

## Article

# Factors Influencing Sexual Health Service Use by South Asian Immigrant Men Living in Ontario, Canada: A Qualitative Study

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**Abstract:** Introduction: South Asian communities comprise one of the fastest-growing populations in Canada, but there is a paucity of research on if and how immigrant men use sexual health services. Objectives: Our study aimed to understand factors influencing sexual health service use by South Asian immigrant men living in Ontario, Canada. Methods: An interpretive description (ID) research methodology was used, followed by Braun and Clarke's thematic guidelines to collect and analyze data. Altogether, 18 semi-structured interviews were conducted between May and July 2021 with South Asian immigrant men between 20 and 45 years of age in Ontario. Results: We found that culture shaped the overall perception and use of sexual health services, while the perceived severity of sexual illness also affected the utilization of preventative care. Moreover, there are taboos about sexual health, and while sex positivity and sex negativity exist, sexual health information is shared with trusted sources. We also found South Asian men shared sexual health more openly by following a lifestyle that normalizes sexual health discussions rather than South Asian cultural norms. Conclusions: This study provides a comprehensive understanding of the individual, structural and cultural determinants of health influencing sexual health service use to strengthen existing health communication strategies to improve service utilization for diverse communities in Canada.



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**Keywords:** sexual health service; South Asian immigrant men; sexual health service use; immigrant men; use of sexual health services; men's health in Ontario; Canada

## 1. Introduction

Over the years, migration patterns in high-income countries have changed considerably, and in recent years, a greater proportion of migrants have been from Asia, particularly South Asia [1–3]. The term 'South Asian' is an individual who self-identifies as having ancestry relations and/or that originates in South Asia, (e.g., having an origin as a Bangladeshi, Gujrati, Pakistani, Punjabi, Nepali, Sinhalese, Sri Lankan, Tamil) [4]. It is projected that by 2031, 55% of Canada's foreign-born population will report origins in South Asia [5].

However, among many healthcare services that are available for new immigrants, sexual health remains less prioritized [6–8]. Sexual health services include primary and secondary preventative care, health promotion on sexual health, screening, testing, treatment, and follow-up for sexually transmitted infections (STIs) [9]. However, a paucity of research has focused particularly on South Asian immigrant men's health and consequently, how to develop effective services for these populations [8]. Indeed, most sexual health programs prioritize women and overlook the sexual healthcare needs of men, and despite a steady rise in cases of sexual illness in Canada, there is little data available to explain the infection rates among South Asian men [10]. Instead, studies have found that men do not prioritize their health and wellbeing and often delay in accessing health care services, particularly for STI illnesses [11–14].

Sexual health services in Canada range from 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 [15]. Furthermore, sexual health services can be accessed through public health units, various community health services, or through university campuses [15]. Apart from the clinical services, Canada also focuses heavily on sexual health promotion and health education, such as on sexually transmitted and blood-borne infection (STBBI) prevention guides (e.g., prophylaxis, antimicrobial resistance treatment, co-infection management and follow-ups) [16–18]. Besides, a comprehensive sexual health education guide also considers physiological, emotional, social, and cultural dimensions of health [19,20]. However, sexually transmitted infections (STIs) continue to be a significant and ever-increasing public health concern in Canada [21]. There also remains an alarming gap in the sexual health knowledge among diverse populations in Canada [22].

Insofar, we have found that there are differences in the way sexual health services are used by South Asian men in high-income economy countries (e.g., in terms of screening, diagnosis, treatment and preventative care) [23,24]. Also, there is limited research to understand if and how new immigrants utilize sexual healthcare services in Canada [25]. Moreover, studies found that in comparison to the non-immigrant populations, South Asian immigrant men's use of sexual health services is often hindered by cultural stigma, provider attitude, lack of information about service availability, language barriers, time constraints, unavailability of viable transport options, and length of stay in a community [26–30]. Likewise, culture can further shape how South Asian immigrant men discuss and perceive sexual health, and conflicts between the cultural and traditional values regarding sexual health often remain within South Asian communities [28,31]. Also, literature found that ethnicity and socioeconomic status may affect some South Asian men psychologically and emotionally, which may further hinder their use of healthcare services [32]. Furthermore, it has been found that there is reported variability in terms of sexual health service use by South Asian immigrant men and that the uptake remains low, that is, while some men are accessing sexual healthcare services (e.g., testing regularly for STIs and HIV), others are not accessing sexual healthcare services due to lack of awareness of sexual health and poor health literacy [24].

Reports also suggest that due to this misinformation and lack of knowledge, South Asian men are not aware of the sexual healthcare services available in their vicinity [21,23]. Additionally, illness stigma related to sexual health and patient confidentiality issues are also concerning factors that result in poor sexual health service use [26]. For example, privacy concerns, inaccessible clinic hours, and perceived homophobia were also found to further act as factors that decrease the uptake of sexual healthcare services for men [33,34]. In addition, study reports related to social support networks, sexual orientation, health beliefs, and personal health practices all act as barriers to the use of sexual healthcare services among culturally diverse communities [35]. Furthermore, findings suggest that South Asian men or women do not want to follow the prescribed Western biomedicine or access healthcare services in general since they perceive their lives are shaped by entirely different social and cultural norms [36]. Therefore, more attention is needed to understand factors that can influence South Asian men's utilization of sexual health services to improve service uptake strategies.

Likewise, in many study contexts, gender, which is defined as a social and cultural construct that shapes relationships, behaviours, relative power, and other traits that societies ascribe to men or women, is also an important indicator that may influence overall health-seeking behavior [37–41]. Gender can also affect the sexual behaviour of men that is also influenced by all other social and cultural factors [42,43]. For example, studies found that immigrants from culturally diverse backgrounds often undergo the process of adaptation to the cultures and traditions of the high-income societies in their host country while they also try to retain their own cultural beliefs and practices [44–46]. However, the South Asian community is often represented more collectively as national markers [47]. Also, the term South Asian should not be used as a collective identifier considering the diversity of

experiences captured under the term ‘South Asian’, and it is important to be mindful of the social and spatial complexities embedded within South Asian communities [47]. 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 [48]. Likewise, this may relate to various ethnic traditions (e.g., Dali, Terai, Chhetri/Brahmin, Janajati) and the religion of South Asian men that may define their gender roles and sexual behaviour through cultural beliefs and practices [48,49]. What we know from other documented findings are the unique aspects of South Asians that 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—all of which may further influence overall gender roles [47].

The aforementioned contexts suggest 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. While the South Asian population is growing, we know little about if and how South Asian men use sexual healthcare services in Canada. Therefore, it is important to learn more about the overall sexual health service use by South Asian men, particularly those who identify as immigrants/newcomers to Canada. As a result, this study aimed to explore the factors influencing sexual health service use by South Asian immigrant men in Canada. Beyond what is documented above, our study originality lies in understanding the healthcare needs of South Asian immigrant men and in doing so, we identify the factors that influence sexual health service uptake by South Asian men in Canada to recommend more robust and improved sexual healthcare services for this population.

## 2. Methods

### 2.1. Study Context and Participant Selection

This study was conducted between May and July 2021 in Ontario, Canada, where most immigrants of South Asian origin reside [50,51]. Even though in Canada it is recommended that sexually active men and women should go for regular sexual health check-ups, 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 [52]. Participants were selected according to the immigration status defined by Immigration, Refugees and Citizenship Canada (IRCC) [53]. Inclusion criteria included: (1) South Asian immigrant men living in Canada (2) living in Canada for at least one year and currently residing in Ontario (3) users of independent practice clinics (e.g., independent family doctor clinics), community health centers, and other healthcare facilities in Ontario. Men who had engaged with these services were included as participants. We wanted to understand their perspectives or experiences on the challenges in access to and utilization of healthcare services and identify the factors that enabled them to use services. This would allow us to identify barriers and means to overcome these barriers and increase service uptake by men in Canada.

Additionally, non-users of sexual healthcare services were included as a part of the sample characteristics to gain further insights into their perspectives about access to and utilization of sexual healthcare services. However, no discernable differences related to the study aim were noted in the participant groups. Participants were recruited through ads on social media platforms, non-government websites, organization e-newsletters, and poster distribution within several non-government organizations. Interested participants contacted the first author by email, and screening was conducted by email or telephone.

### 2.2. Data Collection and Analysis

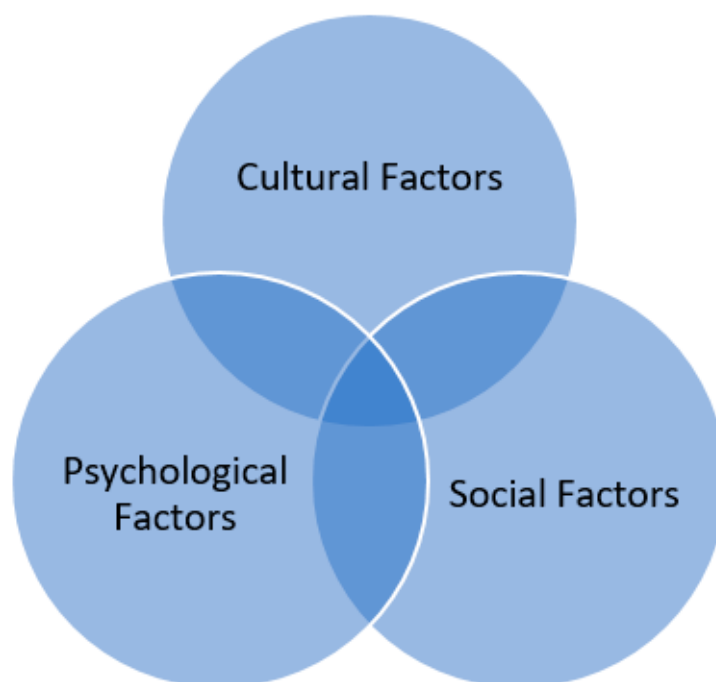
In total, 18 semi-structured telephone interviews were conducted, and the interview guide was tailored to elicit insights related to the use of sexual health services. Some of the key questions to our participants included practices or beliefs about sexual health; South Asian men’s education (formal 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 the research team coded verbatim transcripts. Interviews and discussions were facilitated in English and for the nature of the interview, participants provided informed consent verbally that has been recorded, while 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) [54], 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 [55,56]. As this methodology provides a structure for qualitative studies of clinical phenomena of interest for health professions, it fits our study aim. In addition, 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) [57] guidelines for thematic analysis. The adequate density of data was reached when no new significant data were emerging to deepen the understanding of the phenomenon [56,58]. Following Braun and Clarke's (2006) thematic summary guidelines [57], an analytic exercise guided the thematic statements relevant to the aim of our study that was organized by conceptually relevant categories using NVivo Pro software 12 [57,59].

### 3. Results

Drawing on the ecological model [60,61], our data represent the cultural, social and psychological domains that often have overlapped, as illustrated in Figure 1. However, we parse them out here and speak to the psychological, social and cultural factors influencing sexual health service use. In addition, the sociodemographic characteristics of the participants, including age, country of origin, length of time in Ontario, education, occupation, and religion, are presented in Table 1.



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

**Table 1.** Sociodemographic characteristics of all respondents.

Characteristics	Participants (n)
<b>Age (years)</b>	
20–22	2
23–25	2
>25	14
<b>Length of time in Ontario (years)</b>	
1–2	13
3–4	5
<b>Education Level</b>	
Master’s Degree	6
Undergraduate Degree	12
<b>Country of Origin</b>	
Bangladesh	5
India	9
Pakistan	2
Nepal	2
<b>Occupation</b>	
Full-time employment	8
Part-time employment	7
Self-employment	3
<b>Religion</b>	
Islam	7
Hindu	11

### 3.1. Cultural Factors

#### 3.1.1. Culture Influences Perceptions about Sexual Health

From our in-depth interviews, we found that culture shapes overall perceptions about sexual health and wellbeing. Our participants believe that South Asian culture may influence perceptions 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). We highlight the views of a 22-year-old Anand from India, who mentioned that culture can influence sexual health perceptions in certain ways, such as how people would use sexual healthcare services. He explained as follows,

*“Yes! I would say so [culture does influence sexual health use], because the culture like within different states or a different part of the country, I could experience that, some people follow their culture strictly, because of the way they were brought up, so your culture has a particular influence on you, and also it shapes your overall understanding about health in general and also about using sexual health information and using these services.”*

—(Anand, an immigrant from India)

We also learned from our participants that culture often formed the foundation for how sexual health would be perceived in a particular South Asian society. These perceptions are valued and retained even after migrating to a new country. Hence, considering the use of sexual health services, such perceptions about culture as mentioned by our participants are more related to individual factors rather than health system-level factors and can influence the use of sexual health services in Canada. Therefore, it is important to address these aspects of cultural dominance to ensure improved utilization of sexual health services within the South Asian communities.

### 3.1.2. Prescriptive Gender Stereotypes about South Asian Men

Our participants mentioned prescriptive gender stereotypes that often exist in South Asian communities that can also influence overall sexual health service use. For example, some of our participants mentioned South Asian men being reluctant to use services as they have certain cultural views or due to the issue of gender stereotypes. Participants mentioned that men are often concerned about visiting a provider as familiarity within the South Asian communities can influence how people would interact with the healthcare provider (e.g., if they are South Asian). The extract from a 33-year-old Sriram of Indian origin explains how gender stereotypes play an integral role in both South Asian men's use of sexual health services.

*"I think men and women from South Asian origin would be reluctant to use [sexual] health clinics or feel uncomfortable or insecure [in using services]. [The reason being] the set cultural views and opinions you may have. Like, you may go to a clinic, and you might see somebody or, you know, the clinic is located [nearby], and you feel uncomfortable going there because somebody from your community might also see you there. So, you know, it's quite common that people talk about people, and, if someone sees you, then they can tell your family or others about your visit [to the sexual health clinic]. There are some prescriptive gender stereotypes about sexual health in our society. People [men] will be stereotyped as not worthy [as a man in the society]. Yeah, culture can play a big part in not letting people use these [sexual health] services."*

—(Sriram, an immigrant from India)

From these interviews, we have learned that the social scripts on gender roles play an important part and that prescriptive gender stereotypes may hinder access to sexual health services for some South Asian men.

## 3.2. Psychological Factors

### 3.2.1. Perceived Severity of Illness

We learned from our interviews that there are facets that can influence an individual psychologically and/or socially and how these domains overlap in influencing the use of sexual health services. For example, from our participants' perspectives, the perceived severity of sexual illness plays a role in their health-seeking decisions. For instance, our participant Zaiyan, a 20-year-old man from Bangladesh who is unmarried and working a full-time job in Ontario, said,

*"Yes, [the choice of using sexual health services] depends on the severity of the [sexual] illness as well and the level of my tolerance. If this [the sexual complication/illness] is something that gets cured easily like with medication and stuff, then I think I wouldn't bother to use services [ . . . ]."*

—(Zaiyan, an immigrant from Bangladesh)

Our participants mentioned they would prefer to continue with their everyday life and not be concerned about their sexual health. While for some of our participants like 23-year old Ezaan, who did not visit any sexual health service for a long time in Canada, and others like Hossain, a 23-year old unmarried man working in a part-time job from a Pakistani ethnic background in Canada, said that even though he is sexually active, he would only consider using a sexual health service once there is something that is bothering him daily and only then would seek for a doctor consultation, otherwise not.

*"I mean, if you ask me, 'oh, do you know, this [sexual health services] does exist? I would say probably, but I wouldn't tell you [ . . . ] I don't think . . . I would probably not inquire. I probably not go for it [sexual health service]. I see it [sexual health check-ups] not to be so important, and just go for it when I need to, yeah. But, yeah, so, I guess I would probably seek help if something [sexual health complications/illness] happened."*

—(Hossain, an immigrant from Pakistan)

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.

### 3.2.2. 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 would opt for sexual health services as a matter of personal choice, and many prefer to get screened occasionally. Some of these participants also 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 21-year old participant Ikram as follows,

*“Generally, you don’t need them [sexual health services]. So it can be important. But it’s largely a personal thing where you choose to go, and it [availing services] can be considered as an optional choice for a check-up. And I guess going to the doctor for the right reasons it’s more of a tool, I would say. And they can be used, or you don’t need it all the time.”*

—(Ikram, an immigrant from Bangladesh)

We learned from our interviews that some of our unmarried South Asian participants are quite reluctant about their sexual health status and see the existing services as a needs-based service, and they would often see utilizing these services as a personal choice. Hence, it was interesting to learn from our data that some of our participants’ attitude toward sexual health in their everyday lives is related to making personal choices for using these services.

### 3.2.3. Sexual Health Considered Negatively by Some South Asian Men

From our in-depth interviews with immigrant participants, we found that seeking information about sexual health could be perceived negatively by some men in the South Asian communities. For example, some men would personally think that learning about sexual health or accessing sexual health education resources is a way of getting derailed from academics and other life lessons. Furthermore, some men are concerned about privacy or confidentiality when it comes to talking about sexual health. We provide an extract from Hossain, a 23-year-old man from Pakistan and living in Ontario for 3 years,

*“Oh, boy, I mean, my family, my parents, they never taught me anything [about sexual health]. You know, my dad was a strong, silent type. But I have found on many occasions that some of the [sexual health] things you know what it is [meaning sexual illness/complications], to discuss about them is kind of prohibited as some see these things negatively, you know, people look at it as something that’s kind of a bad thing. Or even learning about it is seen as a bad thing to do.”*

—(Hossain, an immigrant from Pakistan)

In addition, some of our participants said the overall lack of information about sexual health from an early stage of life could also affect some South Asian men to delay in seeking treatment and face consequences when conditions are more symptomatic. For example, our 23-year-old unmarried participant Ezaan from Bangladesh, shared that South Asian men often have limited knowledge about sexual health from their early childhood, which may hinder the proper use of sexual health services as men may not fully understand service options. This, Ezaan 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,

*“But I think society takes the wrong ideas and like makes these implications [about sexual health] and there remains limited access to information in South Asian communities, like from childhood or school days. And it’s been a tradition, and it has been passed down*



*from like generations. And I think part of it is cultural and the other part could be how people take sexual health negatively [the mentality]."*

—(Ezaan, an immigrant from Bangladesh)

Therefore, while there remains uncertainty about privacy and confidentiality among some South Asian men to discuss sexual health matters, often cultural and psychological factors may overlap for South Asian communities in terms of how South Asians receive health education, or the lack of education resources can influence service use.

### 3.3. Social Factors

#### 3.3.1. Sexual Health as Taboo

Sexual health has been considered a taboo by our South Asian participants. To elucidate, as mentioned by 24-year-old immigrant Mizaan from Bangladesh, beliefs about sex and sexual health are often left upspoken within families or communities and sexual health is often seen by many as tied to the religion. He further mentioned that discussing sexual health is strictly prohibited within the family sphere. Mizaan explained as follows,

*"Well, really, in my house, usually this [sexual health] was a really taboo subject, so no one really spoke about it [sexual health], and we didn't have any sort of like sexual health or sex ed at school. But so, when I was coming of age, like during puberty, my dad kind of told me how to, like, get through that stage. But I wouldn't really call it like, being made aware of sexual health. It was more of being made aware of what I might be going through [as a teenager] like during that time. Yeah, I definitely think there's this sort of stigma or taboo associated with it [sexual health], or there is the religion that is tied to it [in not discussing sexual health] as well in the South Asian communities, like, oh, it's something you shouldn't talk about within the family and it is prohibited."*

—(Mizaan, an immigrant from Bangladesh)

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 immigrant men.

#### 3.3.2. Issues Related to Sex Positivity and Sex Negativity

From our in-depth interviews, our participants emphasized the notions of sex positivity or sex negativity existing within the South Asian social environment. Some participants related sex positivity to learning about the various aspects of sexual health and well-being. Such education would allow sexual health more of a general topic in South Asian communities for discussions, minimize any illness stigma attached to sexual health, and improve access and use of sexual health services. In addition, we learned from our participants that being sex-positive could be a way for the South Asian youth to be more educated and proactively seek regular check-ups. Ezaan further explained as follows,

*"I think being sex positive is really important, as it helps you to be educated and become proactive to get like sexual health check-ups regularly because like, you never know when you might be infected with some type of disease or even if it's not a disease, it's some . . . like some sort of like dysfunction. Like because if you do not have proper [sex] education, you don't have the mindset and maybe never went for a check-up, so you wouldn't know what's wrong with you unless, like, sometimes it [illness] might even be hidden and you wouldn't know until you're like in a situation where you find it out, and it's like, it's affecting you."*

—(Ezaan, an immigrant from Bangladesh)

On the contrary, some of our participants described the existence of sex negativity in South Asian social circles. One of our participants, 22-year-old Rohan from India, explained that some South Asian men think there is nothing important to learn about sexual health and that all efforts should be given to other aspects of life, such as improving life skills. He mentioned as follows,



*“The culture we grew up in is more directed towards academics, so, for some South Asian men, they would be very sex negative and would be like, ‘hey, you should be focused more on studies. This [sexual health education] is stuff you should not be getting into because we know what the . . . what this stuff can get you to end’, that you’ll be stuck there [thinking about sexual health] because that’s a lot of people who grew up, they, when they’re exposed to these things [sexual health education] and when they get a lot of knowledge about it, they get stuck there. And like that’s the belief that we had. Like, ‘hey, they got stuck there.’ But these South Asian men think people should focus more on other stuff, like improving life skills, etc., and not on sexual health.”*

—(Rohan, an immigrant from India)

These extracts above explain that sex positivity and sex negativity exist within the South Asian communities, while there may be varied explanations for each term. However, it is important to consider if and how sexual health education and discussions about sexual health and wellbeing are shared in South Asian communities as it may provide more insight into how South Asian men understand the terms sex positivity and sex negatively more comprehensively.

### 3.3.3. Sexual Health Discussion with Trusted Sources and Following the Western Lifestyle Approach

From our in-depth interviews, we learned that some participants discuss sexual health only with their trusted sources (e.g., friends, family, or relatives). For example, friends and family of similar age range would be more easily approached to discuss sexual health, and as explained by our participant Rashed,

*“It [sexual health discussion] went relatively well, especially like it depends also on the type of friendship that we have and also if I can confide in a particular family member to talk to. And so, I think based on the type of friendship that I had with my friends, or family bonding like that was the main factor that led to a very open conversation [about sexual health]. But like, if I were to discuss this just about like someone who I just met or like who I’ve been talking to for a few days, and it wouldn’t go so well. So that’s kind of the environment that you were in. Also, similar age range matters in an open discussion.”*

—(Rashed, an immigrant from Bangladesh)

Furthermore, our participants highlighted that a South Asian family would openly discuss sexual health if they get accustomed to sharing sexual health information more openly by adapting to the lifestyle where sexual health discussions are more normalized (i.e., as our participants said by being more ‘Canadian’) and by being less conservative to discuss sexual health. According to some participants, adapting to Canadian life and the norms and cultures of the host country may influence their liberal views about sexual health. For example, even though sexual health is not proactively discussed in Canadian society, it is still a normalized topic and people can have discussions when necessary. As explained by our participants Ahmed and Zaiyan,

*“Like for someone who is purely Canadian or Canadianized [following a lifestyle that participants understand as relate to being open-minded in Canada], they’re going to think in the Western-lifestyle way, and they’re gonna assume that everyone or they would want their significant other to have that mindset and discuss sexual health more openly.”*

—(Ahmed, an immigrant from Pakistan)

*“In my family, we are quite ‘Canadianized’ [following a lifestyle that participants understand as related to being open-minded in Canada] and can talk about it [sexual health]. We do not have any issues within our family as we can share openly. You know we are more Canadian than South Asian in our culture, and we are less conservative.”*

—(Zaiyan, an immigrant from Bangladesh)

These extracts illustrate that as some South Asian men get more accustomed to the host country’s culture and norms, they may feel less conservative, unlike others who follow the

South Asian values and traditions and would prefer a more normalized discussion about sexual health within their social environment.

#### 4. Discussion

The findings from our study in the cultural, social, and psychological domains coincide with the literature as perceptions towards sexual health are often shaped by various cultural, social, educational, and psychosocial factors and behaviours for men [62]. Since Canada passed the *Canada Health Act* in 1984, the country has been committed to health promotion activities, and although it is situated mainly in the realm of primary healthcare, there remain many under-served populations that continue to experience considerable barriers in accessing and utilizing necessary health services (e.g., treatment and preventative care) in Canada including, Aboriginal people, people with alternate sexual orientation, immigrants, refugees, ethnically or racially diverse populations [63]. Likewise, it has been found from a survey in Canada that only 13% of sexually active youth populations visit the family physicians while only 6% of the youth mainly use sexual healthcare services [33]. While perceived severity of sexual illness plays an important role in health-seeking behaviour from our findings, men in our study often do not want to access services, and they view it as a personal choice and not deemed important. Our findings were consistent with other studies that found men to be less compliant with STI treatments, and they only access services when they needed them [64–66]. While this approach of delay in treatment-seeking behaviour may be related to a sense of masculinized stigma, men often would knowingly or unknowingly show a sense of patriarchal views about sexual health illness. Such behaviour also stems from constructed masculine practice behaviour of men who would often also hide their emotions and fears about STIs and delay in seeking care [67,68].

Furthermore, we found that poor use of preventative services might relate to sexual health taboos and concerns about confidentiality. We found similarities with one study where taboos related to sexual health, cultural issues, and stigma may shape the use of sexual health services by South Asian communities [69]. As there is a lack of disaggregated data on South Asian communities, it is challenging to identify major health concerns and strategies across South Asian communities [70]. Therefore, it is important to focus on building knowledge networks in the context of South Asian health.

Although these aforementioned factors are more individualistic than health system barriers, it is still important to focus on relevant, inclusive, and age-appropriate programs to improve sexual health outcomes. For example, expanding sexual healthcare service more in out-of-reach and under-served communities in Ontario is necessary since research found that men and women would often seek healthcare elsewhere, while other systemic barriers (e.g., racism, homophobia, sexism) limit the service use, which also needs to be addressed [34]. Hence, concerted efforts are needed to create a robust community health program (e.g., culturally appropriate health promotion strategies, gender-affirming health information) to normalize sexual healthcare services and eliminate barriers to timely care [18].

In addition, we found that sex positivity and sex negativity do exist within the South Asian communities and while sex positivity advocates for continuous, age-appropriate learning and access to comprehensive sexual healthcare and treatments, it is also important to realize that sex negativity can be viewed to be a risky behavior [71,72]. A sex-positive approach refers to the acceptance of a wide range of sexual expressions that sexual identities, orientations and behaviours, gender presentation, and access to healthcare and education, while the sex positivity approach further encompasses a cultural philosophy and celebrates sexual diversity, relationship structures, and individual choices based on consent [72]. On the contrary, sex negativity is considered a negative attitude towards any type of sexual behaviour other than married sex [72]. Therefore, improving access to sexual health education from an early age is important, and it is relevant to increase access to information opportunities for diverse communities.

It was interesting to learn from some of our participants that sexual health information was shared more openly by some participants who chose to adapt to the social lifestyle trends of the high-income economy host country and preferred to be less conservative and proactively discussed sexual health with their families and others. Given the time that our participants had living in Canada, we believe the adoption of more liberal views has led to discussing sexual health openly or normalizing sexual health as a topic of conversation. Our views have similarities with one study that suggests adaptation to the cultural norms of high-income economy host countries may often allow better choices in accessing and using preventive care or discussing health information for South Asians [24]. However, although much progress has been made in recognizing the importance of culture and ethnicity in sexual behaviours here in Canada, there is a need for a more holistic understanding of healthcare services that are made to be available for culturally diverse communities, as they comprise 19.1% of the Canadian population [73]. Hence, although age-appropriate sexual health information provisions are available in the Ontario healthcare system [15], it is important to focus on the new adult immigrants who may have had limited resources in gaining knowledge on sexual health to help them integrate better with the Canadian sexual health services [25].

Lastly, it is important to acknowledge that, although most of the aforementioned factors as our findings are not specific to the South Asian communities, these factors are worthy of attention as they continue to hinder the overall uptake of sexual health services among diverse populations in Canada. Besides, we learned about the cultural stigma regarding sexual health that exist among 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, while the literature further reinforces that gender stereotypes are not universal but are said to be moderated by culture [74]. Additionally, community healthcare service centres might prove unpopular if clients encounter the risk of meeting with peers from the same communities [75]. Therefore, it is important to aim to take a more behaviour change communication approach by addressing the challenges of prescriptive gender norms within South Asian communities and reducing individual illness stigma about sexual health.

## 5. Implications

Our study documented the complex interactions between social, cultural, and individual-level determinants of sexual health, thereby emphasizing creating more robust health communication and health promotion opportunities for South Asian communities in Ontario and beyond. There is also a need for a more patient-centred care approach and to ensure confidentiality that will improve service uptake among men. Using contextualized models of health promotion can recognize health disparities of culturally diverse communities and recommend tailored behaviour change interventions. However, it should be acknowledged that the participants in our study preferred to converse in the English language. Therefore, we further recommend that health promotional messages should also consider non-English-speaking South Asians with added barriers to utilizing healthcare services.

## 6. Limitations

One of the limitations of our study is that our sample was quite heterogeneous with regard to age, ethnicity, and religion, while sexual orientation, gender identity, and other factors may also pose greater challenges in sexual healthcare use that would require further investigation in the future studies. With a limited sample size, we may also have missed the opportunity to further understand the various factors in access to and utilization of overall sexual health 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.' Although we have made efforts to create thick inductive reasoning, which was the 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 possibilities of social desirability bias, and some selection bias as all participants were unmarried except for one.

## 7. Conclusions

It is important to recognize the various individual, social, and/or health systems perspectives together with the overall cultural influences in the utilization of sexual health-care services. Our data suggest there is a need for a more holistic approach in terms of strengthening the existing health education and health promotion models to address the various cultural, social, and psychological domains in South Asian communities regarding sexual health in Canada. It is imperative to strengthen the existing health communication structure that would help to de-stigmatize South Asian male sexuality from an early age, while behaviour change interventions such as abstinence and regular health check-ups should be emphasized among diverse communities.

Our study provides a unique understanding of the various factors shaping sexual health service use while recognizing the cultural determinants of sexual health-seeking behaviour among South Asian immigrant men.

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