

Exploring the factors influencing access to and utilization of sexual health services by South Asian men in Ontario

by

Yamin Tauseef Jahangir

A thesis
presented to the University of Waterloo
in fulfillment of the
thesis requirement for the degree of
Doctor of Philosophy
in
Public Health and Health Systems

Waterloo, Ontario, Canada, 2022

© Yamin Tauseef Jahangir 2022

Examining Committee Membership

The following served on the Examining Committee for this thesis. The decision of the Examining Committee is by majority vote.

External Examiner

Dr. SARAH FLICKER
Professor
York Research Chair (Tier2) in
Community-Based Participatory Research
Environmental Arts & Justice Coordinator
York University

Supervisor

Dr. SAMANTHA MEYER
Associate Professor
Associate Director, Graduate Studies
School of Public Health Sciences
University of Waterloo

Internal-External Member

Dr. KIMBERLY J. LOPEZ
Assistant Professor
Recreation and Leisure Studies
University of Waterloo

Thesis Committee Members

Dr. CRAIG R. JANES
Professor
Director, School of Public Health Sciences
University of Waterloo

Dr. ELENA NEITERMAN
Continuing Lecturer
School of Public Health Sciences
University of Waterloo

Author's Declaration

This thesis consists of material all of which I authored or co-authored: see Statement of Contributions included in the thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Statement of Contributions

This thesis adopts a manuscript-based approach. This thesis consists in part of four manuscripts written for publication. Manuscripts in Chapter 2 and Chapter 3 have been published in peer-reviewed journals for which Yamin Tauseef Jahangir is the first author. For all four manuscripts in this thesis, exceptions to sole authorship of material are as follows:

Chapter 2 and 3:

Yamin Tauseef Jahangir was responsible for study design conceptualization, data collection, analysis, and drafting, submitting, and revising manuscripts. Co-authors Drs. Samantha B. Meyer, Elena Neiterman and Craig R. Janes provided methodological guidance and feedback on all the draft manuscripts.

Citations:

Chapter 2: Jahangir, YT, Meyer, SB. Understanding Access to and Utilisation of Sexual Health Services by South Asian Immigrant Men in Western Countries: A Scoping Review. *J Immigrant Minority Health* 22, 621–633 (2020). <https://doi.org/10.1007/s10903-020-00981-z>

Chapter 3: Jahangir YT, Neiterman E, Janes CR, Meyer SB. Healthcare access, quality of care and efficiency as healthcare performance measures: A Canadian health service view. *J Health Soc Sci.* 2020;5(3):309-316

Research Presented in Chapter 4 and 5:

This research was conducted at the University of Waterloo by Yamin Tauseef Jahangir under the direct supervision on Dr. Samantha Meyer. Drs. Elena Neiterman and Craig R. Janes provided intellectual input on manuscript drafts. For both manuscripts from the study, Yamin Tauseef Jahangir was responsible for conceptualization, data collection, coding, analysis, and writing of the original drafts.

Citations:

Chapter 4: Jahangir YT, Neiterman E, Janes CR, Meyer SB. Exploring the factors influencing access to and utilization of sexual health services by South Asian men in Ontario.

Chapter 5: Jahangir YT, Neiterman E, Janes CR, Meyer SB. Exploring South Asian men's perspective on the role of provider attitude in experiences of sexual healthcare services in Ontario.

As lead author of these four chapters, I was responsible for contributing to conceptualizing study design, carrying out data collection and analysis, and drafting and submitting manuscripts. My coauthors provided guidance during each step of the research and provided feedback on draft manuscripts.

Abstract

Introduction

As the South Asian immigrant population continues to grow in developed countries, research focused on providing culturally appropriate healthcare services has become of central concern. In addition, studies have found that South Asian men's lack of perceived or actual accessibility to healthcare often leads to these men being treated later for health complications and particularly for sexual health illnesses. Although pregnancy and sexually transmitted diseases involve both men and women, literature suggests that most sexual health programs only target women and ignore the sexual health needs of men. Therefore, the aim of this thesis is to have a broader understanding on if and how South Asian men access and utilize sexual health services in a Western country setting, particularly in Canada. Literature suggests that in many developed countries, there is a paucity of work that investigates the needs of immigrant populations with regards to sexual health, and consequently how to develop appropriate services for these populations. Therefore, as shown in this thesis, it is deemed necessary to explore the contextual factors that influence sexual health service uptake by South Asian men in Canada in order to create a more robust and improved sexual healthcare service for this population.

Objectives

The first study (Study I) of this thesis was a scoping review focused on South Asian men in Western countries and explores broadly the accessibility and utilization of sexual health services by this population group in a developed country setting. In the conceptual paper, I documented critical concepts for investigating, understanding, and explaining patient experiences with healthcare system in Canada; namely access to healthcare services, utilization of service, quality of care and healthcare service efficiency. The objective of Study III paper 1 was aimed to explore contextual factors (e.g. cultural, psychological, social) influencing the accessibility (actual and/or perceived) and utilization of sexual health services by South Asian men in Canada.

Finally, the Study III paper 2 aimed to explore if and how South Asian men perceive provider attitude as playing a role in sexual health service experiences for South Asian men in Ontario.

Methods

Study I followed Arksey and O'Malley's established methodology for mapping out and identifying the extent, range, and nature of research activity, and identify research gaps in the existing literature. For Study III paper 1, an interpretive description (ID) research methodology was used to concurrently collect and analyze data in Ontario. The overall analysis further followed Braun and Clarke guidelines for thematic analysis. As for Study III paper 2, thematic analysis was also conducted following Braun and Clarke (2006) thematic guidelines. Altogether eighteen semi-structured interviews were conducted between May – July 2021 with South Asian born immigrant men between the age range of 20-45 years for Study III.

Results

For Study I, four multi-disciplinary electronic databases were searched to between 1998 and 2018. The search yielded 586 articles; 407 duplicate articles were removed, and 376 did not meet the inclusion criteria. A total of 10 articles were included in this review. Herein we report the factors shaping sexual health service access and use, namely: (1) cultural and psychological factors; (2) sexual health service accessibility; (3) personal beliefs and patterns in service use; (4) social perspectives and conflicting values on sexual health. We identify the gaps in research needed for policymakers, formal healthcare providers, and South Asian community stakeholders to develop effective and inclusive sexual health programs for South Asian men in Western countries. In addition, the conceptual paper contributed to the broader literature in identifying the knowledge gaps within the Canadian health service system, in terms of understanding the variable indicators that are used in measuring health systems performance. In Study III paper 1, we found sexual health is perceived negatively by some South Asian men and limited sexual health information was said to exist within the community. Furthermore, perceived severity of sexual illness also influenced sexual health service access. Participants also mentioned sexual health as taboo, the social nature of sex positivity and sex negativity and that men share sexual

health information with only trusted sources (e.g. friends and family). Our participants also mentioned that sexual health information was shared more openly by following Western rather than South Asian cultural norms. Findings further suggest South Asian men's culture influences their perceptions of sexual health and overall access to care which they often think to be an optional service. For example, gender stereotypes about men within the South Asian cultures can influence sexual health seeking behaviours among men.

Lastly, in Study III paper 2, participants discussed providers as being inattentive to care and that they, as patients, are often concerned about being judged by their provider. Participants suggested that to improve care, providers should focus on building a common ground of interest and respect during service delivery. In addition, participants viewed the one-provider-one-service policy in Ontario as a hindrance to men accessing healthcare. The notion of doctor-hopping was also discussed as a response to care that does not meet patient expectations. The notion of gender also emerged, with recommendations put forward for non-judgemental separate sexual health service provision for men from women.

Conclusion

The scoping review was important to identify the knowledge gaps and identify relevant methodological tools, ultimately guiding the design of Study III, investigating what contextual factors (e.g., cultural, physical, psychological, or social) play a role in South Asian immigrant men's access (actual and/or perceived accessibility) to and utilization of sexual health services in Canada. The conceptual paper made a stand-alone contribution to the wider thesis (such as, in investigating, understanding, and explaining patient experiences with healthcare system in Canada; namely access to healthcare services, utilization of service, quality of care and healthcare service efficiency) and mainly in proceeding towards a critical investigation in Study III, that aimed to explore access to care, utilization of services, and patient-provider interactions in healthcare service experience in Ontario. Furthermore, Study III paper 1 provided unique understanding regarding the various contextual factors that influence access to and utilization of sexual healthcare services by South Asian men living in Ontario. Also, our findings suggest that health and wellbeing of South Asian men are integrally connected to their culture in South Asian

communities, and that there is an increased need for sexual health education and promotion opportunities within the South Asian male communities that is a crucial process and would require appropriate locations for clinic or service promotion. Lastly, Study III paper 2 found that healthcare provider attitude may play as an important role in the overall in health service delivery and consequently if and how they are used. Indeed, it is important for healthcare professionals to be more reflexive of their attitudes in a clinical setting and perform not by ignoring the other cultural knowledge in medicine practice, but by embracing it.

Acknowledgements

Through my qualitative research fieldwork and teaching experience of five years in access to and utilization of healthcare services and health promotion for marginalized and culturally diverse communities, I have approached sexual health studies through a lens of gender and in consideration of culture. My work experiences in projects with the World Health Organization in Thailand and the European Union projects in Bangladesh made me get exposed to public health crisis in sexual health in Africa and Asian countries. As I embarked in this doctoral program, my journey has evolved and changed in the way I capture and understand participant stories, engage critically with my own positionality of my research paradigm, and think about the relationships within culturally diverse communities that influence access to healthcare services. After four years (and one semester) as I look back and reflect on my doctoral journey, I would like to thank some important people without whom this journey would not have been possible.

I am thankful to all the participants who participated in this crucial study, openly discussed, and provided their valuable insights on a sensitive topic like sexual health for men.

To my supervisor Dr. Samantha Meyer, thank you! Thank you for all your support that you have given me right from the first day I met you as an international student at UWaterloo. Your encouraging words, thoughtful mentorship, and guidance in every aspect of my doctoral journey was always so motivating. Thank you for shaping me to be the scholar I am and the scholar that I have always aspired to be! For your unconditional support and care, I am forever grateful to you!

I would also like to thank my thesis committee members for your enormous support and guidance in shaping my research as my advisors.

To my family, my parents, I am forever grateful for your unconditional love, affection, and care and for trusting me to be the scholar that you have always dreamed of. We did it! I am grateful to my brother and my sister-in-law who have always been a strong support and guidance and I am truly thankful to them, that I have my immediate family here in Canada while studying as an international student. Your support always kept me grounded to my work and to progress stronger. To my in-laws, my father and mother in-law, thank you, for your kind affection and

support to my emotional and mental wellbeing, especially in critical times of the pandemic. I am grateful for your kind and valuable support.

Lastly, I would like to thank all the readers of this thesis work. I hope reading this doctoral thesis will also make you feel connected and be a part of my research journey.

Dedication

My doctoral journey became extremely challenging during the ongoing COVID-19 pandemic, when I was separated from my wife for nine months due to provincial lockdown rules and Canada border closures, but I could reunite later. Even in these challenging times, my adorable wife, Tasmia, you have been an incredible force of strength, perseverance, and compassion. Thank you for being such a wonderful person that you are, for your sacrifices and for your endless support that made me complete this journey with all smiles! I dedicate this thesis work to you.

Table of Contents

EXAMINING COMMITTEE MEMBERSHIP.....	ii
AUTHOR’S DECLARATION.....	iii
STATEMENT OF CONTRIBUTIONS.....	iv
ABSTRACT	vi
ACKNOWLEDGEMENTS.....	x
DEDICATION.....	xii
LIST OF FIGURES.....	xv
LIST OF TABLES.....	xvi
CHAPTER 1: BACKGROUND	1
STATEMENT OF RESEARCH PROBLEM.....	1
THESIS STRUCTURE	3
METHODOLOGICAL CONSIDERATIONS	5
SUMMARY OF CHAPTER 1.....	7
CHAPTER 2: UNDERSTANDING ACCESS TO AND UTILISATION OF SEXUAL HEALTH SERVICES BY SOUTH ASIAN IMMIGRANT MEN IN WESTERN COUNTRIES: A SCOPING REVIEW	9
INTRODUCTION.....	10
METHODS.....	13
SEARCH STRATEGY AND STUDY SELECTION	13
RESULTS	17
CULTURAL AND PSYCHOLOGICAL FACTORS AFFECTING SEXUAL HEALTH	18
<i>Cultural factors.....</i>	<i>18</i>
<i>Psychological factors.....</i>	<i>18</i>
SEXUAL HEALTH SERVICE ACCESSIBILITY.....	19
PERSONAL BELIEFS AND PATTERNS IN SERVICE USE	21
SOCIAL PERSPECTIVES AND CONFLICTING VALUES ON SEXUAL HEALTH	22
DISCUSSION.....	24
LIMITATIONS	26
CONCLUSION.....	27
REFERENCES	36
CHAPTER 3: HEALTHCARE ACCESS, QUALITY OF CARE AND EFFICIENCY AS HEALTHCARE PERFORMANCE MEASURES: A CANADIAN HEALTH SERVICE VIEW	41
INTRODUCTION.....	42
DISCUSSION.....	42
<i>Healthcare access.....</i>	<i>42</i>
<i>Quality of care.....</i>	<i>44</i>
<i>Healthcare service efficiency.....</i>	<i>45</i>
THE WAY FORWARD	47
CONCLUSION.....	48
REFERENCES	48
CHAPTER 4: EXPLORING THE FACTORS INFLUENCING ACCESS TO AND UTILIZATION OF SEXUAL HEALTH SERVICES BY SOUTH ASIAN MEN IN ONTARIO.....	52
INTRODUCTION.....	53

BACKGROUND.....	54
<i>Sexual health in Ontario and Canada</i>	54
<i>Sexual health service accessibility and barriers to use</i>	55
<i>South Asian gender roles and sexual health</i>	56
<i>Cultural and psychological influences on sexual health</i>	58
METHODS.....	59
<i>Study Context and Participant Selection</i>	59
<i>Data Collection and Analysis</i>	60
<i>Ethics</i>	62
RESULTS	62
1. PSYCHOLOGICAL FACTORS	64
1.1 <i>Perceived severity of sexual illness</i>	64
1.2 <i>The general attitude towards sexual health</i>	65
1.3 <i>Sexual health is perceived negatively</i>	66
2. SOCIAL FACTORS.....	68
2.1 <i>Sexual health as a taboo topic within the South Asian communities</i>	68
2.2 <i>Sex positivity and sex negativity exist in the social sphere</i>	69
2.3 <i>Sexual health discussion with trusted sources and following Western lifestyle approach</i>	70
3. CULTURAL FACTORS.....	73
3.1 <i>Culture shapes the overall perceptions about sexual health</i>	73
3.2 <i>Prescriptive gender stereotypes about sexual health</i>	74
DISCUSSION.....	76
LIMITATIONS.....	81
CONCLUSION.....	82
REFERENCES	82
CHAPTER 5: EXPLORING SOUTH ASIAN MEN’S PERSPECTIVE ON THE ROLE OF PROVIDER ATTITUDE IN EXPERIENCES OF SEXUAL HEALTHCARE SERVICES IN ONTARIO.	90
INTRODUCTION.....	91
METHODS.....	94
RESULTS	96
1. PATIENT EXPERIENCES WITH HEALTHCARE PROVIDERS	97
1.1 <i>Providers do not understand patient needs</i>	97
1.2 <i>Patients are concerned about being judged by the provider</i>	98
2. PATIENT RECOMMENDATIONS REGARDING CULTURAL AWARENESS FOR PROVIDERS	100
2.1 <i>Need to build a common ground of interest between patient and provider</i>	100
2.2 <i>Providers need to be respectful towards patient’s culture</i>	101
3. SOUTH ASIAN MEN’S VIEWS ABOUT CANADIAN HEALTH SYSTEMS	102
3.1 <i>Implications of negative service experiences</i>	102
3.2 <i>Need for non-judgmental separate service for men</i>	104
DISCUSSION.....	105
LIMITATIONS.....	109
CONCLUSION.....	109
REFERENCES	110
CHAPTER 6: CONCLUSION	116
REFERENCES.....	122
APPENDIX A – PARTICIPANT INFORMATION LETTER	125
APPENDIX B – RECRUITMENT POSTER.....	128
APPENDIX C – PARTICIPANT CONSENT FORM	129

List of Figures

	Page
<u>Chapter 2</u>	
Figure 1. PRISMA Flow Diagram	15
<u>Chapter 4</u>	
Figure 1. A proposed diagram representing the contextual factors influencing access to and utilization of healthcare services by South Asian men	49

List of Tables

	Page
<u>Chapter 2</u>	
Table 1. Search Key Words for Scoping Review	14
Table 2. Inclusion and Exclusion Criteria	16
Table 3. Search Strategy Database	27
Table 4. Selected demographic and design details of the included studies	29
<u>Chapter 4</u>	
Table 1. Sociodemographic characteristics of all respondents	50
<u>Chapter 5</u>	
Table 1. Sociodemographic characteristics of all respondents	73

Chapter 1: Background

Statement of Research Problem

As the South Asian immigrant population continues to grow in high-income countries (i.e. according to the World Bank, countries having a high-income economy and a gross national income per capita of more than \$12,000)[1], research focused on providing culturally appropriate healthcare services for migrant populations has become of central concern[2]. In recent years, there has been an increase in migration of South Asians in Canada with over 1.26 million people from South Asian countries specifically calling Canada their home, making up the largest culturally diverse population group[3]. Although much research has focused on immigrant health and wellbeing, among the range of healthcare services available to immigrants, sexual health remains neglected, though an important and critical domain[3][4]. Furthermore, in many healthcare settings in high-income countries, while pregnancy and sexual illnesses involve both men and women, the literature suggests that most sexual health programs mainly focus on women while overlooking the sexual healthcare needs of men[4][5]. In addition, studies have found that South Asian men's lack of perceived or actual accessibility to healthcare often leads to these men being treated later for health complications and particularly for sexual health illnesses[6]. Therefore, there need to be more considerations on preventative measures of sexual health services, all the while giving attention to understanding factors that can influence access to and utilization of sexual health services for South Asian men.

Literature suggests that sexual health services include education about sexual health, diagnosis and testing of sexually transmitted infections (STIs), treatment and follow-up services for STIs, and reproductive healthcare services[7]. However, studies suggest that cultural stigma, lack of information or misinformation about service availability, provider attitude, language barriers, time constraints, unavailability of viable transport options, and length of stay in a community – can influence the use of sexual health services for South Asian men[8][9]. For example, misinformation among men in Canada about sexual health testing remains, which may hinder access to sexual healthcare services [10]. Likewise, literature also found that without adequate knowledge, South Asian men are often not aware of the services available during sexual health

illness[8]. Additionally, although much progress has been made in recognizing the importance of culture and ethnicity in sexual behaviours in Canada, studies suggest the delivery of sexual health services and education in Canada require more consideration of how culture and ethnicity interact with sexuality and sexual health, particularly for culturally diverse population groups (i.e. including South Asians) as they comprise 19.1% of the Canadian population[11]. Furthermore, studies suggest issues related to stigma about sexual health of men or women along with patient confidentiality – all can be additional concerns influencing sexual health service access in Canada[12]. For example, many South Asian men often find it very difficult to communicate with healthcare professionals about their sexual health due to embarrassment and also for fear of breaches in confidentiality[13] Negative experiences in communication have also been documented as discouraging South Asian individuals from accessing follow-up services and affects the perceptions and health service use of the family or community[14]. Such as, in regards to healthcare disparities, previous research with South Asian populations has found that provider attitudes towards youth populations are among the most important factors in quality of care in sexual healthcare services, particularly due to discrimination in availing sexual health services from the provider[9]. Similarly, it has been noted that there is a deficit in culturally appropriate prevention and care strategies for male communities in many healthcare settings[15].

The cultural construction of norms and values (e.g. custom, traditions, and honour) is documented to be influential in shaping overall understanding of sexual health [13]. Culture can be defined as a “repertoire of socially transmitted and intergenerationally generated ideas about how to live and make judgements, both in general terms and in regards to specific domains of life”(p.208)[16]. For South Asian men, culture is an important factor shaping the way men perceive sexual health and how they discuss these topics within and between the South Asian communities[17]. For example, gender is viewed as the central organizer of sexual behaviour that crosscuts all other social and cultural factors. Sexual behaviour is often viewed in light of gendered sexual scripts that vary historically across cultures[18][19]. As such, gender often intersects with race, age and sexual orientation that may also influence how sexuality is expressed or experienced, thereby influencing overall accessibility and utilization of healthcare services[20][21]. Indeed, the cultural systems of gender are seen as a primary force in constructing different beliefs and practices among South Asian men and women thereby further

influencing access to and utilization of healthcare services[22]. While literature also reported experiences of care and culture is often overlooked through patient-provider interactions in many healthcare settings[23][24].

Beyond what is documented above, there is limited research that investigates the healthcare needs of immigrant populations, and particularly of South Asian men populations in Canada, with regards to their sexual healthcare, and consequently how to develop appropriate healthcare services for these populations. Hence, this thesis aims to establish a broader understanding regarding if and how South Asian men access and utilize sexual health services in a high-income economy country setting, particularly here in Canada. In doing so we identify the contextual factors that influence sexual health service uptake by South Asian men in Canada to create a more robust and improved sexual healthcare service for this population.

Thesis Structure

This thesis adopts a paper-based approach. It includes four manuscripts (Chapter 2 and Chapter 3 published in peer-reviewed journals) for which I am the first author. For all studies, I was responsible for study design conceptualization, data collection, analysis, and drafting, submitting, and revising manuscripts. My co-authors provided methodological guidance and feedback on the draft manuscripts. To meet the research aim, the first study (Study I) in Chapter 2 conducted was a scoping review designed to identify the knowledge gaps in access to and utilization of sexual health services in a high-income country setting. This scoping review is focused on the South Asian men in high-income Western countries and explores broadly the accessibility and utilization of sexual health services by this population group in a high-income country setting. As sexual health of immigrant men is understudied, this paper adds value in systematically documenting how accessibility and utilization of sexual health services vary in particular demographic contexts, the overall perception about service use, and factors influencing access to care by immigrant men from South Asia in high-income countries. Hence, this scoping review was important to identify the knowledge gaps and methodological tools needed to understand what contextual factors (e.g., cultural, physical, psychological, or social) play a role

in South Asian immigrant men's access (actual and/or perceived accessibility) to and utilization of sexual health services in Canada.

Study II was a conceptual paper (Chapter 3) designed to understand the concepts related to access to healthcare services, quality of care and efficiency in healthcare services in Canada. Through this conceptual paper, I documented critical concepts for investigating, understanding, and explaining patient experiences with the healthcare system in Canada; namely access to healthcare services, utilization of service, quality of care and healthcare service efficiency. This conceptual article on healthcare access, quality of care and healthcare efficiency helped to refine my understanding of the concepts and to clarify how these three intermediate variables may shape patient assessments in health system performance. This conceptual paper was critical in identifying the knowledge gaps within the Canadian health service system in access and utilization of healthcare services, quality of care and healthcare service efficiency. Finally, as concepts of access to healthcare, quality of care and healthcare efficiency remain quite ambiguous, in terms of operationalizing in qualitative research, this paper also adds value to the existing literature in terms of designing studies to investigate service access and utilization. These conceptual clarifications, for example, helped to inform recommendations that emerged in Chapter 5 paper 2.

Study III (two papers, Chapters 4 and 5) aimed to explore: 1. Contextual factors (e.g. cultural, physical, psychological, social) influencing accessibility (actual and/or perceived accessibility) and utilization of sexual health services by South Asian men in Ontario; 2. South Asian men's perspective on the role of provider attitude in experiences of sexual healthcare services in Ontario.

Besides, given the sensitive nature of this study, ethics approval was obtained from the Office of Research Ethics (ORE), University of Waterloo. To achieve this, all information that could identify participants from the data was deleted permanently. Each participant transcript was de-identified and pseudonyms were provided to ensure the anonymity of the data obtained. Participants were allowed to withdraw their consent to participate and have their data destroyed by contacting us within one week of data collection. In addition, we understand that some

participants may experience some discomfort answering questions on sexual health. Hence, we informed our participants, that during the interview if our participants experienced distress, we would pause the interview and they may choose to end participation at any time.

Although the included studies have been undertaken independently, they are related insofar as they provide empirical knowledge to the broader aim of the thesis study. Their sequential presentation herein also highlights my program of research for my doctoral training. There is a paucity of research regarding the South Asian male population's accessibility and utilization of sexual health services in Canada. Hence, following the development from the scoping review and conceptual article on healthcare access and utilization, this research study provided a more comprehensive understanding regarding factors influencing access to and utilization of sexual healthcare services in Ontario.

Methodological Considerations

For Chapter 2 Study I, I followed Arksey and O'Malley's established methodology [25] for mapping out and identifying the extent, range and nature of research activity, and identifying research gaps in the existing literature. The process involves five stages, namely: (1) identifying research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; (5) collating, summarizing, and reporting the data[25]. The reason for conducting a scoping, rather than a systematic review, was two-fold. One, systematic reviews focus on a well-defined question relating to the research design that can be identified in advance while scoping reviews tend to focus on broader topics where many different study designs might be applicable[25]. Second, systematic reviews aim to address questions from a narrow range of quality assessed papers, while the scoping reviews are less likely to address very specific research questions[25]. Hence, for this study, the scoping review process was most appropriate to address the overall broader research question and the aim of the study.

The analytic approach for Chapter 4 paper 1 was informed by interpretive description (ID)[26]. ID as a methodology "offers a viable alternative to what we sometimes observe as modifying conventional phenomenology, ethnography, or grounded theory"[27] (p.39). This methodology

originally provided a structure for qualitative studies of clinical phenomena of interest for health professions. ID was introduced as a noncategorical methodological approach to developing clinical understanding (e.g. sexual health illness experience)[28]. This methodology was created within health science and focuses on developing knowledge that will inform clinical practice. Hence, this methodology is in line with the aim of Chapter 4 Paper 1 [28]. ID is aligned with a constructivist and naturalistic orientation of inquiry and is inspired by systematic ideas adopting an inductive, constant-comparative approach to analyzing qualitative data, iteratively ‘interrogating’ individual themes for their internal consistencies and variations, and finding potential patterns in the data that might form relationships to be built into a coherent whole[27][28]. The philosophical framework of ID assumes that absolute, wholly objective knowledge is unattainable through empirical analysis[28]. Realities are local in nature, while they are socially and experientially based, and are contingent in form and content on the persons who hold them[26]. Therefore, in such an inquiry, a priori theoretical understandings alone cannot adequately account for the phenomenon under study[29]. Here the researcher’s foreknowledge of the phenomenon under study is considered to be a platform on which to design the project and helps to establish its anticipated boundaries (e.g. the experientially derived foreknowledge of the phenomenon) [26].

Since ID is relatively a new methodology in qualitative research [25], researchers using ID have a limited number of resources to turn to for further guidance regarding this methodology [25][27]. Therefore, to enact an ID that is applicable in the practical science of the discipline, my method further required intellectual processes that extend well beyond collecting and reporting data. Therefore, Chapter 4 paper 1 also made use of the Braun and Clarke (2006)[30] guidelines for thematic analysis. Such guidelines were important during the various iterations of coding, reviewing and recoding, as thematic summary creates a rich nuanced report that has strong inductive qualitative reasoning[30]. The analysis required a representation in a form that explicitly acknowledges the analytic processes and in constructing and interpreting an account of what the themes within the data signify[31]. Therefore, for my research the guidelines of Braun and Clarke’s (2006)[30] thematic summary fit in best with the ID methodology for data collection and analysis strategies, namely: to generate more credible and meaningful knowledge and to provide necessary conceptual linkages of the findings in this study [29].

In the final chapter of my thesis, Chapter 5 Paper 2, I explored South Asian men's perspectives on the role of provider attitude in their experiences of sexual healthcare services in Ontario. This paper is connected to Chapters 2 and 3 in learning further about the need for patient-centred outcome measures in service and clinical quality. My study explored the role of provider attitude in patient-provider interactions, and the paper provides strong evidence that may inform tailored interventions that may improve the future quality of care for South Asian populations. For this paper too, thematic analysis was conducted following Braun and Clarke[30]. The process involved marking, numbering, coding transcripts after each interview, and then organizing the data into conceptually relevant categories for the exploration of patterns and themes using NVivo 12 Pro[30][32][33]. Though coding was conducted in recognition of the existing literature and research aims, as little is known about the highly sensitive research topic, I along with my co-authors approached the data inductively with no prior theory or framework[31][32]. We did not focus on the prevalence of a theme, but rather on the meaningful information that related to the overall research question. Furthermore, all the references of individual articles are provided at the end of this thesis in the reference section.

Summary of Chapter 1

In conclusion, this chapter provided a rationale for the broader objective of my thesis. I discussed the relevance of exploring contextual factors influencing access to and utilization of sexual health services by South Asian men in Ontario. In addition, I provided a literature overview identifying the knowledge gaps known so far that this thesis addresses, while providing an outline of the research objectives that each chapter achieves. Lastly, this chapter only highlights methodological considerations relevant to the studies that were beyond the space allocated in an article written for peer-reviewed publication. Therefore, by conducting a scoping literature review, providing conceptual clarifications on healthcare access, quality of care and service efficiency, exploring the contextual factors influencing access to and utilization of sexual healthcare services, and by further highlighting the importance of provider attitude in overall sexual healthcare service experience – I, along with my co-authors of these studies, have identified and addressed the knowledge gaps regarding South Asian men's access and utilization

of sexual healthcare services in Ontario. The last chapter of this will pull together the results of Studies I to III and provide data-driven recommendations necessary to initiate a more robust sexual health service platform that caters to not only South Asian men populations, but health services for the populations who identify themselves as men in Canada.

Chapter 2: Understanding access to and utilisation of sexual health services by South Asian immigrant men in Western countries: A scoping review

Yamin Tauseef Jahangir¹, Samantha B. Meyer¹

¹ *School of Public Health and Health Systems, University of Waterloo, Ontario, N2L 3G1, Canada*

[This manuscript is a true approved pre-print version of the original published article. The final publication can be found at: link.springer.com]

Citation: Jahangir, YT, Meyer, SB. Understanding Access to and Utilisation of Sexual Health Services by South Asian Immigrant Men in Western Countries: A Scoping Review. *J Immigrant Minority Health*. 2020;22:621–633.

Published: 19 February 2020

Issue Date: June 2020

DOI: <https://doi.org/10.1007/s10903-020-00981-z>

Abstract

Background: South Asian communities comprise one of the fastest growing populations in Western countries. However, the sexual health of immigrant men in particular remains vastly understudied and little is known about how and if men access these services. **Methods:** Four multi-disciplinary electronic databases were searched to between 1998-2018. The search yielded 586 articles; 407 duplicate articles were removed, and 376 did not meet the inclusion criteria.

Results: A total of 10 articles were included in this review. Herein we report the factors shaping sexual health service access and use, namely: (1) cultural and psychological factors; (2) sexual health service accessibility; (3) experiences of prior sexual health service utilization; (4) social perspectives and conflicting values on sexual health.

Conclusions: We identify the gaps in research needed for policymakers, formal healthcare providers, and South Asian community stakeholders to develop effective and inclusive sexual health programs for South Asian men in Western countries.

Keywords: South Asian men, sexual health services, access and utilization, western countries

Introduction

South Asia is one of the major regions from which people have migrated to higher-income countries, either temporarily for education or employment, or to live permanently [1]. A 'South Asian' is defined as an individual who self-identifies as having ancestry that originates in South Asia, including an individual reporting his/her origin as Bangladeshi, Bengali, East Indian, Goan, Gujrati, Kashmiri, Pakistani, Punjabi, Nepali, Sinhalese, Sri Lankan, Tamil, or South Asian [2]. On a global scale, the migrant population was estimated to be approximately 244 million in 2015, a figure that has significantly increased in the past decade [3]. Immigration patterns in developed countries have changed considerably in the past few decades, with a greater proportion of migrants being from Asia, and particularly, South Asia. For example, patterns of immigration in Canada have changed from the 1970s, where migrants were primarily from Europe (70% or more), with Asian migrants making up only 10%; however, as of 2013 European migrants only accounted for 17% while Asian population growth increased to 52% [4]. According to the 2006 Canadian Census, over 1.26 million people from South Asian countries specifically called Canada home, making up the largest visible minority group [2]. It is projected that by 2031, 55% of Canada's foreign-born population will report origins in South Asia [5]. Similar patterns have emerged in the United States, where 3.4 million South Asian Americans are now residing in the United States, mainly from countries like India, Pakistan, Bangladesh, and Sri Lanka [6,7]. Similar trends are present in Australia. In 2011, 8% of the total Australian population was Asian-born, and 27% of this 8% were born in South Asia [8]. As for the entire European Union (EU), approximately 53.8 million migrants were estimated to live in the EU, amounting to >10% of its population [9]. As for Britain, they have the highest influx of South Asian origins constituting to 4% of the population of the UK [10].

As the immigrant population continues to grow in developed countries, the health of the immigrants will be reflective on the overall health status of host countries. As a consequence, considerable research has been conducted on how to improve health services for this population group; most notable is the prevention of non-communicable and infectious diseases. However, research to date identifies that current service provision for this population group is more generally affected by issues of cultural ignorance and communication. Physicians have been

reported as to not listening, not providing adequate information, and demonstrating a lack of concern or lack of respect for the patient [11]. This led to the failure of developing culturally appropriate prevention and care strategies for the South Asian communities [12]. Previous studies found that patients' cultural beliefs and traditions often create misunderstandings between healthcare providers and migrant patients, which adversely affect the quality and efficacy of health service [13].

Central to this paper is the dearth of information regarding South Asians use of sexual health services. Sexually transmitted infections (STIs) can have a negative impact on individual's physical and emotional health [14,15], and there remains an increased risk of developing secondary health conditions, that can be more severe if proper diagnostic care is not available in terms of efficacy and quality [16]. This is evident in the UK where research identified that prevention and service provision - being based on Western models of sexuality, identity, and biomedicine - are inappropriate and ineffective for South Asian communities, whose lives are shaped by entirely different social and cultural norms [16]. However, sexual health remains a neglected domain in current literature on migrant health [17]. Literature suggests that in many developed countries, there is a paucity of work that investigates the needs of immigrant populations with regards to sexual health, and consequently how to develop effective services for these populations [18]. In particular, very few studies examine the nature of the sexual health needs of South Asians or whether these needs are effectively met [18].

Traditionally, women have been the target of sexual and reproductive health services because it is important for them to have access to such care, in order to have safe pregnancies and healthy children [19]. However, although pregnancy and sexually transmitted diseases involve both men and women, most reproductive health programs only target women and ignore the reproductive health needs of men [20]. In recent years, there has been a steady rise in cases of gonorrhoea, chlamydia, and syphilis [20,21], while little to no data is available to justify the overall STI infection rates among the South Asian community men. Further, it has been reported that migrant populations from South Asian regions possess lower knowledge regarding sexual health than other migrant populations and have lower sexual healthcare utilization rates [17]. South Asian male communities have many taboos around the discussion of "shameful" matters such as

sexual behaviour [16]. Studies have found that men's lack of access to healthcare often leads to men being treated later for sexual health illnesses [22]. Taking Canada as an example, men between the age of 15 to 24 years, experience the greatest proportion of STI infections [22,23]. Studies have also found that men may delay in seeking services because they are not planning to be sexually active, while thinking it is unmanly to seek help unless they have a problem, such as STI cases [24]. Consequently, this may further cause underutilization of sexual health services in Western countries like Canada, US, the UK and in Australia [25]. Thus, linguistic matters, cultural issues, and taboos or stigma construct the overall healthcare utilization by South Asian communities [12]. An understanding of how to create culturally relevant and appropriate services, and how to improve service use, is therefore crucial for the sexual health of South Asian men in developed countries.

In a broader construct of understanding how South Asians use sexual health services, it is important to know what exactly sexual health means. Several organizations advocated a more implicit definition of sexual health in terms of: (1) being knowledgeable about reproductive health, (2) being able to make informed choices about parenthood and sexuality, and (3) being comfortable with one's own sexuality. However, the concept of sexual health also varies for certain individuals in terms of uniqueness of sexual experiences, needs and identities [25,26]. Despite the recognition of culture of such immigrants' definition and understanding of sexual health, and their consequential sexual health needs, inadequate attention has been given to the uptake of health services (including sexual health) [27]. Barriers related to stigma, distrust of health system, poor communication, family obligations, economic stability, geographical distribution of service - all require a greater level of inquiry before we can begin to improve services for South Asian men [27].

The aim of the present review is to identify the contextual factors (e.g. cultural, physical, psychological, social) that influence access to and utilisation of sexual health services by the South Asian immigrant men. The two related objectives are: 1. To systematically document existing evidence that may be used to improve service accessibility and utilization for South Asian male immigrants; 2. To identify research agendas required to develop effective and inclusive sexual health programs for South Asian men in Western countries. The ultimate goal is

to assist policymakers, healthcare providers, and stakeholders in South Asian men's health to begin to address the rise in sexually transmitted diseases, and reproductive health issues in this population.

Methods

We followed Arksey and O'Malley's established methodology for mapping out and identifying the extent, range and nature of research activity, and identify research gaps in the existing literature [28]. According to the authors, the process involves a five-stage approach in conducting scoping reviews: (1) identifying a search topic; (2) identifying relevant studies; (3) selecting relevant studies; (4) charting the data collected; and (5) summarizing and reporting the results of data collection (with an optional sixth stage on providing opportunities for consultation on the data) [28]. Scoping reviews differ from full systematic reviews in that they do not evaluate the quality of the included studies and only involve "analytical reinterpretation" of the included studies [29]. While a systematic review follows a structured and a pre-defined study design process, a scoping study focuses on broader topics where many different study designs might be applicable [28]. Hence, for the purpose of this study, the scoping review process was most befitting, to address the overall broader research question and the aim of the study.

Search Strategy and Study Selection

Since a part of our aim of the scoping review was to identify the access to and utilization of sexual health related services by South Asian immigrant men, search terms were identified that would make articles relevant to our aim and meet the inclusion criteria. 'Access' is a multidimensional process that involves factors related to geography, finances and appropriateness, and quality of care [30,31]. It is currently debated whether the notions of acceptability and availability are actually part of the definition of accessibility, or whether they are independent constructs [32]. Within the present study, we identify with the former and have included acceptability and availability as constructs that fall within the umbrella of access. Issues of geographic location (e.g. travel impedance to the nearest primary health service provider), acceptability of relevant services, and availability of a professional health service provider, have been used to understand the physical access to sexual health services. It is important to note that

the characteristics of individuals and place also influence the utilization of care and health outcomes [16].

The scoping review focused entirely on the areas of the contextual factors influencing access to and utilisation of sexual health services by South Asian immigrant men. In addition to access we broadened our research question to identify factors related to health service utilization. See Table 1 for a list of search terms. Our inclusion criteria included peer-reviewed academic journal articles which were only available in English Language. All articles focused on primary research data and studies of South Asian male migrants exploring sexual health and health service settings. Further, as discussed earlier, the study articles were only chosen from the developed countries such as the UK, United States, Canada, New Zealand and Australia – having similar migration patterns of South Asian populations (see Table 2). The primary author searched four multidisciplinary databases for empirical research following the guidance of a reference librarian, who is specialized in health research. Published research studies conducted within the past 20 years were searched using the research databases PubMed, Scopus, PsycINFO and Sociological Abstracts. Detailed search strategy with all databases is provided in Table 3. Search terms were chosen to explore the diversity of what encompasses sexual health for South Asian male populations in terms of access to and utilization of services. For this study, contextual factors are defined as the environment in which patients receive healthcare [32]. Specifically, the contextual factors are mainly based on the site of usual source of care and on the characteristic of the community, as the community healthcare resources and population characteristics are significantly associated with healthcare access and utilization [33,34].

Table 1. Search Key Words for Scoping Review

Concepts	Concept 1	Concept 2	Concept 3	Concept 4
Author Keywords	Sexual Health Sexually transmitted infections HIV/AIDS Sexual behaviour STDs Venereal Diseases	Immigrants Refugee Migrant	Men Male Boys	South Asian Asian Indian Bengali Kashmiri Gujarati Tamil Bangladeshi Pakistani Sri Lankan
MeSH	Chlamydia Gonorrhoea Syphilis Sexually transmitted disease Sexual Practices Sexual behaviour Reproductive health Reproductive health services Sexuality HIV infections Reproductive medicine Genital Diseases, Male Sexual Dysfunction	Immigrants Emigrants Emigrants and Immigrants Emigration and Immigration		

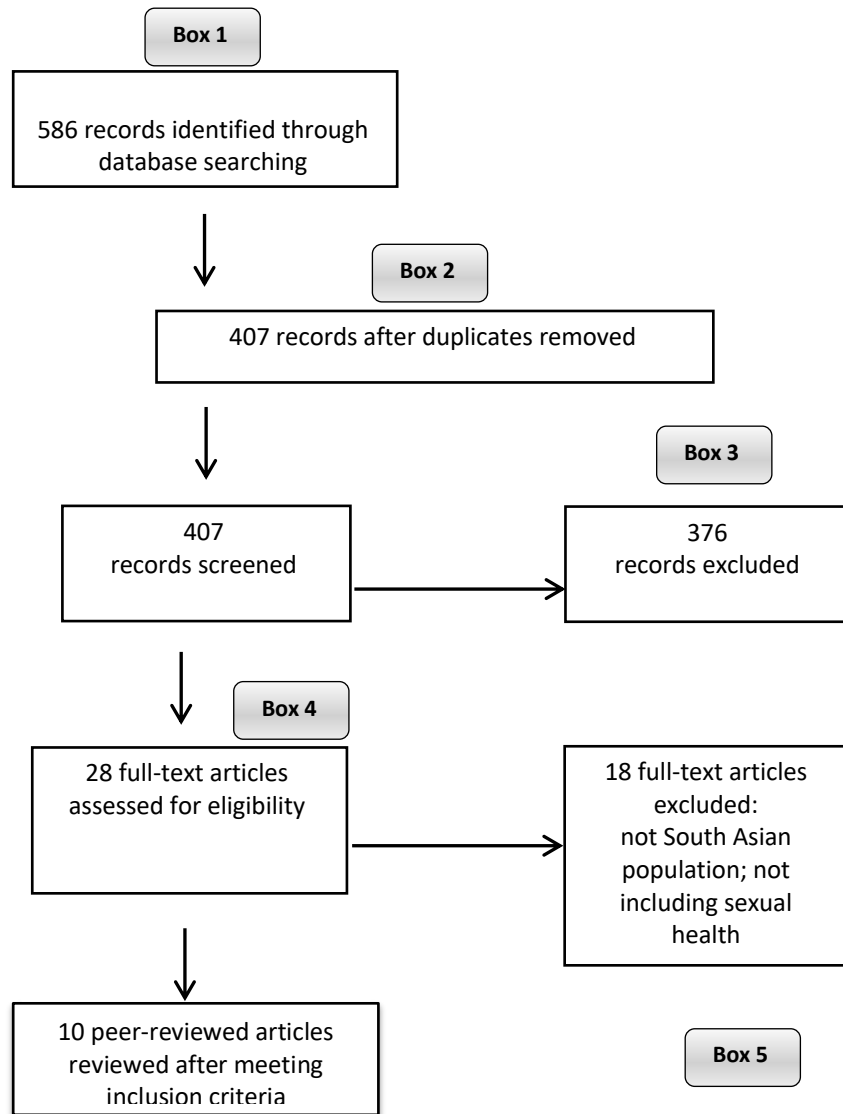


Figure 1. PRISMA Flow Diagram

Figure 1 provides an overview of the extraction process to identify the final set of articles for review. Based on our inclusion and exclusion criteria, after excluding the duplicates, 407 articles remained from which 376 records were further excluded which did not match our study objectives. Further, 18 articles were removed for not having South Asian participants and sexual health in the study. The remaining 10 articles were then reviewed. Article titles and abstracts

were reviewed to determine if they met the inclusion criteria; when insufficient information was available, the entire article was reviewed to determine its inclusion or exclusion criteria. A standard table 4 was in line with Arksey and O'Malley scoping review process [28], to identify the study information on (i) study authors; (ii) year of publication; (iii) study purpose; (iv) study approach; (v) study population and (vi) study country. Each included article was reviewed in its entirety and relevant data was extracted to form the basis for thematic analysis specific to our research aim.

Results

A total of 10 articles met the inclusion criteria. Among these 3 studies were from Canada, 2 from the United States, 3 from Australia, 1 from Eastern Europe and 1 from New Zealand (Table 4). Analysis of the 10 articles generated four themes: (1) cultural and psychological factors affecting sexual health service; (2) sexual health service accessibility; (3) personal beliefs and patterns in service use; (4) social perspectives and conflicting values on sexual health.

Inclusion	Exclusion
Published in English	Published in Language other than English
Peer-reviewed	Non-peer reviewed
Academic journal article	Book, dissertation, conference abstract, etc
Primary study	Not a primary study
Study conducted in developed countries such as US, Canada, UK, New Zealand, Australia	Study conducted in other countries except US, Canada, UK, New Zealand, Australia
Study includes South Asian participants	Studies that do not include South Asian population
Studies that involve sexual health cases	Studies that do not include sexual health

Table 2. Inclusion and Exclusion Criteria

Cultural and Psychological Factors Affecting Sexual Health

Cultural factors

The cultural construction of honour and shame can be seen as an influential factor in shaping many of the issues related to sexual health amongst South Asian men. Taboos such as discussion of sexual matters and the implications of shame were significant in sexual health choices. From the literature reviewed, culture emerged as an important factor shaping the way that South Asian men perceive the issue of sexual health. Study participants pointed out, that cultural stigma surrounding the discussion about sexual health matters was a major constraint in discussing sexual health issues, for example, HIV among South Asian men [35]. Participants also indicated difficulty talking about sexual health at home and indicated that television information or programs are often ignored by switching channels [35]. Some participants mentioned the challenge of misperceptions regarding sexual health, such as thinking that condoms are solely for birth control and not for disease prevention [36]. The articles suggest that the conflicts between the cultural and traditional values regarding sexual health in the South Asian communities remain. Further, those who break the silence and discuss HIV or STI are often found to be socially excluded or have problems in maintaining societal relationships [36]. This reluctance to discuss sexual health matters was identified as problematic in terms of accessing healthcare services. The construct of shame also plays an important part if an individual access prevention services, which may act as a public disclosure that they engage in some kind of stigmatised behaviour [36].

Psychological factors

The literature mentioned that despite the desire to integrate, living in ethnic enclaves generated feelings of isolation and frustration among the South Asian male population. For example, the data highlighted that South Asian men were either unsure about the sexual health services or felt not to be integrated in the health system completely. Despite their desire for integration, vulnerability amongst South Asian men was further complicated by their settlement experiences, social isolation, employment difficulties – thereby affecting them psychologically in choosing preventive care services by the sexual health clinics. One study explained that South Asian

participants viewed STIs and other sexual diseases as risky, but falsely believed that it is curable [37]. Much of the decision (for e.g. choice of treatment, deciding for any follow-up visits, and deciding upon which location for service to be chosen) was driven by how they had been treated in sexual health services in the past. Those who had negative histories were less willing to openly disclose their sexual status [38]. Likewise, some participants mentioned that tension and fear of being ostracized affected participants to avoid social interactions [39]. Consequently, such experiences influence help seeking from both health providers and friends and family, especially in the cases of HIV and STI. Moreover, South Asian male participants also mentioned that they faced additional burden of their residency status, which psychologically added more stress to them, especially when they shared information with the healthcare provider. The term ‘immigrant’ or ‘immigration’ was used against the participant seeking care, and sometimes the service was perceived to be discriminative [37]. Interestingly, one of the study participants mentioned that they were willing to overcome the discomfort of sexual health issues and would opt to share and talk to their children about HIV and STI, which was a positive sign in the research, as noted by the authors [37]. Decisions regarding overcoming the discomfort primarily stemmed due to psychological burden that these participants were said to have endured in accessing sexual health services, which they said they would like to address properly to their children, in order to overcome any sexual health service dilemma. In summary, data from these studies suggest South Asian male participants indicated that culture, ethnicity, and socioeconomic status affected them psychologically and emotionally and acted as a major barrier towards accessing health services and resources [38]. Furthermore, South Asian sentiments often caused less sexual health service utilization, as most participants believed there were health inequalities which made them critically reflect on their experiences with such services.

Sexual Health Service Accessibility

From the literature reviewed, the rate of accessing sexual health services had certain variabilities. South Asian men in two studies especially mentioned about variability in STI and HIV testing as some participants were testing regularly while others were not testing at all [40,41]. The participants said that they are less likely to have STI and HIV check-up than men of other ethnicities or backgrounds. For example, few participants said it was not necessary for them to have HIV/STI testing because of their sexual practices. Further, participants felt hospital walk-in

clinics seemed to be the least appealing places for accessing sexual health services, as they would have to provide a lot of personal information, especially if they have certain issues with their immigration status [39]. As for one study it was mentioned that South Asian men with longer length of stay in a particular community would opt for testing and screening of STI than the men who spent less time in a community [40], as it is related to the process of being acculturated with the host country. Likewise, it is also not uncommon for certain South Asian men to delay in accessing sexual healthcare due to the demands of daily living which affects timely care. Participants from this study by Kang et al. (2003) [38] mentioned that many of them received inadequate care from the private physicians mainly in terms of STI and HIV symptoms. They were treated for common cold or doing X-ray rather than performing any other diagnosis such as HIV-antibody testing or other STI screening.

From the literature reviewed, the factors underpinning the access of sexual health services also related to stigma, lack of information about service availability, language barriers, time constraints, unavailability of viable transport options, and with length of stay in a community [36,37,40,42]. Participants mentioned that stigma was not an isolated phenomenon but was central to the constitution of the social order, that often framed their overall accessibility to care. Without adequate knowledge or sharing of appropriate information, South Asian men were not able to assess the risk to realise the need for accessing sexual health services. In one study, social ties also influenced health accessibility for a person with limited social network and information sharing, and with sexual health complications it often created barriers towards accessing health services [42]. This in turn was also aggravated due to lack of affordable healthcare options stemming from their immigration status. Hence, participants described healthcare as a “privilege” and preventive care as “selfish” option, as they would have to sacrifice family member obligations towards healthcare over their own individual needs [42]. Among these male participants, some mentioned that despite being aware of their health needs, it was very common for them and their families to not seek care “until you are dying pretty much” (p.149) [42]. Moreover, language barriers tend to be most problematic as it prevented people from attending services or lead to misunderstandings or mistakes in the delivery of services [42]. Thus negative experiences in communication discouraged South Asian individuals from accessing services again, and often this feeling would pass onto others in the family or in the community. Likewise,

location of services, or difficulty in navigating through the community to avail sexual health service was also another reason for not accessing sexual health services on time. Participants mentioned about services which were embedded in the community that will make a better choice in accessing preventive care, since they felt limited acculturation with community may have affected in knowing places and in seeking care [43]. Hence, instead of formal healthcare services, the most common place to access healthcare information and advice was the Internet, (e.g. WebMD, Mayo Clinic), friends and family. Therefore, from the literature reviewed it was evident that South Asian male participants required further information about treatment options and also in navigating the sexual health service system, for effective treatment, diagnosis, and getting appropriate sexual health information. The participants said they also required a more inclusive community settlement package (e.g. orientation with community facilities, health education, etc.), and integrated health services within the close proximity of communities that would encourage South Asian men to access service delivery centres more often.

Personal Beliefs and Patterns in Service Use

From the literature it was interesting to note that personal beliefs attached to sexual diseases were a major concern in utilizing health services by the South Asian men [38,39,44]. Participants were concerned of information sharing or disclosure that would affect their service utilization. For South Asian male communities, a strong emphasis on public honour is what shapes their overall belief on sexual health which acts as the core framework for social control. Such control acts as the inability to openly discuss about sexual health matters, and often made it difficult for South Asian men to assess the accuracy of information. Participants also believed that as long as stigmatised behaviours (e.g. sexual practices outside marriage, sexual practices with another man, having sex without using condoms etc.) are not discussed and are concealed from the society, they can remain protected and differentiated against other mainstream society [44]. Participants mentioned such behaviours often create a barrier towards seeking proper information about sexual health which hinder overall service utilization. This was reflective on service utilization from one of the studies, where participants did not understand the relationship between HIV infection and AIDS disease, as well as the implications of STI [37]. From two studies, participants mentioned there was certain reluctance in knowledge sharing by some healthcare providers and for the male participants it was difficult to understand why these

providers behaved in a negative manner, especially when patients revealed their STI and HIV health status [38,40]. In terms of service utilization, participants expressed that their “need-to-know” nature was more related to learning things only when it was necessary, which often made them miss out a great deal on important information in a healthcare centre [38]. Participants also delayed utilizing screening and other medical services because of their non-English proficiency, immigration status, and some were reluctant to seek treatment if they did not meet the required criteria for health services. For example, if they would have to pay out-of-pocket for a service [39]. Further, lack of comfort talking to a doctor and a perception that sexual health problems are not of a medical nature, were also a few reasons for not utilizing proper medical check-up services by the South Asian men [42]. However, in another study, some South Asian participants mentioned that medical doctors were the most preferred source of information and help for sexual health, while the ethnicity and gender of the medical doctors was not important for majority of these male participants [42]. Amongst these male population who preferred to seek medical help from a general practitioner, a large portion preferred to seek it from their regular general practitioner [42]. Moreover, it was interesting to find that data from Sawleshwarkar et al. (2013) [41] study suggest that there is a need for public health and medical services, to consider the cultural diversities in the South Asian male population, and to design respective sexual health information accordingly. Therefore, our findings suggest that health service usage would require healthcare provider cultural competence in serving the South Asian male patients, creating opportunities for accurate health information for STI and HIV patients, and in increasing sexual health screening uptake for the community men. It is interesting to note that lower utilization due to laborious paperwork in claiming immigration status also made South Asian men ignore the health system completely.

Social Perspectives and Conflicting Values on Sexual Health

The social perspectives on sexual health varied which gave an overall understanding on how sexual health was viewed within the South Asian communities. Participants from three studies mentioned, that discrimination or the enacted stigma of STI and HIV was persistent among community men and women in general, while intergenerational communication about sexual health especially HIV was highly discouraged [36,38,44]. Participants further mentioned that stigma or the fear of stigma and its relationship with health services and resource often played an

important underlying factor in influencing and realizing one's sense of self [38]. This process of social stigma was also aggravated by the location where the participants lived, conflicting values between family of the male populations, and regarding sexual health, and where to seek care from. Such as, sexual practice behaviour, values on consenting to screening for STI, and social identities of male participants influenced perceptions on sexuality and sexual health and in diagnosis or treatment. Such values often seemed to evoke a sense of threat along with the stigma, especially when South Asian men sought STI or HIV screening services, as the community believed the participants would eventually spread the infection within their communities [38]. Consequently, some participants tried to overcome the barriers of stigma by not using condoms as they believed and trusted more on their own body, that there would not be any contact of STI. They often exercised a sense of masculinity, believing that their body would be able to fight that kind of infection. This perception added to their own understanding and values of sexual health, driven from a societal viewpoint that, sexual matters should therefore be discussed with partners rather than with a medical health service provider [40,42]. Similar findings were also mentioned in the study by Ramanathan (2015) [44] and here place of residence, participant social networks, their memberships in various socio-cultural groups, relational behaviours, and factors like gender, race, and religion have influenced how South Asian men would acculturate in their host country. Consequently, it influenced their health and wellbeing and their overall access to and use of healthcare. The pattern of exposure to Western culture and differences in the values and opinions on sexuality and on sexual health was thought to impact the origins of culture for some South Asian men [44]. Such changes affected the participants and they often felt discriminated against being Asian, or South Asian and that their illness stigma was often driven by the responses from the broader society, family, peers, strangers and even health professionals [39]. Hence, it was evident in the literature that societal norms and conflicted beliefs negatively impacted South Asian male community in seeking the right kind of sexual healthcare needed. It was also evident that such conflicting values not only hindered access and utilization, but significantly shaped the overall perceptions of the South Asian communities, and how the South Asian men were less attentive towards seeking sexual health services.

Discussion

There is a paucity of research on South Asian male population in accessing to and utilization of sexual health services in the Western countries. Our research aim was to understand the contextual factors (e.g. cultural, physical, psychological, social) that influence this access and utilization of sexual health services. It was also to identify research agendas required to develop effective and inclusive sexual health programs for such community men. Considering the literature, we reviewed how accessibility, social perspectives on sexual health, conflicting beliefs on sexuality and health seeking behaviour, and lower utilization rates of sexual health services are related to the decision making of South Asian men. The literature suggests several known predisposing factors acting as barriers to care, with little guidance in navigating even a structured healthcare system, such as, lack of professional consensus regarding standards of care. Result findings also suggest that as men do receive the healthcare, quite often the services of STI care remain to be fragmented. Several aspects of this scoping review thus warrant further interventions in health systems service delivery setting, to improve the overall quality of care experience by the South Asian male populations.

Considering the barriers to access to care, previous studies have mentioned that men identified numerous attitudinal and institutional barriers for healthcare access, such as denial, fear of stigma, lack of culturally competent provider, lack of resources, lack of transportation, not knowing where to obtain treatment or prevention services, and lack of knowledge about the availability of reproductive health services for men [45,46,47]. The similarities lie with our findings in this review, where South Asian men described their barriers to accessing health services which were mostly related to provider behaviour, lack of understanding about sexual health matters, not knowing the availability of sexual health services, and in finding difficulties navigating the healthcare systems for availing a service. Therefore, locating sexual health resources with multipurpose service setting may provide a better means of utilization for such community men. Consequently, studies mentioned that community service centre might prove unpopular if clients encounter the risk of meeting with peers from the same community [18]. Hence, it is recommended for having drop-in spaces for sexual health information sharing, which can be done in a more informal and non-judgemental environment, while maintaining proper confidentiality of the male clients. Such as, in recent times, the field of “cultural competence” in

healthcare has come to government interest for the Western society, to address the factors that may contribute to racial/ethnic disparities in healthcare. Cultural competence in healthcare describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs [48,49]. Hence more work can be done to include cultural competence into health service delivery policy as an important goal, funding regular staff training programs, offering patient navigators, expanding its relationships with community groups, and creating an environment that celebrates diversity (e.g. language capacity, how to address sexual orientation, etc.) [50,51].

It was also interesting to find that although service providers have training to neutralise vulnerable situations in sexual health complication for treating patients, patients tend to rely on their social context and personal experiences for clues about how to behave, and how to respond towards the service. This is reflective from studies where men often feel the pressure to avoid emotional expression, hide their weaknesses and vulnerability, and try to solve problems without requesting help from others [52]. This not only represent a socially constructed masculine practice, but also provides a way for men to deny and avoid their own fears about STIs and other sexual health complications [53]. The literature had similarity where the male participants often would not choose contraception methods and would believe more on their physical capacity and masculinity to overcome any sexual health problems.

From the literature reviewed, the South Asian male participants were more willing to seek health information from family, friends, and from other sources rather than seeking sexual health information from the formal healthcare provider. These findings do have certain similarities where feelings of inferiority or discomfort in a healthcare setting may be shaped by perceptions of unequal power dynamics between patients and health providers [54]. Moreover, public health experts also mentioned that sexual health service utilization should be more focused on the needs of male patients, and also to inform their friends, families, and communities of the importance of male reproductive health services [19]. But recent study in the United States showed that for sexually active men between the age of 15 and 19 years, 71 percent received a physical exam in the past year in the country, while only 36 percent discussed reproductive healthcare during the visit [54]. Therefore, the lack of sexual health service utilization is more coupled with

disengagement between male population discussing their sexual health problems and strong compliance from the health service provider (e.g. health providers not being culturally oriented to attend to patients). This phenomenon has been explained by Wright & Morgan, (1990) [55] as, “it is the physician who is in the position in labelling the patient as a ‘problem’” (p.957). While according to Donnelly et al., (2016) [36] it remains difficult to understand why certain healthcare providers would have negative attitude or behaviour towards patients who reveal their sexual identities, especially for HIV cases. However, studies also suggest that certain healthcare providers may not have had the opportunity to care for patients with STI or HIV cases throughout their careers, which may have caused an increased stigma in them, resulting in changes in their attitude towards their patients [56]. Therefore, it is highly essential to create a male-friendly environment and recruit providers and staff who would respect men with or without STI or HIV, regardless of age.

From the existing literature it can be concluded that, there is an increasing demand for a more patient-compliant health service setting for South Asian male communities, as many do not opt for availing formal sexual health services for screening and testing. Even from developed country perspectives, there remains a sense of vulnerability, lack of confidence in service provider, fear of disclosing health information, lack of awareness on the preventive measures and social norms, and traditional misconceptions on sexual health issues. Therefore, research should extend further on exploring the cultural competence and social implications between patient-provider interactions and how these patients can “step-up” to the access and utilization of sexual healthcare. Furthermore, sexual health education and promotion for South Asian men is a crucial process and would require appropriate locations for clinic or service promotion. These places could be in schools, malls, emergency rooms, parks, gas stations, convenient stores, community centres, movie theatres, religious centres, other clinics and even in gym. Research should also address the current conceptions of illness stigma in order to develop interventions and policies that will address this formidable barrier to sexual care.

Limitations

In conducting this scoping review, the study authors had to broaden the search question and expand the inclusion criteria to find ten studies that were relevant to the broad topic of South

Asian men access to and utilization of sexual health services. Although the concept of access and utilization was sought as a data collection point, and not being included as keywords in the search topic, the wide variation in research topics, methods, and quality, may make it difficult to combine the data of these studies to perform any meta-analysis [57]. Furthermore, this review may not have identified the grey literature despite attempts to be as comprehensive as possible. Our overall search strategy may have been biased towards health and sciences and searching other bibliographical databases (e.g. Google Scholar or Web of Science) may have yielded more published articles. We adopted Arksey and O'Malley's definition for scoping reviews at the outset of the study and found that their simple definition was generally useful in guiding study selection. However, we encountered some challenges during study selection, with studies that also reported processes or definitions more typically associated with narrative or systematic reviews. For this scoping review, the pair of reviewers used their judgment to determine whether each article as a whole sufficiently met our study definition of a scoping review. Thus, the characterization and interpretation of the included studies may also be subject to reviewer bias.

Conclusion

This literature review identified possible gaps in access and utilization of sexual health services mainly in poor patient-provider interactions, strong cultural and social factors on patient care seeking behaviour, poor compliance in service delivery by formal healthcare providers, and psychological influences acting negatively in overall patient decision making. This scoping review further explained the urgent need of comprehensive research programs that engage South Asian male community to explore the conceptualization and understanding of sexual health, and also to gain more comprehensive learning about sexual healthcare services, to increase screening uptakes. By recognizing the complex interactions between social, structural, and individual-level determinants of health, health service setting can focus more on strengthening health communication and health promotion opportunities. Furthermore, healthcare providers should consider more on the individual and societal views, on sexual values and sexual practices, and to gain cultural competency that would promote sexual health services in communities.

Table 3. Search Strategy Database

Search Database	Search Strategy	Search Findings
PubMed	(Sexual health OR sexually transmitted infections OR HIV OR AIDS OR sexual behaviour OR STDs OR venereal diseases OR Chlamydia OR Gonorrhoea OR Syphilis OR Sexually transmitted disease OR sexual practices OR sexual behavior OR reproductive health OR reproductive health services OR sexuality OR HIV infections OR reproductive medicine OR genital disease, male OR sexual dysfunction) AND (immigrants OR refugee OR migrants OR emigrants OR immigration OR emigration) AND (Men OR Males OR boys OR fathers) AND (South Asian OR Asian OR indian OR Bangladesh OR Pakistan)	226 Articles
Scopus	("Sexual health" OR "sexually transmitted infection*" OR HIV OR AIDS OR "sexual behaviour" OR STD* OR	226 Articles

	<p>“venereal disease*” OR Chlamydia OR Gonorrhea OR Syphilis OR “Sexually transmitted disease*” OR “sexual practices” OR “sexual behavior” OR “reproductive health” OR “reproductive health service*” OR sexuality OR HIV infections OR “reproductive medicine” OR “genital disease*” OR “sexual dysfunction”) AND (immigrant* OR refugee* OR migrant* OR emigrant* OR immigration OR emigration) AND (Men OR Males OR boys OR fathers) AND (“South Asian” OR Asian OR indian OR Bangladesh OR Pakistan) [in title, abstract and keywords]</p>	
PsycINFO	<p>(Sexual health OR sexually transmitted infections OR HIV OR AIDS OR sexual behaviour OR STDs OR venereal diseases OR Chlamydia OR Gonorrhea OR Syphilis OR Sexually transmitted disease OR sexual practices OR sexual behavior OR reproductive health OR reproductive</p>	94 Articles

	health services OR sexuality OR HIV infections OR reproductive medicine OR genital disease, male OR sexual dysfunction) AND (immigrants OR refugee OR migrants OR emigrants OR immigration OR emigration) AND (Men OR Males OR boys OR fathers) AND (South Asian OR Asian OR indian OR Bangladesh OR Pakistan) [in Any Field]	
Sociological Abstracts	(“Sexual health” OR “sexually transmitted infection*” OR HIV OR AIDS OR “sexual behaviour” OR STD* OR “venereal disease*” OR Chlamydia OR Gonorrhoea OR Syphilis OR “Sexually transmitted disease*” OR “sexual practices” OR “sexual behavior” OR “reproductive health” OR “reproductive health service*” OR sexuality OR HIV infections OR “reproductive medicine” OR “genital disease*” OR “sexual dysfunction”) AND (immigrant* OR refugee* OR migrant* OR emigrant* OR	40 Articles

	immigration OR emigration) AND (Men OR Males OR boys OR fathers) AND (“South Asian” OR Asian OR indian OR Bangladesh OR Pakistan) [in document title, abstract and subject heading]	
--	---	--

Table 4. Selected demographic and design details of the included studies

Citation	Study/Article Purpose	Study Approach	Samples	Country
Kang, 2103	The goal of the study was to understand factors that affect access to care among Asian undocumented immigrants living in HIV disease.	Qualitative research was performed. Data analysis was performed using the feminist participatory research and qualitative thematic analysis.	Sample was collected over 37 convenient sampling frames with 2-3 hours of semi-structured interview.	United States
Donnelly, 2016	The study aimed to explore how stigma was attached and	The study employed a community based participatory research	A total of 33 individuals participated in focus group discussions. Five	Canada

	experienced by people from marginalized immigrant communities with HIV and the barriers and facilitators in the utilization of resources and services in the Greater Vancouver Area.	framework to facilitate the sharing of experience, responsibilities and ownership of information	focus groups were performed, and each group had three to eight participants.	
Mansard, 2008	The aim of the cross-sectional descriptive study was to evaluate some epidemiological aspects and main public health issues of communicable diseases with risk of transmission in the European countries.	Quantitative cross-sectional survey was performed	Samples were taken from number of immigrants who attended for the first time for screening of tropical and communicable disease. Total number of patients were 2464.	Eastern Europe
Neville, 2016	The article aimed to identify some the ways men of South Asian and	A qualitative descriptive research design was used for this study.	44 participants were interviewed. Equal number of men who	New Zealand

	Chinese origin talked about and understand issues related to HIV/STI and health promotion, as well as highlighting some of this group's health-promoting behaviours.		moved to New Zealand within the last 5 years and those who were wither born in New Zealand or moved to New Zealand more than 5 years ago were considered for the study.	
Ramanathan, 2015	The study explored the three dimensions of behaviour, values and identity of Indian immigrants to understand how acculturation was shaped which influenced decision making.	Quantitative online survey method was used between December 2010 and August 2011.	Participants were recruited from both paid advertisements and from local media sources. Altogether 278 men took part in the online survey.	Australia
Ramanathan, 2013	The purpose of the study was to explore the help-seeking attitudes for sexual health service	The study employed a mixed methodology, a sequential exploratory design involving	A total of five focus group discussions with 25 South Asian men were held in late 2008	Australia

	utilization of adult Indian immigrant men currently living in Australia.	qualitative (focus group discussions) followed by quantitative (survey) methods.	with the survey carried out in online and paper between December 2010 and August 2011.	
Sawleshwarkar, 2013	The study aimed to investigate whether there were any significant differences between Indian-born and Australian-born counterparts attending sexual health clinic in Western Sydney.	A retrospective cross-sectional study was conducted.	Cases were Indian-born patients whereas gender-matched controls were attendees born in Australia who attended the sexual health clinic. Altogether 166 records were considered for analysis.	Australia
Sudhinaraset, 2017	The aim of the study was to examine the social and community contexts of Asian and Pacific Islanders that influence their health.	Using the social capital theory, qualitative research study was performed.	Four focus group discussions and 24 in-depth interviews were conducted through a purposive sampling frame.	United States
Vlassoff, 2011	The objective of the study was to explore the nature of HIV-related	Qualitative research methodology was chosen to explore the	Focus group discussions were performed and a total of four focus	Canada

	<p>stigma among South Asians in Toronto, its consequences for people living with it and its role in determining access to HIV services.</p>	<p>sensitive nature of the subject.</p>	<p>groups were conducted with 35 participants.</p>	
<p>Zhou, 2016</p>	<p>The paper aimed to present a more contextualized understanding of individual's understandings of, perceptions about, and responses to HIV risk in their post-immigration lives.</p>	<p>Qualitative research method was used to explore the contextual nature of the data.</p>	<p>27 participants were recruited through multiple networks in Indian immigrant communities. The data was collected through semi-structured in-depth interviews.</p>	<p>Canada</p>

References

- [1] Nilaweera I, Doran F, Fisher J. Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: a systematic review of the evidence. *J Affect Disord.* 2014;166:213–26. <https://doi.org/10.1016/j.jad.2014.05.021>.
- [2] Islam F, Khanlou N, Tamim H. South Asian populations in Canada: Migration and mental health. *BMC Psychiatry.* 2014;14(1):1–13. <https://doi.org/10.1186/1471-244X-14-154>.
- [3] United Nations Population Fund. Migration. 2015. <https://www.unfpa.org/migration>. Accessed 10 Apr 2018.
- [4] Statistics Canada. Immigration and ethnocultural diversity in Canada. National Household Survey, 2011. National Household Survey, 2011 (vol. 99-10-X20). 2013.
- [5] Statistics Canada. Canada Yearbook. Ottawa: Statistics Canada; 2011. p. 438–447.
- [6] SAALT Demographic Snapshot. (citing United States Census data on Bangladeshi, Indian, Pakistani, and Sri Lankan groups (2000, 2010)). (2012). <https://saalt.org/resources/reports-and-publications/#factsheets>.
- [7] Lebrun LA, Dubay LC. Access to primary and preventive care among foreign-born adults in Canada and the United States. *Health Serv Res.* 2010;45(6 PART 1):1693–719. <https://doi.org/10.1111/j.1475-6773.2010.01163.x>.
- [8] ABS. Australian Bureau of Statistics web site. 2011. <https://www.abs.gov.au/>. Accessed 10 Apr 2018.
- [9] Vasileva K. 6.5% of the EU population are foreigners and 9.4% are born abroad. *Eurostat Stat Focus.* 2011;34:1–8. Accessed 8 June 2018.
- [10] Davies A, Blake C, Dhavan P. Social determinants and risk factors for non-communicable diseases (NCDs) in south asian migrant populations in Europe. *Asia Eur J.* 2011;8(4):461–73. <https://doi.org/10.1007/s10308-011-0291-1>.
- [11] Degni F, Suominen S, Essén B, El Ansari W, Vehviläinen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. *J Immigr Minor Health.* 2012;14(2):330–43. <https://doi.org/10.1007/s10903-011-9465-6>.
- [12] Doll LS, Beeker C. Male bisexual behavior and HIV risk in the United States: Synthesis of research with implications for behavioral interventions. *AIDS Educ Prev.* 1996;8(3):205–25.

- [13] Leininger MM. *Transcultural nursing: concepts, theories, research and practice*. Columbus: WCB McGraw-Hill; 1995.
- [14] Courtenay WH. Behavioral factors associated with disease, injury, and death among men: evidence and implications for prevention. *J Men's Stud*. 2000;9(1):81–142. <https://doi.org/10.3149/jms.0901.81>.
- [15] Courtenay WH. Engendering health: a social constructionist examination of men's health beliefs and behaviors. *Psychol Men Masc*. 2000;1(1):4–15. <https://doi.org/10.1037//1524-9220.1.1.4>.
- [16] Weston HJ. Public honour, private shame and HIV: Issues affecting sexual health service delivery in London's south asian communities. *Health and Place*. 2003;9(2):109–17. [https://doi.org/10.1016/S1353-8292\(03\)00002-9](https://doi.org/10.1016/S1353-8292(03)00002-9).
- [17] Buzi RS, Smith PB. Access to sexual and reproductive health care services: young men's perspectives. *J Sex Marital Ther*. 2014;40(2):149–57. <https://doi.org/10.1080/0092623X.2012.736923>.
- [18] Hahm HC, Song IH, Ozonoff A, Sassani JC. HIV testing among sexually experienced Asian and pacific islander young women. Association with routine gynecologic care. *Women's Health Issues*. 2009;19(4):279–88. <https://doi.org/10.1016/j.whi.2009.05.001>.
- [19] Willcox A, Gleeson J. Boys, young men and teenage pregnancies: Adrienne willcox and judy gleeson explore the issues around educating boys on teenage pregnancy. *Prim Health Care*. 2003;13:27.
- [20] Ottawa Public Health. *Sexually transmitted infections and sexual health in Ottawa*. Ottawa (ON): Ottawa Public Health; 2011. Accessed 8 June 2018.
- [21] Smith AL. Health policy and the coloring of an American male crisis: a perspective on community-based health services. [Reprint in *Am J Public Health*. 2008 Sep;98(9 Suppl):S158–61; PMID: 18687603]. *Am J Public Health*. 2003; 93:749–52. <https://doi.org/10.2105/AJPH.93.5.749>
- [22] Jayaraman G, Totten S, Perrin M, Fang L, Remes O. *Report on Sexually Transmitted Infections in Canada: 2008*. Centre for Communicable Diseases and Infection Control. 2008. <https://www.phac-aspc.gc.ca>. Accessed 6 June 2018.
- [23] Hancock J. Can mainstream services learn from male only sexual health pilot projects? *Sex Transm Infect*. 2004;80(6):484–7. <https://doi.org/10.1136/sti.2004.011304>.
- [24] Manderson L, Allotey P. Storytelling, marginality, and community in Australia: how immigrants position their difference in health care settings. *Med Anthropol*. 2003;22(1):1–21. <https://doi.org/10.1080/01459740306767>.

- [25] Aggleton P, Campbell C. Working with young people—towards an agenda for sexual health. *Sex Relatsh Ther.* 2010;15(3):283–96. <https://doi.org/10.1080/14681990050109863>.
- [26] Zhou YR. ‘Race’ and HIV vulnerability in a transnational context: The case of Chinese immigrants to Canada. *Cult Health Sex.* 2017;19(6):695–708. <https://doi.org/10.1080/13691058.2016.1192221>.
- [27] Grewal S, Bottorff J, Hilton B. The influence of family on immigrant South Asian women’s health. *J Fam Nurs.* 2005;11(3):242–63. <https://doi.org/10.1177/1074840705278622>.
- [28] Arksey H, O’Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol.* 2005;8(1):19–32. <https://doi.org/10.1080/1364557032000119616>.
- [29] Levac D, Colquhoun H, O’Brien KK. Scoping studies: advancing the methodology. *Implement Sci.* 2010;5(1):1–9. <https://doi.org/10.1186/1748-5908-5-69>.
- [30] Al-Taiar A, Clark A, Longenecker JC, Whitty CJM. Physical accessibility and utilization of health services in Yemen. *Int J Health Geogr.* 2010;9:1–8. <https://doi.org/10.1186/1476-072X-9-38>.
- [31] Goddard M, Smith P. Equity of access to health care services: theory and evidence from the UK. *Soc Sci Med.* 2001;53(9):1149–62. [https://doi.org/10.1016/S0277-9536\(00\)00415-9](https://doi.org/10.1016/S0277-9536(00)00415-9).
- [32] Cook BL, Doksum T, Chen C, Carle A, Alegría M. The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the U.S. *Soc Sci Med.* 2013;84:102–9. <https://doi.org/10.1016/j.socscimed.2013.02.006>.
- [33] Hibbard J. Using systematic measurement to target consumer activation strategies. *Med Care Res Rev.* 2009;66(1):9S–27S. <https://doi.org/10.1177/1077558708326969>.
- [34] Davidson PL, et al. A framework for evaluating safety-net and other community-level factors on access for low-income populations. *Inquiry.* 2004;41(1):21–38.
- [35] Vlassoff C, Ali F. HIV-related stigma among South Asians in Toronto. *Ethn Health.* 2011;16(1):25–422. <https://doi.org/10.1080/13557858.2010.523456>.
- [36] Zhou YR, Majumdar B, Vattikonda N. Culture, but more than culture: an exploratory study of the HIV vulnerability of Indian immigrants in Canada. *Cult Health Sex.* 2016;18(9):1067–80. <https://doi.org/10.1080/13691058.2016.1162328>.
- [37] Donnelly LR, Bailey L, Jessani A, Postnikoff J, Kerston P, Bron-dani M. Stigma experiences in marginalized people living with HIV seeking health services and resources in Canada. *J Assoc Nurses AIDS Care.* 2016;27(6):768–83.

<https://doi.org/10.1016/j.jana.2016.07.003>.

- [38] Kang E, Rapkin BD, Springer C, Kim JH. The “Demon Plague” and access to care among Asian undocumented immigrants living with HIV disease in New York City. *J Immigr Health*. 2003;5(2):49–58. 39.
- [39] Neville S, Adams J. Views about HIV / STI and health promotion among gay and bisexual Chinese and South Asian men living in Auckland New Zealand. *Int J Qual Stud Health Well-being*. 2016;11(1):30764. <https://doi.org/10.3402/qhw.v11.30764>.
- [40] Ramanathan V, Sitharthan G, Pepper K, Wylie K. Sexual health of Indian immigrant men in Australia: exploratory research on help-seeking attitudes. *Sex Health*. 2013;10(4):380–1. <https://doi.org/10.1071/SH12199>.
- [41] Sawleshwarkar S, Kakar SR, Jones R, Lagios K, Mindel A, Hillman RJ. Indian-born patients attending a sexual health clinic in Australia have differing characteristics to their Australian-born counterparts. *Intern Med J*. 2013;43(12):1327–30. <https://doi.org/10.1111/imj.12299>.
- [42] Sudhinaraset M, Ling I, To TM, Melo J, Quach T. Dreams deferred: contextualizing the health and psychosocial needs of undocumented Asian and Pacific Islander young adults in Northern California. *Soc Sci Med*. 2017;184:144–52. <https://doi.org/10.1016/j.socscimed.2017.05.024>.
- [43] Manzardo C, Treviño B, Gómez i Prat J, Cabezós J, Monguí E, Clavería I, Navarro R. Communicable diseases in the immigrant population attended to in a tropical medicine unit: Epidemiological aspects and public health issues. *Travel Med Infect Dis*. 2008;6(1–2):4–11. <https://doi.org/10.1016/j.tmaid.2007.11.002>.
- [44] Ramanathan V. Values, behaviour and identity: acculturation of Indian immigrant men in Australia. *J Int Migr Integr*. 2015;16(3):625–38. <https://doi.org/10.1007/s12134-014-0364-2>.
- [45] Brindis C, Barenbaum M, Sanchez-Flores H, McCarter V, Chand R. Let’s hear it for the guys: California’s male involvement program. *Int J Men’s Health*. 2005;4(1):29–53. <https://doi.org/10.3149/jmh.0401.29>.
- [46] Armstrong B. The young men’s clinic: addressing men’s reproductive health responsibilities. *Perspect Sex Reprod Health*. 2003;35(5):220–5.
- [47] Federal Register “Minority Health and Health Disparities Research and Education Act of 2000,” (S-1880). 2000. <https://www.congress.gov/106/plaws/publ525/PLAW-106publ525.pdf>.
- [48] Brach C, Fraserirector I. Can cultural competency reduce racial and ethnic health

- disparities? A review and conceptual model. *Med Care Res Rev.* 2000;57(1_suppl):181–217. <https://doi.org/10.1177/1077558700057001S09>.
- [49] Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, Bindman AB. The role of black and hispanic physicians in providing health care for underserved populations. *N Engl J Med.* 1996;334(20):1305–10. <https://doi.org/10.1056/NEJM199605163342006>.
- [50] Phillips KA, Mayer ML, Aday LA. Barriers to care among racial/ ethnic groups under managed care. *Health Aff.* 2000;19(4):65–75. 51.
- [51] Marcell AV, Bell DL, Lindberg LD, Takruri A. Prevalence of sexually transmitted infection/human immunodeficiency virus counseling services received by Teen Males, 1995–2002. *J Adolesc Health.* 2010;46(6):553–9. <https://doi.org/10.1016/j.jadohealth.2009.12.002>.
- [52] Smith JA, Braunack-Mayer A, Wittert G. What do we know about men’s help-seeking and health service use? *Med J Aust.* 2006;184:81–3.
- [53] Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol.* 2003. <https://doi.org/10.1037/0003-066X.58.1.5>.
- [54] Raine T, Marcell AV, Rocca CH, Harper CC. The other half of the equation: Serving young men in a young women’s reproductive health clinic. *Perspect Sex Reprod Health.* 2008;35(5):208–14. <https://doi.org/10.1363/psrh.35.208.03>.
- [55] Wright AL, Morgan WJ. On the creation of “problem” patients. *Soc Sci Med.* 1990;30(9):951–9. [https://doi.org/10.1016/0277-9536\(90\)90142-F](https://doi.org/10.1016/0277-9536(90)90142-F).
- [56] Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? *J Int AIDS Soc.* 2009;12(1):15. <https://doi.org/10.1186/1758-2652-12-15>.
- [57] Halcomb E, Fernandez R. Systematic reviews. *Nurs Stand.* 2015;29(33):45–51. <https://doi.org/10.7748/ns.29.33.45.e8868>.

Chapter 3: Healthcare access, quality of care and efficiency as healthcare performance measures: A Canadian health service view

Yamin Tauseef Jahangir¹, Elena Neiterman¹, Craig R. Janes¹, Samantha B. Meyer¹

¹ *School of Public Health and Health Systems, University of Waterloo, Ontario, N2L 3G1, Canada*

[This is an open access article distributed under the Creative Commons Attribution (CC BY 4.0) License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. See: <http://www.creativecommons.org/licenses/by/4.0/>.]

Citation: Jahangir YT, Neiterman E, Janes CR, Meyer SB. Healthcare access, quality of care and efficiency as healthcare performance measures: A Canadian health service view. *J Health Soc Sci.* 2020;5(3):309-316

Copyright © 2020 Yamin Tauseef Jahangir et al.

DOI: 10.19204/2020/hlth2

Published Online: 30 May 2020

Abstract

While most performance judgements are value-relative, in health systems reform it is important to focus on intermediate performance measures like healthcare access, quality of care and efficiency in healthcare on health status of population, the satisfaction of patients, and the degree to which services are made equitable. However, to date these concepts are not well-defined, remain fairly ambiguous and, consequently, are also not well-measured. Therefore, such concepts do not provide sufficient information to inform changes to the health system that may improve population level outcomes related to structural factors. Our paper provides a more conceptual clarification on how these three intermediate variables may shape assessments in health system performance, while drawing from the Canadian healthcare system performance gaps and placing them as evidence. We found an immediate need for patient-centred outcome measures in service and clinical quality instead of surrogate outcome measures, need for improved measures on the rate of service utilization such as in terms of service orientation and patient satisfaction, and a need for more robust approach in measuring allocative efficiency in healthcare to be the key areas of strengthening performance assessments.

Keywords: Canada; healthcare and policy; healthcare access; healthcare outcome indicators; quality of care.

Introduction

The pursuit of equity or fairness is a central objective of many health systems and reflects concerns with the distribution of the burden of ill health across the population [1]. In order to ensure the quality of health services, population health has been measured extensively both internationally and regionally [2]. These measures focused on standardized mortality rates, life expectancy and adjusted for rates of disability in the form of disability-adjusted life years (DALYs) [2]. However, even though they are informative, it is somewhat difficult to assess the extent to which variations in health outcomes can be attributed to the health system [3].

Therefore, in order to inform health system responsiveness, it is important that performance measures reflect the role health sector plays in population health outcomes [4]. This requires an understanding of the connection between the health sector in general, and judgements about its performance, and the larger social and economic systems. It is also important to focus on the structural features of the health care system, including variables that are indicators of ‘access’, ‘quality’ and ‘efficiency’, which are referred to as ‘intermediate performance measures’ [3]. Such characteristics of the system help to understand the level of service delivery performance on health system goals. However, to date these concepts are not well-defined, remain fairly ambiguous and, consequently, are also not well-measured. Therefore, such concepts do not provide sufficient information to inform changes to the health system that may improve population level outcomes related to structural factors [3]. Further, it is important to learn about these concepts relevant to better measures in health system performance. In this viewpoint, this paper argues and provides some conceptual clarification on the terms of healthcare access, quality of care and healthcare efficiency that might guide the development of measures, or mapping of existing indicators or measures, in healthcare performance for equitable care, while giving emphasis on the gaps as evidence from the Canadian healthcare system.

Discussion

Healthcare access

Access to healthcare is central to the performance of healthcare systems around the world [5]. However, access to healthcare remains a complex notion as different authors describe it differently [6–7]. As explained by Levesque et al. (2013), the term ‘access’ is defined as the use

of health care, qualified by need for care [8]. Penchansky (1981) [5] described access in terms of the fit between the characteristics of providers in the health services and the characteristics and expectations of the clients. In this view, access to healthcare is a product of supply factors, such as the location, availability, cost, and appropriateness of services. It is also a product of demand factors, such as the burden of disease and knowledge, attitudes, and skills, self-care practices, past experience with health care, perceived quality of care, health literacy or the ability to pay [9]. Therefore, access can be seen in two separate ways- the physical availability of services (e.g. beds, doctors, nurses) or effective accessibility (e.g. cost, travel times, service levels, waiting times, cultural acceptability) [3]. While it is not easy to collect information on the latter, the term ‘access’ is often used to refer to utilization of service [3]. That is, although various indicators of access might be measured, it is utilization that is observed [10]. Thus, the focus of access studies is mostly related to the rates at which health services are actually used or how satisfactory consumers perceive their care to be, which is often not considered in measures of access [11].

Aday and Andersen (1974) suggest that a distinction must be made between ‘having access’ and ‘gaining access’ – the possibility of using a service if required and the actual use of a service [9–11]. Thus, access is viewed from a broader perspective by Levesque (2013) [8] while describing these determinants of access as: 1) approachability of healthcare needs; 2) acceptability of professional values, norms, culture; 3) availability and accommodation relating to geographic location and appointment mechanisms; 4) affordability such as the direct, indirect and opportunity costs involved; 5) appropriateness regarding interpersonal quality and coordination. Through these approaches, patients go through various stages to access services and is therefore defined heavily as an attribute of services, thereby making it to be more patient-centred [12]. Although Aday and Anderson described access in terms of ‘utilization of services’, for Canada Health Act (CHA) it is mostly related to responding only to needs of health care services [13]. To elucidate, the Federal Government of Canada focuses on utilization mainly in terms of ‘necessary hospital and physician services’, meaning that services should be shared to meet the expectations of equal use for equal needs [13]. This implies to equal health coverage, fair distribution of resources throughout the country, and removing geographic and other barriers to access [12]. However, little attention has actually been paid to the distribution of resource needs of healthcare services within populations [14]. Hence, the policies emerging from the CHA are

less focused on promoting equal use for equal needs, but more with equal access to services across populations heterogeneous in their ability to pay [13]. In a longitudinal study of the National Population Health Survey in Canada, Setia et al. (2011) found that there were unmet healthcare needs among younger men and women, and a significant trend for higher odds of unmet healthcare needs with decreasing income in both these genders [15]. Literature suggests that having a regular doctor increases the ‘potential healthcare access’ and those who have regular doctors are more likely to access care [16]. However, Veugelers (2003) [17] found that specialist services were less used by lower socio-economic groups in Canada, and services are not equitably distributed to this group despite the existence of universal health coverage. Further, the Canadian Institute of Health Information provides series of composite health indicators which focus mainly on the provider level for hospital performance. Consequently, these indicators tend to over-represent inpatient and preventive services, and under-represent ambulatory care and other interventional procedures [1–2]. Therefore, performance measures for access would have to be more patient-centered and as Donabedian (1972) [18] explained that ‘proof of access is use of service, not simply the presence of a facility’, it can be measured in terms of actual utilization of health care and from the level of satisfaction (e.g., how accessible and service-oriented is the care process).

Quality of care

Quality of care is sometimes defined from the patient’s point of view and sometimes from the perspective of the doctor [3]. More inclusive service judgements make quality of care divided into two separate categories. Service quality is considered in terms of travel and waiting times, interpersonal relationships with the provider such as care, respect, and politeness, while clinical quality is related to human inputs such as skills and decision-making, non-human inputs such as equipment and supplies and the production system [3–4, 6].

Considering the United States healthcare system, quality is often associated with price for availing health services. However, the United States, while having the world’s most expensive healthcare system, also has poor patient outcomes [19]. In Canada, the increased use of family physician and hospital services in lower socioeconomic groups seem to correspond to the higher

healthcare need to utilize services resulting from their poorer health [17]. However, studies in Canada do not explicitly analyse the interactions of these higher needs for healthcare with other explanatory variables such as cost, income, or quality of care [13]. For example, the Commonwealth Fund survey found that 25% of Canadians reported waiting longer than 8 weeks to see a specialist, compared with just 3% in Switzerland and the United States, and between 10% and 20% in most other high-income countries [20]. While this is even more complex when analyzing the health systems country-wide and also within provinces in Canada due to geographic make up or remoteness [21]. Therefore, quality measures in Canada may consider on approaches that would bring better evidence to ensure system performance [22]. Instead of surrogate outcome measures (e.g. clinical over-testing or over-medication as indicators of quality outcome measure), a patient-centeredness approach (e.g., outcomes that reflect on experiences and satisfaction) or instead of binary (cut-off) thresholds of risk (e.g., blood pressure or haemoglobin A1c) a more continuous measures of risk (e.g., use of Global Outcome Scores for aggregates risk measures) would be more feasible in quality improvement in healthcare [22].

Quality measures should also focus on meaningful health outcomes in Canada as well, and measures that address social determinants, multimorbidity or individualized care should be some thoughtful approaches as they may provide broader knowledge on quality of care from individual perspectives [23]. For example, Self-Assessed Health (SAH) status or self-reported health questionnaire focus on perceived health status of a patient and are often included in general socio-economic and health surveys which is a measure of socio-economic inequalities in health, and also reflect on quality of health outcomes [1, 24, 25]. Hence, even for a system that is efficient in producing quality, the question remains how much quality and along what dimensions will maximize society's ability to achieve its overall health goals.

Healthcare service efficiency

The concept of efficiency is usually applied when considering the relative performance of organizations within a health system. Healthcare system efficiency is categorised as how services are produced and what services are produced [3]. The first of these is the technical efficiency, referring to a situation in which a good or a service is produced at minimum cost. For example, is

the cost-per-day at the hospital as low as possible or are as many patients are being treated within a given budget? [3]. The second form of efficiency is allocative efficiency, which refers to the maximum level of output that can be produced assuming the cheapest mix of inputs within a limited budget. For example, whether a set of outputs can maximise patient satisfaction [1]. Thus, in health systems it is often common to ask whether a particular set of services is maximising health status gains. If output growth increases than the inputs in health care, it is then a sign of improved productivity as efficiency increases [3].

The annual spending in Canadian health care system in 2013 was 11.2% in comparison to 7% in 1975 while many key indicators have improved the health status at a faster pace in this time period [26, 27]. With increased health expenditure a recent public survey by Environics Research in 2011 placed more priority on efficiency for health systems reform in Canada [26]. However, to date, and as explained by the Ontario Ministry of Finance, little or no attempt has been made to measure systematically what expenditures buy in the Canadian healthcare system, nor to identify factors associated with higher levels of efficiency and have limited influence on decision-makers for strong health system reforms [26, 28, 29]. Moreover, variations in the population health of regions may explain variations in the efficiency, as different health researchers use different output indicators (e.g., potential years of life lost or disability adjusted life years) as measures for the inputs given (such as, dollar value spent on major components in healthcare in Canada like physician payment, pharmaceutical spending, cost of residential facilities and community care) [26]. As few international studies included Canada in a comparative analysis for health care efficiency, a recent OECD (Organization for Economic Cooperation and Development) study found the level of health system inefficiency in Canada to be 20% [28]. We agree with Allin et al. (2015) who confirmed that, the focus should be in investments towards primary care rather than specialized care, thereby increasing healthcare efficiency and equity for the lower income brackets [26]. Thus, we think a diversity of interventions on healthcare services, health promotion and disease prevention, and broader determinants of health is required to improve efficiency [21, 22, 26]. For a healthcare system, the efficiency is determined as whether technical and allocative efficiency allows a society to reach its minimum health goals. Therefore, as studies suggest, increasing efficiency can actually advance equity by making health care less costly to reach equity objectives [3].

The way forward

In Canada, the national family expenditure surveys between 1964 and 1982 showed that in terms of dollar value and as a share of total income, the rich in comparison to the poor spent more on health care and in 1964 the affluent families spent 4.5 times more on healthcare [30]. While although this ratio dropped in 1982, the relative burden remained consistently higher for the lower income population than for the rich, as majority of the family income was spent on out-of-pocket payment expenses, such as, dental care, drugs, and other appliances [30, 31]. Further, national health insurance in Canada has done little to modify the long-term regressive trends in the purchasing of uninsured health care services [17].

As we mentioned earlier, for equity or fairness to be a central objective of health systems, it is frequently observed that physicians and provider organizations treat patients with significant differences in their severity of disease, socio-economic status, behaviours related to health and patterns of compliance with treatment recommendations [1]. These differences make it difficult to draw direct performance comparisons and pose considerable challenges for developing accurate performance measures [1]. Hence, moving forward, our question remains as what improvements in health-sector performance are most important for all consumers which, according to Levesque et al. (2013), is the combination of characteristics of services, providers and systems that are aligned with people, and community capabilities [3, 8]. In terms of quality of care, clinicians and organizations often try ‘gaming the system’ i.e. providing disproportionate care to patients who are barely in the “wrong” end of their treatment line [22]. For example, performing over-testing such as repeated colon cancer screening; or overmedication such as, use of anti-hyperglycemic medications but not metformin to reduce HgbA1c levels in type 2 diabetes, despite limited evidence of benefit [22]. Thus, as mentioned by Mechanic (1976) [32], it is often the physicians rather than the consumers who make the decision of what services should be purchased. Therefore, another way forward is to give importance towards patient-centeredness such as, patient satisfaction should be ensured in quality measures as it evaluates the ‘success’ of the medical services in achieving their curative and caring objectives [9, 22]. At times performance assessment of allocative efficiency focus on treating patients with their

willingness to pay to specific kind of treatment. However, the cost-effectiveness to care will diminish as cost per case increases. Then rather than a 'yes' or 'no' issue of a specific intervention, such as dialysis treatment, the question then remains as, for 'how long' will a dialysis treatment be given and to which patient [3]. Thus, one way of further shaping performance assessment should be by creating 'ethical benchmarking', meaning comparing national performance (variables like access, quality, and efficiency) with various standards to see where performance in healthcare is inadequate and potentially improvable [3]. As the populations have now become more diverse in recent years, fulfilling the priorities of regions and special cultural and national groups in Canada has become the dominant issue on the national legislative agenda [31].

Conclusion

In conclusion, although indicators are available for performance assessment in health systems, there is always a need to understand the variabilities in supply and demand side factors and its influence in patients' characteristics. To our understanding, there still remains lack of information on the *causes* of inequities in access to healthcare which continues to pose challenge in policy-directives. This maybe a fact that causes are multifaceted, and that a single attributable factor (e.g., social class) is hard to acknowledge. However, we understand from evidence that by focusing more on the principles of patient-centeredness and evidence-based interventions on self-assessed healthcare needs, possible concerns of misusing health system performance may be minimised. In sum, healthcare performance measures like access to care, efficiency and quality of care in Canada should also focus on assessing overall productivity in care outcomes and on improving quality of life of patients. Furthermore, we believe healthcare delivery in Canada can be addressed in ways which are policy-informing, and by considering the variations in utilization in healthcare it is imperative that the policy variable of interest should earnestly focus on the case of population characteristics and on their particular healthcare needs.

References

- [1] Smith PC, Mossialos E, Papanicolas I, Leatherman S. Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects; Cambridge University Press; 2010. [Cited 2019 15 December] Available from:

<https://doi.org/10.1017/CBO9780511711800.002>

- [2] Smith P. Measuring Up Improving Health System Performance In OECD Countries. OECD. 2002. doi:10.1160/TH11-07-0511.
- [3] Roberts M, Hsiao W, Berman P, Reich M. Getting Health Reform Right: A Guide to Improving Performance and Equity; Oxford Univeristy Press; 2009. [Cited 17 December 2019]. Available from: doi:10.1093/acprof:oso/9780195371505.001.0001.
- [4] Naylor CD, Iron K, Handa K. Measuring Health System Performance: Problems and Opportunities in the Era of Assessment and Accountability (Chapter 1). Meas Up Improv Health Syst Perform OECD Ctries. OECD Library; 2003. [Cited 1 December 2019] Available from: <https://doi.org/10.1787/9789264195950-en>
- [5] Penchansky, R., & Thomas, J. The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care*. 1981;19(2):127-140.
- [6] Haddad S, Mohindra K. Access, opportunities and communities: ingredients for health equity in the South. In: *Public Health and International Justice Workshop*. New York: Carnegie Council on Ethics and International Affairs; 2002.
- [7] Daniels, N. Equity of Access to Health Care: Some Conceptual and Ethical Issues. *The Milbank Memorial Fund Quarterly*. *Health and Society*. (1982);60(1):51-81. doi:10.2307/3349700
- [8] Levesque JF, Harris MF, Russell G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(1):1. doi:10.1186/1475-9276-12-18.
- [9] Aday LA, Andersen R. A framework for the study of access to medical care. *Health Serv Res*. 1974;9(3):208–220. doi:10.3205/psm000089.
- [10] Goddard M, Smith P. Equity of access to health care services: theory and evidence from the UK. *Social Science & Medicine*. 2001 Nov;53(9):1149-1162. [https://doi.org/10.1016/S0277-9536\(00\)00415-9](https://doi.org/10.1016/S0277-9536(00)00415-9)
- [11] Aday, L., & Andersen, R. Equity of Access to Medical Care: A Conceptual and Empirical Overview. *Medical Care*. 1981;19(12):4-27. doi:10.1097/00005650-198112001-00004.
- [12] Whitehead M. The concepts and principles of equity and health. *Health Promot Int*. 1991;6(3):217–228. doi:10.1093/heapro/6.3.217.
- [13] Birch, S., Eyles, J.S., & Newbold, K.B. Equitable access to health care: methodological extensions to the analysis of physician utilization in Canada. *Health economics*. 1993;2(2):87-101 <https://doi.org/10.1002/hec.4730020203>

- [14] Epp, J. Achieving health for all: a framework for health promotion. Ottawa, ON: Health and Welfare Canada. 1986; [Accessed 10 January 2020]. Retrieved from Health Canada website: <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/1986-frame-plan-promotion/index-eng.php>15.
- [15] Setia MS, Quesnel-Vallee A, Abrahamowicz M, Tousignant P, Lynch J. Access to health-care in Canadian immigrants: A longitudinal study of the National Population Health Survey. *Heal Soc Care Community*. 2011;19(1):70–79. doi:10.1111/j.1365-2524.2010.00950.x.
- [16] Andersen RM. Revisiting the behavioral model and access to medical care: does it matter?. *J Health Soc Behav*. 1995;36(1):1–10. doi:10.2307/2137284.
- [17] Veugelers PJ, Yip AM. Socioeconomic disparities in health care use: Does universal coverage reduce inequalities in health?. *J Epidemiol Community Health*. 2003;57(6):424–428. doi:10.1136/jech.57.6.424
- [18] Donabedian, A. Models for Organizing the Delivery of Personal Health Services and Criteria for Evaluating Them. *The Milbank Memorial Fund Quarterly*. 1972;50(4):103–154. doi:10.2307/3349436
- [19] Woolf SH, Aron LY. The US health disadvantage relative to other high-income countries: Findings from a National Research Council/Institute of Medicine report. *JAMA - J Am Med Assoc*. 2013;309(8):771–772. doi:10.1001/jama.2013.91.
- [20] Lawand C, Paltser G, Cheung G, Ytsma A. Care for Patients with Complex Needs: Canadian Results from the Commonwealth Fund 2015 International Health Policy Survey of Primary Care Physicians. *Healthc Q*. 2016;19(2):10–12. doi:10.12927/hcq.2016.24692
- [21] Dhalla IA, Tepper J. Improving the quality of health care in Canada. *Cmaj*. 2018;190(39):E1162–E1167. doi:10.1503/cmaj.171045.
- [22] Saver BG, Martin SA, Adler RN, Candib LM, Konstantinos ED, Jeremy G et al. Care that Matters: Quality Measurement and Health Care. *PLoS Med*. 2015;12(11):e1001902. Published 2015 Nov 17. doi:10.1371/journal.pmed.1001902
- [23] Eddy DM, Adler J, Patterson B, Lucas D, Smith KA, Morris M. Individualized guidelines: the potential for increasing quality and reducing costs. *Ann Intern Med*. 2011;154(9):627–634. doi:10.7326/0003-4819-154-9-201105030-00008
- [24] Pogach L, Aron D. The other side of quality improvement in diabetes for seniors: a proposal for an overtreatment glycemetic measure. *Arch Intern Med*. 2012;172(19):1510–1512. doi:10.1001/archinternmed.2012.4392
- [25] Pathy R, Mills KE, Gazeley S, Ridgley A, Kiran T. Health is a spiritual thing: perspectives of health care professionals and female Somali and Bangladeshi women on the health

- impacts of fasting during Ramadan. *Ethn Health*. 2011;16(1):43–56.
doi:10.1080/13557858.2010.523780
- [26] Allin S, Veillard J, Wang L, Grignon M. How can health system efficiency be improved in Canada? *Health Policy*. 2015;11(1):33–45. doi:10.12927/hcpol.2015.24361.
- [27] Canadian Institute for Health Information (CIHI). *National Health Expenditure Trends , 1975 to 2015*. Can Inst Health Inf Rep. 2015.
- [28] Joumard, I., C. André and C. Nicq. "Health Care Systems: Efficiency and Institutions", OECD Economics Department Working Papers, No. 769, OECD Publishing, Paris. 2010. <https://doi.org/10.1787/5kmp51f5f9t-en>.
- [29] WHO. World Health Organization Fifty-Third World Health Assembly A53/4 Provisional agenda item 3: The world health report 2000 Message From the Director General. 2000;(March). [Accessed 22 December 2019] Available from: http://apps.who.int/gb/archive/pdf_files/WHA53/ea4.pdf
- [30] Wolfe S. Ethics and Equity in Canadian Health Care: Policy Alternatives. *Int J Health Serv*. 2005;21(4):673–680. doi:10.2190/vkfm-dfjf-jbkb-1lw2.
- [31] Badgley RF. Social and Economic Disparities under Canadian Health Care. *Int J Health Serv*. 2005;21(4):659–671. doi:10.2190/br0t-1mdk-umd7-vwh1.
- [32] Mechanic D. Rationing health care: public policy and the medical marketplace. *Hastings Cent Rep*. 1976;6(1):34–37.

Chapter 4: Exploring the factors influencing access to and utilization of sexual health services by South Asian men in Ontario

Yamin Tauseef Jahangir¹, Elena Neiterman¹, Craig R. Janes¹, Samantha B. Meyer¹

¹*School of Public Health Sciences, Faculty of Health, University of Waterloo, ON*

Abstract

Introduction: South Asian communities comprise one of the fastest-growing populations in Canada. However, the sexual health of South Asian immigrant men, in particular, remains vastly understudied in high-income economy countries, and little is known about how and if men access these services. **Objectives:** This study aimed to explore contextual factors (e.g. cultural, psychological, social) influencing the accessibility (actual and/or perceived) and utilization of sexual health services by South Asian men in Canada. **Methods:** An interpretive description (ID) research methodology was used to concurrently collect and analyze data in Ontario. The overall analysis followed Braun and Clarke's guidelines for thematic analysis. Eighteen semi-structured interviews were conducted between May – July 2021 with South Asian-born immigrant men between the age range of 20-45 years. **Results:** We found sexual health is perceived negatively by some South Asian men and limited sexual health information was said to exist within the community. Furthermore, the perceived severity of sexual illness also influenced sexual health service access. Participants also mentioned sexual health as taboo, the social nature of sex positivity and sex-negativity and that men share sexual health information with only trusted sources (e.g. friends and family). Our participants also mentioned that sexual health information was shared more openly by following a lifestyle that normalizes sexual health discussions rather than South Asian cultural norms. Findings further suggest South Asian men's culture influences their perceptions of sexual health and overall access to care which they often think to be an optional service. For example, gender stereotypes about men within the South Asian cultures can influence sexual health-seeking behaviours among men. **Conclusion:** This study provides insight into the contextual factors shaping the access and utilization by these men – these data may be used to inform efforts to increase service utilization.

Key Words: sexual healthcare; South Asian immigrant men; access to healthcare; sexual health of men; utilization of sexual health; men's health in Ontario; Canada.

Introduction

South Asia is one of the major demographic regions from which people have migrated to high-income countries to settle temporarily or live permanently[1]. According to the literature a ‘South Asian’ is an individual who self-identifies as having ancestry relations and/or that originates in South Asia, including an individual reporting his/her origin as Bangladeshi, Bengali, East Indian, Goan, Gujrati, Kashmiri, Pakistani, Punjabi, Nepali, Sinhalese, Sri Lankan, Tamil, or South Asian[2]. Migration patterns in high-income countries (i.e. according to the World Bank, countries having a high-income economy and a gross national income per capita of more than \$12,000)[3] have changed considerably in the past few decades, with a greater proportion of migrants being from Asia, and particularly, South Asia. For example, patterns of immigration in a high-income economy country like Canada have changed from the 1970s, where migrants were primarily from Europe (70% or more), with Asian migrants making up only 10%; however, as of 2013 European migrants only accounted for 17% while Asian population migration increased to 52%[4][5]. It is projected that by 2031, 55% of Canada’s foreign-born population will report origins in South Asia[6].

Although the literature has mentioned that there is a range of healthcare services that are available to immigrants, sexual health remains neglected, though an important and critical domain[7][8][9]. According to the literature, sexual health services include education about sexual health, diagnosis and testing of sexually transmitted infections (STIs), treatment and follow-up services for STIs, and reproductive healthcare services[10]. However, the literature suggests that in many high-income countries, there is limited research that has focused particularly on South Asian immigrant health, and consequently how to develop effective services for these populations[9]. It is well established that women have been the focus of sexual health services for access to sexual healthcare services to have safe pregnancies and healthy children[11]. Indeed, although pregnancy and sexual illness involve both men and women, most sexual health programs prioritize women and overlook the sexual healthcare needs of men[10][12]. Literature suggests that despite a steady rise in cases of sexual illness in Canada, there is little data available to explain infection rates among South Asian men[12]. Rather,

studies have found that men often delay in accessing health care services for their sexual health illnesses [13][14]. Studies have also found that men may delay seeking services because they are not planning to be sexually active, or may think it is unmanly to seek help unless they have a sexual health problem, such as STI cases[15][16]. Below we provide a brief background regarding sexual healthcare services in Ontario and Canada, clinical and health promotion best practices in place, and what is known about the contextual factors that might shape sexual health service use by South Asian men in Canada.

Background

Sexual health in Ontario and Canada

In a broader context of understanding how South Asians use sexual health services, it is important to know what exactly sexual health means. The definition of sexual health mainly includes: (1) being knowledgeable about reproductive health, (2) being able to make informed choices about parenthood and sexuality, and (3) being comfortable with one's sexuality. However, the concept of sexual health also varies for certain individuals in terms of the uniqueness of sexual experiences, needs and identities[17][18]. In Ontario, sexual health clinics are staffed by physicians, nurses and nurse practitioners to offer free and confidential clinical services. Sexual health services in Ontario usually comprise of: birth control counselling; free confidential sexually transmitted infections (STI) testing and treatment; anonymous HIV testing and HIV/AIDS programs; immunizations for hepatitis A and B and HPV vaccine; pap testing; urine pregnancy testing; low-cost birth control; needle exchange programs[19]. In addition, it has been mentioned by the Government of Ontario that Canadians can use these services when they need confidential counselling or need help with sexual health issues, require diagnosis and treatment of STIs or if they do not have Ontario health insurance[19]. Furthermore, sexual health services are made available in public health units, community healthcare centres, stand-alone clinics in the community, or on any college or university campuses[19]. Apart from the clinical services, a greater part of sexual health education in Canada is also focused on prevention and health promotion[20]. To elucidate, the overall health promotion on sexual health includes a key component of taking preventative measures. Hence, sexually transmitted and blood-borne

infection (STBBI) prevention guides in Canada include: primary and secondary prevention (e.g. assessing and discussing the risk of STBBI, educating people about signs and symptoms of STBBIs, offering vaccination for STBBIs when indicated, offering STBBI screening and testing, treatment and follow-up), sexual health assessment (i.e. physical examination, pre or post-test counselling, reproductive health consultations), and etiology-specific guides (e.g. suppressive therapy and prophylaxis, antimicrobial resistance treatment, co-infection management, a test of cure and follow-up)[21][22]. Furthermore, comprehensive sexual health education as an educational and policy framework is also seen as a holistic approach, that views sexual health as an intersectional site, influenced by physiological, relational, emotional, social, political and cultural dimensions of health[23]. [24]. In this context, health promotion for sexual health includes harm reduction initiatives, access to new vaccines and pre-exposure prophylaxis, and gender-responsive sexual health information [22]. However, sexually transmitted infections (STIs) continue to be a significant and ever-increasing public health concern in Canada[25]. Literature indicates an alarming gap in the sexual health knowledge of youth in Canada, while sexual health services should meet the needs of diverse populations in Ontario[26].

Sexual health service accessibility and barriers to use

There is reported variability in sexual health service use (e.g. STI diagnosis, accessing health information, treatment and follow-up visits) by South Asian men in high-income economy countries and while some men are testing regularly for sexual health illnesses, others are not testing at all as a result of lack of awareness of sexual healthcare services and poor health literacy[27][28]. It has been reported further, that even when healthcare services are available for immigrant populations, there is limited research to understand if and how new immigrants utilize sexual healthcare services in Canada, the location of the present research[29]. What is known is that South Asian men often feel they don't need to have sexual health diagnostics as they believe their sexual practices to be safe[30][31]. Other documented factors influencing access to sexual health services include cultural stigma, provider attitude, lack of information or misinformation about service availability, language barriers, time constraints, unavailability of viable transport options, and length of stay in a community[32][33][27][34]. For example, among men in Canada, misinformation relates to testing procedures for STI diagnosis, such that the assumption

is that Pap tests also test for all STIs, or that STI testing for men involves a painful urethral swab[35][36].

In addition, recent reports suggest that without adequate knowledge, South Asian men are not aware of the services available during sexual health illness[21][27]. Furthermore, the stigma of sexual health among men and women and confidentiality issues are additional concerns regarding utilizing sexual health services [26]. For example, in 2009, 27% of surveyed Toronto youth feared they would be judged or subjected to embarrassment if they accessed sexual health services[37]. Research in British Columbia also found that privacy concerns, inaccessible clinic hours, clinic décor, and perceived homophobia were barriers to testing for some young men and women[35]. Also, while many healthcare service provisions follow the high-income economy, Western country models of sexual healthcare service system, these services may not meet the healthcare needs of South Asian communities, such as, South Asian men or women do not want to follow the prescribed Western biomedicine or access healthcare services in general, since their lives are shaped by entirely different social and cultural norms[38]. In addition, the literature suggests that ethnocultural communities in Canada remain disproportionately affected by sexually transmitted and blood-borne infections[39]. For example, while being from an ethnocultural community in itself is not a risk factor for sexual illness, multiple factors shape individual experiences of health and illness, such as factors related to varying degrees of homophobia, social support networks, socioeconomic status, sex and gender, sexual orientation, gender identity, immigration, health beliefs and personal health practices[39]. Therefore, more attention is needed on resources or materials used to promote sexual health, particularly for South Asian men, all the while giving attention to understanding factors that can influence their access to and utilization of sexual health services in Ontario.

South Asian gender roles and sexual health

To begin this section, it is important to identify that in the literature sex refers to the biological state of being male or female, and gender is defined as the social and cultural norms, roles, attributes, and behaviours that a society considers appropriate for men and women or boys and girls[40]. However, other studies also argue that dichotomizing between sex and/or gender may

not always be particularly useful as they fail to reflect the diversity between different groups of women and men or open the possibility of examining different types of population groups[41]. In such context, the recognition of diversity in gender and health literature is exemplified in the growing flexible nature of the terms sex and gender, acknowledgement of the differences among women and men, and the recognition of gender as a social location and determinant of health[41]. Hence, gender, as a social and cultural construct, shapes relationships, behaviours, relative power and other traits that societies ascribe to men or women, and people of gender diversities[42][43]. As such, gender is an important variable when considering sexual health which ultimately influences health-seeking behaviour [44][45]. Gender is viewed as the central organizer of sexual behaviour that is also influenced by all other social and cultural factors. Therefore, sexual behaviour is viewed in light of gendered sexual scripts that vary historically across cultures[46][47][48][49]. In addition, gender often intersects with race, age and sexual orientation that may also influence how sexuality is expressed or experienced[50]. For example, studies provide evidence that South Asian new Canadian settlers living in high-income societies undergo the process of adaptation of host country cultures and traditions while trying to retain their patriarchal traditions[51][52][53]. While sexual orientation and gender identity expression often appear to be essential in social determinants of health, like heterosexual South Asian men, homosexual (e.g. LGBT) populations are also at higher risk for becoming infected with HIV and other sexually transmitted infections and have common sexual healthcare needs in Canada, including having difficulty in navigating or accessing health care and bad experiences with inadequately trained health professionals[54]. However, in literature reviews, it is quite often a formal effort to define a South Asian community on a confusing array of ethnic, linguistic as well as national markers[55]. But the term South Asian should not be used as a collective identifier especially considering the diversity of experiences captured under the term ‘South Asian’; it is important to be mindful of the social and spatial complexities embedded within South Asian communities[55]. In addition, South Asian communities differ in terms of cultural norms, values, health and behavioural practices[32]. For example, the patriarchal roles within certain South Asian communities, such as Nepalese communities, may have specific gender roles that influence Nepalese men’s overall sexual health decisions[56]. For example, various ethnic traditions (e.g. Dali, Terai, Chhetri/Brahmin, Janajati) and the religion of Nepalese men have a strong influence on male gender roles and sexual behaviour through cultural beliefs and

practices, such as the cultural scripts that impact their age at first sexual intercourse, marital status, lifestyle patterns and access to health information and services[57]. Likewise, other unique aspects of South Asian communities that shape their gender roles include their ethnic identity, religious status (e.g. South Asians vary in religious practices as Sikh, Hindu, Muslims, Buddhists), social cohesion, familial ties, regional and class-based group interactions[55]

The cultural scripts of South Asian gender roles are therefore unique, as other Canadian-born youths perceive sexual health differently[58]. In health research, it is important to recognize the diversity embedded within South Asian communities, as the Canadian census data include information about South Asian communities as a whole, but obscures the diversity among several South Asian groups [59]. Therefore, it is important to acknowledge that issues related to gender norms among different South Asian communities can vary and may further act as a primary force in constructing different beliefs and practices among South Asian men and women thereby influencing access to and utilization of healthcare services[60]. Consequently, it is important to explore if and how gender roles further influence access and utilization of sexual health services among South Asian immigrant men residing in Canada.

Cultural and psychological influences on sexual health

The cultural construction of honour and shame can be seen as an influential factor in shaping the overall understanding of sexual health amongst South Asian men[32]. Culture is defined as a “repertoire of socially transmitted and intergenerationally generated ideas about how to live and make judgements, both in general terms and in regards to specific domains of life”(p.208)[61]. Likewise, for South Asian men, culture is an important factor shaping the way men perceive sexual health and how they discuss these topics within the South Asian communities[62]. In addition, it has been reported that conflicts between the cultural and traditional values regarding sexual health within some South Asian communities remain. For example, those who break the silence and discuss HIV or STI and sexual health matters are often found to be socially excluded or have problems in maintaining societal relationships[32]. Studies also highlight that despite the desire to integrate, living in ethnic enclaves often isolates South Asians to the extent that they may not feel integrated within the sexual health service system[62][63]. Previous literature also

suggests that culture, ethnicity, and socioeconomic status affect South Asian men psychologically and emotionally, which may hinder accessing health services and resources[63]. In addition, poor patient-provider interactions and a perception that sexual health problems are not medical issues may also be reasons for not utilizing proper medical check-up services by the South Asian men[28]. For example, research suggests that men who reported negative prior experiences were less willing to openly disclose their sexual status to healthcare providers[33]. Therefore, both cultural and psychological factors may influence South Asian immigrant men's sexual health service use.

The aforementioned literature suggests that a lack of sexual health knowledge and education among some immigrant South Asian men, and a lack of support and uncertainty experienced in interactions with service providers may play a role in South Asian men's access and utilization of sexual health services, though this remains an understudied area of focus. Furthermore, while the South Asian population is growing, we know little about how to create services/promotional material that is responsive to contextual factors shaping service access and use. It is therefore important to learn more about the overall sexual health service experiences of South Asian men who identify as immigrants/newcomers to Canada. As a result, this study aimed to explore the contextual factors (e.g. cultural, psychological, social) influencing overall accessibility (actual and/or perceived) and utilization of sexual health services by South Asian men in Canada.

Methods

Study Context and Participant Selection

This study was conducted in Ontario, Canada, a region with increased migration of individuals from South and East Asian communities between May to July 2021[64][65][66]. Even though in Canada it is recommended that sexually active men and women should go for regular sexual health checkups, South Asian sexually active men between the age ranges of 20-45 years old have been cited in Canada to have high rates of STIs[67]. Hence, we selected South Asian men between the age ranges of 20-45 years for our interviews who have recently immigrated to Canada. According to Immigration, Refugees and Citizenship Canada (IRCC) an immigrant is any individual living in Canada who was born outside of Canada [68]. Participants were selected

as: (1) South Asian immigrant men living in Canada (2) South Asian immigrant men who are living in Canada for at least one year and currently residing in Ontario. In addition, the overall selection of users and non-users of the health care services in Ontario was also a part of our sample characteristics. Specifically, participants were also selected based on users of independent practice clinics (e.g. independent family doctor clinics, family health teams), community health centers, health facilities offered by any non-government organizations, and emergency rooms of a public/private hospital. We also interviewed participants who did not use sexual healthcare services. Men who had engaged with services were included as participants given that we wanted to understand their perspectives or experiences with barriers to care but also to identify the factors that enabled them to use services. This would allow us to not only identify barriers but also means to overcome these barriers and increase service uptake by men in Canada. In addition, it was important to include further categories to get a broader understanding of the participants who have not yet used sexual healthcare services after immigrating to Canada, to gain further insights on their perspectives about access to and utilization of sexual healthcare services. However, no discernable differences as they relate to the study aim were noted from the participant groups. Participants were recruited through ads on social media platforms, non-government websites, organization e-newsletters, poster distribution within several non-government organizations. Interested participants contacted the first author by email, and screening was conducted by email or telephone.

Data Collection and Analysis

In total, 18 semi-structured telephone interviews were conducted, and the interview guide was tailored to elicit insights related to access to and utilization of sexual health services. All potential participants had the opportunity to read the study information letter before consenting to participate in the interview process. Some of the key questions to our participants included practices or beliefs about sexual health issues in South Asian cultures; South Asian men's education (formal or otherwise) about sexual health, sexual practices, and related changes in beliefs about sexual health after coming to Canada; if participants have had experiences in Canada with programs, services or services providers related to sexual health issues; and concerning factor for men's sexual health and any recommendations or suggestions they had to

share about Canadian sexual health service system. Detailed field notes were made for each interview, and verbatim transcripts were coded by the research team. Interviews and discussions were facilitated by the first author, a South Asian male researcher, in English. Even though participants had the option to speak in their native language (i.e. Bangla, Hindi or Urdu and the South Asian male researcher spoke all three languages), all participants who did not have English as their native language, were fluent in spoken English, and all preferred conversing in the English language. Each participant transcript was de-identified and pseudonyms were provided to ensure the anonymity of the data obtained.

Our analytic approach was informed by interpretive description (ID)[69] which formed the foundation for data analysis in this qualitative research. ID is used for constructivist and naturalistic orientation of inquiry by adopting an inductive, constant-comparative approach to analyzing qualitative data [70][71]. As this methodology provides a structure for qualitative studies of clinical phenomena of interest for health professions, it, therefore, fits with our study aim. Since ID is relatively a new methodology in qualitative research [52], researchers using ID have a limited number of resources to turn to for further guidance regarding this methodology [52][54]. Therefore, to enact an ID that is potentially applicable in the practical science of the discipline, our research also made use of the Braun and Clarke (2006)[72] guidelines for thematic analysis.

The analytic process is characterized by a concurrent and responsive relationship between data collection and analysis through a constant comparative method[71]. We focused on broad questions to apprehend the overall picture of the research data through the overly-detailed line-by-line coding[70]. Reflective memos were used for reflexivity and to write down the researcher's perspectives on individual interviews. The adequate density of data was reached when no new significant data were emerging to deepen the understanding of the phenomenon[71][73]. Following Braun and Clarke's (2006) thematic summary guidelines[72], an analytic exercise guided the thematic statements relevant to the aim of our study that was marked, numbered, coded transcript in each interview, and then organized into conceptually relevant categories and coded using NVivo Pro software 12[55]. The categories were then checked for conceptual overlapping and the emerging themes. However, since thematic analysis

requires a considerable amount of freedom in analyzing data, the authors maintained relative flexibility and did not focus entirely on the prevalence of a theme, but rather on the meaningful information that related to the overall research[72][74].

Ethics

This study received ethics approval from the Office of Research Ethics (ORE), University of Waterloo, Ontario.

Results

We present our data highlighting the role of contextual factors influencing access to and utilization of sexual healthcare services by South Asian men. It is important to note that these factors, or domains, often overlapped, as illustrated in Figure 1. However, we parse them out here, and speak to the psychological factors (e.g. perceived severity of illness influencing access to care, sexual health is considered an optional service, sexual health is perceived negatively), the social factors (e.g. sex positivity or sex-negativity exist in the social sphere, discussing sexual health with social circle, sexual health is seen as a taboo topic, adapting to the lifestyle where sexual health discussions are more normalized rather than following South Asian norm as they relate to sexual health, and cultural factors (e.g. culture as it relates to the perception of healthcare, prescriptive gender stereotype as it influences overall access to sexual health services). For transparency, the sociodemographic characteristics of the participants including, age, country of origin, length of time in Ontario, geographic location in Ontario, education, occupation, and religion are presented in Table 1, and all participants except one were unmarried.

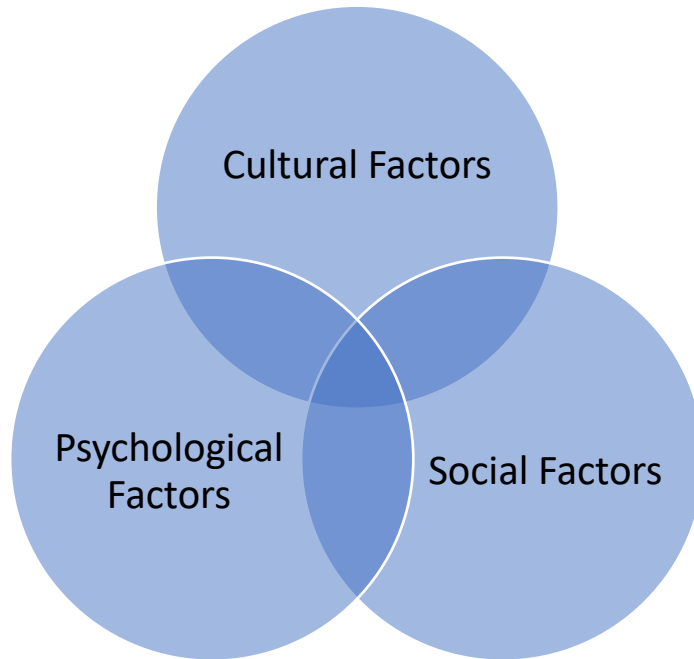


Figure 1. A proposed diagram representing the contextual factors influencing access to and utilization of healthcare services by South Asian men

Age in years (n)	Country of Origin (n)	Length of time in Ontario (n)	Geographic Location in Ontario (n)	Education Level (n)	Occupation (n)	Religion (n)
20-23 years (4) 24-25 years (5)	Bangladesh (5) India (4)	1-2 years (7) 3-4 years (2)	Waterloo (6) Downtown Toronto (2) Mississauga (1)	Undergraduate degree (7) Masters' degree (2)	Permanent full-time employment (6) Part-time employment (3)	Islam (5) Hindu (4)
30-35 years (4) 36-40 years (3) 42-43 years (2)	India (5) Pakistan (2) Nepal (2)	1-2 years (6) 3-4 years (3)	Downtown Toronto (6) East York (1) Hamilton (1) Cambridge (1)	Undergraduate degree (5) Masters' degree (4)	Self-employed (3) Permanent full-time employment (2) Part-time employment (4)	Islam (2) Hindu (7)

Table 1. Sociodemographic characteristics of all respondents

1. Psychological factors

1.1 Perceived severity of sexual illness

From our in-depth interviews, we found the characteristics or facets that influence an individual psychologically and/or socially and how they overlap in influencing access to and utilization of sexual healthcare services. We found that such factors can explain individual relations to their social environment and how these affect their overall healthcare decisions. For example, from our participants' perspectives, the *perceived severity of sexual illness* plays a role in their health-seeking decisions. Our participants mentioned that for South Asian men in general, if sexual illness hampered their daily activities, only then would they opt to seek out sexual health services. For instance, Umer, a 27-year-old from Pakistan who is unmarried and working in a full-time job in Ontario said,

“Yes. It depends on the severity of the [sexual] illness as well and the level of my tolerance, and if it’s something that can go away on its own then I think I wouldn’t bother [...] I think it’s sexually transmitted illnesses. I think that’s the most concerning thing for me because I think it’s very prevalent in the Canadian population.” – Umer

Rather, participants mentioned they would prefer to continue with their day-to-day life without any concern for their sexual health. Some did not visit any sexual health services for a long time as they felt it was not important. Ejaz, a 23-year-old unmarried and working in a part-time job from a Bangladeshi ethnic background, said that even though he is sexually active, it has been a long time since he has ever visited a sexual health service center for a weekly or monthly checkup, as he understands that if anything is bothering him on a day-to-day basis, then only he would seek for a doctor consultation, otherwise not.

“If it’s something that like, that is directly affecting my day to day, like working day to day processes and something that’s bothering me, definitely I will go to the [sexual health] services like at least like ask for the doctor’s advice on what to do. And if I have to pay and if it’s like hampering my day-to-day activities, I will take that service. But apart from that, I know that like a lot of local students over here, just go to the health services for like monthly, checkup or

weekly checkup, I wouldn't like to do that. And speaking from my point, I haven't been to like university, like sexual health services in like three years now that I've been here.” – Ejaz

These extracts illustrate that our young, unmarried South Asian participants see sexual health as not deemed to be an important service for their health and wellbeing. Moreover, men only prefer to go for sexual health services when the perceived severity of sexual illness crosses their tolerance threshold, otherwise, they may ignore these services in their everyday lives. These interpretations along with sample descriptions were further necessary to find their relevance to the overall study aim.

1.2 The general attitude towards sexual health

We found that *sexual health and health services are considered as optional services* by some of our unmarried South Asian participants. For example, some participants said South Asians, as a collective, would prefer to be discreet about sexual health or would not care to know about their sexual health status. Our participants also said some men would get screened for sexual illness once in a while. Furthermore, while sexual health was not a priority in everyday life, our participants also mentioned that it was rather considered as an optional service that is available and could be availed whenever there is a need. Some of our participants mentioned that the way South Asian men culturally have grown up, they do not feel a need to access sexual health services. As mentioned by our participants Ismail (20 years) and Farkul (23 years) as follows,

“Only if they [South Asian men] need to feel or if they're curious about sexual health. Yeah, I mean, you could but it's not like I do that. I don't really [access sexual health services]. Yeah. I don't do that. Just do it once in a while when you think you should [...] generally, no, you don't need them [sexual health services]. So it can be important sometimes. But it's largely a personal thing what you choose to do. And I guess going to the doctor for the right reasons, it's more of a tool, I would say.” – Ismail

“No, we don't really [go for sexual health checkup], it's not really, we don't use it that much. It is not very important to us [South Asian men]. We don't see it. We don't really have to go, only

when you need it. It's [sexual health service] not like, it's not like we have to use, it is not like something important to us [...] We don't see it, 'it's like a job'. We don't feel like something mandatory [about sexual health]. It [sexual health services] is there, but only when something goes wrong. That's how we look at it" – Fakrul

From our interviews, we can understand that some of our unmarried South Asian participants are reluctant to know about sexual health or access healthcare services as they consider it a needs-based service. Some of these participants although are users of the healthcare system perceive sexual health services as an optional service. In addition, we learned that for some South Asian men, sexual health is a personal thing and availing of services is a personal choice and they only visit sexual health services when there are some health complications. Looking across our data it was important to look for any necessary relevance to our study aim. Hence, it was interesting to learn from our data that our unmarried South Asian participants did not take their sexual health seriously in their everyday lives and made more personal choices regarding sexual health.

1.3 Sexual health is perceived negatively

According to our South Asian participants, there are negative impacts of seeking sexual healthcare services, particularly in terms of confidentiality amongst individuals within the South Asian communities. For example, we found that seeking information about *sexual health and sexuality could be perceived negatively* by some South Asian men. Our participants mentioned that some South Asian men would personally or generally think that learning about sexual health is a way of getting derailed from other important activities, such as focusing on academics. Also, men would not feel comfortable openly talking or discussing sexual health due to concerns of confidentiality. As explained by Ashraf, a 40-year-old man from Pakistan and living in Ontario for 2 years,

"[...] But then you have to go there [sexual health service] and talk to them [healthcare providers] in person. So, then they know you. So, you can get noticed in the [South Asian] community and by other [South Asian] men. So, one person who went to one organization for alcoholism and looking for someone to talk to. And the whole local community knew that this

person was an alcoholic. So, I don't know how it got out. So, a lot of people see sexual health topics in a negative way and that's the mentality. That's why it's not safe to tell somebody anything or what your [sexual health] problems are. So, I don't feel safe to say anybody or talk to somebody.” – Ashraf

In addition, we found that some participants felt there is limited sexual health knowledge shared within the South Asian communities. Participants said if there were more education opportunities, then prevention might be more of a focus rather than waiting to be symptomatic. For example, our participant Umer shared that South Asian men have limited access to sexual health education from an early part of their lives within the South Asian social circle, and the lack of access to information often shapes their overall negativity about sexual health and also in accessing and utilizing these services. This, Umer believed, is both cultural (e.g. how sex education is taught or not) and psychological factors, and it influences overall negativity about sexual health. He explained as follows,

“It makes me feel sad and a little bit deprived because I don't think I have the full picture [about sexual health information] because I think if I were taught about it in school, it would have helped me a lot. Instead, what I have is something that I just came across by chance online or on TV, just by chance. So, I don't think I have, like, all the information that I need. And I think that it's also made me a little bit scared about, um, about sexual intercourse. I don't know if those are misconceptions or not, but it's just made me a little bit more cautious. I think if I were to have had sexual education as a...as a kid growing up in school or access within the South Asian society, I think that would have helped in the sense that it would have made me more aware of all of the things surrounding sexual health and services and access to care, and just how I would have better all-round source of knowledge about it.” – Umer

Considering our study aim, from our in-depth interviews we learned that in terms of contextual factors there remains uncertainty about privacy and confidentiality among some South Asian men to discuss sexual health matters with a provider even when they have been living in Ontario for at least one year. Also, often culture and psychological factors may overlap for South Asian communities, for example, how sex education opportunities from an early stage of life and lack

of access to information may influence overall sexual health negatively by some South Asian men, which may influence access to and utilization of healthcare services. It was also interesting to note that this perception may often within South Asian communities intersect with social traditions as some men are more mindful of how other South Asian men will consider their presence in the society if they access sexual health services.

2. Social Factors

2.1 Sexual health as a taboo topic within the South Asian communities

Our participants mentioned that *sexual health is a taboo topic* within the South Asian communities. Our participants believed that sex is seen by many as tied to religion and so talking about it is seen as risky in terms of implying it is casual rather than tied to marriage. To elucidate, sex is seen as a ‘holy’ thing in South Asian society, which is unique in South Asian belief systems and these beliefs are often deeply ingrained in South Asian men and these thoughts are carried over time in Canada as they settle in the host country as immigrants. Hence, as mentioned by 21-year-old Prakash from India, beliefs about sex and sexual health are often left unspoken within families or communities. He further mentioned that discussing sexual health is strictly prohibited due to the customs and manners that some South Asian men are made to follow since birth. Prakash explained as follows,

“I would say it [sexual health] is a taboo, but people are kind of still I think they think that this is bad, and it shouldn’t be discussed with the children or grandchildren, or someone who is younger to them. They think it might create some, I think, sexual impulses into you. And it’s still kind of, I think, the majority of the time I observe that it depends on their belief system. You know, that’s what they’re thinking. So, some of the things you know what it is, kind of prohibited, you know, people look at it as something that’s kind of a bad thing [...] Yeah, because we all are deeply rooted to our belief system from back home, and the region where we were born, our customs and manners, you know, all these things. So, it won’t get changed, it will not get a change in a day, right? So, it takes time. It’s often carried over here in Canada. So, sexual health is seen as like one thing is like a holy thing, but also like it can be seen as an evil thing if it’s outside of marriage. And so, yeah, it’s not something people talk about generally like you, it’s

expected that you'd have kids and stuff, but there are only tell you about how and about like how to create away from stuff. It was kind of it was just like unspoken.” – Prakash

Therefore, sexual health taboos and discussion of sexual matters and the implications of beliefs on sexual health are significant in sexual health choices among some South Asian men.

2.2 Sex positivity and sex negativity exist in the social sphere

Furthermore, our participants highlighted the notions of *sex positivity* or *sex-negativity existing* within the South Asian social environment. Some of our participants mentioned the importance of sex positivity, related to having the right kind of sex education and learning about the various aspects of sexual wellbeing. It was suggested that sex positivity would allow South Asian men to make sexual health more of a general topic in South Asian communities, minimizing the stigma of sexual health, leading to greater respect for one's sexual health, and facilitating access to sexual health services. Further, it was suggested by our participants that South Asian men who are not quite *sex-positive*, (e.g. having sex education, or learning about sexuality, knowing how to access sexual healthcare services, etc.) remain uneducated and leading to risks of teenage pregnancy and STI rates resulting from the avoidance of condoms, for example. Participants also felt that being sex-positive would allow South Asian men to get sexual health checkups which is an essential part of their wellbeing. Furthermore, we learned from our participants that being sex-positive could be a way for the South Asian youth to openly discuss and share information about sexual health. Prakash further explained as follows,

“I think it's a good thing to be so much sex-positive, I would say some people are a little bit too enthusiastic about it. But umm, by being sex-positive, it can educate people about sex, and it can drop these walls and the barriers to speaking about it [sexual health topic]. By dropping the barriers people just learn more about it and they can find what's best for themselves. You can grow more as a person faster by being sex-positive. So, there are all those benefits to it. However, by being so sex-positive I say kind of takes the respect or reverence out of the idea of sex a little bit. But there still is like that respect, but not as much as it may seem [...] by not being sex-positive, people can be quite uneducated about sex and what comes of it as well. For that

reason, like bad things can happen to people who do have sex. They want, for example, children, they'll try to avoid using condoms. I mean, most children I mean, like teenagers will avoid using condoms just so that there's nothing the parents could see. But by doing so then they have the risk of pregnancy at a young age.” – Prakash

On the contrary, some of our participants described the existence of *sex-negativity* in South Asian social circles. Participants explained that some South Asians say they are sex-negative and think sexual health should not be a topic of discussion and said there was nothing important to learn about sexual health, but rather to put all learning efforts into being a better man (e.g. through good academic grades, developing life skills, etc.). One of our participants, 22-year-old Rahul from India mentioned that,

“I mean, some South Asian men are sex-negative and explain sex-negativity as, sexual health is not the only part you live for, or you also live for other stuff, your fun activities, your prosperity, your academics. So why do you put all your energy into that one thought [learning about sexual health or sexuality], one aspect, shouldn't be a priority. So that's something I see [some South Asians agree with]. But that's also kind of cultural stand [for some South Asians to think] that we shouldn't talk about this [sexual health], and we shouldn't get engaged into things but rather focus our energy on teen years, get better, get good [life] skills and be a better man and be a better person for the future.” – Rahul

These extracts above explained that sex-positivity and sex-negativity exist within the South Asian communities while there may be varied explanations for each term. However, considerations for sexual health discussions also stem from how sex education and learning about sexual wellbeing has made its way into the South Asian communities and whether men can understand these terms properly.

2.3 Sexual health discussion with trusted sources and following Western lifestyle approach

We further found that within the social dimensions our participants said they *discuss sexual health only with their trusted sources* (e.g. friends, family, or relatives). For example, our participants would only discuss sexual health with those with whom they can openly talk about

their sexual matters and can connect emotionally as well. Often it would depend on the age gap, as the usual perception is that people of similar age and from known circles would have a similar understanding in sharing and learning about sexual health. Our participant Ejaz explained below,

“Like talking to people about these, these [sexual health] topics? Yes, yeah. I usually talk about like this kind of stuff with my friends, but I prefer not to talk about these topics with like any of my family. I, like, if it’s a cousin or someone who is like my age or maybe like two or three years older, and I’m really close with them, I talk to them about this [sexual health] stuff and bond over this topic. But if they’re like very old, they’re like 10 or 15 years older, and I’m not, like, really close with them and I’m not comfortable sharing these ideas, then I don’t I don’t talk to them [older relatives] about it” – Ejaz

Furthermore, our participants highlighted that a South Asian family, would openly discuss sexual health if they are accustomed to *sharing sexual health information more openly by adapting to the lifestyle where sexual health discussions are more normalized (i.e. as participants said by being more ‘Canadian’)* and by being less conservative to discuss sexual health. Some participants, living in Canada for at least a year, have begun to get accustomed and more habituated to the norms and culture of the host country which make them follow less of their South Asian norms in their communities. For example, some South Asian participants personally perceived that within the Canadian society sexual health is a more normalized topic. However, discussing sexual health is still not proactively brought up by Canadian society. Our 23-year-old participant Fakrul shared his experience about discussing sexual health topics with his parents as,

“No, we’re quite ok, my parents or everybody quite open, quite ‘Canadianized’ [following a lifestyle that participants understand as relate to being open-minded in Canada] often when it comes to that [sexual health topic] kind of stuff. There’s no issues with that. You know we are more Canadian than South Asian and less conservative about sexual health discussions. But he [parent] always said that ‘you know, make sure you don’t do anything stupid’ [regarding sexual health]. That’s all he says [...] I think there are parents, and my parents are more open to allowing more different cultures in the house or the more, more allowing more freedom for us kids.” – Fakrul

Moreover, our participant Sayeed mentioned that the overall topic of sexual health is quite normalized in Canadian society, and it is assumed that a person would receive an adequate level of sexual health education. These views Sayeed believed, may also influence overall access to sexual healthcare services.

“Yeah, I think so. Yeah, yeah. I think the Canadian society almost, well, to some extent assumes especially, especially if you’re a male and you’re an adult, that whatever education you need to have, the level of understanding you need, you’ve already been equipped with. As a result, there’s not as much effort in educating you with it [sexual health information] once you’re an adult, I think [...] Sexual health is more normalized in a [Western lifestyle] Canadian society. However, people, it’s still, it’s still a difficult topic to talk about. Normalized, yes. Spoken about openly in society, yes. However, I don’t think at least, I came to Canada as an adult. It’s not something that’s brought up, proactively [...] Like the community I’m involved with here are all more or less people my age or Canadians, right. As a result in which they’re much more accepting of the ideas and they’re much more open to having that conversation, to begin with. This in itself shapes how we access and use sexual health services as well.” – Sayeed

However, even when there are Canadian families (i.e. who are South Asians but are adapting) who are open to discussing sexual health, there are South Asian cultural influences within the medical field regarding beliefs about sexual health. For example, as Ahmad mentioned, healthcare providers in Canada may still be ingrained with certain cultural beliefs about South Asians seeking sexual health services, which may overall impact health promotion and health provider roles within South Asian communities and beyond.

“I’m just guessing that, and I wouldn’t be surprised if this happened in [name of South Asian country], that, if I tell a doctor and while you’re at it, why are you giving me these tests and stuff? Could you get me tested for mono or could you give me a test for you know, chlamydia or whatever? And if I said that the doctor is gonna, ‘yeah of course,’ he’s gonna sign the test for me, but he’s going to smirk a little or he’s gonna, you know, somehow the situation is going to make it a little uncomfortable. Or if it does, I’m not going to be surprised. That’s also a part of

being sex-negative in the culture and the society. This sentiment often trickles down to South Asian providers here in Canada.” – Ahmad

These extracts illustrate that many unmarried South Asian men believed that following or getting accustomed and more habituated to the host country's social norms or traditions would allow them to deviate from their usual South Asian traditions and social values, which they felt is more conservative. Consequently, participants thought that adapting to the lifestyle where sexual health discussions are more normalized rather than following South Asian conservative norms would allow participants to freely talk about sexual health. Hence, these findings are relevant to the overall study aim as we also learned that some healthcare providers remain ingrained with cultural beliefs that may impact health promotion and provider roles within the South Asian communities.

3. Cultural factors

3.1 Culture shapes the overall perceptions about sexual health

All participants in our in-depth interviews mentioned that *culture shapes overall perceptions* about sexual health and wellbeing. Our participants believe that South Asian culture may influence perceptions and emotions/psychology from an early age which eventually shapes their various aspects of life, including sexual health and wellbeing and perceptions about overall healthcare needs (e.g. how to value health in general or access to health services). For example, 23-year-old Rafid from Bangladesh gave an example of his particular Bangladeshi culture that can influence sexual health perceptions in certain ways, such as, how people would discuss or seek health information, and that the patterns of how people perceive or discuss sexual health would be quite similar. He explained as follows,

“I mean, it [culture] does influence [sexual health] a lot because you have other members from that [same South Asian Bangladeshi] culture, even both here [in Canada] and back there [home country]. Back home, we have other members of that [same] culture who would kind of know about, like what kind of [sexual health] information you're trying to seek [STI prevention, diagnosis, or treatment] or what information you were trying to teach your own family. So

regarding that, yeah. So that [our Bangladeshi culture] would influence how we seek particular sexual health information and what not [here in Canada]” – Rapid

We also learned from 21-year-old Ahmad from Bangladesh that culture often formed the foundation for how sexual health would be perceived in a particular South Asian society, and although a person may travel to a new host country, some cultural values and norms may remain with immigrants which form the basis of their perceptions about topics like sexual health.

Ahmad said,

“Your culture forms like a basis [of sexual health perceptions] and sexual health needs and gives you the very root of your ideals or your beliefs or how you handle or feel about things like [sexual health]. And, when you come to a new country [like Canada], no matter how much we let go of things like that or how much you adopt a culture [Canadian culture], there are certain things that you can't get rid of, from your head. And, you know, if someone has grown up in the extremes of their culture.” – Ahmad

From our interviews, we learned that culture forms the basis of choices men make about sexual health and wellbeing. Cultural implications may move beyond the geographic factors and continue to dominate and shape men’s overall individual perceptions about sexual health, as well as their health-seeking behaviours, especially when South Asian men immigrate to a host country like Canada. Hence, considering access to and utilization of sexual healthcare, such perceptions that stem from culture are more related to individual factors rather than health system-level barriers and may impact the utilization of sexual health services. It is therefore important to address these aspects of cultural dominance to ensure improved access to and utilization of healthcare services within the South Asian communities.

3.2 Prescriptive gender stereotypes about sexual health

Participants also mentioned the *prescriptive gender stereotypes* shaping how South Asian men should learn or explore sexual health in South Asian culture. For example, it was suggested that South Asian men who are reluctant to use services are ingrained with certain cultural views and

related gender stereotypes. Participants further mentioned that men could also be judged by others from their own culture or living in the same South Asian communities, as familiarity within the communities can influence how people interact with the healthcare provider (e.g. if they are South Asian) and whether they would access the clinic for sexual health issues. The extract from Rishi below demonstrates how gender stereotypes play an integral role for both South Asian men and women in accessing sexual health services.

“Yeah, I think there is going to be [South Asian] men and women who are reluctant to use [sexual] health clinics or feel uncomfortable or insecure doing it. You know, it might be just from their culture or the views that know they've possibly been ingrained with. And then there could also be, like I mentioned before, like the idea that, you know, you could be going to a clinic, and you see somebody or, you know, the clinic is located near something else and you're, you know, uncomfortable going because somebody may see you there. So there's always that [...] Well, I think you would feel maybe that someone [from the South Asian community] will have a certain view about you if you're in a sexual health clinic. Yeah, like they're going to say and I'm not talking about somebody potentially also being there as well, which is one, but also somebody let's say, you know, someone sees you walking out of the [sexual health] clinic or going into one. You know, one of the factors of it I don't want to say just the South Asian thing, but it's a common thing is that, you know, people talk and, you know, someone sees you and they tell somebody in your family or whatever. There are some prescriptive gender stereotypes about sexual health in our society. And then all these words spread about, you know, this person going into this [sexual health service] clinic or whatever in the South Asian community, that people will be stereotyped as not worthy [as a man in the society]. Yeah, culture can play a big part in not letting people access these [sexual health] services.” – Rishi

In addition, some participants mentioned that prescriptive gender stereotypes about South Asian men were also related to how other South Asians would view men accessing sexual healthcare services. For example, our participants mentioned that some South Asian men are said to be stereotyped as not worthy of being a man (i.e. not quite manly in their behaviours) in the South Asian society if they were accessing or seeking sexual health services in their communities.

“So that [South Asian] person will be judged and there's going to be a cultural stigma attached to it and that person is going to be thought of as you know, less, less worthy [as a man in the society] and less, you know, responsible and trustworthy, if they access [sexual health] services. Less trustworthy as well. So in that sense, you can say eventually culture affect these men in being gender-stereotyped.” – Umer

From these interviews, we have learned that the social scripts on gender roles play an important part in accessing and utilizing sexual healthcare services within the South Asian communities. It was critical to learn that prescriptive gender stereotypes may hinder access to healthcare for some South Asian men.

Discussion

This study explored the contextual factors (e.g. cultural, psychological, social) influencing access to and utilization of sexual health services by South Asian men in Canada. Our study findings reinforce existing literature regarding the role of overlapping contextual factors, like cultural, social, and psychological, in influencing the access to and utilization of sexual healthcare services by South Asian men. As has been reported previously, perceptions towards sexual health are shaped by various cultural, social, educational, and psychosocial factors and behaviours for men[75].

In 1984 Canada passed the Canada Health Act which stated the “primary objective of Canadian Health Policy is to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers,” and as a nation, Canada has been committed to both health promotion and protection[76]. However, although the primary healthcare structure in Canada caters through the universal health care program, there are under-served populations that continue to experience considerable barriers in access to health services in Canada including, Aboriginal people, people who do not speak either of Canada’s official languages, people with alternate sexual orientation, immigrants, refugees, ethnically or racially diverse populations[76] Likewise, a survey with sexually active youth populations found that 13% visit family physicians, while only 6% youth

visit sexual healthcare services. It was also reported that 33% of these youth surveyed were immigrants and 85% among which have self-identified as racialized youth[37] While perceived severity of sexual illness plays an important role in health-seeking behaviour, men in our study often do not want to access services and they view it personally as a needs-based service and perceive it negatively, rather than as a preventative service. Our findings were consistent with other studies and male sexual health service users were found to be less compliant with STI treatments and they only access services when they needed it, although the continuity of care remains an important aspect to consider in preventative care[77][78][79]. Likewise, literature has noted that male users perceived that the severity of sexual health illness acts as a threshold for service use. For example, male users only decide to seek care when their illness suffering is beyond their perceived threshold of tolerance[78]. It is also interesting to note that the perceived severity of illness may also express a sense of masculinized stigma, where men often would consider their sexual illness as not important to change their health-seeking behaviour until it hinders their daily living. Such individualistic ideology denotes that some South Asian men may knowingly or unknowingly exercise their patriarchal or masculine views on sexual health illness. In addition, studies have found that socially constructed masculine practice may also provide a way for men to deny and avoid their fears about STIs and other sexual health complications[80]. Furthermore, this is reflective from studies where men often feel the pressure to avoid emotional expression, hide their weaknesses and vulnerability, and try to solve problems without requesting help from others, thereby not exercising proper health-seeking behaviour[81].

Besides, we found that poor use of preventative services might relate to sexual health taboos, sex-negativity in the social sphere, and concerns about confidentiality, whereby sexual health discussions are reserved for trusted sources among our mostly unmarried participants. We found similarities from the literature that South Asian men have many personal taboos around the discussion of sexual behaviour, while linguistic matters, cultural issues, and stigma construct the overall healthcare utilization by South Asian communities [82]. However, we did not find linguistic matters to be one of the barriers in accessing healthcare services by our participants which may be related to the time our participants have spent in Canada, allowing them to adapt to the Canadian linguistic system and overcome any possible language barriers. As there is a lack of availability of disaggregated data on South Asian communities, it is a challenge to identify

major health concerns evident across South Asian communities with respect to specific demographic characteristics[59]. This in turn provides additional challenges to identify potential strategies and the effectiveness of strategies to target health concerns[59]. Therefore, it is important to focus on building knowledge networks in the context of South Asian health.

While these aforementioned factors are more individualistic than systemic, they do require considerable attention to expand community-based interventions on sexual health, to provide relevant, inclusive, and appropriate programs aimed at improving sexual health outcomes. Hence, several organization reports have recommended focusing on expanding community outreach programs including agency funding and de-centralize sexual health services from downtown areas and more into diverse communities. In addition, it has been reported that men and women from under-served communities in Ontario are less willing to access healthcare elsewhere, while systemic exclusion barriers (e.g. racism, homophobia, sexism) within service organizations need to be identified and addressed[37]. Hence, concerted efforts are needed to create a robust community health promotion program that caters to under-served and culturally and ethnically diverse communities. Furthermore, a setting-based approach could be adopted for outreach and communication particularly for South Asian communities in locations where South Asians normally gather. For instance, faith-based settings and faith-based leaders could be approached to carry out the dissemination of knowledge through outreach and communication methods[59]. Therefore, rather than focusing on clinical interventions alone, it is more appropriate to focus on expanding existing health promotion initiatives that include: harm reduction strategies; culturally appropriate, gender-affirming sexual health information; eliminating barriers that impede timely access to clinical interventions; strengthening interventions that retain and re-engage people to continuity of sexual healthcare; to normalize the offer of sexually transmitted and blood-borne infections (STBBIs) testing among patients from diverse communities and confidentiality is respected[22].

Messages in popular media regarding the value of sex positivity for sexuality education, prevention of childhood sexual abuse, and improved marriages[83], was echoed by some participants who suggested that greater sex-positivity in the South Asian communities would be beneficial for sexual health. Indeed, in many research settings, it has been found that sex-

positivity advocates for continuous, age-appropriate learning and access to comprehensive sexual healthcare and treatments[84]. On a contrary, the concept of sex-negativity was also present across our data. It is said that sex negativity within a society is a problematic and risky behaviour[83]. Furthermore, studies have found that sex negativity holds the idea of controlling sexuality through limiting sexual education, healthcare services, and promotes shame and guilt in those who exercise personal autonomy[83][84]. Therefore, the data suggest that improved access to and use of services might come from increased access to age-appropriate sexual health education opportunities to foster sex-positivity.

It is important to note that in recent years literature has put the spotlight on structural and individual changes needed in sexual health learning. For example, one of the best practices and success of comprehensive sex education lies in its ability to balance structural change with individual change goals, as the access and ability to apply skills and adapt new behaviours as an individual can be enabled or constrained by structural factors(e.g. socio-political, historical or economic forces)[24]. Therefore, community empowerment through educational efforts should be tailored based on gender or sex as public health experts also mentioned that sexual health service utilization should be more focused on the needs of male patients, and also to inform their friends, families, and communities of the importance of male sexual health services[85][86]. This initiative can be achieved by setting the initial foundations for sex education through health education and promotion programs in local health clinics within the South Asian communities. In addition, it is recommended to work with local leaders for any sexual health interventions in diverse community settings [87]; as the literature suggests South Asian men are more willing to seek health information from family, friends, and from other sources rather than seeking sexual health information from the formal healthcare provider[11].

It was interesting to learn from our majority of unmarried participants that sexual health information was shared more openly when many individual South Asians chose to follow high-income economy society lifestyle trends and by being less conservative and proactively speaking and discussing sexual health with their family and others. Although our data did not specifically represent whether the marital status has any implications to such mindset, we still believe there could be some relevance due to our participants' time here in Canada that may act as a facilitator

for this kind of adoption of liberal views on sexuality or about sexual health. Literature suggests that adaptation to the cultural norms of high-income economy host countries may often allow better choice in accessing preventive care or discussing health information for South Asians[28]. Besides, it is reported that one-in-five is a foreign-born in Canada, while globally Canada holds the status of a multicultural nation[88]. Therefore, in Canada, sexual health is discussed more openly as an overall component of health and wellbeing[29]. However, although much progress has been made in recognizing the importance of culture and ethnicity in sexual behaviours, the role of the broader social context of culture and specifically the mechanisms through which culture impacts other variables remains to be fully elucidated. Hence, studies suggest the delivery of sexual health services and education in Canada requires a thorough understanding of how culture and ethnicity interact with sexuality and sexual health, particularly for culturally diverse communities, as they comprise 19.1% of the Canadian population [89]. Hence, although age-appropriate sexual health information provisions are available in the Ontario healthcare system[19], there should be more collaborative community and health service efforts to make provisions for age-appropriate sex education especially for adult immigrants, as this population group continue to have gaps in sexual health knowledge and sexual literacy after they immigrate to Canada[29].

Lastly, although it is important to acknowledge the sensitive nature of sexual health as a taboo topic, sex positivity, sex-negativity, and prescriptive gender roles, these findings are not specific to South Asian communities. These are barriers worthy of more attention to considering culture in the promotion or delivery of services more broadly here in Canada. Otherwise, it would be challenging to see rates of sexual healthcare service use increase for South Asian population groups. As we learned from our findings, culture has an overall influence in shaping perceptions about sexual health and that there is a cultural influence on overall access to sexual healthcare services. Our findings are similar to other studies highlighting that despite variability within and between countries in South Asia, similarities of family values, cultural perceptions, communication, religion and health beliefs contribute to challenges in accessing healthcare services in high-income countries[90][91]. Besides, we learned about cultural stigma and cultural shame regarding sexual health that exist within some of our participants, which give us the impression of a more individualistic viewpoint on sexual health rather than a health system issue.

We also found prescriptive gender stereotypes about men regarding sexual health in South Asian culture that often influence sexual health-seeking behaviour for men.

Literature suggests that cultures often can be characterized as individualistic versus collectivistic, or independent versus interdependent, based on the degrees to which individuals versus relationships are emphasized, respectively[92]. Consequently, it is reported that cultural values and gender stereotypes often align, where gender stereotypes are not universal but are said to be moderated by culture[92]. Besides, the literature also mentioned that community healthcare service centres might prove unpopular if clients encounter the risk of meeting with peers from the same communities[93]. Therefore, it is important to aim to improve individual health-seeking behaviours of South Asian men by addressing the challenges of prescriptive gender norms within South Asian communities, establishing communication session groups within South Asian communities that would facilitate dialogue around sensitive sexual health topics to reduce individual stigma and then promote behaviour change. Further, it is important to ensure more equal gender roles by strengthening culturally appropriate health initiatives (e.g. improving health promotional messages within the sexual health seminar series for South Asian communities). Conversely, health initiatives that fail to take these individualistic and collective gender perspectives into account not only risk a failure of healthcare service, they also risk perpetuating the harmful stereotypes which are negative determinants of health for men. Further, it is equally important to acknowledge the inequities faced by marginalized groups of men, for example, men from different cultural backgrounds may face similar inequities in healthcare services like women[94]. Hence, it is further recommended for having drop-in spaces for sexual health information sharing for male users in Ontario, which can be done in a more informal and non-judgemental environment, especially for South Asian community men.

Limitations

One of the limitations of our study is that our sample was quite heterogeneous with regard to age, ethnicity, and religion. Furthermore, sexual orientation, gender identity and other factors may also pose greater challenges in sexual healthcare use that would require further investigation in future studies. With a limited sample size, we may also have missed the opportunity to learn

more about the enabling or predisposing factors related to access and utilization of sexual healthcare services. In addition, since our methodology's distinctiveness lies in its practice orientation for interventionist health disciplines, the challenge lies within the term 'interpretive description.' As we have tried to create thick inductive reasoning with our constructed logic throughout our analysis, there may have been instances when we have missed some of the nuances amidst the population because of the interpretive approach that we have taken for our data analysis. Furthermore, the overall process of telephone interviews may lead to social desirability bias, while it was also beyond the scope of our research to explore the perceptions of healthcare providers who may have varied viewpoints about sexual health accessibility and utilization by men in Canada.

Conclusion

It is important to recognize the various individual, social and/or health systems perspectives together with the overall cultural influences in access to and utilization of healthcare services. Our data suggest that more robust efforts (e.g. through sex education, introducing seminar courses in higher education, and/or regular sexual health promotion in the South Asian communities) may begin to address and minimize sexual health illness taboo and adapt approaches to existing sexual health education that takes culture into consideration. Furthermore, it is essential to promote awareness of the importance of early access to sexual health information and services through appropriate community forums. This would help to destigmatize South Asian male sexuality from an early age, while behaviour change interventions such as abstinence, and regular health checkups should be emphasized.

Our study provides a unique understanding regarding the various contextual factors shaping sexual health service use while recognizing the cultural determinants of sexual health seeking behaviour.

References

- [1] Nilaweera I, Doran F, Fisher J. Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income

- countries: A systematic review of the evidence. *J Affect Disord* 2014;166:213–26. <https://doi.org/10.1016/j.jad.2014.05.021>.
- [2] Islam F, Khanlou N, Tamim H. South Asian populations in Canada: Migration and mental health. *BMC Psychiatry* 2014;14:1–13. <https://doi.org/10.1186/1471-244X-14-154>.
- [3] Hamadeh N, Rompaey C Van, Metreau E. New World Bank country classifications by income level: 2021-2022 n.d. <https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2021-2022> (accessed December 26, 2021).
- [4] United Nations Population Fund. Migration. United Nations Popul Fund 2015. <http://www.unfpa.org/migration>.
- [5] Statistics Canada. Immigration and Ethnocultural Diversity in Canada. National Household Survey, 2011. vol. 99-010-X20. 2013. <https://doi.org/99-010-X2011001>.
- [6] Statistics Canada. Canada Year Book 2011. 2011.
- [7] Degni F, Suominen S, Essén B, El Ansari W, Vehviläinen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. *J Immigr Minor Heal* 2012;14:330–43. <https://doi.org/10.1007/s10903-011-9465-6>.
- [8] Doll LS, Beeker C. Male bisexual behavior and HIV risk in the United States: synthesis of research with implications for behavioral interventions. *AIDS Educ Prev* 1996.
- [9] Hahm HC, Song IH, Ozonoff A, Sassani JC. HIV Testing Among Sexually Experienced Asian and Pacific Islander Young Women. Association With Routine Gynecologic Care. *Women's Heal Issues* 2009;19:279–88. <https://doi.org/10.1016/j.whi.2009.05.001>.
- [10] Salehi R, Hynie M, Flicker S. Factors associated with access to sexual health services among teens in Toronto: Does immigration matter? *J Immigr Minor Heal* 2014;16. <https://doi.org/10.1007/s10903-013-9961-y>.
- [11] Willcox A, Gleeson J. Boys, young men and teenage pregnancies. *Prim Heal Care* 2003. <https://doi.org/10.7748/phc2003.10.13.8.27.c456>.
- [12] Ottawa Public Health. Sexually Transmitted Infections and Sexual Health in Ottawa 2011. *Ottawa Public Heal* 2011:1–48.
- [13] Smith AL. Health Policy and the Coloring of an American Male Crisis: A Perspective on Community-Based Health Services. *Am J Public Health* 2003. <https://doi.org/10.2105/AJPH.93.5.749>.
- [14] Jayaraman G, Totten S, Perrin M, Fang L, Remes O. Report on Sexually Transmitted Infections in Canada: 2008. 2008.

- [15] Manderson L, Allotey P. Storytelling, Marginality, and Community in Australia: How Immigrants Position Their Difference in Health Care Settings. *Med Anthropol Cross Cult Stud Heal Illn* 2003;22:1–21. <https://doi.org/10.1080/01459740306767>.
- [16] Hancock J. Can mainstream services learn from male only sexual health pilot projects? *Sex Transm Infect* 2004;80:484–7. <https://doi.org/10.1136/sti.2004.011304>.
- [17] Aggleton P, Campbell C. Working with young people - Towards an agenda for sexual health. *Sex Relatsh Ther* 2000. <https://doi.org/10.1080/14681990050109863>.
- [18] Zhou YR. ‘Race’ and HIV vulnerability in a transnational context: the case of Chinese immigrants to Canada. *Cult Heal Sex* 2017;19:695–708. <https://doi.org/10.1080/13691058.2016.1192221>.
- [19] Government of Ontario: Sexual Health Clinics - How to get free sexual health testing, counselling and treatment services. n.d. <https://www.ontario.ca/page/sexual-health-clinics#section-0> (accessed December 16, 2021).
- [20] Government of Canada. Sexual Health and Promotion n.d.
- [21] Government of Canada. STBBI Prevention Guide n.d.
- [22] The Public Health Agency of Canada. A Pan-Canadian Framework for Action : Reducing the Health Impact of Sexually Transmitted and Blood-Borne Infections in Canada by 2030. 2018:25.
- [23] Public Health Agency of Canada. Canadian Guidelines for Sexual Health Education (Archived). 2009.
- [24] Kennell S. Action Canada for Sexual Health & Rights 2018:18.
- [25] Government of Canada PHA of C. Report on sexually transmitted infections in Canada: 2008 2010:2013–4.
- [26] Boyce W, Doherty M, Fortin C, MacKinnon D. Canadian Youth , Sexual Health and HIV / AIDS Study Canadian Youth , Sexual Health and HIV / AIDS Study. 2003.
- [27] Ramanathan V, Sitharthan G, Pepper K, Wylie K. Sexual health of Indian immigrant men in Australia: An exploratory research on help-seeking attitudes. *Sex Health* 2013;10:380–1. <https://doi.org/10.1071/SH12199>.
- [28] Sawleshwarkar S, Kakar SR, Jones R, Lagios K, Mindel A, Hillman RJ. Indian-born patients attending a sexual health clinic in Australia have differing characteristics to their Australian-born counterparts. *Intern Med J* 2013;43:1327–30. <https://doi.org/10.1111/imj.12299>.
- [29] Maticka-Tyndale E, Shirpak KR, Chinichian M. Providing for the sexual health needs of

- Canadian immigrants: The experience of immigrants from Iran. *Can J Public Heal* 2007;98:183–6. <https://doi.org/10.1007/bf03403709>.
- [30] Neville S, Adams J, Researcher S. Views about HIV / STI and health promotion among gay and bisexual Chinese and South Asian men living in Auckland , New Zealand 2016;1:1–10.
- [31] Kang E, Rapkin BD, Springer C, Kim JH. The “Demon Plague” and Access to Care among Asian Undocumented Immigrants Living with HIV Disease in New York City. *J Immigr Health* 2003;5:49–58.
- [32] Zhou YR, Majumdar B, Vattikonda N. Culture, but more than culture: an exploratory study of the HIV vulnerability of Indian immigrants in Canada. *Cult Heal Sex* 2016;18:1067–80. <https://doi.org/10.1080/13691058.2016.1162328>.
- [33] Donnelly LR, Bailey L, Jessani A, Postnikoff J, Kerston P, Brondani M. Stigma Experiences in Marginalized People Living With HIV Seeking Health Services and Resources in Canada. *J Assoc Nurses AIDS Care* 2016;27:768–83. <https://doi.org/10.1016/j.jana.2016.07.003>.
- [34] Sudhinaraset M, Ling I, To TM, Melo J, Quach T. Dreams deferred: Contextualizing the health and psychosocial needs of undocumented Asian and Pacific Islander young adults in Northern California. *Soc Sci Med* 2017;184:144–52. <https://doi.org/10.1016/j.socscimed.2017.05.024>.
- [35] Shoveller J, Johnson J, Rosenberg M, Greaves L, Patrick DM, Oliffe JL, et al. Youth’s experiences with STI testing in four communities in British Columbia, Canada. *Sex Transm Infect* 2009. <https://doi.org/10.1136/sti.2008.035568>.
- [36] Shoveller JA, Knight R, Johnson J, Oliffe JL, Goldenberg S. Not the swab!’ Young men’s experiences with STI testing. *Sociol Heal Illn* 2010;32:57–73. <https://doi.org/10.1111/j.1467-9566.2009.01222.x>.
- [37] Flicker S, Flynn S, Larkin J, Travers R, Guta A, Pole J, et al. *Sexpress: The Toronto Teen Survey Report*. 2009.
- [38] Weston HJ. Public honour, private shame and HIV: Issues affecting sexual health service delivery in London’s South Asian communities. *Heal. Place*, 2003. [https://doi.org/10.1016/S1353-8292\(03\)00002-9](https://doi.org/10.1016/S1353-8292(03)00002-9).
- [39] Public Health Agency of Canada. *At a glance: Prevention of sexually transmitted and blood borne infections among ethnocultural communities* 2015:1–27.
- [40] *Gender and Health: World Health Organization* n.d. https://www.who.int/health-topics/gender#tab=tab_1 (accessed December 16, 2021).

- [41] Hankivsky O. Women's health, men's health, and gender and health: Implications of intersectionality. *Soc Sci Med* 2012;74:1712–20. <https://doi.org/10.1016/j.socscimed.2011.11.029>.
- [42] Johnson JL, Greaves L, Repta R. Better science with sex and gender: Facilitating the use of a sex and gender-based analysis in health research. *Int J Equity Health* 2009. <https://doi.org/10.1186/1475-9276-8-14>.
- [43] Clow B, Haworth-Broackman M, Bernier J. Rising to the Challenge: Sex- and gender-based analysis for health planning, policy and research in Canada. *Rising to Chall Sex-Gender-based Anal Heal Planning, Policy Res Canada* 2009.
- [44] Ross S. Gender mainstreaming in health. *Gend Med* 2006;3:S22. [https://doi.org/10.1016/s1550-8579\(06\)80026-4](https://doi.org/10.1016/s1550-8579(06)80026-4).
- [45] Barker G, Ricardo C, Nascimento M. Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. *World Heal Organ* 2007.
- [46] Wood W, Eagly AH. A cross-cultural analysis of the behavior of women and men: Implications for the origins of sex differences. *Psychol Bull* 2002. <https://doi.org/10.1037/0033-2909.128.5.699>.
- [47] Baldwin JD, Baldwin JI. Gender differences in sexual interest. *Arch Sex Behav* 1997. <https://doi.org/10.1023/A:1024510528405>.
- [48] Public Health Agency of Canada. Report on the State of Public Health in Canada 2013 2013.
- [49] Health Canada. Canadian Guidelines for Sexual Health Education. *Methodology* 2003. <https://doi.org/10.1037/e611812012-001>.
- [50] Baber KM. Women's Sexualities. In: Biaggio M, Hersen M, editors. *Issues Psychol. Women*, Boston, MA: Springer US; 2002, p. 145–71. https://doi.org/10.1007/0-306-47185-X_8.
- [51] Heinemann J, Atallah S, Rosenbaum T. The Impact of Culture and Ethnicity on Sexuality and Sexual Function. *Curr Sex Heal Reports* 2016;8:144–50. <https://doi.org/10.1007/s11930-016-0088-8>.
- [52] Khan SI, Hudson-Rodd N, Siggers S, Bhuiyan MI, Bhuiya A, Karim SA, et al. Phallus, performance and power: Crisis of masculinity. *Sex Relatsh Ther* 2008. <https://doi.org/10.1080/14681990701790635>.
- [53] Lo SST, Kok WM. Sexual behavior and symptoms among reproductive age chinese women in Hong Kong. *J Sex Med* 2014. <https://doi.org/10.1111/jsm.12508>.

- [54] Ontario HIV Treatment Network. Facilitators and barriers to health care for lesbian, gay and bisexual (LGB) people 2014:1–6.
- [55] Walton-roberts M. South Asian Diasporas in Canada 2013;5:1–5. <https://doi.org/10.1080/19438192.2013.726420>.This.
- [56] Dahal GP, Hennink M, Hinde A. Risky sexual behaviour among young men in Nepal. 2005.
- [57] Nag M. Sexual behaviour in India with risk of HIV/AIDS transmission. *Heal Transit Rev* 1995;5:293–305.
- [58] Boyce W, Doherty-Poirier M, MacKinnon D, Fortin C, al et. Sexual Health of Canadian Youth: Findings from the Canadian Youth, Sexual Health and HIV/AIDS Study. *Can J Hum Sex* 2006;15:59–68.
- [59] Islam T, Selvaratnam I, Shan N. “ Building an Effective South Asian Health Strategy in Ontario ” 2013.
- [60] Blackwood E. Culture and women’s sexualities. *J Soc Issues* 2000. <https://doi.org/10.1111/0022-4537.00162>.
- [61] Patterson O. Taking Culture Seriously: A Framework and an Afro-American Illustration. In: Harrison LE, Huntington SP, editors. *Cult. Matters How Values Shape Hum. Prog.*, New York: Basic Books; 2001, p. 202–18.
- [62] Vlassoff C, Ali F. HIV-related stigma among South Asians in Toronto. *Ethn Heal* 2011;16:25–42. <https://doi.org/10.1080/13557858.2010.523456>.
- [63] Jahangir YT, Meyer SB. Understanding Access to and Utilisation of Sexual Health Services by South Asian Immigrant Men in Western Countries: A Scoping Review. *J Immigr Minor Heal* 2020. <https://doi.org/10.1007/s10903-020-00981-z>.
- [64] Statistics Canada. 2016 Census of Population. Dly Compon Stat Canada Cat No 11-001-X 2017.
- [65] Statistics Canada. Immigration and ethnocultural diversity: Key results from the 2016 Census. Dly 2017. <https://doi.org/11-001-X>.
- [66] The Regional Municipality of Durham Information Report: Commissioner of Planning and Economic Development. 2018. <https://doi.org/.1037//0033-2909.I26.1.78>.
- [67] BC Centre for Disease Control and Prevention. STI in British Columbia: Annual Surveillance Report 2016:24–37.
- [68] Women in Canada: A Gender-based Statistical Report, 5th Edition. Statistics Canda; Catalogue No. 89-503-XIE; 2005.

- [69] Thorne S, Kirkham SR, MacDonald-Emes J. Interpretive Description: A Noncategorical Qualitative Alternative for Developing Nursing Knowledge. *Res Nurs Heal* 1997;20:169–77. [https://doi.org/10.1002/\(SICI\)1098-240X\(199704\)20:2<169::AID-NUR9>3.0.CO;2-I](https://doi.org/10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I).
- [70] Thorne S. Interpretive description. 2013. <https://doi.org/10.4324/9780203409527>.
- [71] Hunt MR. Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qual Health Res* 2009;19:1284–92. <https://doi.org/10.1177/1049732309344612>.
- [72] Braun V, Clarke V. Qualitative Research in Psychology Using thematic analysis in psychology Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- [73] Carnevale FA. Authentic qualitative research and the quest for methodological rigour. *Can J Nurs Res = Rev Can Rech En Sci Infirm* 2002;34:121–8.
- [74] Sandelowski M, Barroso J. Finding the findings in qualitative studies. *J Nurs Scholarsh* 2002;34:213–9. <https://doi.org/10.1111/j.1547-5069.2002.00213.x>.
- [75] Tamang L, Raynes-Greenow C, McGeechan K, Black KI. Knowledge, experience, and utilisation of sexual and reproductive health services amongst Nepalese youth living in the Kathmandu Valley. *Sex Reprod Healthc* 2017. <https://doi.org/10.1016/j.srhc.2016.09.002>.
- [76] Canada. Health Canada., Bowen S. “Certain circumstances”: Issues in equity in and responsiveness of the health care in Canada [a collection of papers and reports prepared for Health Canada.]. 2001.
- [77] Gill JM, Mainous AG 3rd. The role of provider continuity in preventing hospitalizations. *Arch Fam Med* 1998;7:352–7. <https://doi.org/10.1001/archfami.7.4.352>.
- [78] Furber AS, Newell JN, Lubben MM. A systematic review of current knowledge of HIV epidemiology and of sexual behaviour in Nepal. *Trop Med Int Heal* 2002. <https://doi.org/http://dx.doi.org/10.1046/j.1365-3156.2002.00844.x>.
- [79] Jahangir YT, Shrestha A, Alhaan F, Meyer SB. Service user and healthcare provider perspectives on barriers for men using sexually transmitted infection services in public hospital of Nepal: a qualitative study. *J Commun Healthc* 2020:1–11. <https://doi.org/10.1080/17538068.2020.1788373>.
- [80] Smith JA, Braunack-Mayer A, Wittert G. What do we know about men’s help-seeking and health service use? *Med J Aust* 2006;184:81–3. <https://doi.org/10.5694/j.1326-5377.2006.tb00124.x>.
- [81] Addis ME, Mahalik JR. Men, Masculinity, and the Contexts of Help Seeking. *Am Psychol* 2003. <https://doi.org/10.1037/0003-066X.58.1.5>.

- [82] Health P. 2004 Canadian Sexually Transmitted Infections 2007.
- [83] Williams DJ, Prior E, Wegner J. Resolving social problems associated with sexuality: can a “sex-positive” approach help? *Soc Work* 2013;58:273–6. <https://doi.org/10.1093/sw/swt024>.
- [84] Ivanski C, Kohut T. Exploring definitions of sex positivity through thematic analysis. *Can J Hum Sex* 2017;26:216–25. <https://doi.org/10.3138/cjhs.2017-0017>.
- [85] Raine T, Marcell A V, Rocca CH, Harper CC. The other half of the equation: Serving young men in a young women’s reproductive health clinic. *Perspect Sex Reprod Health* 2003;35:208–14. <https://doi.org/10.1363/psrh.35.208.03>.
- [86] Lum ID, Swartz RH, Kwan MYW. Accessibility and use of primary healthcare for immigrants living in the Niagara Region. *Soc Sci Med* 2016;156:73–9. <https://doi.org/10.1016/j.socscimed.2016.03.024>.
- [87] Flicker S, Wilson C, Monchalin R, Restoule JP, Mitchell C, Larkin J, et al. The Impact of Indigenous Youth Sharing Digital Stories About HIV Activism. *Health Promot Pract* 2020;21:802–10. <https://doi.org/10.1177/1524839918822268>.
- [88] Shariff FD. The Liminality of Culture: Second Generation South Asian Canadian Identity and the Potential for Postcolonial Texts. *J Teach Learn* 2008;5. <https://doi.org/10.22329/jtl.v5i2.251>.
- [89] Dang SS, Gorzalka BB, Brotto LA. Dual Control Model in a Cross-Cultural Context: Role of Sexual Excitation in Sexual Response and Behavior Differences Between Chinese and Euro-Caucasian Women in Canada. *Arch Sex Behav* 2019;48:2519–35. <https://doi.org/10.1007/s10508-019-01535-7>.
- [90] Ahmed SM, Lemkau JP. Cultural issues in the primary care of South Asians. *J Immigr Health* 2000;2:89–96. <https://doi.org/10.1023/A:1009585918590>.
- [91] Beiser M. The health of immigrants and refugees in Canada. *Can J Public Heal* 2005;96. <https://doi.org/http://dx.doi.org/10.1108/17506200710779521>.
- [92] Cuddy AJC, Crotty S, Chong J, Norton MI. Men as Cultural Ideals: How Culture Shapes Gender Stereotypes. *Circulation* 2010:1–25.
- [93] Buzi RS, Smith PB. Access to Sexual and Reproductive Health Care Services: Young Men’s Perspectives. *J Sex Marital Ther* 2014;40:149–57. <https://doi.org/10.1080/0092623X.2012.736923>.
- [94] Smith JA. Beyond masculine stereotypes: moving men’s health promotion forward in Australia. *Heal Promot J Aust Off J Aust Assoc Heal Promot Prof* 2007;18:20–5. <https://doi.org/10.1071/he07020>.

Chapter 5: Exploring South Asian men's perspective on the role of provider attitude in experiences of sexual healthcare services in Ontario.

Yamin Tauseef Jahangir¹, Elena Neiterman¹, Craig R. Janes¹, Samantha B. Meyer¹

¹*School of Public Health Sciences, Faculty of Health, University of Waterloo, ON*

Abstract

Introduction: Cultural factors are important in considerations of diagnosis, treatment, and overall care; however they are often overlooked in many clinical settings. **Objectives:** This study aimed to explore if and how South Asian men perceive provider attitude as playing a role in experiences of sexual healthcare services in Ontario. **Methods:** In-depth interviews (n=18) were conducted between May and July 2021 with South Asian men between the ages of 20-45 years and have been living in Ontario for at least one year. A thematic analysis was conducted following Braun and Clarke's (2006) guidelines. **Results:** Participants discussed providers as being inattentive to care and that they, as patients, are often concerned about being judged by their providers. They suggested that to improve care, providers should focus on building a common ground of interest and respect during service delivery. In addition, some participants viewed the one-provider-one-service policy in Ontario as a hindrance to men accessing healthcare. The notion of doctor-hopping was also discussed as a response to care that does not meet patient expectations. The notion of gender also emerged, with recommendations put forward for non-judgemental separate sexual health service provision for men from women. **Conclusion:** In conclusion, healthcare providers' attitudes may play an important role in the overall health service delivery experience. It is therefore important for healthcare professionals to be more reflexive of their attitudes in a clinical setting.

Key Words: patient-provider interaction; provider attitude; South Asian men's healthcare; men's healthcare access; healthcare in Ontario; immigrant men's health; Canada

Introduction

In recent years, there has been an increase in migration of South Asians in Canada with over 1.26 million people from South Asian countries specifically calling Canada their home, making up the largest visible minority group[1]. Literature suggests that the immigrant population continues to grow in high-income countries (i.e. according to the World Bank, countries having a high-income economy and a gross national income per capita of more than \$12,000)[2] and while the health of the immigrants has been prioritized in many healthcare settings, sexual health remained to be a neglected domain and critical for future research [3][4]. Besides, studies have reported that most sexual health programs only target women and ignore the sexual health needs of men [5]. Furthermore, studies have found that men often delay in accessing healthcare services and utilize less sexual healthcare services [6]. Literature suggests that in many high-income countries, there has been limited research particularly on the healthcare needs of immigrant populations specifically with regards to sexual health[7] Likewise, literature also found that in recent times, there has been a steady rise in sexual health illness among Canadian South Asian men between the age range of 20-45 years[4].

The overall understanding of illness and disease is what shapes the health perceptions of an individual and often determines access to and utilization of healthcare services [8][9][10]. However, it has been reported that immigrants in high-income countries possess lower knowledge of sexual health literacy and may have lower sexual health service utilization rates[11][11]. Besides, factors like individual stigma on sexual health, provider attitude, lack of information or misinformation about service availability, language barriers, time constraints, unavailability of viable transport options, and length of stay in a community – all of which may further influence immigrant’s access to sexual healthcare services[12][13][14].

By international standards, Canada has a low physician-to-population ratio, while family physicians comprise of 51 percent of the physician workforce[15]. In practice, medical necessity is broadly defined in Canada, covering the vast majority of physicians’ services. But the extent of public coverage for pharmaceuticals, home care, long-term care, and the services of

nonphysician providers such as chiropractors, optometrists, and physiotherapists vary across the provinces and territories[15]. Hence, although 91 percent of Canadians say they have a regular source of care (usually a family physician), many still report difficulty in getting access to both primary and referred care[15]. According to the literature, an ideal healthcare setting should include educational input about a patient's disease together with the help from a multidisciplinary team for better health outcomes[16]. Therefore, ideally, healthcare practitioners should understand what a patient's health, wellbeing and illness mean to them, the healthcare practices that they already undertake, and their interpretations of the treatments that are prescribed [17][18]. However, the literature suggests that high-income society Western medical training is based upon the positivist scientific method, centering on the rapid accumulation of 'facts' with little space devoted to consideration of human communication or the history and epistemology of medicine[19][20] Therefore, literature found that in many clinical settings, a physician-centred orientation is a common scenario with the limited flow of information, doctor control of the interaction, and little active participation on the part of the patient[21][22].

In addition, the literature suggests that health professionals often have this distinct belief system and attitude arising from their biomedical worldview [23]. In clinical care, physicians believe that diagnostic reasoning is: inductive, heuristic and identifying a variety of symptoms, examining laboratory data for a probable diagnostic, and making assumptions based on experience and knowledge are the common medical characteristics to be considered [23]. In such a context, healthcare providers often think of medical culture as the only culture available to follow and often overlook the cultural diversity in patient care [24]. As a result, healthcare providers also overlook the patient's lived experiences and cultural orientations only to reach possible clinical outcomes [25]. In this regard, the literature suggests that although the notion of the term 'cultural competence in healthcare has been very popular and studied widely in recent times as a part of physician skill development, there remains ambiguity in learning about the characteristics and practical aspects of cultural competence in medical education curriculum and clinical practice [21]. Likewise, literature further denotes that it is rather imperative to encourage healthcare professionals to understand the complexity of an individual's health within the broader context of health systems [26]. Hence, the term 'cultural safety' coined by Ramsden in 1990 was thought to be more appropriate in physician skill development, as it defines providing

quality care for people from different ethnicities and cultures and within the cultural values and norms of the patient[27]. Therefore, the concept of cultural safety focuses on a practical meaning towards the indigenous and marginalized populations and to their medical decision-making, as it forms the aspects of patient-centred care and the professional advocacy role in healthcare delivery[27]. Hence, the literature suggests that cultural safety should be integrated into a more constructivist definition of cultural competence by recognizing the existence of power relations and their influence on social relations and the construction of realities[26].

The clinical encounter is also often shaped by the differences between patient and clinician in social position and power, which are associated with differences in knowledge and identity, provider attitude, language, and other aspects of cultural identity [28]. Likewise, feelings of inferiority or discomfort in a healthcare setting may also be shaped by perceptions of unequal power dynamics between patients and healthcare providers [29]. In regards to healthcare disparities, providers often do not acknowledge their lack of cultural understanding, and that unequal treatment exists, and the stereotype belief increases with their increased experience in the medical field [30]. That is, the providers become more indifferent as they become more socialized in their medical field [31]. Consequently, literature found healthcare providers have been described as exhibiting unfriendly or judgmental attitudes towards patients, behaving in a way that is disrespectful or stigmatizing, providing youth or older patients with poor quality of care, or unnecessarily restricting access to certain services to youth by requiring parental or spousal permission when not required [32]. Further, there may not be clear service guidelines on what services should be provided to patients, thus, leaving providers to offer services based on their discretion or their values and beliefs [16][33]. Besides, literature also suggests that the gender of the healthcare provider and patient (along with age/ethnicity) may shape their social interactions and encounters [29]. This further portrays a more complex picture of the role of culture/identity in the medical encounter and how it impacts overall healthcare outcome [29].

In this view, despite the recognition of differences in culture among South Asian communities and their overall understanding of healthcare needs, the growing South Asian communities in Canada provide challenges in delivering needful health services [34][35]. Barriers related to individual stigma about sexual health, distrust of the health system, poor health communication –

all require a considerable inquiry to improve the quality of care for South Asian populations.[35] As patients' views on the quality of care can have a considerable impact on health outcomes, low perceived quality of care may also lead to non-adherence to medical prescriptions or inadequate attendance to healthcare providers [36]. For example, it has been found that there is reported variability in sexual health service use by South Asian men in high-income countries [33]. While some men are accessing sexual healthcare services (e.g. testing regularly for STIs and HIV), others are not accessing sexual healthcare services as a result of a lack of awareness of sexual health and poor health literacy [37].

Previously, research with South Asian populations has found that poor patient-provider interactions often lead to low quality of care and particularly due to perceived discrimination in availing sexual health services [6]. However, the literature suggests that in many high-income countries including Canada, there is limited research that investigates the needs of immigrant populations especially South Asians, with regards to sexual health, and consequently how to develop effective services for these populations [5][33]. Further, the literature suggests that physicians have been reported as not listening, not providing adequate information, and demonstrating a lack of concern or lack of respect for patients who are especially from varied cultural backgrounds and who are particularly immigrants[3]. Globally and within Canada specifically, few studies have sought to explore the role of healthcare provider attitudes within the context of providing quality sexual healthcare services, and experiences that might affect access to and utilization of healthcare. As such, the present study aimed to explore if and how South Asian men perceive provider attitude as playing a role in sexual health service experiences for South Asian men in Ontario.

Methods

Considering the aforementioned literature regarding a lack of sexual health knowledge and poor utilization of sexual healthcare services by South Asian men in Canada and a lack of support and judgemental attitude from service providers with immigrants and newcomer South Asians, it was important to learn more about the overall sexual health experiences of South Asian men who are termed as immigrants/newcomers to Canada. In line with the study aim, South Asian sexually active men between the age ranges of 20-45 years old were interviewed, as this population has

been cited in Canada to have high rates of STIs [4]. Over the past two decades, there has been a notable increase in the use of qualitative methods to explore sensitive issues, including sexuality [38]. Hence, qualitative methods were used as they have been demonstrated as a useful method for researching sexual health and sexuality issues of young people [39][40]. We developed a semi-structured interview guide based upon our knowledge of the literature and gaps this research was designed to interrogate, with questions reflecting on South Asian men's perspectives on the role of healthcare provider attitude in experiences of sexual healthcare services in Ontario. Some of the key questions asked include if healthcare provider attitude plays a role in sexual health service use; what our participants perceived in terms of attitude from providers during a clinical encounter (e.g. feel/do not feel comfortable talking about sexual health/provider do not think it is an important topic to discuss with the patient, or how this shaped their use of service if at all). On average each interview lasted for about 45 minutes to 1 hour. Altogether 18 in-depth interviews were conducted between May and July 2021 with South Asian men selected based on: (1) South Asian immigrant/newcomer men who are considered as 'new Canadians' by the definition set by Immigration, Refugees and Citizenship Canada (IRCC)[41]; (2) who are living in Canada for at least one year and currently residing in Ontario. Participants were recruited through ads on social media platforms, through non-government websites, organization e-newsletters, poster distribution within the non-government organization.

Thematic analysis was conducted using Braun and Clarke[42] thematic guidelines. Such guidelines were important during the various iterations of coding, reviewing, and recoding, as thematic summaries create a rich nuanced report that has strong inductive qualitative reasoning [42][43]. The process involved marking, numbering, coding transcript in each interview, and then organizing into conceptually relevant categories for the exploration of patterns and themes using NVivo 12 Pro [42][43][44][45]. As little is known about the highly sensitive research topic, we approached the data inductively with no prior theory or framework [42][45]. We did not focus on the prevalence of a theme, but rather on the meaningful information that related to the overall research question. Transcripts were checked to ensure that no relevant content was overlooked.

Results

This study aimed to explore if and how South Asian men perceive provider attitude as playing a role in sexual health service experiences for South Asian men in Ontario. Our study identified themes that were grouped into three main categories, (1) patient experiences with healthcare providers; (2) patient recommendations regarding cultural awareness for providers; (3) South Asian men's views about the Canadian healthcare system. For transparency, the sociodemographic characteristics of the participants including, age, country of origin, length of stay in Ontario, geographic location in Ontario, education, occupation, and religion are presented in Table 1.

Age in years (n)	Country of Origin (n)	Length of stay in Ontario (n)	Geographic Location in Ontario (n)	Education Level (n)	Occupation (n)	Religion (n)
20-23 years (4) 24-25 years (5)	Bangladesh (5) India (4)	1-2 years (7) 3-4 years (2)	Waterloo (6) Downtown Toronto (2) Mississauga (1)	Undergraduate degree (7) Masters' degree (2)	Permanent full-time employment (6) Part-time employment (3)	Islam (5) Hindu (4)
30-35 years (4) 36-40 years (3) 42-43 years (2)	India (5) Pakistan (2) Nepal (2)	1-2 years (6) 3-4 years (3)	Downtown Toronto (6) East York (1) Hamilton (1) Cambridge (1)	Undergraduate degree (5) Masters' degree (4)	Self-employed (3) Permanent full-time employment (2) Part-time employment (4)	Islam (2) Hindu (7)

Table 1. Sociodemographic characteristics of all respondents

1. Patient experiences with healthcare providers

1.1 Providers do not understand patient needs

Majority of our South Asian participants who accessed sexual healthcare services were unmarried except for one. From these participants, sexual health service was mainly used either in a sexual health clinic, a visit to the family physician or accessing hospital ER. Some of our participants availing services from these healthcare centers mentioned that healthcare providers sometimes lacked professional behaviours (i.e. being relaxed or indifferent towards patient's queries in a negative sense), while others perceived that patients are not prioritized to know about patient's healthcare needs. As sexual health is a sensitive topic, our 21-year-old participant Ahmad said, some South Asian patients shared their experiences where providers did not understand the patient's needs, as it depends on how a doctor understands and approach sexual health issue. He explained as follows,

You know. Because this [sexual health], like, as you said in the beginning of this interview, like this [sexual health] is a very sensitive topic and some people might take it very seriously. And some people like take their sexual health really casually and they wouldn't care too much. But most people, I believe that would care how the doctor approaches this issue [...] If someone's going for a sexual health like service, they [sexual healthcare providers] they're like, I feel like there is a need for more compassionate doctors to take care of them [South Asian men]. But providers may not often understand patient's needs [...] Sometimes they act in an unprofessional manner like they are not listening to the patient.” – Ahmad

Similarly, our 21-year-old participant Ismail mentioned that from his personal experience, he did not have a good interaction with the provider regarding his sexual health consultation, as he felt some providers try to complete the service hastily. He explained as follows,

They [doctors] usually give, like, answers like, like they know it seems like, they don't care about you, and they don't like people in general or their line of work, from my experience [...] I think doctors are inattentive. In my experience [in accessing sexual healthcare service] some providers are always seemed to be very angry with you for showing up or, I just, they just want you out, to get to the next person so that they don't have to check patients.” – Ismail

We learned from these interviews that participant experiences regarding sexual health services are subjective. While some participants mentioned about services were not conducted professionally, few others felt providers did not prioritize patients' healthcare needs. Such negative patient experiences from diverse healthcare settings may be indicative of a lack of health communication during patient-provider interactions in certain circumstances.

1.2 Patients are concerned about being judged by the provider

Our participants who were mostly young and unmarried spoke about their perceived feeling of getting judged by some healthcare providers. As for one of our married participants, 23-year-old Fakrul, it was quite difficult for him to make the provider understand his sexual health concerns in a sexual health clinic. Although Fakrul acknowledged that the provider was trying to be helpful and inquire about the situation, Fakrul felt the provider did not quite understand his illness history and may have made preconceived assumptions about his sexual health situation. He explained as follows,

“Yes, I met with somebody [healthcare provider] last year and the person would be like sort of like an ass, you know, she was being like a smart ass, so she wouldn't let me talk to, that would try to explain how my wife and I [had sexual health issues], if you like, by the way you talk, you are an active listener. You mean you participate. So, you're trying to be more helpful. So, the woman [physician] who I was talking to, her was being more, she was sort of like a smart ass. Every time I said something [during the consultation session on sexual health] she was trying to go on ahead. So, she was like, 'well, why don't you do this? Why don't you do this, to without even trying to listen to the story. She was already trying to make an assessment of the situation and kind of fix me, but she didn't even hear the [sexual health issue] story. Even so, she came to help me. So, it's hard to find somebody who wants to try to help you without judging you. They don't want, I don't know how to help you. So, I left her a very bad review.” – Fakrul

In addition, some participants shared concerns of confidentiality or privacy as they have said other South Asian men had bad experiences of healthcare providers discussing their patients in known social circles. For example, some of our participants mentioned incidents within South Asian communities where a patient met the same doctor in community social events and there was a risk of being talked about the patient's sexual illness. This type of unusual circumstances often led some participants to personally not to confide in their healthcare providers and to discuss their sexual health. We found from one of our participants Rafid that although the

aforementioned situation did not take place with his provider, Rafid still thinks he may get judged as a patient when discussing sexual health issues. He explained,

“For example, I’m like, theoretically, if I go to him [family physician] and tell him that, like, I got my girlfriend pregnant, for example, I feel I would be judged. About like for example, like this particular topic of [sexual health], probably not [discuss with the provider], just because I like, even if I didn’t tell, doctor, I like, I would kind of feel that he is unconsciously judging me, even though I have known him for several years. So I feel I wouldn’t want to be judged as well. – Rafid

In Rafid’s context, personal concerns of being judged by a known provider may prevent him from discussing sexual health. However, our participants also shared a few experiences in sexual health clinics, family physician visits and walk-in clinics, that healthcare providers do not listen to them or treat them without consideration of patient’s cultural context. Such as, according to our participants, the cultural differences between the patient and the provider can play a critical part in clinical decision making, as participants said providers may make assumptions about South Asian men and their sexual health. For example, one of our participants Rishi explained that his provider was not from a South Asian background, and her culture was different from his. As Rishi explained his sexual health issues with the provider, he felt the provider did not understand his illness context and there were arguments during his visit to a sexual health clinic. In this situation, Rishi felt the provider was judging him based on his experience in provider interaction. He explained,

“[...] She was from a different cultural background, and she is not South Asian [...] It was just that everything was this argument with the provider. I also had to, it almost took like an hour just to explain everything to her about my sexual health issues, every time, and then she would argue with me too. So I said at one point, ‘there’s no point arguing with you. I’m telling you this is how it works in my culture; I’m not making things up [regarding sexual health issues].’ So yeah, in a sense she kinda made up her mind about me. I felt I was being judged all along!” – Rishi

It was interesting to learn from this data that our South Asian participants often perceived providers to be judgemental about a patient’s illness history. Besides, although providers were recognized to be helpful as they tried to inquire about patients’ health complications, some participants felt providers made assumptions about patients’ illness history. However, these perceived or actual experiences on provider judgement were not uniform and are rather

subjective, as there had been varied responses regarding how and in which ways participants felt of being judged (e.g. in terms of provider behaviour). Interestingly, our data provides substantial knowledge in learning about how participants perceived their differential sexual healthcare experiences.

2. Patient recommendations regarding cultural awareness for providers

2.1 Need to build a common ground of interest between patient and provider

Participants commonly mentioned that there is a need to have a mutual common ground of interest between patients and providers that may improve the quality of care in sexual health services. Also, it depends on the provider how he/she would interact with patients from various cultural backgrounds. We found that participants mentioned provider attitude as playing an important role in patient-provider interaction. Participant Rahul mentioned that a positive attitude may influence better health communication and build a stronger rapport between the patient and the provider. Rahul further suggested that positive attitudes will build a mutual common ground of interest especially in discussing sexual health and understanding or being mindful of whether patients are taking the information seriously or not.

“So kind of depends on the healthcare workers, like how, what kind of plans they have, what kind of South Asian male patients they have, what kind of stuff they go through while treating the patients and how the patients are proceeding their issues. Like the healthcare worker, workers, talking about a patient's issues, like, ‘OK, these are the things you have. That's the things we can do about it,’ then see how the patient is taking it, how serious is the patient taking them regarding their own [sexual health] issues. If they're serious at all or not. And all in those are, or they're just ignoring, OK, wherever I go, whatever. So if you're having a mutual attitude or having a common ground of interest with, like all the, all the issues like, hey, this is something important, that's not a good thing. That's not a normal thing. It can actually make the client serious or the patient serious about their issues as well. Maybe because yeah, I don't have many examples to support that, but that's like my thoughts right now.” – Rahul

In addition, some participants said it was important for them to know that a healthcare provider is trying to come to a mutual understanding with the patient by acknowledging the patient's cultural differences. For example, 23-year-old Mehtab explained that the friendly attitude of his

provider showed that the provider simply cared for his patient and that was important to improve the service experience.

“Well, he [healthcare provider] was like, I would say, professional, but he was also like he had a friendly attitude, I would say. So like he was making, like, I wouldn't say, making fun. He was just asking, like, small details about, 'OK, so where are you from?' And I said, like, 'okay, so I'm from this part of the country [of origin] and that I'm a recent immigrant.' And then he was like, 'okay, so I have friends from that country. I heard this is really good about this, your country.' And, you know, he tried to build a connection or a common interest. So that's one I felt like, OK, so this person is [trying] to get to know me a little bit more and [showing they care] that improves the experience than sort of like asking, you know, questions from a [medical] book just to see where I'm at in terms of my health. So he was trying to build a mutual understanding between us.” – Mehtab

The findings suggest the importance of providers to be culturally aware of South Asian patients as it will positively impact patient-provider interaction to discuss sexual health and have improved health communication.

2.2 Providers need to be respectful towards patient's culture

From our in-depth interviews, participants recommended that a more respectful clinical experience can create better health service experiences especially among South Asian patients who are often quite reserved and share less about sexual health in the consultation session. Some of our participants like Sayeed further mentioned that it is important for providers to have gentle communication and be culturally aware of the patient which may significantly improve the overall service experience. Also, Sayeed felt that providers should proactively take steps by being mindful of their surroundings and how they position themselves and how they explain sexual health diagnoses to patients, especially the medical phrases or terms that could be explained in much simpler ways.

“I think the first step is with, so I guess having I'm not sure, to be honest, I think step one has to be more frequent and more gentle communication. I think like, so you have to understand who you are trying to educate and what is the type of [sexual health] education you're trying to give them [South Asian patients]. So you have to be gentle in the introduction of it [sexual health topic] and be respectful. And so you need, so it has to be more targeted. So, when you're trying to market all of these [sexual health] services that are available, you can't, you cannot simply say, here's a service, if you need it, it's there. I think it should be a more proactive approach in terms of like, hey, this is so, for each demographic, it should be a tailored approach.” – Sayeed

On the contrary, atypically one of our participants Ahmad felt that the Canadian healthcare system is quite robust, and it is unfair to expect healthcare providers in Canada will have the right kind of cultural skills to cater to a particular group of patients. However, he felt it is important to have the optimum level of professionalism and respect and be mindful of the patient's needs.

“What I'm saying is I think it's unfair for a patient to expect that the doctor would know, would be educated in his [patient's] culture and do something out of the doctor's norm just to fit his [patient's] culture. I feel that as long as the doctors and the nurses are all, in general, more respectful and do things that are, you know, as long as they don't do something that's super out of the way or something, that's very crazy. As long as that doesn't happen, a doctor, I don't feel health professionals need to be super mindful of their patient's culture, because they just feel that's there's already a good portion of Canada's GDP is being spent on healthcare.” – Ahmad

The data portrayed an overall understanding that often a more respectful patient-provider environment may go a long way in delivering quality care to patients from diverse cultural backgrounds. However, it was also interesting to learn that understanding patient-centeredness not only should encompass compassion or a cordial approach during sexual health consultations but also provide equal importance to the patient's culture. There could be a missing link in health communication, if patients feel disengaged with the provider and if the provider is not taking a tailored approach by being mindful of the cultural differences.

3. South Asian men's views about Canadian health systems

3.1 Implications of negative service experiences

Participants also discussed the implications of negative service experiences. For example, some of our participants who accessed walk-in clinics, sexual healthcare services and family physicians for sexual health issues, mentioned that if the service expectations are not met properly, it is quite likely that they would prefer to select a different healthcare provider. Our participants further mentioned that this scenario was quite common among South Asian men, as it often happens if South Asian men feel they are waiting for too long for service or the healthcare provider not giving enough time during the consultation, and/or if the patient is being rushed during the visit. This situation has been explained by Rafid in the extract below,

“I guess it [service expectations] depends on like there I guess it depends on the person right there. Some of them, it would be like more confrontational [with the provider], would like straight up to the doctor that, like, ‘give me some more time, I want to, I want to talk and figure out what's wrong,’ and then you have other South Asian men, who were just like, for example, I don't like to argue with the doctor, and I just think I'll find another doctor, right. Because, yeah, there's like a bunch of walk-in clinics near me, but you have to like this doctor [...] Yeah, it would be like I feel, I feel doctor hopping, would be fine just because, like, you want to find someone who is like who meet your needs and expectations as a doctor.” – Rafid

Furthermore, some participants like 40-year-old Ashraf gave his personal opinion as he mentioned that the overall concept of ‘one-provider-one-service’ treatment policy in Ontario may hinder some South Asian people from accessing the needful sexual healthcare services or discussing the subject matter with a provider. Ashraf further mentioned that if he went to a provider for some other health issue, he will not be able to discuss additional matters like sexual health due to time constraints. Ashraf explained as follows,

“Because when you go for a four o'clock appointment it comes down to five o'clock. You sit there for half an hour, or you lose 45 minutes in the waiting room already. There's no time anyway. And then if you have two questions, he's [the doctor] is already mad at you and he really knows which people are going to ask him more questions. So he has a bias, hate you already [...] So right away he has an attitude, and when I said, ‘my son needs this and I am waiting on the other one [test]’, then he goes on like, ‘I told you, you see on the board, one item per visit, you see on the board it says one list, one item per visit. You already have three, four. So, I'll do you a favour, I'll give you an answer for two. So if you re-book right now, and come tomorrow, and I'll give you the answer for another one.’” – Ashraf

Furthermore, some of our participants also discussed changing providers when they are asked to make frequent health service appointments. As mentioned by Umer, he believed this type of practice by some providers is mainly to use more resources, such as, going for the first visit, or multiple visits use more resources, which Umer believed is to make the most out of a patient's Ontario Health Insurance Policy (OHIP) coverage.

“Yes, I changed my main doctor two times, because some [healthcare providers] look to you and just ask for my health card, and then they don't want to know or help you with the problem. So we are going there [doctor's office] for two or three things, I needed a prescription for this one and I need a refill for this one, and I have a problem with my foot. So then you were like telling them and they will say, ‘did you see the sign on the door?’ I said ‘yes.’ Then the doctor said, ‘so

you have three problems, so make three appointments'. So that they can build more on your OHIP coverage.” – Umer

We found varied responses from our participants in regards to how they would explain their views of the Canadian health system. As some of our participants explored different healthcare services, the overall context of service expectations was not adequately explained by our participants. Although some participants mentioned about certain criteria should be given preference in terms of service expectations, they do not weigh in to explain further if and how these factors would ensure effective clinical interventions or influence their overall sexual health care experiences within the Canadian health system. However, it is important to recognize frequently changing healthcare providers may cause challenges among providers to ensure continuity of care, which overall may further reduce/hinder sexual health service uptake.

3.2 Need for non-judgmental separate service for men

Our South Asian participants also mentioned that they felt there is a need for a non-judgmental separate stand-alone sexual healthcare clinic for men. Among a few participants, 27-year-old unmarried Umer living in Canada for more than one year explained that a dedicated separate sexual healthcare service for men would minimize the patient traffic from other healthcare providers (e.g. family physicians). Umer felt that due to the high volume of patients, family physicians may not have adequate time to explain everything regarding sexual health and may not meet the perceived required expectations of the patient. As he explained,

“Well, I think that the best way to go about it [sexual healthcare services] would be to have a dedicated, separate service, for sexual health, particularly for men. And I think if you had to say, I don't think it's a good idea to have family doctors, you know to answer these things, because they're [family doctors] very rushed for time, they have a lot of patients and they just have too many patients, and so I don't think that they can adequately explain everything that needs to be explained [about sexual health]. And one visit is used, or they're always very rushed. They [family doctors] don't want to talk to you. So I think that you need a very dedicated kind of service for sexual health. Yeah, but it's not just that, I think it is in every area of health. They're [healthcare providers] just kind of rushed, but I think that it's [sexual health service] very important, it's the most important to be able to talk about this [sexual health]. But then since they [providers] are not very good at talking about anything, in particular, it [sexual health services] becomes really the most damaging when it comes to this area.” – Umer

In addition, as shared by our participant Rishi, a separate culturally safe sexual health clinic option may encourage future male South Asian teenagers to avail sexual healthcare services without risking patient confidentiality. That way, male teenagers may feel more comfortable in accessing and utilizing sexual healthcare services. He explained as follows,

“[...] When it comes to treatment options, like, you know, whether it's prescription drugs or whatever else it is [of sexual health], you know, it's, you know, providing those [culturally safe] treatment options because there may be more than just one or two options in the context of, you know, how would that affect, you know, you take a male [South Asian] teenager or someone young who's maybe, you know, who are scared to go in there [clinic] and they're scared to maybe go back home and their family find out that they need to take a prescription for something, right. You know, so how can we work through that to, you know, make it more discreet or make the person feel more comfortable or things like that, yeah. So a separate service could be an option.” – Rishi

Therefore, we learned from our participants that culturally safe healthcare service options for men may allow patients from various age range to access and utilize services better. It is important to consider that separate healthcare service options are more related to if providers can adequately serve patients in a given time frame. Also, our participants raised the importance of separate services due to the overall concern of breaching patient confidentiality.

Discussion

In Canada, it is important to recognize that service quality has taken a leap forward over the years, and particularly Ontario province has primarily given importance to healthcare services that are safe, timely, effective, efficient, equitable and patient-centred [46]. Further, it is important to consider that healthcare quality is often examined through the lens of the clinician-patient encounter, yet the quality of care that healthcare providers deliver is determined by the broader context in which they train and work [46]. For example, in Canada, the importance of healthcare provider cultural safety training include: reflecting on one's own culture, attitude and beliefs of others, having open and respectful communication, developing trust, recognizing and avoiding stereotypical barriers, being prepared for two-way dialogue, and understanding the influence of cultural shock [47]. Hence, the results of this study highlight several important issues regarding perceptions of provider attitudes towards South Asian men in terms of how it shapes service use. As our participants spoke of their perceived unprofessional attitudes from the

provider (such as, not being compassionate or listening to the patient's sexual illness history), we also found that participants felt healthcare providers did not prioritize the patient's healthcare needs. We found consistency with the literature that suggests many barriers that prevent youth from obtaining sexual healthcare services originate from within the service delivery experiences (e.g. lack of integration in services that involve counselling) [48]. Likewise, other studies found that providers often find themselves facing a conflict between their values, dominant norms in the community, and their role as caregivers, resulting in an ignorant attitude towards patients [49][50]. However, the literature suggests in Canada there is no single healthcare delivery system, hence the quality of care varies in terms of geographic location across 10 provinces [46]. Furthermore, the Commonwealth Fund surveys show that in general Canadians tend to report good experiences with their physicians compared with individuals living in other high-income countries[51]. However, in certain circumstances, the literature suggests the focus should be given to areas in which patient-centredness could be improved in Canada. For example, many patients report that they do not receive care in a culturally sensitive way[52]. Our findings further suggest that healthcare providers were perceived to be judgmental towards South Asian men while some providers made assessments based on certain preconceived assumptions about South Asian culture. Also, we found that participants recommended of positive attitude by healthcare providers and having mutual understanding and respect to improve overall health communication and patient-provider interaction. The importance of improving provider attitude has been reported through other studies where healthcare providers may have difficulty in differentiating their role as a medical professional from the social scripts that prioritize social thoughts, norms and values, and that they may judge clients based on their instinct and patient's identity[50][53]. Also, literature found that creating a balance between learning about the culture of an individual and a group (e.g. South Asian populations) is one of the key tightropes in overall provider cultural skill development training, in where practitioners may often stereotype and oversimplify the culture without realizing its complexities. For example, Latinos may have commonalities (e.g. speaking the Spanish language) but differ in the country of nationalities, ethnicities and cultures, and practitioners oftentimes generalize this culture and are creating a "cultural blindness" towards a whole community [54]. Literature also suggests that healthcare providers view patients with limited knowledge about a patient's diagnosis, while they intentionally or unintentionally create "cognitive shortcuts" and resort to bias by relying on group stereotypes

which help them to expedite their clinical decisions [55]. Therefore, reflective thinking around such provider attitudes and tailored training programs that include self-awareness and introspective activities (e.g. strategies to increase diversity, inclusion and equity) could help providers feel more comfortable in fulfilling their responsibilities as caregivers regardless of their personal beliefs thereby improving provider attitudes and quality of care [49]. In addition, critical thinking around both cultural and moral dimensions of sexual health of South Asian populations could be integrated with both pre-service and in-service training to help support providers when they encounter South Asian patients.

Ontario provides existing separate stand-alone sexual healthcare services delivering services that include birth control counselling, free confidential sexually transmitted infections (STI) testing and treatment, anonymous HIV testing and HIV/AIDS programs, immunizations for hepatitis A and B and the HPV vaccine, pap testing, urine pregnancy testing, low-cost birth control, and needle exchange programs[56]. We found that some of our participants recommended there is a need for a non-judgemental service platform, as our participants felt uncomfortable in sharing sexual health matters with the provider in terms of patient confidentiality and privacy. Although existing sexual health care caters to a wide range of services, it is important to consider how these services are delivered and whether they are delivered in a culturally safe manner to patients from diverse cultural backgrounds. Hence, studies suggest that it is critical to consider whether a healthcare setting is often shaped by perceptions of unequal power dynamics between the patient and the healthcare provider, which also can compromise privacy in delivering services [57][27]. In light of these findings, we propose more broadly for safe drop-in spaces that adequately consider men's healthcare needs (e.g. for sexual health information sharing and separate sexual healthcare services for men), to provide quality sexual healthcare and needful user-oriented resources to men. Further, existing stand-alone sexual health service spaces should be more informal while considering the cultural implications and maintaining user dignity and privacy.

It has been reported that often providers think that patients seek out services for treatment instead of prevention, and there is a lack of awareness of existing sexual healthcare services within communities[58]. Furthermore, issues related to homophobia, fear of racism and sexism may further hinder access to healthcare by sexually diverse populations[58]. Consequently, the

challenge for service providers in Canada remains to ensure continuity of sexual health care and create a safe space for patients to come back to if they need to[58]. We also found from our findings that South Asian men would often prefer to change healthcare providers if their service expectations are not met properly. Frequent doctor appointments, long wait times, provider rushing patients during a clinic visit, and a perceived one-provider-one-service treatment policy in Ontario – all led some South Asian participants to consider that healthcare providers do not prioritize patient needs. Therefore, it has been suggested through findings that healthcare providers may require a broader understanding of implementing health-related theory models and skills, such as motivational interviewing, into their consultation when engaging with patients of South Asian origin [59]. Furthermore, the literature suggests that a patient-centeredness approach that encompasses the qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient may further improve patient-provider interaction [9]. While these steps may ensure continuity to sexual healthcare, patient-centred service outcome measures should be another consideration towards obtaining a comprehensive understanding of healthcare systems performance thereby improving the overall quality of care in healthcare services[60] Also, it was reported that providers who indicated that they have had previous training focused on sexual health exhibited significantly more supportive attitudes towards user-friendly services than providers who did not report having received any training[61][62]. Hence, it is imperative to have more sexual health training, and have organized periodic cultural awareness programs for healthcare providers that have proven effective in improving overall patient outcomes and can be implemented in providing quality sexual healthcare services [52] [63][64][65]. Therefore, the overall training should evolve from learning information and making assumptions about patients based on their racial, ethnic, or cultural background, to focusing on the development of skills that follow the principles of patient-centred care.

Lastly, our data suggest an opportunity to help embed skills in sexual healthcare clinical practice by implementing training theory models in skill development that proposes shared care decision-making and how it might increase the likelihood of successful patient outcomes [66]. Therefore, given the experiences of our South Asian participants and their perceived role of provider attitudes in sexual health service experiences, we recommend further attention should focus on

healthcare providers to be reflexive about their social positions, such as social class, privilege, and power, as the literature suggests these components tie into subjective values and worldviews, that may later guide provider behaviours and attitude towards taking necessary healthcare decisions for the patient [67][68].

Limitations

One limitation to our work is that our qualitative study was designed to understand data in Ontario context and especially in urban settings. Hence, these findings may not be a representation of the inter-provincial sexual healthcare scenario which may require further investigation. With eighteen interviews, our sample size was relatively small and hence we could have missed opportunities to collate more data to learn comprehensively about healthcare provider attitude as an important role in patient care. Another limitation relates to the fact that we conducted telephone interviews which may have affected our data because of social desirability biases. Notwithstanding the strengths of the study include exploration for the understanding of the role of provider attitude in overall sexual health service experiences from South Asian men's perspectives while learning about the missing links of provider cultural sensitivity and awareness that would require further investigations in the future.

Conclusion

In conclusion, healthcare provider attitude may play an important role in the overall health service delivery experiences and if and how services are used. From our participants, we learned that provider attitude further shapes the use of sexual healthcare services. Although some of the factors identified are not unique to South Asian men, but this study highlights ways that sexual healthcare services might be altered to foster service used by this population group who have high rates of STIs in Canada and low rates of service use. Hence, the concept of culturally appropriate healthcare strategies still has more improvements to follow, particularly to strengthen its stance in medical training. Therefore, it is imperative to mention that healthcare providers should focus on how to “situate” themselves to learn the contextual nature of other cultures, but also to be more self-critical in their attitude towards patient care and be more familiar with their own social and economic positions to understand health disparities. Indeed, healthcare

professionals need to be more reflexive of their attitudes in a clinical setting and perform not by ignoring the other cultural knowledge in medical practice, but by embracing it.

References

- [1] Islam F, Khanlou N, Tamim H. South Asian populations in Canada: Migration and mental health. *BMC Psychiatry* 2014;14:1–13. <https://doi.org/10.1186/1471-244X-14-154>.
- [2] Hamadeh N, Rompaey C Van, Metreau E. New World Bank country classifications by income level: 2021-2022 n.d. <https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2021-2022> (accessed December 26, 2021).
- [3] Degni F, Suominen S, Essén B, El Ansari W, Vehviläinen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. *J Immigr Minor Heal* 2012;14:330–43. <https://doi.org/10.1007/s10903-011-9465-6>.
- [4] BC Centre for Disease Control and Prevention. *STI in British Columbia: Annual Surveillance Report 2016*:24–37.
- [5] Ottawa Public Health. *Sexually Transmitted Infections and Sexual Health in Ottawa 2011*. *Ottawa Public Heal* 2011:1–48.
- [6] Ramanathan V, Sitharthan G, Pepper K, Wylie K. Sexual health of Indian immigrant men in Australia: An exploratory research on help-seeking attitudes. *Sex Health* 2013;10:380–1. <https://doi.org/10.1071/SH12199>.
- [7] Buzi RS, Smith PB. Access to Sexual and Reproductive Health Care Services: Young Men's Perspectives. *J Sex Marital Ther* 2014;40:149–57. <https://doi.org/10.1080/0092623X.2012.736923>.
- [8] Roberts M, Hsiao W, Berman P, Reich M. *Getting Health Reform Right: A Guide to Improving Performance and Equity*. 2009. <https://doi.org/10.1093/acprof:oso/9780195371505.001.0001>.
- [9] Wilson D, Heaslip V, Jackson D. Improving equity and cultural responsiveness with marginalised communities: Understanding competing worldviews. *J Clin Nurs* 2018;27:3810–9. <https://doi.org/10.1111/jocn.14546>.
- [10] Marmot M. The Health Gap: The Challenge of an Unequal World: the argument. *Int J Epidemiol* 2017;46:1312–8. <https://doi.org/10.1093/ije/dyx163>.
- [11] Hahm HC, Song IH, Ozonoff A, Sassani JC. HIV Testing Among Sexually Experienced Asian and Pacific Islander Young Women. Association With Routine Gynecologic Care.

- Women's Heal Issues 2009;19:279–88. <https://doi.org/10.1016/j.whi.2009.05.001>.
- [12] Zhou YR, Majumdar B, Vattikonda N. Culture, but more than culture: an exploratory study of the HIV vulnerability of Indian immigrants in Canada. *Cult Heal Sex* 2016;18:1067–80. <https://doi.org/10.1080/13691058.2016.1162328>.
- [13] Donnelly LR, Bailey L, Jessani A, Postnikoff J, Kerston P, Brondani M. Stigma Experiences in Marginalized People Living With HIV Seeking Health Services and Resources in Canada. *J Assoc Nurses AIDS Care* 2016;27:768–83. <https://doi.org/10.1016/j.jana.2016.07.003>.
- [14] Sudhinaraset M, Ling I, To TM, Melo J, Quach T. Dreams deferred: Contextualizing the health and psychosocial needs of undocumented Asian and Pacific Islander young adults in Northern California. *Soc Sci Med* 2017;184:144–52. <https://doi.org/10.1016/j.socscimed.2017.05.024>.
- [15] Hutchison B, Levesque JF, Strumpf E, Coyle N. Primary health care in Canada: Systems in motion. *Milbank Q* 2011;89:256–88. <https://doi.org/10.1111/j.1468-0009.2011.00628.x>.
- [16] Dures E, Almeida C, Caesley J, Peterson A, Ambler N, Morris M, et al. Patient preferences for psychological support in inflammatory arthritis: a multicentre survey. *Ann Rheum Dis* 2016;75:142–7. <https://doi.org/10.1136/annrheumdis-2014-205636>.
- [17] Russell S, Rn P, Daly J, Menvsc B, Hughes Bsc E, Op ' C, et al. Nurses and "Difficult" Patients: Negotiating Non-Compliance. *Philos Ethical Issues* 2003:281–7.
- [18] Wilson D. The significance of a culturally appropriate health service for Indigenous Maori women. *Contemp Nurse* 2008;28:173–88. <https://doi.org/10.5172/conu.673.28.1-2.173>.
- [19] Lupton D. *Medicine as culture: Illness, disease and the body*. 2012. <https://doi.org/10.4135/9781446254530>.
- [20] Lopez KJ, Dupuis SL. Exploring meanings and experiences of wellness from residents living in long-term care homes. *World Leis J* 2014;56:141–50. <https://doi.org/10.1080/16078055.2014.903724>.
- [21] Cvengros JA, Christensen AJ, Hillis SL, Rosenthal GE. Patient and physician attitudes in the health care context: attitudinal symmetry predicts patient satisfaction and adherence. *Ann Behav Med* 2007;33:262–8. <https://doi.org/10.1007/BF02879908>.
- [22] Janis IL, Mann L. *Decision making: A psychological analysis of conflict, choice, and commitment*. New York, NY, US: Free Press; 1977.

- [23] Gregg J, Saha S. Losing culture on the way to competence: The use and misuse of culture in medical education. *Acad Med* 2006.
<https://doi.org/10.1097/01.ACM.0000225218.15207.30>.
- [24] Taylor JS. Confronting “Culture” in Medicine’s “Culture of No Culture” 2003;555–9.
<https://doi.org/10.1097/00001888-200306000-00003>.
- [25] Good M-JD. *American medicine, the quest for competence*. University of California Press, Berkeley; 1995.
- [26] Garneau AB, Pepin J. Cultural Competence: A Constructivist Definition. *J Transcult Nurs* 2015;26:9–15. <https://doi.org/10.1177/1043659614541294>.
- [27] Brascoupe S, Waters C. Cultural Safety: Exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *J Aborig Heal* 2009.
<https://doi.org/10.1177/1043659611414139>.
- [28] Kirmayer LJ. Rethinking cultural competence. *Transcult Psychiatry* 2012.
<https://doi.org/10.1177/1363461512444673>.
- [29] Addis ME, Mahalik JR. Men, Masculinity, and the Contexts of Help Seeking. *Am Psychol* 2003. <https://doi.org/10.1037/0003-066X.58.1.5>.
- [30] Harris GLA. Cultural competence: Its promise for reducing healthcare disparities. *J Health Hum Serv Adm* 2010.
- [31] Street RL, Gordon H, Haidet P. Physicians’ communication and perceptions of patients: Is it how they look, how they talk, or is it just the doctor? *Soc Sci Med* 2007.
<https://doi.org/10.1016/j.socscimed.2007.03.036>.
- [32] Tangmunkongvorakul A, Kane R, Wellings K. Gender double standards in young people attending sexual health services in Northern Thailand. *Cult Health Sex* 2005;7:361–73.
<https://doi.org/10.1080/13691050500100740>.
- [33] Mmari KN, Magnani RJ. Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *J Adolesc Heal Off Publ Soc Adolesc Med* 2003;33:259–70.
[https://doi.org/10.1016/s1054-139x\(03\)00062-4](https://doi.org/10.1016/s1054-139x(03)00062-4).
- [34] Aggleton P, Campbell C. Working with young people - towards an agenda for sexual health. *Sex Relatsh Ther* 2010;15:283–96. <https://doi.org/10.1080/14681990050109863>.
- [35] Salehi R, Hynie M, Flicker S. Factors associated with access to sexual health services among teens in Toronto: Does immigration matter? *J Immigr Minor Heal* 2014;16.
<https://doi.org/10.1007/s10903-013-9961-y>.

- [36] Lamkaddem M, Spreeuwenberg PM, Devillé WL, Foets MM, Groenewegen PP. Importance of quality aspects of GP care among ethnic minorities: role of cultural attitudes, language and healthcare system of reference. *Scand J Public Health* 2012;40:25–34. <https://doi.org/10.1177/1403494811425710>.
- [37] Sawleshwarkar S, Kakar SR, Jones R, Lagios K, Mindel A, Hillman RJ. Indian-born patients attending a sexual health clinic in Australia have differing characteristics to their Australian-born counterparts. *Intern Med J* 2013;43:1327–30. <https://doi.org/10.1111/imj.12299>.
- [38] Price N, Hawkins K. Researching sexual and reproductive behaviour: A peer ethnographic approach. *Soc Sci Med* 2002;55:1325–36. [https://doi.org/10.1016/S0277-9536\(01\)00277-5](https://doi.org/10.1016/S0277-9536(01)00277-5).
- [39] Regmi PR, van Teijlingen E, Simkhada P, Acharya DR. Barriers to sexual health services for young people in Nepal. *J Heal Popul Nutr* 2010. <https://doi.org/10.3329/jhpn.v28i6.6611>.
- [40] Pokharel S, Kulczycki A, Shakya S. School-Based Sex Education in Western Nepal: Uncomfortable for Both Teachers and Students. *Reprod Health Matters* 2006. [https://doi.org/10.1016/S0968-8080\(06\)28255-7](https://doi.org/10.1016/S0968-8080(06)28255-7).
- [41] Women in Canada: A Gender-based Statistical Report, 5th Edition. Statistics Canada; Catalogue No. 89-503-XIE; 2005.
- [42] Braun V, Clarke V. Using thematic analysis in psychology. *J Chem Inf Model* 2013;53:1689–99. <https://doi.org/10.1017/CBO9781107415324.004>.
- [43] Sandelowski M, Barroso J. Finding the findings in qualitative studies. *J Nurs Scholarsh* 2002;34:213–9. <https://doi.org/10.1111/j.1547-5069.2002.00213.x>.
- [44] Roulston K. Data analysis and ‘theorizing as ideology.’ *Qual Res* 2001. <https://doi.org/10.1177/146879410100100302>.
- [45] Boyatzis R. Transforming qualitative information. 1998.
- [46] Dhalla IA, Tepper J. Improving the quality of health care in Canada. *Cmaj* 2018;190:E1162–7. <https://doi.org/10.1503/cmaj.171045>.
- [47] BC Centre for Disease Control. Culturally Safe Care n.d. <http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/education-and-training/culturally-safe-care> (accessed December 27, 2021).
- [48] Morris JL, Rushwan H. Adolescent sexual and reproductive health: The global challenges. *Int J Gynaecol Obstet Off Organ Int Fed Gynaecol Obstet* 2015;131 Suppl:S40-2. <https://doi.org/10.1016/j.ijgo.2015.02.006>.

- [49] Mngadi PT, Faxelid E, Zwane IT, Höjer B, Ransjo-Arvidson A-B. Health providers' perceptions of adolescent sexual and reproductive health care in Swaziland. *Int Nurs Rev* 2008;55:148–55. <https://doi.org/10.1111/j.1466-7657.2007.00625.x>.
- [50] Chilinda I, Hourahane G, Pindani M, Chitsulo C, Maluwa A. Attitude of Health Care Providers towards Adolescent Sexual and Reproductive Health Services in Developing Countries: A Systematic Review. *Health (Irvine Calif)* 2014;06:1706–13. <https://doi.org/10.4236/health.2014.614203>.
- [51] Commonwealth Fund Survey 2016: How Canada Compares Results From The Commonwealth Fund 's 2016 International Health Policy Survey of Adults in 11 Countries 2016. <https://www.cihi.ca/sites/default/files/document/text-alternative-version-2016-cmwf-en-web.pdf> (accessed December 18, 2021).
- [52] Pathy R, Mills KE, Gazeley S, Ridgley A, Kiran T. Health is a spiritual thing: Perspectives of health care professionals and female Somali and Bangladeshi women on the health impacts of fasting during Ramadan. *Ethn Heal* 2011;16:43–56. <https://doi.org/10.1080/13557858.2010.523780>.
- [53] Godia PM, Olenja JM, Lavussa JA, Quinney D, Hofman JJ, van den Broek N. Sexual reproductive health service provision to young people in Kenya; health service providers' experiences. *BMC Health Serv Res* 2013;13:476. <https://doi.org/10.1186/1472-6963-13-476>.
- [54] Paniagua F. *Assessing and Treating Culturally Diverse Clients: A Practical Guide*. 2016. <https://doi.org/10.4135/9781506335728>.
- [55] Burgess DJ, Fu SS, Van Ryn M. Why do providers contribute to disparities and what can be done about it? *J Gen Intern Med* 2004. <https://doi.org/10.1111/j.1525-1497.2004.30227.x>.
- [56] Government of Ontario: Sexual Health Clinics - How to get free sexual health testing, counselling and treatment services. n.d. <https://www.ontario.ca/page/sexual-health-clinics#section-0> (accessed December 16, 2021).
- [57] Raine T, Marcell A V, Rocca CH, Harper CC. The other half of the equation: Serving young men in a young women's reproductive health clinic. *Perspect Sex Reprod Health* 2003;35:208–14. <https://doi.org/10.1363/psrh.35.208.03>.
- [58] Flicker S, Flynn S, Larkin J, Travers R, Guta A, Pole J, et al. *Sexpress: The Toronto Teen Survey Report*. 2009.
- [59] Kumar K, Stack RJ, Adebajo A, Adams J. Health-care professionals' perceptions of interacting with patients of South Asian origin attending early inflammatory arthritis clinics. *Rheumatol Adv Pract* 2019;3:rkz042. <https://doi.org/10.1093/rap/rkz042>.

- [60] Jahangir YT, Neiterman E, Janes CR, Meyer SB. Healthcare access, quality of care and efficiency as healthcare performance measures: A Canadian health service view. *J Heal Soc Sci* 2020;5:309–16. <https://doi.org/10.19204/2020/hlth2>.
- [61] Tilahun M, Mengistie B, Egata G, Reda AA. Health workers' attitudes toward sexual and reproductive health services for unmarried adolescents in Ethiopia. *Reprod Health* 2012;9:19. <https://doi.org/10.1186/1742-4755-9-19>.
- [62] Paternotte E, van Dulmen S, van der Lee N, Scherpbier AJJA, Scheele F. Factors influencing intercultural doctor-patient communication: a realist review. *Patient Educ Couns* 2015;98:420–45. <https://doi.org/10.1016/j.pec.2014.11.018>.
- [63] Greenhalgh T, Clinch M, Afsar N, Choudhury Y, Sudra R, Campbell-Richards D, et al. Socio-cultural influences on the behaviour of South Asian women with diabetes in pregnancy: qualitative study using a multi-level theoretical approach. *BMC Med* 2015;13:120. <https://doi.org/10.1186/s12916-015-0360-1>.
- [64] Chipps JA, Simpson B, Brysiewicz P. The effectiveness of cultural-competence training for health professionals in community-based rehabilitation: a systematic review of literature. *Worldviews Evidence-Based Nurs* 2008;5:85–94. <https://doi.org/10.1111/j.1741-6787.2008.00117.x>.
- [65] Ali N, Atkin K, Neal R. The role of culture in the general practice consultation process. *Ethn Health* 2006;11:389–408. <https://doi.org/10.1080/13557850600824286>.
- [66] Phillips LA, Leventhal H, Leventhal EA. Physicians' communication of the common-sense self-regulation model results in greater reported adherence than physicians' use of interpersonal skills. *Br J Health Psychol* 2012;17:244–57. <https://doi.org/10.1111/j.2044-8287.2011.02035.x>.
- [67] Wear D, Kumagai AK, Varley J, Zarconi J. Cultural Competency 2.0. *Acad Med* 2012;87:752–8. <https://doi.org/10.1097/ACM.0b013e318253cef8>.
- [68] Mukerji C. The cultural power of tacit knowledge: Inarticulacy and Bourdieu's habitus. *Am J Cult Sociol* 2014;2:348–75. <https://doi.org/10.1057/ajcs.2014.8>.

Chapter 6: Conclusion

In this final chapter of the thesis, I provide an overview of the contributions of each of the four papers as they relate to the aim of the thesis, (i.e. to establish a broader understanding regarding if and how South Asian men access and utilize sexual health services in a high-income economy country setting, particularly here in Canada). I then end by stating recommendations, driven by the data collected, that might help to improve access and use of sexual health by South Asian men in Ontario.

Study I, a scoping review, investigated the wider body of literature regarding access to and utilization of sexual health services in the high-income Western country context. We reviewed how accessibility, social perspectives on sexual health, conflicting beliefs on sexuality and health-seeking behaviour, and lower utilization rates of sexual health services impact the overall healthcare decision-making of South Asian men. Findings also suggest that as men do receive healthcare, quite often sexual health services remain fragmented. Findings suggested a need for further interventions in health systems service delivery to improve the overall quality of care experienced by the South Asian male populations. The review led us to identify how accessibility and utilization of sexual health services vary for immigrant men from South Asia in different contexts. Hence, this scoping review was important to identify the knowledge gaps and methodological tools needed to further investigate what contextual factors (e.g., cultural, physical, psychological, or social) play a role in South Asian immigrant men's access (actual and/or perceived accessibility) to and utilization of sexual health services, particularly here in Canada.

Study II, the conceptual paper, contributed to the broader literature in identifying the knowledge gaps within the Canadian health service system, in terms of understanding the various indicators that are used in measuring health systems performance. We learned that by focusing on the principles of patient-centeredness and evidence-based interventions on self-assessed healthcare needs, possible concerns of compromising health system performance may be minimized. This paper made a stand-alone contribution to the wider thesis (such as, in investigating, understanding, and explaining patient experiences with the healthcare system in Canada; namely

access to healthcare services, utilization of service, quality of care and healthcare service efficiency) and mainly in proceeding towards a critical investigation in Study III, Chapters 4 and 5, that aimed to explore access to care, utilization of services, and patient-provider interactions in healthcare service experience in Ontario. Finally, as concepts of access to healthcare, quality of care and healthcare efficiency remain quite ambiguous, in terms of operationalizing in qualitative research, this paper also adds value to the existing literature in terms of designing studies to investigate service access and utilization. This study also helped to inform recommendations that emerged in Chapter 5 paper 2.

As the sexual health of immigrant men is quite understudied, learning about these knowledge gaps from the previous studies led to the development of specific research questions answered in Chapters 4 and 5. Chapter 4 explored the contextual factors shaping access to and utilization of sexual healthcare services of South Asian men particularly residing in Ontario. In Chapter 4, I speak to the psychological factors (e.g. perceived severity of illness influencing access to care, sexual health is considered an optional service, sexual health is perceived negatively), the social factors (e.g. sex positivity or sex-negativity exist in the social sphere, discussing sexual health with social circle, adapting to the lifestyle where sexual health discussions are more normalized rather than following South Asian norm as they relate to sexual health), and cultural factors (e.g. culture as it relates to the perception of healthcare, prescriptive gender stereotype as it influences overall access to sexual health services). – all of which were responsible for influencing overall access to and utilization of sexual healthcare services by South Asian men in Ontario. Although it is important to acknowledge the sensitive nature of sexual health as a taboo topic, sex positivity, sex-negativity, and prescriptive gender roles, these findings are not specific to South Asian communities. These are barriers worthy of more attention to considering culture in the promotion or delivery of services more broadly here in Canada.

Through Chapter 5, South Asian participant voices spoke to the real/perceived attitudes of providers in delivering healthcare broadly and about sexual health. We learned that our participants experienced the least favourable attitudes towards issues that relate specifically to South Asian men's sexual health matters (such as, not being compassionate or listening to the patient's sexual illness history). Participants mentioned the importance of a positive provider

attitude and cultural awareness to build a respectful environment and improve health communication and patient-provider interaction. In addition, participants made recommendations for changes to services that include more informal and non-judgemental environments by considering the cultural implications and maintaining user dignity and privacy. Our findings also suggest the importance of patient-centeredness to ensure continued engagement in a patient-provider interaction, thereby improving service uptake and follow-up visit experience.

There are several limitations to this research. In conducting the scoping review, it was important to broaden the search question and expand the inclusion criteria to find ten studies that were relevant to the broad topic of South Asian men's access to and utilization of sexual health services. In addition, no grey literature was identified despite attempts to be as comprehensive as possible. Furthermore, in this study, the overall search strategy may have been biased towards health and sciences and searching other bibliographical databases (e.g. Google Scholar or Web of Science) may have yielded more published articles. I adopted Arksey and O'Malley's definition for scoping reviews at the outset of the study and found that their simple definition was generally useful in guiding study selection. For this scoping review, the pair of reviewers used their judgment to determine whether each article as a whole sufficiently met our study definition of a scoping review, which at times was challenging in the process of characterization and interpretation.

Chapters 4 and 5 (both papers 1 and 2) employed a qualitative research methodology. One of the limitations of these studies is that due to COVID-19 Ontario provincial lockdown measures, these unprecedented circumstances delayed the participant recruitment and data collection process from the year 2020 towards May until July 2021. In addition, although I did extensive communication through social media forums, job recruitment sites, tried liaison with non-government organizations and health service clinics to get my sample, I could only interview eighteen South Asian men for the study. There could be a missed opportunity to collate more data which was hindered by COVID-19 lockdown rules and remote interview process. Considering our data collection processes, the focus was mainly on the Ontario province. Hence, these findings may not be a representation of the inter-provincial sexual healthcare scenario which may require further investigation, as there may be more diversity in terms of geographic

locations and ethnic or cultural backgrounds of people.

Nonetheless, the strengths of this thesis include recognizing and documenting the complex interactions between social, structural, and individual-level determinants of sexual health and health service settings and focusing on strengthening health communication and health promotion opportunities for South Asian communities in Ontario and beyond. Furthermore, this thesis allowed us to gain a comprehensive understanding of the various contextual factors (e.g. cultural, psychological, and social dimensions) that may enable or hinder access to and utilization of healthcare services.

Lastly, in light of our findings, we conclude by providing below, some possible recommendations, drawing from findings presented in each paper:

Chapter 2 and 3

- As we have learned that there is an increasing demand for more culturally appropriate healthcare services for South Asian male communities, there remains a sense of vulnerability among South Asian men, lack of confidence in service providers, concerns in disclosing health information, lack of awareness and traditional misconceptions on sexual health issues. Hence, we recognize there is a greater need to strengthen our existing self-awareness and introspective training activities (e.g. strategies to increase diversity, inclusion, and equity) to enhance competency and skills programs for healthcare providers, that may help providers feel more comfortable in fulfilling their responsibilities as caregivers and help patients engage better with providers.

Chapter 4 and 5

- Studies suggest that existing health promotion practices in public health often focus on individual models of risk [34]. However, these approaches are often left un-contextualised while studying social determinants of health in health sciences [35]. By

contrast, contextualized models of health promotion recognize health disparities of the marginalized populations and can focus on behaviour change interventions that move beyond the individual context [34]. This approach of health promotion prioritizes entirely on the interpersonal, social, environmental, cultural, and structural factors, which can be effective in prevention efforts [36]. While the South Asian population is growing in Canada, we know little about how to create services/promotional material that is responsive to contextual factors shaping service access and use. It was, therefore, important to learn more about the overall sexual health service experiences of South Asian men and we learned from our participants that the sexual healthcare experiences vary among South Asian communities. Hence, since our findings suggest that the health and wellbeing of South Asian men are integrally connected to their culture in South Asian communities, there is an increased need for sexual health education and promotion opportunities within the South Asian male communities, which is a crucial process and would require appropriate locations for clinic or service promotion. We, therefore, recommend through our study findings that South Asian men should have access to age-appropriate sexual health education opportunities in an informal and culturally safe environment within their communities.

- Our findings further suggest that the positive attitude of the provider helps to build strong health communication in patient-provider interactions. We, therefore, recommend patient-centeredness approaches in clinical settings, that encompass the qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient [37]. We believe such processes would allow patients to have a continued engagement with the provider thereby improving service uptake.
- It is crucial for the healthcare provider to recognize the contextual nature of other cultures, but also to be more self-critical in their attitude towards patient care and be more familiar with their own social and economic positions to understand health disparities.
- Our participants have mentioned the importance of improved sexual health education

around prevention. This may include periodic health promotional interventions at the local South Asian communities. However, it should be acknowledged that the participants in our study preferred to converse in the English language. Hence, we did not have non-English speaking participants in our study. As a result, we further recommend that health promotional messages should consider non-English speaking South Asians with added barriers in utilizing healthcare services.

References

- [1] Hamadeh N, Rompaey C Van, Metreau E. New World Bank country classifications by income level: 2021-2022 n.d. <https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2021-2022> (accessed December 26, 2021).
- [2] Nilaweera I, Doran F, Fisher J. Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: A systematic review of the evidence. *J Affect Disord* 2014;166:213–26. <https://doi.org/10.1016/j.jad.2014.05.021>.
- [3] BC Centre for Disease Control and Prevention. STI in British Columbia: Annual Surveillance Report 2016:24–37.
- [4] Hahm HC, Song IH, Ozonoff A, Sassani JC. HIV Testing Among Sexually Experienced Asian and Pacific Islander Young Women. Association With Routine Gynecologic Care. *Women’s Heal Issues* 2009;19:279–88. <https://doi.org/10.1016/j.whi.2009.05.001>.
- [5] Ottawa Public Health. Sexually Transmitted Infections and Sexual Health in Ottawa 2011. *Ottawa Public Heal* 2011:1–48.
- [6] Kang E, Rapkin BD, Springer C, Kim JH. The “Demon Plague” and Access to Care among Asian Undocumented Immigrants Living with HIV Disease in New York City. *J Immigr Health* 2003;5:49–58.
- [7] Salehi R, Hynie M, Flicker S. Factors associated with access to sexual health services among teens in Toronto: Does immigration matter? *J Immigr Minor Heal* 2014;16. <https://doi.org/10.1007/s10903-013-9961-y>.
- [8] Zhou YR, Majumdar B, Vattikonda N. Culture, but more than culture: an exploratory study of the HIV vulnerability of Indian immigrants in Canada. *Cult Heal Sex* 2016;18:1067–80. <https://doi.org/10.1080/13691058.2016.1162328>.
- [9] Ramanathan V, Sitharthan G, Pepper K, Wylie K. Sexual health of Indian immigrant men in Australia: An exploratory research on help-seeking attitudes. *Sex Health* 2013;10:380–1. <https://doi.org/10.1071/SH12199>.
- [10] Shoveller JA, Knight R, Johnson J, Oliffe JL, Goldenberg S. Not the swab!’ Young men’s experiences with STI testing. *Social Heal Illn* 2010;32:57–73. <https://doi.org/10.1111/j.1467-9566.2009.01222.x>.
- [11] Dang SS, Gorzalka BB, Brotto LA. Dual Control Model in a Cross-Cultural Context: Role of Sexual Excitation in Sexual Response and Behavior Differences Between Chinese and Euro-Caucasian Women in Canada. *Arch Sex Behav* 2019;48:2519–35. <https://doi.org/10.1007/s10508-019-01535-7>.

- [12] Flicker S, Flynn S, Larkin J, Travers R, Guta A, Pole J, et al. Sexpress: The Toronto Teen Survey Report. 2009.
- [13] Mishra SR. Reaching adolescents with health services in Nepal. *Bull World Health Organ* 2017;95:90–1. <https://doi.org/10.2471/BLT.17.020217>.
- [14] Sawleshwarkar S, Kakar SR, Jones R, Lagios K, Mindel A, Hillman RJ. Indian-born patients attending a sexual health clinic in Australia have different characteristics to their Australian-born counterparts. *Intern Med J* 2013;43:1327–30. <https://doi.org/10.1111/imj.12299>.
- [15] Doll LS, Beeker C. Male bisexual behaviour and HIV risk in the United States: synthesis of research with implications for behavioural interventions. *AIDS Educ Prev* 1996.
- [16] Patterson O. Taking Culture Seriously: A Framework and an Afro-American Illustration. In: Harrison LE, Huntington SP, editors. *Cult. Matters How Values Shape Hum. Prog.*, New York: Basic Books; 2001, p. 202–18.
- [17] Vlassoff C, Ali F. HIV-related stigma among South Asians in Toronto. *Ethn Heal* 2011;16:25–42. <https://doi.org/10.1080/13557858.2010.523456>.
- [18] Wood W, Eagly AH. A cross-cultural analysis of the behaviour of women and men: Implications for the origins of sex differences. *Psychol Bull* 2002. <https://doi.org/10.1037/0033-2909.128.5.699>.
- [19] Baldwin JD, Baldwin JI. Gender differences in sexual interest. *Arch Sex Behav* 1997. <https://doi.org/10.1023/A:1024510528405>.
- [20] Health Canada. Canadian Guidelines for Sexual Health Education. *Methodology* 2003. <https://doi.org/10.1037/e611812012-001>.
- [21] Baber KM. Women’s Sexualities. In: Biaggio M, Hersen M, editors. *Issues Psychol. Women*, Boston, MA: Springer US; 2002, p. 145–71. https://doi.org/10.1007/0-306-47185-X_8.
- [22] Blackwood E. Culture and women’s sexualities. *J Soc Issues* 2000. <https://doi.org/10.1111/0022-4537.00162>.
- [23] Harris GLA. Cultural competence: Its promise for reducing healthcare disparities. *J Health Hum Serv Adm* 2010.
- [24] Tangmunkongvorakul A, Kane R, Wellings K. Gender double standards in young people attending sexual health services in Northern Thailand. *Cult Health Sex* 2005;7:361–73. <https://doi.org/10.1080/13691050500100740>.
- [25] Arksey H, O’Malley L. Scoping studies: Towards a methodological framework. *Int J Soc*

- Res Methodol Theory Pract 2005;8:19–32.
<https://doi.org/10.1080/1364557032000119616>.
- [26] Thorne S, Kirkham SR, MacDonald-Emes J. Interpretive Description: A Noncategorical Qualitative Alternative for Developing Nursing Knowledge. *Res Nurs Heal* 1997;20:169–77. [https://doi.org/10.1002/\(SICI\)1098-240X\(199704\)20:2<169::AID-NUR9>3.0.CO;2-I](https://doi.org/10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I).
- [27] Thorne S. Interpretive description. 2013. <https://doi.org/10.4324/9780203409527>.
- [28] Hunt MR. Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qual Health Res* 2009;19:1284–92. <https://doi.org/10.1177/1049732309344612>.
- [29] Thorne S, Kirkham SR, O’Flynn-Magee K. The Analytic Challenge in Interpretive Description. *Int J Qual Methods* 2004;3:1–11.
<https://doi.org/10.1177/160940690400300101>.
- [30] Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006.
<https://doi.org/10.1191/1478088706qp063oa>.
- [31] Sandelowski M, Barroso J. Finding the findings in qualitative studies. *J Nurs Scholarsh* 2002;34:213–9. <https://doi.org/10.1111/j.1547-5069.2002.00213.x>.
- [32] Roulston K. Data analysis and ‘theorizing as ideology.’ *Qual Res* 2001.
<https://doi.org/10.1177/146879410100100302>.
- [33] Boyatzis R. Transforming qualitative information. 1998.
- [34] Wilson C, Oliver V, Flicker S, Sexual Health Network NY, Prentice T, Jackson R, et al. “Culture” as HIV prevention: Indigenous youth speak up! *Gateways Int J Community Res Engagem* 2016;9. <https://doi.org/10.5130/ijcre.v9i1.4802>.
- [35] Lawrence B. Gender, Race, and the Regulation of Native Identity in Canada and the United States: An Overview. *Hypatia* 2003;18:3–31.
- [36] Devries KM, Free CJ, Morison L, Saewyc E. Factors Associated With the Sexual Behavior of Canadian Aboriginal Young People and Their Implications for Health Promotion. *Am J Public Health* 2009;99:855–62.
<https://doi.org/10.2105/AJPH.2007.132597>.
- [37] Wilson D, Heaslip V, Jackson D. Improving equity and cultural responsiveness with marginalized communities: Understanding competing worldviews. *J Clin Nurs* 2018;27:3810–9. <https://doi.org/10.1111/jocn.14546>.

Appendix A – Participant Information Letter



FACULTY OF APPLIED HEALTH SCIENCES | School of Public Health and Health Systems
519-888-4567 | fax 519-746-6776
uwaterloo.ca/public-health-and-health-systems

Date: April 05, 2021

South Asian communities comprise one of the fastest growing populations in Canada. However, the sexual health of South Asian immigrant men in particular remains vastly understudied in developed countries, and little is known about how and if men access these services. Traditionally, women have been the target of sexual health services while research on men's sexual health is limited. Studies suggest that South Asian men often possess lower knowledge regarding sexual health mainly due to cultural and other contextual factors than other migrant populations and have lower sexual healthcare utilization rates.

Despite a steady rise in cases of sexual health complications in Canada (e.g., gonorrhoea, chlamydia and syphilis), little to no data is available to better understand the overall sexual health service uptake of South Asian men community. In addition, inadequate attention has been given to the sexual health needs of South Asian immigrant men. Further, there remains an increased risk of developing secondary health conditions if proper sexual health diagnostic care is not available in terms of efficacy and quality. Therefore, it is imperative to understand how to create a more robust and improved sexual health services (e.g., as related to improved access, utilization of sexually transmitted infections screening services, increase awareness of sexual infection prevention, and increase compliance to treatment). The results of this study will deepen our understanding of the contextual factors that affect the overall uptake of sexual health services by the South Asian immigrant men and how to make sexual health services more helpful and respectful to immigrant and newcomer Canadian men.

The purpose of this study is to explore contextual factors (e.g., cultural, physical, psychological, social) specifically influencing overall accessibility (actual and/or perceived accessibility) and utilization of sexual health services by South Asian men in Canada. Knowledge and information generated from this study may assist policymakers, health care providers, and stakeholders in South Asian men's health to improve use of sexual health services (e.g., STI prevention, screening and treatment services) in Canada.

It is my hope to connect with the respectful South-Asian Canadian male community members from Durham and Waterloo Regions and to invite them to participate in this research project. I believe that the male participants will have unique understandings and stories relating to access and utilization of health services in Canada. The study will involve an interview of 30 minutes to 1 hour taking place via telephone or online platform. At the end of this study the publication of this thesis will share the knowledge from this study with those working on access and utilization of health care services and South-Asian community members.

I intend to provide the relevant community organizations with information flyers to be distributed by the organizations at their discretion. Study online-ad will be made available in social media platforms for any interested male volunteer to participate. Contact information for me will be contained on the flyers. If a member is interested in participating, they will be invited to contact me, Yamin Tauseef Jahangir, to discuss participation in this study in further detail.

200 UNIVERSITY AVENUE WEST, WATERLOO, ON, CANADA N2L 3G1

Participation is completely voluntary. You will make your own decision about whether or not you would like to be involved. You have the right to withdraw before any interview, skip any question, or at any time in the study, and you will still receive the remuneration. You will be asked questions such as, “I’m wondering if we can now talk about what you have learned about sexual health in general, sexual practices and beliefs after coming here in Canada?” or, “So, I would like to know, if we can talk about how important culture is to sexual health?” A thank you amount of \$20 will be provided at the end of the interview session. The amount received is taxable. It is participants’ responsibility to report this amount for income tax purposes. We will remove all information that could identify you from the data we have collected within 1 week and delete it permanently. You can withdraw your consent to participate and have your data destroyed by contacting us within this time period. After this time, it is not possible to withdraw your consent to participate as we have no way of knowing which responses are yours. Additionally, you will not be able to withdraw consent once papers and publications have been submitted to publishers. In addition, I understand that some participants may experience some discomfort answering questions on sexual health. If you experience distress, we will pause the interview and you may choose to end participation at any time. If you become upset following the interview, please consider contacting available services in our area (see table below). In addition, some demographic information (e.g., country of origin, marital status, education) would be collected at the end of the interview. This information is required to gain a comprehensive understanding to describe the sample of people in this study and to examine differences and trends across these characteristics.

Name	Contact
KW Counselling services in Kitchener	(519) 884-0000
Waterloo Pentecostal Assembly support groups	(519) 884-0530
Grand River Hospital - Kitchener-Waterloo Campus - Mental Health and Addiction Program - Adult Outpatient Services	519-749-4300 ext 2109
Here 24/7 Crisis Services	1-844-437-2347
Durham Counselling	905-666-6240 ext. 1

To support the findings of this study, quotations and excerpts from the stories will be used labelled with pseudonyms to protect the identity of the participants. Names of participants will not appear in the thesis or reports resulting from this study. Participants will not be identifiable in any way or by their medical experiences. Furthermore, participants are assured that their participation in this study will not hinder their access to or utilization of sexual health services in Canada in any way.

All paper field notes collected will be retained locked in my office and in a secure cabinet in the School of Public Health and Health Systems at the University of Waterloo. All paper notes will be confidentially destroyed after a minimum of seven years. Further, all electronic data will be stored in a CD with no personal identifiers and will be kept encrypted. Finally, only myself and my advisor, Dr. Samantha Meyer in the School of Public Health and Health Systems at the University of Waterloo will only have access to

these materials. While we will be discussing access to sexual health services you are in no way obligated to disclose any health related issue/diagnosis you may have experienced.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#42816). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca. However, the final decision about participation belongs to the male South-Asian Canadian members.

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me at 437-984-5133 or by email ytjahangir@uwaterloo.ca. You may also contact my supervisor, Dr. Samantha Meyer at 519-888-4567, ext. 49187 or by email samantha.meyer@uwaterloo.ca

I hope that the results of our study will be beneficial to the South Asian communities and families including South Asian youth across Canada, as well as the broader research community. I very much look forward to speaking with you and thank you in advance for your assistance with this project.

Yours sincerely,

Yamin Tauseef Jahangir
PhD Candidate
School of Public Health and Health Systems
University of Waterloo

Dr. Samantha Meyer
Associate Professor and Associate Director, Graduate Studies
School of Public Health and Health Systems
University of Waterloo



Appendix B – Recruitment Poster



UNIVERSITY OF
WATERLOO

FACULTY
OF HEALTH

MALE PARTICIPANTS NEEDED FOR SEXUAL HEALTH RESEARCH

Looking for South Asian men, age between 20-45 years, and in Canada for at least 1 year

Your participation would involve a 30 min -1 hour interview

Interview will take place via phone or online platform

In appreciation of your time, you will receive \$20

For more information about this study, or to volunteer for this study, please contact:

Yamin Tauseef Jahangir
ytjahangir@uwaterloo.ca

This study has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#42816)

Appendix C – Participant Consent Form

CONSENT FORM

By By agreeing to participate in the study, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about a study being conducted by Yamin Tauseef Jahangir of the School of Public Health and Health Systems at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#42816). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact Yamin Tauseef Jahangir at ytjahangir@uwaterloo.ca

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

YES NO

I agree to have my interview audio recorded.

YES NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

YES NO

Participant Name: _____ (Please print)

Verbal consent was received YES NO

Witness Name: _____ (Please print)

Date: _____