ARTICLE

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

Samantha Wong-Merrick, BSc, MD, FRCSC, Lori Brotto, PhD, RPsych, and Zoë Hodgson, BSc, BMW, PhD, RM

ABSTRACT

Background: Pregnancy and the postpartum period raise many sexual health concerns for women. Registered midwives (RMs) care for an increasing proportion of Canadian pregnancies. The study objective was to assess RMs' experiences providing sexual health counselling.

Methods: A 22-item questionnaire exploring RMs' experiences, competence, and comfort, as well as barriers to discussing sexual health, was distributed electronically to British Columbian RMs.

Results: Of 330 RMs, 91 (28%) responded. The majority of midwives reported discussing sexual health concerns with greater than 75% of clients (49/91 [53.8%]). Most estimated the time spent was less than 30 minutes over the pregnancy (69/91 [76%]). Common topics were sexual activity postpartum (82/91 [90.1%]), contraception (89/91 [97.8%]), and cervical cancer screening (86/91 [94.5%]). Less than half discussed sexual problems, including pain or low desire. RMs rated themselves highly competent and comfortable addressing sexual health. However, many identified lack of training, time, and cultural differences as barriers. Respondents cited desire for community resources and training in the areas of contraception, pain and, low desire.

Conclusions: British Columbian RMs feel confident addressing many sexual health concerns during pregnancy but cited lack of training as a common barrier. Investment in educational resources for RMs may help to improve sexual health care for all Canadian women.

KEYWORDS

sexual health, counselling, midwives, pregnancy

This article has been peer reviewed.

RÉSUMÉ

Contexte : La grossesse et la période postpartum occasionnent de nombreuses préoccupations relatives à la santé sexuelle chez les femmes. Les sages-femmes autorisées s'occupent d'une proportion croissante de grossesses au Canada. L'étude avait pour objectif d'évaluer leurs expériences en matière de counseling en santé sexuelle.

Méthodes : Un document comportant 22 questions sur les expériences, les compétences, le degré d'aise et les obstacles entourant la discussion de la santé sexuelle a été envoyé par voie électronique aux sages-femmes autorisées de la Colombie-Britannique.

Résultats : Quatre-vingt-onze (28 %) des 330 sages-femmes autorisées ont répondu. La majorité des sages-femmes ont indiqué avoir discuté de préoccupations liées à la santé sexuelle avec plus de 75 % de leurs clients (49/91 [53,8 %]). La plupart estiment que le temps consacré à ces préoccupations était inférieur à 30 minutes au cours de la grossesse (69/91 [76 %]). Les sujets les plus courants ont été l'activité sexuelle postpartum (82/91 [90,1 %]), la contraception (89/91 [97,8 %]) et le dépistage du cancer du col de l'utérus (86/91 [94,5 %]). Moins de la moitié des échanges ont porté sur des problèmes sexuels, y compris la douleur ou la faiblesse du désir sexuel. Les sages-femmes autorisées s'estimaient très compétentes et à l'aise lorsqu'il s'agissait de traiter de santé sexuelle. Cependant, beaucoup ont mentionné l'absence de formation, le manque de temps et les différences culturelles comme obstacles. Les répondants ont exprimé le souhait de ressources communautaires et d'une formation dans les domaines de la contraception, de la douleur et de la faiblesse du désir sexuel.

Conclusions : Les sages-femmes de la Colombie-Britannique se sentent à l'aise d'aborder de nombreuses préoccupations liées à la santé sexuelle durant la grossesse, mais ont mentionné le manque de formation comme obstacle commun. L'investissement dans des ressources éducatives à l'intention des sages-femmes autorisées pourrait aider à améliorer les soins de santé sexuelle pour toutes les Canadiennes.

MOTS-CLÉS
santé sexuelle, counseling, sages-femmes, grossesse

Cet article a été évalué par un comité de lecture.

INTRODUCTION

Pregnancy and the postpartum period raise a number of sexual health concerns for women. Physical and hormonal changes, changes in relationship dynamics, and sleep deprivation all have the potential to negatively affect sexual functioning.[1] Postpartum sexual dysfunction is common. One study found that 83% of women at 3 months postpartum reported sexual dysfunction, but only 15% of these women had ever discussed it with a health care provider.[2] Reasons for this may include patient and provider discomfort and a lack of training for maternity care providers in regard to sexual functioning during pregnancy and the postpartum period.[3–5]

An increasing proportion of pregnancies are attended by registered midwives across Canada. The largest percentage (22.4% of all births in 2017) occurred in British Columbia.[6] Registered midwives are an established part of the British Columbia health care system and offer primary maternity care to healthy pregnant clients and their newborns through pregnancy, labour, and 6 weeks postpartum.[7]

Despite the increase in pregnancies attended by registered midwives (RMs), research on RMs' capacity and training in the assessment and management of sexual health issues is limited. Most of the research emphasizes the difficulties encountered. Olsson et al. examined Swedish midwives' experiences counselling women on generalized sexual health issues at the postnatal check and found that a lack of time and knowledge to adequately address concerns were key barriers.[8] They also cited additional challenges in communicating with immigrants because of language and cultural differences. A Canadian study examining maternity care in women who experience the sexual pain condition vulvodynia found that RMs were significantly more likely to feel uncomfortable managing these women than were physicians.[9]

Several studies have looked specifically at contraception counselling. A qualitative study with British midwives found that although contraceptive advice is a routine part of postpartum visits, it is regarded as less important than advice on other postpartum topics.[10] Again, time constraints and lack of training were cited as barriers. In contrast, in a quantitative Swedish study on emergency contraceptive pill administration, nurse-midwives reported themselves as being consistently thorough in their counselling around medication use, but this result was an outlier.[11] Walker and Davis explored the effects of contraception and sexual health education on the practice of final-year midwifery students in Britain. They found that the self-assessed confidence of these students correlated poorly with competence measured in practice-based scenarios.[12] As echoed by practicing midwives in the other studies, students expressed a desire for more directed learning opportunities within their curriculum, as well as for role modelling by senior midwife clinicians.[12] Overall, research to date shows that many midwives feel underprepared for the task of managing the sexual health of their clients.

OBJECTIVE

The aim of our study was to document British Columbia RMs' self-assessed current practices in sexual health counselling, their comfort and competence in counselling, and perceived barriers to caring for the general sexual health needs of their clients.

METHODS

Clinician-scientists from the fields of midwifery, obstetrics and gynecology, and sexual health developed a questionnaire to assess the delivery of sexual health care in pregnancy by British Columbia RMs. Sexual health was broadly defined as aspects of sexual response (e.g., desire, arousal, orgasm),

> Midwives feel underprepared for the task of managing the sexual health of their clients.

aspects of sexual satisfaction, sex-related distress, genital (vulvovaginal) pain, contraception, and sexually transmitted infections.

As shown in the Appendix, the questionnaire comprised four sections. Section 1, Background Information, consisted of questions about respondent demographics (age, gender, practice status, and years in practice) and questions about the client population (including questions on the size of the population served and practice settings). The section also asked participants to describe the patient population they served.

Section 2, Experience Discussing Sexual Health with Clients, included questions about RMs' experiences discussing sexual health concerns with clients. Specifically, we asked about the frequency and quantity of sexual health counselling, timeline in pregnancy, common topics, and motivation for discussion. This section also included questions about the percentage of clients with whom sexual health is discussed, the amount of time spent discussing sexual health with each client over the course of the pregnancy and postpartum period, and the time period in pregnancy or postpartum when topics are usually discussed. Multiple-choice responses for topics discussed were subdivided into those typically brought up by respondents and those brought up by their clients.

Section 3, Comfort Discussing Sexual Health with Clients, asked respondents to rate their personal competence and comfort discussing sexual health and their knowledge about available resources and referral patterns. Personal competence and comfort were rated on a Likert scale from 0 (not at all competent/comfortable) to 10 (extremely competent/comfortable). Competence was defined as having "the knowledge and skills required to address the topic." Comfort was not explicitly defined.

Section 4, Barriers to Discussing Sexual Health, contained questions about barriers to providing care. Respondents were asked to rate the importance of addressing sexual health topics with their clients on a Likert scale from 0 (not at all important) to 10 (extremely important). The remainder of the section consisted of a multiple-choice question about which specific topics respondents felt were important, a multiple-choice question about specific barriers to addressing those topics, and an open-ended question asking what would be helpful in addressing these barriers.

An invitation with a link to the online questionnaire was sent out via email to the British Columbia RM electronic mailing list. The invitation was sent once in March 2017, and a reminder was sent in May 2017. The study was approved by the Research Ethics Board of the University of British Columbia, and all participants provided informed consent. Data were stored in REDCap (Research Electronic Data Capture, Nashville, TN) and analyzed using frequency and descriptive analyses with Excel (Microsoft, Redmond, WA).

FINDINGS

Demographics

As shown in Table 1, 91 out of 330 British Columbia RMs (2017) participated, a response rate of 28%. Respondents ranged in age from 25 to 70 years, with a mean of 41 years. The median age was 40 years; the mode was 41 years. Almost all respondents identified as female, and one identified as other. The majority (72/91 [79.1%]) were currently involved in independent clinical practice, with a mean of 10 years in practice. Most respondents practiced

Table 1. Demographic Characteristics (*N* = 91)

Variable	Categories	n (%)
Age (years)		Mean 41 Range [25–70] St Dev [9.95]
Gender	Female Male Other	90 (98.9) 0 (0) 1 (1.1)
Practice status	Currently practicing Retired On leave Student	72 (79.1) 1 (1.1) 8 (8.8) 10 (11.0)
Years in practice (n = 80)		Mean 10 Range [1–38] St Dev (8.8)
Population of practice location	< 10,000 < 50,000 < 100,000 ≥ 100,000	6 (6.6) 14 (15.4) 12 (13.2) 59 (64.8)
Practice setting	Clinic Majority home birth, majority hospital birth Equal home and hospital birth Other	83 (91.2) 4 (4.4) 66 (72.5) 21 (23.1) 2 (2.2)

St Dev, standard deviation

in urban settings with populations over 100,000 (59/91 [64.8%]), seeing clients in a combination of clinic, hospital, and home settings. Respondents cared for clients from a variety of socio-economic and cultural backgrounds, including low-, middle-, and high-income families, and persons of multiple ethnicities. The study also included commonly underserved populations of new immigrants, refugees, and clients who identified as LGBTQ.

Experience Discussing Sexual Health with Clients

Most RM respondents reported that they discussed sexual health concerns with most (50%–75%; 16/91 [18%]) or almost all (> 75%; 49/91 [53.8%]) of their clients. The majority of RMs spent between 5 and 30 minutes over the course of perinatal care discussing these issues with their clients (58/91 [64%]), both to address specific client-driven concerns and to discuss routine sexual health topics.

Common sexual health concerns brought up by clients included return to sexual activity postpartum, safety of intercourse during pregnancy, contraception postpartum, low sexual desire, and sexual pain during pregnancy and postpartum (Table 2). Clients brought up sexual pain (68/91 [75%]) and low desire (45/91 [50%]) at a much higher rate than did midwives. These concerns were most commonly voiced in the postpartum period (52/91 [57%]), but the experiences causing them occurred throughout pregnancy.

Sexual health discussions initiated by RMs addressed slightly different areas. Discussions focused on medical topics, such as contraception postpartum, cervical cancer screening, screening for intimate-partner violence, and sexually transmitted infections, and were less likely to be about sexual pain (38/91 [42%]) or low libido (34/91 [37%]) (see Table 2). These topics, although discussed during other time periods, tended to be discussed early in the first trimester (37/91 [41%]) and in the postpartum period (27/91 [30%]) (Table 3).

Table 2. Sexual Health Concerns Discussed in Pregnancy (*N* = 91)

Topics*	Brought up by clients (*n* [%])	Brought up by midwives (*n* [%])
Sexuality during pregnancy	52 (57)	36 (40)
Safety of intercourse during pregnancy	77 (85)	55 (60)
Sexual pain in pregnancy or postpartum	68 (75)	38 (42)
Return to sexual activity postpartum	84 (92)	82 (90)
Lack of sexual desire	45 (50)	34 (37)
Contraception postpartum	80 (88)	89 (98)
Sexually transmitted infections	38 (42)	72 (79)
Cervical cancer screening	59 (65)	86 (95)
Screening for intimate-partner violence†	Not applicable	74 (81)

*One respondent stated that their clients never brought up sexual health concerns.
†This category was not offered under topics brought up by clients.

Comfort Discussing Sexual Health with Clients

Most RMs considered themselves to have moderate-to-high competence in addressing their clients' sexual health concerns. In the survey, competence was defined as having "the knowledge and skills required to address the topic." Sixty-two out of ninety-one respondents rated themselves at 7/10 or higher on a Likert competence scale (68%). Seven (7.7%) respondents rated themselves at 10/10 on the scale, and twelve (13%) respondents rated themselves at less than 5/10 on the scale.

Although comfort was not explicitly defined, midwives rated themselves even higher in regard to their comfort in addressing sexual health issues. Four respondents (4.4%) did not answer this question. Sixty-four of 87 respondents (73.6%) assessed their comfort at 7/10 or greater on a Likert scale, ten respondents (11.5%) rated themselves at 10/10 on the scale, and eight respondents (9.2%) rated themselves at less than 5/10 on the scale. No respondents rated themselves at less than 3/10.

All respondents felt that addressing sexual health concerns with their clients was highly important. Ninety (98.9%) rated it as 7/10 or higher on a Likert scale. Many rated it as extremely important (40/91 [44%]).

Most respondents (74/89 [83%]) stated they learned to address sexual health concerns, at least in part, during their clinical training. Common sources of training included academic teaching and clinical training, journal articles, and conferences. Other sources mentioned were online courses, personal experience, and conversations with colleagues.
Respondents who were unable to address a sexual health concern themselves commonly referred clients to an obstetrician-gynecologist (44/56 [79%]), a family doctor (28/56 [45%]), or a sexual health therapist (16/56 [29%]). Other referrals mentioned were to a pelvic floor physiotherapist for pelvic pain, as to counsellors and peer support groups.

The respondents rated all listed sexual health topics as important to discuss with clients, including the topics of sexual intimacy during pregnancy and postpartum, sexual pain, lack of desire, postpartum contraception, intimate-partner violence, sexually transmitted infections, and cervical cancer screening. Pelvic floor health was also mentioned as an important topic to address.

Table 3. Self-Rated Attitudes Towards Sexual Health (N = 91)

Category	Scale	Mean (SD); Median (Range)
Competence discussing sexual health with clients	10-point Likert	6.91 (1.90); 7 [2–10]
Comfort discussing sexual health with clients*	10-point Likert	7.60 (2.04); 8 [3–10]
Importance of addressing sexual health with clients	10-point Likert	9.02 (1.06); 9 [5–10]

SD, standard deviation
*87/91 respondents answered this question.

Barriers to Care

Respondents identified many barriers to providing sexual health care for their clients. The most frequently cited ones were lack of training (49/90 [54.4%]), intercultural differences between clients and midwives (44/90 [48.9%]), and time constraints during visits (43/90 [47.8%]). Among other identified barriers were inadequate community resources, language barriers, patriarchal societal values, and client discomfort.

The most commonly suggested ways to decrease these barriers were (1) increased time allotted to sexual health care during regular training, (2) continuation of professional development, (3) a formalized guide for midwives on perinatal sexual health, and (4) online resources and handouts for clients. Respondents also suggested additional training focused on sexual pain and low desire, as well as an increased scope of practice for contraceptives and placement of intrauterine devices.

DISCUSSION

Our objective was to investigate current practices in sexual health counselling by RMs in British Columbia. The majority of participating midwives routinely address their clients' sexual health needs during the course of perinatal care. They rated themselves as moderately to highly competent and even more comfortable in providing this care. All respondents rated sexual health counselling as an important part of perinatal care. The most common barriers to adequate care were lack of training, intercultural differences between midwives and their clients, and time constraints. With some exceptions (discussed below), these findings are comparable to those of other studies in this area.[8–10,12–15]

Although most respondents stated that they routinely addressed sexual health concerns with most of their clients, a moderate portion (29%) reported discussing sexual health concerns with fewer than half of their clients. On the questionnaire, many of the topics that were listed under the umbrella of sexual health—including sexually transmitted infections, cervical cancer screening, and contraception postpartum—were topics routinely addressed by standardized perinatal care in British Columbia. If this 29% of participant midwives are not discussing these topics with all of their clients, they have not been providing the standard of care. However, the respondents may have misinterpreted the question. Midwifery prescription of contraceptives in British Columbia requires specialized practice certification, which may explain this in part.

Discussion topics were both client and provider driven. Provider-driven topics were more likely to be medically focused (e.g., cervical cancer screening) and brought up earlier in the pregnancy. RMs were less likely to discuss sexual pain and low sexual desire. This may reflect a lack of comfort and competence on the part of midwives in regard to these topics or may indicate that they are not

regularly screening all of their clients for sexual pain and desire. Previous research by Smith et al. shows that midwives overall feel less comfortable and confident discussing sexual pain than do physician providers.[9] The authors were unable to find any previous studies that looked specifically at midwives' experiences discussing low sexual desire.

Respondents rated the importance of sexual health counselling as very high. Concurrently, the majority rated their comfort and competence in addressing these concerns as high; compared to RMs in other studies, British Columbian RMs rated themselves much higher. In British Columbia, RMs follow a continuity-of-care model in which they function as autonomous primary care providers for their clients throughout the entire pregnancy and postpartum period.[16] This allows RMs to develop a relationship with clients and may foster more comfort in addressing sensitive sexual health topics. A qualitative study of Swedish midwives found that midwives considered general sexual counselling to be important but difficult to address.[13] Other studies that looked at midwives' comfort in providing care to women with more specialized sexual health needs generally found them to be less comfortable in these areas, as expected. Jackson and Fraser reported that most midwives in the United Kingdom felt uncomfortable and unprepared to deal with their clients' disclosures of sexual abuse.[14] Smith et al. reported that British Columbia midwives feel less comfortable than their physician counterparts in providing maternity care to women with vulvodynia.[9] However, the discomfort reported in these studies was not correlated with objective measures of skill in practicing midwives, an area for potential future research.

Our findings echo the results found in studies of trainees as well. These studies generally reported that students considered sexual health an important aspect of care.[12,15,17–19] An interesting UK-based study by Walker and Davis found that midwifery students had higher self-rated confidence in giving contraceptive advice than factual quiz-based competence.[12] There was also no correlation between expressed confidence levels and competence as assessed by a fact-based test.[12] Midwives in this study may also be affected by over- or underconfidence, as we have no concurrent objective measures of client care. A study of Turkish midwifery students reported that many students felt discomfort in discussing various sexual health concerns and that just under half did not consider it an important aspect of care.[20] These variations, however, may be explained by cultural and religious differences in the populations studied. Further to our findings regarding comfort and competence, respondents may have been confused by the wording of the questionnaire. The authors hypothesized that personal comfort with sexual health topics might differ from self-rated competence. However, only competence was explicitly defined as having "the knowledge and skills required to address the topic," whereas comfort was implied to mean personal ease with the subject matter. This may have been confusing to some respondents and may explain why four respondents did not finish answering this question. However, enough respondents answered that we think the results are still of interest.

The barriers to providing sexual health care commonly cited by British Columbia midwives included lack of training, intercultural differences between clients and midwives, and time constraints. These barriers are commonly cited by midwives in other studies as well.[8–10,12–15] The intercultural differences cited may reflect the larger proportion of midwife respondents providing care to either an urban multicultural or Aboriginal population. The demographics portion of the questionnaire did not ask about the ethnicity of the study participants themselves.

Respondents commonly suggested targeted clinical training as a way to reduce barriers to providing improved sexual health care. This is echoed by studies looking at midwifery and nursing students.[12,15,17–20] Specific topics for focused additional training included contraception, sexual pain, and low desire. Currently, the prescription of contraceptives by midwives in British Columbia is restricted to midwives who have completed specialized certification by the College of Midwives of British Columbia.[21] The aforementioned topics correspond to common client concerns as well as to

specific topics that respondents were less likely to bring up with their clients, perhaps due to lack of comfort. Midwives also expressed the desire for a common reference resource on sexual health for practitioners as well as for clients.

This study has a number of limitations. The response rate was only 28%. The participants' experiences managing sexual health as midwives may have been different from those of nonrespondents. Also, the study is based on a questionnaire that has not been formally validated. However, it was developed by a multidisciplinary team, and the questions were based on a combination of clinical and academic experience directly relevant to the topic. These results, along with target population RM input, could be used to refine the questionnaire for future use. It would be of particular interest to see if competence and comfort are as closely linked when explicitly defined.

Areas for future study include a more detailed look at whether comfort with sexual health topics reflects objective measures of competence; which topics are most difficult for RMs to address; and studies measuring the effect of educational interventions on RMs' competence in and comfort with sexual health counselling.

CONCLUSION

This project is one of the first to document midwives experiences with sexual health counselling in Canada. It supports the development of midwife training curricula specifically targeting contraception, sexual pain, and low desire, and is a common resource for practicing midwives on the topic of perinatal sexual health. As midwives continue to take on a greater proportion of maternity care, this will lead to overall improved care for expecting Canadian women.

ACKNOWLEDGEMENTS

The authors thank the responding registered midwives for their time and their thoughtful responses.

REFERENCES

1. Jawed-Wessel S, Sevick E. The impact of pregnancy and childbirth on sexual behaviours: a systematic review. J Sex Res. 2017;54(4-5):411-23. doi: 10.1080/00224499.2016.1274715.
2. Barrett G, Pendry E, Peacock J, Victor C, Thakar R, Manyonda I. Women's sexual health after childbirth. Br J Obstet Gynaecol. 2000;107(2):186-95.
3. Leeman LM, Rogers RG. Sex after childbirth: postpartum sexual function. Obstet Gynecol. 2012;119(3):647-55. doi: 10.1097/AOG.0b013e3182479611.
4. Bartellas E, Crane JM, Daley M, Bennett KA, Hutchens D. Sexuality and sexual activity in pregnancy. Br J Obstet Gynaecol. 2000;107(8):964-8.
5. Pauleta JR, Pereira NM, Graça LM. Sexuality during pregnancy. J Sex Med. 2010;7:136-42. doi: 10.1111/j.1743-6109.2009.01538.x.
6. Canadian Association of Midwives. Annual report 2017–2018, Report No. 12. Montreal: Canadian Association of Midwives; 2018. Available from: https://canadianmidwives.org/wp-content/uploads/2018/10/Annual-Report-2017-2018.pdf
7. College of Midwives of British Columbia. Registrant's handbook. Section 5: Competencies of registered midwives [Internet]. Vancouver, BC: College of Midwives of British Columbia; 2017. Available from: https://www.cmbc.bc.ca/wp-content/uploads/2017/10/Competencies-of-Registered-Midwives.pdf
8. Olsson A, Robertson E, Falk K, Nissen E. Assessing women's sexual life after childbirth: the role of the postnatal check. Midwifery. 2011;27(2):195-202. Available from: doi:10.1016/j.midw.2009.04.003
9. Smith KB, Sadownik LA, Basson R, Isaacson J, Brotto LA. Clinicians' perspectives and experiences regarding maternity care in women with vulvodynia. J Obstet Gynecol Can. 2016;38(9):811-819. doi:10.1016/j.jogc.2016.04.008.
10. McCance K, Cameron S. Midwives experiences and views of giving postpartum contraceptive advice and providing long-acting reversible contraception: a qualitative study. J Fam Plann Reprod Health Care. 2014;40(3):177-83. doi: 10.1136/jfprhc-2013-100770.
11. Aneblom G, Lundborg CS, Carlsten A, Eurenius K, Tydén T. Emergency contraceptive pills over-the-counter: practices and attitudes of pharmacy and nurse-midwife providers. Patient Educ Couns. 2004;55(1):129-35.
12. Walker SH, Davis G. Knowledge and reported confidence of final year midwifery students regarding giving advice on contraception and sexual health. Midwifery. 2014;30(5):e169-76. doi: 10.1016/j.midw.2014.02.002.
13. Percat A, Elmerstig E. "We should be experts but we're not": Sexual counselling at the antenatal care clinic. Sex Reprod Healthc. 2017;14:85-90. doi: 10.1016/j.srhc.2017.10.001.
14. Jackson KB, Fraser D. A study exploring UK midwives' knowledge and attitudes towards caring for women who have been sexually abused. Midwifery. 2009; 25(3):253-263.
15. Dattilo JE, Brewer MK. Assessing clients' sexual health

as a component of holistic nursing practice: senior nursing students share their experiences. J Holist Nurs. 2005;23(2):208-19.
16. College of Midwives of British Columbia. Registrant's handbook: section 8. Midwifery scope and model of practice [Internet]. Vancouver, BC: College of Midwives of British Columbia; 2018. Available from: https://www.cmbc.bc.ca/wp-content/uploads/2018/12/Midwifery-Scope-and-Model-of-Practice.pdf
17. Johnston JH. The preparation of child health nurses in sexual health education: an exploratory study. Nurse Educ Today. 2009;29(8):845-9. doi: 10.1016/j.nedt.2009.03.011.
18. Thurston C, Walker S. Experiences and training in delivering sexual health care. Br J School Nurs. 2013;6(6):289-93. doi: 10.12968/bjsn.2011.6.6.289.
19. Tsai LY, Huang CY, Liao WC, Tseng TH, Lai TJ. Assessing student nurses learning needs for addressing patients sexual health concerns in Taiwan. Nurse Educ Today. 2013;33(2):152-9. doi: 10.1016/j.nedt.2012.05.014.
20. Ören B, Zengin N, Yazici S, Akinci AÇ. Attitudes, beliefs and comfort levels of midwifery students regarding sexual counseling in Turkey. Midwifery. 2018;56:152-7. doi: 10.1016/j.midw.2017.10.014.
21. College of Midwives of British Columbia. Registrant's handbook: section 2. Standards, limits and conditions for prescribing, ordering and administering contraceptives [Internet]. Vancouver, BC: College of Midwives of British Columbia; 2019. Available from: https://www.cmbc.bc.ca/wp-content/uploads/2019/03/Standards-Limits-and-Conditions-for-PrescribingOrdering-and-Administering-Contraceptives.pdf

AUTHOR BIOGRAPHIES

Samantha Wong-Merrick is a clinical instructor with the University of British Columbia Department of Obstetrics and Gynaecology. She completed her postgraduate training in obstetrics and gynecology at the University of British Columbia. She is currently working in fertility and as a locum general obstetrician-gynecologist on Vancouver Island.

Lori Brotto is a professor in the University of British Columbia Department of Obstetrics and Gynaecology.

Zoë Hodgson is a clinical assistant professor in the University of British Columbia Department of Family Practice.

BIOGRAPHIES DES AUTEURS

Samatha Wong-Merrick est enseignante clinique du Département d'obstétrique et de gynécologie de l'Université de la Colombie-Britannique. Elle a effectué ses études supérieures en obstétrique et en gynécologie à cet établissement. Elle travaille actuellement dans le domaine de la fertilité et est obstétricienne gynécologue générale suppléante sur l'île de Vancouver.

Lori Brotto est professeure au Département d'obstétrique et de gynécologie de l'Université de la Colombie-Britannique.

Zoë Hodgson est professeure clinique adjointe au Département d'obstétrique et de gynécologie de l'Université de la Colombie-Britannique.