

Exploring the Barriers to Sexual and Reproductive Health Education for Men in Iran: A Qualitative Study

Abstract

Background: Considering the obvious reasons for the necessity of men's sexual and reproductive health education, the present qualitative study aims to identify and contextualize the barriers to sexual and reproductive health education to men in Iran. **Materials and Methods:** This qualitative research was conducted using conventional procedures of content analysis. A total of 34 participants consisting of authorities in health organizations, healthcare providers, clergies, and adult men in a general population were interviewed in two large cities of Iran including Tehran and Mashhad in 2016. Purposive sampling continued until data saturation was ensured. Data were collected through individual in-depth semi-structured interviews. All interviews were tape-recorded and transcribed in verbatim. Finally, the data were analyzed using conventional qualitative content analysis. **Results:** Participants' experiences were categorized into three main themes including (1) individual barriers, (2) sociocultural barriers, and (3) structural barriers along with seven subthemes including low perceived threat, unwillingness to learn, sociocultural taboos, family's lack of knowledge and malperformance, policy-making barriers, executive barriers, and health system deficiency barriers. **Conclusions:** Considering the results obtained, many barriers to men's sexual and reproductive health education could be eliminated through overcoming the individual and structural barriers and sociocultural taboos, as major obstacles. The findings suggest overcoming these barriers and promoting men's health require raising awareness overcoming sociocultural taboos. In this regard, policy-makers should provide sexual and reproductive health education programs and create opportunities and facilities along with appropriate learning environments for men.

Keywords: Iran, men, qualitative research, reproductive health, sex education

Introduction

The United Nations Guidelines on Reproductive Health define reproductive health as a state of complete physical, mental, and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with reproductive processes, functions, and system at all stages of life. Human reproduction involves a man and a woman.^[1] In spite of this fact, efforts to improve reproductive health in Iran and elsewhere have typically targeted women.^[2] Men, especially in traditional societies, have particular roles and responsibilities in terms of women's reproductive health. Men's role is of high significance due to various factors: they are responsible for many decisions regarding family size, birth interval, use of contraceptive methods,

and prevention of sexually transmitted diseases (STDs)/human immunodeficiency virus (HIV).^[3] Men also determine their spouses' attitudes toward different aspects of sexual and reproductive health.^[4] For instance, in some countries, women cannot use family planning methods without obtaining an official permission from their partner.^[5] In addition, a high percentage of women (32%–92%) with a prior history of abortion stated that their sexual partners had forced them to terminate their pregnancy.^[3] Although men form a significant part of Iran's population and have a significant role in both the society and family, they have been largely ignored, where their sexual and reproductive health has remained one of the most unexplored issues of health in our society.^[6] The conducted studies confirm that men have requirements with regard to reproductive health and its subcategories, such as STDs and acquired immune deficiency syndrome

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(AIDS), which have been overlooked.^[2,7,8] Therefore, promotion of men's sexual and reproductive health, which has been highly neglected, is a keystone to enhancing their health, thereby promoting healthier lifestyles, preventing STD/HIV, and reducing the unplanned pregnancies and unsafe abortions. All these eventually lead to reduced major health risks they may face.^[9] The main purpose of sexual and reproductive health promotion programs is authorizing a person through augmenting their sexual and reproductive health knowledge so that they can lead a healthy lifestyle and avoid unhealthy behaviors.^[10] It is not possible to promote the sexual and reproductive health of men without considering men's knowledge, understanding, and participation.^[3]

Undoubtedly, education is necessary for changing and improving men's knowledge and attitude which can lead to their appropriate functioning and lifestyle changes.^[3] Indeed, men, who are aware of their own reproductive and sexual health issues, are more successful fathers and partners.^[11] As various studies have indicated, dismissing men's role results in the failure of sexual and reproductive health programs in society. A study reported the success of the Thai '100% Condom Program', which educated young Thai male military conscripts about condom use using a series of education sessions and a leaflet/poster campaign in 1991. In their cohort study, they found that the incidence of HIV and STI among college students declined dramatically between 1991 and 1995.^[12] This study would seem to suggest that it is indeed possible for men to alter their high-risk behaviors through education. Furthermore, research also indicated low knowledge of young men about sexual and reproductive health, highlighting the importance of educating them.^[13,14]

According to World Health Organization, there are social and cultural barriers against sex education in many parts of the world.^[15] Indeed, sexual topics are considered taboo in some Asian countries.^[16,17] Similarly, there are many social and cultural challenges in the family and at school about sexual education in Iran.^[1,13] A study stated that despite the significance of these conditions, especially the more serious ones such as AIDS, Iranian male students, in comparison to those in other countries, were not much aware of STDs, showing the necessity of offering scientific programs on men's sexual health.^[18] To resolve this issue, obstacles should be discovered. Indeed, no study has evaluated barriers to sexual and reproductive health education for men in Iran, and few studies have focused on barriers to male involvement in women's sexual and reproductive health or explored the barriers on reproductive health education and prospects among teachers and female students in schools.^[19-21] Considering the significant role of education in planning and enhancing men's reproductive health, it seems that some existing issues and barriers hinder the implementation of education about this issue in Iran that have not been fully explored

deeply in published data. Accordingly, qualitative research was applied as the methodological approach for this study. Qualitative research seeks to uncover meanings and places primary value in interpreting the reasons given by participants.^[22] This qualitative research was conducted to explore perceptions of Iranian key professionals and men from the general population on issues and barriers affecting the men's sexual and reproductive health education in Iran.

Materials and Methods

A qualitative design with semi-structured in-depth interviews and conventional methods of content analysis was used from May to October 2016. A qualitative approach was used thanks to its strengths in understanding the voices of participants and when little is known about the phenomenon being studied.^[22] Qualitative content analysis is a research method for analyzing content of text data and interpreting meaning from them.^[23] The participants were men from the general population and key adults including healthcare providers, policy-makers at Ministry of Health, and clergies in two large provinces in Iran, Tehran, and Mashhad.

The reason for choosing Tehran was its socioeconomic and cultural diversity and easily meeting policy-makers. On the other hand, Mashhad city was chosen as the city is a religious and traditional symbol, which in combination with Tehran offers an acceptable variety of features. The Ministry of Health in Tehran and healthcare centers, behavioral health counseling center, and public places such as parks and the libraries in Tehran and Mashhad constituted the settings of the study.

Purposeful sampling with maximum variation was adopted. Purposeful sampling is widely used in qualitative research for identifying and selecting information-rich cases related to the phenomenon of interest.^[24] For maintaining maximum variation, the participants were selected and included in the study in terms of age, grade, job, age, marital status, socioeconomic status, and socioeconomic localities.

Inclusion criteria for the participants were being 18 years old and above and no mental disorders. Furthermore, the healthcare providers, policy-makers, and clergies were included in case they had more than 4 years of experience of research or teaching in the relevant field according to their Curriculum Vitae(CV).

All the interviews were conducted in a suitable environment. Before initiating the interviews, demographic information including age, educational level, marital status, and occupation were collected. Then, semi-structured in-depth interviews were initiated with a general question (e.g., "How do you think about sexual health education for men in Iran?"). Then, subsequent questions were asked to encourage the participants to express their own views (e.g., "Please state the experiences of the training you have

ever received about AIDS and STDs” or “What type of education was provided for you?”). The interviews were recorded and transcribed verbatim by the author. Each individual interview lasted 60–90 min.

Immediately following the interview, the author listened to the recorded tape to see whether the complete interview or some elements of it are required to be continual or processed. The conventional qualitative content analysis was used for data analysis. This is a research method focusing on understanding, describing, and interpreting a phenomenon as perceived by individuals. This design allows researchers to immerse themselves in data to attain new insights about a phenomenon. The analysis was based on content analysis method of Graneheim. Collection and analysis of qualitative inductive content analysis consist of three main phases: preparation, organization, and reporting.^[25]

From the beginning and throughout the study, analysis of textual data was conducted from the transcripts comprising the steps of reading and rereading the texts to get an overall insight of each interview. They were then read word by word to identify meaning units, which was followed by immersion in the data and a cross-reading of all texts to identify the similarities and differences in the narratives to understand what was the most relevant content. Through the process of reduction and condensation, codes were emerged and categorized using MAXqda software.^[26]

After interviewing with 34 participants, the sampling was terminated as data saturation was reached. Saturation occurred once no new content or data were extracted from the information and no new codes or themes were added to the findings. When data saturation occurred, two additional interviews were done to ensure that other possible findings were not neglected during content analysis.

The procedures used in this study for rigor and trustworthiness were triangulation and member checking for credibility. Triangulation of sources was conducted first in this research (interviewing with different participants at different points and different settings and comparing people with different perspectives). Then, for member checking, a brief report of the findings was given to the participants; they were asked to confirm that those reflected their perspectives and comments. It also involved listening to the interviews and reading the transcriptions for several times, asking the outside researchers who examined the processes of data collection, data analysis and the results and incorporating their feedback into findings (for dependability), and the maximum variation in sampling. Also, external auditing was conducted by a team of experts to check the compatibility between the study objective, analysis process, and findings (for confirmability). Attempts were made to improve the transferability of findings through provision of details of the study process and the

participants’ direct quotations and adequate thick description of the phenomenon under study (for transferability).

Ethical considerations

Ethics committee of Mashhad university of Medical Sciences approved this study (project code: 931429). Interviews were done after all participants became informed about the aim of the study and signed an informed consent form to participate in the study. They were assured that their data would remain confidential and anonymous. They were also informed of their right to withdraw from the study at any time.

Results

The study population consisted of 34 men, aging from 22 to 66 years, the majority having Bachelor’s or a higher degree and being mostly married [Table 1]. Analysis of the experiences and perceptions of the participants was categorized into three main themes including (1) individual barriers, (2) sociocultural barriers, and (3) structural barriers plus seven subthemes including low perceived threat, unwillingness to learn, sociocultural taboos, family’s lack of knowledge and malperformance, policy-making barriers, executive barriers, and health system deficiency barriers [Table 2].

Table 1: Sociodemographic characteristics of participants

Variables	Groups	Frequency ^a
Participants	Adult men	20 (58.80)
	Policy-makers	5 (14.70)
	Clergies	2 (5.80)
	Healthcare providers	7 (20.50)
Age (years)	22-35	7 (20.50)
	36-50; 19 (55.80%)	19 (55.80)
	>50; 8 (23.50%)	8 (23.50)
Educational level	Elementary	1 (2.90)
	Secondary	4 (11.70)
	Postsecondary	13 (38.23)
	Postgraduate	16 (53.33)
Marital status	Married	24 (70.50)
	Single	10 (29.40)

^aFrequency are presented as No. (%)

Table 2: Barriers to sexual and reproductive health education to men

Them	Subtheme
Individual barriers	Low perceived threat
	Unwillingness to learn
Sociocultural barriers	Sociocultural taboos
	Family’s lack of knowledge and malperformance
Structural barriers	Policy-making barriers
	Executive barriers
	Health system deficiency barriers

Individual barriers

Individual barriers were mentioned as one of the education barriers by most participants. “Low perceived threat” and “unwillingness to learn” were among the subthemes of this barrier.

Low perceived threat

One of the participants said, “Most men who refer to this clinic for their disease mention that they never thought the disease could be easily passed on; they thought the sexual disease was for specific people and they would never catch the disease. They were confident that they had not done anything special to inflict them with the disease” (Behavioral Diseases Counseling Center consultant, 40 years old).

Perceived susceptibility about STD among subjects was low. Note that low perceived threat prevents admission of education.

Unwillingness for learning

The other individual barrier expressed by the majority of the men was “unwillingness to learn” due to their occupation and lack of time. Also, they stated that female healthcare providers in clinics were not appropriate instructors. Most participants emphasized that the educational settings were not appropriate for men, “Unhappily, if there is any training, it is in healthcare clinics and is usually provided in the mornings. Their staff are all women. Considering all these, when can one attend such courses? It is not possible for me to attend these trainings as I am at my workplace from morning till evening” (Bank clerk, 52 years old).

Sociocultural barrier

Participants mentioned that taboos surrounding sexuality were the main sociocultural barriers for sexual health education for men in Iran. Perceived stigma and embarrassment, sexual discourse as a sociocultural taboo, and the negative attitude toward sexual issues were the obstacles to sexual and reproductive health training.

Sociocultural taboos

In this regard, an infectious disease specialist stated, “Currently, sexual relations exist underground. I don't know who should be trained and who should be more focused upon... high risk people are not identified and they infect the others as well ...” (Infectious disease specialists, 36 years old).

Some participants welcomed trainings in this field and considered it as necessary; however, despite all their questions and lack of knowledge, they preferred to remain silent for the taboo attached to these issues.

The statements of this participant represent this issue, “I myself had thousands of questions on sexual and health issues since my teenage years. I also have had questions

on adulthood before marriage and even after marriage, but I did not refer to anywhere as I was afraid to ask. For instance, if I ask about AIDS, they may think I have had a high risk behavior. When I had questions on sexual issues, I refer to books or my close friends or the Internet” (Seller, 32 years old).

Negative attitudes held toward sexual issues were another noteworthy issue raised by some of the participants.

A participant said, “If you add the word sexual to any other thing, it becomes taboo. You have to hide it. If I teach students at high school about sexual issues, the parents would instantly call the high-school manager and complain ...” (General physician, 34 years old).

Family's lack of knowledge and malperformance

A participant said, “Families themselves don't know much about sexual issues; then, how can one expect them to train their children? The reason for this is that all previous generations have dealt with such issues secretly, and if the families are not educated or have not sought accurate information, then they practically have no information to provide to their children, or have no accurate information to offer ...” (Master student of psychology, 21 years old).

Another participant said, “I don't know what to teach him. I don't even know how to begin. What to say what not to say. If I tell him, doesn't he get cheeky then? I don't really know. That's why I think schools must have a plan for such trainings ...” (Male employee of oil company, 33 years old).

Structural barriers

Structural barriers were among other categories of barriers including “policy-making barriers,” “executive barriers,” and “health system deficiency barriers.” According to participants, the structural barriers are considered as the most fundamental challenges in sexual and reproductive health training. From the perspective of some participants, support from governmental authorities, health policy-makers, and involved organizations, as well as contribution of nongovernmental institutions and empowerment of teachers and families seem to be necessary for overcoming these barriers.

Policy-making barriers

This issue was mentioned by one of the participants as follows: “In developed countries, there are information dissemination campaigns on public health which attempt to enhance individual-dependent health attitude through adopting new approaches to health education, training patients, providing consultation, developing active health resources, enhancing responsibility and public contribution, as well as a wide range of services empowering people for self-care. However, this is not possible in Iran due to the insufficient number of resources and the fact it is

not accepted culturally ...” (Provincial deputy of health organization, 62 years old).

In relation to this issue, one of the participants, who was a policy-maker, said, *“We need real statistics for policy-making. How many real patients are out there? What has been the prevalent route of disease transmission? Whom have they contacted after receiving the disease? We don't really know” (Psychologist, 47 years old).*

Preventing the outbreak of fear among people was mentioned as the other reason for nonpublication of real statistics which was evident in some participants' statements. In this regard, a provincial deputy of health organization said, *“If they only knew the real statistics and the high number of AIDS patients, that would then disrupt their life and work or even threat their health ... for instance they would never refer to any dentistry then” (Provincial deputy of health organization, 62 years old).*

Another participant said, *“Sexual diseases and problems are unhappily kept underground. High risk sexual relations are kept hidden. When individuals hide their disease, how can we identify them, treat them, and advise them” (Social medicine specialist, 54 years old).*

Executive barriers

One of the participants, emphasizing the key role of healthcare providers, considered nonprovision of education facilities, lack of encouragement for trainers, and even authorities' disagreement with sexual health education especially in schools, and generally lack of support for trainers, as discouraging factors for trainings. He also felt sorry for authorities' disregard for training in this field. He said, *“I, as a health authority, warned other authorities against the existing sexual problems, and advised them that the idea of offering sexual training programs should be taken into greater consideration. Resources should be provided to schools, to offices, to places where men, especially young men, are present. Facilities and equipment should be provided through educational movies, CDs, and pamphlets. Trainers should also be paid. However, the advice was not accepted as families and even authorities do not agree with the idea” (Provincial deputy of health organization, 62 years old).*

The other barrier to men's sexual and reproductive health training, which was reflected in participants' statements, was variations with regard to men's puberty, their information and knowledge level, their marital status, their job condition, and difficulty in accessing this group of people.

The following quotation confirms this matter: *“Unhappily, the majorities of men work and are not available in the mornings. Their work often continues until night. So, we don't have access to them. We try to train them indirectly by training their spouse so their spouse conveys the*

lessons to them, but direct training is more effective ...” (Midwife, 42 years old).

Another participant said, *“The education level is also different from one person to another; some men have good information and therefore our courses sound quite simple to them, while some know nothing and then all issues should be explained to them completely. This causes a challenge for education” (Counseling center supervisor, physician, 49 years old).*

Health system deficiency barriers

Healthcare providers' unwillingness and lack of a collective agreement with regard to reproductive health standards were among other points mentioned by participants which is mainly rooted in their ignorance of men's sexual and reproductive health needs caused by mismanagement and lack of specialized executive force. One participant said, *“Ignorance about men's sexual and reproductive health requirements and a lack of collective agreement on men's reproductive health standards is like a vicious cycle compromising many of such care provisions at individual, social, and structural levels” (General physician, 39 years old).*

The fact that insurance policies do not have coverage for consultation fees is another barrier to men's care, education, and consultation. This ultimately leads to men's unwillingness to refer to consultants for these issues. This was reflected in one of participant's statements as follows: *“One of the barriers to healthcare, including most men's unwillingness for regular checkups, is the fact that health insurance policies in governmental and private sectors do not cover the cost of education and consultation, especially for poor people. This is one of the reasons for health system deficiency, lack of attention to men's health” (PhD in health education, 29 years old).*

The fundamental strength of this study was performing it in two cities with various cultural and religious settings allowing the researchers to compare the findings. The findings demonstrated distinctions in participant's attitudes between two cities about sexual issues due to their sociocultural structure. In Tehran, talking about sexual issues was easier for participants. They also had a positive attitude about sex education in schools more than participants in Mashhad. Nevertheless, we supposed that extramarital relationships are more frequent in Tehran than in Mashhad, but these relationships were similar in both cities. This implies that access to various communication technologies has changed social traditions about prohibition of premarital sex in people.

In our study, the majority of the findings were similar in both cities, affirming formation of a global society. This implies that because of global communication technologies, people are not constrained to their social setting; rather for the most part they rely on a universal society.

Discussion

Our results revealed that the main challenges to sexual health education for men in Iran are associated with three groups of barriers consisting of individual, sociocultural, and structural barriers. Individual barriers were one of the major themes according to the participants' experiences. "Low perceived threat" and "unwillingness to learn" were among the subthemes of this barrier.

Some participants held that one of the important barriers to sexual and reproductive health education was caused by men's attitudes in that they were certain about not being exposed to STDs. Alternatively, their confidence with regard to knowing all sexual issues made them overlook education; such a confidence was in itself a barrier to their willingness for learning. Therefore, increasing perceived susceptibility and severity may induce increased willingness to sexual and reproductive health education among men. The reason for this attitude is the low awareness of men in sexual and reproductive health. The findings of many studies have revealed poor knowledge of Iranian men about reproductive and sexual issues. A study showed that 85% of Iranian men have poor knowledge and therefore need to receive information on these issues.^[27] Similarly, another study revealed that poor knowledge of men is a major barrier to male reproductive and sexual health education. To obviate this challenge, their knowledge should be increased through designed programs and male sexual and reproductive health services for men. Therefore, men are equally important as women to receive sexual and reproductive health programs.^[28]

Men's unwillingness to training programs was one of the emerged subthemes. It was caused by inappropriate working hours of training centers and woman personnel working in the centers. Similarly, a study indicated that barriers such as improper working hours of health clinics and the presence of female health workers in these centers, sexual attitudes, and ignorance about preventive methods caused men's lesser contribution to a satisfactory reproductive health program. Some interventions were then recommended in the aforementioned study for enhancing men's contribution to reproductive health.^[15]

The second extracted theme was sociocultural barriers. Sociocultural taboos and family's lack of knowledge and malperformance were subthemes of this them.

In several other studies conducted throughout the world, cultural challenges have been mentioned as a barrier to sexual training. There is evidence from Africa and Asia^[26,29,30] suggesting cultural resistance against sexual training for adolescents. Even in more liberal communities such as those in Europe and Canada,^[31] it seems talking about sexual issues is sometimes forbidden even in the family. Family's lack of knowledge and malperformance of parents, lack of knowledge, and lack of necessary skills

were among the most important challenges revealed with regard to reproductive and sexual health training. They complicated expectations from parents and families for sexual training in many regions of the world, where social and cultural barriers against sex training and positive articulation of sexual matters have led to the absence or low level of sexual health quality.^[15] In a study conducted on Nepali adolescents, discussion over sexual issues was accompanied by great prudence and embarrassment.^[32] The same finding was obtained by a study conducted in Iran.^[33] This finding conforms to the finding of this study. Indeed, in many Asian countries, sexual issues are considered as a taboo.^[16,17] There is no evidence that sexuality among Muslims is taboo or that religious belief guarantees abstinence from premarital sex.^[34] In Iran, there are many social and cultural barriers in the family and at society.^[35] In a study, cultural factors proved to be the most significant sexual health education's barrier for students.^[19] Another study showed that cultural challenges are a barrier to sexual health education. They concluded that cultural resistances are more important than religious prohibitions and affect the nature and content of sexual health education.^[3]

Indeed, cultural resistances appear to be more important than religious prohibitions and have an effect on many characteristics and contents of sexual health education. However, despite existence of salient sociocultural uncertain problems regarding sexual health education for men, the rising challenges are manageable to some extent. It is hoped that the acceptableness of sexual health education for men can be promoted through overcoming the cultural taboos and barriers. It is recommended to negotiate with religious groups about the importance of providing sex education and use multimedia for making the messages relevant to today's men for encouraging them to learn sex education.

Thus, this is a very important strategy to ensure parents and key people in the society about the necessity of sexual health education which should be included in the dialogue. Furthermore, social processes should be prioritized to gain support for sex education programs in schools.

Another theme obtained from the participants' experiences was structural barriers. As indicated by this study, policy-making, executive barriers, and health system deficiency barriers were among the significant barriers. In this regard, a change in policy-makers' attitude and their support for sexual training programs for men can be an effective step toward enhancing men's health and, as a result, the social health. A qualitative study emphasized successful implementation of any programs aiming to reduce the prevalence of STDs and HIV/AIDS, where policy-makers and authorities should stop their silence and publicly speak about the burden of these diseases on society and design strategies to prevent them. Such an achievement requires dedicated support by all individuals,

organizations, and key sectors to promote health programs. Indeed, the majority of reproductive health issues cannot be resolved without dedicated support from policy-makers and decision-makers.^[2]

The other issue mentioned was the fact that the real statistics of individuals suffering from STDs are not published. Notably, as expressed by participants, there seem to be prohibitions with regard to the publication of real statistics. One of the reasons for nonpublication of real statistics is patients' unwillingness for registration; there are more patients than what the statistics show, but they do not refer. Even if they refer, they receive their prescription and laboratory services and leave without registration. If the real statistics, indicating the real level of disease prevalence, are published, then authorities and people may exhibit greater sensitivity with regard to offering solutions and take more serious preventive measures. To remove these barriers, accurate planning based on evidence as well as healthcare policy-makers' and authorities' support is required. Supports from nongovernmental institutes and organizations involved in education as well as empowerment of teachers and families are all necessary for ensuring the health and well-being of the society.

A limitation in this study was the small sample size which is common in many qualitative studies. Data collection through interviewing men would be strengthened by implementing focused group discussions. However, because of the sensitivity of sexual issues in our culture and society and to respect the privacy of individuals, the researcher decided to perform data collection through individual interviews; hence, the lack of group discussions was one of the limitations of this study.

It was difficult to get cooperation from policy-makers and some officials because of their time constraints. The researcher tried, with enough explanation, to select the key, knowledgeable, and interested individuals to solve these problems.

Conclusion

Considering the results obtained, there seem to be many barriers to men's sexual and reproductive health training, especially regarding the sensitivity of sexual education in the religious and cultural context of Iran. Sexual health education for men could be made more approvable through overcoming the individual and structural barriers and sociocultural taboos as major obstacles. The findings suggest that there is a need for interventional strategies for socioculturally suitable educational contents for men. Policy-makers have to allocate resources for training and empowerment of male personnel for employment in healthcare centers for provision of reproductive and sexual healthcare services to men. Furthermore, facilities should provide access to these educational and healthcare services at the men's workplace based on the needs and

norms of the community. Some indicators should also be developed for evaluating programs in terms ensuring fair and discrimination-free services for quality improvement. Overall, policy-makers must plan programs for promoting male reproductive and sexual health through overcoming taboos that impede men's fair access to reproductive and sexual health services and create opportunities and facilities and appropriate learning environments for men.

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Conflict of interests

Nothing to declare.

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