

Sexual and Reproductive Health Education Needs of Engaged Couples in North of Iran: A Qualitative Study

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Abstract

Background

Sexual and reproductive health (SRH) education is important for marriage preparation, but standardized premarital education may not address individual couples' concerns, information needs, and preferred learning approaches. This qualitative study, informed by a constructivist orientation, explored SRH educational needs, perceived educational challenges, and preferred educational strategies among engaged couples attending premarital counseling services in northern Iran.

Methods

Conducted in premarital counseling centers, the study used purposive sampling with maximum variation. Data were collected through 23 in-depth interviews with engaged individuals, one mini focus group with four engaged individuals representing two couples, and five interviews with key informants. Semi-structured interviews and the focus group were audio-recorded and transcribed verbatim. Conventional inductive content analysis was used. The Health Belief Model served as a sensitizing framework rather than a predetermined coding framework. Trustworthiness was addressed through triangulation, peer debriefing, member checking, reflexive journaling, an audit trail, and double-coding of transcripts.

Results

Four main categories and 16 subcategories were identified. Participants described SRH education needs extending beyond basic reproductive information to sexual health, contraception, understanding partner differences, problem-solving, communication, mutual understanding, trust, commitment, and responsibility. Educational challenges included cultural sensitivity, limited access to credible information, insufficient continuity of governmental educational services, poor provider client interactions, and limited providers' SRH knowledge. Participants preferred technology-based, interactive, and continuing education. They also described a perceived mismatch between changing expectations and existing educational practices, including generational differences, traditional-modern discourse tensions, and perceived constraints surrounding sexual health education. Views differed on formal and contraceptive education. [9]

Conclusions

Engaged couples described SRH education as a multidimensional need involving knowledge, communication, relationship skills, credible information, and supportive educational interactions.

Findings suggest premarital SRH education may benefit from interactive, accessible, multi-channel approaches that extend beyond a single premarital encounter.

Introduction

Sexual and reproductive health (SRH) is a fundamental component of health and well-being [1].

It includes sexual health, contraception, fertility, pregnancy, childbirth, and prevention of sexually transmitted infections (STIs) [2]. It also includes access to accurate information and appropriate health services [3]. The transition to marriage is an important period for SRH education [4].

Engaged couples face decisions about sexual relationships, contraception, fertility, and childbearing [5]. They may also need information about STIs, infertility, and preconception health [6]. Accurate information can support informed decisions and healthier relationships [3]. Sexuality education can improve knowledge and correct misconceptions. It can also support responsible decision-making and healthy relationships [7]. Evidence suggests that well-designed education can improve protective sexual and reproductive health behaviors [8]. However, access to appropriate education remains uneven across settings [9]. Iran has provided premarital education through its health system for several decades. These programs aim to prepare couples for marriage and family formation [10]. However, previous research has identified limitations in the content and delivery of premarital education [11]. Some educational approaches remain primarily information-based [12]. Such approaches may not fully address the concerns of individual couples [13]. This issue is important because SRH needs are not uniform across populations [7]. They are shaped by cultural norms, gender roles, social expectations, and access to information [14].

These factors can influence how couples understand and discuss sexual and reproductive issues [15]. They can also influence what couples expect from health professionals and educational programs [16].

A central challenge is the gap between what educational programs provide and what couples actually need [11]. Standardized curricula are often developed around predefined topics [12].

They may therefore overlook questions that couples consider important in their own lives [13].

This limitation is particularly relevant for sensitive topics such as sexuality, fertility, contraception, and marital communication [15]. The available Iranian evidence also remains fragmented [17].

Some studies have focused on SRH knowledge [18]. Others have evaluated educational interventions or premarital counseling [19]. These studies provide useful information about outcomes but may not capture the full range of couples' experiences and priorities [20].

Importantly, a previous qualitative study in Rasht examined sexual health education among engaged couples. It identified inadequate sexual knowledge and sociocultural barriers as important concerns. However, that study primarily focused on the necessity of sexual health education [21]. A broader

examination of SRH educational needs, educational challenges, and preferred strategies remains important. This distinction is particularly relevant when educational programs are expected to respond to changing needs and contexts [22].

Qualitative inquiry is well suited to this purpose. It allows participants to describe their needs in their own words [23]. It can also uncover concerns that structured questionnaires may not anticipate [24]. This is particularly valuable when studying sensitive and context-dependent issues [25]. Understanding these needs has practical importance for premarital education [26].

It can help identify topics that couples consider relevant and insufficiently addressed [27].

It can also inform the design of more responsive and culturally appropriate educational strategies [22]. Importantly, education that reflects users' perspectives may be more relevant to their real-life concerns [28]. Therefore, this study explored the SRH education needs of engaged couples. We examined the topics that couples considered important or insufficiently addressed.

We also explored their educational challenges, expectations, and preferred strategies.

Methods

Paradigmatic Orientation

This study was grounded in a constructivist paradigm, which views knowledge and social realities as context dependent and shaped through interactions between individuals and their social worlds. Accordingly, participants' SRH educational needs were understood as experiences and meanings shaped by personal, relational, and sociocultural contexts. The Health Belief Model (HBM) was used as a sensitizing framework. Its constructs informed the development of the interview guide and helped the researchers remain attentive to individual perceptions relevant to SRH education.

The HBM was not used as a predetermined coding framework. Instead, it provided a flexible conceptual lens during data collection and interpretation. The analysis remained inductive and data driven, allowing categories and interpretations to emerge from participants' accounts rather than being imposed solely by the theoretical framework.

Setting

The study was conducted in premarital counseling centers in Rasht, the capital of Guilan Province, northern Iran. Participants were recruited from centers providing routine premarital counseling and health services. The findings should therefore be interpreted in relation to this specific setting and may not be directly transferable to couples in other regions of Iran or other sociocultural contexts.

Sampling and Participants

Purposive sampling with maximum variation was used to capture diverse perspectives. Variation was sought across age, educational level, socioeconomic status, and urban or rural residence. Eligible participants were engaged individuals who attended a premarital counseling center in Rasht, were willing to participate, spoke Persian, and resided in Rasht. Participants were excluded if they were unable or unwilling to participate in an interview or declined audio recording.

The study included three participant groups: 23 engaged individuals participated in individual in-depth interviews, including 15 women and 8 men; Four engaged individuals participated in one mini focus group discussion comprising two engaged couples; Five key informants participated in individual interviews. All key informants were women aged 38–51 years with professional experience in reproductive health, midwifery, health education, or obstetrics and gynecology.

The higher representation of women among engaged participants reflected the composition of attendees recruited from the participating premarital counseling centers. All key informants were women because the SRH providers available through the participating governmental services were women. One participant was 17 years old. Written consent was obtained from the participant and her legal guardian in accordance with the applicable ethical requirements.

Data Sufficiency

Data collection continued until the research team judged that the major categories were sufficiently developed and additional interviews were no longer generating substantively new codes. As an operational criterion, data sufficiency was considered reached after three consecutive interviews produced no new codes. The research team reviewed emerging codes and categories throughout data collection and agreed that the main areas relevant to the research questions had been adequately explored.

Data Collection

Data collection was completed before participants attended routine premarital education classes. This timing was intended to minimize the influence of prior exposure to the standard educational curriculum on participants' accounts. Semi-structured individual interviews lasted approximately 45–60 minutes. One mini focus group discussion lasted approximately 90 minutes. All sessions were conducted in a private room at the premarital counseling center. The interview guide was developed based on the study objectives and relevant literature and was refined following three pilot interviews. Two sensitive questions were reworded to reduce potentially judgmental wording and facilitate more open discussion. Pilot interviews were not included in the final analysis.

All interviews and the focus group discussion were audio-recorded with participants’ permission and transcribed verbatim. Field notes were completed after each session.

The first author maintained a reflexive journal throughout data collection and analysis. The journal documented methodological decisions, emerging interpretations, and reflections on how the researcher’s gender, professional background, and previous experience in premarital counseling might have influenced interactions with participants and interpretation of their accounts.

Data Analysis

Data were analyzed using conventional content analysis with an inductive approach. Transcripts were read several times to achieve familiarity with the data and identify meaningful segments related to the research questions. Initial codes were assigned to relevant segments. Codes with conceptual similarities were compared and grouped into subcategories. Related subcategories were then organized into broader categories representing recurring patterns in participants’ accounts.

The researchers moved iteratively between transcripts, codes, subcategories, and categories. Categories were revised when new data challenged or expanded emerging interpretations.

Approximately 20% of transcripts were independently coded by two researchers. Differences were discussed and the coding framework was refined through discussion and consensus. This process was intended to enhance analytic consistency and identify alternative interpretations rather than establish statistical reliability. Data were managed using MAXQDA 2010.

Table 1 presents an example of the coding progression from raw quotations to initial codes, subcategories, and main categories.

Table 1 Example of Coding Progression			
Raw quotation	Initial code	Subcategory	Main category
“I don't know how to talk to my future spouse about sexual issues.”	Difficulty discussing sexual issues	Need for sexual communication skills	SRH education needs

Trustworthiness

Trustworthiness was addressed using the criteria of credibility, transferability, dependability, and confirmability. Credibility was supported through maximum-variation purposive sampling, iterative comparison of codes and categories, peer debriefing, triangulation across individual interviews, the mini focus group, and key informant interviews, and member checking with five participants. Transferability was supported by detailed descriptions of the study setting, participant characteristics, recruitment

context, and data collection procedures. Dependability was supported through an audit trail documenting decisions related to data collection, coding, category development, and changes to the analytical framework. Confirmability was addressed through reflexive journaling, peer discussion, documentation of analytical decisions, and triangulation across participant groups and data sources.

Reflexivity

The first author holds a PhD in reproductive health and has previous clinical experience in premarital counseling. This background provided contextual knowledge of premarital SRH services but also created the possibility of preconceived expectations regarding participants' educational needs. The first author therefore maintained a reflexive journal and discussed emerging interpretations with a qualitative researcher who did not have a clinical background in marital counseling. The research team deliberately explored both positive and negative experiences of premarital education rather than assuming that the existing program was inadequate. The researchers also considered the potential influence of interviewer gender. The first author was female, and some male participants appeared more hesitant when discussing sensitive sexual topics. This possibility was documented in the reflexive journal and considered during interpretation.

Ethical Considerations

All methods were performed in accordance with the relevant guidelines and regulations. The study was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was obtained from the Research Ethics Committee of Guilan University of Medical Sciences (IR.GUMS.REC.1402.555). Written informed consent was obtained from all participants before participation. For the participant aged 17 years, written consent was obtained from both the participant and her legal guardian in accordance with the applicable ethical requirements. Participants were informed of the study objectives, procedures, potential risks and benefits, confidentiality, and their right to withdraw at any time without consequences for their counseling services.

Results

The analysis generated four main categories and 16 subcategories reflecting educational needs, perceived barriers, preferred educational approaches, and broader tensions surrounding SRH education. The characteristics of the study participants are presented in Table 2.

Table 2
Participant Characteristics Reported in the Manuscript

Participant group	Number	Sex	Age information available	Other characteristics
Individual engaged participants	23	15 women, 8 men	Individual ages reported in quotations, but complete distribution not provided	Educational level and occupation reported for selected quoted participants
Mini focus group	4	Engaged participants; exact sex distribution not separately summarized	Individual information partially reported	Two engaged couples; complete characteristics not summarized
Key informants	5	All women	38–51 years	Professional experience in reproductive health, midwifery, health education, or obstetrics/gynecology

Category 1. Educational Needs

Participants described SRH education as extending beyond basic reproductive information. Five subcategories were identified.

1.1 Sexual Health Education

Participants commonly described sexual health education as an important component of premarital education and emphasized the need for accurate, scientific, and non-judgmental information.

“Unfortunately, many people marry without any education and later face many problems. If the government or counseling centers hold scientific and non-shameful courses on sexual issues, many divorces and misunderstandings would definitely be prevented.” (*Male, 32 years, diploma, self-employed*).

1.2 Contraceptive Methods Education

Participants identified contraception as an insufficiently addressed topic in existing premarital classes and emphasized practical and scientifically based information.

“In these classes, they didn't talk about contraceptive methods at all. If we don't have formal and scientific education, we are forced to rely on websites and social media, and it's not clear how accurate that information is.” (*Female, 25 years, bachelor's degree in education, teacher*).

Another participant emphasized the practical nature of the information needed:

“Many young people are caught between feeling and logic. Many want to have children, but logic and reality do not allow it. I think contraceptive methods should definitely be taught in a completely operational and practical way.” (*Male, 29 years, master's degree in mechanical engineering, self-employed*).

1.3 Gender Differences and Adaptation

Participants described a need to understand differences between partners and how such differences could be managed within married life. “I know the generalities about gender differences to some extent... But I don't know the details and the impact of these differences on shared life very deeply. I think they should spend more time on these topics.” (*Female, 32 years, bachelor's degree in mathematics, homemaker, FGD*).

1.4 Problem-Solving Skills

Participants identified problem-solving as another educational need and described the value of practical skills for managing disagreements. “I think no problem is unsolvable; we just may not have enough time or tools. Problem-solving skills can prevent small disagreements from turning into big crises.” (*Female, 29 years, diploma, homemaker*).

1.5 Mutual Understanding, Trust, Commitment, and Responsibility

Participants discussed mutual understanding, trust, commitment, and shared responsibility as relevant to healthy married life and SRH. “Commitment and responsibility for me mean choosing this relationship daily. It's not enough to say 'yes' at the wedding ceremony.” (*Female, 33 years, master's degree in literature, teacher*).

Another participant emphasized reciprocity: “Unfortunately, my spouse does not consider my needs in these [sexual] matters, which has created distrust in me.”

Female, 31 years, associate degree in computer science, homemaker.

Category 2. Educational Challenges

Five subcategories concerned barriers to accessing or engaging with SRH education.

2.1 Cultural Resistance

Participants described sexuality as a sensitive and sometimes taboo topic. “Taboo, shame, and modesty have caused people either to hide their problems or to turn to social media and the internet to solve their [sexual] problems.” (*Female, 40 years, PhD in physics, teacher*).

A younger participant described the lack of discussion during earlier education:

“Honestly, this topic [sexuality] has always been a taboo. In my family, no one ever talked about it... Now that I am about to get married, I feel I am facing an unknown world for which no one has prepared me.”

(Female, 23 years, diploma, homemaker).

2.2 Lack of Access to Credible Resources

Participants reported difficulties identifying reliable sources of SRH information. “Many of my friends get their information in this area from unreliable sources like social media or movies, which are full of false beliefs.” (Female, 29 years, associate degree, employee).

A key informant similarly stated: “Lack of access to credible SRH educational resources affects the preparedness of young couples for shared life.” (Female, 47 years, PhD in reproductive health, faculty member).

2.3 Lack of Continuous Governmental Educational Services

Participants and key informants described premarital education as insufficiently continuous.

“Implementing a comprehensive plan for educating young couples in SRH nationally and continuously could be an important step in improving the health of Iranian families...” (Female, 46 years, PhD in health education, faculty member).

2.4 Poor Provider-Client Interactions

Participants described communication with health providers as an important aspect of their educational experiences. “Even if you have little time, devote those few minutes to us with full attention and without judgment.” (Female, 31 years, master's degree in physiotherapy, employee).

2.5 Insufficient Provider SRH Knowledge

Some participants perceived limitations in providers’ knowledge and communication skills. “I think the health workers themselves have not been trained, so they don't know how to talk about these topics.” (Female, 19 years, associate degree, homemaker).

This finding represents participants’ perceptions; provider knowledge was not independently assessed in the present study.

Category 3. Educational Strategy Preferences

Three subcategories described preferred educational approaches.

3.1 Technology-Based Education

Participants expressed interest in videos, mobile applications, and online resources. “Nowadays, most people use mobile phones and the internet. Education that comes with videos or mobile apps is much more effective than just attending an in-person class.” (Male, 28 years, diploma, self-employed).

3.2 Interactive Education

Participants preferred active participation rather than one-way delivery. “Education must be interactive; a place where couples can ask questions without fear of judgment, participate in discussions, and even learn communication skills... through practical exercises.” (*Male, 39 years, diploma, self-employed*).

3.3 Continuous Education

Participants described a need for continuing education beyond the premarital sessions.

“Premarital education should not be limited to a few sessions before the wedding... The learning process must continue.” (*Female, 28 years, diploma, employee*).

A key informant similarly emphasized continuity: “Education is effective when it is continuous. We should not be satisfied with just one session or one short course.” (*Female, 38 years, PhD in reproductive health, faculty member*).

Category 4. Perceived Mismatch Between Changing Information Environments and Existing Educational Practices

To avoid over claiming, this category should preferably replace the original title “System-Level Tensions in SRH Education.” The data support participants’ perceptions of mismatch more directly than an independent assessment of the health system.

4.1 Generational Gap

Participants perceived differences between younger couples’ expectations and the communication styles used by older educators. “The new generation has grown up with the internet and social media, is used to frankness and clarity, but many educators are still caught up in past stereotypes and taboos.” (*Female, 34 years, master's degree in sports physiology, employee*).

4.2 Traditional–Modern Discourse Conflict

Participants described a perceived mismatch between rapid social and cultural change and educational approaches. “The speed of cultural change is very high, and I think many educators have not been able to keep up with this speed of progress.” (*Male, 30 years, master's degree in law, employee*).

4.3 Perceived Constraints in Sexual Health Education

Some participants and key informants perceived the educational environment as constrained by traditional norms. “Conservative educational systems may avoid teaching sexual issues so as not to question 'traditional norms'.” (*Female, 49 years, specialist in obstetrics and gynecology, private sector*).

These statements should remain explicitly attributed to participants and should not be presented as an independent finding about national policy.

Disconfirming and Contrasting Views

Although SRH education was widely valued, two participants a 36-year-old man and a 41-year-old woman reported that they had obtained sufficient information from family and the internet and did not perceive a need for formal education. A contrasting view concerned contraception. One 34-year-old male participant opposed contraceptive education and stated: “God provides for everyone; whatever He gives is our right. These teachings go against God's will.”

This perspective differed from accounts in which participants requested contraceptive education.

Differences were also observed in the emphasis placed on educational content. Women more frequently discussed mutual understanding and trust, whereas some male participants emphasized technical information about sexual function. These observations are presented as differences in emphasis within the dataset rather than fixed gender differences.

Table 3 provides an overview of the main categories, subcategories, and illustrative quotations identified during the analysis.

Table 3
Categories, Subcategories, and Illustrative Quotations

Main category	Subcategory	Illustrative quotation source
Educational Needs	Sexual Health Education	Male, 32 years, diploma, self-employed
	Contraceptive Methods Education	Female, 25 years, bachelor's degree, teacher
	Gender Differences and Adaptation	Female, 32 years, bachelor's degree, homemaker, FGD
	Problem-Solving Skills	Female, 29 years, diploma, homemaker
	Mutual Understanding, Trust, Commitment, and Responsibility	Female, 33 years, master's degree, teacher
Educational Challenges	Cultural Resistance	Female, 40 years, PhD, teacher
	Lack of Access to Credible Resources	Female, 29 years, associate degree, employee
	Lack of Continuous Governmental Educational Services	Female, 46 years, PhD, faculty member
	Poor Provider–Client Interactions	Female, 31 years, master's degree, employee
	Insufficient Provider SRH Knowledge	Female, 19 years, associate degree, homemaker
Educational Strategy Preferences	Technology-Based Education	Male, 28 years, diploma, self-employed
	Interactive Education	Male, 39 years, diploma, self-employed
	Continuous Education	Female, 28 years, diploma, employee
Perceived Mismatch Between Changing Information Environments and Existing Educational Practices	Generational Gap	Female, 34 years, master's degree, employee
	Traditional-Modern Discourse Conflict	Male, 30 years, master's degree, employee

Main category	Subcategory	Illustrative quotation source
	Perceived Constraints in Sexual Health Education	Female, 49 years, specialist in obstetrics and gynecology

Discussion

This qualitative study explored SRH educational needs, perceived challenges, and preferred educational strategies among engaged couples attending premarital counseling services in Rasht, Iran. Four broad categories were identified: educational needs, educational challenges, preferred educational strategies, and perceived mismatch between changing information environments and existing educational practices. Participants described SRH education as extending beyond basic information about reproduction and contraception. Their accounts included practical knowledge, communication skills, relationship-related skills, credible information, and supportive educational interactions.

Educational Needs

Comprehensive sexual health education was identified as an important component of premarital preparation. This finding should be interpreted as evidence of a perceived educational need, rather than evidence that participants had objectively inadequate SRH knowledge.

Communication was another important component of participants’ accounts. Participants described the need to understand partners, communicate about sensitive issues, solve problems, and develop mutual trust and responsibility. These findings indicate that participants conceptualized SRH education broadly, incorporating relational and communication dimensions alongside biomedical information.

Contraceptive Education

Contraceptive education emerged as a specific educational need. Participants emphasized practical information and expressed concern about relying on informal online sources.

Importantly, the present study did not measure contraceptive knowledge or actual contraceptive practices. Therefore, these findings should not be interpreted as evidence of inadequate contraceptive use at the population level. The contrasting view of one participant who opposed contraceptive education further demonstrates that educational needs were not homogeneous.

Cultural and Informational Challenges

Participants described cultural sensitivity, shame, discomfort, and limited opportunities for open discussion as barriers to SRH education [5, 6, 18].

The findings are consistent with the earlier qualitative study conducted in Rasht, but the present study should not claim to establish a newly recognized need. Rather, its contribution is the integration of

educational content, barriers, provider-related concerns, preferred strategies, continuity, and perceived changes in the information environment. Participants also reported difficulty identifying credible SRH information. This highlights a tension between increased access to information and uncertainty about its accuracy.

Provider-Related Challenges

Provider–client communication was perceived as an important component of educational quality. Participants described the importance of respectful, attentive, and non-judgmental communication.

Some participants also perceived insufficient provider SRH knowledge. However, because provider knowledge was not independently assessed, this finding should remain explicitly framed as a participant perception. Future research could directly assess providers' SRH knowledge, communication skills, and educational practices.

Preferred Educational Strategies

Participants expressed interest in technology-supported education, interactive approaches, and continuing education. The present study does not demonstrate that digital education is superior to face-to-face education. Rather, participants' accounts suggest that digital resources may represent an additional channel for accessing sensitive information, particularly when privacy and flexibility are valued [10, 11].

Similarly, the preference for continuing education should not be interpreted as evidence that continuous education is effective. Its feasibility, acceptability, cost, and effectiveness require empirical evaluation.

Perceived Mismatch Between Changing Information Environments and Existing Educational Practices

Participants described generational differences and perceived tensions between changing social environments and existing educational practices. These findings should be interpreted as participants' perceptions rather than as an independent assessment of national policy or educational curricula. The study did not formally evaluate national sexual health policy, curriculum content, or institutional performance.

The more defensible interpretation is therefore a perceived mismatch between changing information environments and existing educational experiences.

Implications for Premarital SRH Education

The findings suggest that future premarital SRH programs could be designed to address multiple dimensions of couples' expressed needs, including reproductive health information, communication, relationship skills, and practical decision-making. A blended model combining face-to-face interaction

with digital resources may warrant investigation. However, this represents a hypothesis for future intervention research rather than a demonstrated intervention effect.

Similarly, continuing opportunities after marriage may be worth evaluating because participants described educational needs extending beyond the premarital period.

Strengths and Limitations

Strengths

A major strength of this study is the exploration of SRH educational needs from multiple participant perspectives, including engaged individuals and key informants. The study also used several qualitative strategies to enhance trustworthiness, including maximum-variation sampling, triangulation, member checking, peer discussion, reflexive journaling, an audit trail, and independent coding of a subset of transcripts. The explicit inclusion of contrasting views also strengthens the interpretation by demonstrating that participants did not hold completely homogeneous perspectives.

Limitations

The findings should be interpreted in relation to the study setting. Participants were recruited from premarital counseling centers in Rasht and may not represent engaged couples in other regions of Iran. The predominance of women among engaged participants may have influenced the range of perspectives represented. All key informants were women, which may also have limited professional diversity. The sensitive nature of SRH topics may have influenced participants' willingness to disclose some experiences. The first author's professional background in reproductive health and premarital counseling may also have influenced interactions and interpretation. Reflexive journaling and team discussions were therefore used to examine potential researcher influence. Finally, the qualitative design was intended to explore experiences and meanings rather than estimate prevalence or establish causal relationships.

Conclusion

Engaged couples described SRH education as a multidimensional need involving sexual health knowledge, contraception, communication, relationship skills, credible information, and supportive interactions. Participants also identified cultural, informational, provider-related, and educational-system challenges and expressed interest in interactive, technology-supported, and continuing approaches. These findings support further investigation of broader and more flexible approaches to premarital SRH education. Future intervention research should determine whether such approaches improve SRH knowledge, communication skills, service satisfaction, or other relevant outcomes.

Declarations

Ethics Approval and Consent to Participate: Ethical approval was obtained from the Research Ethics Committee of Guilan University of Medical Sciences (IR.GUMS.REC.1402.555). All participants received information about the study objectives, procedures, potential risks and benefits, confidentiality, and their right to withdraw from the study at any time without consequences for their counseling services. Written informed consent was obtained before participation. For the participant aged 17 years, written consent was obtained from both the participant and her legal guardian in accordance with the applicable ethical requirements.

Informed Consent: Written informed consent was obtained from all participants before participation in the study. For the participant aged 17 years, written consent was obtained from both the participant and her legal guardian in accordance with the applicable ethical requirements.

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Author Contributions: MTA conceived and designed the study, contributed to data collection, conducted the qualitative analysis, and drafted the manuscript. ZBK contributed to the study design, data analysis, and interpretation of the findings. SFMA contributed to data interpretation and critically revised the manuscript for important intellectual content. All authors reviewed and approved the final manuscript and agreed to be accountable for all aspects of the work.

Data Availability: The data that support the findings of this study are available from the corresponding author upon reasonable request.

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