Middle-Aged Iranian Women's Accounts of Their Sexual Health Care Practices: A Conventional Content Analysis

CONTEXT: *Little research has been done to examine sexual health care among middle-aged women, particularly in developing countries that are socioculturally conservative, such as Iran.*

METHODS: *In 2015, as part of a descriptive qualitative study, face-to-face interviews were conducted with 17 women aged 40–65 residing in Golestan Province, Iran. Graneheim and Lundman's approach to conventional content analysis was used to interpret the sexual health care narratives of the women.*

RESULTS: *Sexual health care for middle-aged Iranian women often took the form of self-care to preserve their privacy and confidentiality, and in general, any information on sexual health was appreciated. Data analysis identified three main categories of strategies for sexual self-care: sexual risk protection, prevention of sexual problems and undesirability, and sexual information seeking. Also, sexual self-care emerged as the central theme.*

CONCLUSIONS: *To meet the needs of middle-aged Iranian women, health care providers should become familiar with such women's sexual health care and self-care practices. Socioculturally sensitive policies and interventions should be developed to improve the sexual and reproductive health care conditions of middle-aged women.*

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Sexual health, according to the World Health Organization's current definition,[1] goes beyond considerations of dysfunction and disease to highlight the importance of a positive approach to sexuality that respects the sexual rights of all people. Individual and social changes affect a person's sexuality throughout their lifetime, including during midlife. Although people of all ages have the right to obtain sexual health care services, in general, the sexual health needs of middle-aged women in developing countries are ignored or are met less often than those of others.[2,3] This occurs, in part, because of neglect by health care providers and the commonly held belief that sexual impairment is a normal part of aging.[4] Hence, most middle-aged and older people prefer to remain silent about their sexual problems or to seek self-help therapies.[5]

Results from the Global Study of Sexual Attitudes and Behaviors indicate that most people middle-aged or older with at least one sexual problem do not seek medical help for their problems.[6] Although no gender differences were found in help-seeking behaviors, considerable variation existed across country clusters. For instance, compared with people in other countries, people in Southeast Asian and Middle Eastern countries more often sought the counsel of clergy and religious advisors for sexual problems.

Religious beliefs influence sexual practices, including the type and timing of sexual activities, as well as the number and gender of partners.[7] For example, according to Islamic jurisprudence, marriage is considered to be the starting point of sexual activity, and every extramarital relationship is a sin; however, religious beliefs do not guarantee abstinence before or after marriage.[8] In Islamic countries, particularly in the Middle East, religious beliefs have been found to influence access to sexual health services, choice of source for consultation and treatment, and individuals' approaches to their sexual problems.[7,8] Decisions on these matters have the potential to negatively affect an individual's quality of life,[9] which highlights the salience of religious belief.

Although Iran's health care system has achieved some success in certain aspects of sexual and reproductive health care, such as family planning, the system has some shortfalls, including insufficient official sexual health services and education.[10,11] Sexuality among Iranian women is strongly influenced by an androcentric perspective: In marital relationships, women are mostly task oriented and silent;[12] shame and modesty are perceived as an integral part of femininity.[13] This sociocultural condition is enhanced by the lack of sexual health services and education.

The high levels of taboo and stigma related to female sexuality—especially among middle-aged women[3] in countries such as Iran—make research about women's sexual health care in these areas a priority. Few studies have examined how women preserve and promote their sexual health as they age in socioculturally conservative contexts.[14] Furthermore, most of the existing research was conducted in developed countries,[15] used quantitative methods and focused on sexual dysfunction.[3,15] Given the increased mean age of the world's population[16] and the importance of sexual issues among aging individuals,[3] greater exploration of the sexual experiences of middle-aged women is warranted. Findings from such research

can be used to devise strategies and interventions to improve middle-aged women's sexual health.

Sexuality is multidimensional by nature, and has a complex interconnectedness with such social categories as gender, age, social class and ethnicity; thus, examining it requires taking an intersectional approach.[17,18] Intersectionality is central to the study of sexuality because it accounts for the mutually constitutive relations among social identities, including gender.[19] Likewise, the study of individuals' experiences and the meanings of such complex socioculturally constructed topics as sexuality calls for a naturalist approach, which explores people's understanding of their reference framework and the reality they experience.[20] With such an approach in mind, this study aims to explore middle-aged women's experiences with and accounts of sexual health care within the Iranian cultural context.

METHODS

Study Setting and Participants

The study was conducted in Gorgan, the capital of Golestan Province. Golestan is located southeast of the Caspian Sea and encompasses 2% of the country's total population (1,777,014 people).[21] Although the vast majority (98%) of its residents practice Islam, the region is home to members of more than 10 ethnicities, including Mazandarani (Tabari), Turkmens and Sistanies. The aim of the current study, however, was not to compare the meaning of sexual health care across ethnicities. Moreover, the sampling strategy in qualitative research is not based on the need for generalizability of the findings, but aims for deep understanding of the concepts and phenomena.[22] Therefore, because the main researcher had lived in Gorgan and had worked in health centers throughout the city for approximately seven years, the city was chosen as the study setting in hopes that this familiarity would facilitate communication with participants and make interviews more feasible.

In Golestan, as in the other provinces of Iran, health care and public health services are provided through a network of health centers—peripheral sites that provide primary health care free of charge. Most people have a family health record and code at the health center nearest to their residence that enables them to receive services such as immunization and prenatal care.[23] All of the women who participated in this study had a medical record in the public health centers of Golestan University of Medical Sciences in Gorgan. However, health record numbers were not used in the participant selection process.

For this descriptive qualitative study, we used a purposive sampling method with consideration of maximum variation to recruit middle-aged women (aged 40–65). There is no agreement in the literature about the age of midlife;[24] however, it is most commonly considered to be between the ages of 40 and 60 or 65.[2] To be included in the study, the women had to live in Golestan Province, speak Persian, and be willing and able to talk about their sexual experiences. Because midwives are the health care providers with whom the women are most familiar, four midwives from three health centers invited eligible women to participate in the study. A midwife contacted the selected women by phone, explained the aim of the study, and coordinated the time and place of interviews; participants chose the location of their interview, which included a private room at Golha Health Center (located near the city center), a participant's home and a park. All of the women who were invited participated in the study. A written informed consent form was obtained from participants prior to the interviews. The study was approved by the Ethical Board of the Shahid Beheshti University of Medical Sciences in Tehran, Iran.

Data Collection

Data were collected between May and October 2015. Face-to-face semistructured interviews were held with 17 middle-aged women; we believed face-to-face interviews would provide a safe environment in which to speak about private and taboo topics, such as sexual issues. All interviews were conducted in Persian by a female doctoral student in reproductive health who was also a midwife; Persian was the first language of the interviewer and of all but three participants, who were nonetheless fluent in it. The interviewer used strategies to foster the participants' trust, such as being introduced to them by the midwife who had recruited them, ensuring them of the confidentiality of data collection and describing the aim of the study to them. All participants were interviewed once. The interviews were tape recorded, and lasted 30–90 minutes (average duration, 60 minutes).

During the interviews, participants were asked "Will you share your experiences of your marital life?" "What are you doing to have better sexual experiences?" and "What do you do when you face a sexual problem/concern?" The interviews proceeded on the basis of the participants' answers, and probing questions were asked to get them to expand on their thoughts and increase the depth of interviews. During the interviews, the interviewer took field notes about participants' demographic characteristics, reactions, tone of speech and body language, and keywords about the interview.

Data Analysis

Graneheim and Lundman's approach to conventional content analysis guided the analyses.[25] In keeping with this approach, the first author listened to all interviews several times to obtain a sense of the whole and then transcribed them verbatim. We then reviewed the interview transcripts and coded them. MAXQDA 10 was used for saving and organizing data.

Data collection and analysis ran concurrently. Words, sentences or paragraphs from the participants' quotations that contained important data about the study topic were selected as meaning units. Next, we condensed the meaning units, and labeled them with codes. Two authors

agreed on the method of coding and organizing the data, and the other two confirmed the process and findings. In cases of disagreement, discussions and clarifications continued until a consensus was reached. We continually assessed the codes to determine their conceptual similarities and differences; the integration of similar codes led to the development of subcategories. Data reduction throughout the analysis process helped the development of categories. Finally, the review of categories, subcategories and codes resulted in the development of the study's theme. After data analysis, the findings and quotations were translated from Persian into English by two bilingual academicians.

Rigor

The trustworthiness of this study was established according to Lincoln and Guba's criteria: credibility, dependability, confirmability and transferability.[26] To increase credibility, the interviewer continuously reflected on the quality of each interview, and we conducted interviews until data saturation was achieved to ensure the appropriate sample size. Also, member checks were done on the contributions of two participants. The dependability of the data was maintained through accurate documentation of the steps taken for the study. To ensure confirmability, an audit trail was performed by researchers familiar with qualitative research methodology on some parts of the transcripts, along with codes, subcategories and categories; also, appropriate quotations were provided. Transferability was improved by maximizing variation in sampling, providing suggestions for future research, determining limitations of the study and confirming the findings with eight middle-aged women who did not participate in this study.

RESULTS

Participant Characteristics

The mean age of the participants was 50.2 years; nine women were aged 40–49, five were 50–59 and three were 60–65 (Table 1). Most were married; one participant was single, and two were divorced. The participants' mean marital duration was 26.5 years (not shown). Eight women were postmenopausal.

TABLE 1. Selected characteristics of women aged 40–65 participating in a qualitative study on sexual health care, Golestan Province, Iran, 2015

Characteristic	(N=17)
Age	
40–49	9
50–59	5
60–65	3
Marital status	
Married	14
Single	1
Divorced	2
Education level	
<high school	5
High school	8
≥university	4
Menopausal status	
Early menopausal transition	7
Late menopausal transition	2
Postmenopausal	8
Employed	
Yes	5
No	12
Ethnicity	
Turkman	2
Turk	1
Kord	1
Fars	13

Note: Early menopausal transition is defined by a variation in normal cycle length of ≥7 days, late menopausal transition by at least two delayed cycles and an interval of amenorrhea ≥60 days, and postmenopausal transition by the cessation of menses for at least 12 months (*source*: Soules MR et al., Executive summary: Stages of Reproductive Aging Workshop [STRAW], *Fertility and Sterility*, 2001, 76(5):874–878).

TABLE 2. Subcategories, categories and theme resulting from the conventional content analysis of qualitative data from middle-aged Iranian women

Subcategory	Category	Theme
Personal hygiene Harmful sex avoidance Actions to prevent STIs Reproduction-related care	Sexual risk protection	Sexual self-care
Testing and treatment of sexual problems Home remedies and diet modification Religious-based psychological strategies Beautification and body restoration	Prevention of sexual problems and undesirability	
Information seeking from formal sources Information seeking from informal sources	Sexual information seeking	

Qualitative Findings

Data analysis led to the development of three main categories of strategies for sexual self-care: sexual risk protection, prevention of sexual problems and undesirability, and sexual information seeking. Overall, sexual self-care was identified as the main theme of this study (Table 2).

Sexual Risk Protection

Participants followed a variety of preventive and preservation interventions in sexual health–related matters. Subcategories under this category were personal hygiene, harmful sex avoidance, actions to prevent STIs and reproduction-related care.

• *Personal hygiene.* Participants considered personal hygiene to be an important part of sexual vigilance and protection. Preventing infections (other than STIs) and feeling clean were the most commonly cited reasons women gave for personal hygiene. Examples of personal hygiene included washing and drying the urogenital zone, changing underwear, and shaving pubic and underarm hair. Some participants used condoms to have a clean sexual relationship. For example, a 43-year-old who had been married for 25 years explained "I've used a condom for the past 10 years, just for personal hygiene."

Following Islamic commands was another reason for personal hygiene. The women emphasized one such

command, *ghusl* (washing the body), as the most important hygienic practice related to sex. Most participants knew that such practices were established on the basis of confirmed or suspected disease prevention, and all adhered to them. According to a 52-year-old who had been married for 32 years, "God said to us that after having sex, take a shower. You know that washing the genital areas after sex prevents diseases."

• *Harmful sex avoidance.* Although a few women mentioned that they had experienced vaginal sex during menstruation or anal sex, all of them believed that such sex was wrong and potentially harmful. This belief was somewhat based on religious teachings, as one participant explained:

"There is definitely harm and because of this, Islam said that during menstruation sex is forbidden. It's unlawful, and we shouldn't have intercourse at this time."*–52 years old, married 32 years*

Women also abstained from anal sex and sexual activity during menstruation because of complications expected from anal sex, such as pain, fissure, gas and fecal incontinence; suprapubic pain from vaginal intercourse; and infections from both. A 43-year-old who had been married for 23 years said "Because my husband asked me for anal sex, we tried it once, but as it was so painful, I don't want to try it again."

Pain was perceived as the most significant symptom of harmful sex. When faced with pain, women tried to find a way to prevent or decrease it. For instance, some women used natural lubricants, such as water or saliva. As one participant said:

"When you get older than 50, your body, hormones and all of your members...weaken, and as a result, your womb's orifice gets dry and sex is disturbing for both woman and man. It came to my mind to use cooled boiled water to lubricate and wet my genitalia when I had sex. It was helpful to some degree."*–60 years old, married 40 years*

Women's avoidance of harmful sex also depended on their ability to negotiate with their husband about things they considered risky, unsafe or unpleasant in sex. As one of the participants said:

"Following natural [vaginal] delivery, I had some sutures [from an episiotomy] that got painful during sex. I told [my husband] what kind of thrusting bothered me. Now he knows and doesn't do anything that makes sex painful."*–43 years old, married 23 years*

If the women were not successful in negotiating with their partner, they used other strategies to help them avoid sex. Some women made excuses, saying that they had a headache or were too old for sex; others changed the time or place that they slept or their style of clothes, or stopped wearing makeup at home.

One participant described her unsuccessful negotiation and its outcome:

"At the beginning of my marriage, I told [my husband] I need more caressing and hugging than sex, but he always wants to do his job [sex] harshly multiple times every night. Therefore, I always sleep in pajamas and never wear lingerie [to avoid arousing husband]."*–57 years old, married 35 years*

• *Actions to prevent STIs, including HIV.* Only one participant (whose spouse had another wife) knew that she might be at the risk of STIs; all others assumed that they and their husband were protected because they were in a committed relationship. One participant said:

"Well, if I have no sex with any man except my spouse, [then] I am sure that I am healthy; well, a strange man may have HIV or AIDS or other diseases that no one knows about [but] him. My husband is not such a man that has relationships with others and hurts me in this way, so there is no reason to be concerned about sexual diseases." *–45 years old, married 27 years*

Some women did try to prevent STIs, but their interventions were based on personal judgments. For example, a 46-year-old participant who was married for 23 years to a man who had another wife said "one reason that I am satisfied with...withdrawal as contraception [is] because I think that it may be useful for HIV prevention."

Also, women considered their spouse's hygiene as an essential element of STI prevention. A 65-year-old participant, divorced after 35 years and then remarried 10 months prior to the interview, declared "I wish my husband changed his underwear [more] frequently; this is for myself...because he has sex with me and diseases can be transmitted to me."

• *Reproduction-related care.* Some women mentioned that the consequences of vaginal delivery—such as pelvic organ prolapse, vaginal laxity, episiotomy scarring and anal sphincter impairment—had undesirable effects on their sexual relationships. For example, episiotomy scarring or anal sphincter problems stemming from childbirth forced them to choose more comfortable sexual activities and positions. For example, a 43-year-old participant married for 23 years commented:

"I heard [anal sex] causes anus laxity and I had sphincter laxity before, after my first childbirth, and had so many difficulties, such as incontinence, for a year. I never think about [anal sex] any more."

Some participants believed that one of the advantages of a cesarean section was a tight vagina, which they believed made them more attractive to their husband. One participant remarked:

"I feel that women with a history of vaginal delivery have [a] wider womb and men do not like it. Personally, I think I am better than others because I had cesarean childbirth."*–46 years old, married 23 years*

Prevention of Sexual Problems and Undesirability

For the prevention of sexual weaknesses or diseases and improvement of sexual relationships, most women sought testing and treatment for sexual problems, home remedies and diet modifications, religious-based psychological strategies, and beautification and body restoration.

• *Testing and treatment of sexual problems*. Pain during intercourse was perceived as an obstacle to sexual enjoyment that motivated some women to visit a doctor. However, some participants did not consult health care providers because they considered their symptoms to be normal experiences. For example, a 43-year-old participant who was married for 21 years said "Perhaps, I have a problem, but think that it is nothing; it's a natural state, so I didn't do anything."

Most women had undergone at least one Pap smear test while married as a way to have confidence about the health of their reproductive organs. Of those, however, only a few had been tested regularly and knew about the importance of the test for cancer screening. For example, a 43-year-old participant married for 23 years stated "I did [a] Pap smear test...but I did it many years ago."

Many of the women identified breast health as an important part of a good sexual relationship with their spouse, but only a few had undergone a clinical breast exam or mammogram. Experiencing symptoms or having a spouse suggest they take care of their health caused some women to seek screening tests or treatment. One participant commented:

"When my breasts got painful and tender, I was referred to sonography and mammography to remove my breast issues. You know that [breasts] are so important to men." *–43 years old, married 25 years*

A 43-year-old participant who was married for 23 years stated:

"I had discharge from my breasts but I didn't notice [it]. My husband noticed...and advised me to go to a doctor to find [out] the reason. After that, I [was] referred to the hospital [to] check my breasts."

Sometimes, the comments of others dissuaded women from seeking treatment. One participant who had pelvic organ prolapse said:

"I told my friend...'my prolapse is severe, should I go for surgery?' She told me 'don't do that because [the surgery] has a lot of complications.' Thus, I didn't go to restore the prolapse."*–57 years old, married 42 years*

• *Home remedies and diet modifications*. Herbs and foods were the most popular home remedies used by women to prevent menopausal symptoms, sexual dysfunction and diseases of the sex organs, and to improve their sexual relationship. As one participant explained:

"When I feel pain or inflammation in my womb, I use [herbs]. I believe in [herbs] and use them a lot. For example, I take [a] sitz bath with white vinegar, marshmallow or the water of peas."*–60 years old, married 40 years*

Some participants used herbal remedies to increase their sexual desire. As one participant said:

"I take [herbs] now, I drink fumariaceae [essence] and cichorium [essence] and tribulus terrestris [essence] and willow [essence]. All of these are useful for the marital relationship."*–57 years old, married 42 years*

Some participants reported being able to control menopausal symptoms by excluding such foods as garlic and chili from their diets and replacing them with flaxseeds, sesame seeds and celery seeds. This approach helped them to enjoy the positive effects of menopause in their sexual relationships. As one participant commented:

"I believe that menopause improves the [sexual] relationship because I have no concerns about pregnancy anymore. Although hot flashes and sweating are annoying, I can manage these symptoms by adding flaxseed to my meals, and it [is] so helpful."*–51 years old, married 26 years*

• *Religion-based psychological strategies*. Some women used their religious beliefs to inform their management of sexual concerns. They mentioned talking to God and praying to handle uncomfortable feelings and thoughts. For example, a 45-year-old participant married for 27 years stated "Once I got so upset due to my husband's asexuality [that] I looked up to the sky and cried and just spoke to God. After that, I felt peaceful."

Religious instruction about women's sexual obedience had a prominent role in relieving the participants' mental distress. One participant commented:

"When [my husband] came close, I was unwilling [to have sex]; perhaps I was rather modest and timid. However, I reviewed and repeated Imam Ali's narration 'if a woman was on a camel and her husband requested for sex, she should obey.' It seems that I [have become] better now."*–43 years old, married 21 years*

• *Beautification and body restoration*. Face beautification, breast shaping, pelvic organ prolapse repair and vaginal tightening were considered by most participants to enhance attractiveness. One participant, a 51-year-old married for 26 years, explained "The day I'm going to have sex with my husband, I use [a] jelly for breast tightening, because men don't like loose breasts."

Another participant, who suffered from pelvic organ prolapse, stated:

"Men like [a] more contracted [vagina], more youthful women; therefore, I take a sitz bath with vinegar prior to... sexual relations so that [my vagina] gets tighter."*–57 years old, married 42 years*

One of the most important reasons that motivated women to care about their appearance and being attractive was the prevention of extramarital affairs. One participant stated:

"It's a male creature that has more sexual need, so if women don't care about their beatification and dress up, and [aren't] ready to have sex whenever their men ask, [men] would easily start new relationships with other women."*–42 years old, married 5 years*

Sexual Information Seeking

Seeking information about sexual matters from direct or indirect sources was one of the most important dimensions of sexual health care for participants in this study. Women tended to heed commonly known sexual information without consulting an expert. Most mentioned that they have paid attention to any sexual talk that they have

heard since marriage (which, for some, occurred while they were in puberty) and that they continue to do so in midlife.

Participants tended to pay more attention to information from informal sources than from formal ones. Examples of informal sources include friends and close relatives, husbands, illegal social media (banned by the government), sexual self-discovery and personal sexual experiences. A 45-year-old participant married for 27 years described how she became familiar with sex via pornographic movies: "I know all kinds of lovemaking, [my husband] taught me by showing me porn videos."

One participant described her sexual self-discovery as follows:

"Gradually, I [asked] myself 'why do I not get an orgasm? Why [does] just [the husband] get an orgasm?' After that, I searched myself to find which part of my body is sensitive...where is my body excitable? [Everybody] should find her own sensitive zones in her own body."*–42 years old, divorced*

We considered books, magazines and medicine brochures; TV and radio programs; health workers; and religious experts as formal resources of sexual information. A 65-year-old participant who was married first for 35 years and then for 10 months said "I have learned a lot from TV programs, most of them from the TV show entitled *Samt-e khoda* [In the Light and Line of God]." Another participant, who was 45 years old and had been married for 27 years, stated "Most of the time, I agreed with my husband's sexual requests except once–he asked me [for] anal sex. I rejected his request because [a midwife] told me that it is a bad thing."

DISCUSSION

The major finding of this study was that, in the context of Iran's Muslim and patriarchal society, sexual health care for middle-aged women often takes the form of self-care. Sexual self-care was revealed as the main health action taken by Iranian middle-aged women to manage their sexual issues. This approach sometimes promoted and maintained sexual health, but sometimes it contributed to dysfunction.

In this study, sexual self-protection among middle-aged women was most often informed by their religious values. Ghusl was considered to be the most important hygienic practice for sex. According to Islamic doctrine, the woman's discharge during sex and the man's discharge during ejaculation necessitate ghusl for both partners. Being clean is essential for certain religious duties, such as praying and fasting,[27] and ghusl is considered to be not only a cleansing of the body but also a way to achieve a feeling of purity.

According to the Quran, anything that is harmful to humans is forbidden. Also, in a study conducted in Australia, Muslim Iranian women reported that they considered vaginal sex during menstruation and anal sex forbidden sexual practices.[28] In the current study, most of the participants cited Islam's teachings when they described avoiding vaginal intercourse during menstruation and anal sex. Other studies from Iran and the United States have found that nonvaginal sex, especially anal intercourse, and vaginal intercourse during menstruation were not popular among women.[11,29–32] According to a U.S. study that used data from the 2009 National Survey of Sexual Health and Behavior, the maximum frequency of anal sex reported by women was "a few times per year to monthly"; this frequency was reported by fewer than 10% of middle-aged women.[30] In a study from Iran, the form of nonvaginal sex most frequently requested of wives by their husband was anal sex–57% of women had received such a request, and half of them accepted it.[29]

In the sociocultural context of Iran, the male is the initiator, the manager and the decision maker in sexual relations; the female, most often, is the silent acceptor.[11] However, it seems that women may sometimes avoid an undesired sexual act by turning to religious teachings. When women do not have enough power to protect themselves, their reliance on religious doctrine may provide some safety.

In general, married women perceived sex to be harmful if they felt pain or discomfort, or if the act was not in compliance with religious teachings. These factors persuaded participants to adopt such protective strategies as avoiding sex, negotiating with their spouses and making excuses. When describing ways to improve sex, some participants indicated that lubrication was a way to increase sexual satisfaction; however, the use of noncommercial methods–such as boiled water and saliva–was considered, even by those with a serious need for lubricants. These attempts highlight women's efforts to seek solutions while maintaining privacy in the context of silence on sexual matters.[13] Unfortunately, these strategies also indicate women's limited access to information and new products required for healthy sexual relationships.[33]

Women chose sexual self-care strategies on the basis of their assessment of their sexual affairs. Although the participants tried to negotiate with their husband to avoid sexual acts that they perceived to be damaging or unpleasant, failure to persuade their husband forced the women to use pretexts, such as being sick or too old, to reject their husband's request. Also, some women would avoid fixing themselves up or wearing provocative clothing, in an attempt to avoid arousing their husband. As in the current study, most married women aged 23–45 in a qualitative study in Iran mentioned making excuses as a way to say no to their spouse's request.[11] These strategies suggest that middle-aged women operate covertly for sexual self-protection.

Perceived risk of STIs was low among the vast majority of participants. Epidemiological studies on the prevalence of STIs in the general population of Iran are limited and inconsistent.[34] After drug injection, sexual contact is the second-most prevalent route of HIV transmission in Iran (67% and 18%, respectively).[35] Also, in an Iranian study by Yari et al.,[36] spousal infidelity was reported by 13% of women aged 15–75. Contradictorily, cultural and religious

taboos about extramarital sexual relationships in Islamic countries have resulted in married people not knowing themselves to be at risk of STIs, including HIV.[37] Although the preventive role of marriage in the spread of HIV cannot be underestimated,[38] the potential impact of extramarital relationships must be acknowledged. Therefore, at the very least, everyone should know the potential risk factors and routes of transmission for STIs, as well as possible STI symptoms and prevention methods. The assumption of marital commitment is not a good reason to not have information about STIs. Any reduction in the spread of HIV requires both increasing individuals' perceived risk for STIs[39] and rectifying their false beliefs.[40]

As was the case with STIs, cancer screening tests were not taken seriously. A lack of awareness and motivation were the reasons for low perceived risks for gynecologic cancers.[41,42]

Because of the silence on women's sexual health caused by cultural sexual scripts, help-seeking behaviors for sexual problems were mostly hidden, and women did not pursue standard screenings and checkups. As shown in other studies, information was found from such informal sources as spouses, relatives and friends.[5,13,43] A qualitative study showed that women in Taiwan handled midlife changes with self-management and self-medication.[43] Similarly, our participants used home remedies to relieve their sexual issues. The popularity of self-management and home remedies for the treatment, prevention and relief of symptoms related to sexual issues could result in a delay in diagnosis and cure, and have adverse effects on women's health. Altogether, the way that the women dealt with sexual problems is in line with the phenomenon of silence found in Iranian women's sexual interactions.[13]

Participants perceived that the attributes of a young woman—a tight vagina and firm, well-formed breasts—were attractive to their husband and having them improved their self-confidence. Some women attempted to restore impairments by using home remedies or undergoing surgeries. The aim of body restoration was mainly to satisfy men's desires and prevent extramarital affairs. These findings are consistent with those of Azar et al. that suggested middle-aged Lebanese women perceived sexuality as a symbol of femininity and youthfulness.[14] Similarly, Slevec and Tiggemann reported that aging, anxiety and the desire for attractiveness encouraged middle-aged women in Australia to undergo cosmetic surgeries.[44]

The right to access sexual information is fundamental to sexual health.[1] However, access to sexual health information and education is limited in Iran. Therefore, women seek information from various sources, especially peers.[45] Given the shadow of silence in sexual relationships, the restrictions imposed on sexual health information and the lack of sexual education, any information on sexual health was appreciated by the women in the current study. In a study on the sexual rights of Iranian married women, Janghorban et al. found that after unsuccessful sexual negotiations, women sought help and sexual information from various sources, including their female family members, friends, social media and their health care providers;[13] however, health professionals were not considered to be a helpful source because of the women's perceptions of their low levels of sexual health education skills and competencies, as well as the women's shame over discussing their sexual issues.

None of the participants had used the Internet as a reliable source for receiving sexual health information. This may be because this technology is rather new to Iran, and few middle-aged people have the knowledge to search websites for answers to their questions.[46]

Limitations

The limitations of this study include the women's unwillingness and shyness to talk about the sensitive topic of sexual relationships. Women's reluctance to talk about these issues meant that sometimes they spoke in complicated and confounding ways. In these situations, the interviewer attempted to clarify the conversation by asking questions and giving feedback to the participant. Having an interviewer who was the same sex as the participants and also a midwife helped to facilitate the conversations, because Iranian women trust and respect midwives as their and their babies' main health care providers. Interviewing in a private place and starting with reproductive health history-taking as an icebreaker helped the interviewer create an environment in which the participants were able to talk about their experiences easily.

Also, women's experiences with menopause and its effects on sexuality were not the focus of this study. The focal point of the present study was midlife, and menopause was just a part of the findings; studies that focus on women's menopausal experiences could have more specific findings about menopause.

Implications

Given that the middle-aged women in this study rarely sought care or information from health care providers and often practiced self-care, it is necessary to facilitate their access to accurate and timely sexual health care and information. For instance, sexual self-help or self-care educational products—such as books, films and TV programs—could improve women's sexual health knowledge, attitudes and practices. In addition, to develop and implement sexual health–promoting behaviors and to provide services that are based on unmet needs, health care providers need to be familiar with the culture, religion and customs that influence individuals' health behaviors. Some attention should be given to creating the appropriate sociocultural conditions that encourage sexual health–related questions from clients of all ages, including middle-aged women. Moreover, health care providers should be trained to respond to and manage the sexual problems of middle-aged women, and sexual health services should be available to all, regardless of age and reproductive capacity.

Furthermore, policymakers and program developers need to consider the sexual health needs of middle-aged women so that policies and interventions are socioculturally sensitive and work to improve the sexual and reproductive health care conditions of these women.

Conclusions

In cultural contexts such as Iran, middle-aged women most often use self-care strategies to preserve their privacy and confidentiality in sexual matters. As a result, their sexual health problems and needs remain concealed, and their use of inefficient methods to treat their issues increases. The findings of this study highlight the multifaceted social, cultural and religious aspects of sexual health care for middle-aged Iranian women—all of which needs to be accounted for in the planning and implementation of sexual health programs.

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RESUMEN

Contexto: *Se ha realizado poca investigación para examinar la atención de la salud sexual en mujeres de mediana edad, especialmente en países en desarrollo que son socioculturalmente conservadores, como Irán.*

Métodos: *En 2015, como parte de un estudio cualitativo descriptivo, se realizaron entrevistas personales con 17 mujeres de 40 a 65 años de edad, que residían en la provincia de Golestan, Irán. Se utilizó el enfoque de Graneheim y Lundman en el análisis de contenido convencional para interpretar las narrativas de atención de la salud sexual de las mujeres.*

Resultados: *En el estudio, la atención de la salud sexual para mujeres iraníes de mediana edad con frecuencia adoptó la forma de autocuidado para preservar su privacidad y confidencialidad; y, en general, cualquier información sobre salud sexual fue apreciada. El análisis de los datos identificó tres categorías principales de estrategias para el autocuidado sexual: protección contra el riesgo sexual; prevención de problemas sexuales y de carácter indeseable; y búsqueda de información sexual. Además, el autocuidado sexual surgió como el tema central.*

Conclusiones: *Para satisfacer las necesidades de las mujeres iraníes de mediana edad, los proveedores de servicios de salud deben familiarizarse con la atención de la salud sexual y las prácticas de autocuidado de esas mujeres. Se deben desarrollar políticas e intervenciones socioculturalmente sensibles para mejorar las condiciones de atención de la salud sexual y reproductiva de las mujeres de mediana edad.*

RÉSUMÉ

Contexte: *La recherche sur les pratiques de santé sexuelle des femmes d'âge moyen est rare, en particulier dans les pays en développement soumis au conservatisme socioculturel, comme l'Iran.*

Méthodes: *En 2015, dans le cadre d'une étude qualitative descriptive, des entrevues en personne ont été menées avec 17 femmes âgées de 40 à 65 ans résidentes de la province iranienne du Golestan. Les descriptions données par les femmes de leurs soins de santé sexuelle ont été interprétées par analyse de contenu conventionnelle, selon l'approche de Graneheim et Lundman.*

Résultats: *Les soins de santé sexuelle des Iraniennes d'âge moyen relevaient souvent de l'auto-traitement, pour protéger leur vie privée et confidentialité, et toute information relative à la santé sexuelle était généralement appréciée. L'analyse des données a identifié trois grandes catégories de stratégies sous-tendant l'auto-traitement sexuel: se protéger contre le risque sexuel, prévenir les problèmes sexuels et de l'absence de désirabilité et rechercher une information sexuelle. L'auto-traitement en matière sexuelle s'est du reste révélé le thème central.*

Conclusions: *Pour répondre aux besoins des Iraniennes d'âge moyen, les prestataires de la santé doivent se familiariser avec les pratiques de soins et d'auto-traitement de ces femmes en matière sexuelle. Des politiques et des interventions socioculturellement sensibles doivent être élaborées pour améliorer l'état des soins de santé sexuelle et reproductive des femmes d'âge moyen.*

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