



## Sexual Health Services among Primary Healthcare Units in İstanbul

Asya Banu Babaoğlu<sup>1</sup>, Selma Karabey<sup>2</sup>, Ahmet Topuzoğlu<sup>3</sup>

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### ABSTRACT

**Objective:** To evaluate factors that influence the frequency and quality of sexual health examinations performed by physicians working in İstanbul primary healthcare units and to develop auxiliary strategies based on these factors that would improve sexual healthcare.

**Materials and Methods:** In this cross-sectional study, a postal questionnaire was administered to a representative group of physicians working in primary healthcare units (i.e., family health centers) in İstanbul between January and February 2007.

**Results:** The response rate was 84.9%. While 84% of the physicians questioned the history of sexual health in their patients in case of a presence of a sexual health problem, only 8% questioned even if their patients reported any sexual health problems. Major barriers in obtaining a patient's sexual health history included language and comprehension problems, lack of time, presence of the patient's mother or other relatives during the evaluation, low level of patient education, and strong religious beliefs. Forty-two percent of the responding physicians shared the opinion that their pre-graduate training provided inadequate preparation for sexual health counseling, and 55.1% did not perform such counseling.

**Conclusion:** Major advancements toward the prevention of sexual disease and improvement of the population's sexual health can be made by emphasizing the importance of sexual health in both pre- and post-graduate medical training, encouraging physicians to routinely ask their patients about their sexual health during examinations, and providing qualified consultancy services in primary healthcare units.

**Keywords:** Primary healthcare physicians, physiologic, sexuality, sexual dysfunctions, sexual disorders, sexually transmitted diseases

### INTRODUCTION

Sexuality and sexual feelings are a permanent part of life and are essential emotions regardless of a person's profession. This fact does not vary among physicians, nurses, or healthcare workers. Because of their position, physicians frequently become aware of patient or counselee sexual health problems while providing diagnostic and counseling services and treatment. Despite the complexity and importance of this sensitive topic, many healthcare workers begin their careers in patient care without appropriate education on basic sexual health. When patients tell a physician about their sexual health problem, the physician may feel unprepared and can ignore the problem instead of providing adequate care.

Sexually transmitted infections (STIs) represent an ongoing and increasing public health concern (1-3). Messages communicating "safe sex" practices have become very important following the human immunodeficiency virus (HIV) pandemic and have increased public awareness about other sexual issues and sexual health (1). Although STI incidence trended downward in 1980s and 1990s, this incidence has increased in recent years (1, 2, 4). In parallel with these findings, a study investigating sexual behaviors in Britain revealed an increase in risky sexual behaviors between 1999 and 2001 compared with that reported in 1990 (5). Sexual dysfunctions (SDs), if ignored, are problems that deeply affect human life. Exaggerated and false beliefs (i.e., myths) that are common in society may place undue emphasis on non-existent problems. In fact, sexual problems caused by these myths can be overcome by simple notifications and adequate public education (6-8).

Primary healthcare units have a critical role in public health systems. Recently, patient expectations of their healthcare providers and physician responsibilities have expanded along with the public's increased knowledge about general health. This shift in public awareness is largely because of the expanded healthcare coverage in the media and digital resources related to issues such as disease occurrence, prevention, diagnosis, and treatment methods (9, 10). Unfortunately, services such as disease prevention, public training, and patient consultancy that can improve public health, decrease health expenses, and prevent adverse side effects are not being addressed. On the contrary, therapeutic services are focused on completing busy schedules due to an insufficient number of

<sup>1</sup>Konak Public Health Center, Public Health, İzmir, Turkey

<sup>2</sup>Department of Public Health, İstanbul University Faculty of Medicine, İstanbul, Turkey

<sup>3</sup>Department of Mental Health and Mental Diseases, Dokuz Eylül University Faculty of Medicine, İzmir, Turkey

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#### Correspondance

Asya Banu Babaoğlu MD,  
Konak Public Health Center,  
Public Health, İzmir, Turkey,  
35240 İzmir, Turkey  
Phone: +90 232 248 33 10  
e.mail:  
asyabanu@yahoo.com

As poster presentation,  
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primary healthcare units per population. As a natural consequence of this situation, neither patient nor physician mentions the issue of “sexual health,” which has traditionally been considered a taboo until it eventually becomes a “real” problem. Sexual health counseling is rarely provided and is insufficient (1, 11). A 2006 report from the Sexual Education, Treatment and Research Association [Cinsel Eğitim Tedavi ve Araştırma Derneği (CETAD)] stated that in a sample representing a typical urban population, approximately half of the individuals had problems related to sexual and reproductive health (SH/RH) and that more than half of the individuals had received no healthcare or counseling. In the same report, sharing and expressing SH/RH issues was stated as the major issue; the study population placed a priority on making these issues easier to address (9).

A majority of individuals avail medical care at primary healthcare units, making them critically important places to discuss and treat SH problems (1, 12). There are few published studies on the barriers to patient–physician communication on SH in primary healthcare units. However, this information is of great importance and is required to improve SH services in the primary healthcare setting. The limited amount of data available on this subject suggests that there is a large number of communication problems in the current healthcare system.

The aim of this study was to evaluate factors that impact the frequency and quality of physician SH examinations in the primary healthcare setting. This information may help in determining the knowledge and skills related to SH that physicians currently have and the knowledge and skills that should be acquired during their pre- and post-graduate training.

## MATERIALS and METHODS

This study was approved by the Local Ethics Committee of İstanbul University, İstanbul Medical Faculty, on October 11, 2006.

This cross-sectional study surveyed a representative sample of physicians of primary healthcare units (i.e., family health centers from 2010) in İstanbul. Data were collected using a postal questionnaire distributed between January and February 2007. The responsible physicians received up to four reminder phone calls to increase the response rate. The questionnaires were distributed and responses were collected via cargo companies. Physicians provided signed consent for study participation.

The estimated sample size required for an adequate physician sampling was found to be 285 using the sample size calculations for population studies in the EPI-Info Statcalc software program. Variables were set at a confidence interval of 95%, with a 50% frequency of obtaining an SH history and a 5% variance among the 1100 physicians working at primary healthcare units in İstanbul.

One hundred primary healthcare units ( $100 \times 3.08 = 308$  physicians) were selected using a simple random sampling method to achieve the target sample size based on the assumption that each primary healthcare unit had three physicians ( $1100/356 = 3.08$ ). These primary healthcare units were located in 28 of the 32 districts in the İstanbul province.

The study questionnaire included the following topics: collection of physician data regarding sociodemographic characteristics, obtaining SH history of the patient, time allocated for each patient, frequency of diagnosis and treatment of STIs and SDs during routine practice, frequency and quality of SH examinations and counseling services, pre- and post-graduate knowledge on SH issues, factors limiting physician-patient discussions about SH, and the physician’s opinions on the early diagnosis and treatment of STIs and SDs. The questionnaire was based on a 5-point Likert-type scale, with scoring and close-ended questions.

Statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) software. The analyses performed included the Chi-square test, Fisher’s exact test, relative risk calculations, and Spearman’s correlation tests.

## RESULTS

There were a total of 335 physicians who were working at the selected primary healthcare facilities. A total of 242 questionnaires were collected, representing 84.9% of the 285 surveys distributed.

Female physicians comprised 48.1% ( $n=115$ ) of all respondents. The mean physician age was  $32.8 \pm 6.2$  years (range 23–48 years) for females and  $38.3 \pm 8.4$  years (range 24–59 years) for males, with an overall mean physician age of  $35.9 \pm 8.2$  years (range 23–62 years). Family demographics included 66.4% ( $n=160$ ) married physicians, 28.2% ( $n=68$ ) who were single, and 5.4% ( $n=13$ ) who were widowed or divorced. The mean number of years worked was  $11.4 \pm 7.7$  years (range, 1–32 years), with 16.4% ( $n=39$ ) of the physicians who had worked for  $\leq 1$  year. The mean number of work years at their current healthcare unit was  $6.9 \pm 6.5$  years (range 1–33 years). Physician marital status and the number of years of working experience did not significantly affect the frequency of obtaining a patient’s SH history ( $p > 0.05$ ).

The majority of respondents (78.4%,  $n=189$ ) reported previous employment at another healthcare facility. Among this subset, the distribution across facility types was 49.6% ( $n=120$ ) in primary healthcare units, 16.9% ( $n=41$ ) in state hospitals, 9.5% ( $n=23$ ) in workplace health units, 8.7% ( $n=21$ ) in private hospitals or polyclinics, 7.4% ( $n=18$ ) in Emergency 112 or hospital emergency departments, 7% ( $n=17$ ) in a maternal and child health and family planning center, and 0.4% ( $n=1$ ) in a skin and venereal diseases hospital. Previous work history did not significantly alter the frequency of asking about a patient’s SH history ( $p > 0.05$ ).

The primary healthcare units surveyed were located in city centers (75.4%,  $n=180$ ), towns (19.2%,  $n=46$ ), and rural villages (5.4%,  $n=13$ ). Moreover, 50%, 73.9%, and 15.4% of the physicians working in the city centers, towns, and villages, respectively, reported that they generally obtained a patient’s SH history. Thus, the frequency of obtaining SH history at facilities located in towns was significantly greater than in the other two locations ( $p < 0.001$ ).

Responses to questions on physician workload revealed that 25.1% ( $n=59$ ) examined  $< 50$  patients in a day, 63.8% ( $n=150$ ) examined 50–100 patients in a day, and 11.1% ( $n=26$ ) examined  $> 100$  patients in a day. The mean examination duration per patient was 1–5 min for 59.2% ( $n=141$ ) of physicians, 6–10 min

**Table 1.** Mean scores of the frequency of certain services related to sexual health (SH) and reproduction health (RH) and their distribution

Services (n)	Mean score	n (%)				
		Never	≤1 time a month	2-4 times a month	1-2 times a week	Everyday
Counseling on birth control (227)	3.23	25 (11.0)	44 (19.4)	54 (23.8)	60 (26.4)	44 (19.4)
Obtaining history of sexual health (225)	2.72	37 (16.4)	74 (32.9)	52 (23.1)	37 (16.4)	25 (11.1)
STI diagnosis and treatment (224)	2.64	27 (12.1)	95 (42.4)	51 (22.8)	33 (14.7)	18 (8.0)
Counseling on condom use (215)	2.59	66 (30.7)	51 (23.7)	33 (15.4)	34 (15.8)	31 (14.4)
Counseling on STIs (213)	2.21	67 (31.5)	78 (36.6)	37 (17.4)	17 (8.0)	14 (6.6)
Genital examination (218)	2.05	94 (43.1)	61 (28.0)	32 (14.7)	19 (8.7)	12 (5.5)
Counseling on happy and safe sex (214)	1.73	125 (58.4)	50 (23.4)	21 (9.8)	6 (2.8)	12 (5.6)
Cervical smear (210)	1.10	196 (93.3)	11 (5.2)	0 (0.0)	1 (0.5)	2 (1.0)

(1, never; 2, ≤1 time a month; 3, 2-4 times a month; 4, 1-2 times a week; 5, Everyday)

for 32.8% (n=78) of physicians, and >10 min for 8% (n=19) of physicians. Overall, the mean examination duration per patient was 6.8±3.8 min (range, 1-30 min; median, 5 min). As expected, there was a significant negative correlation between patient examination duration and the number of patients (Spearman's rho=-0.485, p<0.001).

Significantly more physicians asked about a patient's SH history when the patient presented with an SH problem than when no problem was presented [84% (n=200) vs 8% (n=19), p<0.001]. Physicians were also asked about specific diagnostic methods and their use in diagnosing STIs and SDs, with responses scored on a 5-point Likert-type scale (1=never, 2=rarely, 3=sometimes, 4=frequently, 5=always). The most common method of diagnosing both STIs and SDs was "obtaining history" (means scores 4.62 and 4.68, respectively). Physical examinations and diagnostic tests were used less frequently.

Physician and patient embarrassment during delivery of SH/RH services was also evaluated using a 5-point Likert-type scale for responses. Responses revealed that 75.5% of physicians were never embarrassed when discussing a patient's SH history. On the other hand, more than half of the physicians indicated that both male and female patients either always or frequently expressed embarrassment. Male patients were most embarrassed when examined by a female physician, whereas female patients were most embarrassed when examined by a male physician (means 3.81 and 3.89, respectively). A large proportion of the respondents (38%, n=91) did not provide information on their own feelings of embarrassment. Among the respondents, 80.6% (n=54) of female physicians and 71.1% (n=59) of male physicians were "never" embarrassed to discuss a patient's SH history. These responses were not significantly different (p=0.2). The frequency of certain services related to SH/RH that were provided by physicians is presented in Table 1.

The physicians were asked whether they had received sufficient training about SH and STIs and whether they felt qualified to diagnose and treat STIs. Responses were again scored on a 5-point Likert-type scale (1=definitely do not agree, 2=do not agree,

3=uncertain, 4=agree, 5=completely agree). While the physicians responded that their pre- and post-graduate trainings were mostly insufficient with respect to SH and STI "counseling" (mean scores 2.91 and 2.47, respectively), they nevertheless felt qualified to diagnose and treat STIs (mean scores 3.41 and 3.47, respectively).

The questionnaire also included a list of items that may prevent them from obtaining a patient's SH history, with each item being scored from 1 (not a factor) to 10 (a primary factor) (Table 2). The primary barrier to obtain a patient's SH history was the lack of adequate time (6.74±3.12), followed by patient language and comprehension problems (6.65±3.01). The presence of the patient's mother or other relatives during the examination (5.78±2.86) and a low level of patient education (5.34±2.84) were other important barriers (Table 2).

The potential effects of training materials on physicians obtaining an SH history were investigated by asking the question: "Which training materials related to sexual health are present in your working units?" The frequency of obtaining a patient's SH history was significantly higher in primary healthcare units that had educational and training materials such as informative posters, brochures, models and condoms than in those that did not have such materials (p<0.05). The availability of female condoms and educational videos had no significant effect on the frequency of obtaining a patient's SH history.

Finally, the physicians were asked to evaluate suggestions on the early diagnosis and treatment of STIs and SDs. Responses were scored from 1 to 10. The results are presented in Table 3. According to these findings, the physicians were aware of the importance of the SH/STI and SD, with a mean score of 8 (Table 3).

## DISCUSSION

There is a limited number of reports that have studied factors that limit patient-physician communication on SH. The lack of published data on this subject suggests that it is a problematic issue. As has been true in the past, current societal attitudes toward sexuality are largely binary. Although sexuality is freely expressed in the media, internet, entertainment industries, and daily life, many

**Table 2.** Mean and median scores for the factors causing difficulties while obtaining sexual health history

Factors	Mean	SD	Median
Lack of time	6.74	3.12	7
Language and comprehension problems	6.65	3.01	8
Presence of the patient's mother or relatives during the visit	5.78	2.86	5
Low educational level	5.34	2.84	5
Strong religious beliefs	5.05	3.03	5
Concerns about misunderstanding	4.73	3.18	5
Presence of the patient's sexual partner during the visit	4.29	2.75	5
First visit of the patient	4.10	2.65	4
Patient is a friend or relative of the physician	4.12	2.79	4
Patient is a homosexual male	4.11	3.04	4
Patient is a homosexual female	3.94	2.97	3
Patient is of the opposite sex	3.74	2.64	3
Concerns about patient's embarrassment	3.77	2.77	3
Patient is single	3.43	2.62	2
Patient is elderly	3.19	2.05	2
Patient is very young	2.98	2.41	2
Patient is widowed/divorced	2.66	2.18	2
Embarrassment to the physician	2.38	2.46	1
Patient is married	2.18	1.88	1

(1, definitely not an affecting factor; 10, always an affecting factor)

**Table 3.** Mean scores given by the physicians for some reasons regarding the early diagnosis and treatment of STIs and SDs

	n	Mean	SD
Transmission and spread to others in the population	235	9.5	1.3
Leading to poor quality of life of individuals	236	9.1	1.7
Leading to problems such as congenital infection, preterm birth, miscarriage, and extrauterine pregnancy	234	9.0	1.8
Leading to the development of secondary infections such as pelvic infection	234	8.9	1.7
Increasing the risk of transmission of HIV/AIDS because of the presence of other STIs	233	8.8	2.2
Causing infertility	235	8.6	1.9
STIs are precursors of other diseases such as depression, atherosclerosis, and diabetes	231	8.3	2.2

(1, not an important reason; 10, a very important reason)

individuals and even healthcare workers still consider it as a taboo for discussions (1, 13-15). The fact that the majority of physicians participating in the current study stated that they would not ask a question about a patient's SH when they have no SH complaints could be attributed to this situation.

Only 8% (n=19) of the responding physicians asked about a patient's SH when the patient had no related complaints. This low frequency suggests that physicians at primary healthcare units are generally not addressing SH and/or that there are many barriers related to this health issue. Similar situations have been reported in other countries. For example, one study investigated SD prevalence and characteristics in London, England and also primary healthcare physicians' ability to diagnose SDs. From 170 patients examined by their general practitioner, 35% males and 42% females reported having an SD. Among these, 70% thought that their practitioners were capable of consulting with them on this issue. However, at the end of the study, only 2% practitioners actually discussed SH with their patients (16). Another study evaluating whether Swiss physicians discussed sexuality and HIV prevention with their patients found that sexual history was not generally evaluated, particularly when patients were admitted for "usual" conditions (17).

When patient SH is in question, "obtaining a history" is the most important method to establish an accurate finding (18). In the present study, the most frequent method for diagnosing an STI or SD was "obtaining a history", followed by "physical examination" and "diagnostic tests." Not only patient complaints and symptoms but also advanced technology and laboratory methods are important for the diagnosis and treatment of infections. However, to detect STIs and SDs, particularly in asymptomatic patients, physicians should obtain a patient's SH history even if no SH problems are reported. In addition, a physical examination is essential for an accurate diagnosis. Diagnostic tests are not sufficiently used in primary healthcare units because they require experienced personnel and additional materials and costs. Therefore, the World Health Organization recommends that, when necessary, "syndromic management" should be used for patient diagnosis and treatment based on both patient history and physical examination (19).

Physicians are frequently concerned about patient embarrassment when SH is in question (20). However, this common opinion can be an unnecessary prejudice and may not accurately reflect the patients' actual thoughts. In the present study, 56.6% of the physicians stated that male patients were always or frequently embarrassed, whereas 53.8% stated the same for female patients. Similar results were reported in a Belgian study, with 43% and 39.5% of the surveyed physicians stating that male and female patients, respectively, were frequently embarrassed to discuss their SH history (1). Nevertheless, some studies have demonstrated that although many patients find questions related to SH embarrassing, they are still important for physicians to ask (1). The 2006 Sexual Health and Reproduction Health Research study in Turkey demonstrated that individuals examined by a physician for SH/RH expected the physician to initiate the conversation (9).

In the present study, 75.5% of the physicians stated that they were never embarrassed to obtain a patient's SH history. However, the

relevant question was not answered by 38% of those surveyed. Failure to respond may be because of a lack of embarrassment by the topic or because of a constant embarrassment and hesitation to admit this situation. Similarly, another study found that 18.3% of physicians were uncomfortable obtaining a patient's SH history (1). In the present study, 22.5% of the physicians reported that they sometimes or rarely felt embarrassed in this situation.

This study also found that fertility management in Istanbul was most commonly provided by primary healthcare physicians along with services related to SH/RH. "Happy and safe counseling" and "cervical smear" were performed the least. This finding is not surprising because the issue of "fertility management" is "easy to talk and not taboo" for both the physician and the patient. Moreover, Turkish medical education for primary healthcare workers has included family planning training in their curriculum since a long time. A similar situation exists in many countries, including Canada, where "contraception" was the most mentioned issue in SH/RH physician-patient discussions in primary healthcare units (20).

Verhoeven et al. (1) reported that the most common activity in SH practices was "contraception counseling" (79.5%), followed by "cervical smear" (68.8%), "safe sex counseling" (39.3%), "STI counseling" (24%), and "obtaining SH history" (12.3%). In a qualitative study evaluating barriers to SH discussions in primary healthcare units in England, majority of the physicians reported many other priorities (21). Their priorities in SH management were prevention and treatment of STIs, birth control counseling, and performing cervical smears, while SDs were considered less important (21). Although SH/RH priorities vary between primary healthcare units, physicians mainly focus on birth control counseling. This may be attributed to a simple continuation of past RH policies that targeted fertility management. Another reason could be that "reproduction" is regarded as a more safe and acceptable SH topic for discussion by the general population.

Major barriers to obtaining an SH history included lack of time, language and comprehension problems, and the presence of a patient's mother or other relatives during the examination (Table 2). Studies conducted in Belgium and the United States reported similar results; language problems, lack of time, and presence of the patient's mother during the examination were the most important barriers (1, 21, 22). In Australia, the major barriers reported were the presence of a third party during the examination, language problems, and when it is the patient's first visit to the physician (23). In another study investigating the perceptions affecting the use of prenatal and postnatal care services and health behaviors in Turkey, the majority of the women could only be examined by the physician only in the presence of their mothers or mothers-in-law (24).

Physicians and patients of different genders was less of a barrier to SH discussions, with a mean score of 3.74 (Table 2). However, 42.4% of the physicians scored this barrier as  $\geq 5$ , indicating that this potential barrier should not be underestimated. Similarly, a 2005 study found that the United States physicians also felt uncomfortable when obtaining an SH history from a patient of the opposite gender (25).

Several studies have emphasized the importance of pre- and post-graduate training on SH/RH issues for improving its awareness

and prioritization by physicians providing primary healthcare services (1, 12, 14-18, 21-23, 26, 27). A pilot study to improve RH service quality, provided by Turkish interns and specialist physicians from various areas of expertise, reported favorable outcomes from improvements in post-graduate reproduction health training (28). At the end of the study, physician communication skills had improved and SH counseling was being provided during healthcare appointments.

Providing SH awareness materials and resources such as posters, brochures, models, videos, and male condoms, in particular, greatly improved the likelihood of obtaining a patient's SH history. This outcome was particularly positive because posters and brochures are readily available and cost effective public training materials. These results are in agreement with other studies that found that access to informative materials on SH and general health, such as posters and brochures, encouraged patients to initiate SH discussions and made them more receptive to physicians discussing the topic (29, 23).

The primary healthcare physicians that participated in the current study reported that they paid quite close attention to patient SH because of various reasons (Table 3). The issues of disease transmission and spread of STIs to sexual partners received the most focus, followed by STI effects on patient quality of life; infection outcomes such as infertility, congenital anomalies, and mortality; the increased risk of HIV/AIDS transmission when other STIs are present; and STIs as precursors of some chronic diseases. This finding was quite important to improve physician-patient communication because a subject that physicians regard as important can be easily reinforced by training and result in its inclusion in daily routine practice.

Establishment of the Family Medicine System in Istanbul in 2010 has stimulated several changes in the delivery of primary healthcare services. There was a significant increase in the number of primary healthcare units, the staff of these facilities has increased, and the number of patients per primary healthcare physician has decreased. These improvements have reduced the average number of individuals per examination room in Turkish primary healthcare units and family health centers from 4575 individuals in 2008 to 3696 individuals in 2011 (30, 31). Similarly, there were 22 healthcare practitioners per 100,000 individuals in Istanbul in 2003 and 31/100,000 in 2011 (31). Referral rates from primary healthcare units decreased from 22% in 2002 to 1.3% in 2008 and 0.7% in 2011. However, the number of admissions to primary healthcare physicians increased during this time frame (31). Collectively, these changes demonstrate that primary healthcare services in Istanbul have improved in recent years.

Nevertheless, the individual right "to choose and change family physician," a component of the Turkish Family Medicine System, facilitates the development of trust between a patient and physician, better physician recognition of individual patients, and physicians obtaining a detailed patient history when necessary.

### Limitations

In the present study, an effort was made to obtain a high response rate with the objective of collecting realistic and reliable data on ex-

isiting barriers to physician-patient discussions on SH. Responses totaled 84.9% of the targeted postal questionnaire study sample size, which reinforced the validity of the study's results. However, some limitation should be considered when evaluating these results. Because the total number of physicians working in primary healthcare units in Istanbul was an estimate, the sample size calculation was based on the number of primary healthcare units. However, because the selected primary healthcare units were spread across nearly every district of Istanbul, the study sample was accepted as being representative of the total population of primary healthcare unit physicians in Istanbul. Nevertheless, the physician responses may not be fully representative. In some studies, verbal disclosures of physicians about their attitudes during the examination could differ from their attitudes in real (13).

In addition, the quality of physician questions while obtaining a patient's SH history was not evaluated. However, only examination room conditions and questioning methods were evaluated. In addition to these limitations, the present study included only physicians. However, nurses and midwives also have important roles in collecting patient SH/RH information.

The fact that marital status, working duration, and previous experiences of the physicians had no effect on obtaining SH history facilitated the evaluation of other related factors.

## CONCLUSION

Healthcare workers do not adequately address patient SH issues as part of routine medical practice. Although primary healthcare units are priority centers for the initial assessment and care of individuals presenting with an SH issue or a sexually transmitted infection, there are many factors that make it more difficult for physicians to initiate conversations with patients on this issue.

The addition of topics such as communication skills and methods for obtaining SH history to pre- and post-graduate medical training would better prepare physicians for their role in the delivery of SH care. This change would also provide an opportunity for primary healthcare units to have a significant role in the prevention and development of SH, which is an essential part of an individual's lives. Favorable developments in health delivery systems would help facilitate improvements in these services.

**Ethics Committee Approval:** Ethics committee approval was received for this study from the ethics committee of İstanbul University İstanbul School of Medicine.

**Informed Consent:** Written informed consent was obtained from patients who participated in this study.

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