57.5

As shown in figure (1) more than two third 76.5% and 74.5% of the study sample were agreed that pregnancy , mode of delivery and psychological status can affect female sexual function compared to 58.5% and 51.5% of the study sample disagree that surgeries and hormonal contraceptive methods can affects female sexual function.

Figure (1) Nurses knowledge regarding issues affecting female sexual function

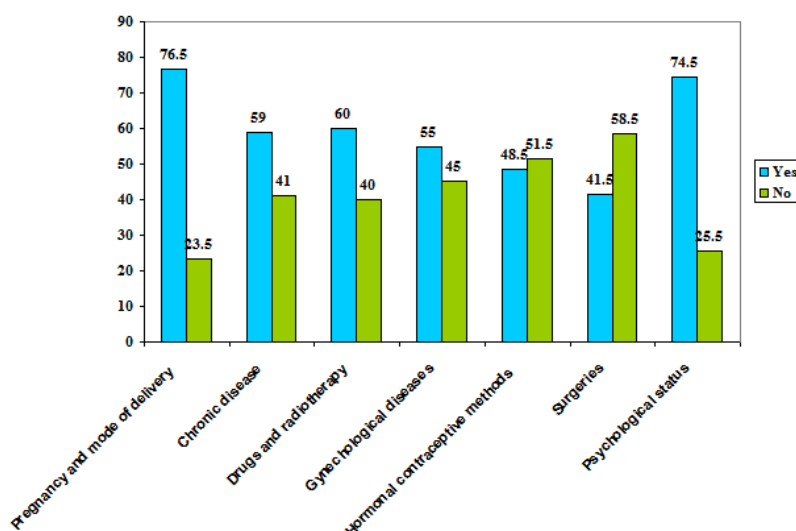


Table (2) shows that the mean SABS scores of each item varied from 3.14 to 4.70, more than three quarter (77.7%) of the study sample viewed that sexuality as “ too private issue to discuss with patient , and 65.8 % agreed that they do not make time to discuss sexual issues with their patient , 63.4% and 63.3% of them

assume that most hospitalized patients are too sick to be interested in sex .These three items had high mean scores with mean of (4.70 ± 1.45, 4.14 ± 49 and 4.12 ± 41)

Table (2) Nurse's attitude toward communicate female sexual issues in practice.

SABS Items	Agree%	Disagree %	Mean (SD)
1. Sexuality is too private issue to discuss with women	77.7	22.3	4.70 ± 1.45
2. Most hospitalized women are too sick to be interested in sex	63.4	36.6	4.14 ± 49
3. I do not make time to discuss sexual issues with my patients	65.8	34.2	4.12 ± 41
4. I am less comfortable to talk about this issue	65.3	34.7	3.99 ± 1.27
5. I feel less confident in my ability to communicate women sexual issues	64.9	35.1	3.98 ± 1.45
6. Sexuality should be discussed only if initiated by women	59.4	40.6	3.78 ± 1.41
7. Patient expect nurses to ask about their sexual concern	27.0	73.0	3.68 ± 1.48
8. When women ask me a sexuality related question, I advice them to ask the physician	52.0	48.0	3.52 ± 1.44
9. communicating sexuality is essential to patients health outcomes	51.0	49.0	3.41 ± 1.69
10. I am uncomfortable to talk about sexual issues	58.5	41.6	3.21 ± 1.47
11. I understand how my patients disease and treatment can affect their sexuality	57.4	42.6	3.20 ± 1.38
12. Giving a woman permission to talk about sexuality concern is a nursing responsibility	37.1	62.9	3.14 ± 1.48
Total Mean attitude of SABS Score is (44.94 ± 8.12 SD)			

Table (3 and 4) shows nurses agreement with the statement about barriers and facilitators influencing whether or not nurses communicating female sexuality issues. The common barriers related to discussing sexuality issues as mentioned by the study sample were attributed to organizational barriers such as staff shortages (74.8%), work place limitation (72.8%),.. sexuality care not being part of nursing routine (68.3%). Also, other related barriers among the study sample attitude were fear of violating patient privacy (69.3%, inadequate educational preparation (68.8%), feeling embarrassed at addressing patients' sexuality (67.8%), and lack of relevant experience (64.9%). Women are concerned about many things other than having sex (72.3 %), patients' felt embarrassment at discussing their sexuality concerns and sexuality representing a low health priority among women were the similar agreement among the study sample (71.3%) compared to 66.3% from the study sample agreed that patients feeling that sexuality assessment is not relevant to treatment.

Table (3) Barriers influencing communicating female sexuality issues

	Mean (SD)	Agree (%)	Disagree (%)
Barriers			
Organization Barriers			
1. Staff shortages resulting in limited time and energy	4.48 (1.47)	74.8	25.2
2. work place limitation	4.33 (1.40)	72.8	27.2
3. Lack of appropriate preventive care and referral system	4.20 (1.51)	64.9	35.1
4. Sexuality care not being part of nursing routine care	4.17 (1.50)	68.3	31.7
5. Lack of private setting	3.79 (1.74)	55.9	44.1
Nurses' Barriers			
6. Inadequate educational preparation	4.40 (1.65)	68.8	31.2
7. Fear of violating patients privacy	4.32 (1.57)	69.3	30.7
8. Feeling embarrassed at addressing patients' sexuality	4.20 (1.54)	67.8	32.2
9. Lack of relevant experience	3.98 (1.50)	64.9	35.1
10. Limited knowledge	3.93 (1.70)	60.9	39.1
Women's Barriers			
11. woman felt embarrassment at discussing their sexuality concerns	4.39 (1.59)	71.3	28.7
12. women concealing information	4.19 (1.48)	65.3	34.7
13. women feeling that sexuality assessment is not relevant treatment	4.08 (1.47)	66.3	33.7
14. women declining to answer nurses' questions	4.08 (1.45)	65.3	34.7
15. gender preference	3.84 (1.57)	57.9	42.1
16. Women are concerned about many things other than having sex	4.51 (1.51)	72.3	27.7
17. Sexuality representing a low health priority	4.31 (1.43)	71.3	28.7

The facilitators for communicating female sexuality issues in nursing practice were having a good nurse-patient relationship (Mean = 4.97 ± 1.21), good communication skills (mean = 4.74 ± 1.25), a viability of private environment (Mean = 4.38 ± 1.55) and patients initiating or expressing their sexuality concerns were the main facilitators influencing practice related to discussing sexuality issues . (Table, 4).

Table (4) Facilitators for communicating female sexuality issues in nursing practice

	Mean (SD)	Agreement (%)	Disagreement (%)
Enhancer			
1. Having a good nurse-patient relationship	4.97 (1.21)	87.6	12.4
2. Possessing good communication skills	4.74 (1.25)	82.7	17.3
3. Availability of private environment	4.38 (1.55)	72.3	27.7
4. Sexuality care being included in routine nursing practice	4.32 (1.42)	71.3	28.7
5. Patients initiating or expressing their sexuality concerns	4.18 (1.68)	66.8	33.2
6. Patients requesting information related to sexual history and disease	4.15 (1.71)	64.4	35.6
7. Provision of relevant training	3.70 (1.48)	56.9	43.1
8. Possession of sound sexual knowledge	3.65 (1.61)	56.4	43.6

- **Factors affecting to communicate female sexuality issues in nursing practice**, by using multiple regression analysis, table (5) show that year of experience, type of setting, educational level and marital status were statistically significant predictors of sexuality care in nursing practice.

Table (5) Regression analysis of significant factors related to communicating sexuality issues in nursing practice.

Significant predictors	Std B	SE	95% CI		P .value
			Lower Boundary	Upper Boundary	
Years of experience	0.340	0.868	1.238	4.751	0.001
Educational level	0.259	0.911	1.755	5.300	< 0.001
Setting	0.193	1.393	1.320	6.814	0.004
Marital status	0.213	0.702	0.998	3.768	0.001

Note: Std (Standardized B Coefficient; SE (Standard error; CI (Confidence interval)

III. Discussion

The present study aims to describe nurses' attitudes to communicate female sexuality issues in practice. The results of this study revealed that the study sample had a total mean SABS score of 44.94 + 8.12 SD) indicating higher levels of barriers to addressing patients' sexuality care in practice higher than either among Swedish nurses (with total mean SABS of 40.7 ± 7.8SD) (Saunamaki et al. 2010) or American nurses (with total mean SABS of 37.48 ± 8.19 SD) (Magnan & Reynolds 2006). Also, this findings not supported by Tsai (2004) who reported that Taiwan nurses had total mean barriers score (89.8 ±11.8) and Akinci et al., (2011) mentioned that Turkish nurses had a total mean barriers score (43.28 ± 6.51). Also, Arikian et al., (2014) reported that Turkish nurses had a total mean barriers score (41.58 ± 7.67). This discrepancy in mean barriers score might be due to the approach of individuals to sexuality is influenced from religious, cultural values of their society and its political and economic status.

Specifically, a majority of study sample held the attitude that 'sexuality is too private issue to discuss with patients. From the socio-cultural perspective, sexuality is situated in the sphere of prohibitions and, thus, addressing it is often only touched upon or even avoided. The professionals interviewed considered sexuality a sensitive and delicate issue which belongs in the private sphere, therefore many women do not feel comfortable talking about intimate matters in the hospital environment. This repression is intensified when sexuality is considered from the perspective of gender. Inequalities in the construction of the male and female roles characterize life in society. Also, the nursing professionals also explained the absence of addressing sexuality in nursing care because of the cultural issues they experience in the process of constructing their female identity. Due to current gender standards, women learn to isolate themselves early; therefore they do not raise the issue with the team. Similar results were founded by a study conducted in a large metropolitan medical center in the USA with nurses, which showed that they believed sexuality to be a private matter which, therefore, should not be addressed. (Magnan et al, 2006).

Finding of this study revealed that (63.4%) of the study sample reported that patient concerned with other problems more than discussing sexual issues. This result was supported by Byrne, Doherty. & Murphy, (2010). they reported that most hospitalized patients too sick to be interested with sexuality. Also, Hordern & Street, (2007) reported that patient having more things to be concerned about than having sex. Also, Arikian, et al (2014) revealed that sexuality representing a low priority issue among people with cancer. Moreover, Kotronoulas et al.,(2009) mentioned that 54% of the study sample reported that patient too ill to discuss sexuality concern. Similar results were founded by a study conducted in a large metropolitan medical center in the USA with nurses, which showed that they believed sexuality to be a private matter which, therefore, should not be addressed.

Although discussions of sexuality are relevant to patient care, nurses do not actually take time to discuss sexuality with patients. The results show that the majority of study sample (65.8%) do not take time to discuss sexuality with patients. This findings supported by (Magnan et al. 2006.; Higgins et al. 2008 ; Julien et al. 2010; Saunamaki et al. 2010.; Quinn et al. 2011, and Zeng et al. 2011 and Huang et al. 2013.). On the contrary, studies that report participants taking time to discuss sexuality with patients are male nurses are more likely to discuss sexuality with their patients than female nurses (Saunamaki et al. 2010.; Quinn et al. 2011; Zeng et al. 2011, and Huang et al. 2013.).

The reasons to explain why nurses do not take time to discuss sexuality with patients, the study sample reported that heavy workloads, staff shortages, and a lack of resources such as time or a private area for discussions (Higgins et al. 2008, Quinn et al. 2011, and Zeng et al. 2011.) Also, the study sample also draw attention to the fact that discussing sexuality with patients is not a priority for the healthcare setting (Quinn et al. 2011.) . According to Magnan et al. (2006.), this disparity between what nurses believe and what nurses do in practice can be explained by a cognitive dissonance or a situation involving conflicting attitudes, beliefs or behaviors that come from how nurses perceive their roles compared to how they actualize their roles. Quinn et al. (2011.) suggest heavy workloads and lack of privacy may also be used as justification for avoiding sexual conversation. Even when ward areas are quiet and nurses have time to discuss sexuality with their patients they do not provide it.

Moreover, a study regarding personal attitudes and beliefs about incorporating a patient sexuality assessment and counseling into nursing practice, 148 nurses were interviewed, who worked in selected inpatient units and outpatient clinics from a large metropolitan medical Centre in (USA). The result highlighted that the majority of the nurses (70.2%) reported that there was no time to discuss sexuality with their patients (Magnan, Reynolds & Galvin, 2005). Similar characteristics were also reported in the hospital context in China. Chinese nurses believed that insufficient staff - resulting in a lack of time and energy and insufficient resources were the main barriers to addressing sexuality (Zeng et al., 2011). In addition to the embarrassment of the patients, there is the discomfort of the health team. Hence, it cannot be ignored that nursing, as a predominantly female profession, transports the standards and values inherent in the cultural construction of women's sexuality into the profession. The gender issues that influence the construction of women's sexuality are the same ones that determine nursing actions and prevent them from expressing their sensitivity, leading to the censorship of discussions related to the topic and further increasing prejudice. Nurses often feel too uncomfortable and embarrassed to discuss sexuality with the patients and are afraid of violating their privacy (Stilos et al., 2008).

Crucial to any interaction between a nurse and a patient is the nurse-patient relationship. The nurse-patient relationship is considered a therapeutic relationship as well as a professional one. Its progressive aim is to enhance the patient's physical, psychological and spiritual well-being. Communication between the nurse and the patient is the foundation on which the relationship is built. A nurse-patient relationship needs to be based on trust. Confidentiality makes the relationship safe allowing the patient to comfortably disclose personal information and ask questions (Webb, 2011). The study findings revealed that (87.6%) from the study sample generally agreed that the key facilitating factors for nursing practice related to sexuality concerns are 'good nurse-patient relationship', 'good communication skills', 'availability of a private environment Resources' are the key facilitators to nursing practice related to sexuality concerns.

Examining the relationships between the total nursing attitude scores and the nurses' demographic variables, the study findings revealed that nurses with longer work experience had higher total nursing attitude scores ($P < 0.05$). This indicates that these nurses were more likely to address the sexuality concerns with patients than younger nurses with less work experience and in lower positions. It is understandable that the maturity of nurses has implications for their readiness to discuss sexuality concerns with their patients. Also, the regression analysis revealed that married nurses were more likely than single nurses to address sexuality issues with their patients. A systematic review identified that marital status as one of the potential influencing factors in providing sexual health care in clinical practice (Kotronoulas et al. 2009).

As regard to educational level, the current study indicated that a significant relation between nurse's level of education and total attitude scores as nurses with diploma degree has a higher attitude scores ($P < 0.05$). This finding is supported by many researches as Tsai (2004) who founded that, nurses who had a bachelor of science or masters' degree in nursing had lower attitude score than those nurses who possessed an associate degree or a certificate in nursing. These results are contradicted with Arikian et al., (2014) who founded no relation between attitude scores of the nurses and their level of education.

In the current study, experience was a predictor variables, that there was positive relation between nurse's experience and total barriers scores ($P = 0.017$). This finding supported by Tsai, (2004) who founded that nurses who had experience had lower barriers. Also Zeng et al., (2011) founded that nurses with longer work experience had higher enhancers and lower barrier. As regard work setting that there was a positive relation existed between work setting and total enhancers scores ($p = 0.000$). Also, Zeng et al., (2011) reported that

Chinese nurses working in general hospitals were more likely to discuss sexuality issues than those in tumor hospitals.

Other studies conducted in the UK and Greece also reported that nurses working in clinical settings cited lack of privacy as one of their reasons for not discussing sexuality with patients in practice (Nakopoulou et al. 2009). Due to the fact that sexuality is such a sensitive and confidential issue, Chinese nurses should be aware of the need to provide an environment conducive to discussing sexuality issues with patients.

Overcoming Barriers: The Road-Map for Sexual Communication in Nursing Practice

Barriers to optimal sexual health outcomes for women are numerous, complex, and often inter-related. Some problems are more solvable than others. The first step is to foster more open and informed dialog about sexual health between women and their Health care providers (HCPs) to improve women's health outcomes and quality of life (Reiter ,2013, Nappi, Lachowsky ,2009) . Therefore, there are several strategies to enable health care providers (HCP) including nurses focusing on training skills to facilitate communication; Establishing and maintaining patient trust; Overcoming time constraints; Making the most of medical intake forms ; and Educating and empowering patients.

Training HCPs and facilitating communication:

All HCPs (physicians, nurse practitioners, physician assistants, mental health professionals, nurses, etc.) who provide health care for women can benefit from training in the basics of female sexual health and dysfunctions in combination with communication skills training to facilitate successful, candid discussion about sexuality. Moreover, HCP training should focus on integrating knowledge about sexual health with skills for counseling women and shared decision-making based on individual needs and goals. Knowledge acquisition about basic sexual health content and fundamental interviewing/communication skills should begin at the earliest stage of professional training, for example, in medical and professional schools. Despite the ever-growing competition for time with exponential growth in knowledge to be learned, advocacy efforts must be expanded to protect sexual health content and communication skills in core curricula. Further training (or in some cases, even initial training) can occur in residency or other postgraduate training. HCPs already in clinical practice who need basic training or are interested in enhanced training in female sexual medicine can seek out programs on sexual health education. Women's health and/or sexuality- related professional associations can also play an important role in creating and disseminating resources and best practices for practitioners. (Eardley, Reisman, Goldstein, Kramer, Dean etal,2017). This practice can be accomplished in almost any office visit setting. The HCPs can first legitimize the importance of assessing sexual function and normalize the discussion by including it as part of the routine medical history. One suggestion to put patients at ease may be to mention at the outset that many patients have sexual health concerns or symptoms, providing an opening for them to ask if the patient has similar concerns. HCPs can use open-ended questions about sexual concerns instead of "yes/no" questions, which tend to hinder women's ability to accurately describe symptoms or concerns.

In addition, open-ended inquiries give patients permission to talk about their sexual concerns. Routine discussion of sexual health allows HCPs to reassure women that some feelings and symptoms are common and legitimate. Any problems related to sexual response, including desire, arousal, orgasm, and pain can be explored, along with potential treatment options. This is an efficient model for HCPs to simultaneously educate women about normal sexual response and assess for problems with desire, arousal, orgasm, or pain. The PLISSIT model is one types of models that can be used by the health care providers to initiate sexuality communication and is considered an helpful tool for discussing sexual health or concerns with patients. (Annon ,1976, Wallace ,2008).

The PLISSIT Model stands for permission (P), limited information (LI), specific suggestions (SS), and intensive therapy (IT), When conducting an interview, the Partnership (P), Empathy (E), Apology (A), Respect/Reflect/Reinforce (R), Legitimize (L), Support (S) . PEARLS model on the other hand, can also provide a useful structure to facilitate open communication (Coleand , Bird ,2013). In addition ,essential clinical competencies for communication about sexual health concerns include the ability to initiate a direct and concise conversation about sexual health in a space that ensures privacy and comfort. For example, the HCP and patient should both be seated face-to-face with the patient clothed. The HCP should complete a brief sexual health history, discuss any concerns, and close the conversation with shared decision-making and a suggestion for a follow-up appointment to further assess and treat. Alternatively, the HCP can provide a referral to a sexual medicine expert or sex therapist who can address more complex concerns. The International Urogynecological Association (IUGA) and International Continence Society (ICS) stress that sexual concerns should be addressed routinely and in a recent report suggested an educational process similar to the above to be used in women with pelvic floor dysfunction, given that most pelvic floor dysfunctions are believed to negatively affect sexual health (Rogers, Pauls,and Thakar ,2018) .

The American College of Obstetricians and Gynecologists (ACOG, 2017) Committee Opinion on sexual health, meant to increase awareness of the importance of addressing women's sexual health in routine practice, provides a listing of questions to be utilized during sexual history taking. The health care providers including nurses in any specialty should be able to initially address sexual health issues, or if not comfortable doing so, have a streamlined, care-path referral in place as part of their routine practice. In addition, beyond providing basic information and suggestions, many HCPs may still want to refer a patient to qualified sexuality specialists. Appropriate sexual health referrals could apply to HCPs in any specialty area. For example, a neurologist treating a patient with multiple sclerosis could discuss sexual health with her patients, and if lacking in expertise, be able to provide them with some appropriate HCP recommendations. Professional associations could help HCPs direct women to sexual health specialists by having a mechanism for HCPs to identify appropriate professionals by location and areas of expertise (Bober, Reese and, Barbera, 2016).

Establishing and maintaining patient trust.

A theory-based qualitative study of women older than 50 years of age found that women who wanted to communicate with their HCPs about sexual health would only do so if they felt comfortable and trusted their provider (Hughes & Lewinson, 2015). The health care providers can build rapport with a patient by asking questions about sexual health as comfortably as they would ask other health questions, by not rushing them through the discussion, by remaining nonjudgmental, and by assuring them that what is discussed will remain confidential and that what they are experiencing is normal (Andrews, 2000, Hughes and Lewinson, 2015). Explanation that these are common conditions, and reassurance that they are treatable may help women relax when discussing these topics. HCPs may initially feel confused by the common overlap of sexual concerns (i.e., problems with desire, arousal, and orgasm). However, simple inquiry regarding which problem developed first or is most distressing typically informs treatment decisions. Once a sexual health concern has been identified and addressed, HCPs should continue to check in with patients and discuss issues of sexual health on subsequent visits. At any stage, conversations about sexual health may be enhanced by providing credible and accurate educational information and resources to women. Guidance should be given to HCPs to begin conversations on sexual health without any assumptions about sexual activity, sexual orientation, relationship status, or any other topics that would impede a connection with the patient, or could make them feel judged or ashamed (Politi, Clark, Armstrong, McGarry, Sciamanna, 2009).

Moreover, Developing and using language that puts women at ease is also helpful in building trust. For example, postmenopausal women do not consider "vaginal atrophy" a suitable term for vaginal discomfort (Nappi, Kokot-Kierepa, 2012; Simon, Kokot-Kierepa, Goldstein and Nappi, 2013). Using plain language, props, and/or illustrative aids, and describing sexual anatomy and physiology in simple terms may help to make the explanations clearer (Andrews, 2000). A survey among women aged between 40–75 years old found that women were more likely to discuss sexual health when the HCP did not make assumptions and appeared non-judgmental (Politi et al, 2009).

Overcoming time constraints. To overcome time constraint issues, HCPs can be trained on time-saving strategies that can be implemented at various stages of the initial office visit. A practical suggestion is to first take a sexual history using open-ended questions (as opposed to "yes/no" questions), which can convey a great deal of information in a relatively short amount of time (≤ 5 minutes). In addition, HCPs can use pre-formulated questionnaires, such as the decreased sexual desire screener, meant to facilitate the diagnosis of female sexual dysfunction when clinician-patient time is limited (Clayton, Goldfischer and Goldstein, 2013). Also, Clinicians could consider questionnaires before seeing patients in the office to save time; however, follow-up on the questionnaire during in office, clinician-patient interaction is critical, as not all patients are comfortable with providing written documentation on this sensitive subject. HCPs should also address the most important topics that can be covered in a limited amount of time. Instead of feeling pressured to cover it all in one visit, they should convey to patients that their sexual health is important and encourage a follow-up appointment that focuses solely on sexual health concerns. As well as, providing written information for patients to review may help facilitate a patient's return visit.

-Making the most of medical intake forms. In addition to sexual health being addressed in routine medical history, other strategies to assess sexual health concerns include adding prompts in the electronic medical record or including sexual health questions on medical intake forms (Politi et al, 2009). Although some women may be concerned that inclusion of such information in an electronic record violates their privacy, they should be reassured that such information is kept secure and confidential, and only accessible by their health care providers.

-Educating and empowering patients

In addition to offering education to HCPs, women themselves should be better educated and empowered to discuss sexual health. Educational tools explaining normal anatomy, biological and etiological factors, and sexual response, as well as possible causes of dysfunction, should clear up misconceptions and emphasize that sexual health-related conditions are common, real, and curable. In addition, providing women with easily available educational materials in the office also demonstrates a HCP's comfort and awareness of sexual health treatments. A recent international survey found that nearly half of menopausal women with vaginal discomfort would have liked information or a pamphlet on the topic to help decide whether to consult with their physician about it (Nappi and, Kokot-,2010). Moreover, better information, resources, and tools can help women to believe that sexual health is a critical part of their overall health and well-being and should be regarded with importance similar to other aspects of health. When patients are empowered this way, they may feel more competent to manage their own health and may be more likely to follow through with treatment (Bober, Reese and Barbera ,2016).

IV. Conclusion

Sexuality is a basic human right and fundamental part for quality of life. Certain barriers can hinder nurses to discuss female sexual issues in nursing practice such as values and beliefs present in society related to sexuality, characteristics of the organization of the nursing work, as well as, characteristics of the nurses itself. It can be concluded that nursing care routines requires changes in the health system and the work dynamic to integrate holistic care, addressing female sexual issues in nursing care practice in the Egyptian context, as well as, nursing team must be more aware of the issues faced by women during her reproductive cycle . Educating women, training HCPs, and providing communication tools to HCPs can facilitate effective dialog between patients and HCPs. More Specifically,

HCPs can be trained to initiate and maintain a sexual health conversation in a manner that is comfortable for women to convey sexual health needs and concerns, and for HCPs to correctly identify, diagnose, and treat the sexual problems of their female patients.

V. Recommendations:

Based on the findings of this study, the following are recommended:

- 1- Nurses felt less confident in discussing sexuality issues with patients. So, more training related to sexuality care is needed, especially in equipping nurses with necessary communication skills.
- 2- Exploring the importance of sexuality issue discussion from patients' Perspectives.
- 3- Sexual education is needed in basic nursing education to equip nurses with the relevant knowledge and competent to discuss sexuality issues for women.
- 4- Developing an evaluation tool that involves sexual history taking as part of nursing practice within clinical settings.

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