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Exploring Australian midwives' experiences providing sexual health information to women in the postnatal period

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ABSTRACT

Problem: Little is known about the influences on postnatal sexual health conversations from the midwife's perspective.
Background: Women frequently experience sexual health challenges in the postnatal period. Women have stated that midwives do not enquire about postnatal sexual health challenges, and when concerns are raised, unhelpful advice is received. The lack of recognition from midwives leaves women feeling isolated, ashamed, and as though their experiences are abnormal.
Question: What are Australian midwives' experiences providing sexual health information to women in the postnatal period?
Methods: A qualitative descriptive study utilising purposive sampling and individualised semi-structured interviews to collect data from registered midwives (n=7) working across various contexts in Australia. Data was analysed using Braun and Clarke's method.
Findings: Four major themes were identified from the data: 1) The medicalisation of birth, 2) Postnatal sexual health: It's complicated, 3) In our interest but whose responsibility? And 4) Enhancing the provision of postnatal sexual health information.
Discussion: Although the midwife participants acknowledged the importance of discussing postnatal sexual health, the findings of this study highlight the various barriers Australian midwives face when providing sexual health information to postnatal women.
Conclusion: There are various influences on a midwife's ability to provide sexual health information to women in the postnatal period. The barriers of the medical system, inadequate training and professional development and an undefined role in sexual health create challenges for Australian midwives to effectively provide sexual health information.

Statement of significance

Problem

There is a dearth of research exploring the experiences of midwives providing postnatal sexual health information to women.

What is already known

Women commonly experience sexual health challenges in the postnatal period. Research exploring these challenges from the woman's perspective revealed that midwives rarely enquire about sexual health, leaving women to feel isolated and ashamed.

What this Paper Adds

This paper provides insight into midwives' experiences providing sexual health information to postnatal women and helps in identifying factors that need to be addressed to optimise practice.

Introduction

Sexual health is challenging to define however, the World Health Organization (2006) outlines sexual health as a complex biological, emotional, social, and psychological concept. The World Health Organization's concept of sexual health will be followed for the purpose of

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this study. Sexuality is essential to overall health and can contribute to quality of life, personal development, and wellbeing (World Health Organization, 2006). Sexual and reproductive health are frequently linked with components of reproductive health often taking focus (Wellings & Johnson, 2013). Whilst placing sex within the context of reproduction may be easier for some to deal with, sexual activity is more commonly recreational than procreational (Wellings & Johnson, 2013). There is increasing recognition of separating sexual health from reproductive health as increased access to contraception, abortion, and assisted reproduction has weakened the link (Wellings & Johnson, 2013). This link has been addressed with the World Health Organization (2017) publishing a framework for an operational approach to sexual health to ensure aspects of sexual health receive attention outside of reproductive health.

There may be many influences on an individual's sexual health throughout their lifespan, including physiological life cycles, hormonal factors, and physical and mental health (Darooneh et al., 2023). For women, the postnatal period is one of these significant life cycles that can influence sexual health due to many physical, psychological, social, emotional, and relational changes. A pivotal publication by Barrett et al. (2000) explored the impact of birth on a first-time mother's sexual health and found that 83% of women experienced challenges with their sexual health in the first three months after birth. However, only 15% of women experiencing these sexual health issues reported discussing their challenges with a health professional (Barrett et al., 2000). Following the publication by Barrett et al. (2000), researchers over the next decade took a one-dimensional view of postnatal sexual health, focusing on the biological aspects and, in particular, sexual function. Many of these studies utilised the Female Sexual Function Index (FSFI) and therefore, it is suggested that postnatal sexual dysfunction is over diagnosed due to the outdated model that underpins the FSFI (O'Malley et al., 2021). The FSFI is a tool often used to assess key dimensions of a woman's sexual function and to diagnose dysfunction (Rosen et al., 2000). The use of this tool in assessing sexual function is problematic as it was created using the disputed Masters and Johnson's (1966) model of sexual response which utilises a male model of sexual response with no consideration to the emotional and relational aspects of sexuality (O'Malley et al., 2021; Pines, 1968). The FSFI was not developed or validated to be used for postnatal women. It can be argued that classifying sexual dysfunction in the postnatal period based on FSFI results ignores the complexity of this vulnerable period as well as the influence of the broader context of women's lives and relationships, including the transition to parenthood on intimate relationships (O'Malley et al., 2021). This argument is not to detract from the evidence that women experience sexual dysfunction in the postnatal period but to highlight that merely focusing on postnatal sexual function to explore postnatal sexual health can be problematic. A large-scale prospective cohort study in Australia found that 89% of women experience postnatal sexual health issues (McDonald et al., 2015). These findings help to highlight the number of different sexual health problems that women may encounter in the postnatal period rather than report on postnatal sexual dysfunction prevalence, as many other studies do (O'Malley et al., 2021).

Research commonly found that women experienced dyspareunia, difficulty reaching orgasm and decreased libido and desire in the postnatal period (Barrett et al., 2000; McDonald et al., 2015; O'Malley et al., 2018). Studies exploring emotional, social, and relational dynamics of sexual health also found that concerns with body image, relationship dissatisfaction, changed priorities, depression, tiredness, increased responsibilities, differing desire levels to partner, and feelings of guilt influenced sexual health (DeMaria et al., 2019; Khajehei & Doherty, 2018; Pardell-Dominguez et al., 2021; Woolhouse et al., 2012). These findings indicate that postnatal sexual distress is multi-faceted and encompasses physical, emotional, social, and relational aspects (Dawson et al., 2020). For most women, difficulties appear transient and improve with time as the postnatal period elapses, with some women reporting persistent challenges for 12 months following birth and others even longer (O'Malley et al., 2018).

Postnatal sexual health has received little attention from midwives and other health professionals, even though considerable research illustrates the high number of women experiencing postnatal sexual difficulties. Midwives are recognised as the leading providers of postnatal care for Australian women (Australian Institute of Health and Welfare, 2022). They are vital in providing life-enhancing information to women and their families (Bradfield et al., 2022). Providing sexual health information is an essential aspect of routine postnatal care to ensure women feel knowledgeable, prepared, and empowered to manage any challenges that may arise (Darooneh et al., 2023). Therefore, midwives can be crucial in improving women's postnatal sexual health experiences and outcomes (Bradfield et al., 2022). There is a dearth of literature exploring midwives' experiences providing sexual health information to women in the postnatal period with majority of the research focusing on the provision of contraceptive information instead of sexual health from a broad perspective (Cheney et al., 2024; Botfield et al., 2021). This study was undertaken to provide insight into midwives' experience in this area, identifying and improving understanding of the factors that might be addressed to optimise practice.

The question that guided this study:

> What are Australian midwives' experiences providing sexual health information to women in the postnatal period?

Participants, Ethics and Methods

Study design

A qualitative descriptive approach was considered appropriate for this research as it gains insights from participants into a poorly understood phenomenon and offers the opportunity to discover and understand a phenomenon through rich descriptions (Bradshaw et al., 2017). Various methods can be utilised in this methodology providing it remains congruent with the research question and aim (Sandelowski, 2010). The study took place online in Australia. Ethical approval was obtained from the University's Human Research Ethics Committee (HREC 2022/375).

Recruitment

Midwives were recruited through purposeful sampling. Registered midwives currently providing postnatal care to women in any context in Australia were invited to participate through a research flyer distributed through the Australian College of Midwives e-bulletin and midwifery-related social media sites. Potential participants were provided with the participant information and consent form. Eligible participants were invited to participate in an interview on a date and time that suited the participant. Consent and confidentiality were confirmed verbally at the beginning of each interview. As the study had narrow aims, the specificity of the sample was dense, the quality of the dialogue was strong and thematic analysis involved reflexivity (Braun & Clarke, 2022), the principles of information power guided sample size (Malterud et al., 2016).

Participants

Ten midwives contacted the researcher and received the participant information sheet and participant consent form. Three midwives did not respond to the initial email. A follow-up email was sent after two weeks with no response and no further contact was made. A total of seven participants were involved in the study. The participants ages ranged from 27 to 60 years old with one participant not disclosing their age. Four of the participants had completed additional midwifery qualifications, with one completing education relevant to the sexual health discipline. All the participants identified as female, and the years of

midwifery experience ranged from five to 42 years. The models of care participants were working in ranged from midwifery group practice within public maternity care (*n*=*3*), a women's health centre (*n*=*1*) and public maternity care (*n*=*3*). One of the midwives in public maternity care also worked in a GP clinic. At the time of the study, the participants were located in rural Queensland (*n*=*1*), New South Wales (*n*=*1*), Victoria (*n*=*2*), South Australia (*n*=*2*) and Tasmania (*n*=*1*). Nearly all participants had worked in various contexts and settings across Australia earlier in their careers Table 1

Data Collection and Analysis

Individual semi-structured interviews were conducted, recorded and transcribed using Microsoft Teams, an online application. An interview guide was used to enhance consistency with flexibility afforded throughout the interviews so a natural flow could occur. Participants were allocated pseudonyms to ensure confidentiality. Participant descriptions, gestures and facial expressions, together with the primary researcher's reflective insights, were recorded as field notes during the interviews. Transcripts were read as the primary researcher listened to the audio files to ensure accuracy.

Braun and Clarke's (2022) six-phase reflexive process was undertaken during multiple readings of each transcript, as the data was coded and analysed thematically. Throughout data analysis, the primary researcher recorded and regularly reviewed a reflective journal to ensure she was aware of her philosophical and theoretical assumptions and how these shaped and informed the research (Braun & Clarke, 2022). The primary researcher's supervisors were involved in the data analysis by discussing and critically revising the transcripts, notes, codes and the themes and subthemes.

Findings

Four major themes were identified in the data '*the medicalisation of birth*', *'postnatal sexual health: It's complicated,' 'in our interest but whose responsibility?'* and *'enhancing the provision of postnatal sexual health information.'*

The first theme explores the participant's reflections on the political challenges of a technocratic and medical paradigm in the hospital system and midwifery care for postnatal women.

Theme 1: The medicalisation of birth

Barriers to midwives providing postnatal sexual health information within a dominant medical culture were illustrated by the following three subthemes.

Keeping everyone alive

All midwife participants discussed the limitations of only being able to provide basic information focused on the immediate physical needs of the woman and baby. Providing postnatal sexual health information was commonly neglected as it was felt it was unnecessary for the basic survival needs of women and their babies:

> *I'm going to prioritise the things that are going to keep you and the baby alive and hope that if your sex life is important enough to you, it is something you'll be researching* (Brooke).

A focus on contraception

When asking participants what sexual health information they discuss with postnatal women, most of the participants responded with information about contraception only:

> *you're just handing over information that can tick a box and is often limited to contraception (Megan).*

The participants' stories of the provision of contraceptive information reflected a medicalised approach. Contraception was acknowledged as an important aspect of sexual wellbeing, although there were comments such as:

> *we're worried that you're not conceiving another baby but not about you actually enjoying sex (Poppy).*

The participants commonly shared stories of the provision of contraceptive information being a conveyor belt management strategy:

> *We want to push her having a rod in her arm so she's got something when she leaves so that they can discharge her and wipe their hands and feel like, OK, cool, she's not going to turn up again (Charlotte).*

Structural Barriers

The participants described various structural barriers within the hospital system that hinder their ability to provide sexual health information to postnatal women. A common challenge raised by all participants was:

> *definitely time (Brooke).*

The participants reflected on a system structured to foster productivity and efficiency with minimal focus on providing holistic care. Staff shortages added pressure on the midwives and further impacted time constraints. The participants reflected on a task-orientated approach following a checklist for postnatal education, which often led to disengaged information sharing for discharge and continuous movement of a conveyor belt-like system:

> *I feel incredibly restricted when working on the floor in a postnatal ward in what I'm able to provide because I feel very strongly that postnatal sexual health should be a two-way conversation that comes from a holistic perspective (Megan).*

Minimal recognition from management in the hospital system was considered a barrier, and the fragmented aspect of the medical model with minimal, if any, continuity of midwifery care was also discussed. Postnatal sexual health was acknowledged as a sensitive topic that required a holistic and individualised approach, which was considered optimal in continuity of midwifery care models.

Theme 2: Postnatal sexual health: It's complicated.

The following four subthemes highlight the complex nature of postnatal sexual health, with many underlying factors influencing the provision of information

Sexual health is multifaceted

The participants discussed the many layers of sexual health: *sexual health is not just physical sex.*

> *It's multifaceted (Zoe).*

Table 1
Sociodemographic characteristics of participants

Participants	Demographic attributes
Midwives (n=7)	27 – 60 years of age; one chose not to answer
Gender	Female
Years of experience	5-42 years
Additional Qualifications	Yes (n=5) sexual health (n=1)
	No (n=2)
Model of Care	Public midwifery group practice (n=3)
	Women's health centre (n=1)
	Public maternity care (n=3) 1 also worked in GP practice
Location	Rural Queensland (n=1)
	New South Wales (n=1)
	Victoria (n=2)
	South Australia (n=2)
	Tasmania (n=1)

The physical and medical aspects were discussed among the participants, with some discussion on how relational, psychological, emotional, and mental aspects can influence an individual's sexual health:

Sexuality changes so much in that pregnancy, birth and postnatal period. You know, because of all of our emotions and you know, our mental health, physical health and breastfeeding, all that sort of stuff, how we feel about our breasts and the sexual aspects of all of that (Mary).

The participants discussed the importance of midwives acknowledging the complexity of sexual health and having the skills to provide appropriate information and support during the postnatal period.

Breaking a lifetime of stigma

There was overwhelming discussion from the participants about the stigma associated with postnatal sexual health, making it increasingly difficult to discuss with women:

There is definitely still an enormous taboo, even in our so-called Western society, where we feel like we're, you know, quite advanced and we're all for sex positivity (Megan).

Brooke said:

It's weird, they talk about vaginas in birth suite, but then it comes to postnatal and all of a sudden, they're scared to talk about it.

This comment reflects the norm in discussing sexual organs for function rather than holistic aspects.

The participants reflected on a society that constantly dismissed women's sexual health, leading to women dismissing conversations or finding it difficult to talk about. It was recognised that stigmatisation begins at an early age from societal influence, with the midwife participants using childhood education as an example of women learning that their sexual health is unimportant. There was discussion regarding motherhood and sexuality having more stigma than for child-free women:

There's still that whole Madonna versus the whole mentality of once you've had children, then you're not a sexual being anymore, and you shouldn't have sexual desires. And it's gross to think about a woman who's had children having sex (Brooke).

There was discussion around same-sex couples and gender identity, with the participants embracing this progression in society; however, experiences of disrespect and reluctance to change from other midwives were discussed. The participants spoke about the importance of being inclusive and aware of differing choices.

It's the patriarchy

The participants discussed an underpinning patriarchal ideology in society that influences sexual health:

We can go right into the misogyny… Women don't want to have sex, do they? Women have sex to have babies (Charlotte).

The participants discussed the one-dimensional view of sex post-birth, focusing on male pleasure:

It's very male-centric. It just reduces her to a sheath (Poppy).

Individual barriers

The midwives' comfort levels were discussed as either an enabler or barrier to facilitating conversations about sexual health. The participants reflected on their personalities and lived experiences and how this influenced their comfort levels:

I think I am pretty OK with most things just because that's my personality. I've always grown up around, you know, sex being quite a normal part of life (Brooke).

Mary discussed how her experience through this clinic has enhanced her comfort levels. In contrast, when talking about other midwives, she commented:

Whether it's that they don't know how or they don't feel like they're skilled enough to answer questions.

The midwives' thoughts, beliefs and values were discussed as influential in providing postnatal sexual health information. The midwives shared stories of disrespectful comments made by midwives, demonstrating how personal beliefs can impact the provision of postnatal sexual health information. Providing sexual health information to postnatal women with differing cultural and socioeconomic backgrounds was also considered challenging:

The main cultural group I work with is Aboriginal women. They're often a lot more shy about discussing it … they don't necessarily want to be discussing their sex life with a white girl (Poppy).

Theme 3: In our interest but whose responsibility?

Four subthemes underpin the participants' discussions about whose role it was to discuss postnatal sexual health.

Acknowledged importance

The midwives were asked about their views on providing postnatal sexual health information, and all responses acknowledged the importance of the topic:

Women and their partners are wanting to know these things (Mary).

The midwife's role

All participants agreed that providing postnatal sexual health information should be part of a midwife's role:

I think it primarily is all postnatal midwives' roles to discuss it (Zoe).

It was highlighted that midwives' play a vital role in ensuring women are supported, prepared, and empowered to make the right decisions:

I feel like it's obviously our role to sort of discuss those topics with our women and ensuring that they are prepared for, you know, that first six weeks and ongoing to, you know, years after birth and probably in terms of planning for another baby as well, if that's what they're wanting (Jessica).

Despite recognising the importance of providing postnatal sexual health information, it was evident in the participant's stories that this aspect of midwifery care is lacking:

It's non-existent. I actually think midwives are not good in regards to talking about sex (Mary).

Handballing

Midwives discussed "handballing", where the responsibility of providing postnatal sexual health information is placed on someone else. Most commonly, the participants stated that the woman's GP would be expected to provide this information at the six-week check-up. The participants acknowledged that women see the GP at six weeks to fill the gap of midwifery care not extending to six weeks despite:

Midwives being the specialist in the early postnatal period and qualified to work with families right up until six weeks (Megan).

Mary, a midwife working in a women's health clinic, stated that

fewer women are being referred to the women's health clinic, highlighting a lack of awareness of community support and minimal referral to support services other than the GP.

Professional barriers

The most prominent barrier in providing sexual health information to women was education. The participants reflected on their lack of knowledge on the topic:

I haven't done lots of extra study in it; I don't feel qualified to give any more details on that (Charlotte).

This lack of knowledge resulted from minimal education in the midwifery undergraduate degree:

It was a very small sort of portion and probably more so about contraception (Jessica).

The participants described this as impacting their confidence in facilitating conversations with women and contributing to confusion about their role. The fragmented model of care was also considered a professional barrier to providing optimal information about sexual health.

Theme 4: Enhancing the provision of postnatal sexual health information

The two following subthemes discuss the midwife participants' recommendations to enhance the provision of postnatal sexual health information.

Structural enablers

Extending midwifery care up to six weeks was seen as an enabler for having more time to discuss information such as postnatal sexual health with a holistic approach. The participants stated that it would allow for more appropriate timing of initiating conversations about sexual health instead of a pressurised attempt to provide information within 48 hours of birth:

It would be really nice if we could actually give that care until six weeks (Charlotte).

Increasing continuity of midwifery care models was discussed as a recommendation to optimise discussions on postnatal sexual health:

We can refer to information that was garnered during pregnancy visits and tailor information to be much more holistic and talk about communication (Megan).

Professional and individual enablers

The participants commonly reflected on their lack of skills and knowledge in postnatal sexual health which led to recommendations for increased education and training for midwives:

I think more onus needs to be taken on by the education sector, so universities need to be teaching more thorough sexual health units (Brooke).

Incorporating postnatal sexual health information into undergraduate training was thought to be beneficial:

It would be amazing to see it be a whole topic (Zoe).

Providing education in the workplace and professional development opportunities was discussed as an enabler. The participants discussed how these educational opportunities could help midwives overcome individual barriers:

If we do things right, it shouldn't matter what your personal experience has been (Megan).

The participants discussed the importance of normalising sexuality which starts with improving midwives' comfort and confidence levels through the development of knowledge and skills. Various platforms to deliver education for midwives were discussed, including accessible videos and in-service training. The participants discussed resources as an enabler to providing postnatal sexual health information. Developing a *fact sheet that's low literacy (Mary)* was provided as a recommendation to improve midwives' conversations with women.

Discussion

While other studies explore midwives' practices in providing sexual health information (Bradfield et al., 2022; Percat & Elmerstig, 2017), this is the first study focusing on the provision of postnatal sexual health information with midwives from various locations across Australia. The focus of the other Australian studies is contraception, whereas this study focuses on sexual health from a broader perspective (Cheney et al., 2024; Botfield et al., 2021).

International research has highlighted the ongoing debate on providing maternity care, specifically regarding medical and midwifery discourse (Newnham et al., 2018; Prosen and Krajnc, 2019). This study exploring midwives' experiences providing postnatal sexual health information affirms the ongoing tension between the provision of holistic and medically focused care found in the literature (Newnham et al., 2018; Walsh, 2011). The midwives in this study felt conflicted about the kind of care and information they could provide in the postnatal period. The midwives' workload, time constraints and postnatal women's length of hospital stay meant midwives in the postnatal wards were often limited to meeting the woman and baby's basic survival needs, which restricted their care to physical aspects of maternal and infant health only. The midwives in this study discussed a task-orientated approach to postnatal care in which the provision of information was reduced to a 'tick-box' moment. The task-orientated method discussed by participants has resonance in the literature. Research has highlighted a 'one size fits all' approach to maternity care (Feeley et al., 2022). Although the importance of providing individualised care is stressed politically and professionally, midwives frequently express that this is not actualised in practice (Feeley et al., 2022). The midwives' stories in this study depicted this conveyor belt-like system described in the literature (O'Malley et al., 2022; Byrom et al., 2021). The postnatal ward is considered the last stop on the industrialised medical conveyor belt, and it is a service-driven imperative to process women through the system as efficiently as possible (Byrom et al., 2021).

It can be argued that the medicalisation of pregnancy and birth is reflected in postnatal care; however, this impact is less understood (Walsh, 2011). Scholars have discussed the medicalisation and medical control of the female reproductive system through contraception (Mann, 2022; White, 2016; Temkina, 2015). Midwives in this study prioritised contraceptive information and frequently neglected other aspects of sexual health, providing some insight into the medical power asserted over the postnatal period. The midwives' stories reflected an element of medical control over reproductive techniques, with the hospital system placing importance on women receiving contraceptive methods before discharge, particularly procedures with a high effectiveness rate, such as the intrauterine device (IUD) or the single-rod implant. Postnatal sexual health research primarily focuses on contraception and reproductive health, highlighting a prioritisation of contraceptive effectiveness in research and practice (Cheney et al., 2024; Botfield et al., 2021).

The midwives in this study acknowledged the diverse nature of sexual health. They commented on sexual health moving beyond physical aspects and spoke about the emotional, relational, and mental factors influencing sexual health. Whilst discourse on postnatal sexual health has historically focused on bodily sensations and concerns, there is a shift to highlighting the need to encompass all aspects of health (Ollivier et al., 2020). Researchers have examined the physical aspects of sexual health in the postnatal period using the FSFI (Ollivier et al., 2020). There is now growing qualitative research that has enhanced an

understanding amongst scholars of women's complex sexual health experiences in the postnatal period (Pardell-Dominguez et al., 2021; O'Malley et al., 2019), which the FSFI is unable to capture (Ollivier et al., 2020). It is clear that the postnatal period is a unique time in a woman's life with many physical, psychological, relational and social changes that can influence sexual health (Pardell-Dominguez et al., 2021). Future research on postnatal sexual health should not limit findings to physical and biological aspects of sexual health. The FSFI to assess sexual function in the postnatal period should be used with caution due to its limitations. A measurement tool which has been created and explicitly validated specifically to assess sexual function for postnatal women is recommended (O'Malley et al., 2021). Ensuring this tool considers the relational, psychological, and social aspects of sexual and physical health will further enhance an understanding of women's postnatal sexual health experiences.

The stigma associated with sexual health was mentioned by the midwives in this study, with the initiation of conversations deemed difficult due to the taboo nature of the topic. The research has also found the stigma surrounding sexual health to be a barrier to providing information (O'Malley et al., 2022; McDonald et al., 2015). The midwives in this study identified the way that societal discourse and cultural norms shape and perpetuate silence on female sexual health generally and postnatal sexual health specifically, a perspective reflected in the literature (O'Malley et al., 2022; Kingsberg et al., 2019). There is also the thought that society's unrealistic expectation of motherhood impacts sexual health, as media suggest there will be little to no changes to a woman's body and relationship (O'Malley et al., 2022; McBride & Kwee, 2017). This societal expectation makes women feel isolated and less likely to seek support and advice for their challenges (O'Malley et al., 2022). Midwives in this study agreed that midwives must ensure an open dialogue to mitigate the stigma and silence regarding postnatal sexual health.

The midwives in this study acknowledged the importance of sharing information on postnatal sexual health with women. This is a similar finding to the literature where midwives acknowledged their crucial role in promoting sexual health and wellbeing (Bradfield et al., 2022; Botfield et al., 2021). Midwives recognised their unique position with women and how this made them well-placed to provide postnatal sexual health information. Literature focusing on women's postnatal sexual health challenges has highlighted the importance of midwives initiating conversations to ensure women feel supported when navigating challenges (O'Malley et al., 2022). Despite this recognition, research has found that midwives neglect to broach the topic, and if women do, the advice they receive is often unhelpful (O'Malley et al., 2022). The findings in this study and the literature highlight the confusion around the midwife's role in providing sexual health information (McCance & Cameron, 2014). There are no clear guidelines or expectations regarding how sexuality should be addressed in the postnatal period, which can further confuse midwives. Clear policies that empower midwives to strengthen women's postnatal sexual health and wellbeing are needed (Percat & Elmerstig, 2017).

Research has highlighted that postnatal women want to receive individualised, women-centred care within a trusting relationship and from a skilled, knowledgeable midwife (Finlayson et al., 2020). The participants' recommendations to enhance the provision of postnatal sexual health information align with the needs of postnatal women. The midwife participants in the interviews identified the implementation and expansion of continuity of midwifery care models of care as an enabler in providing postnatal sexual health information. The participants in this study also recommended that sexual health content be included in undergraduate midwifery education. This finding is consistent with the research that has recommended theoretical input on sexual health across the lifespan in midwifery pre-registration degrees to ensure midwifery students are equipped to help women develop strategies to navigate sexual health challenges (O'Malley et al., 2022; Bradfield et al., 2022; Botfield et al., 2021). The findings of this study indicate that professional development education is also required at the post-graduate level to ensure midwives are knowledgeable, competent, and able to provide evidence-based information (Bradfield et al., 2022; Wong-Merrick et al., 2021). The midwives in Bradfield et al.'s (2022) study suggested using online platforms to deliver training modules or study days, including simulation, case-based learning, and modelled interviewing.

The rich descriptions gained from the midwifery participants by adopting a qualitative descriptive approach and individual interviews are a strength of this study. The methodology and data collection technique elicit a deeper understanding of midwives' beliefs and perspectives than other data collection methods such as surveys (Bradshaw et al., 2017). Gaining an in-depth understanding of the influences of providing postnatal sexual health information in the postnatal period allows for recommendations for future practice and policies to be made. Another strength of this study is the diverse experience of the midwifery participants. The midwives worked in different jurisdictions across Australia in different models of care with varying years of experience. A limitation of this study is the small sample size of seven participants. Recruitment for this study was slow, which could be due to the sensitive nature of the topic. Midwives might not feel they have anything to add if they do not provide postnatal sexual health information. This study's results may not represent the midwifery profession, as some midwives may be more likely to volunteer to participate if they have a particular interest in sexual health.

Conclusion

This study has uncovered the influences in providing postnatal sexual health information to women in the postnatal period from the midwifery perspective. By identifying the effects on the provision of postnatal sexual health information, recommendations that can be translated into practice and policy are made. These recommendations can improve women's experiences of postnatal sexual health by enhancing communication, support, and advice from midwives.

CRediT authorship contribution statement

Chloe Harris: Writing – original draft, Validation, Methodology, Investigation, Conceptualization. **Carolyn Hastie:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization. **Roslyn Donnellan-Fernandez:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization. **Laura Gabriel:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

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References

Australian Institute of Health and Welfare. Maternity models of care in Australia, 2022: Australian Institute of Health and Welfare; 2022. Available from: https://www.aihw.

gov.au/reports/mothers-babies/maternity-models-of-care/contents/how-many-models-of-care-are-there.
Barrett, G, Pendry, E, Peacock, J, Victor, C, Thakar, R, Manyonda, I., 2000. Women's sexual health after childbirth. BJOG. 107 (2), 186–195. https://doi.org/10.1111/j.1471-0528.2000.tb11689.x. PubMed PMID: 10688502.
Botfield, JR, Tulloch, M, Contziu, H, Phipps, H, Bateson, D, Wright, SM, et al., 2021. Contraception provision in the postpartum period: Knowledge, views and practices of midwives. Women. Birth 34 (1), e1–e6. https://doi.org/10.1016/j.wombi.2020.07.013. Epub 20200908PubMed PMID: 32912738.
Bradfield, Z, Officer, K, Barnes, C, Mignacca, E, Butt, J, Hauck, Y., 2022. Sexual and reproductive health education: Midwives' confidence and practices. Women. Birth 35 (4), 360–366. https://doi.org/10.1016/j.wombi.2021.09.005. Epub 20210915PubMed PMID: 34535424.
Bradshaw, C, Atkinson, S, Doody, O., 2017. Employing a qualitative description approach in health care research. Glob. Qual. Nurs. Res. 4, 2333393617742282. https://doi.org/10.1177/2333393617742282. Epub 20171124PubMed PMID: 29204457; PubMed Central PMCID: PMC5703087.
Braun V, Clarke V. Thematic analysis: A practical guide. Sage, London; 2022.
Byrom, A, Thomson, G, Dooris, M, Dykes, F., 2021. UNICEF UK Baby Friendly Initiative: Providing, receiving and leading infant feeding care in a hospital maternity setting—A critical ethnography. Matern. Child Nutr. 17 (2), e13114.
Cheney, K, Mignacca, E, Black, KI, Homer, C, Bradfield, Z., 2024. An exploration of the contraceptive counselling practices of midwives who provide postpartum care in Australia. Midwifery. 131, 103948.
Darooneh, T, Ozgoli, G, Keshavarz, Z, Nasiri, M, Khiabani, A, Roosta, F., 2023. Development of an educational guide for postpartum sexual health promotion: The Delphi method. J. Educ. Health Promot. 12, 444. https://doi.org/10.4103/jehp.jehp_1839_22. Epub 20240122PubMed PMID: 38464651; PubMed Central PMCID: PMC10920744.
Dawson, SJ, Vaillancourt-Morel, M-P, Pierce, M, Rosen, NO, 2020. Biopsychosocial predictors of trajectories of postpartum sexual function in first-time mothers. Health Psychology 39 (8), 700.
DeMaria, AL, Delay, C, Sundstrom, B, Wakefield, AL, Avina, A, Meier, S., 2019. Understanding women's postpartum sexual experiences. Cult. Health Sex. 21 (10), 1162–1176.
Feeley, C, Downe, S, Thomson, G., 2022. Stories of distress versus fulfilment': A narrative inquiry of midwives' experiences supporting alternative birth choices in the UK National Health Service. Women and Birth 35 (5), e446–ee55.
Finlayson, K, Crossland, N, Bonet, M, Downe, S., 2020. What matters to women in the postnatal period: A meta-synthesis of qualitative studies. PLoS. One 15 (4), e0231415. https://doi.org/10.1371/journal.pone.0231415. Epub 20200422PubMed PMID: 32320424; PubMed Central PMCID: PMC7176084.
Khajehei, M, Doherty, M., 2018. Women's experience of their sexual function during pregnancy and after childbirth: a qualitative survey. Br. J. Midwifery. 26 (5), 318–328.
Kingsberg, SA, Schaffir, J, Faught, BM, Pinkerton, JV, Parish, SJ, Iglesia, CB, et al., 2019. Female sexual health: barriers to optimal outcomes and a roadmap for improved patient–clinician communications. J. Womens Health 28 (4), 432–443.
Malterud, K, Siersma, VD, Guassora, AD., 2016. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qual. Health Res. 26 (13), 1753–1760. https://doi.org/10.1177/1049732315617444. Epub 20160710PubMed PMID: 26613970.
Mann, ES., 2022. The power of persuasion: normative accountability and clinicians' practices of contraceptive counseling. SSM-Qual. Res. Health 2, 100049.
Masters, WH, Johnson, V., 1966. Human Sexual Response, 1st ed. Little Brown.
McBride, HL, Kwee, JL., 2017. Sex after baby: Women's sexual function in the postpartum period. Curr. Sex. Health Rep. 9, 142–149.
McCance, K, Cameron, S., 2014. Midwives' experiences and views of giving postpartum contraceptive advice and providing long-acting reversible contraception: a qualitative study. J. Fam. Plann. Reprod. Health Care 40 (3), 177–183. https://doi.org/10.1136/jfprhc-2013-100770. Epub 20140205PubMed PMID: 24500869.
McDonald, E, Woolhouse, H, Brown, SJ., 2015. Consultation about Sexual Health Issues in the Year after Childbirth: A Cohort Study. Birth 42 (4), 354–361. https://doi.org/10.1111/birt.12193. Epub 20151015PubMed PMID: 26467855.
Newnham E, McKellar L, Pincombe J. Towards the humanisation of birth. A study of epidural analgesia & hospital birth culture Cham: Palgrave Macmillan. 2018.
Ollivier, RA, Aston, ML, Price, SL., 2020. Exploring postpartum sexual health: A feminist poststructural analysis. Health Care Women. Int. 41 (10), 1081–1100. https://doi.org/10.1080/07399332.2019.1638923. Epub 20190802PubMed PMID: 31373883.
O'Malley, D, Higgins, A, Begley, C, Daly, D, Smith, V., 2018. Prevalence of and risk factors associated with sexual health issues in primiparous women at 6 and 12 months postpartum; a longitudinal prospective cohort study (the MAMMI study). BMC. Pregnancy. ChildBirth 18 (1), 196. https://doi.org/10.1186/s12884-018-1838-6. Epub 20180531PubMed PMID: 29855357; PubMed Central PMCID: PMC5984394.
O'Malley, D, Higgins, A, Smith, V, 2021. Exploring the complexities of postpartum sexual health. Curr. Sex. Health Rep. 1–8.
O'Malley, D, Smith, V, Higgins, A, 2022. Sexual health issues postpartum-A mixed methods study of women's help-seeking behavior after the birth of their first baby. Midwifery. 104, 103196. https://doi.org/10.1016/j.midw.2021.103196. Epub 20211031PubMed PMID: 34767981.
O'Malley, D, Smith, V, Higgins, A., 2019. Women's solutioning and strategising in relation to their postpartum sexual health: A qualitative study. Midwifery. 77, 53–59. https://doi.org/10.1016/j.midw.2019.06.012. Epub 20190621PubMed PMID: 31255909.
Pardell-Dominguez, L, Palmieri, PA, Dominguez-Cancino, KA, Camacho-Rodriguez, DE, Edwards, JE, Watson, J, et al., 2021. The meaning of postpartum sexual health for women living in Spain: a phenomenological inquiry. BMC. Pregnancy. ChildBirth 21 (1), 92. https://doi.org/10.1186/s12884-021-03578-y. Epub 20210128PubMed PMID: 33509133; PubMed Central PMCID: PMC7844957.
Percat, A, Elmerstig, E., 2017. We should be experts, but we're not": Sexual counselling at the antenatal care clinic. Sex. Reprod. Healthc. 14, 85–90. https://doi.org/10.1016/j.srhc.2017.10.001. Epub 20171012PubMed PMID: 29195640.
Pines, M., 1968. Human Sexual Response"–A discussion of the work of Masters and Johnson. J. Psychosom. Res. 12 (1), 39–49. https://doi.org/10.1016/0022-3999(68)90007-x. PubMed PMID: 5663944.
Prosen, M, Krajnc, MT., 2019. Perspectives and experiences of healthcare professionals regarding the medicalisation of pregnancy and childbirth. Women. Birth 32 (2), e173–ee81. https://doi.org/10.1016/j.wombi.2018.06.018. Epub 20180707PubMed PMID: 31007207.
Rosen, R, Brown, C, Heiman, J, Leiblum, S, Meston, C, Shabsigh, R, et al., 2000. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. J. Sex. Marital. Ther. 26 (2), 191–208. https://doi.org/10.1080/009262300278597. PubMed PMID: 10782451.
Sandelowski, M., 2010. What's in a name? Qualitative description revisited. Res. Nurs. Health 33 (1), 77–84. https://doi.org/10.1002/nur.20362. PubMed PMID: 20014004.
Temkina, A., 2015. The gynaecologist's gaze: the inconsistent medicalisation of contraception in contemporary Russia. Eur. Asia Stud. 67 (10), 1527–1546.
Walsh, D., 2011. A review of evidence around postnatal care and breastfeeding. Obstetrics, Gynaecol. Reprod. Medicine 21 (12), 346–350.
Wellings, K, Johnson, AM., 2013. Framing sexual health research: adopting a broader perspective. Lancet 382 (9907), 1759–1762. https://doi.org/10.1016/S0140-6736(13)62378-8. Epub 20131126PubMed PMID: 24286782.
White K. An introduction to the sociology of health and illness: SAGE; 2016.
Wong-Merrick, S, Brotto, L, Hodgson, Z., 2021. Registered midwives' experiences and self-assessed competence with sexual health counselling: expériences et compétence auto-évaluée des sages-femmes autorisées en matière de counseling en santé sexuelle. Canadian J. Midwif. Res. Practice 20 (1), 31–40.
Woolhouse, H, McDonald, E, Brown, S., 2012. Women's experiences of sex and intimacy after childbirth: making the adjustment to motherhood. J. Psychosom. Obstet. Gynaecol. 33 (4), 185–190. https://doi.org/10.3109/0167482X.2012.720314. Epub 20120913PubMed PMID: 22973871.
World Health Organization. Defining sexual health: Report of a technical consultation on sexual health. 2006. Available from: http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf.
World Health Organization. Sexual health and its linkages to reproductive health: An operational approach. 2017. Available from: https://www.who.int/publications/i/item/978924151288.