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Addressing Sexual Health Issues, among Women in Rural Karachi, Pakistan

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ABSTRACT

This literature synthesis explores the topic of addressing sexual problems among women aged 20-39 years in rural primary health care centers in Karachi, Sindh, Pakistan, using the PLISSIT model. The study aims to provide an overview of relevant literature and highlight the importance of implementing the PLISSIT model in addressing sexual health issues in this specific population. The literature review was conducted through comprehensive searches using databases such as Google Scholar, PubMed, CINAHAL, and ScienceDirect. A total of 45 articles were selected for review, with a focus on research articles, review articles, reports, and books published within the past five years. The search strategy also included accessing relevant publications through the Aga Khan University library, resulting in the inclusion of 31 references for paraphrasing and inclusion in the study. The background section emphasizes the significance of reproductive health and sexual health as essential components of overall well-being. Sexual health is often considered a sensitive and taboo topic in rural communities, making it challenging to openly discuss sexual health issues. The literature review reveals those developing countries, including Pakistan, face challenges in addressing sexual health effectively. Limited awareness and information contribute to the prevalence of sexual problems and concerns among women. Specific educational programs, seminars, and workshops targeting rural communities are necessary to raise awareness and provide information about sexual behaviors and practices. The literature synthesis concludes by emphasizing the need for governments, policymakers, and public health authorities to prioritize sexual health as an integral component of overall health and well-being. The prevalence of female sexual dysfunction is found to be high in both developed and developing countries, including Iran. The review also highlights the marginalization and neglect of sexual health issues faced by women with disabilities. In conclusion, this literature synthesis provides a comprehensive overview of relevant literature related to sexual health issues among women aged 20-39 years in rural primary health care centers in Karachi, Sindh, Pakistan.

Keywords: Sexual health, PLISSSIT model, Pakistan

SYNTHESIS OF LITERATURE

This includes literature relevant to the study objectives. This synthesis starts with a drawing of the method of searching strategy to obtain data significant to the study topic. Google Scholar, PubMed, CINAHAL, and science direct were used as search databases. This whole chapter consists of six parts in which the first part is about sexual health and their perception globally, and the second part is about the prevalence of sexual problems among women globally, in Asia, and in Pakistan. Moreover, the third part is about sexual education, a counseling program for tackling sexual problems, while the fourth part is about the implementation of the PLISSIT model in primary health care centers, the fifth part is about a brief summary of the literature and the last part is about why my study is important and how it will contribute to the literature.

SEARCH STRATEGY

The search strategy for this study begins with the literature review parts, which directed that keyword, used in google scholar, PubMed, CINAHL, and science direct used as search databases. Research articles, review articles, reports, and books has studied. Furthermore, published and peer review journals were thoroughly searched through the AKU

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library. The searched literature filtered, recent publications about the past 5 years mostly selected reviews. About 45 articles were selected for the literature review and about 31 were referenced for paraphrase. Then finally the main body is paraphrased from the literature in a systematic way with resonating own ideas.

BACKGROUND

Reproductive health is the bodily state and function of the reproductive system as well as mental adjustment in the reproductive process [1]. Sexual health or sexuality is an integral part of health, which can be measured, in the form of sexual functioning. Sexual satisfaction and pleasure are other aspects of human life [2]. The word sexual is a taboo and a very sensitive topic in rural communities it cannot be discussed openly. People feel embarrassed to discuss health sexual health issues. Sexual right is one of the human rights and it is the protection of sexuality against discrimination, while sexual pleasure is the bodily, psychological, and emotional satisfaction derived from sexual health. Sexual pleasure can be achieved through Privacy, discussion, and safety. It is the right of every human being to acquire the highest standard of sexual pleasure in the framework of sexual rights but not to violate the human right of others [3]. The developing countries are lagging behind in the progress of sexual health even though it is internationally highlighted [1]. Limited source of awareness and information has led the sexual problems and concerns therefore Specific Educational programs seminars, and workshops, need to be addressed at the rural community level to aware rural women of Sexual behaviors and practices [4]. According to one qualitative study conducted in Taiwan among pregnant women, their study results showed most sexual problems experienced pregnant women along with stress and anxiety so the study suggested that pregnant women should be emotionally encouraged and their knowledge should be increased [5]. According to one cross-sectional study conducted in Turkey among postpartum women, the study revealed that most postpartum women have developed sexual problems and persistently sexual problems increased with their age [6]. The world association for sexual health (WAS) has recognized since 2008 that sexuality is integral to health and well-being. Unfortunately, public health is widely ignoring sexual health. Governments, Policy, and lawmakers could not addressthe complexity of sexual health. Governments should be encouraged to know their responsibilities for sexual health [7]. Female sexual dysfunction (FSD) was first composed by the international consensus development conference (ICPD) followed by DSM IV and WHO and then it is classified into four domains desire, arousal, orgasmic and sexual pain [8]. Sexual dysfunction among women is highly prevalent in both developed and developing countries s as well. According to study findings conducted in Iran sexual, health problems is extremely widespread which is about 31-51% of Iranian women [9-10]. A study conducted in the UK among women with disability, the results of the studyshowed that sexual problems, issues, and desires are worsened with margination encounters as compared to non-disabled women [11]. It is because most people considered sex and sexual pleasure for rich people rather than to be considered as a basic need for every human. Another study conducted in South Africa suggested that there is significant discrimination observed among women with disability in reproductive health clinics and that these disabled women were ignored in the context of sexuality and safe motherhood [11]. According to one study results, 91% of the patient from rural regions had sexual dysfunction symptoms while they ignored their problems because of sensitivity mostly the women aged between 19 and 26 years [12]. Ruralpeople think that sexual problem is a stigma so they cannot address their problem because of their conservative culture. A quasi-experimental study was conducted among rural postmenopausal women having sexual dysfunction problems. In the study discussion-based midwives, had intervened in their sexual problems. After the post-intervention, the results showed there was significant improvement observed for postmenopausal problems [13].

PREVALENCE OF SEXUAL PROBLEMS

Sometimes one sexual problem if not treated on time can cause another problem according to one study conducted in the USA through the Internet 23 to 29 % of women has a second sexual problem after the first [15]. Sexual problems are mostly associated with distress, and lack of enjoyment so satisfaction is related to sexual functioning [15]. The government needs to put placed health care workers at the community level for helping women with their sexual problems in order to improve the gap, advance knowledge, create awareness and allow access to family planning services in a culturally accepted manner [16]. Pakistan is a developing country, and because of its conservative culture men and women mostly ignore and remain silent when having sexual problems and reproductive health issues, they face losing when they come through these issues mostly the women feel thinking of rejection when their husbands came to know about the problem [17]. According to one global attitude survey conducted in multiple countries among women less than 19% have tried to seek health care for their sexual problems, and 39% have asked their partners to seek help and less than 9% have asked doctors in routine visits in the past 3 years, [9]. Another study conducted in 28 less developed countries, evaluated sexual function by FSFI questionnaire which showed the prevalence of sexual dysfunction is increased with age 26% in 20 to 39 years and 39% to 50 years [10]. In spite of the high occurrence of sexual problems, these issues have not been combated properly in primary healthcare centers so skills and practices should be incorporated for a better solution to the sexual dysfunctions of the problems [18].

COUNSELING AND SEXUAL EDUCATION

The WHO has suggested that sexual health should be incorporated into existing primary health centers, education by midwives and healthcare worker is the best solution to the problem. Women's sexuality is descriptive in nature and relative to psychosexual development. It is also described by their present and past sexual health status. Identifying sexual complaints through education and sexual complaints may infer the problems [19]. To protect sexual and reproductive health we need to invest in health services and education. Tunisia country had started a willing health service program for unmarried while Iran provided a valuable and culturally accepted model-like program called the premarital counseling program supporting young sexual health [20]. People have the right to choose when and how to reproduce at any stage of life but to have a safe sex life free of problems [21]. Mostly at the community level as well as in rural health centers sexual health education had widely ignored. Mostly in Pakistan Midwives, LHWs and LHVs are unskilled in counseling and education for sexual problems. Applying the PLSISIST model for reducing sexual problems is the right option to improve sexual health [22]. In a session of sexual education and counseling, attraction, perceive values, and behaviors are discussed openly. The patient should be encouraged to start the discussion openly and elaborate on their problems [23].

USING OF PLISSIT MODEL

To tackle the discussed sexual problems and concerns one of the effective models is used called PLISSIT (permission, little information, special suggestion, and intensive therapy) model, which provides a comprehensive solution to sexual and reproductive issues. In this model the midwives, LHWs, and LHVs will start open discussions with the patients who visit the primary health care center having sexual problems, then important information from the discussion will be integrated into the next care plan in the model [24]. There are many studies conducted on the effectiveness of the PLISSIT model, showing there is significant improvement observed in sexual health [25]. According to one study conducted in Korea on gynecologic cancer patients, this study evaluated the improvement in sexual function. The outcomes of this study showed substantial improvement in sexual health. The female sexual function index (FSFI) was ($p<0.001$) [26]. Hence, this study is evidence that the PLISSIT model is effective for tackling sexual problems. Another study conducted in Egypt among women with dyspareunia, the outcomes of this study showed significant mean differences in pre and post-intervention of the PLISSIT model, the score of FSFI in multiple domains for desire, arousal, orgasm, satisfaction, and for pain the ($p<0.005$) [23]. The above both studies were intervention base study, which showed sexual health, can be improved through little education counseling so sexual problems are easily treatable. According to another study conducted by Ayaz and Kubaily [27] in Turkey among patients with stoma bags. Their results showed there is significant sexual satisfaction with the implementation of the PLISSIT model [27]. Therefore, the most suggested solution for discussing and solving sexual problems is the implementation of the PLSSSIT model. Every healthcare worker needs to have a better understanding of knowledge and skills about sexual health problems. Multiple pieces of training and information can diagnose sexual problems [8]. Therefore, the above evidence has shown a suggestion for the PLISSIT model for combating sexual problems. The PLISSIT model consists of 4 levels of intervention for sexual problems; one is permission (p), little information (LI), special suggestion (SI), and intensive therapy (IT). In the first permission level initiations of a friendly discussion and trusted relationship are built up for sexual concerns, behaviors, and problems. In level two the information phase, the client will focus for increase knowledge and skills about normal sexual behaviors [29]. In the third level, specific suggestions are given to the patient for specific problems if the patient has. In the fourth level patient will refer to the specialist if there is a more serious specific problem [27]. Therefore, we hypothesized that this PLISSIT model will be in effect, adequate and achievable in primary health centers of rural regions Sindh Karachi Pakistan.

GAP IN THE SYNTHESIS

There is extensive literature available on sexual problems among women in developed countries, while less developed countries have ignored the sexual problems. In less developed countries sexual health is a taboo, and cannot be addressed openly. The government has placed sexual health at kept aside. However, there is no known research found to address the sexual problems among women in the rural region of Sindh Karachi. There is a lack of intervention for tackling problems. The goal of my study is to implement a model PLISSIT for tackling problems and my study is the best opportunity to fill the gap this will improve sexual health. In primary health care centers sexual health, education, and counseling should be encouraged.

CONCLUSION OF LITERATURE

More studies are required for further understanding of sexual problems among women in less developed countries. The word sexual health is taboo and is a very sensitive topic in rural communities it cannot be discussed openly. While Sexual right is one of the human rights and it is the protection of sexuality against discrimination. It is the right of every human being to acquire the highest standard of sexual health. We the developing countries are lagging behind in the progress of sexual health. Moreover, at the community level as well as in rural health centers sexual health education had widely ignored. Mostly in Pakistan Midwives, LHWs andLHVs are unskilled for counseling and education for sexual health problems. Therefore, using the PLSISIST model for reducing sexual problems among

women of age 20 to 39 years of age in the rural region visiting a primary health care center in Karachi Sindh Pakistan is the best approach. This can improve sexual health by educating and counseling. This model will effectively work out the sexual problems among women of rural regions in primary health care centers in Karachi Sindh Pakistan.

Authors' Information

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Authors' Contributions

Ihsan Ullah and Zohra Imran Lakhani conceptualized and designed the study. Ihsan Ullah prepared the first draft of the manuscript. Zohra Bano and Rafat Jan reviewed the manuscript several times and provided critical feedback. All authors (IU, ZIL, ZB, and RJ) read and approved the final version of the manuscript.

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Competing interests

The authors declare that they have no competing interests.

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