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Midwives', Obstetrics and Gynecology Residents', and General Practitioners' Perceptions and Experiences of Discussing Sexual Health with Postmenopausal Women: A Theory of Planned Behavior–Based Qualitative Study

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Abstract

Background: Sexual health concerns are prevalent yet frequently neglected during menopause. This qualitative study explored the perceptions and experiences of midwives, obstetrics and gynecology (OB/GYN) residents, and general practitioners (GPs) regarding discussions of sexual health with postmenopausal women, using the Theory of Planned Behavior (TPB) as a guiding framework.

Materials and Methods: We conducted a directed content analysis integrating Theory of Planned Behavior constructs with conventional content analysis, following Graneheim and Lundman. Using purposive maximum-variation and snowball sampling, we recruited 32 participants from multiple settings in Mashhad, Iran. In-depth, semi-structured interviews were conducted and analyzed until thematic saturation.

Results: Fourteen midwives, 13 general practitioners, and 5 obstetrics and gynecology residents participated. Analysis yielded 1,156 initial codes, refined to 226 final codes, 54 subcategories, 18 categories, and five Theory of Planned Behavior–aligned themes: attitudes, subjective norms, perceived behavioral control, intention, and behavior. Attitudes reflected tension between protecting professional dignity and the potential benefits of discussing sexual health, including family stability, biopsychosocial well-being, and improved sexual health literacy. Subjective norms emphasized cultural and religious sensitivity, respectful care, and adherence to professional codes. Perceived behavioral control was hindered by inadequate knowledge and communication skills, weak policies, low prioritization of sexual health services, and cultural taboos. Intentions relied on assessing women's readiness and creating supportive environments; behaviors included patient priming, counseling, and therapeutic services.

Conclusion: Healthcare providers face tension between the benefits of sexual health discussions and perceived risks to professional standing. Their intentions and practices are constrained by social expectations, inadequate knowledge and skills, and structural barriers. Interventions should strengthen communication skills, address sociocultural taboos, and improve healthcare-delivery protocols.

Key Words: Healthcare Providers, Theory of Planned Behavior, Postmenopausal Women, Sexual Health, Qualitative Content Analysis.

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1- INTRODUCTION

Sexual health concerns are common during the menopausal transition but remain among the most neglected aspects of women's health (1, 2). Menopause is often associated with sexual difficulties, including reduced sexual desire, impaired arousal, vaginal dryness, dyspareunia, and decreased sexual satisfaction. These concerns can adversely affect quality of life, intimate relationships, and psychological well-being (1, 2). Although many women experience sexual concerns during midlife and later life, a substantial proportion do not seek professional help. Studies conducted in Iran have shown that women with sexual dysfunction often do not consult healthcare providers, reflecting individual, cultural, and structural barriers to care (3, 4). Within the Iranian sociocultural context, sexual matters are frequently associated with modesty, shame, and silence. These factors may discourage women from disclosing their concerns and make sexual health discussions challenging for both patients and healthcare providers (4).

Despite the importance of sexual health assessment as a component of comprehensive healthcare and the recognition of sexual health and related rights within a human rights framework (5), sexual concerns are infrequently addressed during routine clinical encounters. Earlier evidence indicated that only a small proportion of general practitioners asked patients about sexual problems (6). More recent studies suggest that provider- and system-level barriers continue to impede communication about sexual health. For example, a 2024 study of Brazilian gynecologists identified limited consultation time and patient discomfort as major barriers to discussing sexual health during menopausal care. Physical concerns, such as vaginal lubrication and dyspareunia, were addressed more frequently than the broader psychosocial dimensions of sexuality (7). Similarly, qualitative research from Iran found that taboos, embarrassment, limited provider-initiated inquiry, inadequate resources, and organizational constraints hindered the provision of sexual health services to menopausal women (8). Collectively, these findings indicate a substantial gap between women's need for sexual healthcare and the routine provision of such care across clinical settings.

Previous studies have identified several factors that influence sexual health communication, including healthcare providers' knowledge, communication skills, attitudes, perceived professional responsibility, cultural sensitivity, and perceptions of patients' receptivity (5, 9–13). However, discussing sexual health is not merely a technical clinical task; it is a complex professional behavior shaped by cognitive, interpersonal, social, and organizational factors. Understanding why healthcare providers initiate—or refrain from initiating—sexual health discussions therefore requires a theoretical framework capable of integrating these determinants into a coherent explanatory model.

The Theory of Planned Behavior (TPB) provides a useful framework for this purpose. According to the TPB, behavior is directly influenced by behavioral intention, which is shaped by attitudes toward the behavior, subjective norms, and perceived behavioral control (14–18). The use of the TPB in the present study is supported by two considerations. First, the theory has been widely applied to health-related behaviors and professional practices, particularly behaviors influenced by motivation, perceived social expectations, and perceived behavioral control. Second, previous research suggests that TPB constructs are relevant to sexual health communication in clinical settings. Salinas et al. found that the TPB explained a meaningful proportion of

physicians' intentions to initiate sexual health discussions with women (14). Other studies have similarly shown that attitudes, subjective norms, and perceived behavioral control influence healthcare providers' willingness to address sexual concerns in clinical practice (9,12,15–18). In addition, research among Iranian healthcare professionals found that incorporating perceived barriers increased the explanatory power of the TPB model for sexual counseling behavior (19).

Nevertheless, most existing studies have used quantitative methods and have not adequately examined how TPB constructs are experienced, expressed, and shaped within real-world clinical and sociocultural contexts, particularly in relation to postmenopausal women. In Iran, where sexual health remains a sensitive and under-discussed topic, limited evidence exists regarding how midwives, obstetrics and gynecology (OB/GYN) residents, and general practitioners perceive and experience discussions of sexual health with postmenopausal women. These professional groups play important roles in women's healthcare but may differ in their training, clinical exposure, confidence, perceived responsibilities, and opportunities to address sexual concerns. A qualitative investigation is therefore warranted to develop a deeper, context-sensitive understanding of the beliefs, experiences, intentions, and behaviors underlying sexual health discussions in menopausal care. Accordingly, this study used a TPB-informed directed content analysis to explore midwives', OB/GYN residents', and general practitioners' perceptions and experiences of discussing sexual health with postmenopausal women.

2- MATERIALS AND METHODS

2-1. Study design and setting

This qualitative study used directed content analysis to explore midwives', obstetrics and gynecology (OB/GYN) residents', and general practitioners' perceptions and experiences of discussing sexual health with postmenopausal women. The study was conducted in Mashhad, Iran, across diverse settings, including private clinics, public healthcare centers, participants' homes, and coffee shops. Interview locations were selected based on participants' preferences to provide a comfortable and relatively natural environment for discussion.

2-2. Participants and sampling

A total of 32 healthcare professionals participated: 14 midwives, 13 general practitioners, and 5 OB/GYN residents. Participants were eligible if they had at least two years of clinical experience in a healthcare center or private practice and were willing to participate.

Participants were recruited using purposive sampling with maximum variation according to professional role, work setting, age, and clinical experience. Snowball sampling was used when necessary to identify additional eligible participants. Recruitment and data collection continued until data saturation was reached; that is, no substantively new codes or categories emerged from subsequent interviews.

2-3. Data collection

Data were collected through in-depth, semi-structured individual interviews. At the beginning of each interview, the researcher introduced herself, explained the study objectives and procedures, and obtained written informed consent, including consent for audio recording.

Interviews began with the following broad, open-ended question:

"Could you please describe your experiences of discussing sexual health with postmenopausal women?"

Additional probing questions were used to clarify responses and encourage elaboration. The semi-structured interview guide was informed by the Theory of Planned Behavior (TPB) and developed with reference to Ajzen's and Francis et al.'s guidance for TPB-based instrument development (20, 21). The target behavior was defined in terms of the action, target population, clinical context, and relevant time frame, consistent with TPB measurement guidance.

The interview guide addressed five domains:

- **Attitudes:** What are the perceived advantages of discussing sexual health with postmenopausal women? How valuable are these outcomes? What disadvantages or negative consequences do you perceive?
- **Subjective norms:** What do important referents, such as patients, spouses, and colleagues, think about these discussions? How do their views influence your clinical practice?
- **Perceived behavioral control:** What factors facilitate or hinder your ability to discuss sexual health with postmenopausal women? How do healthcare policies, cultural beliefs, and social attitudes affect these discussions?
- **Behavioral intention:** How willing are you to discuss sexual health with postmenopausal women in your clinical practice? What factors influence your intention to initiate such discussions?
- **Behavior:** Have you discussed sexual health with postmenopausal women in your clinical practice? If so, please describe the circumstances and your approach.

All interviews were audio-recorded using an MP3 recording device and transcribed verbatim immediately after each interview. Field notes were recorded, when appropriate, to document contextual observations and preliminary impressions.

2-4. Data analysis

Data were analyzed using directed content analysis, following Hsieh and Shannon's approach (22). First, transcripts were read repeatedly to achieve immersion in the data. Meaning units relevant to the research question were identified, condensed, and assigned preliminary codes according to the procedures described by Graneheim and Lundman (23).

An initial deductive coding framework was developed based on the Theory of Planned Behavior, including attitudes, subjective norms, perceived behavioral control, behavioral intention, and sexual-health discussion behavior. The first three domains represented the core TPB determinants of behavioral intention, whereas behavioral intention and sexual-health discussion behavior were examined as proximal components in the pathway from beliefs to clinical practice. Data that did not fit the initial framework were assigned new codes and examined for potential additional categories.

Codes were compared for similarities and differences, grouped into subcategories, abstracted into categories, and then organized into overarching themes. Throughout the analysis, the research team reviewed the coding framework and emerging categories to ensure that interpretations remained consistent with the data.

2-5. Trustworthiness

Trustworthiness was evaluated according to Lincoln and Guba's criteria of credibility, dependability, confirmability, and transferability (24). Credibility and dependability were enhanced through prolonged engagement with the data, repeated review of transcripts and codes, member checking, and peer debriefing with experienced qualitative researchers.

Confirmability was supported through an audit of selected transcripts, field notes, codes, subcategories, and categories by qualitative research experts, who assessed the consistency and plausibility of the interpretations. Transferability was enhanced by providing detailed descriptions of the study setting, participants, sampling strategy, data-collection procedures, and analytic process, enabling readers to assess the applicability of the findings to other contexts.

2-6. Ethical considerations

The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Ethical approval was obtained from the Ethics Committee of Mashhad University of Medical Sciences, Mashhad, Iran (approval code: IR.MUMS.REC.1394.217).

Before participation, all eligible participants received verbal and written information regarding the study purpose, procedures, voluntary nature of participation, interview audio-recording, anticipated use of anonymized data, and measures taken to protect privacy and confidentiality. Written informed consent was obtained from all participants before the interviews commenced, including specific consent for audio recording.

Participants were informed that they could decline to answer any interview question, pause or terminate the interview, or withdraw from the study at any stage without penalty, effect on their employment or professional relationships, or loss of services or benefits. No identifying information was included in interview transcripts, analytic documents, or reports. Participants were assigned unique identification codes, and pseudonyms or codes were used when reporting quotations.

Audio files, transcripts, consent forms, and study records were stored securely with access restricted to the research team. Consent forms and other documents containing personally identifiable information were stored separately from de-identified interview data. Findings are reported in aggregate form, and quotations have been edited where necessary to prevent indirect identification of participants.

3- RESULTS

3-1. Participant characteristics and coding process

A total of 32 healthcare providers participated in the study, including 14 midwives, 13 general practitioners, and 5 obstetrics and gynecology (OB/GYN) residents. Participants varied in age, clinical experience, educational background, marital status, and interview setting, providing diverse perspectives on discussing sexual health with postmenopausal women. Interviews lasted between 35 and 90 minutes. Participant characteristics are presented in **Table 1**.

The analysis generated 1,156 initial codes. After conceptually similar codes were merged and overlapping codes were consolidated, 226 final codes remained. These codes were organized into 54 subcategories, 18 categories, and five themes structured according to the TPB framework: attitudes toward sexual health discussions, subjective norms surrounding such discussions, perceived behavioral control over initiating them, behavioral intention to engage in them, and sexual health discussion behavior.

Overall, participants described discussing sexual health with postmenopausal women as a complex, sensitive, and context-dependent clinical practice. This practice was shaped by personal beliefs, sociocultural expectations, professional norms, communication skills, organizational conditions, and women's readiness to engage in discussion.

3-2. Attitudes toward sexual health discussions

This theme reflected participants' evaluations of the perceived benefits and potential risks of discussing sexual health with postmenopausal women. Although many participants considered these discussions beneficial to women's health and family well-being, some expressed concerns about possible social, ethical, and professional consequences.

Four categories were identified: perceived threats to the dignity and professional standing of healthcare providers and to patients' self-esteem; strengthening family relationships; improving psychological and physical well-being; and enhancing women's sexual health literacy.

Some participants feared that raising sexual issues could be misunderstood by patients, family members, or regulatory authorities, particularly when trust had not yet been established. These concerns were associated with potential threats to providers' professional reputations and patients' sense of dignity.

"The patient may go and tell her family, and they may feel that their private matters have been interfered with…" (Participant 21)

Conversely, many participants described sexual health discussions as a means of identifying underlying marital problems and reducing tension within intimate relationships. They believed that timely discussion and appropriate guidance could improve sexual and marital satisfaction and contribute to family stability.

"When we guide them to think more in this direction, I see that their problems gradually begin to resolve." (Participant 23)

Participants also linked sexual health discussions to broader psychological and physical well-being. They emphasized that sexual health was inseparable from overall health and that addressing sexual concerns could reduce anxiety, improve self-esteem, and enhance quality of life.

"When it is discussed… the person feels a sense of joy and youthfulness in her life." (Participant 15)

Another perceived benefit was improved sexual health literacy. Participants believed that discussing sexual concerns during menopause could correct misconceptions, provide accurate information, and help women understand and manage changes in their sexual lives.

"When she has sexual information, she can convey the correct information herself." (Participant 29)

3-3. Subjective norms surrounding sexual health discussions

This theme reflected the influence of social, cultural, familial, and professional expectations on participants' willingness to engage in sexual health discussions. Participants considered such discussions acceptable when conducted within clear boundaries of respect, confidentiality, and cultural sensitivity.

Three categories were identified: sensitivity to religious and cultural values; expectations regarding privacy and confidentiality; and expectations of scientific and professional conduct.

Participants frequently referred to religious and cultural norms as factors influencing both provider behavior and women's willingness to discuss sexual concerns. They were concerned that explicit discussions of sexuality might be interpreted as culturally inappropriate or morally questionable.

"Her husband said he didn't want her to go; it would spread around town that Mrs. so-and-so is involved in these things." (Participant 5)

Privacy and confidentiality were regarded as essential conditions for these

conversations. Participants noted that women were unlikely to disclose sexual concerns unless they felt safe, respected, and protected from judgment or unauthorized disclosure.

“Women usually define a boundary for themselves…” (Participant 21)

Participants also described sexual health discussions as a professional responsibility that should be guided by scientific evidence and clinical standards rather than by personal comfort or preference.

“History taking in textbooks includes sexual issues; that is, it is part of a physician’s duties.” (Participant 23)

3-4. Perceived behavioral control over sexual health discussions

This theme reflected participants’ perceptions of their ability and opportunities to engage in sexual health discussions. Although some participants held favorable attitudes toward these discussions, they often reported limited control over implementing them in routine practice.

Six categories were identified: insufficient knowledge and clinical skills; inadequate healthcare and sexual health policies; low prioritization of sexual health services; sociocultural influences on sexual health care; opportunities to initiate sexual health discussions; and effective communication with postmenopausal women.

A commonly reported barrier was inadequate education and insufficient practical training in sexual counseling. Participants felt that their formal education had not adequately prepared them to discuss sexual concerns confidently and competently.

“When there is no unit for couple therapy or sex therapy, one should not expect a midwife to do it.” (Participant 7)

Structural and policy-level barriers were also frequently reported. These included the absence of reimbursement mechanisms, referral pathways, trained personnel, and organizational support for sexual health services.

“They could allow midwives to provide sexual counseling and receive payment for it.” (Participant 7)

In routine practice, sexual health concerns were often assigned low priority because of heavy workloads, limited consultation time, and the need to address urgent or higher-priority clinical problems.

“A postmenopausal woman comes in with bleeding… so I do not go straight to those secondary issues.” (Participant 2)

Participants further emphasized the influence of shame, taboo, limited sexual health literacy, restrictive socialization, and stereotypes regarding aging and sexuality. These sociocultural factors often discouraged both providers and patients from initiating discussions.

“They learn that sexual matters are not for women…” (Participant 7)

Despite these barriers, participants identified several clinical situations as potential opportunities to initiate sexual health discussions, including menopausal symptoms, marital concerns, and psychological distress.

“We ask about menopause… then I ask a few related questions so the issue can open up more.” (Participant 19)

Effective communication skills were considered essential for initiating and sustaining sexual health discussions. Participants emphasized the importance of building trust, using culturally appropriate language, and adapting communication to each woman’s background and level of understanding.

“It is important to speak with each person according to her own cultural level.” (Participant 4)

3-5. Behavioral intention to engage in sexual health discussions

This theme reflected participants' readiness and planning to engage in sexual health discussions. Before introducing the topic, participants commonly assessed the situation, prepared the patient, and attempted to create conditions conducive to a constructive exchange.

Three categories were identified: creating conditions and opportunities for discussion; assessing patients' readiness; and empowering patients to participate in sexual health discussions.

Participants described using gradual and indirect approaches to reduce discomfort and establish a sense of safety before introducing sexual concerns.

"Usually, I try to ask the first question more generally." (Participant 21)

They also assessed whether women were emotionally, culturally, and interpersonally ready to discuss sexual concerns, recognizing that readiness varied considerably between individuals.

"Some people can be asked more easily, but for some, you cannot ask directly." (Participant 31)

In addition, participants emphasized the importance of adequate time, privacy, and a supportive atmosphere in making these discussions possible and meaningful.

3-6. Sexual health discussion behavior

This theme reflected participants' reported engagement in sexual health discussions during clinical practice. When these discussions occurred, they generally followed a staged process in which providers first prepared patients and then proceeded to education, counseling, treatment, or referral.

Two categories were identified: preparing patients for sexual health discussions and providing counseling and treatment services.

Participants described using gradual introduction, indirect questioning, normalization of sexual concerns, and trust-building strategies to help women feel comfortable discussing intimate issues.

"I ask, 'Do you have any problems related to your hormones or women's health?'" (Participant 21)

Once a discussion had been established, it often led to practical interventions, including education, marital counseling, behavioral recommendations, treatment for sexual discomfort, and referral when necessary.

"I tell her to use this gel for intercourse…" (Participant 1)

Overall, the findings indicated that discussing sexual health with postmenopausal women was neither routine nor straightforward. Rather, it was a negotiated interpersonal and professional practice shaped by attitudes, subjective norms, perceived behavioral control, behavioral intention, and real-world service conditions. Participants' accounts suggested that translating favorable beliefs into practice required not only willingness but also adequate knowledge, communication skills, institutional support, privacy, sufficient time, and patient readiness.

Table-1: Characteristics of Healthcare Providers Participating in the Study (n=32).

No.	Professional role	Age, years	Gender	Marital status	Educational qualification	Work experience, years	Interview location	Interview duration, min	Sexual health workshop attendance	Menopausal status
1	Midwife	40	Female	Single	Master of Midwifery	10	School of Nursing and Midwifery	90	Yes	—
2	Midwife	37	Female	Married	Bachelor of Midwifery; Master of Psychology	8	Participant's home	60	Yes	—
3	Midwife	50	Female	Married	Bachelor of Midwifery	25	Participant's home	65	Yes	Postmenopausal
4	Midwife	40	Female	Married	Bachelor of Midwifery	3	Office	60	No	—
5	Midwife	25	Female	Single	Bachelor of Midwifery	3	Office	45	No	—
6	Midwife	59	Female	Married	Bachelor of Midwifery	21	Clinic	60	No	—
7	Midwife	38	Female	Married	Bachelor of Midwifery	10	Clinic	60	No	—
8	Midwife	44	Female	Married	Bachelor of Midwifery	18	Office	60	No	—
9	Midwife	60	Female	Married	Bachelor of Midwifery	30	Coffee shop	70	No	Postmenopausal
10	Midwife	50	Female	Married	PhD in Reproductive Health	20	School of Nursing and Midwifery	40	Yes	Postmenopausal
11	Midwife	35	Female	Married	Master of Midwifery	5	Office	65	Yes	—
12	Midwife	37	Female	Married	Bachelor of Midwifery	4	Clinic	35	Yes	—
13	Midwife	59	Female	Married	Bachelor of Midwifery	3	Clinic	40	Yes	Postmenopausal
14	Midwife	70	Female	Married	Medical degree	44	Participant's home	60	No	Postmenopausal
15	General practitioner	32	Female	Married	Medical degree	5	Office	45	No	—
16	General practitioner	33	Female	Married	Medical degree	5	Clinic	45	No	—
17	General	39	Female	Married	Medical	14	Clinic	40	No	—

No.	Professional role	Age, years	Gender	Marital status	Educational qualification	Work experience, years	Interview location	Interview duration, min	Sexual health workshop attendance	Menopausal status
	practitioner				degree					
18	General practitioner	38	Female	Married	Medical degree	10	Office	50	No	—
19	General practitioner	45	Female	Married	Medical degree	19	Office	50	No	—
20	General practitioner	42	Female	Married	Medical degree	16	Clinic	45	No	—
21	General practitioner	60	Male	Married	Medical degree	35	Office	45	No	Not applicable
22	General practitioner	32	Male	Married	Medical degree	6	Office	60	No	Not applicable
23	General practitioner	45	Male	Married	Medical degree	18	Clinic	60	No	Not applicable
24	General practitioner	45	Male	Married	Medical degree	8	Clinic	60	No	Not applicable
25	General practitioner	47	Male	Married	Medical degree	18	Office	60	No	Not applicable
26	General practitioner	50	Male	Married	Medical degree	22	Office	90	No	Not applicable
27	General practitioner	49	Female	Married	Medical degree	20	Office	60	No	Not applicable
28	OB/GYN resident	30	Female	Single	Gynecology residency	4	Hospital	42	No	—
29	OB/GYN resident	32	Female	Single	Gynecology residency	4	Hospital	60	No	—
30	OB/GYN resident	34	Female	Married	Gynecology residency	2	Hospital	40	No	—
31	OB/GYN resident	36	Female	Married	Gynecology residency	2	Hospital	65	No	—
32	OB/GYN resident	38	Female	Married	Gynecology residency	2	Hospital	40	No	—

Notes: Values are presented for individual participants. Where applicable, interview locations were standardized as "participant's home." An em dash (—) indicates that menopausal status was either not reported or not applicable; "not applicable" was used for male participants. OB/GYN, obstetrics and gynecology.

Table-2: Analytical summary of climate and planetary health education and relevance to Iran.

Theory of Planned Behavior construct (theme)	Category	Subcategory
Attitudes toward discussing sexual health	Concerns about tarnishing the dignity and professional status of healthcare providers and harming clients' self-esteem	Perceiving healthcare providers who discuss sexual health as immoral
		Fear of insult and ridicule
		Fear of legal consequences arising from sexual-health discussions
		Potential harm to clients' self-esteem
	Strengthening family foundations	Improved sexual and marital satisfaction
		Reduced social harm
	Improving clients' psychological and physical health	Improved psychological well-being of clients
		Internal satisfaction among healthcare providers
		Improved physical health of clients
	Increasing clients' sexual-health literacy	Exchange of accurate information about sexual health during menopause
		Increased knowledge of sexual health during menopause
Subjective norms regarding discussing sexual health	Expectations regarding sensitivity to religious and cultural values	Expectations of patients, spouses, families, and healthcare providers to observe social norms and taboos
		Expectation to maintain Islamic dignity in professional practice
		Expectation to observe religious rulings in professional practice
	Expectations regarding privacy and confidentiality	Expectation of confidentiality
		Expectation of privacy protection
		Expectation of respect and dignity
	Expectations regarding scientific and professional performance	Expectation to fulfill assigned professional duties
		Expectation to follow scientific sources and adapt them to the local context
Perceived behavioral control regarding discussing sexual health	Lack of sexual-health knowledge and clinical skills	Ineffectiveness of formal educational programs in women's and sexual health
		Lack of access to valid educational programs
	Ability to communicate effectively with postmenopausal women	Understanding the sexual needs and problems of postmenopausal women through peer counselors
		Possession of effective communication skills
	Inappropriate policymaking in health and sexual-health programs	Shortage of specialized human resources
		Inappropriate tariffs for the services provided
		Lack of an effective hierarchical referral system
		Neglect of sexual health and aging
	Low prioritization of sexual-health services by healthcare providers	Prioritization of life-threatening services
		Prioritization of income-generating activities
Intention to discuss sexual health	Interplay between sexual-health care and sociocultural factors	Limited access to information among postmenopausal clients
		Presentation for care during acute emotional or sexual distress
		Negative attitudes and stereotypes regarding sexuality and aging
		Concealment of sexual needs and problems
		Self-treatment
		Perception among postmenopausal women that sexual issues are unimportant
		Inadequate cultural groundwork by the media
		Strict social upbringing
		Medicalization of sexual problems
		Public distrust of healthcare providers

	Opportunities for initiating sexual-health discussions	Topics related to sexual and marital health
		Topics related to mental health
		Implementation of the Older Adult Health Program in health centers
	Creating conditions and opportunities for sexual-health discussions	Taking steps to improve sexual-health literacy
		Creating an appropriate setting for sexual-health discussions
		Allocating time for sexual-health discussions
	Assessing postmenopausal women's readiness for sexual-health discussions	Assessing clients' comfort with sexual-health topics
		Assessing clients' perceived importance of sexual-health issues
	Empowering patients to participate in sexual-health discussions	Creating a sense of comfort among patients
		Creating a sense of being valued among patients
		Increasing clients' awareness
Sexual-health discussion behavior	Preparing patients for sexual-health discussions	Desensitizing patients to sexual-health topics
		Building patient trust
	Providing counseling and treatment services	Therapeutic recommendations

Note: Themes correspond to the constructs of the Theory of Planned Behavior.

4- DISCUSSION

This qualitative study explored the experiences and perceptions of 32 healthcare professionals—14 midwives, 13 general practitioners (GPs), and 5 obstetrics and gynecology (OB/GYN) residents—regarding sexual health discussions with postmenopausal women. The findings indicate that such discussions are not merely technical clinical tasks but complex professional behaviors shaped by attitudes, subjective norms, perceived behavioral control, behavioral intention, patient readiness, and organizational conditions.

Five TPB-informed themes were identified: attitudes, subjective norms, perceived behavioral control, behavioral intention, and sexual health discussion behavior. The first three themes correspond to the core constructs of the Theory of Planned Behavior (TPB), whereas behavioral intention and discussion behavior represent subsequent components linking providers' beliefs and perceived control to their reported clinical practices.

4-1. Attitudes Toward Sexual Health Discussions

Participants described concerns about threats to professional dignity, particularly the fear of being misunderstood, ridiculed, or criticized by patients or their families. These concerns may be intensified by gender discordance, cultural taboos, and the sensitivity surrounding female sexuality in Iran. Similar barriers, including fear of patient resistance, embarrassment, and concerns about violating personal boundaries, have been reported in previous studies (8,11,15,16). Recent research among Iranian postmenopausal women also identified shame, limited knowledge, and concerns about disclosure as barriers to seeking help for sexual problems (25).

Conversely, participants viewed sexual health discussions as beneficial for improving sexual function, psychological well-being, marital satisfaction, family stability, and sexual health literacy. These perceptions are consistent with evidence showing that sexual health education can improve sexual function among postmenopausal women and that sexual dysfunction may negatively affect intimate relationships and psychological well-being (1–4). However, sexual health should not be justified solely by its potential effects

on marriage or family stability. Women's autonomy, individual well-being, right to information, and right to confidential care should remain central to sexual health services (4, 5).

4-2. Subjective Norms

Cultural, religious, familial, and professional expectations strongly influenced providers' willingness to discuss sexual health. Participants emphasized privacy, confidentiality, respect, and adherence to scientific and professional standards. Some considered sexual health content culturally or religiously sensitive, which limited their willingness to participate in training or initiate discussions.

Participants also described a gap between formal professional responsibilities and routine clinical practice. Sexual counseling was not always perceived by colleagues or supervisors as an essential clinical duty. Consequently, providers might regard it as an optional or specialized service. Clarifying professional roles, incorporating sexual health into clinical protocols, strengthening supervisory support, and establishing clear referral pathways may improve professional norms and increase providers' intention to engage in these discussions (7,10,12–16).

Educational interventions should be culturally and religiously responsive. They should distinguish evidence-based clinical sexual health care from morally inappropriate or nonclinical content while emphasizing confidentiality, respect, patient autonomy, and professional responsibility. This approach may help providers reconcile their personal values with their professional obligations.

4-3. Perceived Behavioral Control

Providers reported inadequate knowledge and counseling skills, limited consultation time, heavy workloads, weak policies, insufficient reimbursement mechanisms, inadequate referral systems, and limited organizational support. These barriers reduced their confidence and ability to initiate sexual health discussions, despite recognizing their importance. Similar barriers have been reported in primary care and menopausal services (8,11,14–18).

Participants also described shame, taboo, restrictive gender socialization, limited sexual health literacy, and stereotypes about sexuality in later life as barriers affecting both providers and patients. These findings suggest that improving perceived behavioral control requires more than information provision. Training should include practical sexual history taking, culturally appropriate communication, patient-readiness assessment, basic counseling, and referral skills. Health-system interventions should also provide privacy, adequate consultation time, trained personnel, and supportive clinical protocols.

4-4. Intention and Behavior

Participants commonly assessed women's readiness, established trust, and used gradual or indirect approaches before introducing sexual health questions. Discussions typically progressed from patient preparation to education, counseling, treatment, or referral. However, sexual health communication was not routine or standardized; it depended on provider confidence, patient readiness, available time, privacy, and organizational support.

These findings illustrate the gap between intention and behavior. Although providers' attitudes and intentions may be favorable, structural and sociocultural barriers can prevent them from translating these intentions into clinical practice. Recent evidence similarly indicates that women may receive limited professional support for sexuality-related concerns during menopause and that provider knowledge gaps, stigma, and insufficiently

targeted services remain important barriers (25,26). Theory-informed education may help strengthen health-related intentions and behaviors, although the complete bibliographic details of the relevant recent study should be verified before its inclusion in the final reference list (27).

4-5. Strengths and Limitations

This study has several strengths. The inclusion of midwives, GPs, and OB/GYN residents provided perspectives from professional groups involved in different aspects of women's healthcare. Maximum-variation sampling also enabled the inclusion of participants with diverse professional and clinical backgrounds. In addition, TPB-informed directed content analysis provided a structured framework for examining the relationship between providers' beliefs, intentions, and reported practices while allowing new codes and categories to emerge from the data.

Several limitations should be considered. The study was conducted in Mashhad, Iran, and the findings may not be transferable to other regions or healthcare systems with different cultural, religious, professional, or organizational conditions. The findings were based on self-reported experiences and may therefore have been influenced by recall and social desirability biases, particularly given the sensitive nature of the topic. In addition, the number of OB/GYN residents was smaller than the number of midwives and GPs; therefore, the findings should not be interpreted as a direct comparison between professional groups. Finally, the study examined reported behavior rather than directly observing clinical encounters or assessing patients' experiences.

4-6. Implications for Practice

Sexual health education should be integrated into the initial and continuing education of midwives, GPs, and OB/GYN residents. Training should be skills-based, culturally sensitive, and focused on communication, confidentiality, patient autonomy, assessment of sexual concerns, basic counseling, and appropriate referral.

Healthcare organizations should clarify professional responsibilities and incorporate sexual health into menopausal care protocols rather than treating it as an optional service. Adequate consultation time, private clinical environments, trained personnel, supportive supervision, reimbursement mechanisms, and clear referral pathways may further strengthen providers' perceived behavioral control.

5- CONCLUSION

This study demonstrated that sexual health discussions with postmenopausal women are shaped by providers' attitudes, subjective norms, perceived behavioral control, behavioral intentions, and clinical conditions. Although participants recognized the potential benefits of these discussions for women's psychological and physical well-being, sexual health literacy, marital relationships, and family stability, communication was constrained by concerns about professional dignity, privacy, gender discordance, cultural and religious sensitivities, inadequate knowledge and skills, limited time, weak policies, and unclear professional responsibilities.

Reducing the intention–behavior gap requires more than information provision. Interventions should include structured, skills-based sexual health education; clearly defined professional roles and referral pathways; supportive healthcare policies; adequate consultation time and privacy; and gender-sensitive, culturally responsive communication strategies. These measures may strengthen providers' capacity to integrate respectful, confidential, and comprehensive sexual health care into routine services for postmenopausal women in Iran.

6- AUTHORS' CONTRIBUTIONS

Study conception or design: MM, TK; Data analyzing and draft manuscript preparation: FM, RL, MG, and MM; Critical revision of the paper: TK; Supervision of the research: RL and TK; Final approval of the version to be published: MM, FM, RL, MG, TK, and MM.

7- CONFLICT OF INTEREST: None.

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