

To Accept or Not to Accept: Female Patients' Views on Intimate Nursing Care by Male Nurses at a Teaching Hospital in Ghana

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Abstract

Background

Despite increasing gender diversity in nursing, the acceptance of intimate nursing care provided by male nurses remains a sensitive issue, particularly in sociocultural contexts where gender norms and modesty are emphasized. Evidence from sub-Saharan Africa remains limited.

Aim

This study explored female patients' perceptions on receiving intimate nursing care from male nurses at a teaching hospital in Ghana.

Methods

A qualitative phenomenological design was employed. Seventeen female patients who had experienced intimate nursing care from male nurses at a teaching hospital in Ghana were purposively sampled. Data were collected through semi-structured interviews conducted between March 2025 and June 2025 and analyzed using Braun and Clarke's thematic analysis approach. Trustworthiness was ensured by adhering to Lincoln and Guba's criteria, including credibility, dependability, confirmability, and transferability

Results

Three main themes emerged that include perceptions of male nurses, lived experiences of care, and factors influencing acceptance. Participants reported feelings of embarrassment, anxiety, and vulnerability. Cultural and religious beliefs strongly influenced acceptance. Professionalism, effective communication, and respect for privacy improved patient experiences. However, most participants expressed a strong preference for female nurses and were often reluctant to voice discomfort.

Conclusion

Acceptance of intimate care from male nurses is shaped by complex psychological, cultural, and religious factors. Respecting patient preferences and enhancing culturally sensitive communication are essential for improving patient-centered care.

Background

Nursing has historically been constructed as a female-dominated profession, strongly shaped by sociocultural norms that associate caregiving, empathy, and emotional labour with women [1]. Although men have long participated in care roles, modern nursing has largely evolved within a feminized professional identity, reinforcing stereotypes that position women as naturally suited for caregiving [2].

In recent decades, male participation in nursing has increased globally due to workforce shortages, gender equity policies, and changing social norms [3]. Similar trends are emerging in sub-Saharan Africa, including Ghana, where men remain a minority in the nursing workforce but are steadily increasing [4]. This diversification is widely recognized as beneficial for strengthening healthcare systems and improving workforce resilience.

However, gender-related challenges persist, particularly in intimate nursing care. Male nurses often face role strain, stereotyping, and patient discomfort when providing care involving exposure of private body parts [5]. Intimate care such as perineal hygiene, catheterization, wound care, and bed bathing requires physical proximity and exposure of sensitive body regions, making it emotionally and culturally sensitive for both patients and providers [6].

Importantly, intimate care is not only a clinical procedure but also a culturally mediated interaction shaped by beliefs about modesty, sexuality, dignity, and gender boundaries. Evidence shows that female patients frequently experience embarrassment and vulnerability when receiving intimate care from male nurses [7]. These reactions are not necessarily linked to perceived incompetence but to deeply embedded sociocultural expectations.

In many societies, including Ghana, modesty norms strongly regulate male–female interactions, particularly where bodily exposure is involved. Religious teachings in Christianity and Islam further reinforce expectations of bodily privacy and gender boundaries [8]. Consequently, cross-gender intimate care may be perceived as culturally incongruent.

Within the Ghanaian context, the female body is often socially constructed as private and sacred, and nursing itself is widely perceived as a female profession [9]. These cultural meanings influence both patient expectations and acceptance of care.

Although international studies have explored perceptions of male nurses, most evidence originates from Western and Asian settings, limiting relevance to African contexts. There is limited qualitative evidence from Ghana exploring female patients' lived experiences of intimate care provided by male nurses, particularly in tertiary hospitals. Understanding these perspectives is essential for improving patient-centered care, which emphasizes respect for patient values, preferences, and dignity [10].

This study is therefore guided by Leininger's Transcultural Nursing Theory [11], which emphasizes that care must be culturally congruent and shaped by patients' cultural beliefs, values, and lifeways. The theory proposes three modes of care action: cultural care preservation, accommodation/negotiation, and repatterning/restructuring [21].

Materials and methods

Study setting

The study was conducted at Sunyani Teaching Hospital (STH), a major tertiary healthcare facility located in the Bono Region of Ghana. The hospital serves as a referral center for the Bono, Bono East, Ahafo, and parts of the Western North regions. It provides a wide range of specialized medical and surgical services, including obstetrics and gynecology, internal medicine, surgery, pediatrics, and emergency care. The hospital has a diverse nursing workforce comprising both male and female nurses who provide care across various units. Due to the nature of services offered, intimate nursing care procedures such as bed bathing, catheterization, perineal care, and wound management are routinely performed, making the setting appropriate for exploring female patients' experiences of intimate care provided by male nurses.

Study design and population

A descriptive phenomenological qualitative design was employed to explore and understand the lived experiences of female patients who received intimate nursing care from male nurses. This approach enabled an in-depth exploration of participants' subjective experiences, perceptions, and the meanings they attached to intimate care within a hospital context, without imposing preconceived theoretical assumptions.

The study population comprised female patients admitted to selected wards at Sunyani Teaching Hospital. Data were collected between March 2025 and June 2025 following ethical approval from the Committee for Human Research Publication and Ethics (Reference number: CHRE/AP/43/025) at the University of Energy and Natural Resources. Written permission was obtained from hospital authorities. All participants provided written informed consent prior to participation and were assured of confidentiality, anonymity, and their right to withdraw at any stage without consequences. Participation was voluntary.

Theoretical Framework

The present study was guided by Transcultural Nursing Theory, which emphasizes the influence of cultural values, beliefs, and practices on health-related behaviors and care preferences. This theoretical lens informed the development of the interview guide for this study, the organization of emergent themes during analysis, and the interpretation of female patients' perspectives on receiving intimate nursing care from male nurses. By applying this framework, the study explored how sociocultural norms, gender roles, and personal beliefs shaped patients' acceptance or rejection of such care within the Ghanaian healthcare context.

Sampling and recruitment

A purposive sampling technique was used to recruit participants with direct experience of the phenomenon under study. Seventeen (17) female patients were recruited. Sampling continued until data saturation was achieved, defined as the point at which no new themes or insights emerged from the interviews. This sample size was consistent with phenomenological research, which emphasizes depth rather than numerical representation.

Inclusion criteria

Participants were eligible if they:

- • Were female patients aged 18 years and above
- • Had been admitted for at least five (5) days
- • Had received intimate nursing care from at least one male nurse during admission
- • Were mentally and physically stable to participate
- • Provided informed consent

Exclusion criteria

Patients were excluded if they were critically ill, cognitively impaired, or unwilling to participate.

Data collection

During interviews, the researcher remained mindful that their professional identity as a nurse could influence participants' responses, potentially leading to socially desirable answers or reluctance to express discomfort with intimate care provided by male nurses. To mitigate this, confidentiality, anonymity, and the researcher's non-involvement in participants' direct care were emphasized to create a safe and open environment. Interviews were conducted one-on-one in quiet, private spaces within the hospital, free from staff presence or interruptions, to minimize fear of judgment or repercussions. Participants were informed of their right to decline answering any questions they found uncomfortable, and emotional support was made available where needed. Field notes were taken to capture nonverbal cues such as hesitation, discomfort, or emotional reactions, which informed probing and ensured a more authentic representation of participants' experiences.

Data were collected through in-depth, semi-structured interviews guided by key domains, including experiences of intimate nursing care by male nurses, emotional and psychological responses, perceptions of professionalism, sociocultural and religious influences, and gender preferences in care. The interview guide was developed purposely for this study and was reviewed by qualitative research experts to ensure clarity, relevance, and sensitivity, and was piloted with a small number of participants (excluded from the final sample). Each interview lasted approximately 30–60 minutes and was audio-recorded with participants' consent using a Philips DVT4110 Voice Tracer recorder, complemented by

detailed field notes. Recruitment continued until data saturation was achieved, ensuring depth and variation in participants' experiences.

A comprehensive audit trail was maintained throughout the study. This included verbatim interview transcripts and field notes as raw data; data reduction outputs such as initial codes, coding frameworks, and thematic maps; and analytic memos documenting decisions to refine, merge, or redefine themes. The audit trail also incorporated reflexive journal entries, records of methodological decisions, and iterative refinements to the interview guide based on emerging insights. Peer debriefing with experienced qualitative researchers provided external validation, and records of how their feedback informed the analysis were retained. Additionally, member-checking summaries were returned to selected participants to verify accuracy and ensure that the findings faithfully reflected their intended meanings.

Data analysis

All interviews were transcribed verbatim by the lead researcher, who acknowledged that their professional background as a nurse and qualitative researcher could influence data interpretation. While this positionality enhanced understanding of clinical context and terminology, it also posed the risk of emphasizing familiar perspectives. To address this, a reflexive journal was maintained throughout the analysis to document personal reflections, potential biases, and emotional responses after each transcription and coding session. These reflections were reviewed regularly to minimize the influence of prior assumptions and to remain open to diverse and unexpected meanings in participants' accounts.

Data analysis followed Braun and Clarke's six-step thematic analysis framework: (1) familiarization with the data, (2) generation of initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the final report [12]. An inductive approach was employed to allow themes to emerge directly from the narratives of female patients regarding their experiences of intimate nursing care provided by male nurses. Data were managed systematically, and open coding was conducted line-by-line, with codes grouped into broader categories reflecting recurring patterns. These categories were subsequently refined into subthemes and overarching themes through iterative comparison and team discussions.

An audit trail was maintained throughout the analytical process, including coding outputs, thematic maps, and analytic memos documenting decisions to merge, refine, or redefine themes. Peer debriefing with experienced qualitative researchers provided external validation, and their feedback informed the refinement of themes. In addition, selected participants were engaged in member checking to verify the accuracy of interpretations, ensuring that the final thematic framework faithfully represented their lived experiences.

Trustworthiness of the study

Rigor was ensured using Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability [12]. Credibility was achieved through prolonged engagement, member checking, and the

use of verbatim quotes. Transferability was enhanced by providing detailed descriptions of the study context and participants. Dependability was ensured through the maintenance of an audit trail documenting all stages of the research process. Confirmability was established through reflexivity and by grounding findings in participants' accounts rather than researcher assumptions.

Results

Demographic characteristics of participants

The study included 17 female participants with diverse socio-demographic backgrounds, providing a broad perspective on experiences of intimate nursing care. Slightly more than half of the participants were unmarried (9), while 8 were married, suggesting a relatively balanced representation of marital status, which may influence perceptions of privacy, modesty, and acceptability of male-provided intimate care.

In terms of age distribution, the majority of participants were young adults, with 7 participants aged 18–30 years and 5 aged 31–40 years. Fewer participants were in the older age groups (41–50 years, 3; above 50 years, 2). This indicates that the findings are largely reflective of younger and middle-aged women, whose views may differ from older patients due to generational and cultural variations in attitudes toward gender roles in healthcare.

Regarding duration of admission, most participants had relatively short hospital stays, with 8 admitted for 1–7 days. However, a notable proportion had extended admissions (14–21 days, 4; more than 21 days, 3), suggesting that some participants had prolonged exposure to nursing care, which likely enriched their experiences and reflections on intimate care practices.

Educational levels varied, though most participants had basic to secondary education (primary, 6; high school, 6), with fewer having tertiary education (4) and a small number with no formal education (2). This variation is important, as educational background may shape patients' understanding of professional roles, autonomy, and communication with healthcare providers.

Occupationally, participants were drawn from diverse fields, including teaching ($n = 5$), nursing (5), trading (4), and students (3). The inclusion of participants with healthcare backgrounds (nurses) is particularly noteworthy, as their insider knowledge may influence their perceptions of male nurses' roles in providing intimate care (Table 1).

Table 1
Background characteristics of respondents

Characteristics of Nurse participants (N = 17)	Category	Frequency(N)
Marital status	Married	8
	Unmarried	9
Age	18–30	7
	31–40	5
	41–50	3
	Above 50	2
Number of Days of admission	1–7	8
	7–14	2
	14–21	4
	21 and more	3
Educational level	Non-formal	2
	Primary	6
	High school	6
	Tertiary	4
Occupation	Trading	4
	Teaching	5
	Nursing	5
	Student	3

Table 2
Themes and Subthemes

S/N	Themes	Categories
1	Perceptions of male nurses providing intimate care	1.1 Feelings of Embarrassment and Vulnerability 1.2 Tension between Professionalism and Traditional Gender Roles 1.3 Perceived Differences between Male and Female Nurses
2	Experiences of intimate care	2.1. Positive Experiences: Professionalism, Communication, and Respect for Privacy 2.2. Negative Experiences: Anxiety, Shame, and Emotional Distress 2.3. Reluctance to Express Discomfort
3	Factors influencing acceptance of intimate care	3.1 Cultural and Religious Beliefs 3.2 Communication Gaps and Perceived Disregard 3.3. Presence of Chaperones 3.4 Age and Marital Status 3.5. Nurse Demeanor and Communication 3.6. Preference for Same-Gender Care

Themes and Subthemes

Three major themes emerged from the data: (1) perceptions of male nurses providing intimate care, (2) experiences of intimate care, and (3) factors influencing acceptance of such care (Table 2).

1. Perceptions of Male Nurses Providing Intimate Care

This theme captures how female patients viewed male nurses in the context of intimate care. While participants generally acknowledged the competence of male nurses, their perceptions were strongly shaped by sociocultural expectations and personal feelings.

1.1 Feelings of Embarrassment and Vulnerability

Most participants expressed discomfort when receiving intimate care from male nurses, describing feelings of embarrassment and exposure.

"I felt very shy because, as a woman, exposing my private parts to a man who is not my husband is not easy for me. In my culture, such parts of the body are considered very private and should only be seen by one's spouse. Even though I understood that the nurse was only doing his job, I could not control the feeling of embarrassment. I kept thinking about how I was raised and what is considered appropriate behavior for a

woman. It made me feel uneasy, and at some point, I wished a female nurse had attended to me instead.” (Participant 3)

“Even though he was professional, I still felt uncomfortable and vulnerable because of the nature of the care. The way he spoke and handled the procedure showed that he was well trained, and I appreciated that, but it did not completely remove my discomfort. Being in such a position made me feel exposed, and I was constantly aware that he was a man. It created a sense of vulnerability that made it difficult for me to relax throughout the procedure. I kept thinking about my dignity and how easily it could be compromised in that moment.” (Participant 7)

1.2 Tension Between Professionalism and Traditional Gender Roles

Participants often experienced an internal conflict between recognizing the professionalism of male nurses and adhering to cultural expectations regarding gender interactions.

“I know he is trained and doing his job, but culturally, it doesn’t feel right for a man to do that kind of care for a woman. Where I come from, there are clear boundaries between men and women, especially when it comes to anything involving the body. Intimate care is seen as something very sensitive, and it is expected that a woman should be cared for by another woman in such situations. Even though I could see that he was respectful and professional, I still felt a kind of inner conflict because what I have been taught all my life does not align with what was happening. It made me feel uneasy, not because of him personally, but because it goes against what I believe is culturally appropriate.” (Participant 1)

“It is difficult because you respect the nurse as a professional, but your tradition tells you it should be a woman. You find yourself torn between two ways of thinking-on one hand, you trust that the nurse is qualified and capable, and you don’t want to disrespect his role. On the other hand, your upbringing and cultural values keep reminding you that certain types of care, especially those involving private parts of the body, are meant to be handled by women. This creates a kind of discomfort that is hard to ignore. Even if you try to accept the situation, deep down you still feel that it is not the right thing according to your tradition.” (Participant 5)

1.3 Perceived Differences Between Male and Female Nurses

Participants highlighted differences in comfort levels and communication styles between male and female nurses.

“With female nurses, I feel more relaxed because they understand how a woman feels in such situations. There is a certain level of comfort that comes from knowing the person attending to you shares similar bodily experiences and can relate to your feelings of embarrassment or sensitivity. It makes it easier to trust them and to feel less exposed during intimate procedures. I do not feel the need to over-explain myself, and I am less self-conscious because I believe they naturally understand the discomfort that comes with such care. This makes the whole experience less stressful and more acceptable for me.” (Participant 8)

"The male nurse was careful, but I still preferred a female nurse because I could talk more freely with her. With a woman, I feel more at ease discussing personal or sensitive issues without holding back. I am able to express my concerns, ask questions, and even share how I am feeling without feeling judged or embarrassed. With the male nurse, even though he was professional and respectful, I found myself being more reserved and cautious in my communication. It was not easy to open up fully, and that affected how comfortable I felt during the care. I believe that with a female nurse, the interaction would have felt more natural and less restrictive." (Participant 17)

2. Experiences of Intimate Care

This theme reflects the actual lived experiences of participants during intimate care procedures, which ranged from positive to distressing.

2.1 Positive Experiences: Professionalism, Communication, and Respect for Privacy

Some participants reported positive experiences, particularly when male nurses demonstrated professionalism and communicated effectively.

"He explained everything he was going to do before starting, and that made me feel a bit more comfortable. Before touching me, he took time to describe each step of the procedure in simple terms, which helped me understand what to expect. Even though I was still a bit nervous because of the nature of the care, his explanation reduced my anxiety because I was not left in the dark. I felt that I had some level of control over the situation since I knew what was coming next. His communication made the experience more bearable, and I could tell he was trying to ensure I felt safe and informed throughout the process." (Participant 4)

"He respected my privacy by covering me properly, so I didn't feel too exposed. Throughout the procedure, he was very mindful of my dignity and made sure that only the necessary parts of my body were exposed at any given time. He used a sheet to cover me and adjusted it carefully whenever he needed access to a specific area. This helped reduce my embarrassment because I did not feel completely uncovered in front of him. Even though I was still aware of the situation, his attention to privacy made me feel more respected and less vulnerable during the care." (Participant 9)

2.2. Negative Experiences: Anxiety, Shame, and Emotional Distress

Despite some positive encounters, many participants described negative emotional responses during intimate care.

"I felt very anxious the whole time. I just wanted it to be over quickly. From the moment the procedure started, I was tense and uncomfortable, constantly thinking about how long it would take and when it would end. I could not relax or focus on anything else because of the anxiety I felt about being exposed and the nature of the care. Even though I knew it was necessary for my treatment, my mind kept racing, and I was silently hoping the nurse would finish as fast as possible so I could regain my comfort and privacy. The entire experience felt emotionally draining, and I was only relieved when it was finally over." (Participant 6)

"It was embarrassing for me, and I felt ashamed even though I knew it was for my treatment. I understood that the procedure was medically necessary and meant to help me recover, but I still could not overcome the feeling of embarrassment in the moment. Being in such a vulnerable position made me feel exposed and self-conscious, as though my dignity was temporarily set aside. I kept thinking about the fact that another person was seeing and handling parts of my body that are usually kept private. Even though I tried to remind myself that it was professional care, the emotional reaction of shame was still very strong and difficult to suppress." (Participant 10)

2.3 Reluctance to Express Discomfort

A recurring finding was that participants often did not voice their discomfort, even when they felt uneasy.

"I couldn't tell him I was not comfortable because I didn't want to seem disrespectful. Even though I was feeling uneasy about the situation, especially given the intimate nature of the care, I felt that expressing my discomfort might come across as insulting his professionalism or questioning his competence. He was polite and doing his job, so I kept my feelings to myself. I was also afraid that speaking up might affect the way I was treated or make the situation more awkward. So, I endured the discomfort silently, even though internally I wished I could have requested a female nurse or at least voiced my concerns in a way that would not offend him." (Participant 2)

"I just kept quiet because I thought maybe that is how things are done in the hospital. I assumed that since the male nurse was assigned to my care, it must be the standard practice, and perhaps patients are not expected to question such decisions. I did not feel confident enough to challenge the situation or ask for a change, especially because I was already in a vulnerable position. I also did not want to appear difficult or uncooperative. So, I accepted the situation as it was, even though I was not fully comfortable, believing that the hospital system had its own way of organizing care that I needed to respect." (Participant 16)

3. Factors Influencing Acceptance of Intimate Care

This theme highlights the various factors that shaped participants' willingness to accept or reject intimate care from male nurses.

3.1 Cultural and Religious Beliefs

Cultural norms and religious values were the most influential factors affecting acceptance.

"In my religion, it is not acceptable for a man to see a woman's body like that unless it is absolutely necessary. From my upbringing and religious teachings, a woman's body is considered sacred and should be kept private, especially from men who are not her husband. Even in situations of illness, there are expectations that such exposure should be minimized and only done when there is no alternative. So, even though I recognized that the nurse was providing professional care, I still struggled internally because it went against my deeply held religious beliefs. This created a moral and emotional conflict for me, where I

felt uncomfortable and somewhat guilty for being in that situation, even though it was for my health.”
(Participant 13)

“Our culture does not encourage such exposure to men, so it made me uncomfortable. Growing up, I was taught that certain parts of the body are private and should not be exposed to men outside of one’s immediate family or spouse. Because of this, receiving intimate care from a male nurse felt inappropriate to me, regardless of his professionalism. I kept thinking about how cultural expectations shape how a woman is supposed to behave and what is considered acceptable. This cultural background made the experience emotionally difficult, as I felt exposed in a way that did not align with what I have always been taught is proper conduct.” (Participant 14)

3.2 Age and Marital Status

Participants indicated that age and marital status influenced their comfort levels.

“As a married woman, I felt it was not appropriate for another man to provide that kind of care. Being in a marital relationship carries certain expectations of privacy and boundaries, especially regarding intimate aspects of the body. I personally felt that such care should ideally be provided by a female nurse, as it aligns better with my sense of dignity and marital respect. Even though I understand that the male nurse was professionally trained and assigned to do the job, I still felt uncomfortable because it did not sit well with my personal values as a married woman. Throughout the procedure, I kept reminding myself that it was for my health, but emotionally, I still felt a sense of unease and internal conflict about the situation.”
(Participant 15)

“Maybe younger girls may not mind, but for me, it is difficult to accept. I think younger patients might be more open or less concerned about such issues, possibly because of changing attitudes or less strict cultural conditioning. However, in my case, due to my age, upbringing, and personal beliefs, I find it very hard to accept a male nurse providing intimate care. I feel more reserved and conscious about my body, and that makes the experience uncomfortable for me. Even when I try to understand it from a professional point of view, my personal values still influence how I feel, and I cannot easily overcome that discomfort.”
(Participant 11)

3.3 Presence of Chaperones

The presence of a third person, especially a female nurse, increased participants’ comfort.

“When a female nurse was present, I felt more at ease because I was not alone with the male nurse. Her presence gave me a sense of emotional safety and reduced the tension I initially felt about the situation. I was more relaxed knowing that another woman was in the room, which made the environment feel less intimidating and more balanced. It also helped me feel that my privacy and dignity were being indirectly protected, as I was not completely alone with a male nurse during such an intimate procedure. This presence reassured me and made it easier for me to cooperate with the care being provided, even though I was still somewhat uncomfortable with the nature of the procedure itself.” (Participant 7)

"I would prefer if someone else is there during such procedures. Being alone with a male nurse during intimate care made me feel exposed and uneasy, so having another person present would make the situation more acceptable for me. It could be another nurse or even a female staff member who would act as a form of reassurance and emotional support. I believe that the presence of a third person would help reduce the feeling of vulnerability and also ensure that I feel more secure and respected during the process. It would make it easier for me to relax and accept the care without feeling completely isolated in such a sensitive situation." (Participant 9)

3.4 Nurse Demeanor and Communication

The attitude and communication style of the nurse significantly influenced patient experiences.

"The way he talked to me calmly made me feel respected. From the beginning of the procedure, his tone of voice was gentle and reassuring, and he did not rush me or make me feel like just another patient. He took time to address me politely, explained what he was about to do, and checked in on how I was feeling throughout the process. This calm manner of communication helped reduce my anxiety, even though I was still aware of the sensitivity of the care being given. I felt that he valued my dignity and emotional comfort, not just the clinical task, and that made the experience more tolerable and respectful for me." (Participant 4)

"If the nurse is not friendly or does not explain things, it makes the situation worse. When a nurse is cold, distant, or fails to communicate properly, it increases fear and discomfort, especially during intimate procedures. I tend to become more anxious when I do not understand what is happening or what will happen next. It makes me feel ignored or like my feelings do not matter. On the other hand, when a nurse is friendly, approachable, and takes time to explain each step, it helps me feel more relaxed and involved in my own care. Without that communication and friendliness, the experience becomes more stressful and emotionally difficult to endure." (Participant 10)

3.5 Preference for Same-Gender Care

A strong preference for female nurses emerged across most participants.

"If I have a choice, I will always choose a female nurse for such care. This is because I feel more comfortable and emotionally secure when a woman is attending to me during intimate procedures. I do not have to struggle with feelings of embarrassment or constantly remind myself that I am being examined by a man. With a female nurse, I feel that there is a natural understanding and shared sensitivity that makes the experience less stressful. Even if the male nurse is skilled and professional, my personal preference is still strongly guided by my sense of privacy, cultural upbringing, and emotional comfort. Given the option, I would always prioritize a female nurse because it allows me to feel more relaxed and respected in such vulnerable situations." (Participant 7)

"I believe intimate care should be done by female nurses for female patients. In my opinion, this arrangement aligns better with cultural expectations and personal comfort levels. Female patients are generally more likely to feel at ease when another woman is providing care that involves exposure of private

body parts. It reduces feelings of shame, embarrassment, and vulnerability that may arise during such procedures. Even though I recognize that male nurses are trained and capable of providing high-quality care, I still feel that assigning female nurses to female patients for intimate procedures would promote better emotional comfort, acceptance, and dignity during care. It is about respecting the sensitive nature of such situations and making patients feel more secure.” (Participant 2)

Discussion

This study was interpreted through the lens of Transcultural Nursing Theory, which emphasizes that health behaviours, care preferences, and patient experiences are profoundly shaped by cultural values, beliefs, and social structures. The theory proposes that culturally congruent care can be achieved through three action modes: cultural care preservation and maintenance, cultural care accommodation and negotiation, and cultural care repatterning and restructuring [13]. Applying this framework provides a nuanced understanding of how female patients in this study navigated the acceptance of intimate nursing care from male nurses within a culturally embedded context.

Perceptions of Male Nurses: Cultural Meanings, Modesty, and Gender Norms

The findings revealed that female patients’ perceptions of male nurses providing intimate care were largely shaped by feelings of embarrassment, vulnerability, and culturally informed gender expectations. These reactions reflect deeply rooted cultural constructions of modesty and bodily privacy, which are central to many African and Ghanaian sociocultural systems [14]. Within the transcultural framework, such beliefs represent cultural care values that must be preserved, as they are integral to patients’ sense of dignity and identity.

Participants’ discomfort when exposing their bodies to male nurses aligns with existing evidence that cross-gender intimate care challenges socially constructed norms regarding appropriate male-female interactions [15]. Similar studies have reported that female patients often perceive intimate care by male nurses as culturally incongruent, regardless of the nurses’ professional competence [16]. The tension between recognizing professionalism and adhering to traditional gender roles reflects the intersection between biomedical care and sociocultural expectations, a phenomenon widely documented in gender and nursing literature [17].

The strong preference for female nurses observed in this study further reinforces the importance of cultural congruence in care delivery. Previous studies have shown that patients are more comfortable and satisfied when care is provided by same-gender healthcare professionals, particularly in situations involving bodily exposure [18]. Female patients often associate female nurses with shared experiences, empathy, and a better understanding of gender-specific sensitivities, which enhances emotional comfort during intimate procedures.

Experiences of Intimate Care: The Role of Culturally Sensitive Practice

Participants' experiences of intimate care ranged from positive to distressing, largely depending on how care was delivered. Positive experiences were associated with professionalism, effective communication, and respect for privacy, which align with the concept of cultural care accommodation [19]. These findings are consistent with studies indicating that respectful communication and clear explanations can significantly reduce patient anxiety and improve acceptance of intimate care [20].

Explaining procedures beforehand and ensuring adequate physical covering were perceived as respectful behaviours that mitigated discomfort. Such practices have been identified as essential components of maintaining patient dignity and promoting trust in nurse–patient interactions [21]. These actions demonstrate that while intimate care procedures are often unavoidable, their delivery can be adapted to align with patients' cultural expectations.

Conversely, negative experiences characterized by anxiety, shame, and emotional distress highlight the consequences of culturally incongruent care. Similar findings have been reported in other settings, where lack of sensitivity to cultural norms regarding modesty and gender interactions resulted in psychological discomfort among patients [22]. This underscores the importance of integrating cultural awareness into routine nursing practice.

The reluctance of participants to express discomfort is particularly noteworthy. This finding aligns with studies in African healthcare contexts, where patients often defer to healthcare professionals due to perceived power imbalances and cultural norms emphasizing respect for authority [23]. Within the transcultural framework, this highlights the need for proactive communication by nurses to elicit patients' preferences and concerns, rather than relying on patients to voice them independently.

Factors Influencing Acceptance: Cultural Care Negotiation in Practice

The study identified several factors influencing acceptance of intimate care, with cultural and religious beliefs emerging as the most dominant. These findings are consistent with previous research demonstrating that cultural and religious values strongly influence healthcare decisions, particularly those involving bodily exposure and gender interactions [24]. Within the transcultural framework, these beliefs require cultural care preservation, as they are deeply embedded and central to patients' identities.

Religious considerations, especially within Islamic and conservative Christian contexts, have been shown to significantly shape attitudes toward cross-gender care, often emphasizing modesty and restricting physical contact between unrelated individuals [25]. This reinforces the need for cultural care accommodation, where healthcare providers negotiate care practices that respect these beliefs while ensuring clinical effectiveness.

Age and marital status also influenced acceptance, reflecting variations in adherence to traditional values. Similar findings have been reported in other studies, where older and married women expressed stronger preferences for same-gender care due to heightened concerns about modesty and social expectations [26]. This highlights the importance of individualized care, a key principle of transcultural nursing.

The presence of chaperones emerged as an important facilitating factor. Previous studies have shown that the use of chaperones during intimate procedures can enhance patient comfort, reduce anxiety, and promote a sense of safety, particularly in cross-gender interactions [27]. In this study, the presence of a female nurse served as a form of cultural negotiation, helping to bridge the gap between clinical necessity and cultural expectations.

Nurse demeanor and communication were also critical determinants of patient acceptance. Respectful, empathetic, and patient-centered communication has been widely recognized as essential for building trust and improving patient experiences [28]. Within the transcultural framework, such interpersonal competence is crucial for delivering culturally congruent care.

Despite these mitigating strategies, a strong preference for same-gender care persisted. This finding is consistent with global evidence indicating that gender concordance remains a significant determinant of patient comfort in intimate care situations [29]. Within the transcultural model, this suggests the need for cultural care repatterning at the institutional level, including policies that accommodate patient preferences where feasible.

Implications for Practice

Applying the transcultural nursing model highlights that acceptance of intimate nursing care is a culturally mediated process rather than purely a clinical one. Healthcare providers must therefore integrate cultural competence into routine practice. Strategies such as offering patients a choice of caregiver gender, ensuring the presence of chaperones, and enhancing communication have been shown to improve patient satisfaction and care outcomes.

Furthermore, incorporating cultural competence training into nursing education and practice is essential for equipping nurses with the skills required to navigate culturally sensitive situations effectively. Such interventions can promote culturally congruent care and improve the overall quality of healthcare delivery.

Conclusion

Using Transcultural Nursing Theory as an interpretive lens reveals that female patients' acceptance of intimate nursing care from male nurses is deeply embedded within cultural, religious, and social frameworks. While professionalism and effective communication can mitigate discomfort, culturally grounded preferences particularly for same-gender care remain strong. Achieving patient-centered care

in such contexts therefore requires deliberate efforts to align clinical practices with patients' cultural values through preservation, accommodation, and negotiated adaptation.

Declarations

Abbreviation

Not applicable

Ethics approval and consent to participate

The research was conducted in accordance with the Declaration of Helsinki. Data collection was done after obtaining approval from the Committee for Human Research Publication and Ethics (Ref No.: CHRE/AP/43/025) of the University of Energy and Natural Resources and a written permit from the Sunyani Teaching Hospital. An informed consent was obtained from all participants

Consent for publication

Not applicable

Clinical trial number

Not applicable

Availability of data and materials

Data will be made available upon reasonable request from the corresponding author (Ba-Etilayoo Atinga (ba-etilayoo.atinga@uenr.edu.gh)

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

BEA: Conceptualization, original draft, investigation, data collection, analysis

CAA: Data collection, validation, review of the manuscript

VSB: Validation, review and editing of the manuscript

GGWA: Analysis, validation, writing critical review and editing

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