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The Paradox of Silence: Universal Inadequacy of Sexual Health Literacy and Its Lifespan Impact on Quality of Life among Iranian Women

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Background and Objectives: Sexual health literacy enables individuals to access, understand, and apply sexual health information, while low literacy is associated with unsafe behaviors and negative outcomes. Quality of life is a key aspect of women's overall well-being. This study examines the association between sexual health literacy and sexual quality of life among women in Isfahan.

Material and Methods: This cross-sectional study was conducted in 2022 among women in Isfahan, Iran. A total of 212 women aged over 18 years were recruited through two-stage cluster sampling from health centers. Data were collected using the Sexual Health Literacy for Adults (SHELA) questionnaire, which assesses four indicators (access, understanding, analysis, and application of sexual health information), and the Sexual Quality of Life Questionnaire (SQOL-F), which assesses indicators such as sexual satisfaction and emotional well-being. Statistical analyses were performed in SPSS 27 using generalized linear regression models (GLM).

Results: The majority of participants exhibited limited (inadequate or problematic) sexual health literacy. The mean quality of life score among participants was 75.35 ± 10.39 (in 18-108 score range). In this study, sexual health literacy was directly associated with sexual quality of life (β= 0.11, 95%CI: 0.04, 0.19, P=0.004). Longer duration of marriage (β= -0.16, 95%CI: -0.30, -0.02, P=0.022) and lower education (β= -11.69, 95%CI: -22.35, -1.03, P=0.031) were significantly associated with lower quality of life scores.

Conclusion: This study revealed that women had limited sexual health literacy in most domains, which was positively associated with quality of life. Longer marital duration and lower education were related to lower quality of life scores. These findings highlight the need for interventions aimed at improving sexual health literacy, which may enhance women's overall well-being.

Keywords: Health literacy, Quality of life, Sexual health, Women

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Introduction

Sexual health literacy (SHL) is defined as a set of knowledge, attitudes, beliefs, motivations, and individual competencies that enable people to access, understand, appraise, and apply information related to sexual health (1). This construct encompasses a wide range of core domains, including sexual development, contraceptive methods, consequences of unintended pregnancy, sexually transmitted infections, communication and relationship-management skills, and the positive, romantic, and intimacy-related dimensions of sexual relationships (2, 3). Enhancing sexual health literacy strengthens individuals' capacity to analyze sexual risks, recognize personal responsibilities within intimate relationships, and make informed, evidence-based decisions (4, 5). Furthermore, sexual health literacy is considered a key determinant for achieving several Sustainable Development Goals, particularly quality education (SDG4), gender equality (SDG5), and health and well-being (SDG3) (6).

An adequate level of sexual health literacy facilitates cognitive and behavioral competencies related to analysis, judgment, effective communication, decision-making, and modification of sexual behaviors, thereby empowering individuals to maintain and improve their sexual health (7). In contrast, low levels of sexual health literacy have been associated with high-risk sexual behaviors, selection of high-risk partners, reduced use of protective methods, and increased vulnerability to sexually transmitted infections (4, 7). Evidence also indicates that sexual knowledge can directly influence couple interactions and marital dynamics, improving sexual satisfaction and relationship quality (8, 9).

Sexual function and sexual experience are fundamental dimensions of human health and exert substantial influence on individuals' quality of life and that of their partners (10). Women, who represent half of the population and are central to the health of future generations, have unique needs in the domain of sexual health, and healthy sexual functioning is closely linked to enhanced well-being and improved quality of life among them (11, 12). Conversely, poor sexual quality of life has been associated with adverse psychological outcomes, marital dissatisfaction, and relationship instability (10, 13) .

Health literacy, particularly sexual health literacy, plays a fundamental role in women's ability to access, understand, and apply health information related to their sexual well-being (14). The importance of sexual health literacy extends beyond knowledge acquisition; it directly

influences sexual behaviors, decision-making, and ultimately, the quality of life of women (15). Previous research confirms a significant positive relationship between sexual health literacy and sexual quality of life in women. Panahi et al. found that women with lower sexual health literacy had significantly lower sexual quality of life (14). Similarly, a study on rural Iranian women reported that lower scores in access and analysis-evaluation skills were correlated with lower education level and higher gravidity (15).

Despite the importance of women's sexual health, evidence suggests that the lack of structured sexual education in Iran, particularly among women, remains a major challenge (16, 17). Evidence-based educational interventions can prevent adverse outcomes and contribute to improved relational quality and enhanced sexual satisfaction (17). Studies conducted in Iran have consistently demonstrated low levels of sexual health literacy; for example, a study in Amol reported that more than one-fifth of women exhibited limited sexual health literacy (4).

Sexual quality of life, as a multidimensional construct reflecting an individual's appraisal of the positive and negative aspects of sexual relationships and sexual functioning, plays a critical role in marital satisfaction, couple functioning, and relationship stability (10, 13, 18). Neglecting women's sexual health may lead to widespread consequences for family well-being, relationship dynamics, mental health, and the health of future generations (11, 19).

Despite the critical importance of sexual health to women's overall well-being, women's sexual needs and concerns have historically been overlooked and marginalized in both clinical practice and public health policy (20, 21). This neglect is particularly concerning given that women constitute half of the population and play an equally vital role in shaping the dynamics, quality, and satisfaction of intimate partnerships (22). The World Health Organization has emphasized that sexual health is a fundamental component of overall health and well-being, yet women's sexual health needs remain largely unmet in many societies, including Iran (23).

Given the strategic importance of sexual health literacy, its role in promoting sexual quality of life, and the limited evidence available in this area in Iran, particularly in Isfahan Province, this study aimed to determine the association between sexual health literacy and sexual quality of life among married women in Isfahan.

Materials and Methods

Study Design

This cross-sectional study was conducted from October to December 2022 in Isfahan city, Iran. The study population consisted of all married women aged over 18 years residing in Isfahan.

Inclusion criteria were: (a) being a married woman aged 18 to 49 years (this age range represents the reproductive age and the period during which women are most likely to be sexually active and concerned with sexual health issues); (b) being literate (to ensure the ability to complete self-administered questionnaires); (c) having no documented psychiatric disorder in the national "Sib" health system (to avoid confounding effects of mental health conditions on sexual quality of life); (d) voluntarily agreeing to participate; and (e) not being pregnant or breastfeeding at the time of enrollment (to eliminate temporary physiological changes that may affect sexual function and quality of life). Participants who failed to complete the questionnaire were excluded from the analysis.

Sampling

The sample size was calculated based on the "Sample Size Formula for Estimating a Proportion (n = (Z ^ 2 * P(1 - P))/(d ^ 2))", using the prevalence of “inadequate sexual health literacy” reported by Jamali et al. (4), (Approximately 30%), with a 95% confidence level, a margin of error of 0.07, and a design effect of 1.2 to account for cluster sampling. The final required sample size was estimated to be 214 participants. A two-stage cluster sampling method was used. In the first stage, the city of Isfahan was divided into five geographical districts (north, south, east, west, and center). From these districts, seven comprehensive health centers were randomly selected as clusters. In the second stage, within each selected health center, convenience sampling was applied. Research assistants approached all married women aged 18–49 years who attended the health center for any reason (e.g., routine check-ups, vaccination, or other health services). Eligible women who met the inclusion criteria were invited to participate. After providing written informed consent, participants completed the paper-based questionnaires in a private room at the health center to ensure confidentiality. Questionnaires were collected immediately upon completion. Data collection was conducted from October to December 2022.

Tools and variables

Data were collected using a demographic–reproductive checklist, including variables such as age, spouse's age, duration of marriage (years), number of pregnancies, number of deliveries, first age child, number of abortions, education, spouse's education, job, spouse's job, income status, type of delivery, child under 2 years, abortion experience, sexually transmitted infection (based on self-report), and last pap smear (based on self-report). Additionally, two standardized instruments were used. The 18-item Sexual Quality of Life–Female (SQOL-F) questionnaire is a validated, self-report instrument designed to assess women’s subjective evaluations of their sexual functioning and the impact of sexual life on overall well-being. The tool measures sexual quality of life across multiple dimensions, including sexual confidence, emotional well-being, relationship issues, and sexual satisfaction. Each of the 18 items is rated on a six-point Likert scale ranging from 1 (“strongly disagree”) to 6 (“strongly agree”), yielding a total score between 18 and

108, with higher scores indicating a better sexual quality of life (10). The psychometric properties of the SQOL-F, including construct validity, internal consistency, and reliability, have been well established in previous research (10).

Based on the total SHELA score, participants were categorized into four levels of sexual health literacy: inadequate (0–50), problematic (51–66), adequate (67–84), and excellent (85–100) (4). For the purpose of identifying vulnerable groups, the inadequate and problematic categories were merged to form the limited sexual health literacy group (0–66). Similarly, the adequate and excellent categories were combined and classified as the adequate sexual health literacy group (67–100).

The 40-item Iranian Adult Sexual Health Literacy Assessment (SHELA) questionnaire is a self-administered instrument designed to evaluate sexual health literacy in adults. It consists of 40 items scored on a five-point Likert scale, covering four domains: access skills, reading and comprehension, analysis and appraisal, and application. The total scores classify individuals' sexual health literacy levels from inadequate to excellent. Higher scores indicate better sexual health literacy. The validity and reliability of the SHELA questionnaire have been previously confirmed in Iranian populations. This instrument allows for a comprehensive assessment of participants' knowledge, attitudes, and competencies related to sexual health, facilitating the examination of its association with sexual quality of life (4).

Analysis

The data were entered into SPSS version 27. After assessing normality, descriptive statistics were reported. To examine the distribution of variables across relevant subgroups and to assess the association between sexual quality of life and sexual health literacy, univariable and multivariable generalized linear regression models (GLM), adjusted for potential confounders, were employed to examine the associations between sociodemographic, reproductive, and health-related variables and sexual quality of life. Variables with a p-value ≤ 0.20 in the univariable analysis were entered into the multivariable model. A significance level of 0.05 was considered for the multivariable model. Before inclusion in the multivariable model, multicollinearity among the independent variables was assessed using the Variance Inflation Factor (VIF), and all variables had VIF values below 10, indicating no significant multicollinearity (Table 1-Appendix).

The reliability of the study instruments was examined using internal consistency analysis. Cronbach's alpha coefficient was calculated for each questionnaire to assess the homogeneity of items within their respective scales. Cronbach's alpha values of 0.70 or higher were considered acceptable for internal consistency.

Results

Of the 214 questionnaires, two were incomplete and therefore were excluded from the data analysis. The mean age of participants was 34.81 years (SD = 7.04), ranging from 19 to 45 years. The mean age of spouses was 38.60 years (SD = 7.51), ranging from 22 to 61 years. **Table 1** showed the demographic and reproductive characteristics of the study population. Most participants had a university education (74.1%), and similarly, 64.4% of spouses held a university degree. Nearly half of the women were housekeeper (45.8%), whereas the majority of spouses were self-employed (43.4%). More than half of the participants reported a "somewhat satisfactory" income (51.9%).

In terms of reproductive history, 46.2% had delivered via cesarean section, and 26.9% reported no prior delivery. A history of miscarriage was present in 25.9% of participants. Additionally, 13.2% had a child younger than two years. Regarding sexual and cervical health, 6.6% reported a sexually transmitted infection, 157 (74.1%) reported no history of abortion, and 67.5% had undergone a Pap smear within the past five years.

All participants demonstrated inadequate or problematic skills in the domains of access, evaluation and analysis, and application of information. In contrast, 75% of participants showed adequate or excellent performance in the reading and comprehension domain, while 25% remained at inadequate/problematic levels.

As presented in Table 2, the mean total score of sexual health literacy (SHELA) among participants was 152.49 (SD = 17.62), with subscale means ranging from 17.92 (analysis & appraisal) to 70.62 (reading & comprehension). The mean total score of sexual quality of life was 75.36 (SD = 10.39). The minimum and maximum observed scores for each subscale and total scores are also reported in **Table 2.**

Table 1. Demographic and Reproductive Characteristics of the Study Participants (n=212)

Variable	Range (min-max)	Mean	SD
Age	(19-45)	34.81	7.04
Spouse age	(22-61)	38.60	7.51
Duration of Marriage (years)	(1-16)	11.71	9.75
Number of Pregnancies	(0-7)	1.69	1.14
Number of Deliveries	(0-5)	1.42	1.20
First Child Age	(0-22)	8.61	7.92
Number of Abortion	(1-2)	1.93	0.24
	Category / Level	**Frequency (N)**	**Percentage (%)**
Education	Illiterate	0	0
	Elementary	4	1.9
	High school	51	24.1
	University	157	74.1
Spouse's Education	Illiterate	0	0

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	Elementary	11	5.2
	High school	64	30.2
	University	137	64.6
Job	Housekeeper	97	45.8
	Worker	0	0
	Employee	78	36.8
	Self-employed	13	6.1
	Retired	0	0
	Other	24	11.3
Spouse's job	Unemployed	0	0
	Worker	26	12.3
	Employee	74	34.9
	Self-employed	92	43.4
	Retired	0	0
	Other	20	9.4
Income Status	Unsatisfactory	25	11.8
	Somewhat Satisfactory	110	51.9
	Satisfactory	77	36.3
Type of Delivery	No Delivery Experience	59	27.8
	Vaginal	47	22.2
	Cesarean	98	46.2
	Both	8	3.8
Child under 2 years	No	188	88.6
	Yes	24	11.4
Abortion Experience	No	157	74.1
	Yes	55	25.9
Sexually Transmitted Infection	No	198	93.4
	Yes	14	6.6
Last Pap Smear	Within past 5 years	143	67.5
	5–10 years ago	31	14.6
	Never	38	17.9

Table 2. Descriptive statistics of research tool scores broken down by subscales (N=212)

Instrument / Subscale	Minimum	Maximum	Mean	SD
Sexual Health Literacy (SHELA) – Total	82.00	200.00	152.49	17.62
- Access skills	7.00	35.00	25.17	4.97
- Reading & comprehension	38.00	90.00	70.62	8.79
- Analysis & appraisal	10.00	25.00	17.92	3.35
- Application	20.00	50.00	38.75	5.19
Sexual Quality of Life – Total	41.00	95.00	75.36	10.39

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Table 3 presents the univariable GLM regression results evaluating the association between sociodemographic, reproductive, and health-related variables and sexual quality of life among participating women.

Table 4 summarizes the results of the multivariable GLM regression examining the independent effects of sociodemographic, reproductive, and health-related variables on sexual quality of life among participating women. After adjusting for potential confounders, lower education (β= -11.69, 95% CI: -22.35, -1.03), and longer duration of marriage (β= -0.16, 95% CI: -0.30, -0.02) were significantly associated with a decrease in sexual quality of life scores. Increasing health literacy score (β= 0.11, 95% CI: 0.04, 0.19) and had both types of delivery (β= 2.97, 95% CI: -0.93, 6.88) was statistically significantly associated with increased sexual quality of life scores. Other variables, including spouse's education, job status, spouse's job, income status, and last pap smear history, did not demonstrate significant independent associations in the adjusted model (P>0.05).

The internal consistency of the instruments was acceptable. The Cronbach's alpha coefficient for the Women's Sexual Health Literacy Questionnaire was 0.94, indicating excellent reliability, and the coefficient for the Sexual Quality of Life Questionnaire was 0.74, demonstrating acceptable reliability.

Table 3. Univariable General Linear Model (GLM) Regression of Factors Associated with Sexual Quality of Life

Variables		Univariable GLM Regression		
		β	95% CI (Lower – Upper)	P-value
Age		-0.11	-0.30, 0.88	0.275
Husband's age		-0.04	-0.23, 0.14	0.631
Education	Elementary	-18.74	-28.68, -8.79	0.001*
	High school	-2.20	-5.36, 0.96	0.173*
	University	Ref	Ref	-
Spouse's Education	Elementary	-4.47	-10.78, 1.82	0.164*
	High school	-2.63	-5.68, 0.41	0.090*
	University	Ref	Ref	-
Job	Housekeeper	-1.14	-5.76, 3.48	0.628
	Employee	-0.038	-4.77, 4.69	0.987
	Self-employed	-1.69	-8.67, 5.29	0.635
	Other	Ref	Ref	-
Spouse's job	Worker	-6.32	-12.31, -0.43	0.035*
	Employee	-0.26	-5.25, 4.72	0.918
	Self-employed	1.09	-3.79, 5.95	0.660
	Other	Ref	Ref	-
Income Status	Unsatisfactory	-3.65	-8.27, 0.96	0.121*
	Somewhat Satisfactory	-3.36	-6.34, -0.37	0.027*
	Satisfactory	Ref	Ref	-

Duration of Marriage (years)	Discrete	-0.24	-0.38, -0.100	0.001*
Number of Pregnancies	Discrete	-0.73	-1.95, 0.49	0.242
Number of Deliveries	Discrete	-0.51	-1.67, 0.63	0.379
Type of Delivery	Vaginal	-1.70	-9.38, 5.97	0.663
	Cesarean	-0.15	-4.16, 3.84	0.938
	Both	0.07	-3.31, 3.46	0.966
	No Delivery Experience	Ref	Ref	-
Child under 2 years	Yes	-1.68	-5.80, 2.42	0.421
	No	Ref	Ref	-
Age at First Child	Discrete	-0.09	-0.27, 0.08	0.296
Abortion Experience	Yes	-2.64	-5.80, 0.51	0.101*
	No	Ref	Ref	-
Sexually Transmitted Infection	Yes	2.29	-3.31, 7.90	0.423
	No	Ref	Ref	-
Last Pap Smear	Within past 5 years	-2.06	-5.76, 1.63	0.274
	5–10 years ago	-0.99	-5.89, 3.91	0.692
	Never	Ref	Ref	-
Health literacy	Total score	0.12	0.04, 0.20	0.001*

CI = confidence interval; Ref = reference category.

* Variables with P < 0.20 were entered into the multivariable model (Table 4)

Table 4. Multivariable GLM Regression Analysis of Factors Associated with Sexual Quality of Life

Variables		Multivariable GLM Regression		
		β	95% CI (Lower – Upper)	P-value
Education	Elementary	-11.69	-22.35, -1.03	0.031*
	High school	0.13	-4.05, 3.79	0.948
	University	Ref	Ref	-
Spouse's Education	Elementary	-0.86	-7.70, 5.97	0.804
	High school	-0.30	-4.05, 3.43	0.871
	University	Ref	Ref	-
Job	Housekeeper	-0.91	-6.14, 4.32	0.731
	Employee	-0.22	-5.47, 5.02	0.930
	Self-employed	-3.42	-11.16, 4.32	0.380
	Other	Ref	Ref	-
Spouse's job	Worker	-3.01	-9.08, 3.05	0.330
	Employee	-1.01	-6.03, 3.99	0.692
	Self-employed	0.44	-4.81, 5.24	0.855
	Other	Ref	Ref	-
Income Status	Unsatisfactory	-1.55	-6.03, 2.92	0.495
	Somewhat Satisfactory	-1.81	-4.81, 1.19	0.237
	Satisfactory	Ref	Ref	-
Duration of Marriage (years)	Discrete	-0.16	-0.30, -0.02	0.022*
Type of Delivery	Vaginal	0.73	-7.14, 8.61	0.850
	Cesarean	4.33	-0.25, 8.92	0.064
	Both	2.97	0.93, 6.88	0.012*

	No Delivery Experience	Ref	Ref	-
Last Pap Smear	Within past 5 years	-0.19	-5.70, 5.32	0.940
	5–10 years ago	-2.19	-6.20, 1.80	0.282
	Never	Ref	Ref	-
Health literacy	Total score	0.11	0.04, 0.19	0.004*

CI = confidence interval; Ref = reference category. Models adjusted for all variables shown.

* P < 0.05 was considered statistically significant.

Discussion

The aim of this study was to assess the relationship between sexual health literacy and sexual quality of life among women in Isfahan. The findings of this study indicated that sexual health literacy was positively associated with sexual quality of life, such that participants with higher sexual health literacy scores reported higher sexual quality of life scores. In addition, longer marriage duration and lower educational level were associated with lower sexual quality of life scores.

From a theoretical perspective, the positive association between sexual health literacy and sexual quality of life can be explained through several well-established health behavior models. According to the Health Literacy Model (24), health literacy functions at three levels: functional (basic reading and writing skills), communicative (ability to extract and understand information), and critical (ability to analyze and apply information to changing circumstances). In the context of sexual health, higher sexual health literacy enables women to move beyond passive receipt of information toward active appraisal and application of sexual health knowledge, which in turn facilitates healthier sexual behaviors, more effective communication with partners, and better management of sexual concerns (24). Furthermore, the Information-Motivation-Behavioral Skills (IMB) model (25) posits that sexual health-related behaviors are determined by three core factors: information, motivation, and behavioral skills. Sexual health literacy directly addresses the information component while also reinforcing motivation through increased awareness and self-efficacy, ultimately leading to improved sexual health outcomes, including higher sexual quality of life. Thus, the present findings are not only empirically consistent with prior research but also theoretically grounded in established frameworks of health behavior and health literacy (25).

The present study demonstrated that higher sexual health literacy scores were associated with higher sexual quality of life among married women. This finding aligns with the results of Panahi et al. in Qazvin, who reported that sexual health literacy is a key determinant of women's sexual quality of life (26). Similarly, the study by Bahrampour et al. in southern Iran indicated that higher sexual health literacy scores were associated with greater sexual empowerment (i.e., the ability to express sexual needs and desires), which indirectly enhances relationship quality and sexual

satisfaction (27). In line with these findings, Dülger et al. also confirmed that sexual health literacy is related to healthier quality of life and the adoption of health-promoting behaviors (28). Collectively, these consistent results underscore the importance of designing targeted educational and counseling interventions to improve sexual health literacy among married women.

The results indicated that a longer duration of marriage was associated with lower sexual quality of life scores among women, a finding that is partially consistent with existing literature and partially divergent. Tehranian et al. (29) and Yilmaz (30) also reported a decline in sexual satisfaction or an increase in sexual dysfunction over time, suggesting that relationship fatigue, decreased novelty in sexual interactions, and changing roles (e.g., from spouse to mother) may contribute to reduced sexual quality of life. In contrast, studies such as Rakhshani et al. (31) found that longer marriage duration was significantly associated with higher quality of life among middle-aged women, while Jenabi et al. (32) reported no significant relationship between marriage duration and sexual satisfaction, emphasizing that sexual quality of life is more strongly influenced by factors such as marital satisfaction, sexual function, number of children, and spouse's age. These inconsistencies indicate that the decline in sexual quality of life over the course of marriage is a multifactorial phenomenon, with interactions among psychological, social, and cultural variables affecting both the magnitude and direction of these relationships (33). Accordingly, the findings of the present study, while confirming longer marital duration as a risk factor, underscore the importance of educational and social interventions aimed at improving sexual health literacy to prevent gradual declines in sexual quality of life over extended periods of married life.

The findings of the present study also indicated that lower educational levels were associated with lower sexual quality of life scores among women, a result that aligns with a substantial portion of existing evidence. Specifically, Gutacker reported that education level is a strong predictor of quality of life (34). Similarly, Panahi et al. confirmed that education, along with age at marriage, spouse's education, employment status, and number of children, was positively associated with sexual quality of life (26). Studies by Higgins (35) have shown that lower education may limit awareness, communication skills, and the ability to express sexual needs, ultimately reducing relationship quality. Therefore, while the present study and most previous research highlight the positive role of education in enhancing sexual quality of life, other evidence suggests that higher education alone does not guarantee improved sexual quality of life and must be considered alongside psychological, social, and cultural factors (36).

This finding showed that women with a history of both vaginal and cesarean deliveries (i.e., at least two childbirths) had higher quality of life than nulliparous women, consistent with

population-based studies linking higher parity to better physical and psychological well-being (37). Short-term postpartum studies, however, often report higher quality of life after vaginal delivery compared to cesarean (38, 39), while systematic reviews show mixed results (40, 41). Differences in study design, assessment timing, and demographics may explain these discrepancies. Overall, higher parity appears beneficial, but further longitudinal studies are needed to clarify the impact of delivery type on women's quality of life.

Study Limitations and Strengths: Strengths of the present study include the use of standardized and culturally adapted instruments with established validity and reliability, as well as cluster sampling, which enhances the generalizability of the findings to some extent. The application of appropriate statistical methods, including GLM, further strengthens the analytical validity of the results. However, the cross-sectional design of the study limits the ability to infer causal relationships between sexual health literacy and sexual quality of life. Additionally, focusing on women attending comprehensive health centers may limit the generalizability of the findings to the wider female population. Finally, this study did not collect data on participants' history of cancer, reproductive system surgery, or mode of delivery, which may have influenced sexual quality of life. Future studies should consider these variables as potential confounders.

Conclusion

This study showed that women's sexual health literacy was directly and positively associated with sexual quality of life. Longer marital duration and lower educational levels were associated with lower sexual quality of life scores. It appears that proper, continuous, and culturally tailored education on sexual health literacy by improving access, understanding, and application of information can contribute to enhancing sexual quality of life. Therefore, integrating sexual health literacy education into reproductive health service packages at comprehensive health centers may be beneficial. Future research is recommended to employ longitudinal designs and implement educational interventions aimed at improving sexual health literacy to allow for a more precise examination of the causal relationships between sexual health literacy and sexual quality of life.

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Conflicts of Interest: The authors declare that they have no conflicts of interest.

Consent for Publication: Not applicable.

Ethics approval and consent to participate: This study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki–Tokyo for research involving human subjects. Ethical approval was obtained from the Institutional Ethics Committee of Isfahan University of Medical Sciences (Approval Code: IR.ARI.MUI.REC.1400.018). All participants were fully informed about the objectives and procedures of the study, and written informed consent was obtained from each participant prior to data collection. Participation was voluntary, confidentiality was ensured, and all data were handled anonymously.

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