Evidence-Based Nursing Research Vol. 7 No. 4 October 2025

# Relationship between Nurses' Sexual Self-Concept and Performance of Sexual Health Care among Inpatients in South Rift, Kenya

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Received June 19, 2025, accepted August 7, 2025, published October 1, 2025.

**ABSTRACT**

***Context:*** Sexual health is an essential component of human health and wellness, encompassing not only physical but also emotional and psychosocial well-being related to sexuality. This domain of life among hospitalized patients has, however, received little attention from health workers globally, with existing gaps between patients' care needs and sexual health services provided by nurses.

***Aim:*** This study determined the relationship between nurses' sexual self-concept and performance of sexual health care among inpatients in the South Rift, Kenya.

***Methods:*** This study employed an analytical cross-sectional design, utilizing a self-administered questionnaire that was adapted to suit the study's aim. The study involved 171 nurses, drawn from a sample of 300 nurses working in medical and surgical units of level four and five hospitals in two counties.

***Results:*** The results showed that 65.5% of nurses had satisfactory performance in implementing sexual healthcare. Nurses' sexual self-concepts had a strong bearing on the performance of sexual health care (p-value =0.021; R Square=0.586)

***Conclusion:*** Nurses performed fairly in providing sexual health care services; however, there existed significant gaps related to nurses' sexual self-concept characteristics. A significant relationship was revealed between nurses' self-concept and their performance of sexual health care. The study recommends that hospitals adopt guidelines to support the incorporation of sexual health care in every patient's routine care protocols in all clinical settings, and sexual health content should be expanded in nursing training curricular.

***Keywords:*** Inpatients, multidimensional, nurses' performance, sexual self-concept

***Citation:*** *Keitany, S. K., Morema, E. N., Sakwa, G. O, & Matheka, F. M. (2025).* Relationship between nurses' sexual self-concept and performance of sexual health care among inpatients in South Rift, Kenya. *Evidence-Based Nursing Research, 7*(4), 20-27. https://doi.org/10.47104/ebnrojs3.v7i4.411

## 1. Introduction

Sexuality is a fundamental aspect of health and well-being in life *(Kavanagh & Lilljegren, 2022). S*tudies show that among sexually active individuals of all ages, over 50% and 40% of men and women, respectively, consider satisfactory sexual health to be a highly significant parameter of good quality of life *(Manninen et al., 2021; Pascual et al., 2021).* This concept has also been found to be true among people with moderate to poor health as well as those with chronic illnesses *(Manninen et al., 2021).* However, because of the delicate and highly intimate nature of sexual issues, many patients have difficulties bringing up sexuality issues during hospitalization *(Culp, 2020).*

The WHO in 2000 defined sexuality as a fundamental aspect forming a continuum in human life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Human sexuality goes beyond physical sexual contact but also includes an individual's personal identity, which includes emotional and mental aspects *(Papadopoulou et al., 2019).* This explanation implies that compromised sexuality adversely affects one's psycho-emotional, physical, and social well-being because human needs related to sexuality form an integral part of health and wellness. According to Abraham Maslow's hierarchy of needs, sex is also a basic human need that must be satisfied for the body to function optimally *(McLeod, 2025).*

Globally, it has been reported that hospitalized patients with both medical and surgical conditions experience some form of sexual dysfunction as a result of the illnesses, as well as therapy; thus, understanding the potential for drug-induced sexual problems enables care providers to make appropriate considerations for both the patient and their

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partner *(Evcili & Demirel, 2018)*. The North American Nursing Diagnosis Association International recognizes and places sexuality as the eighth domain with three sub-classes, namely sexual identity, sexual function, and reproduction *(NANDA International, 2021)*. This inclusion makes sexual health very crucial in the routine planning of nursing care for all patients and at all levels.

In Africa, little has been done in the field of sexuality with a few studies carried out in Ethiopia, Nigeria, Kenya and South Africa revealing an increasing prevalence of sexual health related problems among patients hospitalized with chronic non communicable diseases like hypertension, diabetes mellitus (DM), renal failure and cancer among others *(Asefa et al., 2019; Udo & Effiong, 2018)*. Despite the increasing prevalence, health workers, particularly nurses, are not comfortable addressing the issue because it is culturally considered sensitive and too personal *(Asefa et al., 2019)*. Moreover, for nurses to effectively evaluate patients' sexuality, they must be competent, possessing relevant knowledge, updated skills, and appropriate attitudes *(Evcili & Demire, 2018)*.

The inclusion of care related to sexual health into nursing practice remains a challenge, partly due to inadequate knowledge, training, and nurses' confidence *(Lloyd, 2018)*. Studies show that healthcare workers in hospitals and other facilities are unable to meet patients' needs regarding sexual health because they lack adequate preparation *(Verrastro et al., 2020)*. This poor preparation has largely been attributed to inadequate sexual health training, skills, and discomfort discussing sexual health issues *(Wang & Rong, 2019)*. As a result, patient sexuality is often neglected by nurses and other healthcare workers despite being an integral component of patient care.

## 2. Significance of the study

Addressing a patient's sexual health is a primary nursing role in holistic patient care. Adequate sexual healthcare improves patient coping with illness, promotes healing, social interactions, medication compliance, acceptance, and quality of life *(Seid et al., 2022)*. Most practicing nurses are not competent enough to handle the sexual needs of patients, with a lack of sexual health care knowledge and negative attitudes cited as the major barriers *(AbdRabo et al., 2019; Culp, 2020; Barnhoorn et al., 2021)*.

Additionally, studies on sexual health and nursing care conducted in Europe and America often employed varied study designs, had fewer nurses participating, or lower response rates *(Manninen et al., 2021)*, making generalizations difficult. Currently, there is scant literature on nurses' performance in providing sexual health care in the current setting. Therefore, nurses must be competent in taking the initiative to address sexual matters with their patients. Moreover, most studies have focused on reproductive health services, leaving out the patients' sexuality component not addressed. Due to a lack of information on sexuality in nursing care, inclusion in nurses' care notes and handover reports, as required by the nursing care standards, it is imperative to establish the factors that prevent this from happening.

This study, therefore, aims to generate credible information on nurses' performance in sexual healthcare *(Wang & Rong, 2019)* and its influence on care in the South Rift, Kenya. It will also inform the development of setting-specific sexual health care strategies to promote holistic nursing care to hospitalized patients, pegged on evidence-based practices.

## 3. Aim of the study

The study aimed at examining the relationship between nurses' sexual self-concept and performance of sexual health care among inpatients in South Rift, Kenya.

### 3.1. Operational definition

Performance in this study is operationally defined as the ability to assess, diagnose, treat, and rehabilitate patients with sexual health needs according to available guidelines

Inpatients are patients admitted to a level four or five hospital within the South Rift, Kenya, and diagnosed with a medical or surgical condition.

Sexual health is the presence of a sexual health need arising from illness or treatment.

Multidimensional sexual self-concept is the sum of the selected five domains, which are sexual anxiety, sexual self-efficacy, sexual consciousness, sexual self-esteem, and sexual self-monitoring and awareness.

## 4. Subjects & Methods

### *4.1. Research Design*

This research study employed an analytical cross-sectional design, where data were collected at a single point in time to capture the phenomenon under study. The design was suitable because the study aimed at describing nurses' sexual self-concept as well as explaining the relationship with the performance of sexual health care at a fixed point in time.

### *4.2. Study setting*

The study was conducted in Kericho and Bomet Counties in the South Rift Valley region of Kenya. Their total population was projected to be 1,137,716 and 1,028,130 by 2022, respectively *(CGK, 2018; CIDP, 2023)*. The choice of the study area was based on clinical practice experience and findings of research studies showing that implementation of sexual health care within inpatient settings was poorer among culturally conservative societies. The community in the study area upholds a very rich and conservative culture where sexual health matters are not always openly discussed because it is considered taboo and too sensitive, which compromises the implementation of relevant care as required by the nursing care standards.

### *4.3. Subjects*

Nurses are attached to adult medical and surgical wards of level four and five hospitals. The inclusion criteria were qualified nurses working in adult medical and surgical units, who were available during the data collection period and had consented to participate. Nurses who had worked in the unit for less than one month before the data collection period were excluded from participation.

Multistage sampling was applied, where the two counties (Kericho and Bomet) in the South Rift were purposefully selected. Stratified random sampling was used to group facilities according to their levels in the Kenya Essential Package for Health (KEPH) and type of ownership (Public, Faith-Based, and Private). Nurses in each of the two wards (medical and surgical) were randomly selected using prepared lists of nurses on duty at the time of actual data collection.

The sample size was determined using the formula proposed by *Yamane (1967)*.

$$n = N/1+N(e)^2$$

where:
n = sample size
N = population size
e = level of precision

In this study, N=300 (total number of nurses drawn from adult medical and surgical wards of all the level four and five hospitals). e =5% (at 95 % level of confidence). Therefore, $n=300/(1 + 300 \times 0.05^2)$, which yields a sample size of 171.

### 4.4. Tools of Data Collection

#### 4.4.1. Self-Administered Questionnaire

Data for this study were gathered using a self-administered questionnaire from the study subjects. It is designed to assess the demographic variables of subjects. These variables included gender, age, marital status, level of educational, and years of experience.

#### 4.4.2. Self-Reported Performance Questionnaire

This questionnaire is a self-reporting tool used in assessing the management of sexual health issues among healthcare providers during practice. The tool was adopted from a study by *Manninen et al. (2021*) and adapted by adding 14 statements in Part II. Part I consisted of seven questions that addressed the level of health workers' performance in discussing and managing patients with sexual health concerns. Part II consisted of 14 statements scored on a 4-point Likert scale, describing the frequency with which nurses implemented sexual healthcare during their practice.

*Scoring system*

The answers were coded as follows: 1 = Never, 2 = Sometimes, 3 = Often, and 4 = Always, resulting in a minimum score of 14 points and a maximum score of 56 points. Lower numbers indicated the lowest frequencies with the statements and vice versa. Performance of 50% and above (≥35 points) was considered satisfactory.

#### 4.4.3. The Multidimensional Sexual Self-Concept Questionnaire (MSSCQ)

It was developed by *Snell (1996)* to evaluate sexual self-concept among healthcare workers. It is a self-report instrument that focuses on twenty aspects of sexual self–concept in a five-point Likert scale. In this study, only five, i.e., sexual anxiety, sexual self-efficacy, sexual consciousness, sexual self-esteem, and sexual monitoring and awareness, were selected in relation to the study context guided by various previous research studies *(Wang & Rong, 2019).*

*Scoring system*

Each aspect contained five (5) items, giving a total of 25. Responses were then coded so that A = 1(not at all characteristics of me); B = 2(slightly characteristics of me); C = 3(somewhat characteristics of me); D = 4(moderately characteristic of me); and E = 5(very characteristic of me) with scores ranging from 1-5. The five items on each subscale were averaged to generate three categories: high (>20), moderate (15–20), and low (<15). Higher scores corresponded to greater amounts of each respective sexual tendency. A score of 50% and above implied positive sexual self-concept, while a score of 49% and below denoted negative sexual self-concept.

### 4.5. Procedures

Before conducting the study, administrative approval was obtained from the Health Services departments of both counties, as well as approval from the Masinde Muliro University of Science and Technology Ethics Review Committee (MMUST/IERC/169/2023). A research permit was obtained from the National Commission for Science, Technology, and Innovation (NACOSTI) under reference number NACOSTI/P/23/27335.

All study subjects were given the freedom to voluntarily participate and withdraw at any point if they were not comfortable, as well as the free will to share or withhold information. No form of coercion was applied. All subjects were treated fairly through a nondiscriminatory selection process, respecting their cultural and social diversity and honoring all agreements made during the study.

The privacy and confidentiality of the subjects were maintained by using serial numbers on data collection tools, which did not reveal the identity of any individual subjects. The collected data were stored in password-secured computer files, with hard copies kept in lockable cabinets by the researcher, so that it was only available to the research team.

All potential participants also signed an informed consent form prior to participation in the study, after receiving a full explanation of the research process from the researcher. They were also protected from harm through the pretesting of the tools and the development of adequate data collection plans.

The validity of the instrument was achieved by adopting the MSSCQ tool, whose validity had been determined and recommended in various research studies across the globe, such as those on sexual health assessment by *Culp (2020)* and factors associated with sexual healthcare provision (Wang & Rong, 2019). The self-reporting performance tool was also adopted and subjected to expert reviews for validity checks in relation to the study aim.

Following previous reliability tests, the Cronbach's α values for the MSSCQ ranged from 0.78 to 0.91 across the five subscales *(Lin, 2004).* Training of research assistants and standardization of procedures were also undertaken for all the tools.

Pretesting of the questionnaires was conducted among 17 nurses selected from the adult surgical and medical wards at Eldama Ravine Sub-County Hospital, a level four hospital located in neighboring Baringo County. This pretest was conducted on 10% of the sample population. Following the pretest, a few adjustments were made to the items in the questionnaire.

Ten research assistants were selected, five from each county, to facilitate data collection. The assistants were registered nurses working in the two counties but not part of the sample. A one-day training session was conducted for the assistants on how to identify study participants and provide guidance on completing the questionnaires. Clear instructions were provided for all the subjects on how to answer questions from the various sections of the questionnaire. A data collection exercise was conducted over a period of five months.

### *4.6. Data analysis*

Statistical analyses were performed using version 28.0. of the Statistical Package for Social Sciences (SPSS). Descriptive statistics (frequency and percentages) were used to identify nurses' demographic features and responses to the questionnaire items. A simultaneous multiple regression test was conducted to examine the influence of nurses' sexual self-concept characteristics on their performance level during the implementation of sexual healthcare to patients hospitalized with medical and surgical conditions. The statistical significance for the analyses was set at a P value ≤0.05.

## 5. Results

Table 1 presents the demographic characteristics of the participants, with the majority of nurses who responded being aged between 31 and 40 years and comprising 60.2% females. 74.3% were married, and the majority (57.9%) had a diploma as the highest level of education. Regarding work experience, 40.9% of the nurses had worked for 5-10 years. Equally, a majority (42.1%) were working in both medical and surgical care units.

Table 2 shows that 65.5% (n=112) of the studied nurses implemented sexual health care activities satisfactorily, as indicated by a performance above 50% (≥35 points), while 34.5% (n=59) exhibited unsatisfactory performance.

Table 3 presents the responses of nurses on the multidimensional sexual self-concept questionnaire items for the five domains included in the study. The mean score for sexual anxiety is 4.79±1.15, sexual self-efficacy 5.66±1.33, sexual consciousness 17.11±1.01, sexual self-esteem 15.47±1.04, and sexual self-monitoring and awareness 10.30±1.26. The overall mean score was 10.66±1.12.

Table 4 gives a summary of the five subscales of the MDSSCQ. The mean scores ranged from as low as 4.79±1.15 for sexual anxiety to 17.11±1.01 for sexual consciousness, being the highest.

Table 5 presents the multiple regression analysis that sought to bring out the relationship among the five sexual self-concept characteristics and the nurses' performance of sexual health to inpatients. The model summary table indicated that 58.6% (R Square = 0.586) of the data computed was used in the regression. As this was above the 50% threshold, this was considered sufficient to compute the model, and it shows that sexual self-concept characteristics explained 58.6% variation in performance regarding the implementation of sexual health. At 0.05 level of significance the ANOVA test indicated that in this model each of the independent variables; Sexual anxiety (p=0.017), Sexual self-efficacy (p=0.001), sexual consciousness (p=0.003), sexual self-esteem (p=0.000), and sexual self-monitoring (p=0.048) were predictors of nurses' performance in implementation of sexual health to inpatients in the South Rift, Kenya as indicated by overall significance value of 0.021 which is less than the set value.

**Table (1): Frequency and percentage distribution of the nurses' socio-demographic characteristics (n=171).**

| Demographic characteristics | No. | % |
|---|---|---|
| **Age (in years)** | | |
| ≤30 years | 48 | 28.1 |
| 31-40 years | 76 | 44.4 |
| 41-50 years | 32 | 18.7 |
| >50 years | 15 | 8.8 |
| **Gender** | | |
| Male | 68 | 39.8 |
| Female | 103 | 60.2 |
| **Marital status** | | |
| Married | 127 | 74.3 |
| Single | 38 | 22.2 |
| Widowed | 4 | 2.3 |
| Divorced/separated | 2 | 1.2 |
| **Highest Education level** | | |
| Certificate | 3 | 1.8 |
| Diploma | 99 | 57.9 |
| Higher National Diploma | 18 | 10.5 |
| Degree | 51 | 29.8 |
| **Experience (years)** | | |
| Less than five years | 42 | 24.6 |
| 5-10 Years | 70 | 40.9 |
| Above 10 years | 59 | 34.5 |
| Hospital Unit/section working in | | |
| Medical | 55 | 32.2 |
| Surgical | 44 | 25.7 |
| Both | 72 | 42.1 |

**Table (2): Performance of sexual health care among nurses (n=171).**

| Performance level | Frequency | Percentage |
|---|---|---|
| Satisfactory | 112 | 65.5 |
| Unsatisfactory | 59 | 34.5 |

**Table (3): Responses of the multidimensional sexual self-concept characteristics.**

| Variables | Possible scores | Mean (SD) | Min | Max |
|---|---|---|---|---|
| **Sexual anxiety** | | | | |
| I feel anxious when I think about the sexual aspects of my life | 1-5 | 0.89±1.14 | 1.00 | 5.00 |
| I worry about the sexual aspects of my life | 1-5 | 0.84±1.00 | 1.00 | 5.00 |
| Thinking about the sexual aspects of my life often leaves me with an uneasy feeling | 1-5 | 0.82±1.06 | 1.00 | 5.00 |
| I do not worry about the sexual aspects of my life | 1-5 | 1.18±1.31 | 1.00 | 5.00 |
| I feel nervous when I think about the sexual aspects of my life | 1-5 | 1.06±1.24 | 1.00 | 5.00 |
| Total scores | 5-25 | 4.79±1.15 | | |
| **Sexual self-efficacy** | | | | |
| I have the ability to take care of any sexual needs and desires that I may have | 1-5 | 2.64±1.23 | 1.00 | 5.00 |
| I am competent enough to make sure that my sexual needs are fulfilled | 1-5 | 2.92±1.19 | 1.00 | 5.00 |
| I have the skills and ability to ensure rewarding sexual behaviors for myself | 1-5 | 2.99±1.14 | 1.00 | 5.00 |
| I can cope with and handle my own sexual needs and wants | 1-5 | 3.08±1.07 | 1.00 | 5.00 |
| I can take care of my own sexual needs and desires | 1-5 | 3.26±1.02 | 1.00 | 5.00 |
| Total scores | 5-25 | 5.66±1.13 | 1.00 | 4.00 |
| **Sexual consciousness** | | | | |
| I am very aware of my sexual feelings and needs | 1-5 | 3.43±0.98 | 1.00 | 5.00 |
| I am very aware of my sexual motivations and desires | 1-5 | 3.47±0.95 | 1.00 | 5.00 |
| I tend to think about my own sexual beliefs and attitudes | 1-5 | 3.36±1.09 | 1.00 | 5.00 |
| I am very alert to changes in my sexual thoughts, feelings, and desires | 1-5 | 3.43±1.00 | 1.00 | 5.00 |
| I am very aware of sexual aspects of myself (e.g, habits, thoughts, beliefs) | 1-5 | 3.42 ±1.01 | 1.00 | 5.00 |
| Total scores | 5-25 | 17.11±1.01 | | |
| **Sexual self-esteem** | | | | |
| I derive a sense of self-pride from the way I handle my own sexual needs and desires | 1-5 | 2.96 ±1.158 | 1.00 | 5.00 |
| I am proud of the way I deal with and handle my own sexual desires and needs | 1-5 | 3.04 ±1.031 | 1.00 | 5.00 |
| I am pleased with how I handle my own sexual tendencies and behaviors | 1-5 | 3.06 ±1.085 | 1.00 | 5.00 |
| I have positive feelings about the way I approach my own sexual needs and desires | 1-5 | 3.18 ± 0.984 | 1.00 | 5.00 |
| I feel good about the way I express my own sexual needs and desires | 1-5 | 3.23± 0.990 | 1.00 | 5.00 |
| Total scores | 5-25 | 15.47±1.04 | | |
| **Sexual self-monitoring** | | | | |
| I do notice how others perceive and react to the sexual aspects of my life | 1-5 | 1.98±1.229 | 1.00 | 5.00 |
| I am concerned with how others evaluate my own sexual beliefs and behaviors | 1-5 | 1.90±1.206 | 1.00 | 5.00 |
| I am quick to notice other people’s reactions to sexual aspects of my own life | 1-5 | 2.04±1.238 | 1.00 | 5.00 |
| I am concerned about how the sexual aspects of my life appear to others | 1-5 | 2.15±1.333 | 1.00 | 5.00 |
| I am aware of the public impression created by my own sexual behaviors and attitudes | 1-5 | 2.23±1.311 | 1.00 | 5.00 |
| Total scores | 5-25 | 10.30± 1.26 | | |
| **Overall score** | | 10.668±1.12 | | |

**Table (4): Summary of the multidimensional sexual self-concept characteristics (n=171).**

| Indicators | RATING | | | | | | | | | | Mean±SD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | | 2 | | 3 | | 4 | | 5 | | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | |
| Sexual anxiety | 80 | 46.8 | 51 | 29.8 | 19 | 11.1 | 11 | 6.4 | 10 | 5.9 | 4.79±1.15 |
| Sexual self-efficacy | 11 | 6.4 | 9 | 5.3 | 24 | 14.0 | 57 | 33.3 | 70 | 41.0 | 5.66±1.133 |
| Sexual consciousness | 6 | 3.5 | 6 | 3.5 | 9 | 5.3 | 39 | 22.8 | 111 | 64.9 | 17.11±1.01 |
| Sexual self-esteem | 4 | 2.3 | 11 | 6.4 | 29 | 17.0 | 46 | 26.9 | 81 | 47.4 | 15.47±1.04 |
| Sexual self-monitoring and awareness | 23 | 13.5 | 34 | 19.9 | 36 | 21.1 | 50 | 29.2 | 28 | 16.3 | 10.30±1.26 |

## 6. Discussion

Nurses’ sexual self-concept remains a fundamental attribute towards successful performance of sexual health care among hospitalized patients. This current study sought to determine the relationship between nurses’ sexual self-concept and performance of sexual health care among inpatients in the South Rift, Kenya.

Demographically, the majority of the participants were aged between 31 and 40 years, accounting for near half, while the female gender dominated the sample at around two-thirds. Regarding the highest level of education, more than half of the studied nurses held a diploma in nursing. At the same time, only a third had a bachelor's degree, indicating that the majority of nurses in level four and five hospitals in the South Rift, Kenya, are trained at the diploma level.

It was also noted that more than three-quarters of the study participants had work experience of over five years since attaining their first nursing qualification. At the time of the study, approximately a quarter of the participants were working in surgical units, a third in medical units, and nearly half in both medical and surgical units. This distribution was a clear indication that staffing shortages exist in many facilities, forcing nurses to work concurrently in both medical and surgical units.

The findings reveal that nearly two-thirds of all nurses who took part in the study satisfactorily implemented sexual health care interventions, while only a third rated their performance level as unsatisfactory. This finding clearly shows that nurses in South Rift hospitals have a

**Table (5): Regression analysis of sexual self-concept characteristics and performance in the implementation of sexual health to inpatients.**

**Model summary**

| R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|
| **0.766[a]** | 0.586 | 0.579 | 0.52993 |

**a. Predictors: (Constant), Sexual anxiety, Sexual self-efficacy, Sexual consciousness, Sexual self-esteem, Sexual self-monitoring**

| | Model | Sum of Squares | Df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 5826.80 | 5 | 1165.36 | 33.12 | .021[a] |
| | Residual | 3721.66 | 166 | 22.420 | | |
| | Total | 9548.47 | 171 | | | |

| | Model | Unstandardized Coefficients | | Standardized Coefficients | T | Sig. |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | | |
| 1 | (Constant) | 13.296 | 2.218 | | 15.99 | 0.002 |
| | Sexual anxiety | 0.211 | 0.065 | .229 | 43.22 | 0.017 |
| | Sexual self-efficacy | 0.338 | 0.083 | .071 | 11.94 | 0.001 |
| | Sexual consciousness | 0.198 | 0.102 | .156 | 51.94 | 0.003 |
| | Sexual self-esteem | 0.428 | 0.201 | .396 | 14.89 | 0.000 |
| | Sexual self-monitoring | 0.312 | 0.066 | .377 | 45.00 | 0.048 |

*a. Predictors: (Constant), Sexual anxiety, Sexual self-efficacy, Sexual consciousness, Sexual self-esteem, Sexual self-monitoring*
*b. Dependent Variable: Implementation of sexual health to inpatients*

greater potential to meet the sexual health needs of hospitalized patients, thereby enhancing their quality of life. Similar findings were seen in a study done in Spain, in which half of the nurses expressed confidence and willingness to engage patients on issues about their sexual health and believed they could effectively manage sexual issues with either men or women patients *(Leyva-Moral et al., 2020).*

These findings, however, were slightly higher compared to many other studies, in which less than 50% of nurses exhibit satisfactory levels of performance regarding the implementation of sexual healthcare *(Leyva-Moral et al., 2020; Al-Ghabeesh et al., 2019; Afiyanti, 2017; Ekström & Nilsson, 2016)*.

Nurses' sexual self-concept (SSC) is considered an important determinant of sexual health care performance. Based on the indicators assessed, nurses posed moderate levels of sexual consciousness and sexual self-esteem. On the other hand, sexual self-efficacy and sexual self-monitoring were low, while sexual anxiety was more obvious. The findings therefore show that nurses who took part in this study posted more negative sexual self-concept evaluations, which may negatively affect how they provided care to inpatients on matters of sexual health. According to *Wang and Rong (2019),* nurses who have more positive sexual self-concept evaluations always understand their own strengths and weaknesses, are confident in handling such concerns, and hence are capable of addressing their patients' sexual health needs when they arise in the course of duty. On the contrary, those exhibiting negative sexual self-concept evaluations tend to lack the courage and competence to address their patients' needs.

Young and inexperienced nurses are often the most uncomfortable and incompetent group due to possession of negative sexual self–concepts that give them negative convictions and uncertainties about sexual health issues *(Åling et al., 2021).* They perceive the risk of triggering emotional responses in themselves and in patients, which can lead to compromised nurse-patient relationships.

The findings also reveal that 58% of the variation in the satisfactory implementation of nursing care related to inpatients' sexuality in the research area was explained by sexual self-concept characteristics. All five indicators were found to be significant predictors of nurses' performance in inpatient sexual healthcare. Having a strong self-concept has been found to greatly influence nurses' overall performance in addressing patients' sexual health needs *(Lloyd, 2018).* This finding suggests that an increase in each attribute leads to a more positive self-concept and, consequently, better performance. It is therefore crucial that strategies aimed at enhancing nurses' positive sexual self-concept be developed and incorporated in nursing training curricula in Kenya in order for the nurses to develop competencies and practical skills for sexual health care performance.

## 7. Conclusion

Based on the results, more than half of the research participants exhibited a satisfactory level of performance in terms of sexual healthcare provision to the hospitalized patients. On the influence of sexual self-concept on the overall performance of sexual health care, the study reveals moderately low levels of the five sexual concept indicators. Additionally, all of them were found to serve as significant predictors of nurses' overall performance in implementing sexual healthcare to inpatients.

## 8. Recommendations

From the findings of this study, the following recommendations were made;

- Hospitals have to adopt guidelines to support the incorporation of sexual healthcare in every patient's routine care protocol in all clinical settings to increase nurses' performance levels.
- Nurse training schools and colleges should expand the content on sexual health in their nursing training curricula to include evidence-based theoretical and practical components for all levels of nursing cadres. These will enable nurses to be more scientific and competent in approaching the complex domain that has remained neglected or inadequately addressed in routine nursing care over time.
- More interventional research is needed on the implementation of existing sexual health care tools and

models to determine setting-specific approaches that can yield better outcomes.

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