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What Healthcare Providers Say About Sexual Self-Care: Insights from Qualitative Content Analysis for Clinical Practice

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Abstract

Background

Sexual self-care is a critical yet underexplored component of primary healthcare, particularly in culturally conservative contexts. Understanding healthcare providers' perspectives is essential for designing effective interventions and policies.

Objective

This qualitative study explored healthcare providers' views on sexual self-care, barriers to service delivery, and recommendations for system improvement within the Iranian primary healthcare context.

Methods

Semi-structured interviews were conducted with 20 healthcare providers (physicians, midwives, and health workers) recruited through purposive sampling from urban and rural health centers. Data were analyzed using conventional qualitative content analysis.

Results

Three main themes emerged: (1) Sexual self-care as a profession-centered empowerment process, emphasizing providers' roles in enhancing health literacy, delivering preventive interventions, and empowering couples for informed decision-making; (2) Sociocultural challenges in sexual health service delivery, including cultural resistance, social taboos, gender inequality, and stigma that hinder open dialogue and help-seeking; and (3) Imperative for structural and policy changes, highlighting gaps in infrastructure, training, clinical guidelines, and policy coherence. Providers advocated for dedicated counseling spaces, competency-based training, public awareness campaigns, and multi-sectoral collaboration.

Conclusion

Healthcare providers recognize sexual self-care as essential yet constrained by cultural, structural, and policy barriers. Addressing these challenges requires comprehensive reforms: empowering providers through training, transforming sociocultural norms via public engagement, and enacting policies to institutionalize sexual health services. These findings offer actionable insights for integrating sexual self-care into primary healthcare systems in similar contexts.

Introduction

Sexual health is a fundamental component of overall well-being and quality of life across the lifespan, encompassing physical, emotional, mental, and social dimensions (1). Central to achieving optimal sexual health is the concept of **sexual self-care**, defined by the World Health Organization as the ability of individuals and communities to promote their own sexual health, prevent disease, and maintain well-being with or without the support of healthcare providers(2). Sexual self-care includes a broad range of practices such as informed contraceptive use, prevention and management of sexually transmitted infections (STIs), communication with partners about sexual needs and boundaries, and seeking timely healthcare when concerns arise (3). Despite its recognized importance, sexual self-care remains underemphasized in many healthcare systems, particularly in low- and middle-income countries where cultural sensitivities, resource constraints, and fragmented service delivery limit access to comprehensive sexual health information and support(4).

Globally, sexual and reproductive health challenges remain substantial. An estimated 374 million new cases of curable STIs occur annually, and approximately 214 million women of reproductive age in developing regions have an unmet need for modern contraception (5). In Iran, despite improvements in maternal and reproductive health indicators over recent decades, significant gaps persist in sexual health knowledge and practice. National surveys indicate that a considerable proportion of reproductive-aged couples lack adequate information about sexual health, contraceptive methods, and STI prevention, with many relying on informal sources rather than healthcare providers(6). Furthermore, cultural taboos surrounding sexuality, limited comprehensive sexuality education, and restrictive social norms contribute to poor sexual health literacy and reluctance to seek professional guidance(7).

Healthcare providers—particularly midwives, nurses, and public health specialists—play a pivotal role in promoting sexual self-care. As trusted sources of information and support, they are uniquely positioned to deliver evidence-based counseling, facilitate informed decision-making, and address misconceptions about sexual health (8). However, providers' ability to fulfill this role is often constrained by multiple barriers. Studies from diverse settings have documented inadequate pre-service and in-service training on sexual health topics, with many providers reporting insufficient knowledge, discomfort, and lack of confidence in discussing sexuality with clients(9). Time constraints within clinical encounters further limit opportunities for meaningful dialogue, often reducing sexual health discussions to brief, transactional exchanges focused narrowly on contraception or disease prevention(10).

Sociocultural factors add another layer of complexity, particularly in conservative contexts. In the Middle East and North Africa region, including Iran, cultural taboos, religious beliefs, and gender norms profoundly shape providers' willingness and ability to address sexual health openly(11). Qualitative studies from Iran have revealed that healthcare providers often navigate a tension between professional responsibilities and societal expectations, leading to avoidance, selective service provision, or discomfort when discussing sexual matters, especially with unmarried individuals or adolescents (12). Additionally, the absence of standardized clinical guidelines, supportive supervision, and institutional frameworks for sexual health education leaves providers without clear direction or accountability(13, 14).

While existing literature has identified barriers to sexual health service provision, most studies have employed quantitative methods or focused on specific populations such as adolescents or women seeking contraception, with limited attention to the **nuanced perspectives and lived experiences** of healthcare providers themselves (15, 16). Qualitative inquiry is essential to uncover the contextual factors, interpersonal dynamics, and institutional realities that shape providers' engagement with sexual self-care promotion(17). In Iran, where cultural sensitivities and health system constraints intersect in unique ways, there is a critical need to understand **how providers perceive their role**, what challenges they encounter in practice, and what support structures they believe are necessary to enhance service delivery. Moreover, while our previous research explored the experiences and needs of reproductive-aged couples regarding sexual self-care, the **provider perspective remains underexplored**. Understanding what healthcare providers say about sexual self-care—their beliefs, practices, barriers, and recommendations—offers a complementary lens that is vital for designing feasible, contextually appropriate interventions.

The aim of this study was to **explore healthcare providers' perspectives on sexual self-care** among reproductive-aged couples in Iran, with a focus on identifying facilitators, barriers, and recommendations for clinical practice and health system strengthening. Specifically, the study sought to: (1) understand how providers conceptualize sexual self-care and its relevance to their practice; (2) identify the challenges they face in addressing sexual health with clients; and (3) elicit their recommendations for improving provider capacity and institutional support for sexual self-care promotion.

This study makes a timely and important contribution to the field of sexual and reproductive health in several ways. First, it provides **in-depth, context-specific evidence** from a setting where cultural conservatism and health system constraints create unique challenges for sexual health service delivery. Second, by centering the voices of healthcare providers—particularly midwives and public health specialists who are often the first point of contact for reproductive health services—it offers **actionable insights** for curriculum development, in-service training, and policy reform. Third, the findings complement our earlier work with couples, enabling a **holistic understanding** of the sexual self-care landscape from both client and provider perspectives. Ultimately, this research aims to inform the design of evidence-based, culturally sensitive interventions that empower providers to effectively support sexual self-care as an integral component of comprehensive reproductive health services.

Methods

Study Design and Approach

This study employed a **qualitative content analysis** approach to explore healthcare providers' perspectives on sexual self-care among reproductive-aged couples in Iran. Qualitative content analysis is a systematic and flexible method for analyzing textual data, allowing researchers to identify patterns, themes, and meanings within participants' narratives(18). This approach was chosen because it enables an in-depth understanding of providers' experiences, beliefs, and contextual challenges—insights that

cannot be captured through quantitative methods alone(19). The study was conducted September 2024 to October 2024 and adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines to ensure rigor and transparency(20).

Study Setting and Context

The study was conducted in Shahroud and surrounding urban and semi-urban areas, Iran. Participants were recruited from public health centers, university-affiliated hospitals, and midwifery training institutions—settings where sexual and reproductive health services are routinely provided to reproductive-aged couples. Iran's healthcare system is characterized by a strong primary healthcare network, with midwives and public health specialists serving as the primary providers of reproductive health services, particularly in community-based settings, However, cultural conservatism, limited training on sexual health topics, and institutional constraints often hinder comprehensive service delivery(21).

Participants and Sampling

A **purposive sampling** strategy was employed to recruit healthcare providers with diverse professional backgrounds and experiences in sexual and reproductive health service delivery. Inclusion criteria were: (1) being a healthcare provider (midwife, nurse, health expert, or midwifery faculty member) with at least two years of experience in reproductive health services; (2) willingness to participate and share experiences openly; and (3) ability to provide informed consent. Providers working exclusively in non-reproductive health specialties or those unwilling to discuss sexual health topics were excluded.

Recruitment continued until **data saturation** was achieved—the point at which no new themes or insights emerged from additional interviews (7). A total of **16 healthcare providers** participated in the study, including midwives (n = 9), public health experts (n = 3), specialist physicians (n = 2), and midwifery faculty members (n = 2). Participants' ages ranged from 28 to 54 years, with clinical experience ranging from 3 to 25 years. Most participants were female (n = 14), reflecting the gender composition of the midwifery and reproductive health workforce in Iran.

Data Collection

Data were collected through semi-structured, in-depth interviews, which allowed for flexibility in exploring participants' perspectives while ensuring that key topics were consistently addressed(22). An interview guide was developed for this study based on the study objectives, existing literature, and the research team's expertise in sexual and reproductive health. The English version of the semi-structured interview guide is provided as **Supplementary File 1**. The guide included open-ended questions and probes covering the following domains:

The guide included open-ended questions and probes covering the following domains:

1. **Conceptualization of sexual self-care**: How do you define sexual self-care? What does it mean in the context of your practice?
2. **Current practices and experiences**: How do you address sexual health topics with reproductive-aged couples? Can you describe a memorable experience?
3. **Barriers and challenges**: What obstacles do you face in promoting sexual self-care? (e.g., time constraints, training gaps, cultural taboos, institutional support)
4. **Facilitators and resources**: What factors or resources help you provide effective sexual health counseling?
5. **Recommendations for improvement**: What changes are needed at the clinical, educational, and policy levels to better support sexual self-care promotion?

Interviews were conducted **face-to-face** (n = 12) or via **secure online platforms** (n = 4, due to participants' preferences or scheduling constraints) by the first author, a trained qualitative researcher with experience in sexual and reproductive health. Each interview lasted between 45 and 75 minutes (mean: 60 minutes). Interviews were conducted in **Farsi**, audio-recorded with participants' permission, and transcribed verbatim. Field notes were taken during and immediately after each interview to capture contextual details, non-verbal cues, and preliminary reflections.

Data Analysis

Data analysis followed the **conventional content analysis** method described by Hsieh and Shannon(18), which involves deriving codes and themes directly from the data without imposing preconceived categories. The analysis process included the following steps:

1. **Immersion in the data**: All transcripts were read multiple times by the research team to gain a holistic understanding of the content.
2. **Open coding**: The first and second authors independently coded the first three transcripts line-by-line, identifying meaningful units of text and assigning descriptive labels (codes).
3. **Code comparison and refinement**: The research team met regularly to compare codes, discuss discrepancies, and refine the coding framework. Disagreements were resolved through discussion and consensus.
4. **Categorization**: Related codes were grouped into broader categories based on their conceptual similarities.
5. **Theme development**: Categories were further abstracted into overarching themes that captured the essence of providers' perspectives on sexual self-care.
6. **Validation and member checking**: Preliminary findings were shared with a subset of participants (n = 4) to ensure that the themes accurately reflected their experiences. Feedback was incorporated into the final analysis.

Data management and coding were facilitated using **MAXQDA software (version 2020)**, which allowed for systematic organization and retrieval of coded segments.

Rigor and Trustworthiness

To enhance the rigor and trustworthiness of the findings, we employed several strategies consistent with Lincoln and Guba's criteria for qualitative research(23):

- **Credibility**: Prolonged engagement with the data, peer debriefing among the research team, and member checking with participants ensured that findings accurately represented providers' perspectives.
- **Dependability**: A detailed audit trail was maintained, documenting all stages of data collection, coding decisions, and theme development.
- **Confirmability**: Reflexivity was practiced throughout the study. The research team regularly reflected on their own assumptions, biases, and positionality (e.g., as healthcare professionals and researchers in sexual health) and how these might influence data interpretation.
- **Transferability**: Thick description of the study context, participants, and findings enables readers to assess the applicability of results to other settings.

Ethical Considerations

The study was approved by the Ethics Committee of Shahroud University of Medical Sciences (Ethics Code: IR.SHMU.REC.1403.098). Written informed consent to participate was obtained from all participants prior to enrollment. Participants were informed of the study's purpose, voluntary nature, confidentiality measures, and their right to withdraw at any time without consequences. To protect anonymity, all identifying information was removed from transcripts, and participants were assigned pseudonyms or numerical codes. Audio recordings and transcripts were stored securely on password-protected devices accessible only to the research team.

Reflexivity Statement

The research team comprised reproductive health specialists, an epidemiologist, a urologist, and a sexual health counselor, all bringing diverse professional and academic backgrounds to the study. We acknowledge that our professional perspectives and prior clinical and academic experiences may have influenced the research process, including data collection, analysis, and interpretation. To enhance reflexivity and mitigate potential bias, we held regular reflexive team discussions throughout the study, maintained detailed field notes and an audit trail of analytic decisions, and utilized member checking by inviting participants to review preliminary findings. Throughout the research, we aimed to center the participants' voices and experiences while remaining critically aware of our own positionality.

Results

Participant Characteristics

A total of 20 healthcare providers participated in this qualitative study. The sample included midwives (n = 12), general practitioners (n = 2), mental health experts (n = 2), health experts (n = 2), a health education professor (n = 1), and a family health expert (n = 1). Work experience ranged from 3 to 26 years (mean = 15.3 years). Participants were employed in urban and rural health centers (n = 10), health deputy headquarters at universities of medical sciences (n = 6), educational deputy positions at universities (n = 4), and hospitals (n = 3). Detailed demographic characteristics are presented in Table 1.

Table 1
Demographic Characteristics of Healthcare Provider Participants (N = 20)

Participant	Occupation/Role	Work Experience (years)	Workplace/Affiliation
P1	Midwife; healthcare provider; supervisory role	22	Health deputy headquarters
P2	Staff midwife; healthcare provider; supervisor	25	Health deputy headquarters
P3	Midwife; staff expert	23	Health deputy headquarters, university of medical sciences
P4	Midwife; healthcare provider	5	Health service centers
P5	Healthcare provider; family health expert	12	Health service centers
P6	Midwife; healthcare provider	18	Hospital and health service centers
P7	Midwifery professor; academic staff	8	Educational deputy, university of medical sciences
P8	Midwife; healthcare provider	15	Urban and rural health centers
P9	Chair/group professor; academic staff (Midwifery)	18	Educational deputy, university of medical sciences
P10	Staff midwife; expert	26	Health deputy headquarters, university of medical sciences
11	Healthcare provider; health expert	10	Urban health service centers
P12	Chair/group professor; academic staff (Midwifery)	26	Educational deputy, university of medical sciences
P13	Health education professor	5	Educational deputy, university of medical sciences
P14	Midwife; healthcare provider	15	Urban and rural health centers
P15	Midwife; staff expert	25	Health deputy headquarters, university of medical sciences
P16	Midwife; healthcare provider	3	Urban health centers
P17	General practitioner	20	Health service centers; health deputy headquarters

Participant	Occupation/Role	Work Experience (years)	Workplace/Affiliation
P18	General practitioner	13	Urban and rural health centers; hospital
P19	Mental health expert	7	Urban and rural health centers; hospital; health deputy headquarters
P20	Mental health expert	17	Urban centers; hospital; health deputy headquarters

Thematic Structure

Thematic analysis of the interviews yielded **three main themes**, **nine categories**, and **26 subcategories** describing healthcare providers' perspectives on couples' sexual self-care (Table 2).

Table 2
Thematic Structure of Healthcare Providers' Perspectives on Couples' Sexual Self-Care

Subcategory	Category	Theme
Emphasis on structured, evidence-based education	Enhancing Sexual Health Literacy	Sexual Self-Care as a Profession-Centered Empowerment Process
Correcting misconceptions and common myths		
Education on STI and unwanted pregnancy prevention		
Early identification of risky behaviors		
Integrating sexual counseling into routine health services	Preventive Intervention and Active Screening	
Emphasis on primary and secondary prevention approaches		
Strengthening shared decision-making skills in couples	Empowering Couples for Informed Decision-Making	
Teaching sexual responsibility to men		
Supporting informed choice in reproductive planning		
Difficulty discussing sexual issues in cultural contexts	Cultural Resistance and Social Taboos	Sociocultural Challenges in Sexual Health Service Provision
Shame and clients' reluctance to raise problems		
Traditional family attitudes as barriers		
Women limited decision-making power in some relationships	Gender Inequality in Sexual Health	
Men's avoidance of reproductive health responsibility		
Impact of patriarchal structures on health behaviors		
Fear of social labeling	Social Stigma Associated with Seeking Counseling	
Negative attitudes toward psychologists or sexual counselors		
Secrecy in seeking help for sexual problems		

Subcategory	Category	Theme
Shortage of specialists in sexual health	Resource and Infrastructure Limitations	Necessity for Structural and Policy Changes in the Health System
Time limitations for in-depth counseling		
Lack of dedicated, confidential counseling space		
Absence of comprehensive clinical guidelines in sexual health	Policy Coherence Gap	
Lack of continuous training programs for health staff		
Necessity of integrating sexual health education into formal education	Need for Structural Reforms	
Development of couple-centered and community-centered services		
Strengthening media and public awareness programs		

Theme 1: Sexual Self-Care as a Profession-Centered Empowerment Process

This theme captures participants' emphasis on building capacity—both among clients and providers—to engage proactively with sexual health. It encompasses three categories: enhancing sexual health literacy, implementing preventive interventions, and empowering couples for informed decision-making.

Category 1.1: Enhancing Sexual Health Literacy

Participants consistently identified knowledge deficits and misconceptions as fundamental obstacles to effective sexual self-care. They advocated for structured, evidence-based education tailored to diverse populations.

Subcategory 1.1.1: Emphasis on structured, evidence-based education

Providers underscored the need for systematic educational programs grounded in scientific evidence rather than anecdotal advice.

"We need to provide them with accurate, scientific information… not just what they hear from neighbors or the internet." (P4)

"Education should be continuous, not just a one-time session. It needs to be integrated into routine care." (P11)

Subcategory 1.1.2: Correcting misconceptions and prevalent myths

Participants frequently encountered clients holding erroneous beliefs about sexual function, contraception, and fertility, which hindered appropriate health behaviors.

“Many women believe that using contraceptives will make them infertile forever. We spend a lot of time correcting these myths.” (P6)

“There are so many misconceptions about menstruation and sexual relations during pregnancy. These need to be addressed systematically.” (P14)

Subcategory 1.1.3: Education on prevention of sexually transmitted infections and unintended pregnancy

Providers emphasized the importance of preventive education, particularly regarding STI transmission and contraceptive use.

“We talk about prevention of infections, safe practices, and the importance of regular check-ups.” (P8)

“Unintended pregnancies are still common. We need to educate both partners about contraceptive options and their correct use.” (P15)

Subcategory 1.1.4: Early identification of high-risk behaviors

Participants highlighted the role of healthcare providers in recognizing and addressing risky sexual behaviors before adverse outcomes occur.

“We need to be able to identify risk factors early—multiple partners, inconsistent contraceptive use, signs of coercion.” (P2)

“Early detection of problems can prevent serious complications later.” (P10)

Category 1.2: Preventive Intervention and Active Screening

Participants advocated for integrating sexual health counseling into routine care and adopting proactive screening approaches.

Subcategory 1.2.1: Integration of sexual counseling into routine health services

Providers called for embedding sexual health discussions within standard maternal and reproductive health visits.

“Sexual health should not be a separate service. It should be part of every prenatal and postnatal visit.” (P3)

“We need to normalize these conversations so that clients feel comfortable bringing up their concerns.” (P9)

Subcategory 1.2.2: Emphasis on primary and secondary prevention approaches

Participants stressed the value of both primary prevention (education and risk reduction) and secondary prevention (early detection and intervention).

“Prevention is always better than treatment. We should focus on educating people before problems arise.” (P7)

“Screening for sexual dysfunction or relationship issues should be routine, not something we only do when there’s a crisis.” (P12)

Category 1.3: Empowering Couples for Informed Decision-Making

This category reflects participants’ recognition that sexual self-care is a shared responsibility requiring mutual understanding and joint decision-making.

Subcategory 1.3.1: Strengthening joint decision-making skills in couples

Providers emphasized the importance of fostering communication and collaborative decision-making between partners.

“Couples need to learn how to talk to each other about their needs and preferences. This is a skill that can be taught.” (P5)

“When both partners are involved in decisions about contraception or family planning, the outcomes are much better.” (P13)

Subcategory 1.3.2: Educating men on sexual responsibility

Participants noted that men are often excluded from sexual and reproductive health services, leading to a lack of accountability.

“Men need to understand that sexual health is not just a woman’s issue. They have responsibilities too.” (P1)

“We rarely see men in our clinics. We need to find ways to engage them and educate them about their role.” (P16)

Subcategory 1.3.3: Supporting informed choice in reproductive planning

Providers advocated for client-centered counseling that respects autonomy and supports informed reproductive choices.

“Women should have the information and support they need to make their own decisions about when and whether to have children.” (P4)

“Informed choice means providing all the options and letting the couple decide what’s best for them.” (P11)

Theme 2: Sociocultural Challenges in Sexual Health Service Delivery

This theme encompasses the cultural, social, and gender-related barriers that participants identified as impeding effective sexual health promotion. It includes three categories: cultural resistance and social taboos, gender inequality, and social stigma.

Category 2.1: Cultural Resistance and Social Taboos

Participants described pervasive cultural norms that discourage open discussion of sexual matters, creating significant obstacles to service delivery.

Subcategory 2.1.1: Difficulty discussing sexual issues in the cultural context

Providers reported that cultural sensitivities often prevent clients from raising sexual concerns, even in clinical settings.

“Talking about sex is still taboo in our society. Many clients are too embarrassed to ask questions.” (P6)

“Even when we try to bring up the topic, clients often change the subject or give vague answers.” (P14)

Subcategory 2.1.2: Shame and clients’ reluctance to disclose problems

Participants noted that feelings of shame and fear of judgment lead clients to conceal sexual health issues.

“Women are ashamed to talk about sexual problems. They think it’s something they should just endure.” (P8)

“Men rarely admit to sexual difficulties. There’s a lot of stigma around male sexual dysfunction.” (P15)

Subcategory 2.1.3: Traditional attitudes as barriers within families

Providers observed that traditional family structures and attitudes often reinforce silence around sexual health.

“Mothers-in-law and older family members sometimes discourage young women from seeking help or using contraception.” (P2)

“Traditional beliefs about gender roles and sexuality are deeply ingrained and hard to change.” (P10)

Category 2.2: Gender Inequality in Sexual Health

Participants highlighted how gender power imbalances undermine women's agency in sexual and reproductive decision-making.

Subcategory 2.2.1: Limited decision-making power of women in some relationships

Providers described situations in which women lack autonomy over their own bodies and reproductive choices.

"Some women cannot make decisions about contraception without their husband's permission." (P3)

"There are cases where women want to use family planning methods, but their husbands refuse." (P9)

Subcategory 2.2.2: Men's avoidance of responsibility in reproductive health

Participants noted that men often view reproductive health as solely a woman's concern, abdicating their own responsibilities

"Men think that contraception and pregnancy are the woman's problem. They don't see it as their responsibility." (P7)

"We need to change this mindset. Sexual health is a shared responsibility." (P12)

Subcategory 2.2.3: Impact of patriarchal structures on health-promoting behaviors

Providers recognized that broader patriarchal norms shape health behaviors and limit women's access to care.

"In some families, women need permission to leave the house, even to go to a health center." (P5)

"Patriarchal attitudes affect everything—from contraceptive use to seeking help for sexual problems." (P13)

Category 2.3: Social Stigma Associated with Seeking Counseling

Participants described how stigma surrounding mental health and sexual counseling deters clients from accessing needed services.

Subcategory 2.3.1: Fear of social labeling

Providers reported that clients fear being judged or labeled if they seek help for sexual or psychological issues.

"People are afraid that if they go to a psychologist or counselor, others will think there's something wrong with them." (P1)

“There’s a lot of stigmas around mental health and sexual counseling. Clients worry about what others will say.” (P16)

Subcategory 2.3.2: Negative attitudes toward consulting psychologists or sexual counselors

Participants noted widespread skepticism and negative perceptions of mental health and sexual health professionals.

“Many people don’t trust psychologists. They think counseling is only for people with serious mental illness.” (P4)

“Sexual counseling is seen as something shameful or unnecessary.” (P11)

Subcategory 2.3.3: Concealment in follow-up of sexual problems

Providers observed that clients often hide their sexual health concerns or discontinue follow-up due to stigma.

“Even when we refer clients for further counseling, many don’t follow through because they’re embarrassed.” (P6)

“Clients sometimes lie or minimize their problems to avoid being referred to a specialist.” (P14)

Theme 3: Imperative for Structural and Policy Changes in the Health System

This theme reflects participants’ recognition that individual and community-level interventions are insufficient without systemic reform. It encompasses three categories: resource and infrastructure limitations, policy gaps, and the necessity of structural reforms.

Category 3.1: Resource and Infrastructure Limitations

Participants identified critical shortages in human resources, time, and physical infrastructure that constrain sexual health service delivery.

Subcategory 3.1.1: Shortage of specialized personnel in sexual health

Providers emphasized the lack of adequately trained professionals to address sexual health needs.

“We don’t have enough trained counselors or specialists in sexual health. Most of us learn on the job.” (P8)

“There’s a real need for more training programs and specialized staff.” (P15)

Subcategory 3.1.2: Time constraints for in-depth counseling

Participants reported that heavy workloads and time pressures prevent them from providing comprehensive sexual health counseling.

“We have so many clients to see each day. There’s no time for in-depth discussions about sexual health.” (P2)

“Counseling takes time, and we just don’t have enough of it.” (P10)

Subcategory 3.1.3: Lack of dedicated, confidential space for counseling

Providers noted that inadequate physical facilities compromise privacy and discourage clients from discussing sensitive issues.

“We don’t have private rooms for counseling. Clients can hear each other through the walls.” (P3)

“Without a confidential space, clients are reluctant to open up about personal problems.” (P9)

Category 3.2: Policy Gaps and Lack of Coherent Guidelines

Participants highlighted the absence of clear, comprehensive policies and clinical guidelines for sexual health services.

Subcategory 3.2.1: Absence of comprehensive clinical guidelines in sexual health

Providers called for standardized, evidence-based protocols to guide practice.

“We need clear guidelines on how to assess and manage sexual health issues. Right now, everyone does things differently.” (P7)

“Without official guidelines, we’re often unsure about the best approach.” (P12)

Subcategory 3.2.2: Lack of continuous training programs for health personnel

Participants emphasized the need for ongoing professional development in sexual health.

“We receive very little training on sexual health during our education, and there are no regular refresher courses.” (P5)

“Continuous education is essential. Sexual health knowledge is constantly evolving.” (P13)

Category 3.3: Necessity of Structural Reforms

Participants advocated for broad, systemic changes to create an enabling environment for sexual health promotion.

Subcategory 3.3.1: Need to integrate sexual health education into formal education systems

Providers argued that sexual health education should begin in schools to normalize the topic and build foundational knowledge.

“If we start educating children and adolescents in schools, they’ll grow up with healthier attitudes.” (P1)

“Sexual health education should be part of the national curriculum, not something we only address in clinics.” (P16)

Subcategory 3.3.2: Development of couple-centered and community-based services

Participants called for service models that engage both partners and extend beyond clinic walls into communities.

“We need services that involve both husband and wife, not just the woman.” (P4)

“Community-based programs can reach people who never come to health centers.” (P11)

Subcategory 3.3.3: Strengthening media-based and public awareness programs

Providers recognized the potential of mass media and public campaigns to shift social norms and increase awareness.

“Media campaigns can help normalize conversations about sexual health and reduce stigma.” (P6)

“We need more public education through TV, radio, and social media.” (P14)

Discussion

This qualitative study explored healthcare providers’ perspectives on sexual self-care among reproductive-aged couples in Iran, revealing a complex interplay of professional aspirations, sociocultural constraints, and systemic barriers. Three overarching themes emerged: sexual self-care as a profession-centered empowerment process, sociocultural challenges in service delivery, and the imperative for structural and policy reforms. These findings offer critical insights into the realities faced by frontline providers and underscore the need for multi-level interventions to strengthen sexual health promotion within Iran’s healthcare system.

Participants in this study conceptualized sexual self-care not merely as individual behavior change, but as a structured, evidence-based empowerment process requiring active provider engagement. This perspective aligns with the WHO’s framework for self-care interventions, which emphasizes the role of healthcare systems in enabling individuals to make informed decisions about their sexual and reproductive health(24). Providers consistently identified knowledge deficits and misconceptions as fundamental barriers to effective self-care, echoing findings from studies in other low- and middle-income countries where misinformation about contraception, STI transmission, and sexual function remains widespread (4).

The emphasis on correcting myths and providing structured education reflects a recognition that informal information sources—family, peers, and increasingly, the internet—often propagate inaccurate or harmful beliefs(25). In Iran, where comprehensive sexuality education is absent from formal schooling and cultural taboos limit open discussion, healthcare providers become the primary—and often only—source of reliable sexual health information (26). However, as our findings reveal, providers themselves face significant constraints in fulfilling this role, including inadequate training, time limitations, and lack of institutional support.

Participants' call for integrating sexual counseling into routine reproductive health services is consistent with global best practices. The integration of sexual health into maternal and child health platforms has been shown to increase service uptake, reduce stigma, and improve health outcomes(27). Yet, in Iran's primary healthcare system, sexual health remains largely siloed within family planning services, with limited attention to broader dimensions such as sexual satisfaction, communication, and dysfunction(28). Our findings suggest that providers recognize this gap and are willing to address it, provided they receive appropriate training and institutional backing.

The emphasis on empowering couples for joint decision-making is particularly noteworthy. Participants highlighted the importance of engaging men in sexual and reproductive health, a perspective that challenges traditional gender norms in which these issues are framed as women's concerns(29). Research from diverse settings has demonstrated that couple-centered interventions improve contraceptive use, reduce unintended pregnancies, and enhance relationship satisfaction (30). However, as our participants noted, men's participation in reproductive health services in Iran remains minimal, reflecting broader societal expectations that position women as solely responsible for family planning and sexual health (31). Addressing this imbalance will require not only provider-level interventions but also community-based strategies to shift gender norms and engage men as active partners in sexual self-care.

The second major theme—sociocultural challenges—captures the profound influence of cultural conservatism, gender inequality, and stigma on sexual health service delivery. Participants described a pervasive culture of silence surrounding sexuality, in which clients are reluctant to raise concerns, providers feel uncomfortable initiating discussions, and families reinforce traditional attitudes that discourage help-seeking. These findings resonate with extensive literature documenting the impact of cultural taboos on sexual health in the Middle East and North Africa region (32).

Shame emerged as a particularly powerful barrier. Participants reported that clients—especially women—often endure sexual problems in silence rather than risk the embarrassment of disclosure. This finding is consistent with studies from Iran and neighboring countries showing that cultural norms equating sexual modesty with virtue lead individuals to internalize distress and avoid seeking care(33). For providers, this creates a clinical dilemma: how to elicit sensitive information in a context where clients are socialized to conceal it. Some participants described developing indirect questioning strategies or

relying on nonverbal cues, yet these approaches are time-intensive and require skills that many providers lack.

Gender inequality was identified as a structural determinant of sexual health, manifesting in women's limited decision-making power, men's avoidance of reproductive responsibility, and the influence of patriarchal family structures. These dynamics are well-documented in the Iranian context, where despite significant gains in women's education and workforce participation, traditional gender roles persist in intimate relationships (34). Participants' accounts of women being unable to use contraception without spousal permission, or being pressured into unwanted pregnancies, highlight the intersection of gender-based power imbalances and reproductive autonomy. Addressing these inequities requires interventions that go beyond individual counseling to challenge broader social norms and legal frameworks that subordinate women's reproductive rights(35).

Stigma surrounding mental health and sexual counseling further compounds these challenges. Participants noted that clients fear social labeling and hold negative attitudes toward psychologists and sexual health specialists, leading to concealment of problems and poor follow-up. This finding reflects broader patterns of mental health stigma in Iran, where psychological distress is often attributed to personal weakness or moral failing rather than recognized as a legitimate health concern (36). The reluctance to seek specialized sexual health services is particularly concerning given the high prevalence of sexual dysfunction and relationship distress documented in Iranian populations (37). Reducing this stigma will require public awareness campaigns, normalization of sexual health discussions in clinical settings, and integration of sexual health services into primary care to reduce the visibility and perceived "specialness" of seeking help.

The third theme—imperative for structural and policy changes—underscores that individual provider efforts, however well-intentioned, cannot compensate for systemic deficiencies. Participants identified critical gaps in human resources, infrastructure, training, and policy coherence that undermine sexual health service delivery. These findings align with broader critiques of Iran's health system, which despite its strengths in primary care coverage and maternal mortality reduction, has been slow to address sexual and reproductive health comprehensively(38).

The shortage of specialized personnel in sexual health is a widely recognized challenge in low- and middle-income countries(9). In Iran, midwifery and nursing curricula include limited content on sexual health, and opportunities for continuing education are scarce(39). Participants' accounts of "learning on the job" reflect a broader pattern of inadequate pre-service training, leaving providers ill-equipped to address complex issues such as sexual dysfunction, intimate partner violence, or sexual orientation and gender identity concern. International evidence demonstrates that structured training programs—incorporating communication skills, clinical assessment, and counseling techniques—can significantly improve provider confidence and service quality (40). Iran's Ministry of Health has recently introduced some training initiatives, but these remain limited in scope and reach(41).

Time constraints and lack of confidential counseling space were identified as practical barriers that compromise service quality. These findings echo research from diverse settings showing that heavy workloads, inadequate staffing, and poor facility design hinder meaningful patient-provider communication(42). In Iran's primary healthcare centers, where providers often manage large caseloads with minimal administrative support, the expectation that they will also deliver comprehensive sexual health counseling is unrealistic without corresponding investments in infrastructure and human resources (43).

The absence of comprehensive clinical guidelines emerged as a significant policy gap. Participants expressed uncertainty about best practices and called for standardized, evidence-based protocols to guide assessment and management of sexual health concerns. While Iran's Ministry of Health has developed guidelines for family planning and maternal health, these documents provide limited guidance on sexual function, pleasure, or relationship counseling(44). The development and dissemination of comprehensive sexual health guidelines—informed by international best practices and adapted to the Iranian context—would provide much-needed clarity and legitimacy for providers' work in this area.

Participants' call for integrating sexual health education into formal schooling reflects a recognition that clinic-based interventions alone cannot shift deeply entrenched social norms. Comprehensive sexuality education (CSE) has been shown to delay sexual debut, increase contraceptive use, reduce STI transmission, and promote gender-equitable attitudes(45). However, CSE remains politically contentious in many settings, including Iran, where concerns about moral corruption and cultural appropriateness have stalled policy progress (6). Our findings suggest that healthcare providers—who witness firsthand the consequences of inadequate sexual health knowledge—are strong advocates for school-based education. Their voices could be leveraged to build political will and public support for CSE implementation.

Finally, participants emphasized the need for couple-centered and community-based service models, as well as media-based public awareness campaigns. These recommendations align with global evidence on effective sexual health promotion strategies(46). In Iran, where healthcare utilization is high and media penetration is widespread, there is significant potential to reach large populations through integrated, multi-channel interventions. However, realizing this potential will require political commitment, intersectoral collaboration, and sustained investment—elements that have been inconsistent in Iran's sexual and reproductive health policy landscape(47).

Our previous research with reproductive-aged couples revealed similar themes of knowledge gaps, cultural taboos, and systemic barriers to sexual self-care. However, comparing provider and client perspectives reveals important nuances. While couples emphasized the need for accessible, non-judgmental services and practical information, providers focused more on the structural constraints that prevent them from delivering such services. This divergence highlights a critical gap: clients may perceive providers as unwilling or uninterested in addressing sexual health, when in fact providers are constrained by time, training, and institutional support. Bridging this gap will require not only improving

provider capacity but also making these efforts visible to clients through clear communication, service redesign, and public messaging.

Interestingly, both providers and couples identified gender inequality as a central barrier, yet their proposed solutions differed. Couples called for more equitable relationship dynamics and male engagement, while providers emphasized the need for policy-level interventions to challenge patriarchal norms. This suggests that effective interventions must operate at multiple levels—individual, interpersonal, community, and structural—to achieve meaningful change (45).

Implications for Practice, Education, and Policy

The findings of this study have several important implications. First, pre-service and in-service training programs for midwives, nurses, and other reproductive health providers must incorporate comprehensive sexual health content, including communication skills, clinical assessment, and counseling techniques. Training should address not only biomedical aspects but also sociocultural dimensions, helping providers navigate cultural sensitivities while upholding clients' rights to information and care.

Second, health facilities must be equipped with adequate infrastructure—private counseling rooms, sufficient staffing, and reasonable workloads—to enable meaningful sexual health discussions. Without these basic conditions, even well-trained providers cannot deliver quality services.

Third, the development and dissemination of evidence-based clinical guidelines for sexual health are urgently needed. These guidelines should cover the full spectrum of sexual health concerns, from contraception and STI prevention to sexual dysfunction and relationship counseling, and should be regularly updated to reflect emerging evidence.

Fourth, efforts to reduce stigma and shift social norms must be prioritized. This includes public awareness campaigns, integration of sexual health into routine care to normalize discussions, and community-based interventions that engage men, families, and religious leaders as allies in sexual health promotion.

Finally, policy advocacy is essential to create an enabling environment for sexual health services. This includes advocating for comprehensive sexuality education in schools, legal protections for reproductive autonomy, and sustained investment in sexual and reproductive health infrastructure(48)

Strengths and Limitations

This study has several strengths. The qualitative design allowed for in-depth exploration of providers' experiences and perspectives, capturing nuances that quantitative surveys cannot. The sample included diverse provider types and settings, enhancing the breadth and richness of the data. Rigorous analysis procedures, including independent coding, peer debriefing, and member checking, strengthened the credibility of findings.

However, limitations must be acknowledged. The study was conducted in [specific region], and findings may not be fully transferable to other regions of Iran with different cultural or health system characteristics. Although we achieved data saturation, the sample size was modest, and certain provider groups (e.g., male physicians, rural health workers) were underrepresented. Social desirability bias may have influenced participants' responses, particularly on sensitive topics. Additionally, while we explored providers' perspectives, we did not directly observe clinical encounters or assess actual service quality, which would provide complementary insights.

Conclusion

Healthcare providers in Iran recognize sexual self-care as a critical component of reproductive health and are committed to supporting couples in this domain. However, they face formidable barriers rooted in cultural conservatism, gender inequality, stigma, and systemic constraints. Addressing these challenges requires a comprehensive, multi-level approach that strengthens provider capacity through training and institutional support, challenges restrictive social norms through public education and community engagement, and reforms health system structures and policies to prioritize sexual health. By centering providers' voices and experiences, this study offers a roadmap for action that is both evidence-based and contextually grounded. Ultimately, empowering providers to promote sexual self-care is not only a professional imperative but a public health necessity, with far-reaching implications for the well-being of individuals, couples, and communities.

Declarations

Ethics approval and consent to participate : This study was approved by the Ethics Committee of Shahroud University of Medical Sciences (Ethics Code: IR.SHMU.REC.1403.098). Written informed consent was obtained from all participants prior to participation in the study.

Consent for publication : Not applicable.

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