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Australian Health Professionals Identify Barriers to Asian Women's Sexual Health

By Sandra Basham¹ and Jaya Dantas²

Abstract

This research article reports on the results of thematic analysis of semi-structured interviews conducted with 10 key informants as part of a larger study about barriers to Asian migrant women's sexual health. Thematic analysis was conducted with data to identify key themes about barriers to Asian women's engagement with sexual health services in Australia. Key informants identified four core barriers: external cultural and relational influences, the internal beliefs of the women informants, professional health workers' practices, and the health system service models. Key informants agreed that Asian women need time to build trust before discussing sexual topics with health workers predominantly due to lack of information and cultural shame. A cultural humility approach is advocated for health professionals and sexologists engaging Asian migrant women in sexual health services in Australia because Asian women's sexual health context does not fit with time-restrictive models of health care.

Keywords: Asia, Women's sexual health, Health professionals, Thematic analysis, Cultural humility

Introduction

Health professionals agree that migrant women residents in Australia do not easily present for screening tests like breast screening or pap tests (Department of Health, 2018). Some recent studies with Asian migrant populations are exploring reasons why Asian women do not seek these medical examinations (Mengesha et al., 2017). An assumption that bulk-billed Medicare services incentivize migrant women to seek sexual health services or sexual therapy in Australia is erroneous, as research indicates some women were unaware of this entitlement (Mengesha et al., 2017) or were anxious they may be serviced by a male practitioner, which is culturally or religiously unacceptable (Ussher et al., 2017).

Gender Bias in Asia

Asian nations like China, India, Indonesia, Malaysia and the Philippines have a history of cultural gender bias and are largely governed by men. Singapore's traditional society also possesses gender bias (Shah, 2016). This societal gender bias manifests in poor sex education for girls and little sexual health information being available to Asian women (Khuo, 2016; Steinhauer, 2016). The incidence of women's cancers is high in Asian developing nations (Ginsburg et al., 2017). STI's are similarly high (HIV and AIDS in India, 2017; Sully et al.,

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2019) and in some low-income nations the teen pregnancy incidence continues to rise (ARROW, 2015; Khoo, 2016) without adequate sex education and contraceptive options available (ARROW, 2015). The lack of health and sexual health information for women means sexual health self-care via screening tests in their nation of origin is not normalized by positive reinforcement (Bandura, 2003). It would be illogical to believe that women migrating from these cultural contexts change what has been normalized for them in a new nation. Australia is not free of gender bias; women still face gender discrimination in multiple arenas of life, examples being sexual discrimination, sexual harassment, employment discrimination, and not receiving equal pay (Australian Human Rights Commission, 2018). This places migrant women at further disadvantage.

Australian Context for Women's Sexual Health

Australia aims to make cervical cancer a thing of the past with HPV vaccinations and cervical screening tests (Cervical cancer, 2018). The country also aims to catch breast cancer at early stages via the free mammogram program (Breast Screen Australia, 2021). Additionally, doctors can provide bulk-billed medical assistance for sexual difficulties, yet these goals may be unachievable if a portion of the population remains unrepresented in the health statistics because they do not present for available services or treatment due to lack of knowledge or cultural reasons carried over through migration (Asif, 2018; Mengesha et al., 2017).

Australian medical systems do not generally work in client-centered ways as they are focused upon the professional expertise of staff, services offered, and a fast turnover for client sessions with 10-minute consultations on average (Department of Health & Human Services, 2015). Financial management of health organizations pressures staffing levels, and thus the aspiration of a clinic to help all peoples considering their culture is not achieved despite being aimed for (Department of Health, 2018). Cultural sensitivity is alluded to in documentation yet is not provided in practice. Staff have no cultural sensitivity training inclusive of cultural or religious needs of clients, and no time to build trust with clients (Lawrence, 2020). In Australia, medical training in cultural sensitivity is restricted to Aboriginal and Torres Strait Islanders (Royal Australian College of General Practitioners, 2020), yet Asian migrants are the largest non-Caucasian Australian community (Australian Bureau of Statistics, 2019); hence the researcher observed a need for this study.

Health professionals and women community leaders have a valuable perspective on reasons why Asian women clients struggle with sexual health issues or treatments. This article presents the results of thematic analysis of semi-structured interviews conducted with eight women health professionals and two religious ministers serving Asian communities in Australia. The results identify barriers discussed by the key informants, the core themes of the barriers from thematic analysis (Castleberry & Nolen, 2018), and the informant's ideas for best practices in engaging Asian migrant women in sexual health services.

Background

China, India, Indonesia, Malaysia, the Philippines, and Singapore are the migrant nations of this research. For clarity, the World Health Organization's (WHO) definition of sexual health was utilized in the research (World Health Organization, 2020). This definition includes broad categories about gender diversities, sexual identity, sexual orientation differences, sexual behaviors, sexual pleasure, and informed consent as part of sexual health. Current research of the six Asian nations of this study evidences that these criteria are not included in government-provided sex education programs (ARROW, 2015).

Asian migrant women do not readily engage in sexual health screening services in their nations of origin or in Australia nor present to sex therapists or sexologists for assistance with sexual health problems (Crawford et al., 2016). Researching why they do not is vital for public health. A goal of this research was to identify barriers to Asian migrant women engaging with

sexual health professionals or women's sexual health services in Australia from health professionals' perspectives as a point of comparison to the research participants' identified barriers. The religious ministers were asked their perspective on barriers from religious and cultural perspectives because the research participants all shared a common religion.

Another research goal was having the health professionals identify what practice changes they thought could help Asian migrant women to engage in preventative sexual health practices like pap screening, breast checks, or seeking sexual health assistance for difficulties such as painful sex or psychological problems related to sexual activity and trauma.

Theoretical Framework

The appropriateness of using reductionist medical methods utilized in western medical and health practice with culturally, religiously, and linguistically diverse (CRaLD) migrant clients is under question. CRaLD women, as the researcher titles them, may be from one national culture yet have a differing religion. For example, India has Hindu, Sikh, Islamic, and Christian populations, and these religions will influence women's ideas of what is normal practice within their dominant culture. Hence, religion is an influential variable as well as culture and language, on women's ideas about sexual health (Bhartiya, 2013).

A medical anthropological method espoused by the Canadian Medical Protective Association (CMPA) (2014) is a foundation for engagement with migrant communities, health promotion, and effective sexual health practice with migrant women. The CMPA espouses that health practitioners should build practice environments where "cultural safety" (n. p.) for clients includes respecting the client's autonomy within the context of the client's worldview and building a relationship of trust over time. This includes the concept that health practitioners take time and learn from their clients with "cultural humility" (n. p.) and curiosity about how the clients can best meet their own needs with the assistance of the practitioner and the resources they have (Canadian Medical Protective Association, 2014).

Underpinning this paper is the concept of cultural humility (Foronda et al., 2016; MacKenzie & Hatala, 2019), which differs from cultural competence in that cultural competence focuses on acquiring knowledge of differing cultures and cultural practices in an attempt to understand the people from those cultures. Yet, cultural competence implies that the professional retains an expert position without necessarily having to demonstrate "openness" to new ideas and influences, or to show awareness of "power imbalances" in the therapeutic relationship with "institutional accountability" (e. 125) for ethical practice over a lifetime (MacKenzie & Hatala, 2019). In contrast, cultural humility in practitioners is manifested by working with the client in person-centered, non-directive, and respectful ways, helping the client achieve their desired outcome within a trusted, safe relationship built over time. The health professional enters a supportive, listening, and respectful relationship to meet client needs (Foronda et al., 2016). This medical anthropological practice is an emic approach to working with patients that is respectful of culture, religion, and gender roles in migrant communities (Leung & Nakayama, 2017).

Methods

It is accepted in qualitative research that the research sample size for studies is smaller than quantitative samples due to the depth of data and the time taken to gather and analyze it (Palinkas et al., 2015). A goal of qualitative research is to use the "information rich" (p. 534) interviews to find a "saturation" point of data (p. 535) from question responses, where no new ideas are forthcoming from the participants (Palinkas et al., 2015). This research matched these criteria. Qualitative research methods were chosen as the most appropriate method to identify barriers to sexual health from two emic perspectives: the participants and key informants who engage in sexual health related consultations. Semi-structured interviews were conducted and

transcribed verbatim into word documents for coding using NVivo11 as the basis for thematic analysis of the coded data (Liamputtong, 2019).

Recruitment of Participants

The key informants were a purposeful sample (Palinkas et al., 2015) of eight health professionals residing in Australia who had worked with Asian women in Asia or within Australia and were conversant with cultural issues. They were accessed via churches, professional associations, and social contacts working in health care who distributed invitations from the researcher about participating in the research as an informant (Liamputtong, 2019). All participants provided written consent prior to audio recorded interviews and verbal consent during and after the interviews for their data to be used for publication.

The two religious leaders ministering to large Asian communities were included. The women leaders were directly contacted via an information pack and email to ask for key informants who had experience with Asian women asking them about sexual problems. Six of the ten key informants were Asians, which added to the relevance of their inclusion in the study.

As this study focused on women's sexual health in cultures where it is inappropriate for men to treat women (True.org, 2018a), no men were recruited as key informants. Key informants needed to have evidence of working with women's sexual health within the six Asian communities of the doctoral study. Asian women were preferred as key informants due to cultural relevance; however, other health professionals of differing ethnicity with experience working with Asian women were included. Women who could not speak English were excluded as hiring translators would have been cost prohibitive for the researcher.

Setting

The researcher hired premises with confidential spaces to conduct face-to-face audio interviews using the same open-ended questions (Palinkas et al., 2015) for each key informant so that the responses could be a foundation for coding. No interviews were conducted in a home or church due to privacy concerns.

Interviews

A recognized qualitative methodology is audio interviews (Castleberry & Nolen, 2018). Semi-structured audio interviews of eight health professionals and two ministers of religion were conducted using the same open-ended questions (Farrell, 2016). The health professionals were asked to discuss barriers within the health system and in their professional practice. Identifying barriers facing Asian migrant women is a reason why they do not engage. Professional health workers and religious ministers can identify other barriers to women's engagement with sexual health services from a service-provider perspective.

The average interview lasted one hour when the data saturation point was reached (Castleberry & Nolen, 2018). The audio interviews were transcribed verbatim by a hired assistant who signed a confidentiality agreement, and the transcriptions were uploaded into NVivo11 for coding and analysis of transcriptions by the researcher.

Ethics

The research complied with the National Statement on Ethical Conduct in Human research (NHMRC, 2018). All key informants received information from the researcher in advance of their audio interview, identifying the question topics in advance (Farrell, 2016) so they were prepared to give informed consent and respond to questions. Key informants were advised that they could rescind their participation at any stage prior to and after the interviews. None of the informants chose to rescind their participation.

All informants provided written consent for their de-identified data to be used for Thematic Analysis and this article. Key informants were de-identified to protect their privacy

during transcription and in the article. Researchers assured any identifying information and the audio-recording would be destroyed at the completion of the research (NHMRC, 2018). The de-identified demographics of the key informants are included in Table 1.

Research Rigor

The researcher notated the process of the research, keeping secure copies of the consent forms, de-identified questions, interview transcripts and relevant correspondence. In the analysis section, a description of the coding process and thematic analysis is provided. The researcher ensures an audit trail is possible and that similar research could be duplicated (Nowell et al., 2017).

Table 1: Demographics of Key Informants

Name	Profession
R	Sri Lankan. 55-65 y/o. Medical doctor. Retired
E	Australian. 55-65 y/o. Medical doctor. Retired. Minister of religion
F	Filipina. 25-35 y/o. Nurse/Midwife
M	Singaporean. 35-45 y/o. Nurse
Me	Filipina. 35-45 y/o. Nurse/Midwife
T	Malaysian 45-55 y/o. Nurse
H	English-Australian 55-65 y/o. Medical doctor in practice
A	Australian 45-55 y/o. Nurse. Incontinence specialist
La	Chinese Malaysian 55-65 y/o. Religious minister
Ro	Australian 35-45 y/o. Minister

Coding

Interview transcriptions were uploaded into NVivo 11 software for coding based upon topical responses to questions asked of all key informants. The coding process entailed categorizing words from the 10 key informant transcripts into distinct topical subject groups shared across the dataset (Saldana, 2015). The primary codes related directly to key informant's responses to the interview questions about their experience with Asian women's sexual health

and barriers they could identify. For example, cultural sensitivity, sexual health, taboo, shame, poor knowledge, and the husband's influence related to topical questions and collective responses across the dataset (Saldana, 2015). Secondary codes were distilled from the primary codes and revealed the underlying core barriers; for example, the taboo about women discussing sexual matters distilled into a secondary code, a barrier of embarrassment and shame about sex.

Table 2: Primary and Secondary Barrier Codes

Primary Codes	Secondary Codes
Low cultural sensitivity of professional	Health professional imposes their own worldview
Client wants female professional	Asian women not trusting male health professionals
Client's cultural taboo & shame	Women not talking about sexual topics easily due to embarrassment and shame
Client's poor sexual-health education	Asian women ashamed of poor knowledge
Influence of husband	Asian women's reliance upon husband's permission
Low trust of health workers	Time not allowed for longer sessions to build trust. A bad prior experience.
The language health workers use	Some Asian languages do not have words for women's gynecology/physiology
Client anxiety	Health workers not explaining what is required and why
Asian women ignoring pain	Asian tradition that women look after others first

Analysis

Thematic Analysis

Thematic Analysis (Nowell et al., 2017) of the data was utilized to analyze the coded data by looking for shared patterns of ideas, meanings, or concepts that interviewees identified:

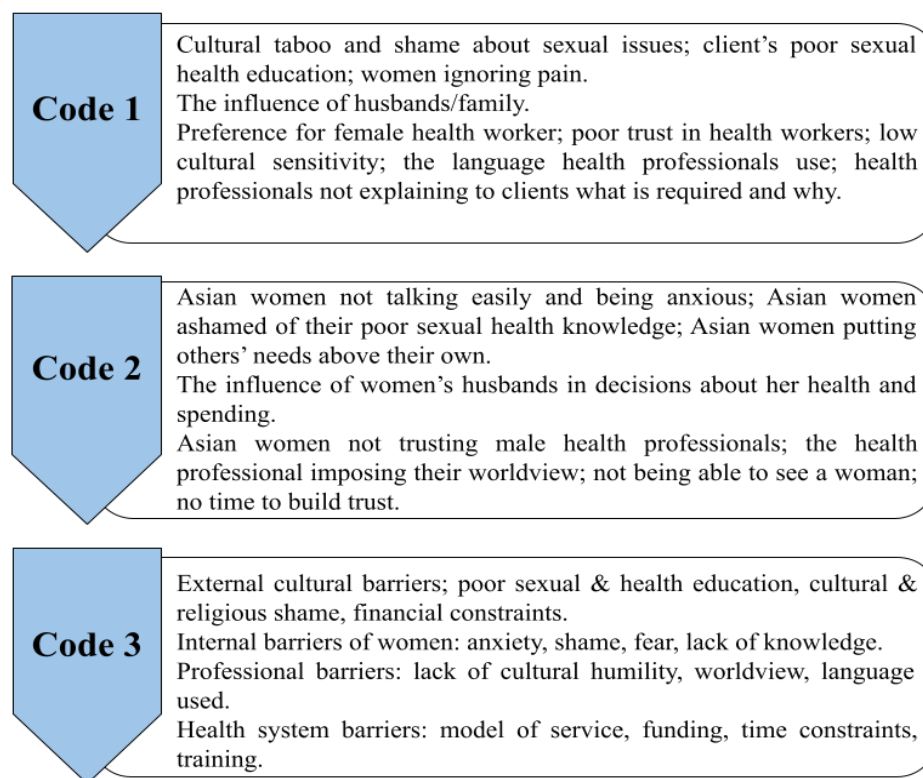
1. Shared barriers the key informants identified as blocking Asian women from engaging in sexual health care in Australia
2. Barriers the practitioners identified related to their work with Asian women, including women's cultural or religious issues
3. What the health practitioners identified that they needed to develop cultural humility

The process of Thematic Analysis (Nowell et al., 2017) identifies commonly held experiences, ideas, and core beliefs about a shared phenomenon and encapsulates these concepts into overarching meanings; the process is shown in Figure 1. Thematic analysis was

undertaken with the coded data to group the primary and secondary codes into core concepts or shared themes about barriers, these being underlying concepts commonly held by the key informants (Nowell et al., 2017).

The coding process revealed interconnected patterns of meaning shared by key informants. Codes were sorted into core life context influences that were barriers to Asian women engaging within the Australian health system. For example, the shame and embarrassment Asian women felt about sexual topics was an internal psychological barrier the women needed to overcome to engage in sexual health treatment. The poor sex education women received in their nation of origin was an external barrier socially learnt, reinforced, and internalized (Bandura, 2003). The bad experience an Asian woman had with a health professional was a professional barrier while the time constraints of a 10-minute medical consultation with an Asian woman client was a health system barrier as these women take longer to disclose sexual problems (Department of Health, 2018). Figure 1 shows the distillation process from coding to identifying core barriers.

Figure 1: Thematic Analysis Process to Identify Barriers Results



Thematic analysis revealed four types of core barriers. Barriers external to the client that key informants identified were culturally based: the lack of necessary sexual health information available in their nation of origin, Asian governments not providing sexual health education and information, cultural expectations of Asian woman being quiet and not assertive, and Asian women's need to ask their husband for funds to access health care.

The analysis identified internal barriers that Asian women faced: embarrassment, anxiety, and shame about asking for sexual information; feeling ashamed about their lack of knowledge about sexual health matters, body, and genital shame.

Professional barriers identified were male health workers, health workers who used a language the women do not understand, professionals not explaining the need for a service or how a service will be performed, and professionals not taking time to build trust with a client.

Health system barriers identified were focused on the professional's capacity and not the client's need, i.e., service models emphasizing short consultations and service models focused on high patient turnover. A lack of women's health services is a common reality for women in Asian low- and middle-income nations (IWHC, 2019). There is a lack of government provided sex education; Asian governments other than Singapore do not prioritize policy and funding for women's sexual health and offer poor sexual health service provisions.

External barriers were centered in the cultural context of the nation of origin. Verbatim examples of key informant's comments on the disadvantages Asian women face are listed below to provide examples of the four core barriers identified.

External Barriers

Lack of knowledge and information Asian women had about their body structures, sexuality, and health was identified by the key informants as a major external barrier. The 22 participants also contextualized this barrier in their religious, cultural, educational, and public health program backgrounds. These external socio-political forces prevented Asian women having knowledge that could protect their health and lives. "E," a retired doctor who practiced in Asia, commented about the lack of knowledge of the women she helped: "A lot of ignorance about their bodies and sex...people aren't well educated about women's health or sex, so there was a lot of... just, misunderstanding."

"F," a Filipina midwife, explains the lack of knowledge and the consequences: "That's why some young girls became pregnant, because they don't know about sex, they were not aware of what it was they did to be pregnant." "Me," also a Filipina midwife, added to the narrative of lack of information: "They're not aware of it, how it happens and what sex really is. They know bits, but do not understand...some are shown porn by boyfriends." The phenomena of pornography being a source of information about sex for women in Asia and the issue of sexual practices being modeled in a way that could damage a woman's sexual health is a topic worth exploring in the future.

"H," a doctor currently in practice in Australia, outlines how lack of information increases women's anxiety:

They were incredibly uneducated about their bodies. They would come to the clinic and have no idea what was going on, it was terrifying and distressing for them. Um, very little education, very little understanding of their bodies, very little responsibility for knowing anything that was about them.

"R," a retired Asian doctor, had difficulty raising sexual health conversations with women patients when she was practicing medicine. She said the sexual health of women she treated was "not as important as family needs or her husband's needs." This external cultural barrier influenced her professional work which led her worldview to inform her practice: "Asian women of my generation are not very demanding. Maybe they do not like to make a fuss or cause a problem by complaining." She described her sexual health consultations: "These were hardly discussed by my patients, or hardly ever presented by me. Women would rarely, if ever, present for such issues because they are so shy and just may have thought it was just their lot in life."

The lack of necessary sexual health information is an external barrier to the women. Asian governments are responsible for sexual education and health programs in their nations, and from the key informant's perspective, the nations' governments are failing women. "M" said, "It never gets discussed...we women don't talk about it. We don't have sex education. It's not taught in schools. We just learn by ourselves and find out what we need to know. It's just part of life." This is a fatalistic comment about being disempowered, ill-informed, and resigning herself to not having information about her own body and health.

Internal Barriers

Internal barriers were the associated emotional and psychological results of external barriers which became internalized, reinforced, and normalized (Bandura, 2003). The shame and embarrassment the research participants felt about discussing sexual matters was a strong barrier that all the key informants also identified, rating this barrier as a major internal barrier for Asian women. This barrier was linked to a gender preference for a female health worker and to cultural norms about women, sex, and not talking with others about sexual issues, especially not with men. "E" said cultural shame was all-encompassing for her patients: "They won't have always told even their husband they are ill, in pain or the real reason for seeing a GP... Why they don't come?... cultural shame."

The shame about women's gynecological functions and structures runs deep with Asian women according to "A," even when health professionals are testing for a vaginal infection, "Shame... yeah, that's it: she felt ashamed. When she was asked to have high vaginal swabs, it disgusted her. She felt ashamed." "R" had a similar comment:

Cultural shame... And saving face, and the absolute lack of sex education there. Yeah, I think that some of them would actually view their genitals like as not being who they are, like part of who they are. It belongs to whoever they are, can I say... sleeping with at the time?

"T" commented similarly: "It's shameful... shameful... it's their private area, and the kids are there and the husbands are there, the husband is going there, or other men. They just feel very, very, embarrassed."

Internalized anxiety about the social taboo of discussing or asking for sexual information also stopped the women discussing or asking about sexual health. "La," a religious minister, describes how that discussion taboo is generational, yet still influential:

Because we are traditional Asians. But today I must say that many of them, I mean the younger ones, are like, you know, quite open, 'ok, it doesn't matter anymore', but I will say, I will safely say that those Asians 50 and above, who are educated back in Asian countries... its sin, shame. I would say at least 70% are very secretive, are very you know, shameful, or embarrassed to share in family about such things like sex.

"Ro," a minister to an Asian church, described the difficulty Asian women had in discussing health and sexual matters:

You'd actually need to try and get them to speak very specifically about what that problem was, but they would actually feel very embarrassed about that, and they would be 'saving face' and saving the husbands name, so they will actually not even participate or even... be very specific about what the problem is, they would be very general, so you need to actually spend more time with them, to be able to build that stronger trust and actually ask probing questions.

This internal barrier of shame of one's genitals is enforced by external social, cultural, and political policies which withhold sexual health information from Asian women.

Professional Barriers

The professional barrier of a bad experience with a health worker was mentioned by research participants and key informants in terms of women feeling belittled, confused, and disrespected by health professionals who did not explain what was required of them, what a

procedure was for, the benefit of the procedure and thus, not did not facilitate informed consent. This affected the women's ability to trust health professionals thereafter. "F," a Filipina midwife, described how she has had only one "bad" pap test in Australia. She had not had a pap test in the Philippines, despite having had children. "A" described how long a bad experience can affect an Asian woman's decision to seek help:

One in particular, she had a bad experience with going to a women's hospital for help and they wanted her to have swabs and tests and she felt very degraded. She refused to go back there because she thought they believed she had a sexual disease...She never went back. It took her two more years to get the courage to ask her GP, who referred her to me, and it took another 6 months before I could get her to see a physiotherapist here.

"M," a Singaporean Chinese nurse, had a similar experience herself:

Then I was called into hospital. But the way it was...they needed to do a biopsy...but the way they did it was so torturous; it was a horrendous experience for me...I said 'stop, I can't take this anymore, it's so painful'...I think they stopped because I complained.

Bad experiences with health professionals and procedures create external barriers for women to engage or re-engage with sexual health services as well as reinforce the woman's internal barriers of anxiety, shame, and embarrassment.

Health System Barriers

The health system barrier of the sexual health worker's gender was mentioned by all the female key informants as a major barrier. They identified this issue as dependent on the women's husbands not wanting a male health worker involved. This barrier was not emphasized in the research references for the researcher's literature review as a major barrier. This may be due to the researchers being part of western medical models or trained in western nations emphasizing the expertise of the health professional and the treatment required, while not considering the needs of the client first (Atkinson, 2015).

"A" described how her role as a nurse specializing with incontinent women could not be facilitated by a man: "Most certainly impossible with a male nurse. Most Asians I've seen would be most uncomfortable with a male...If you're working with women with prolapses, it's a bit more comfortable for them, and culturally, it's better to have a female worker." "R," a retired Asian doctor, described how Asian women prefer female health workers: "Women from Asian nations want to see a woman doctor to discuss such personal matters." This implies that discussing sexual matters for women is embarrassing, thus an internal barrier, yet the gender of the health worker is an external barrier.

"E," a retired doctor, describes how a husband's influence is strong in an Asian woman's choice of a health practitioner: "Women tend to like to see women in India or Nepal, so, I got a lot of women patients...Um, their husbands won't want them to be seen by a male doctor, either, you know, they'll be very unhappy about that." "M," a nurse, described how the gender of a health worker influenced her own sexual health care:

I would prefer if I have to see a doctor, I will still prefer a female. I wouldn't be comfortable to go with a male. I have always refrained from going to a male for any sexual consultation, because I always believe that a man only has the knowledge; they don't know how to empathize, because they don't have the female genitals.

The external issue of a preference for a female health worker to provide sexual health services is not one that a secular, humanistic government health system will necessarily prioritize; hence, it is a health system barrier.

Discussion

It was evident during the interviews, reading the verbatim transcriptions, and analysis, that the influence of medical model service delivery—focusing on the reduction of a patient case to symptom management without consideration of the client’s social context (Lawrence, 2020)—impacted the health professionals’ ability to engage with clients in respectful ways that built trust. There is simply no time to establish a trusting relationship in this model. They also sometimes did not see the woman in the context of her culture, religion, relationships, or priorities. This is a professional and health system barrier to engaging Asian women; it is a barrier external to Asian women and can be rectified by changes to the health service delivery models used in Australian medical practice.

The health professionals as key informants all aspired to be culturally sensitive yet did not have the training to understand ethnically diverse women and their differing religious and cultural values or taboos. They also worked within systems focused on a fast turnover of clients, not allowing the time to build trusting relationships with Asian female clients. For example, with Australian doctors, their cultural sensitivity training is restricted to Aboriginal and Torres Strait Islander cultural issues (Royal Australian College of General Practitioners, 2020), which ignores the large migrant populations of Asians in Australia who collectively are the largest non-European ethnic groups (Australian Bureau of Statistics, 2019). This professional and health system barrier can be remedied with cultural humility (MacKenzie & Hatala, 2019) training for sexual health professionals so they can deliver appropriate services. Cultural humility (True.org, 2018b) focuses on “the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are important to the person” (p. 1). Similarly, the client’s trust rests in the professional’s respect of their life context, inclusive of religious beliefs or cultural values about sex (MacKenzie & Hatala, 2019).

Eighteen of the 22 women who participated in the larger research expressed a desire for cultural and religious sensitivity by a health practitioner, putting their health concerns within their cultural context. The key informants all agreed cultural sensitivity was a requirement, yet only five of the eight described how they did this in practice. Interestingly, in the content analysis (Columbia Public Health, 2020) of references, 34 research references mentioned cultural sensitivity or cultural competence, yet only seven references discussed how health professionals could practically do this. Thus, there is a gap in practical knowledge.

Asian migrant women and Asian health professionals are products of their culture, training, and worldview; so are western health professionals. The barriers the thematic analysis identified are barriers to engaging Asian women in preventative sexual health practice in a Western context. A larger qualitative sample size in a similar study would add veracity to the research outcomes and may identify other barriers within the four categories.

The influence of external political, cultural, relational, and internal barriers the women experienced had become normalized. External issues from their original culture and society which prevented women from having sexual health information that could benefit or save their lives became internal psychological barriers involving shame, fear, and avoidance of discussing sexual health topics. These socially learned and reinforced norms aligned with Bandura’s social cognitive theory for social and personal change (Bandura, 2003). Change cannot occur to a society or the individual without that society engaging in new ideas to solve health problems and devising health promotion methods to socially reinforce the positive benefits of that change.

The external barriers Asian women face growing up need to change in order to transform personal behavior.

There are major differences between the literature review information, the research participant's data, and the key informant data. The research participant and key informant data was emic data from the participant's perspective, and checks with the participants confirmed the accuracy of the analysis (Birt et al., 2016). The academic research data from peer and non-peer reviewed journals, reference books, theses, and professional associations used for the literature review was mainly etic, observational data which showed a bias to scientific method observation and reductionism by those working in the sexual health fields (Lawrence, 2020). Both perspectives are valid, yet only the emic accurately describes the needs and barriers of those needing to access sexual health services. More emic research of migrant populations is required to reinforce this article's findings.

No mention of shame and embarrassment as a patient barrier in academic references could be explained by the differences between the professionals, academics, and the research participants. Academics and professionals are more educated about sex and health, and are predominantly from high-income nations, or trained in scientific reductionist methods where the gender of a sexual health professional is not a major determinant of access to services; this is not the case for migrant Asian women. Australian Woman's Health Network (2012) also identified this barrier in their research of migrants.

Only three of the 22 research participants would visit a GP for sexual pain or discuss sexual matters easily. The participant's shame, embarrassment, lack of knowledge, poor sex education, and their dependence on a partner or family member's consent to pay for treatment cannot be underestimated as deterrents. The health professional key informants all identified the husband's permission as a barrier, yet they worked within a system where only the patient needs to be informed for the professional to gain consent for treatment, not the spouse. This places health workers in an ethical dilemma (Sue et al., 2019) about informed consent. The two religious ministers did not perceive this barrier. Further research involving female religious leaders as advocates for women's sexual health is recommended.

Similar research conducted with health professionals (Mengesha et al., 2017) identified the following health system barriers to engaging with migrant women: "Barriers within the healthcare system included the lack of services to address sexual functioning and relationship issues, as well as lack of resources, time constraints, cost of services, and funding" (p. 1). This study's outcomes coincide with this statement. Of the key informants, only two maintained their own sexual health within Australia, which is a common practice (Multicultural Women's Health Australia, 2016) even for Australian women (Willis, 2019). Being a professional health worker is no guarantee of preventative sexual health care practice, or of promoting sexual health practices for other women.

Overall, the four areas of barriers to Asian women engaging with Australian health professionals for sexual health issues are from two perspectives: the women client's life context, values, and relationships; and the health professionals who work within a health system that does not acknowledge cultural diversity or provide training necessary to work towards cultural sensitivity.

Recommendations

The researcher advocates for further targeted qualitative research with sexual health professionals and migrant populations to identify how sexual health practices in Australia can be improved in ways that prioritize and meet the needs of migrant populations, along with their cultural and religious norms. There should be additional research for methods of increasing Asian women's participation in health services (Lu et al., 2012), so best practice does not remain an unrealized ethical aspiration.

Mandatory cultural sensitivity or cultural humility training for all medical practitioners, nurses, and sexologists in Australia is needed. Sexual health training is a specialization in Australian medicine (Royal Australian College of Physicians, 2019). Public sexual health programs for Asian women need to be empowerment focused and rights-based for service provision, which has historically been advocated for in industrialized nations (Laverack, 2009), yet not realized in Asia.

Research involving key female leaders within Asian communities in how to conduct effective health promotions in Asian migrant communities is recommended. The researcher advocates using cultural humility (MacKenzie & Hatala, 2019) and long-term health service models as approaches that will better engage Asian migrant women with their sexual health in Australia.

Conclusion

The four core barriers identified by this key informant study—the external, internal, health professional and health system barriers as well as the research participants' barriers—are interrelated. The perception of the intensity of the barriers differed little between the research participants and key informants.

This research has shown sexual health professionals in Australia need to be aware of the four identified kinds of barriers in their practice and to engage Asian migrant women with a cultural humility approach (MacKenzie & Hatala, 2019). Women's sexual health practices need service models where time is allowed for migrant women's consultations because migrant women do not change cultural norms after migrating to a nation with available, publicly funded sexual health services. Models of service delivery not considering the multiple levels of barriers will not engage CRaLD women well (True.org, 2018a).

This research importantly contributes to growing awareness of the need for Australian health professionals to value and engage in further training in sexual health, sexology, and cultural humility if they want to practice ethical and respectful practice with CRaLD women. CRaLD women will not engage in services, nor return if they feel shamed for lack of knowledge and their culture or beliefs are dismissed by a practitioner who reduces a woman to symptoms and does not see her within her cultural context (Shainwald, 2011).

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