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Asian Christian female migrants and barriers to their sexual health in Australia: implications for sexual health practice

Sandra Basham

ORCID ID:0000-0001-9817-6554

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Approval for the study was obtained from the Human Research Ethics Committee at Curtin University before engaging with any participants. The approval number is HR.

Date: 17 December 2021

Signature:
Sandra A. Basham

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Abstract

Background: This research was conducted between 2015 and 2020. I have worked in sexology and counselling practice since 2000 observing Asian women lack knowledge about their bodies, sexual pleasure, diverse sexualities and self-care. Querying the level of influence of culture or religion on women's sexual health was distilled into a research proposal in 2014. The main goal of this research was to identify religious or culturally reinforced barriers Asian women faced for sexual health: comparing what they identified and what health professionals working with Asian women identified. I chose the Christian faith as the religious influence based upon Asian Christian women being more familiar to myself. An *emic* perspective being the best basis to identify barriers within the research population. Why barriers to sexual health existed in a society and how they could be changed was based on Bandura's Social Cognitive Theory of Personal and Social Change (2003), which focuses on the power of positive or negative reinforcement by government, culture, religion and society at large to either maintain status quo or make change.

Methods: The research used qualitative methodology. Semi-structured interviews were conducted with 22 women from six Asian nations being substantial sources of migration to Australia: China, India, Indonesia, Malaysia, the Philippines, and Singapore. The interviews used open-ended and clarifying questions to prompt discussion about cultural and religious attitudes and norms about sexual health for women in their nation of origin, their sex education experience and sexual health knowledge and to identify changes to their sexual health practices after migration to Australia. 10 key informants were interviewed to identify practice barriers in Australia. Thematic analysis of data was conducted to identify the barriers.

Findings: A web of socio-political, gender-based, *external* barriers dominated participants' lives. Cultural traditions restricted the sexual knowledge women could access because males dominated socio-political, economic, religious, and medical arenas, women requiring male consent to attend health appointments. *External* barriers were reinforced by discriminatory legislation, no sex education and sexual health information being unavailable to women apart from in Singapore. From a human rights and political perspective, the data indicated women in Asia are

discriminated against in most areas of social and political life. Key *internal* barriers were founded on internalised *external* barriers as a mind-set of inferiority and dependence upon males. Shame, embarrassment, and anxiety about discussing sexual topics, especially with men, resulting in these women remaining silent about their sexual health, and unwilling to see a male health practitioner. Disempowered by their lack of female sexual health knowledge, they did not discuss sexual topics amongst themselves.

Results indicated women over 40 years of age were unlikely to change their sexual health behaviours. For example, a Pap test was avoided at all costs. Women under 40 were more likely to access sexual health checks and seek information or help. All research participants said they wanted better sex education, sexual experience and sexual health for their daughters, however the women over 40 years did not discuss sex with their daughters easily. Women over 60 years refused. Key informants identified the health system did not meet the needs of culturally or religiously diverse women, recognising Asian migrant women had little knowledge of their physiology, sexual function, contraception, or the need for preventative sexual health screening tests and their right to health service without permission of a man. The barriers key informants identified mirrored participants barriers, differing only in intensity and those specific to the health service they were part of. Significantly, most key informants wanted more cultural sensitivity training. They knew Australian health services focus on expertise and short consultations within the Medicare system did not meet Asian women's health needs.

Conclusion: A more flexible service delivery model and targeted health promotion to Asian women is highly recommended. As an outcome of this research, the *external*, *internal*, *professional* and *health system barriers* identified became a guide to develop a framework to address these barriers within sexual health practices. Female staff using a person-centred, culturally humble way to form relationships of trust could ask about the context of their client's life to identify their *external* barriers before discussing *internal* barriers, and then talk about the benefits of sexual health screening tests or treatment for painful sex or continence problems.
Key words: Asian women, sexual health, barriers, culture, religion, discrimination

Co-author Contributions

Co-author contribution statements are required for submission of thesis that contain published articles arising from doctoral research at Curtin University. An adaptation of The International Committee of Medical Journal Editors (ICMJE) guidelines for authorship is presented below for each published manuscript contained within this thesis. A rating of 0 –3 + symbols is given to differentiate levels of contribution from each co-author, with 3+ being the highest contribution. The articles are listed below in the order they appear in the thesis.

Paper 1

Article 1: Women's sexuality, sex education and sexual health in cultural context: historical influences on women from six Asian nations.

Journal: Asian Journal of Women's Studies

Name of Author	Conception of study	Study Design & Methods	Data Collection	Data Analysis	Interpretation & Discussion
Sandra Basham PhD Student First author	+++	+++	+++	+++	+++
I acknowledge that these represent my contribution to the above research output. Signed					
Professor Jaya Dantas Co author	++	+	+	+	++
I acknowledge that these represent my contribution to the above research output Signed:					

Paper 2

Article 2: Portrayals of Asian women's sexuality in 40 years of media content: A content analysis.

Journal: Platform

Name of Author	Conception of study	Study Design & Methods	Data Collection	Data Analysis	Interpretation & Discussion
Sandra Basham PhD Student First author	+++	+++	+++	+++	+++
I acknowledge that these represent my contribution to the above research output. Signed					
Professor Jaya Dantas Co author	++	+	+	+	++
I acknowledge that these represent my contribution to the above research output					

Paper 3

Article 3: Asian migrant women identify barriers to engagement with sexual health services.

Journal: Journal of Immigrant and Minority Health

Name of Author	Conception of study	Study Design & Methods	Data Collection	Data Analysis	Interpretation & Discussion
Sandra Basham PhD Student First author	+++	+++	+++	+++	+++
I acknowledge that these represent my contribution to the above research output. Signed					
Professor Jaya Dantas Co author	++	+	+	+	++
I acknowledge that these represent my contribution to the above research output					

Paper 4

Article 4: Health Professionals Identify Barriers to Asian Women's Sexual Health

Journal: Journal of International Women's Studies

Name of Author	Conception of study	Study Design & Methods	Data Collection	Data Analysis	Interpretation & Discussion
Sandra Basham PhD Student First author	+++	+++	+++	+++	+++
I acknowledge that these represent my contribution to the above research output					
Professor Jaya Dantas Co author	++	+	+	+	++
I acknowledge that these represent my contribution to the above research output					

Paper 5

Article 5: Generational differences in sex education and sexual health practices of Asian, migrant women in Australia

Journal: Journal of Migration and Health

This research has shown that Asian migrant women resident in Australia have specific sexual health needs that a change to Australian service delivery models and CRaLD training of staffs can meet.

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Name of Author	Conception of study	Study Design & Methods	Data Collection	Data Analysis	Interpretation & Discussion

Sandra Basham PhD Student First author	+++	+++	+++	+++	+++
I acknowledge that these represent my contribution to the above research output.					
Professor Jaya Dantas Co author	++	+	+	+	++
I acknowledge that these represent my contribution to the above research output					

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List of Definitions

Anthropology: “Anthropology seeks to understand similarities and differences in behaviour and biology across cultures and populations” (Wiley & Allen, 2013, p. 2). Anthropological research focuses on understanding the meanings people assign to their lives and communities: inclusive of cognitive, affective, spiritual, social and other meanings.

Christian: Merriam-Webster’s dictionary definition, “one who professes belief in the teachings of Jesus Christ” ("Christian," 2015, p. n.p). For the purposes of this research, participants identified themselves as Christian.

Cultural competence: “Cultural competency, or cultural awareness and sensitivity, is defined as, the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences, self-awareness, knowledge of a patient's culture, and adaptation of skills" (Committee on Health Care for Underserved Women, 2011, p. 1).

Cultural humility: Foronda et al.’s definition: “The term cultural humility was used in a variety of contexts from individuals having ethnic and racial differences, to differences in sexual preference, social status, inter-professional roles, to health care provider–patient relationship. The following attributes were discovered: openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. Cultural humility was described as a lifelong process” (Foronda, Baptiste, Reinholdt, & Ousman, 2016).

Medical Model: A "set of procedures in which all doctors are trained. It includes complaint, history, physical examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment” (Laing, 1971). It is founded on the scientific method of inquiry by the medical professional, by whom observable symptoms are measured; a cause for distress is assigned to a biological deficit, a diagnosis made and treatment plan initiated.

Public health: “Public health is an approach that aims to promote health, prevent disease, treat illnesses, prolong valued life, care for the infirm and to provide public services” (Laverack, 2009, p. 1). Public health service providers are generally government departments, or government funded service agencies that follow a bio-medical, reductionist approach to service provision. Many sexual health service providers within Australia are based on a public health approach.

Scientific Reductionism: Reductionism is “a tenet of the modern bioscientific approach to knowledge according to which anything complex can be explained primarily in terms of its simpler components” (Mosby, 2009, p. n.p.). A reductionist approach to people involves itemising the sum of observable and measurable human behaviours according to scientific methodology, thus, ignoring the inner being of people's complex lives, beliefs, relationships and influences on their behaviour.

Sexual health: “… a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (World Health Organization, 2013, p. a). People with religious beliefs have a right to their sexual health as they define it, not as is defined by bioscientific reductionism. Sexual health issues therefore, can involve sexual problems that are informational (sex education and anatomy), physiological, psychological (emotional or belief based) or biological in origin, that require medical or other expert therapeutic intervention with the full informed consent of the client concerned.

Thematic Analysis: "Thematic analyses move beyond counting explicit words or phrases and focus on identifying and describing both implicit and explicit ideas within the data, that is, themes" (G. S. Guest, K. M. Macqueen, & E. E. Namey, 2012, p. 10). A qualitative, epistemological methodology originating in anthropology and social sciences research. Such research is exploratory, being content and context driven. It can be immersive within the subject population, utilise purposeful sampling, devise

analytical categories or themes arising from the varied forms of data and does not propose to have a yes/no hypothesis to confirm or prove, according to quantifying the research subject's phenomena, beliefs and behaviours.

Worldview: A *worldview* is an anthropological term in which "each culture has a basic configuration (which describes) "the foundational cognitive, affective and evaluative assumptions and frameworks a group of people makes about the nature of reality which they use to order their lives" (Hiebert, 2008, p. 14) This includes spiritual beliefs and practices held by a cultural or sub-cultural people group. Hiebert (2008) indicates that two core cultural structures exist: the "collectivist" culture or the "individualistic" culture. Collectivist cultures are predominantly non-Western; Asian nations are predominantly collectivist.

Chapter One: Introduction and overview

1.1 Introduction to the chapter

This doctoral thesis investigates the sexual health of Christian Asian migrant women resident in Australia, examining the women's rationales for not engaging in sexual health screening or therapeutic services to benefit their overall health and sexuality, and empower themselves as persons entitled to sexual information about themselves. The research was approved by the ethics committee of Curtin University (see Appendix A). It is comprised of five articles and dissertation chapters including a literature review, methods with underlying theory, data analysis and outcomes, recommendations, and conclusions.

This research was qualitative and based upon anthropological inquiry (Wiley & Allen, 2013) using recognised qualitative methods: semi-structured interviews, thematic analysis, content analysis of the literature review, data triangulation using key informants and member checks with participants during the analysis process to ensure the researcher accurately interpreted the data (Nowell, Norris, White, & Moules, 2017; Palinkas et al., 2015). It was determined that qualitative and emic methods could identify the specific barriers to sexual health Asian women face, separate the cultural influences from the religious and address the research questions outlined further in this chapter. An etic perspective is not a first-person perspective, thus, is not likely to answer the research aims and questions sufficiently in depth.

Marketing material inviting participation was distributed (see Appendix B). Semi-structured interviews of 22 research participants who were Asian migrants resident in Australia were conducted after consent was provided. The research participants answered the same open-ended questions designed to provide information for the research questions (see Appendix C). Eight key informants who had worked with Asian women's sexual health and 2 religious leaders were interviewed with open-ended questions asking about Asian women and their sexual health (see Appendix D). The researcher aimed to identify the barriers to Asian migrant women's engagement with sexual health services and if these barriers were cultural or religiously based. Importantly, identifying barriers from an emic perspective provided opportunity to

compare and contrast barriers identified in academic and medical literature which focus on etic observation of patients or research participants who attend medical services aligned with research or training (Stusser, 2008; Vieira et al., 2015).

The foundational theory used to explain how barriers to women's health are maintained within a culture is Bandura's Social Cognitive Theory of Personal and Social Change (A. Bandura, 2003a), an extension of social learning theory (Albert Bandura, 1971), by which the socially reinforced norms of a society can be positively reinforced, which promotes desired change, or negatively reinforced, which promotes the maintenance of a status quo that can be harmful to members of a society.

The most powerful barriers to women's sexual health identified in this research proved to be systemic and *external* to the women. Bandura's 2003 theory proved accurate in reflecting how women of Asian cultures are deprived of necessary sexual health information which could save their life. They are deprived of this information because of cultural taboos about women, gender-biased traditions operating within political spheres of the nations, a gender bias to males having more worth, inequality of opportunity for women in commercial and educational sectors, and social anxiety about change to the status quo. These barriers are culturally reinforced and internalised by the women resulting in sexual and gender shame, anxiety and embarrassment about sexual matters, feeling ignorant due to lack of information and knowing they could not discuss such matters, even amongst themselves, especially by women over 40 years of age. These barriers are described in more detail in the analysis chapter and articles. A *member check* (Birt, Scott, Cavers, Campbell, & Walter, 2016) was conducted to check the barriers identified reflected the participant's views (see Appendix E). It was important to consider cultural barriers when examining migration to Australia, which is a secular, Western nation that has different cultural foundations and societal norms, as described in the following sections.

1.2 Historical context of migration to Australia

The Australian Government and nation was founded upon British Christian values, albeit, with an expectation that what began as a convict settlement would become a Christian nation, upholding the values and beliefs of its *mother* nation (Australian

Bureau of Statistics, 2017b, 2017c). Christianity dominated the thinking of the founding fathers, even as they composed a Constitution which enshrined freedom of religious observance separating Church and State. The Australian Bureau of Statistics (ABS) noted that in 1911 the census started asking religious questions to monitor the population and 96% of Australians identified as Christian.

Christianity, of the mainly British or Western European church format (i.e., Anglican or Catholic) has declined since colonisation, compared to a rise of evangelical forms of Christianity (i.e., Baptist, Church of Christ, Pentecostals). However, Christianity has and does still influence Australian society, despite Australia identifying as a secular nation in Government and international discourse. *Secular* in Australia defined for this thesis by Taylor's 3rd version of secularism (2007), cited by Barker (*Sensus Penduduk 2010.[Population by Region and Religion]*, 2010), which describes secular:

> Religion is not removed from the public sphere; rather it is just once voice among many, including those with no religion. As a result, a state may have a relatively high level of interaction with religion and still be considered secular so long as the state does not endorse one religion to the exclusion of other points of view (n. p.).

Traditional Christian affiliation and church attendance has declined, with the 2016 Census showing one third of respondents claiming they have no religion (*2016 Census: Religion.*, 2017). Conversely, Asian Christianity appears to be growing, with seven Asian nations among the top 20 nations in which growth in Christian churches has been measured (Center for the Study of Global Christianity, 2013a).

The ethnic demographic make-up of Australia has changed rapidly since the abolition of the White Australia Policy (Immigration Restriction Act, 1901) and the rise of Asian migration in the post-Vietnam War era (Department of Immigration and Border Protection, n.d.). This trend of moving away from a European focus grew faster after the 1980s and more so after 2001 (Department of Immigration and Border Protection, 2014, p. 10). In the 2011 census the largest overseas born populations of Australia after British and New Zealand included "Southern Asia, Chinese Asia, Maritime South-East Asia and Mainland South-East Asia", which accounted for 39.5% of the overseas born

population (Department of Immigration and Border Protection, 2014, p. 9). The nations of participants in this present research are included in this grouping.

The ABS has reported Asian migration is increasing (Agarwal & Venkat, 2009), with India and China dominating the statistics. Other census data evidenced a large proportional growth of Indian, Chinese and Filipino migration during 2014: “The proportion of Australians who were born overseas has hit its highest point in 120 years, with 28 per cent of Australia's population—6.6 million people—born overseas, according to figures released today by the Australian Bureau of Statistics” (Agarwal & Venkat, 2009). It makes logical sense to investigate the health and cultural norms of the largest group of migrants to Australia and their children’s generation who face navigating two sets of cultural norms.

1.3 The rise of Asian Christianity

This review will not examine theological rationales for Asian Christian women migrants’ perceptions of self-worth nor doctrines about women. This section provides background to the changing religious and cultural manifestation of Christianity within a large ethnic percentage of the Australian population. The Pew Research Institute’s data on Asian-Pacific Christianity lists among the top 10 nations for Christianity, the Philippines, China, India, Indonesia and Australia. China is regarded as being the 7th largest Christian population in the World (Pew Research Center, 2011).

Phillips (2014), a British journalist based in China, reported on the rise of Christianity there. China has a sizeable Christian population which has suffered systemic persecution for decades, yet now is a very large percentage of the population (Malek, 2011; T. Phillips, 2014), estimated by Xiaowen Ye, the Communist Party Administrator of Religious Affairs, to be over 100 million ("How many Christians are in China?," 2014). Chinese tertiary students on temporary visas often become Australian residents by working in Australia after gaining a temporary skills shortage visa (Department of Home Affairs, 2020), leading to permanent residency (J. Phillips & Simon-Davies, 2014). Some of these young Chinese are Christians.

Even though India has a small Christian demographic for the population

(approximately 3%) the most recent statistics from 2011 (Government of India, 2011) showed the proportion equated to nearly 64 million people. A sizeable proportion of educated Indian Christians could leave India due to religious persecution, for study, or professional employment, which aligns with the Australian statistics on reasons for migration (Department of Immigration and Border Protection, 2015; J. Phillips & Simon-Davies, 2014). By June 2014, more than double the amount of Indian migrants compared to 2006 resided in Australia (Department of Home Affairs, 2015a). Persecution of Christian churches, leaders and members in India has become more frequent, with Christians abused by religious extremists and other government officials (M. Banerjee, 2015; Gowen, 2014; Human Rights Watch, 1999; *World Watch List: The 50 countries where its most dangerous to follow Jesus*, 2018).

Indonesia's philosophical *Pancasila* statement, the basis of the Constitution (Embassy of the Republic of Indonesia, 2000), allows for religious freedom of all monotheist believers, yet, Indonesia has a social and military history of persecution and abuse of Christians (Immigration and Refugee Board of Canada, 2010; "International Christian Concern," 2015; Khouw, 2011). The Christian church is growing in Indonesia despite such persecution (Brazier, 2006; Republic of Indonesia, 2011) and many Indonesian students also temporarily migrate to Australia to study, then gain a temporary work visa and reside here, later applying for residency (J. Phillips & Simon-Davies, 2014). Malaysia, largely an Islamic nation, has a growing population of migrants moving to Australia. Australian Bureau of Statistics data indicate that the majority of Malaysian migrants identified as Christian (Australian Bureau of Statistics, 2008). Census data from 2011 indicated that Malaysia was one of the top 10 sources of migration to Australia (Department of Immigration and Border Protection, 2014). By 2014, Malaysia constituted the ninth largest migrant community (Department of Home Affairs, 2015b).

The Philippines has a Christian population of 90% where Christianity is widely accepted as the social and cultural norm (*Philippines in Figures 2014*, 2014; The Philippine Daily Inquirer, 2011). Migrants to Australia from the Philippines are likely to be Christian, which identifies as 90% Catholic (Central Intelligence Agency, 2019; Pew Research Center, 2011). The Philippines rates as the 4th highest source of family and skilled migrants to Australia. India and China the first and second largest sources

of family and skilled migration to Australia respectively (Department of Immigration and Border Protection, 2015; *Migration to Australia: a quick guide to the statistics*, 2017). In June 2014, 225,110 Philippine-born people lived in Australia, 59% more than in 2006 and was the fifth largest migrant community in Australia (Department of Home Affairs, 2015c).

Singapore, a successful multicultural, industrialised and technologically advanced, multi-religious nation, has a growing evangelical Christian population (Brazier, 2006; Philomin, 2014). Many Singaporean students study in Australian universities and remain in the nation for work thereafter ("History of immigration from Singapore," 2011), becoming Australian residents (J. Phillips & Simon-Davies, 2014). In 2014, Singaporean data on migration to Australia indicated "Close to 200,000 Singaporean citizens live overseas, mainly in Australia" (West, 2014).

1.4 Research rationale

Australian ethnic and religious demographics are changing. Caucasian sources of immigration and population growth are no longer the primary source of the Australian demographic. Asian sources of migration have outnumbered European or other sources in the last 15 years. Five of the 10 chief sources of migrant populations to Australia between 2015 and 2016, were Asian[1] (ABS, 2017). In 2017, 6 of the 10 primary sources of migration to Australia were Asian[2] (ABS, 2017). The country of birth for many Australians and the second generation of migrants are now Asian who are influenced by the norms and values of their culture of origin. Women constitute approximately half of these new Australians. The present research focused upon Asian Christian migrant women to Australia from six sources: India, China, Philippines, Indonesia, Malaysia and Singapore. The women are representative of different sources of migration, each with their specific ethnic and cultural differences, yet all the participants have a common gender and religion.

The rapidly growing Asian population within Australia is a key reason to examine this public health concern, because migrant women do not easily engage in sexual health

[1] China, India, Philippines, Vietnam & Malaysia
[2] India, China, Philippines, Vietnam, Malaysia & Sri Lanka.

screening checks (Mengesha, Perz, Dune, & Ussher, 2017; Willis, 2019) and women's cancers are the largest cause of preventable death in many Asian nations (World Health Organization, 2020a). There is a great danger of national health data misrepresenting reality if these Asian women have not been screened for breast checks, Pap smears or postnatal checks, nor been vaccinated against Human Papilloma Virus [HPV]. Without that data the epidemiological risk to public health is increased when any of the women present for treatment at a late stage of sexually related disease such as gynaecological cancers. A preventative plan needs to be developed to manage the cost implications for the public health budget.

The migration data mandates the Australian Government's Health Department and other sexual health service providers examine the level of cultural and religious sensitivity in the application of their services (Sue, Sue, Neville, & Smith, 2019). The current emphasis in Australian medicine of general practitioners having 10 minute appointments for Medicare rebates, does not work for Asian women who are very shy about discussing anything sexual and who struggle with language to describe their sexual health problems or genital structures (Hach, 2012). Discussion with a male health worker is culturally inappropriate (Willis, 2019).

This present study researched and analysed these concerns by investigating the sex education and sexual health educational experiences of adult, Asian migrant women residing in Australia. A determination was made of the level of influence of culture or religion on their sex education, sexual health and their usage or non-usage of sexual health services within Australia. Such services included Pap smear tests, STI prevention or treatment, contraception advice or consultations for sexual difficulties or menopause related problems.

1.4.1 Aims of the research

1. To identify what Christian Asian migrant women from China, India, Indonesia, Malaysia, the Philippines and Singapore define as sexual health and sexually healthy according to their sexuality education.
2. To examine the sexual health practices of migrant women prior to migration to Australia to see if they change after migration.
3. To identify barriers faced by Asian migrant women hindering them from

accessing sexual health treatment in Australia: and to identify their expectations of sexual health practitioners in Australia.

4. To identify what barriers restrict a secular sexual health practitioner engaging with their client's worldviews; inclusive of assessing the influence of a reductionist approach to human sexuality upon their own professional practice (Atkinson, 2015; Douglas & Fenton, 2013).
5. To propose a basic framework for respectful, culturally humble (Foronda et al., 2016) and person-centred, sexual health practice aligned to further research.

This research is guided by two research questions.

1. How does an Asian migrant woman's worldview about what constitutes healthy sexuality or sexual health, affect: (a) her engagement with and (b) use of sexual health services or sexual therapy practices within a secular individualistic culture that utilises a reductionist approach to medical and sexual health problems?

2. How can sexual health practitioners and sexologists in Australia x better engage with and meet the needs of Culturally, Religiously and Linguistically Diverse (CRaLD) women clients?

The results of this present research could increase access and sexual health screening by these women, prolong their lives and prove to be less economically burdensome for the Australian health care system if the study identifies how Australian sexual health practitioners could respectfully meet the needs of Asian women with religious beliefs. For example, in the case of oncology care for women who have not had regular cervical screening tests, presenting at hospitals for stage 3 or 4 gynaecological cancer treatment.

1.5 Significance

This research will be the first of its kind to investigate the sexual health practices of women who are representative of Asian Christian women migrants within the

Australian population. It will do so in a qualitative and emic way, asking a purposive sample (Palinkas et al., 2015) of 22 women from the target population to discuss their history, culture, education, sex education, beliefs about sex, sexual health practices past and present and examine what changes, if any, have occurred since migration to Australia. Given the large Asian migrant population in Australia, this research is timely.

It is the first study to triangulate three perspectives on Asian women's sexual health: the female participants, key informants who have worked with Asian women's sexual health, and a literature review of cultural history, academia, medicine and media influences. This triangulation of data ensured veracity of the outcomes (Nowell et al., 2017) and tested the participant responses against other perspectives to clearly delineate what the Asian women wanted in a sexual health professional, as well as the kind of service they would engage with compared to what was offered in Australia. Barriers identified by the three sources were identified, compared, contrasted and discussed within the articles as chapters 2, 3, 6 and 7.

This research, importantly, identifies from the participants' perspective the barriers that exist to engagement with sexual health services in Australia. Rationales for barriers identified in the literature review came from an academic and medical perspective rather than from listening to migrant women's specific needs. Best practice and improved service provision require that targeted populations at risk of poor health are engaged in a relevant, culturally sensitive way (Dogra, Reitmanova, & Carter-Pokras, 2010) to address barriers to engagement. As such, this research provides useful information for sexual health practitioners to consider for their practice. Additionally, a proposed framework for sexual health services to address barriers identified in consultation with women is included in chapter 8. Suggested changes to service provision models are included in chapter 7 and 8 and these can be a basis for further research.

1.6 Using a worldwide definition of women's sexual health

The World Health Organization's (WHO) definition of sexual health that is used in this thesis is applied to the discussion of Asian women's sexual health. The clarity of

this definition removes the focus on women's reproductive or sexual function (n. p.):

> …a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (World Health Organisation, 2020).

This definition is comprehensive and ought to be widely used in the literature. Taking an alternate perspective, if a man's sexual health were defined solely by his ability to produce sperm and father children, men would find this definition of their sexuality vastly inadequate. The same applies for women; it is not just about fertility, sex and birth.

1.7 Researcher's professional context

I am a Caucasian migrant woman who grew up with Asian friends related to my father's employment in Singapore from early childhood. I have travelled in Asia multiple times since the late 1960s until recently. I resided in Singapore in the 1980s and have a deep love for Asian art forms and food. I am a professionally accredited sexologist, counsellor and tertiary educator in humanities and social sciences. I previously worked in a not-for-profit sexual assault counselling agency in Perth for 8 years. I have had a private counselling practice for 19 years.

My private practice specialises in culturally and religiously diverse clients. I enjoy counselling culturally and religiously diverse people because I want to understand their culture and religion, and learn from them how to be a culturally humble and reflective practitioner (True.org, 2018a). I have had many Asian female clients however I had not fully understood the deep rationales for how Asian women viewed their worth and how that affected their sexual health priorities. Christian women, especially, who say

they bear God's image and thus, have immense worth did not present as women who lived lives of worth. I wanted to understand if cultural or religious norms socially learnt in a nation of origin (Albert Bandura, 1971) explained Asian women's reticence to change their sexual health practices within Australia and their great anxiety about discussing sexual matters. I also wanted to know what Asian women would need from a sexual health professional to engage in health screening checks such as Pap smear tests, breast screening or sex therapy on a more regular basis: Hence, the motivation for this research.

1.8 Overview of research

This research identified culturally embedded barriers to be a more powerful influence upon Asian women than religious ones. The analysis determined specific and systemic cultural factors influencing the current sexual healthcare behaviours of women from the six Asian nations. *External* barriers operated in a systemic way, discouraging Asian women from pushing back against gender-biased cultural norms and the laws of socio-political regimes that restricted the amount of sexual health information available to them.

Barriers to sexual self-care identified from interviews with 22 women and 10 key informants include:

- cultural shaming for menstruation
- body shaming
- taboos relating to discussing sex and women's issues
- societal gender bias to males controlling socio-political spheres
- little access to sexual health information
- poor sex education that focuses on reproductive function
- men controlling women's access to sexual health services
- the low value assigned to the status of women
- women not talking with other women about sexual topics
- religious shame and discouragement about discussing sexual matters.

Many of these barriers become *internal* due to negative social reinforcement (A. Bandura, 2003a) and appear as shame, embarrassment and silence on issues regarding

sex. The research identified an urgent need for specific cultural sensitivity or cultural humility training of those providing women's sexual health services within Australia. Asian women do not engage with sexual health services readily, especially if men are involved. They strongly prefer women health professionals who understand their culture and beliefs if they do engage. Interestingly, no mandatory training in cultural sensitivity or cultural humility is currently part of medical training, sexual health or sexology training in Australia. This is problematic for a migrant woman if services are being delivered in culturally inappropriate ways (Nazar, Kendall, Day, & Nazar, 2015).

This thesis is a starting point for health services, epidemiologists and government health departments and medical professionals taking CRaLD migrant women's sexual health matters and targeted health promotion to Asian women seriously. Asian women could be encouraged to engage in sexual health screening with the involvement of Asian female community leaders in churches or cultural associations and the use of research focus groups to develop appropriate health promotion campaigns. Current women's health services could adapt policies and practices for employing trained culturally sensitive female staff whom Asian women would be more comfortable having appointments with. Such practices are vital in view of the Asian women's poor sex education in their nation of origin, their embarrassment and shame at gynaecological matters, cultural taboos for the discussion of sexual matters with men, their negligible access of sexual health services in their nation of origin or within Australia and their cultural and religious taboos and values stigmatising and silencing them from having power over their bodies and sexual health. Australia can provide an appropriate, culturally sensitive and respectful forum for these women to alter their sexual health practices and influence the women of their culture who come after them. This is a long-term goal of this research.

1.9 Thesis structure.

This research is based upon qualitative research methodologies and first-person testimony from research participants, thus, the perspective in the chapters may change from a third-person academic perspective to first-person descriptive. The section in this **Chapter 1** describing the primary researcher is a case in point of first-person

perspective.

This dissertation is a *compilation* type (Australian National University, 2021), inclusive of five articles and other chapters providing the depth of information the articles refer to, describing methodology, how analysis was conducted, how the research addressed the research aims and questions and includes recommendations for future research and professional sexual health practice. Chapters 2, 3, 6 and 7 are comprised of, or include articles in peer reviewed journals, each on a specific topic in response to the research questions and goals.

Chapter 2 is a review article titled: *Women's sexuality, sex education and sexual health in cultural context: historical influences on women from six Asian nations*. It examines the historical influences on women's sexuality in China, India, Indonesia, Malaysia, the Philippines, and Singapore. It critically reviews cultural norms, religious teachings and societal structures of the last millennia that have traditionally governed Asian women's attitudes and practices regarding their sexuality. This brief review sets the foundation for the more detailed, recent literature review about Asian women's sexual health and sexuality in chapter 4.

Chapter 3 is an article titled: *Portrayals of Asian women's sexuality in 40 years of media: A content analysis.* It is a content analysis of Asian media's portrayal of Asian women's sexuality in media formats. The significance of print, film, broadcast and online media within the last 40 years is discussed in the context of the use of media to socially engineer traditional values, counter the influence of Westernisation, yet promote an Asian women's sexual image which is Western and hyper-sexualised. Targeted marketing and advertising to Asian women is discussed in relation to promoting anxieties about beauty and sexiness amongst women who have poor sex education. Disparities between sexual misinformation available on the internet, such as in pornography, is discussed in comparison to the lack of comprehensive sexuality education provided by the governments of the six nations represented in this present study. Women have little safe sex training or information, which puts their sexual health and fertility at risk. This chapter places the research participants into a modern context.

Chapter 4 is a literature review that (a) overviews women's sexual health globally, in Asia and within Australia, inclusive of statistics on sexual health screening and gynaecological cancers, sexually transmitted infections and availability of services; (b) outlines the difficulties Asian women have to access basic sex education, contraception, abortion or access to medical care and screening services in their nation of origin and (c) discusses the pathological language used in and the focus of government, academic and medical literature upon women's *reproductive function*, not their sexual health as defined by the World Health Organization (World Health Organization, 2013).

Chapter 5 describes the qualitative research methodologies utilised to gather data from the semi-structured interviews with 22 participants, 10 key informants and the literature review. Emic anthropological inquiry used participant responses to open-ended questions related to the research questions and aims via semi-structured interviews. Interviews were transcribed and uploaded into NVivo 11 software for coding and analysis ("NVivo 11 Pro," 2017). The coding criteria for thematic analysis related to sex education, cultural influences, religious teachings, sexual health practices before and after migration, and participants' past and present access to health or sexual health services. Questions used for research participants and key informants are in Appendices C and D.

Chapter 6 discusses the barriers women faced across cultural and religious spheres of their lives emerged from the themes. The major barriers identified were *systemic* and embedded in culture, being *external* to the woman, yet influential. They included politics, law, power structures of their society of origin, cultural and religious bias to males, male entitlement and control, lack of sexual information available to women, inadequate sex education, cultural taboos about women and sex, and women not discussing sexual matters amongst themselves. *Internalised barriers* that the women described included shame and embarrassment, unwillingness to talk about sexual topics, anxiety about sexual issues, low self-worth, and women thinking sex is for and about men.

Chapter 6 includes an article based upon research outcomes titled: *Asian migrant women identify barriers to engagement with sexual health services*. This article

discusses in detail the barriers to engagement with sexual health services the participants in the research identified. It describes a systemic cultural web of barriers that are socially reinforced in the nation of origin, internalised as normative, and for older Asian migrant women over 40 years of age and adhered to in Australia.

A second article based upon research outcomes, which utilises the key informant data is titled: *Health professionals identify barriers to Asian women's sexual health* based on their practice. Ten key informants were interviewed using the same open-ended and clarifying questions about Asian women's sexual health (see Appendix D). The key informants spoke about their work with and knowledge of Asian women's sexual health behaviours, identifying barriers that hindered Asian women from engaging in sexual health services. The barriers identified included: women's embarrassment and fear, wanting a female health worker, lack of sexual health knowledge, poor trust in health workers, having to ask a male relative for permission to access services, unaffordability, not knowing services existed, and time constraints of the consultants during the appointments. Key informants identified *gaps* in their professional knowledge or people skills, including not using a cultural humility approach (MacKenzie & Hatala, 2019).

Chapter 7 is an article titled: *Generational differences in sex education and sexual health practices of Asian, migrant women in Australia*. This article discusses Asian women's desire of a different sexual and sexual health experience for their daughter's generation in Australia. It discusses women coming from societies where the political, socio-political, commercial and industry leadership is male dominated. The article critiques the lack of Asian women able to advocate at the higher levels of Asian societies and how that contributes to poor sexual health among those nation's women.

Chapter 8 is an overview of the research and discussion. It emphasises how the research outcomes addressed the research aims and questions competently; discusses unexpected research outcomes and limitations of the research; suggests further research; and recommends changes to sexual health service models in Australia. By analysing the barriers identified in this present research, a visual framework has been proposed to help health professionals engage with Asian migrant women and promote sexual health screening within their context after trust has been built. A strong

recommendation is for all sexual health professionals to receive compulsory training in delivering sexual health services, along with training in cultural sensitivity and cultural humility. The Australian health system can reduce barriers to engagement of Asian migrant women in sexual health services.

The chapter following is an article for publication which reviews historical literature on Asian women's sexuality from the six nations of this study. This information is foundational to understanding how Asian cultures developed over time in gender-biased ways which historically disadvantaged women. Disadvantaged women have little political or social power regarding their health.

Chapter 2: Review of Women's sexuality, sex education and sexual health from six Asian nations

Publication 1: 'Women's sexuality, sex education and sexual health in cultural context: historical influences on women from six Asian nations.'

This article has been submitted to the journal 'Asian Journal of Women's Studies'

2.1 Abstract

This article presents a brief review that examines historical religious and cultural literature about female sexuality and sexual education in six Asian nations: China, India, Indonesia, Malaysia, Singapore and the Philippines. Women internalise cultural and religious beliefs transmitted over generations which relate to gender roles, sexuality, menstruation, and reproduction. These beliefs influence their attitudes and actions as women, inclusive of whether to seek gynaecological or sexual health care in the past, if it was available.

A content analysis of literature from multiple sources identified historical obstacles to Asian women's sexual health being the traditional male dominated cultural and religious influences and lack of available information about female physiology and function, sexual health, post-partum checks, gynaecological examinations, Pap or STI testing or women's cancers. Recommendations for further research into the cultural influences on Asian women's sexual health practices in the 21st century within nations like Australia are proposed from a public health perspective due to increased migrant populations. Cultural sensitivity and sexology training of health professionals for ethical, culturally sensitive practice is recommended.

Keywords: Asia, women, culture, religion, sexual health, sex education.

2.2 Introduction

Historically, Asian women's sexuality was not discussed in public. Traditional cultural literature and teachings did not emphasise women's sexual pleasure: sex was about men and for men (Shah, 2016; Sharma, 2020). In the Philippines, China, India, Indonesia and Malaysia, women's sexual education was restricted to limited information about menstrual or reproductive functions (Chandra-Mouli & Vipul-Patel, 2017b; Wijngaards, 2014). Menstrual taboos and shame influenced women's health care, especially sexual health.

Anthropological research into historical Asian writings on human sexuality in the last century traditionally had a male focus, with women portrayed as passive recipients of sexual activity initiated at their husband's request, and with sexual education about pleasure restricted to males (Chandra-Mouli & Vipul-Patel, 2017a; Heinemann, Atallah, & Rosembaum, 2016). Older religious and cultural literature, if available, or more modern religious or cultural literature, follows a similar pattern (Chakraborty & Thakurata, 2013; Liew, 2104).

It is imperative to consider the generational cultural beliefs of the Asian cultures under study because these influence beliefs. In collectivist cultures, beliefs about sexuality are often considered sacred and shared inter-generationally through moral stories, religious teachings, ritual, the arts or spoken and unspoken behavioural rules of belonging and acceptance in the community (A. K. C. Leung & Nakayama, 2017; Louie, 2014). These influences on women's sexual behaviour and healthcare differ from a Western perspective on sexuality, which focuses on individual sexual health, sexual pleasure, sexual diversity, contraception, safe sex practices and treatments (Carteret, 2016). Culturally, religiously and linguistically diverse (CRaLD) women have differing sexual health knowledge and less access to services (Asif, 2018).

Asian nations have high incidence of breast and cervical cancer and STIs (X Jiang, 2018; Maheshwari, Kumar, & Mahantshetty, 2016). Breast and cervical cancers are part of the 5.2 million deaths in Asia estimated in 2018 (American Cancer Society, 2021). STI incidence in 2018 was 108 million cases for China, Japan, Malaysia and

the Philippines (World Health Organization, 2018b). If STIs are unaddressed, women's mortality, risk of infertility, and treatment costs will increase and stop women's economic contribution to their nation (Ginsburg et al., 2017). The Australian Government's goal to eradicate cervical cancer and increase the health of Australian women is at risk (Cancer Australia, 2017; "Cervical cancer could be eliminated in Australia within 40 years, experts say.," 2018b) as women migrants from Asian nations do not practice preventative health (Asif, 2018). Making researching these women's health a vital public health concern.

Four of six Asian nations of this study are substantial sources of migration to Australia (*Migration to Australia: a quick guide to the statistics*, 2017). For example, China's population in 2019 was approximately 1.43 billion, of which 48% were female (The World Bank, 2021). China was the second highest source of migration to Australia until COVID-19. Chinese students residing in Australia comprised nearly 260 thousand persons in 2020 (Hinton, 2020). India's population was 1,366 billion in 2019, of which approximately 48% were female (The World Bank, 2021). India overtook China in migration to Australia in 2016, with student numbers also increasing until COVID-19 (Australian Bureau of Statistics, 2021). The Philippines is in the top 5 sources of migration (ABS, 2021). Australian demographics are changing making this research vital for public health planning.

This paper aims to inform sexual health practitioners' work with Asian women clients by contextualising Asian women's socialised norms about sexuality. The Australian Government Department of Health's *Toolkit for engaging under-screened and never-screened women* (Department of Health, 2018) recognises that CRaLD migrant women have barriers to sexual health, some of which include shame, embarrassment, language problems, lack of financial capacity to pay, lack of understanding by practitioners and not wanting a male to be involved.

2.3 Materials & methods

This paper constitutes a brief literature review and content review (Bengtsson, 2016; Nowell et al., 2017) of historical literature of six nations: China, India, Indonesia, Malaysia and Singapore, as part of a larger study on Asian women's sexual health. A

Content review is a research methodology used to tabulate the incidence of a word, phrase, topic or title in searches within research references (Columbia Public Health, 2020). Searches for relevant information used the following databases: Proquest, JSTOR, Springerlink, Google Scholar and Medline. A key word search related to women's sexual health, women's sexuality, physiology, sex education, women's cancers, reproduction, contraception, diverse sexuality, sexual assault, sexual pain, female genital cutting (FGM), barriers deterring women from accessing services, and women's cancer and STI information was conducted.

542 references related to Asian women's sexual health included 114 peer reviewed journal articles, 87 electronic articles from university-based research or medical institutions like BMC, Medscape, Science, MIMS today, Psychcentral and the Lancet. 72 non-peer reviewed journal articles including nation-based working papers and reports. 71 books. 63 news articles from publications like The Times of India, Straits Times, Asia Watch and South China Morning Post. Magazine articles from Cosmopolitan, SarasSalil, Savvy, Elle India, Islamic Monthly and Outlook. 39 Asian government articles, reports or census'. 29 websites addressing women's sexual topics like Indiafacts, The World Bank, Health Topics, ABS, and YouGov. 21 not-for-profit agency reports from agencies like The World Health Organization, UNICEF, United Nations, and UNESCO. 10 academic papers, reports or conference papers. Digital theses, blogs, film and audio-visual references were less than 15 each. All references were entered into Endnote database for content analysis.

2.4 Historical review

2.4.1 China

Chinese women have traditionally been considered inferior, not needing education. Confucian and Daoist teachings described women as necessary for birthing sons, however, in need of control by family males or by a husband (de Bary & Bloom, 1999; Lin, 2011). Kaining wrote (Kaining, 2011), "Men and women were not allowed to spend time alone, shake hands or even hug each other" in public. Ancient literature such as *The Ten Questions*, *The Harmonisation of Yin and Yang* and *The Supreme Path*, discovered in 1972 in Mawangdui, China, indicated Chinese women were considered to be sexually responsive to their husband: not sexually assertive (Lin, 2007). Buddhist writings after the 4th century continued the idea women were inferior

not able to achieve enlightenment unless reincarnated as a male (Sridhar, 2016).

Cultural beliefs rendered women vassals of men and men's families (Kaining, 2011; Xinran, 2002). A woman could not access medical assistance, nor spend money without a guardian male's consent. This meant her healthcare was at the consent of a man she told her health problem to; culturally inappropriate and unlikely due to shame (E. Yan, Wu, Ho, & Pearson, 2011). Menstrual taboo and shame are part of Confucianism, Daoism and Buddhism: the largest historical religious and long-term cultural influences in China (Bhartiya, 2013). Buddhist beliefs regarded menstruating women as unclean due to loss of Chi energy, which could attract ghosts (Lin, 2011). Traditional Chinese herbal medicine may have been used by Chinese women to manage their Chi energy, believed to be connected to the body's organs (Jiuzhang, 2009; Novella, 2012). Affording the medicine required her husband's approval.

Christianity was not largely influential in China until the last 150 years (Stark & Wang, 2015). Chairman Mao's regime expelled Christians and missionaries in 1949. Christianity became a powerful underground religion in China during the Cultural Revolution and thereafter with numbers of Christians increased to 70.8 million by 2015 (Diamant, 2019). Christianity offered Chinese women more status than traditional religions: Fallman (Fällman, 2008) wrote, "the choice of Christianity is an expression of individuality, freedom and criticism of political structures" (p. 163). Chinese women had not had such freedom before. Sexual freedom and ownership of one's sexuality, however, was not something Christianity advocated (Stark & Wang, 2015).

During the Mao Zedong regime after 1949, the *Cooperative Medical Scheme* brought changes to Chinese women's sexual health as women's prenatal, postnatal, urological and gynaecological examinations were annual (X. M. Chen, Hu, & Lin, 1992): not that women were educated about their sexual organs, sexual pleasure or sexual health (Kaining, 2011). Kaining continued, "It was common for women with 'reproductive tract infections' (RTIs), traditionally called women's diseases or gynaecological conditions, to never talk about the RTIs or simply try to wash them off" (p. 76). Free gynaecological exams for women ceased in China in the early 1990s (X. M. Chen et al., 1992) and fewer women engaged in sexual health checks for economic reasons.

This placed Chinese women at a gender-based disadvantage when it came to their healthcare as Chen and Standing noted (L. Chen & Standing, 2007): "from 1997–2007 only 38 or 39 percent of women are getting the reproductive examinations that they need" (p. 143), including Pap testing. Little has changed since the 2009 *Healthcare Reform Plan*, with no specific program targeting women's sexual and reproductive health (Kahler, 2011).

2.4.2 India

Hinduism (79%) and more recently, Islam (14.23%) are the largest historical influences upon Indian women (*Census*, 2011). Mahajan et al. state (Mahajan, Pimple, Palsetia, Dave, & De Souza, 2013) "Religion is known to affect the pattern of sexual behaviour one follows, attitudes towards pregnancy and premarital sex, desired fertility" (p. 256). Ancient Indian writings refer to sexuality, gender, family and morality. *The Vedas*, for example, expressed the value of women's fertility through prayer and discussion of family structure and polygamous marriage. In Vedic writings, women were more valued than current Indian culture practices (Chakraborty & Thakurata, 2013).

Hindu temple art at Kahurajo, Konark, Karnataka, Modhera and Thirumayam depicts nudity and sex acts; maybe the first public sex education of a people that was not largely literate. Hinduism teaches that a woman's value is dependent upon caste, virginity until marriage, fertility, the birthing of sons and being sexually responsive to her husband as a religious duty. As Jha wrote (G. Jha, 1920): "Her father protects (her) in childhood, her husband protects (her) in youth, and her sons protect (her) in old age; thus a woman is never fit for independence" (Manusmriti 9.3) (n. p.). Hindu beliefs about menstruation indicate that it is considered *Tamas* or toxic and impure (Bhartiya, 2013), thus shame about women's genitalia, apart from sex, is implied.

The Kama Sutra, written by Vatsayana sometime between 300 BCE to 300 CE, openly discussed human relationships, courtship, marriage, sensuality and sex acts (Doniger & Kakar, 2002). The writings are considered sacred for Hindus. The woman reciprocates to her husband and is given permission to enjoy pleasure, with sexual acts being like an act of worship (Chakraborty & Thakurata, 2013). Sex, desire and pleasure are validated as part of the four goals for a good Hindu life (Doniger & Kakar, 2002).

One needed to be literate to read these scriptures and most Hindu women were historically illiterate.

Islamic influence on Indian sexuality emerged after the 12th century conquest of northern India by Moghuls. *The Perfumed Garden*, authored in the 16th century by Sheikh Nafzawi (Burton, 1964) influenced many literate upper caste men. The veto on sex acts during menstruation was part of this writing as Moslems consider menstruation unclean. The Quran outlines in Surah Al-Baqarah 2:222, that menstruation is an impurity and women are unclean during this time until purification (Bhartiya, 2013). Women's genitals were, apart from the sexual use of her husband, unclean things. Bhartiya (2013) noted, "Sikhism is the only religion where the scriptures condemn sexism and do not impose any restriction on menstruating women" (p. 524).

Mangalwadi (2011) states that European traders or colonisers brought Christianity to India as a minor religion with power and influence due to the knowledge held: "The seeds of Western civilisation" (p. xi). Christianity brought to India social infrastructure, political ideologies, civil government, medicine and hospitals for the people and educational opportunity for girls, helping India prepare for independence. Indian girls and women of upper castes now had education; not necessarily sexual education (Mangalwadi, 2011). The churches in India taught similar messages as other religions about the worth of women, chastity until marriage and responding to their husband's sexual desires: sex was for men and procreation (Chakraborty & Thakurata, 2013; Mahajan et al., 2013).

Violence against women in India is tied to the concept of shame, caste, religion, gender and the subservient role of women (Mahajan et al., 2013). Suttee upon the death of an Indian woman's husband was historically practiced in the upper castes in Bengal and Kashmir (J. Banerjee, 2014). Dowry deaths and bride burning were ways for families to get more assets; the woman was expendable (Chakraborty & Thakurata, 2013). Revenge rape of women was practiced for shaming the family and still is (Dearden, 2015; Dhawan, 2014). India's *2018 Gender Equality Index* was categorised as *medium* and positioned at 130 of 189 nations (United Nations Development Program, 2018). Gender bias and sexual discrimination against Indian women is an issue, despite the

Indian government legislating to protect its women (Devendar, 2017). This may be due to religious and cultural norms entrenched in male entitlement (Sanghera, 2011). India was historically, and remains a dangerous place to be a woman, in 2018 polled as the most dangerous (Thomson Reuters Foundation, 2018).

Indian women could not act independently of their male guardians in seeking medical attention for health or gynaecological matters as they needed approval for money to be spent (Malavi, 2016). Menstrual shame and embarrassment at discussing sexual matters with a male making this request unlikely (Bhartiya, 2013). Historically, Indian women's sexuality has been considered responsive to her husband's desire, women's bodies strongly sexually desired, then rejected as unclean when menstruating. This is paradoxical.

2.4.3 Indonesia and Malaysia

Indonesia and Malaysia comprise a close genetic pool with cultures that are historically blended due to Islam, trade and similar language (Razak, 2012). Indonesia had periods of Hindu religious colonisation, then Buddhist influence up until the 4th century. Hinduism resurged in Indonesia and continued after the arrival of Islam in the 10th century. Hindu cultural and religious influence placed women in subordinate positions to men, restricted women's activities and involved menstrual segregation, thus shame (Mahajan et al., 2013).

Islam became the dominant religion of Indonesia and Malaysia by the time European spice traders arrived in the 16th century (N. Ahmed, 2001-2017). Malaysia accepted Islam earlier than Indonesia due to a large Islamic Chinese community near Malacca, becoming the Peranakans (N. Ahmed, 2001-2017). Ancient writings about women or sexuality are rare in Indonesia and Malaysia; religious and cultural traditions and moral stories were verbally transmitted or told via ritual or public performance such as the Ramayana (Gorlinski, 2019), a Hindu tale about gods involving seduction and marriage. In Malaysia, the Hindu epics were known, though when Islam arrived, were replaced by Islamic religious literature for the upper classes and educated Islamic leaders, predominantly men.

Malaysia and parts of Indonesia practice female genital mutilation (FGM) which

impacts women's experiences of menstruation, reproduction and sexuality (UNICEF, 2019). Female genital cutting is promoted by Islamic doctrine to reduce a woman's promiscuity (H. M. Ahmed, Kareem, Shabila, & Mzori, 2018), there is no empirical evidence for this belief. FGM was banned in Indonesia in 2006 but still occurs according to UNICEF's 2019 report on Indonesia and female genital cutting (UNICEF, 2019) noting "The Indonesian Ulema Council (Majelis Ulama Indonesia - MUI) issued a fatwa against the prohibition on FGM on the grounds that female circumcision is part of Sharia (Islamic law) and should be provided by medical professionals if requested by families and communities" (p. 4).

Malaysia's Islamic influence guides the practice of female circumcision of the clitoris in compliance with Koranic interpretation (Renaldi, 2018). Dahlui's (Dahlui, 2012) mixed methods study found "religious obligation" (n. p.) as the key reasoning. Khoo (Khoo, 2016a) validated this research, with Reych (Reych, 2016) saying FGM continues, without providing statistics for evidence. Reych (Reych, 2016) said that despite the United Nations (UN) and World Health Organization (WHO) recommendations, "female circumcision is still not illegal in Malaysia" (n. p.). Some Malaysian medical practitioners argue circumcision is not infibulation or the removal of the labia (Khoo, 2016a). No empirical research exists indicating a benefit of FGM to women's sexual health. Girls are not educated on the choice they have; women comply without access to that available knowledge. The Malaysian media reports range from accepting female circumcision (Renaldi, 2018) to opposing to the practice (Spencer, 2018).

The Indonesian traditional practice of women *drying the vagina* using plant pessaries or betel nut juice, in belief this will clean the vagina and facilitate male sexual pleasure, results in gynaecological health problems including vaginal infections due to changing the natural bacteria and Ph balance of the vagina (Hilber et al., 2009; McIntire, 2017). The vagina is an organ that self-cleans; thus, this practice does not serve a healthy function (McIntire, 2017). Indonesian women damage their gynaecological health using this practice without knowing it.

The influence of Islam on Indonesian and Malaysian women is vast: 12 centuries of teaching covers women's gender roles, public behaviour, modesty, property and

assets, spending money with her husband's consent, obedience to her husband, sexual activity without refusal, leaving the home, travelling rules and who can be permitted to enter their Islamic home (Badawi, 2000). Badawi wrote, "Whenever calls his wife for his desire, let her come to him even if she is occupied at the oven. Thus, a wife must be responsive to her husband even if that involves the wasting of some wealth (by burning the bread)" (n. p). Fessler's (2005) research found "subordinance structures in Asian societies often place women in positions of reliance upon men for health matters: fathers, husbands and male relatives may need to approve a woman's access to, treatment of and payment for her health conditions" (p. 219). Due to cultural menstrual taboo, a woman would not tell her husband about gynaecological problems or ask for money for treatment. Fessler (Fessler, 2005) found: "Embarrassment and shyness shame are highly likely to relate to women of Asian cultures discussing their sexuality or sexual matters with strangers" (p. 219). It would not be modest for another man, even a doctor, to see her genitals (Ussher et al., 2017).

Christianity was introduced by Catholic missions in the 16th century in Malacca. The Dutch Reformed missions came to Indonesia in the 17th and 18th centuries because of trade (Aritonang & Steenbrink, 2008). Other denominations followed. Christianity in Indonesia was 10% of the population in 2010 (*Sensus Penduduk 2010.[Population by Region and Religion]*, 2010). In Malaysia, it was 9.2% in 2011 (Department of Statistics, 2011). Traditional Christianity and Islam share similar characteristics of patriarchy with a lack of consideration for women's needs. Benefits Christianity brought to women of Malaysia and Indonesia were better education, hospitals, medical care, an awareness of rights as well as less restriction by husbands about their movements (Mangalwadi, 2011).

2.4.4 The Philippines

Historical literature on women's sexuality from the Philippines is rare. Filipinas had more status and social power prior to Spanish colonisation and the adoption of Roman Catholicism; they could divorce husbands, own their own property and businesses and were known to have been warriors, nobles and queens (Alejandro & Yuson, 2000; Torralba-Titgemeyer, 1997). Torralba-Titgemeyer (1997) wrote that the pre-Spanish Filipino woman, the *mujer indigena* had an honoured position in the family and

society, which was dispensed with by the Spaniards" (n. p.). Spanish colonialism and Roman Catholic Christianity in the mid sixteenth century changed the role and status of women in the Philippines for 300 years. Passive and obedient women were approved of by the Church and women were taught and expected to *obey their husbands in everything* (Ephesians 5:24). Women could not access education or healthcare without their father's or husband's permission. The only educated women were upper class, educated by nuns as preparation for marriage (L. L. Rodriguez, 2012). One positive for Filipinas at the end of Spanish dominance was the introduction of free education in 1863. However, once menstruation commenced, Catholic teachings about menstruation as unclean and the poor availability of sanitary hygiene products other than menstrual cloths (Wijngaards, 2014) saw girls stop school.

After the 1898 Spanish-American war, America gained the Philippines as a colony, bringing more changes to Philippine society through increased wealth, education and infrastructure. American funding supported the growing economy. During World War II, American media, music and culture influenced the Philippines, with American servicemen and residents engaging in relationships with Filipinas. Karnow wrote (Karnow, 1989): "Just as Americans at home discretely accepted illicit relations between white men and black women, especially in the South, so Americans in Manila tolerated compatriots who kept a native 'querida,' or mistress, a practice common among Americans" (p. 214). Filipina's sexual health was compromised by this exploitation as STIs were introduced to sex workers, who spread the diseases to locals. Filipinas also bore illegitimate children of mixed-race in this religious culture, which ostracised them.

During the 20th century the Roman Catholic religion was the dominant religious influence. Catholic teachings about sex for procreation rather than pleasure, the forbidding of contraception and promotion of large families resulted in a population boom (The Catholic Church, n.d.). Menstrual shame for women remained in the Philippines (Wijngaards, 2014). Gender roles became entrenched according to Catholic teachings. Alcantara wrote (Alcantara, 1994): "the husband is the publicly acknowledged head of the household... conversely, the wife is credited primarily for her ability to have children" (p. 94). Educational opportunities for Filipina girls grew and women took up prominent business and political positions due to better education,

yet they still had to discuss menstrual or gynaecological problems with their husband or father and ask for permission for money for treatment (Anonuevo, 2000).

During the American era after 1898, Filipina's navigated being within a colonised society run by men, in which English language meant power and position (Vartti, 2001). Vartti said (Vartti, 2001) after World War II American media became popular in the Philippines, "After the war, English regained its powerful status. That was a period of magazines… magazines like *Liwayway, Bulaklak, Aliwan* and *Tagumpay* regularly published novels of several women writers" (n. p.). Although magazines were aimed at Filipinas and contributed to by Filipinas, they could not publish sexual information.

Filipinas became part of a work migration practice under the Marcos regime in the 1970s and 1980s, when the economy was crippled. Many Filipinas went to the Middle East, Singapore and Japan to work as nurses, nannies, or maids to provide for their families. This led to some Filipinas being exploited by their employers, suffering physical abuse, sexual assault, unwanted pregnancy and traumatisation which affected their mental health, not just sexual health (Anonuevo, 2000; Vartti, 2001). Filipinas also were affected by mail-order bride businesses, supported by marriage brokers and dating firms, promoted in magazines and (much later) the internet. A mail-order bride had higher status than a sex worker and potential to provide money for the family in the Philippines once the bride had left the nation (Velasco, 2007, 2015). It was assumed by men from western nations that a Filipina bride would be passive, less educated and without feminist leanings, however this was not necessarily the case (Velasco, 2015; Woelz-Stirling, Kelaher, & Manderson, 1998).

Sex education did not exist in the Philippines prior to the 21st century; Catholic schools provided menstrual education for girls in schools, with sexuality education restricted to abstinence. Many young Filipinas learned about sex at the turn of the century via pornography and Western media as censorship relaxed and internet connectivity increased (Hunt & Ana-Gatbonton, 2000). Since the advent of the internet, this trend has continued, with younger people and pornography access becoming problematic and the government legislating to regulate the internet and ban access to pornographic images of children (Daniels, 2017). A survey by Pornhub of Filipino men indicated

they view pornography on that website for the longest duration of time among Asians (Remitio, 2017). Filipino men interviewed by Remitio (2017) after the ban, indicated they had a right to watch pornography. *Freddie* said watching pornography is part of human nature, "'Siyempre tao tayo, may mga pangangailangan tayo diba?' (Translation, 'of course we're people, we have needs, right?')" (n. p.). A cultural attitude of male entitlement to sexual material, without adequate rights-based education for Filipinas put them at risk of sexual exploitation.

2.4.5 Singapore

A Chinese colony has been part of Singapore's merchant history since the 14th century, bringing Confucian, Daoist and Buddhist religious influences (Miksic, 2013). Singapore was an undeveloped island port and part of a Malay sultanate during the spice trade period of the 16th to 18th centuries and centrally located to shipping routes. Stamford Raffles negotiated colonisation of Singapore in 1819 on behalf of Britain. Thereafter, Indian, Chinese and Malay workers moved to the island for work (Sothearoth, 2011). In 1959, Singapore became an independent nation. Ethnic Chinese people are about 75 percent of the population (Singapore Heritage Board, 2014).

Religions historically influencing Singaporean culture are Confucianism, Daoism, Buddhism, Hinduism, Islam, Judaism and more recently, Christianity (Miksic, 2013). The teachings of these religions being the primary source of sexual norms or sex education of the multi-ethnic women of Singapore. Singaporean women were historically illiterate and dependent upon fathers, brothers and husbands for any healthcare or education. Menstrual shame and taboo were part of the religions the women practiced (Bhartiya, 2013; Chandra-Mouli & Vipul-Patel, 2017b). Most women lived in kampongs specific to their ethnicity and religion and matchmaking was arranged for marriages between families (Singapore Heritage Board, 2014).

Rituals specific to women's fertility, birth, culture and religion have been practiced in Singapore. The Singaporean Heritage Centre (Singapore Heritage Board, 2014) outlines some of these. "Some older, more traditional women in Indian families may prefer to remain in the background and not take part in open conversation with guests. They also refrain from shaking hands with visitors" (p. 31). Like Chinese women, Singaporean Indian women did not seek attention or touch from non-family members

due to cultural norms. Confinement periods after birth were practiced in many Singaporean religious and cultural traditions as a way of cleansing the mother and protecting the child. Buddhist, Islamic, Confucian and Daoist women could be socially isolated, indoors, unwashed and unspoken to for anywhere from a month to 44 days (Singapore Heritage Board, 2014). Some women still practice confinement today (Teo et al., 2018).

Singapore's independence in 1959 saw the commencement of a national health program. Singaporean women had their gynaecological and reproductive health checked and records began to be kept of women's health (Ministry of Health, 2018). Government programs and media focused on modernisation and family planning to slow population growth. *The Health Belief Model* (HBM) (Quah, 1985) was utilised by the Singaporean government in the 1970's-1990's to promote awareness of Singaporean people's perceptions of: disease risk, belief they were at risk, the benefit of preventative action and as Quah (1985, p.351) stated that "no major barriers, e.g., cost, convenience, pain, embarrassment would stop a person from engaging in public health programs" (p. 351). Quah (Quah, 1985) wrote that Singaporeans "share similar sex role values regarding what is appropriate behaviour for women as opposed to men… (and) these sex role values are the outcome of cultural and/or religious beliefs on the role of women in society" (p. 357).

After World War II, Singapore's conservative government promoted Asian traditions and values, rejecting Westernisation in culture and legislation, but practicing Westernisation in business (Leong, 2012). From the 1960 to the 1980s Singapore focused on survival driven education of its people, actively promoting secondary and tertiary education and linking them to prestige, power and success (Boon & Gopinathan, 2006). In 1960, bilingualism was legislated for the school system, with English becoming the primary language used in public schools by 1966 (Boon & Gopinathan, 2006). Secondary education was compulsory by 2000.

From foundation to 2000, Singaporean women faced paradoxical pressures: becoming better educated, working to earn income and contribute to the growing economy yet still providing the traditional home environment espoused by Lee Kuan Yew's 1959–1990 government (S. K. J. Lee, Campbell, & Chia, 1999). Singapore's primary

resource was people: women were included in government strategies to make Singapore's economy grow, contrary to many traditional cultural or religious norms. However, better education for Singaporean women did not mean education for their sexual health or sexuality. The medical language used for women's sexual health in high schools and health clinics: *reproductive health* was akin to other Asian nations. This is interesting given that Singapore Government propaganda and health services promoted a two-child family and provided access to Pap smear tests, STI testing and abortion (Quah, 1985; K. Singh, Fai, Prasad, & Ratnam, 1996). Singapore's key sex education messages provided in schools (Ministry of Education, 2018) for many years were: "Love and respect; build positive relationships; make responsible decisions and practice abstinence before marriage" (n. p.).

2.5 Content review results

The content review was specific to the six nations of this study and women's sexual health according to The World Health Organization definition (WHO) as the benchmark definition (World Health Organization, 2013). Key word searches covered women's sexual health terminologies including *sexual education, physiology, contraception, STIs, women's cancers, gender identity, sexual orientation, pleasure, consent, rape, safe sex* and *sexual behaviours*. Of note, is the content search was about Asian *women's sexual health*, yet the searches evidenced discussion of *men* 468 times in relation to women's sexuality. In these references women were mentioned 318 times apart from a man. Women's sexuality in academic resources about Asian nations appeared linked to heteronormative sex. As an example of this bias, the search criterion *male gender* (193) and *gender bias* (111) had more mentions than women's sexual health references about *women's health* (31), sexually related *screening tests for women* (44), *Pap testing* (24) and *HPV vaccination* (32). *Women's cancers* were only mentioned between 12-58 times depending upon the cancer; breast cancer being mentioned more than cervical or ovarian cancer.

Sex was mentioned 281 times in the references searched, but not in relation to women's sexual health as defined by WHO (World Health Organization, 2013) *sex* was related to intercourse or women's reproductive function. *STIs* were mentioned 401 times in references, yet *sex education* was mentioned only 73 times and *safe sex* practices

mentioned only 38 times. These seemed contradictory figures as STIs spread due to lack of knowledge of safe sex practices. The *need of education* (women's sexual health) was mentioned 192 times, yet comprehensive sex education is not available in the nations of this study, including Singapore (UNESCO, 2015).

The *influence of culture* (179 mentions) and *tradition* (133 mentions) on women's sexual health was high compared to mentions of *women's sexual health* (100 mentions). The culture of a nation influences women and cultures with taboo about women's sexuality result in sexual health problems. For example, women's *access to health services* (98) was a low figure, perhaps because some women need permission from a male. *Marriage* (97) and *marital violence* (92) were also found in searches about women's sexual health at higher figures than Pap testing. Women's sexual health *research* was mentioned 184 times, yet the research itself appears to not comprehensively discuss women's sexual health according to WHO criteria.

The growing *role of the media* (149) in providing women with sexual information was mentioned more than *women's sexual health* as defined by WHO, this is not surprising in nations without sex education in schools. *Religion* (106 mentions) rated more highly than *women's sexual health*, though the level of religious discussion about women and sex was not measurable.

The content search results framed women's sexuality and sexual health as related to men and reproduction. For example, *non-heteronormative* women's sexuality like lesbianism was rarely mentioned in the content search (9 mentions). Women's *genital anatomy, function* and *sexual pleasure* were not mentioned in the literature searched; all of these are part of women's sexual health. Asian women's *sexual health* articles of the content review focused upon reproduction, family planning and contraception, with little mention of sex for female pleasure, informed consent, sexual rights or non-heterosexual female sexualities which the WHO include in their sexual health definition (World Health Organization, 2020b). Gynaecological or cervical cancer and Pap testing had little emphasis in government literature from five of the six nations of this study and poor financing or marketing, apart from in Singapore. This reinforces the low social value assigned to Asian women and puts their sexual health at risk.

2.6 Discussion & recommendations

This research identified historic contextual influences on Asian women's sexuality and sexual health from two perspectives, the brief literature review and the content review of women's sexual health literature. Both revealed influences upon Asian women's sexual health were contextual to patriarchal dominance and male control of women's bodies, health, and sexuality maintained by cultural and religious norms that shamed and silenced women, did not inform women of their rights or their health risks, and discouraged women from complaining. The WHO definition of women's sexual health needs to be used by health researchers and taught as part of any national sex education program (World Health Organization, 2020b). The *reproductive* language used in academic literature under review is inaccurate because women's sexual health is more than fertility, sexual activity, reproduction or menstruation (A. K. C. Leung & Nakayama, 2017), researcher's need to use accurate language.

The review was limited by the 542 references searched, yet the available literature was 'purposefully sampled' for the Asian nations under study (Palinkas et al., 2015). A larger review of Asian cultural, religious and women's sexual health literature would add veracity to this study's outcomes and recommendations.

Comprehensive sexuality education was alluded to without detail by the health departments of China, India, the Philippines, Malaysia, Indonesia and Singapore. Governments argued about the content of sex education programs for adolescents due to cultural, traditional, or religious conflicts (Khoo, 2016c) yet no nation has a sex education program outlining more than reproductive function, menstrual information STI risk and basic contraception. Asian women traditionally avoid sexual issues by not seeking health checks early (Department of Health, 2018), they risk contracting STIs as they have poor sex education and little safe sex knowledge. The incidence of gynaecological cancers is increasing in Asia (American Cancer Society, 2021), yet Asian women experience cultural norms inhibiting their sexual health care (Utting, Calcutt, Marsh, & Doherty, 2012).

2.6.1 Recommendations

Funding for research-based women's sexual health programs is required. Ussher (Ussher et al., 2017) discussed the "shame, secrecy and silence" factors (p.1907) when

trying to engage with migrant women and their sexual health, which this research also identified. Mengesha et al. wrote similarly, indicating that health care providers must consider CRaLD variables when working with migrant women attending sexual health services. Culturally appropriate advice and education and information in Asian languages could encourage resistant women to engage with sexual health services (Mengesha et al., 2017). Growing migration to Australia from the Asian nations of this research (*Migration to Australia: a quick guide to the statistics*, 2017) until the recent COVID19 pandemic, means health department policies and procedures for women's health services must change, making access and affordability of services for CRaLD resident women easier, considering their husbands may control finances or make health decisions.

Another aim of this study was to promote cultural sensitivity training to sexual health professionals so CRaLD women receive respectful women's sexual health services (Lawrence, 2020). Without understanding the context of Asian women's sexual health knowledge deficits, this will not occur. The CRaLD issues have implications for general practitioners as consideration of migrant women's shyness, shame, culture and religion by health practitioners constitutes ethical practice (Sue et al., 2019). The researcher advocates longer appointments being scheduled in such cases, which is difficult given GPs are pressured to schedule 10-minute Medicare consultations (Department of Health & Human Services, 2015). The training of medical professionals working with migrant women in Australia needs review because sexual health and sexuality are not a large component of Australian medical training: they are considered specialisations (Royal Australian College of Physicians, 2019). CRaLD women may not be able to afford a specialist which makes affordability of services an issue (Lehmiller, 2018; Royal Australian College of Physicians, 2019). Multicultural women's health clinics are recommended.

In a South-East Asian regional perspective, national sexual health education programs must provide more information to women than reproductive function or menstrual management. Such programs did not exist in any of the six nations, including Singapore. Singapore's current school sex education program focuses on reproduction and sexual abstinence (Liew, 2014; Ministry of Education, 2018). A comprehensive sexual education is foundational to improve Asian women's perception of their body,

sexuality, sexual health and their sexual relationships (World Health Organization, 2013) including women's anatomy, the function of women's sexual organs, women's sexual arousal, sexual pleasure, sexual attraction, practicing gynaecological health care and defining what is informed consent and safe sex practices. Modernisation and westernisation in Asia, inclusive of sexualised mass media via access to internet pornography without adequate sexual education for women is sending unhelpful health information (A. K. C. Leung & Nakayama, 2017)

2.7 Conclusion

This research identified the shaming and silencing of Asian women about their sexuality, gynaecology, and sexual health due to societal gender bias which restricts the information available to Asian women. The historic negative beliefs regarding the worth of women and cleanliness of women's gynaecology remain influential. This study identified cultural, religious and traditional beliefs Asian migrant women are normalised to, affecting how they view their sexuality and sexual health. Asian women's sexual health appeared less important than their sexual availability for a man. All contextual factors affect them accessing sexual health services in Australia and engaging with health professionals. As such, this review has met its informative aim.

Health departments need to address the epidemiological risks of not prioritising, nor engaging with CRaLD women's sexual health context. Migration does not guarantee behavioural change in Australia. Research into women's sexual health issues needs to be conducted in Australia's migrant communities, using qualitative and quantitative methods to ensure any women's sexual health program meets a need expressed by such women (Thomas & Harden, 2008). It is hard to measure women's sexual health in Australia if the migrant women at risk do not present to the health system for cultural or religious reasons and are not represented in the statistics (Multicultural Women's Health Australia, 2016a).

Chapter 3: A content analysis of Asian women's sexuality in 40 years of media content:

Publication 2 - Portrayals of Asian women's sexuality in 40 years of media: A content analysis.

This article has been submitted to Platform

3.1 Abstract

This article examines how Asian women's sexual health has been portrayed in mass media within the last 40 years in China, India, Indonesia, Malaysia, Singapore and the Philippines. A brief literature review describes Asian media in six nations, then a content review of research references analyses media content about women's sexuality and sexual health. 637 Endnote references on the Asian nations were reviewed for words specific to women's physiology, sexuality, sexual health, STIs and sexual information presented in Asian paper, broadcast and online media. The results in Tables 1 and 2 are compared to the brief literature review to identify how Asian media portrayed women's sexuality. Results identified a lack of accurate sexual health information available for women mainly due to censorship, yet a rise in discriminatory sexualisation and objectification in media. Asian governments and media have a duty of care to inform women, yet sexual misinformation distributed by online mass media and used by women as sex education does not promote sexual health.

Keywords: Media, women's sexuality, sexual health, discrimination, censorship

3.2 Introduction

Media has influence. Media is used to disseminate information and promote products or ideas to targeted consumers. This review analyses Asian media content about women's sexual health and sexual health information in media of six nations: China, India, Indonesia, Malaysia, Singapore and the Philippines. It identifies missing information about women's sexual health according to World Health Organization (WHO) definition (World Health Organization, 2013). Nagar and Kirk (Nagar & Virk, 2017) indicated 'Media technologies (magazines, newspapers, television, movies, and social networking websites) provide platform to portray, communicate, and construct how an ideal body looks… women are more vulnerable to body image disturbances than men' (p. 1). Asian media has targeted women by discussing beauty that appeals to men, achieves social status or is sexually normative (Nagar & Virk, 2017; Narang, 2019; Vigu & Dubey, 2010), especially since internet platforms after the 1990s. Research has linked Asian women's body image problems to media messages (Jackson 2020; Nagar, Itisha & Ruksana 2017).

The norms of a society influence the actions of its citizens. Information that media consumers can access is regulated by government policy ensuring content is acceptable for that society (Stewart, Lawrence, & Manvell, 2012). Bandura's *Social Cognitive Theory of Personal and Societal Change via Enabling Media* (A. Bandura, 2003b) postulates what is permitted by society, reinforced or validated by societal power structures, keeps the status quo via pressure to conform to what values are promoted and rewarded. Thus, if little or no information is permitted about women's sexual health, women can remain ignorant about information for healthier lives.

Women's magazines, television, film and website media contributed to the social norms of the six Asian nations of this review. Media reflects consumer interest, markets products, provides forums for discussion and allows cultural narratives to be told. Media informs and educates women about information or services that governments do not provide (Nagar & Virk, 2017; Siddharta, 2017; Vigu & Dubey, 2010; Zhu & Hisgen, 2013). Media in the nations under review is censored or controlled (Stewart et al., 2012). This includes pornography which, for some Asian

women, is a source of sex education, albeit a poor one, risking their sexual health because safe sex practices are not presented (Daniels, 2017; Lau, 2016; Wall, 2013).

3.3 Materials and Methods

This study uses a brief literature review then content review (Bengtsson, 2016) of references utilised for a doctoral thesis. A content review being a research methodology used to identify words and phrases about a specific topic across multi-media and communication sources, the goal being to make deductions about the topic (Columbia Public Health, 2020). The content review of 637 Endnote references was specific to women's sexual health, physiology, STIs, reproduction, sex education, contraception, and cancers. The frequency of words and phrases linked to women's sexual health in media was tallied: the outcomes listed in Tables 1 and 2. Results then triangulated (Nowell et al., 2017) with the brief literature review of 40 years of Asian media content revealed media messages about women's sexual health.

3.4 Brief review

3.4.1 China

Premarital sex was greatly discouraged in traditional Chinese propaganda, sex education for women was non-existent until after marriage (Xinran, 2002) and women were not sexually assertive (E. Chen, 2016). China re-entered world trade in the 1980s when western ideas about women entered China via radio, magazines, television and film (Ireland, 2010; Xiao, Mehrotra, & Zimmerman, 2011). New ideas were promoted by magazines, marketing and advertising. Women had information regarding sexuality, sexual health, and sex for pleasure (Xiao et al., 2011; E. Yan et al., 2011). Xiao et al (2011) wrote that traditions about women's sexuality being responsive were challenged:

> … rapid changes in sexual mores due to several reasons such as decreasing control of the state over private lives of individuals… increased acceptance of premarital sex and extramarital sex in China, especially among youth (p. 105).

San Jose State University ("The Portrayal of Asian Women in the Media (Past vs Present)," 2019) noted in film, Asian women were historically portrayed negatively by European women. The curricula stated, 'Though Asian women are not as patronized anymore, the micro-aggressions against Asian women seen in media spark discomfort amongst their community' (n. p.). For example, Chinese, Philippines and Singaporean women's magazines commonly use Caucasian or Eurasian models as examples of beauty and sex-appeal (A. Yan, 2016).

Xinran, an academic and radio broadcaster advocated for women's issues by discussing women's sexual experiences, rape, incest, sexual harassment, lack of sex education and discrimination. Xinran's (2002) broadcast '*Words on the Night Breeze'* broke cultural taboos. Her broadcasts challenged tradition via open dialogue becoming a catalyst for media discussion of women's roles, China's gender bias and sexual matters when non-state women's magazines entered China in the 1990's (Xinran, 2010).

Chinese print media promoted westernised ideals of beauty and sexiness, a form of social manipulation resulting in dissatisfaction with self (Ursell, 2017). Chinese women accessing cosmetic surgery for their eyelids or nose to become more desirable (Wolff, 2013). By 2010, the *All-China Women's Federation* stated that 'plastic surgery was a 300-billion-yuan (US $4.8 billion) industry' (n. p.). China is second to Thailand for cosmetic surgery in Asia (YouGov 2015) with skin whiteners being popular (C Tai & Sukumaran, 2019).

Social media helped Chinese women get information about sex. China has more social media consumers than anywhere else in the world, despite the unavailability of YouTube, Twitter and Facebook (Chiu, Ip, & Silverman, 2012). The Chinese social media alternatives have millions of users: Youku Tudou (580 million users per month), WeChat (1.12 billion users per month), Tencent QQ (803.2 million users per month), Biadu Teba (300 million users per month) and Sina Weibo (446 million users per month) and control of sexual content via these platforms is not practicable (DeGennaro, 2019).

Prolonged exposure to pornographic images in online media can lead to acting-out the material in the belief it is reality (Lijun Chen et al., 2018). Pornography is prohibited by Chinese law ("Criminal Law of The People's Republic of China ", 1997), with harsh penalties for pornography production or distribution, yet pornography is available via the Internet and considered sex education in media reports (Wall, 2013). Safe sex in pornography is rare; Chinese women risk contracting STIs (Wall, 2013) because pornography does not promote safe sex practices (Hesse & Pedersen, 2017; Steinhauer, 2016). Chinese youth are more sexually active (Hong, Fongkaew, Senaratana, & Tonmukayakul, 2010a; X. Jiang, Tang, & Chen, 2018; Ma et al., 2009; Zhou, 2007) and STIs more prevalent. HIV was estimated at 700,000 cases in 2007 and syphilis infected 9.5% of sex workers (Chan, 2011).

'*If You Are the One'* ("If You Are The One," 2010-2018) a television broadcast, promoted women's choice in a male biased society where there is a shortage of women. The missing women are due to a traditional preference for male children and selective or forced abortion during the *One Child Policy* (Ebenstein, 2010). Yang (2010) commented that government officials issued a directive calling the shows '"vulgar" and faulting them for promoting materialism, openly discussing sexual matters and… hurting the credibility of the media' (n. p.), yet the show was the most popular TV show for a decade (Sun & Han, 2020).

China's government provides no comprehensive sex education media in schools (H. Leung, Shek, Leung, & Shek, 2019), reproductive or menstrual function is taught: not gynaecological anatomy, health care, safe sex practices, sexual pleasure, sexual consent and alternate sexualities (Kaining, 2011). Chinese broadcast media and magazines publish incomplete information about female sexuality and sexual health for women due to censorship. Huang (2017) commented that 'The lack of sex education has contributed to China's HIV crisis, especially among young people' (n. p.). Without safe sex and contraceptive information in Chinese media, STIs and gynaecological disease have increased in China since 2004, with chlamydia the most common STI (Huai, P., Li, F., Li, Z., Sun, L., Fu, X. a., Pan, Q., . . . Zhang, F. 2018).

3.4.2 India

India's tradition of shaming and punishing unaccompanied women is a sexual safety battlefront (Dearden, 2015). Rape is used as punishment especially in rural locations (Government of India, 2015; Human Rights Watch, 2015). Sexual assault is a media topic in larger Indian cities, where sexual assault is common, even though the government has legislated anti-sexual harassment laws and more women report (54% after 2014) (Watts, 2019). Indian public media is facilitating social change in male attitudes to women and sexuality that the government have not kept pace with (Human Rights Watch, 2015) by reporting negatively on sexual harassment and assaults (Watts, 2019). The Indian government's print and online media reflects traditional values, polarising women into obedient, chaste and submissive; or westernised, promiscuous and shameful; and more recently, sexually powerful in marriage (Rasul & Raney, 2016).

Government sex education media for youth did not exist until 2018 (Oomen, 2020). Ismail et al. (2015) wrote that television, film, radio, and internet opened sexual discussion in India concurrent with increasing STI rates, with safe sex practices not promoted in media. Sharma (2020) reported only 50% of Indian women knew about safe sex. Ooman (2020) saying "54% of females use the internet" to access sexual information (n. p.). Indian print and online media publishes on women's sexuality, menstruation and sex education information via websites such as 100 Women 2014 (R. Jha, 2014). Newspapers like the *Times of India* and *Dainik Jagran*, have women's sections discussing menstruation, relationship problems and sex in marriage.

Nagar and Virk (2017) said media promoted westernized ideas about women's sexual attractiveness or physical beauty: 'emergent studies indicate that an increasing number of women in India display body image disturbances… (influenced by) Indian magazines, movies, TV shows, and social media' (p. 2). Being thin and pale skinned is promoted in media along with skin bleaches, including vulvar products (Tai, 2019). The news media report misogynist attitudes to women as common in politics and policing (M. Banerjee, 2015). Younger women of India are asserting their rights, challenging tradition by challenging sexual harassers in public (Horswill, 2015), yet harassment continues (Marathe, 2020). The news media reported positively on the *Pink Sari Gang* who shame alleged rapists and wife beaters by protesting to political leaders, corrupt police, and the judiciary (Gulabi Gang 2016).

The Indian government does not align with its media on women's health. The *National Health Policy* (*National Health Policy 2017.*, 2017) aimed at 'equity, affordability and universal health care' by 2025 (p. 3) does not mention women's sexual health. The language was, 'family planning' (p. 4), 'reproductive morbidities' (p. 14) 'health needs of women beyond the reproductive age group' (p. 14). No mention was made of gynaecological health in the 'Preventative and Promotive Health' section (p. 6), a serious flaw.

Television and movies are censored, with age restrictions. Pornography is illegal, yet pornography is produced and viewed in India (Arora 2018) with increasing frequency and usage by under 30s (Yadav, 2020). The Indian media is sending mixed messages, be sexual as a responsive wife, but do not be sexually educated.

3.4.3 Indonesia

Women are discriminated against in political and social areas of Indonesian society, despite the 1945 Constitution guaranteeing equality. Jurisdictions and laws vary across the archipelago (Johnson, 2012). Women's sexuality and sexual behaviour is expected to comply with Islam, despite the human rights statement *Pancasila* (Embassy of the Republic of Indonesia, 2000), allowing for other monotheistic faiths. There is no Government media on sexual health. The Government's censorship laws regulate sexual information in print and broadcast media. In the 1990's, *Asia Watch* reported Jogjakarta's frenzy about a sex education book for teenagers ("Indonesia: Public pressure and teenage sex," 1991), condemned for 'titillating pictures and a text which was potentially ruinous to the morals of a younger generation' (p. 11). Indonesia has no sex education media provided in schools, other than reproductive function and sexual abstinence information in year 9 (Benedicta, 2014).

During Suharto's regime, government media promoted heterosexuality as normative and an Indonesian woman's role was to stay a virgin until marriage, become a wife, then mother (Blackwood, 2007). After Suharto's regime, conservative Islamists pressed for changes to the law, making sexual activity illegal if it was not within heterosexual marriage. Blackwood wrote (Blackwood, 2007): 'The properness of

marriage and the limitation of sexuality to marriage are concepts supported by both the state, through appeals to 'traditional values of Indonesia' in media (p. 296).

Indonesia legislated for women employees regarding menstrual pain in 1998 (Kretzu, 2000), 'every woman is entitled to two days unpaid menstrual leave per month' (n. p.). Proving she is menstruating is considered humiliating (Kennedy, 2016) because menstrual taboo presented in TV and magazines promotes women hiding menstruation (Bhartiya, 2013).

Indonesian women's magazines include Western titles like *Good Housekeeping*, *Harper's Bazaar, Hello, Girlfriend* and *Cosmopolitan*, however, any sexual content is censored by The Department of Communication and Information Technology (Stewart et al., 2012). Indonesian television is also censored; close-up vision is not allowed of women's breasts, legs or buttocks. Animation is censored if it shows females in bathers or kissing (Siddharta, 2017). The most viewed television broadcasts in Indonesia, *Mamah dan Aa Beraksi* and *Tukang Bubur Naik Haji* focus upon Islamic values and do not discuss sexuality (Siddharta, 2017). LGBTQIO[3] references are illegal in television and media, including 'emoticons' supportive of LGBTQIO persons.

Anti-pornography laws were enacted in 2008. Broadcasting animated material suggestive of sexual activity is illegal (Thompson, 2008). After 2010, the Indonesian government targeted social media platforms: Vimeo, Tumblr, Reddit, WhatsApp, Imgur and Facebook directing them to filter pornographic or sexual content (Baziad, 2016)

News media are reporting on sexual assault. An online poll of 25,213 people conducted by *Lentera Sintas Indonesia* and *Magdalene* magazines in response to a 2016 rape case reported: '58 percent of the respondents - mostly women but also some men and transgender people - said they had experienced verbal sexual harassment. About 25 percent said they had been assaulted' (n. p.). Women will not report rape easily (Beh Lih Yi, 2016).

[3] Lesbian, Gay Bisexual Transgender, Queer, Intersex, Other

News media reports of '*2-finger virginity examinations'* conducted on single women for employment or school graduation, evidence misogynist attitudes to women having status, power or employment (Gerntholtz, 2014). This occurred as recently as 2015 (Kwok, 2015) as apparently 'a virgin is mentally healthier than a non-virgin' (n. p.): A polarised and incongruent view of women and their sexuality is played out in Indonesian media.

3.4.4 Malaysia

The role and sexuality of Malay women was determined by males governing the social, political and religious structures women navigated. The Ministry of Women and Family Development (*The Progress of Malaysian Women Since Independence 1957 - 2000.*, 2003) media release historically stated, 'Gender specific issues that continue to hinder the progress of women… include traditional gender constructs, sex role stereotyping and gender division of work… gender discrimination at work' (p. ix). Malaysian schools had no sex education media allowed until 2016 (Khoo, 2016c). Menstrual education material was provided in non-compliant schools (Mutalip & Mohamed, 2012). Censorship of sexual health information for women (Khoo, 2016c) is across all print and broadcast media forms (Centre for Independent Journalism, 2016). Censorship is rigid for print, television and film media, yet pornography is accessible. FMT news ("More Malyasian women watch porn using mobile devices," 2017) reported Malaysian women access pornography online to learn about sex. This endangers women's sexual health as safe sex is rarely practiced in pornography (Hesse & Pedersen, 2017; Yao, 2016). Pornographic media reinforces misogynist ideas about the status of women as sexual commodities (Harvard University, n.d.)

Mutalip and Mohamed identified Malaysian youth's (Mutalip & Mohamed, 2012) 'lack of precise information on sexual and reproductive health is the core reason for the occurrence of unwanted cases since sex is still a taboo subject' (p. 36). Lau's research gave example (Lau, 2016), 'In Malaysia, the findings of a survey on *Malaysian Youth Sexual and Reproductive Health* (SRH) reported that 42% of youths believe that withdrawal before ejaculation is effective enough protection against unplanned pregnancy, 35% believe pregnancy cannot occur when a woman has sex for the first time' (n. p.). Khoo noted teen pregnancies have become more frequent since 2011(Khoo, 2016c), 'for Malaysia, 28.8% of 13,831 teenagers between the ages of 10

and 19 years have conceived children out of wedlock... with 60% not knowing how babies were born' (n. p.). Lau cited Gomez (Lau, 2016) saying, 'There's scarcely any information on sexually transmitted diseases' (n. p.) in sex education media, yet STIs are a growing problem. STIs have doubled since 2010 (Kaler, 2018) with newspaper reports outlining STIs increasing, yet they cannot mention safe sex practices in print. The internet being the source of STI information for youth with 57.1% using online media to get information about sex and STIs (Shakir, Wong, Abdullah, & Adam, 2019). Malaysian print and broadcast media remain silent on the issues due to censorship, yet online media lobby for sex education (Ram, 2020).

Malaysian religious media promote FGM (Khalid et al., 2010; Reych, 2016) as healthy. The *2018 United Nation's 69th Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), found Malaysia lagged in promoting the status and rights of women, especially regarding banning FGM, which is widely practiced (Hutt, 2018) with medical professionals asked to perform FGM (Renaldi, 2018). Malaysian media is divided on the issue (Khoo, 2016b).

3.4.5 The Philippines

Filipinas have been torn between the religious Catholic woman serving her husband, sacrificing her career for children and the modern, educated, liberated woman with rights to her body, sexuality, education and a career. In 2000, Anonuevo (Anonuevo, 2000), working for *Friedrich-Ebert-Stiftung*, reported: 'The social image of a Filipina is still that of a weak person, poster girl of domestic help, expert in double burden and a sexual object' (n. p.), the media plays into this dichotomy.

Catholicism is influential in the Philippines (Isis International, 2011), Rodriguez (L. L. Rodriguez, 2012) said, 'patriarchy is control over women's sexuality' (p. 15). That patriarchy is a male dominated church teaching women as secondary with their sexuality needing control (The Catholic Church, n.d.). Austria noted (Austria, 2004) patriarchy is 'reflected in the category of sexual crimes, which are still referred to as "crimes against chastity", inclusive of "robbing a woman of virtue"' by breaking her hymen (p. 97).

The Church argued against *The Responsible Parenting and Reproductive Health Act 2012* (Republic of the Philippines, 2012) in media. Political and religious arguments were in media since 1998 when *The Reproductive Health Bill* was introduced (Fogarty, 2013; Mack, 2011). Catholic leaders in the news said (*Promoting Reproductive Health: A Unified Strategy to Achieve the MDGs* 2009): 'the bill will result in promiscuity, abortions and moral decay' (p. 6). Some male politicians wanted gender equality for women and reproductive education for the poor scrapped (Calonzo, 2011). *The Responsible Parenting and Reproductive Health Act* attempted to change society (Republic of the Philippines, 2012). Filipinas guaranteed 'accessible, affordable and effective reproductive health care services nationwide' (n. p.) which required 'age-appropriate reproductive health and sexuality education from fifth grade through high school' (Mack, 2012), yet the textbooks are not helpful. Male gender bias is evident in compulsory school media (Delavin & Buayan, 2020) which portrays females in passive roles. Rodriguez said 'A deeply entrenched and integrated system of male dominance' (p. 16) exists in the Philippines (L. L. Rodriguez, 2012). Implementation of the sex education component has not occurred (Geronimo, 2016; Masilungan, 2014).

Relational violence is reported in Philippine media (L. L. Rodriguez, 2012); if a woman says no to sex, yet contraceptives are not widely available and men do not use condoms, she is in a double-bind. She is expected to submit to a man yet be blamed for unwanted pregnancy. The *Asian-Pacific Resource & Research Centre for Women* (Asian-Pacific Resource & Research Centre for Women, 2015) reported '57% of first sexual experiences for young women and girls in the Philippines were unplanned or non-consensual' (p. 6).

Philippine's print and broadcast media promotes discordant views of women. Rodriguez wrote, (L. L. Rodriguez, 2012): 'Patriarchal and capitalist control over women's sexuality also means treating women as sex objects especially in mass media' (p. 16). Until 2013, there was no ethical code for media about portrayals of women in advertising, film, television, marketing material until *'The Magna Carta for Women'* ("Republic Act No. 9710: An Act Providing for the Magna Carta of Women," 2009), guaranteeing that media will portray women without sexual discrimination (Torrevillas, 2013). *The Movie and Television Review and Classification Board* regulates what sexual content can be shown ("MTRCB," 2019). The Internet was

unregulated until 2017, when *Pornhub*, *Redtube* and *Xvideos* were censored. *Pornhub* listed the Philippines as the third largest consumer of pornography. (Daniels, 2017).

3.4.6 Singapore

Singapore has multiple cultures: Chinese (72%), Malays (15%), Indians (7.4%) and expat nationals ("Population and population structure," 2020). The role and sexual health of women within the last 40 years was conservative (Leong, 2012). The Lee Kuan Yew era (1965-1990) a dominant influence on women's health in the 1970's and 1980's as government media campaigns on family planning and *reproductive health* monitored society, planning for economic, sustainable population growth (Kee & Swee-Hock, 1975).

The Government print and broadcast media distributed ensured *menstrual* and *reproductive* health was taught to girls in schools and married women had access to doctors. Kuan Yew's Singaporean society emphasised population control and provided medical abortion (K. Singh et al., 1996). The Singaporean Government's '*Two-Child Family Policy 1972, the Abortion Act 1974, the Voluntary Sterilisation Act 1974*' were so successful between 1972- 1987 that after 1987, a new national media campaign *'Have three, or more if you can afford it'* encouraged women to have another child and rewarded them (Lim Ting Seng, 2016). Older Singaporean women did not engage in women's health programs despite the Government's media campaigns (Mackey, Hong-Teo, Dramusic, Kim-Lee, & Boughton, 2014).

Singapore has struggled with western influence via international media. Foreign marketing and advertising corporations promoted western ideals of women's beauty, body proportions, skin colour and sex-appeal (C Tai & Sukumaran, 2019; Toland-Frith, Cheng, & Shaw, 2004; A. Yan & Bissel, 2014). This marketing affected women's self-image (A. Yan & Bissel, 2014) evidence being the rising incidence of Singaporean women having plastic surgery in Korea (Marican, n.d.; YouGov, 2015). Singapore's *Information Media Development Authority* (IMDA) controls media, with current censorship not as stringent as the Kuan Yew era (IMDA, 2020; Stewart et al., 2012). Most magazines and television media promote multicultural and family ideals. Singaporean women are more educated, financially independent and aware of their

rights than women of the five other nations of this research: Singaporean media contributes to this knowledge.

3.5 Results of the content review

Table 1 shows results of content review of 637 media references from Asian broadcast, print and online media sources about sexual information, women's physiology, sexual health, sexuality, body image, reproduction, and contraception. The government of the nations reviewed (234 mentions) influenced what the media (203) distributed information (168) about. Websites (92) and Internet media (68) were the major source of sexual information within the six nations.

Women's bodies (87) and models' bodies (84) had similar numbers to women's magazines (52) with Chinese *Elle* (63) the most popular. *Cosmopolitan* had no data available for the online version popular in China, Singapore and the Philippines. Pornography (48) had similar mentions to movies (44) and television (42). Relationships (133) rated highly as sexual health did (120). Detail about methods of contraception (58) was low, this may be due to social taboo (H. Leung et al., 2019; Steinhauer, 2016; Ussher et al., 2017). References mentioned reproduction (81) as a functional part of being a woman along with family planning (53).

Health (319 mentions) was high in the list of words media used in Table 1, yet the gynaecological component of women's health was not discussed other than Pap tests (143), which Asian women in five of the six nations under review do not access regularly (Lu et al., 2012; Seo, Li, & Li, 2017; Wang et al., 2015b). Breast screening was mentioned only 53 times, and cervical screening 47 times. Gynaecological cancer had 15 mentions and ovarian cancer 11; a low number considering these cancers have high incidence in Asia (Ginsburg et al., 2017).

Table 2's results for sexology terminology in media showed sexual problems like vaginal dryness rarely alluded to (10 mentions). Gynaecological structures were not mentioned in Asian media other than the vagina (39) as media do not use correct

terminology. The vulva, labia, clitoris and orgasm were mentioned less than 12 times. From a sexology perspective, accurate physiological, gender and sexual orientation information is restricted in Asian media (Baziad, 2016; Kathleen, 2019; Steinhauer, 2016). Contraceptive options like the pill (6) or intra-uterine device (11) mentioned rarely. Female genital cutting (FGM) had only 12 mentions yet is widely practiced in Malaysia and Indonesia. Rape was mentioned more (70) than sexual pain (60), the vagina (39), contraception (58) safe sex (47), sexual consent (45), female sexual pleasure (39) or abortion (58). Not surprising as sexual assault of women is high in nations like India (Human Rights Watch, 2015). Non-heteronormative sexualities, transgender and asexuality rated few mentions, ignoring lesbians and alternate sexualities. Sexual health relies upon women having language to explain sexual problems if they seek help.

3.5.1 Triangulation

When triangulating the information from Tables 1 and 2 with the brief review, women's health is mentioned in government media (234) as important, however in relation to sex (351), sexuality (136), relationships (133) and marriage (122). *Reproduction* is focused upon more than women's health overall (39). Contraception and family planning are the woman's responsibility, without public information available for women to choose a method apart from areas in India, Singapore and Malaysia.

3.5.2 Recommendations

In view of the contribution of women to Asian economies, the author recommends Asian governments review the past 20 years costs of *not* having women's sexual health programs against the cost of women's cancer treatment, STI incidence, treatment, related fertility problems and mortality. The public health cost of not providing sexual health information to women will be high if women die from ignorance (Ginsburg et al., 2017). A media code of practice in reporting about women's sexual health is advised. Media misinformation and lack of Government provided sexual health information is a breach of duty of care (A. K. C. Leung & Nakayama, 2017; H. Leung et al., 2019; Steinhauer, 2016; Yao, 2016). Asian media organisations could lobby governments to provide sexual health information if censorship were relaxed.

3.6 Conclusion

This review evidenced no long-term plans by media to address STIs, gynaecological cancers or comprehensive sex education in the 6 nations. Women's sexual health is not discussed accurately in Asian media. Asian media could lobby governments for the right to provide sexual health information in contrast to the sexual misinformation distributed by online pornography. Policies on sex education and censorship impair accurate sexual information being available to women, compared to Internet and media misinformation putting women at risk (Stewart et al., 2012). Asian women's sexual health is at threat in an era of rising STIs, sexual violence, discrimination, and menstrual taboo (World Health Organization, 2021a). Sexual health is unachievable if women have inaccurate information. Media companies are telling women how to be, without accurately informing women about their sexual health risks.

Table 1: Incidence of sexual health mentions from 637 Endnote media references

Key word search	Mentions
Men / husband	554/77
STI	481
Women / girl	399/118
Sex / sexual / sexuality	351/303/136
Health	319
Government	234
Research	226
Media / Information	203/168
Pap / pap test	143/115
Relationship /marriage	133 /122
Sexual health	120
Discrimination	104
HIV	96
Shame	94
Website / Internet / Blog / media	92/33/31/25
Social media / Facebook	88/68
Sex education	90
Body / Models/body [female]	87/84/9
Body image	85
Influence [media]	81
Reproduction/reproductive health	81 / 70
Rape	70
Elle / Cosmopolitan [magazine]	52/11
AIDS	60
Contraception / family planning	58/53
Taboo	58
Breast screening	53
Condom	49
Cervical cancer screening	47
Pornography	48
Stigma	48
Safe sex	47
Cinema / film / television	43/25/42
Women's health	39
HPV [virus]	38
Westernisation	37
Non-presentation [screening]	36

Marketing / advertising	35/18
Menstruation	36
Empowerment [women]	32
Censorship	27
Feminine	19
Sexualisation / sexy	16/15
Menopause	11
WeChat / Weibo	9/5
Body image	9
Girlfriend	7
Media literacy	3

Table 2: Incidence of sexology words from 388 Endnote media references

Key word search	Number of mentions
Women	328
Girl	118
Health	319
Women's health	39
Sexual health	120
Pap	143
Pap test [screening]	115
Rape	70
Sexual assault	21
Pain [sexual]	60
Abortion	58
Contraception	58
Family planning	53
Breast screening	53
Cervix screening	47
Safe sex	47
Sexual consent	45
Cervical cancer	39
Vagina	39
Sexual pleasure	39
Sex worker	36
Surgery [gynaecological]	24
Virginity [female]	23
Transgender	17
Incest	17
Gynaecological cancer	15
Ovarian cancer	11
Lesbian	13
Bisexual	13
Female Genital Mutilation	12
Uterus	12
IUD intra-uterine device	11
Orgasm [female]	11
Clitoris	10
Vaginal dryness	10
Gynaecology	9
Kink / fetish	9
Vulva	8
Asexual	8
Labia	6
Breast exam	4
Mammogram	4

Chapter 4: Literature Review

4.1. Introduction

This literature review focused upon global women's sexual health, then within the six Asian nations of this research and finally within Australia. This review discusses and critiques literature discussing women's sexual health in the six nations of this study, investigates gynaecological cancer or women's disease statistics, outlines what sexual health screening services like Pap testing or STI screening services are available, the incidence of sexual disease, the availability of abortion and contraception which allows women to control how many children they birth and discusses how menopause is managed. These topics are reviewed and critiqued because all affect a woman's holistic sexual health, her management of her body and her sense of self. It challenges the use of reductionist medical model methods with Asian women.

4.2. Global, Asian and Australian women's sexual health

This section will review global data on women's gynaecological and sexual health, then focus upon the Asian nations of this thesis and finally, examine Australian women's sexual health data. The research will not focus upon medical procedures, STI testing or treatment methods, cervical screening methodology or women's sexual records and how these are kept, it is not about treatment as much as about Asian women being provided education and information about their sexual health, risk factors for gynaecological cancers, STIs and medical screening as a matter of human rights.

Women's sexual health is of global concern and medically based research in many nations (World Health Organization, 2013). The majority of research in this field follows a reductionist, Western based rationale (American Psychiatric Association, 2013): The *Scientific method* and *reductionism* as the foundation for research inquiry and targeted service delivery. *Reductionism* defined by Lawrence (Lawrence, 2020) as the practice of reducing a person's symptoms by, "compartmentalizing each section of the physical body and denying the fact that there is a connection between the body and mind" (n. p.): reductionism measures symptoms, not putting a person in the context of relationships, social systems, culture or worldview.

Reductionist research, based on the scientific method, uses methodologies that at times detach the patient from their cultural context and focuses upon their observable symptoms and symptom management, according to prescribed formulas that work within a Western cultural and medical context (Lawrence, 2020; Nazar et al., 2015; Small, 2006). Symptom management and treatment of symptoms with medical intervention or pharmacological treatments is part of this model. The focus on the medical model may be due to issues such as financial cost, speed of service, administrative requirements, and a base-standard for service delivery, which all are reasonable rationales within large scale medical facilities who provide public sexual health services, however, does such an approach ignore cultural context?

Globally, the gynaecological and sexual health of women is only monitored and statistics gathered in terms of medical data collected when women present at medical clinics or hospitals for gynaecological examinations for antenatal care, pregnancy, postnatal care, family planning, cancer treatment, sterilisation procedures, contraceptive consultations, post sexual assault consults, pap screening tests, STI treatment, breast checks, abortion, post-partum checks and surgical operations like labiaplasty or gender re-assignment surgery. For example, the Australian Health Department's data is utilised by the Australian Bureau of Statistics for statistical reporting (Australian Bureau of Statistics, 2020). No Government agency keeps statistics on women's sexual experiences, sexual pleasure, sexual difficulties after sexual assault, women's range of sexual experiences outside of cis-gendered, heteronormative activities, the role of fantasy or Paraphilias, how women negotiate consensual sex and safe sex practices and research sexual pleasure after menopause or cancer treatment. All these issues relate to sexual health according to the World Health Organization's definition (World Health Organisation, 2020):

> According to the current working definition, sexual health is: … a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all

persons must be respected, protected and fulfilled (n. p.).

Focusing on the medical or reproductive aspects of women's sexual health and not considering women's rights to sexual safety, pleasure and a comprehensive sexuality education leaves vital information deficits in sex education available in Asian nations.

Women's health and reproductive issues are medically institutionalised in Western industrialised nations due to a medical research focus; this is not the case in many nations of the world. Asian developing nations, though aiming for better health outcomes for their women (Amnesty International, 2010; School of Psychology, 2017), do not research women's sexual health apart from cancer, STIs or menstruation. Menstruation, apart from being related to polycystic ovarian syndrome, heavy bleeding or endometriosis, is not widely considered a pathological problem for an industrialised nation's women; it is no longer an excuse for non-participation in recreation, education, socialising or pleasurable activity: In Asian nations, this is not the case.

Urologists, gynaecologists, obstetricians, surgeons, continence specialists, nurses, midwives, psychiatrists, psychologists, sexologists or sex therapists worldwide would be included in the professions who consult with people requiring assistance with sexual health or sexuality related problems. The first point of contact for many women experiencing sexual health problems however, is their general practitioner or a nurse who may have no *specific* sexology or CRaLD training and may refer a CRaLD patient to one of the above-mentioned specialists (Department of Health & Human Services, 2015). It is highly likely, a migrant woman coming from a culture or religious environment where women's sexuality is a taboo topic, will not disclose sexual health concerns with a male general practitioner or specialist (Baraitser, 1999; Heinemann et al., 2016; Malik, 2103; Utting et al., 2012).

Worldwide, women's breast cancer, sexual health and disease are very costly to any society as the financial costs of treatment or non-treatment are borne by the citizens, taxpayers, or Government facilities which provide services (Li Sun, Legood, dos-Santos-Silva, Gaiha, & Sadique, 2018). In developing nations, where women cannot readily afford medical treatment, or treatment services are unavailable, the women do

not present for medical assistance until it is too late for treatment (Ginsburg et al., 2017). The societal costs include lost labour or production and disruption to family systems when a woman is diagnosed with cancer, is unwell, receiving treatment or dies. The Union for International Cancer Control (UICC) reported in 2018 (Union for International Cancer Control, 2018) that worldwide, "Asia accounts for nearly half of the new cancer cases and more than half of cancer deaths", of which for women include, breast, cervical and gynaecological cancers" (n. p.).

Gynaecological cancers impact women in developing countries far more than industrialised nations where sexual health education, screening services and treatment is available, and women have funds to pay. Incidences of female specific cancers in women worldwide are reported to the Global Cancer Observatory (World Cancer Research Fund, 2018b) as follows: "25.4% of cancers are breast cancer. 6.9% are cervical.5.3% endometrial. 3.6% are ovarian. 0.5% vulval and 0.2% are vaginal" (n. p.). Statistics are gleaned from industrialised nations that have women's cancer databases: some developing nations do not have nationwide databases specific to women's oncology or sexual health (World Cancer Research Fund, 2018a; World Health Organization, 2020a). Ginsburg et al. (Ginsburg et al., 2017) wrote about nations with weak public health systems and the ratio of death from cervical cancer, "approximately 85% of women diagnosed and 88% of women who die from cervical cancer live" in low and middle income countries" (p. 848). Affordability of sexual health services is a key issue for many Asian women.

The world statistics are not truly representative of Asian women's cancer incidence and mortality as women without access, funds, permission, or without locally available medical services to attend screening or treatment will not be measured in the statistics. WHO indicated (World Health Organization, 2020a) "The number of global cancer deaths is projected to increase by 45% between 2008 and 2030" and in women of developing nations, cervical cancer will be the most likely cause of death" (n. p.).

In Asian nations, women do not have regular Pap smear tests for economic, shame-based, problematic travel, poor awareness of need, patriarchal control or religious reasons (Australian Bureau of Statistics, 2017a; Balkwill, 2015; Domingo, Victoria, & Echo, 2009; Tay, Ngan, Chu, Cheung, & Tay, 2008). Who is *not* being screened in

Asian nations could result in specific ethnic populations in Australia being at health risk due to cultural and religious variables not being considered:

> An estimated 50% of cervical cancers occur in women who have never been screened, with a further 28% in women who are lapsed screeners (that is, hadn't had a Pap test in the 2.5 years prior to their cancer diagnosis). Therefore, it is reasonable to expect that cervical cancer incidence patterns may to some degree follow participation patterns (Australian Institute of Health and Welfare, 2015, p. 35).

Menopause in Western industrialised nations is treated pathologically when compared to developing nations: oestrogen *deficiency* is a language of pathology (School of Psychology, 2017), with hormone replacement therapy (HRT) being freely offered for menopausal symptom relief: The bulk of the world's women do not have access to HRT or to low cost medical services specific to menopause, nor are able to afford such medication: Singaporean women may be an exception in this research program.

The natural aging process of female gynaecology, involving vaginal dryness and atrophy, possible urinary incontinence and declining libido are women's health issues generally, as well as related to women's sexual health issues (Ramoran, 2015; Thomas & Harden, 2008). The International Menopause Society's White Paper (Simon et al., 2018), outlines how menopause affects women's sexual health with more clarity, albeit using reductionist and pathological language about "female sexual dysfunction" as a result of pain, decreased arousal or sexual desire, vaginal dryness, pelvic floor problems, anorgasmia or body image problems due to weight gain (p. 1). The paper also addressed contextual issues to the quality of a woman's menopause: poor sexual education, negative sexual experiences, incontinence, whether one had the support or pressure of one's sexual partner and the influence one's culture or religion and affordability of treatment. For many Asian women, lack of sex education, poor affordability, cultural and religious influences and shame would be barriers to menopause treatment to improve their quality of life.

The following sections outline sexual health information relevant to each of the six nations of this study. This background information is contextually relevant to why

migrant women of these nations, from their specific contexts, are under-represented in sexual health statistics in their nation of origin and Australia.

4.2.1. China

In China, historical Government data on women's sexual health was fragmentary, as Kim et al. reported (Kim, Zang, Choi, Ryu, & Kim, 2009) there was not a "national program for cervical cancer prevention" (p. 72). The Centre for Health Information and Statistics [CHIS], the largest epidemiological database in China, does not yet cover all China. Their research indicated older women 44-54 years old were presenting for cancers of the breast, ovaries and cervix, however younger, more sexually active Chinese women were contracting Human Papillomavirus (HPV): China has only had the HPV vaccine available since 2016 and does not have a national safe sex, HPV education or mandated vaccination program (China Medical Board, 2020). Jaing, Tang and Che wrote in 2018 (Xiyi Jiang, Huijuan Tang , & Tianhui Che, 2018): "2 of the top 10 most common types of cancer would be gynaecologic (sic) cancers, with breast cancer being the most prevalent (268.6 thousand new incident cases) and cervical cancer being the 7th most common cancer (98.9 thousand new incident cases)" (p. 2).

China initialised the National Central Cancer Registry (NCCR), after 2009 (Song et al., 2017). "The National Cancer Center (sic) is in charge of population-based cancer registry in China" (p. 472). Song and associates (Song et al., 2017) reported the following:

> China is actively carrying out cervical cancer screening programs nationwide. However, the current incidence and mortality rates of cervical cancer continue to increase. Targeting the cause of cervical cancer could help prevent new cases (p. 474).

Targeting the cause would include educating women about unsafe sexual practices they may not be aware of; however, as there is no nationwide sexual health education program, how this will occur remains unclear. Women's cancer in China is concerning, in 2015 it was reported by Xiyi Jiang and associates (Xiyi Jiang et al., 2018) "4.29 million new incident cases and 2.81 million death cases of cancer would occur" (p. 1). The NCCR was cited, indicating that breast and gynaecological cancers

were increasing in China, with cervical cancer reported as the most common cancer at according to the standardised incidence rate at 98.9 thousand new cases annually. Endometrial cancers were the second most prevalent gynaecological cancer in China and thirdly, ovarian cancer, also increasing in incidence. Breast cancer is the predominant women's cancer in China, with 268.6 thousand incidences (Xiyi Jiang et al., 2018). Women who have not been vaccinated for HPV are at risk of gynaecological cancer, which is a large proportion of China's women. It will take many years for HPV vaccinations to reach all the population. Currently pap screening tests are the best option for detection.

The incidence of STIs in China in younger people is increasing: HIV/AIDs in China is problematic (Kaining, 2011; Tay et al., 2008). HIV increased between 2008 and 2017 within the Chinese population. Zheng wrote, (Sifan Zheng, 2018) "the incidence of HIV in China has increased from 0·23 per 100 000 in 2004 to 4·2 per 100 000 individuals in 2017" (p. 311). Zheng (Sifan Zheng, 2018) indicated that males who had sex with males (MSM), were married and did not practice safe sex "although 84% of married MSM had active female sexual partners, only 16% had used condoms consistently within the last 6 months" (p. 311). This behaviour puts women at risk of contracting HPV, STIs or HIV. Research into sexually transmitted disease in China has focused upon male university students at risk of STIs, without complementary research about the risk of STIs upon the female partners (Ma et al., 2009), this needs urgent reconsideration.

Historically, the International Women's Health Coalition (IWHC) began to promote "Challenging the culture of silence" about gynaecological problems of women in China which is a cultural norm (Zhang, 2011, p. 83). This silent sexual shaming of women in China is evident in the language Zhang used for simple urinary or vaginal tract infections:

> … it was common for women with Reproductive Tract Infections (RTIs), traditionally called 'women's diseases' or 'gynecological conditions' (sic), to never talk about the RTIs… Large numbers of women finally began to break the silence and talked openly about reproductive health issues (p. 76).

Of interest, is that much of the research into Chinese women's sexual health for this review has been conducted by men. This is similar to sexual health research from India being male dominated, as indicated in the following section.

4.2.2. India

India has had medical research facilities funded by the Government for many years, however, a nationwide medical system with an aligned database, does not yet exist. The Department of Health Research and The Ministry of Health and Family Welfare is aligned with the Indian Council of Medical Research (ICMR), to gather available statistics on women's health, incidence of cancer, sexual health and available treatment (Indian Council of Medical Research, 2016). Only women who have presented for screening or treatment are represented in the statistics, which is a minority of the population.

The WHO profile for India indicates the most common female cancer in India is breast cancer (14% of all cancers), followed by cervical cancer (8.4% of all cancers) and ovarian cancer (3.1% of all cancers): given the population of India, this is a high incidence (World Health Organization, 2020a). WHO also recorded that India has no death database linked to sexual diseases or related cancers. Maheshwari and associates (Maheshwari et al., 2016) research on gynaecological cancer in India concurred with WHOs reporting: "Ovarian and cervical cancers are the most common gynecological (sic) cancers affecting women worldwide and in India. Cervical cancer is on a declining trend but remains the second most common cancer in women after breast cancer" (p. 112). Their research indicated that most of the gynaecological cancers presented for treatment at stage 3, with the female patients "(p. 113) between 41 and 50 years of age" (p. 113). Maheshwari and associates also reported Indian women do not present early to medical professionals for gynaecological issues, or do not engage in gynaecological screening tests: "Unfortunately, in developing nations such as India, due to lack of awareness programs and no formal screening programs, most women have presented in the advanced stages of cervical cancer" (p. 118). Financial affordability for the working-class women may be a reason they do not attend screening, or there are no funded, free facilities for testing.

WHO noted the use of mammograms and Pap smear tests do not have a high use in India as there are not widespread public medical facilities there. Visual inspection during Pap tests is the most common form of test for Indian women, who would be those who can afford it. There is no national HPV vaccination program in place yet (World Health Organization, 2020a). In 2016, Rastogi, (Rastogi, 2016a) reporting for the National Institute of Health and Welfare wrote "In India cervical cancer is the second most common form of cancer amongst women... between 15-44 years of age" (n. p.). He continued "India has a population of 436.76 million women aged 15 years or older who are at risk of developing cervical cancer. Every year 122844 women are diagnosed with cervical cancer and 67477 die from the disease" (n. p.). He indicated about 5% of the Indian population of women are infected with HPV (Rastogi, 2016a). Many women will have no idea what HPV is with no comprehensive sexual or sexual health education in schools which would outline what HPV and safe sex was.

In another National Institute of Health and Welfare publication, Rastogi reported that STIs were problematic in India (Rastogi, 2016b): "STIs/ RTI's (reproductive tract infections) are an important public health problem in India... 6% of the adult population in India has one or more STI/RTI. This amounts to occurrence of about 30-35 million episodes of STI/RTI every year in the country" (n. p.). Rastogi further indicated "A large proportion of new STIs occur amongst adolescents and young adults who may not be aware that they are infected, which can have a negative impact upon their future sexual and reproductive health" (n. p). Indian girls and women with no comprehensive sexuality education, inclusive of safe sex information, are being put at risk of becoming infertile, especially from chlamydia which is the most prevalent STI with few obvious symptoms (Rastogi, 2016b).

Without a national sexual health education program in India covering safe sex practices and the need for preventative health checks for women, Indian women remain at risk of death due to lack of knowledge, lack of medical facilities, and for the lower classes, unaffordability of prevention or treatment, especially as most women have to ask their husband for the money for treatment (Malavi, 2016). The patriarchal control of women's sexual health may be diminishing in India over time, with targeted family planning and sterilisation programs, but Indonesia is further behind India's health care progress due to the dispersed nature of the island nation and the lack of

health services and infrastructure.

4.2.3. Indonesia

Indonesia's health care provision is spread across over 13,000 islands and 34 provinces, which is a difficulty when meeting the needs of over 240 million people by 2013. Community Health Centres (*puskesmas*) and village health centres (*pustu*) are the mode of delivering community health programs and services for a fee. In women's sexual health services, only married women can access these services for prenatal and postnatal checks, pap smear tests and contraceptive consultations (National Center for Biotechnology Information, 2013). This endangers the sexual health of single women and sex workers who engage in sex outside of a married relationship because Indonesian men do not regularly use condoms nor access vasectomy (Surbakti & Devasahayam, 2015).

Women's cancers in Indonesia are statistically high; breast cancer being the most common cancer diagnosed in Indonesian women. Solikhah, Promthet and Hurst's research (Solikhah, Promthet, & Hurst, 2019) indicated "that awareness about breast cancer risk factors was poor among women in urban areas" (p. 881). A lack of mandated education for girls and women about their bodies and functions is putting Indonesian women at risk of not noticing breast cancer until it is too late. The Health Department estimated "cancer incidence to be 100 per 100,000 people" (p. 9) as there is no central cancer database. Azis' research concluded that even if a woman only had one sexual partner, she was still at risk of HPV infection (Aziz, 2009).

Historical data from 2007 reported by Tanamal (Tanamal, 2018) indicated that "cervical cancer is the most common malignancy followed by ovary, uterus, vulva and vagina"… "Five-year survival rates of stage I, II, III, IV cervical cancer were 50%, 40%, 20%, and 0% respectively" (n. p.). This is due to multiple factors, such as cost of screening and treatment, medical facilities not being available due to poor infrastructure and women not presenting until disease is at late stage:

> With cancer early detection is key, but in some instances, the national healthcare system puts the procedures needed to find cancer cells early just out of reach. Pap smears, a vital procedure to detect cervical cancer,

> are not covered by BPJS. And at a cost of Rp 400,000 to Rp 800,000 ($28 USD to $55 USD), the procedure itself is too expensive for many Indonesian women.
>
> The same is true for the HPV vaccine, which costs about Rp 700,000 ($49 USD) per shot and isn't covered. It takes three shots to complete the vaccine's course, and, again, those costs prevent most women out from ever getting it. The human papillomavirus (HPV) causes cervical cancer, and the most cancerous strains of the virus are virtually untraceable in men and therefore most easily spread (Tanamal, 2018).

HPV infection is difficult to vaccinate against with such a dispersed population and large distances to travel, yet in 2012 Nuranna and associates reported (Nuranna et al., 2012) "HPV was detected 96% in cervical cancer patients; HPV 16 and HPV 18 were found in 83%" (p. 147). Nuranna and associates said cervical cancer in Indonesia is a concern (Nuranna et al., 2012): "The data from thirteen pathology centers in Indonesia shows that cervical cancer stands the first-ranked among all cancer (23.43%) from 10 most common cancers among men and women" (p. 147). Many Indonesian women would not know they were at risk, know what a cervix was, where it was, nor access Pap smear or STI testing due to cost and cultural shame. Indonesia has no comprehensive sexuality education for women in Indonesia to teach sexual health practices. School health education programs for girls focus upon menstruation and reproduction. In 2015, Surbakti and Devasahayam reported (Surbakti & Devasahayam, 2015) for the United Nations Population Fund that:

> Census data shows that women are lagging behind men in various arenas, as evidenced by the gender parity index10 (GPI) series. The extent to which women have been lagging behind men in the field of reproductive health, empowerment and employment as measured by the gender inequality index (GII) indicates that things have been improving but progress has been slow (p. 3)

Women's *reproductive health* is mentioned regularly in research literature, yet not women's *sexual health*. Surbakti and Devashayam (Surbakti & Devasahayam, 2015)

were concerned about responsibility for contraception falling upon women who had no sexuality education. Men in Indonesia do not take responsibility for contraception:

> The suitable methods/devices made available for men are vasectomy and condoms. It appeared that in 2012 only few acceptors were men, less that 1 percent of the total acceptors chose vasectomy and less than 2 percent chose to use condoms (p. 23).

Societal ignorance about accurate sexual education was verified by research conducted by Bennett and associates in infertility clinics in Jakarta (Mangalwadi, 2011). Results indicated that Indonesian couples learnt more about sex and fertility from their infertility consultant than they had elsewhere, with 87% (p. 364) learning more about sex, infertility, STIs, reproduction and sexual health of women at the clinic (Mangalwadi, 2011). Further outcomes indicated that the patients gained their reproductive and sexuality education from: "Their Obstetrician/Gynaecologist (77%), friends (44%), the Internet (31%) and family members (23%) (p. 367)." Few Indonesian women could afford a visit to an Obstetrician/Gynaecologist and there are no free sexual health clinics. Of note, was that their *religious teacher* accounted for only 4% as a source of necessary information. With no sex education program in Indonesia covering women's sexual health over a lifetime, these older research results will not have changed. Sex education and STI prevention programs will be difficult to initiate across a nation yet need to occur.

Another issue that affects women's sexual health in Indonesia is the issue of female circumcision, or genital cutting. UNICEF reported on this matter in 2019 saying that between 2006 and 2010, the Ministry of Health directed medical professionals not to perform genital cutting. In 2008, the Indonesian Ulema Council of Islamic leaders, argued against the prohibition, stating "that female circumcision is part of Sharia (Islamic law) and should be provided by medical professionals if requested by families" (n. p.). By 2010, the Indonesian Government legislated in *PMK No. 1636/2010* that female circumcision could now only be performed by doctors, midwives or nurses and UNICEF (UNICEF, 2019) reported that "grave types of FGM" (n. p.) were prohibited for women's sexual health as the practice had no health benefit, yet this practice continues in Indonesia. What a *grave type* of FGM is was not defined

by the Indonesian Government. Without a comprehensive sexual health education, Indonesian women will not be empowered to know enough to make choices to not circumcise their daughters. The lack of recent research in Indonesia about STI incidence, contraception, gynaecological cancers and the sexual health of Indonesian women is not helpful to the Indonesian government as they cannot target women's health promotion without research data.

Like Indonesia, in Malaysia the issue of genital cutting is also a controversial issue related to women's sexual health, with some religious and cultural groups wanting the practice to be permitted and some medical professionals agreeing with them. Other medical professionals want the practice banned.

4.2.4. Malaysia

In Malaysia, the National Population and Family Development Board (Government of Malaysia, 2019) was founded in 1966 to forward plan and "improve the reproductive health status of women and men and encourage family planning" (n. p.). That is not to say that comprehensive sex education occurred in Malaysian schools; the plan was based upon meeting the reproductive and contraceptive needs of married women only. One of the government goals (Government of Malaysia, 2019) was, "to increase access to information and communication technology (ICT) for women, families and community" (n. p.). This has not occurred. Malaysian women's sexual health information for all women is not provided by the government: Malaysian women are turning to pornography to get a poor, inaccurate sexual education (Lau, 2016; "More Malyasian women watch porn using mobile devices," 2017).

The Malaysian government introduced menstrual and limited *reproductive* education in secondary schools in 2011, despite religious objections up until 2016 (Khalaf, Low, & Mergati-Khoei, 2014). *Reproductive* education does not address: avoiding STIs, contraception, unwanted pregnancy, cervical cancer risk, safe sex, non-cis-gendered sexualities or teaching that pornography is not realistic sex (Khoo, 2016c; Lau, 2016). Khoo's research indicated, "for Malaysia, 28.8% of 13,831 teenagers between the ages of 10 and 19 years have conceived children out of wedlock according to this year's data by the Ministry of Health" (n. p.) and yet, "60.5% of Malaysians do not know how a baby is born" (Khoo, 2016c).

Pap smear testing rates had not significantly increased after 1982, nor prior to the 21st century: "Among the cancers which affect women, breast and cervical cancers account for about half of total cases… Only 26 per cent of the 16,232 women studied had undergone a pap smear examination" (*The Progress of Malaysian Women Since Independence 1957 - 2000.*, 2003) (p. 81). HIV and AIDs number had also risen during the time of that historical review of Malaysian Women.

Zaridah's review on cervical cancer in Malaysia (Zaridah, 2014) found cervical cancer the second most common cancer in the nation: "The Malaysian National Cancer Registry Report (2003) found that the most frequently occurring cancers in Malaysian women (in descending order) cancers of the breast, cervix, colon, ovary... Cervical cancer caused about 12.9% of all female cancers (an age standardised incidence rate of 19.7 per 100,000)" (p. 33). Presentations for treatment were often at a late stage of the disease: Zaridah stated (Zaridah, 2014) the disease was predominantly due to HPV 16 or HPV 18 infection and the death ratio was "5.6 per 100,000"… a preventative HPV vaccination has been available in Malaysia since 2006 and by 2011, "87.12% of 13 year old girls" were vaccinated, even though they had little knowledge of what cervical cancer was (p. 34). HPV vaccination does not stop other STIs.

The incidence of HIV in Malaysia peaked in the early part of the 21st century. According to Yao, (Yao, 2016): "A recent study conducted in a Malaysian city showed an astonishing 10% of the surveyed population had never heard of STDs…or Human Immunodeficiency Virus (HIV)" (n. p.). Yao reported syphilis and gonorrhoea were decreasing in incidence in Malaysia, though he also said there was little research data available, so it is not certain the increase is nationwide. Kaler's research (Kaler, 2018) cited the Malaysian Health Department which reported: "According to the reports by Health Ministry, STI rates have doubled in the past decade with syphilis doubling from 2.99 infected per 100,000 people in 2011, to 6.5 in 2017" (n. p.). No statistical information on the rate of chlamydia was available, yet this STI presents a serious risk of infertility and pelvic inflammatory disease for women and needs to be monitored: it is not.

In Malaysia, like Indonesia, the cultural practice of female genital cutting remains

popular despite no medical evidence of any benefit to women's sexual health (Spencer, 2018). Reych reported (Reych, 2016):

> A 2012 United Nations resolution deemed both full and partial removal of the clitoris a "human rights violation", and the World Health Organization (WHO) clearly states that the alteration of female genitalia for non-medical reasons has no health benefits but can in fact cause severe complications. However, female circumcision is still not illegal in Malaysia (n. p.).

The Malaysian government provides inadequate sexual health education to its girls and women, contrary to the national goals of the Ministry of Women and Family Development's aim for gender equality (Government of Malaysia, 2019). Malaysian women's sexual health is at risk via STIs, cervical cancer and teenage pregnancy. Kaler (Kaler, 2018) wrote: "An estimated 18,000 underage girls get pregnant in Malaysia each year" without necessarily knowing how not to (n. p.). Archer reported (Archer, 2018) legal abortion is available only if a doctor diagnoses the mother's life is at risk, "the Federation of Reproductive Health Associations Malaysia has estimated that there are about 90,000 abortions performed annually in Malaysia" (p. 3). Inadequate sexual health knowledge by the Malaysian female population results in a high juvenile birth rate, high abortion rate, high STI infections and cervical cancer incidence.

The situation for women in the Philippines is alike Malaysia, with a high birth rate amongst young women, rising STI infection and gynaecological cancer. Malaysia has a better chance of reaching the female population to facilitate improving women's sexual health than the Philippines, where thousands of islands lack infrastructure and health services.

4.2.5. Philippines

Historically, the Philippines has not provided a state funded women's sexual health program, funded cervical screening services, gynaecological cancer treatment services or STI treatment clinics for women. Cervical cancer was the second most prevalent cancer of women that caused death up to 2008 (Domingo & Echo, 2009). Domingo

indicated that the influence of the Catholic Church had parents concerned the HPV vaccination could lead to girl's immorality. The cost of HPV vaccination in a nation without a government public health scheme was a prohibitive factor for the female population who are predominantly poor.

Recent research data on gynaecological cancer or sexually transmitted infections from the Philippines is not easily found. The Philippine government has no central database that covers the widespread population and many islands. Pap testing was initiated in the 1990s for a single test and by 2005 visual pap checks were initiated, but only 7.7% of Filipina women presented for testing (Guerrero et al., 2105). In a nation without a government facilitated sex education or sexual health program and a lot of poverty, poor Pap test access is not surprising. Public health concerns about the rise of cervical cancer and initiating a HPV vaccination program were debated in parliament, with a focus upon repeated HPV vaccination of Filipinas throughout life being believed to be more affordable than individual Pap testing (Guerrero et al., 2105). Guerrero and associates research (Guerrero et al., 2105) indicated lack of widespread public health services, few medical professionals and the high cost of medical services as a cause for cervical cancer being the second highest cause of death to Filipinas. Filipinas do not present for sexual health treatment until late stage of disease; thus mortality was high even up to 2010, at 44% (Guerrero et al., 2105).

A related problem to the rate of HPV infection and STI transmission to Filipinas was the low use of condoms by men, married or not, who paid for sex with female sex workers. There seemed to be a perception by Filipino men that the risk for HIV or STI infection was low, mainly due to poor sexual health education of the men (Regan & Morisk, 2013). Men who have sex with men (MSM) put female sexual partners at risk of HIV and STIs and they are a rising proportion of those who are infected with HIV since 2104; currently 85% of new cases (Ross et al., 2015). Sexual health literacy is low amongst less educated Philippines citizens both male and female (Sentell, Dela Cruz, Heo, & Braun, 2013), so there is a large demographic of Filipinas who are sexual health illiterate.

The Health Department of the Philippines has committed to *The National Cancer Prevention and Control Action Plan 2015-2020* (Department of Health, 2015), which

aims to build capacity for district medical facilities to provide funded screening services for cervical cancer, which is the second most common cancer of Filipinas. This has not yet been realised. Thankfully, one large move by the Philippines Government in 2009 was to legislate for the future sexual health of Filipina women: the '*Magna Carta for Women'*, or the *Republic Act 9710*, which enshrined anti-discriminatory rules for workplaces, promoted equal opportunity, provided for work leave for gynaecological conditions and how women can be represented in the media (Sastrillo & Babao, 2019). The Philippines, despite poor infrastructure for women's sexual health, is addressing the societal structures in which they are disadvantaged.

This action for change mirrors how the Singaporean government changed a traditional male dominated culture between 1959 and the late 20th century, normalising working women and providing for their health to build the national economic capacity.

4.2.6. Singapore

Lee and associates wrote about Singapore (J. Y. Lee et al., 2014), "(during 1966 to 2009, Singapore experienced the highest uterine cancer mortality rates" of four east Asian nations with women over 50 being at higher risk (p. 175). In 2014, the Singaporean Health Department noted on its website (SingHealth, 2014): "Cervix cancer is the 5th commonest cancer among women in Singapore" (n. p.). *SingHealth* also reported that Pap smear testing was readily available, yet not accessed by local Singaporean women.

By 2017, the Ministry of Health in Singapore released statistics about preventative health screening by women (Ministry of Health, 2018). Of note was that only 38.6% of Singaporean women had regular breast checks and a *decrease* in participation to 50.7% of women had a Pap smear test in the last three years. In 2016 The Ministry of Health statistics showed only 38.6% of Singaporean women had a mammogram in the past 2 years and that only 50.7% had a pap test (Ministry of Health, 2018). Having the medical and sexual health services freely available does not mean Singaporean women are using the services, further research of Singaporean migrant women may identify reasons why.

Singapore's 2018 STI statistics released by the *Department of Sexually Transmitted*

Infections Control (DSC) show chlamydia is the most prevalent STI infection (2719 cases), followed by gonorrhoea (2051 cases), syphilis (1441 cases)], genital warts (935 cases) and genital herpes (878 cases) (DSC Clinic, 2018). In a population of just over 5 million, this is not a low incidence and the incidence is highest in the age group 20-29 years of age, an educated demographic who have been exposed to the MOE sex education program in schools (Ministry of Education, 2018) which discusses prevention of STIs. The MOE sexual education program focuses upon reproductive function, prevention of STIs and not sexual pleasure, the benefits of sexual health screening over a lifetime or alternative sexualities; the program is heteronormative and young people are not using the preventative information.

Women's sexual health at risk in Singapore for unidentified reasons because sexual health clinics are available. This may be explained by cultural context or cultural norms about women's sexuality being a taboo or shameful topic and women only accessing services if they are in pain (YouGov., 2017). Like Singaporean women, Australian women also seem resistant to sexual health screening like Pap tests, or visiting sexual health professionals for sexual difficulties, however, the reasons may be different.

4.2.7. Australia

Australian women also have a negative attitude to and poor practices about their sexual health. This may be due to the medically based bias about women's sexuality that they have grown up in and been patients of; women not demanding their right to sex education or women's sexual health services inclusive of respectful culturally and religiously sensitive practice (Utting et al., 2012). Culturally diverse, religiously respectful, sub-culturally specific and rights-based women's sexuality and sexual health education is lacking in Australia. The focus has been female fertility, reproduction and prevention of STIs ("The Australian Institute of Sexual Health Medicine," 2014; Department of Immigration and Border Protection, 2014; Utting et al., 2012).

STIs are increasing amongst women in Australia; specifically chlamydia, which has tripled in incidence for younger women over the age of 15 since 2001 (Department of Health, 2014). Gonorrhoea is an STI on the increase in Australia amongst younger

women over the age of 15, with genital herpes increasing in the 35 to 55 age group (Australian Bureau of Statistics, 2013, n. p.) (Benedicta, 2014). Safe sex messages are not being widely heeded by Australian women, especially middle-aged and older women (Mahajan et al., 2013), who have increasing incidence of STIs and do not use safe sex practices as they missed the safe sex messages of the 1980's to 1990's. Fileborn and associates research (Fileborn et al., 2018) revealed older Australians have poor awareness of safe sex practices and are anxious about discussing safe sex with new partners; this could be a reason for increase in STI's amongst older Australians.

Asian migrant women residing in Australia have a poorer safe sex education than Australian women of a similar age and inadequate knowledge to practice better sexual health self-care. Sex education and STI prevention programs in Australia do not target migrant women, middle-aged or older women: there appears to be a gap in public health planning and prevention programs (Benedicta, 2014).

What is evident from historical research conducted by the Australian Institute of Health and Welfare (AIHW) is only 57% of suitable Australian women aged 20-69 years of age accessed Pap smear tests regularly and that younger women were less inclined to have a Pap smear than older women (Multicultural Women's Health Australia, 2016b), they reported women of higher economic status were more likely to have Pap smear tests regularly than women of lower socioeconomic means. This means a large population of the women of Australia do not access a cheap, or free sexual health service, this is concerning. This data was further confirmed in the *2012-2013 Cervical Cancer Screening in Australia Report* (2015). Cancer Australia reported (Cancer Australia, 2017): "In 2013, there were 5,336 new cases of gynaecological cancer diagnosed in Australia. In 2017, it is estimated that 6,073 new cases of gynaecological cancer will be diagnosed in Australia" (p. 2). Cancer Australia expects the incidence of gynaecological cancers to rise as the population ages (Cancer Australia, 2017). What researchers have not specifically accounted for in the research are migrant women in Australia who for cultural or religious reasons, do not participate in Pap screening or regular gynaecological health checks. This skews the data as the number of women participating in testing reduces as female migration increases.

The *2015 Cancer Screening in Australia Report* also outlines changes to the Cervical

Screening program, by which, “the introduction of the National HPV Vaccination Program in 2007” (2015, p. 14) has seen a preventative measure introduced to further reduce the incidence of cervical cancer ("Cervical cancer could be eliminated in Australia within 40 years, experts say.," 2018b). How women whose culture and religion values gender-based modesty, sexual fidelity and for some, chastity, would perceive participating in a test that requires them to discuss their sex lives, the potential sexual activity of their spouse or partner and an invasive procedure requiring genital nakedness before a potential male, is not discussed in these reports. As previously indicated, these variables may be a deterrent that qualitative research will identify.

Pap smear reminder letters are somewhat successful in helping Australian women choosing to engage in a Pap smear test within 3 months of receiving the letter (Australian Institute of Health and Welfare, 2015. P. vi), however, there is no indication that these letters are available in many other languages, which is problematic considering the rising demographic of Asian and other migrants whose first language is not English. Many Australian women do not engage in cervical screening, so which women are not being tested and how do researchers identify these women?

High quality, peer reviewed research on Australian women’s sexual pleasure, attitudes to sex, women’s erotica, sexual diversity, women’s psychological problems with sex, women’s spiritual beliefs and sexual practices has been lacking when the focus has been upon the medical and pathological model. Research by the *Australian Women’s Health Network* recommended how to “develop women’s health literacy” (Utting et al., 2012):

> Programs should incorporate raising women’s awareness of evidence-based websites, improving their capacity to assess the reliability of information, and building their skills in communicating confidently about private health issues. Critical recognition be given to the availability of low-literacy sexual and reproductive health resources and culturally appropriate materials for specific communities, including CALD and ATSI women. Resources targeting specific groups need to be developed in partnership with these women, an initiative that requires appropriate

funding (p. 6).

A *Toolkit for engaging Under-screened and Never-screened women in the National Cervical Screening Program* exists (Department of Health, 2018) however, it too is in English and no language option is available on the website. The toolkit does state, "This toolkit has been developed to assist healthcare providers to engage under-screened and never-screened women in cervical screening and to support them should they choose to participate" (n. p.). It does not however, offer on the site, or in related information and resources, availability in languages other than English for education or distribution: The toolkit did identify that language was a barrier to engagement and that interpreters may be required for consultations, yet continues to use a language barrier in the public presentation of its material.

The Toolkit (Department of Health, 2018) states, "80% of Australian women who develop cervical cancer are under-screeners or have never screened" and that "There are specific sub-population groups in Australia who are less likely to engage in cervical screening: These include but are not limited to... women from culturally and linguistically diverse backgrounds" (n. p.). The Toolkit (Department of Health, 2018) describes specific populations: "Women from CALD backgrounds are less likely than women from the general population to participate in cervical screening: The reasons for this are related to cultural beliefs, a lack of understanding of the screening program and the Australian health system and language barriers" (n. p.). The Toolkit (Department of Health, 2018) lists barriers to engagement in screening including, women's lack of knowledge of the availability, purpose, importance and benefits of cervical screening, "embarrassment about the procedure" and "cultural issues (related to circumstances, beliefs, background and inequities in society)", "availability of female healthcare providers" and "age and/or cultural background of the healthcare provider" (n. p.). It also mentioned the health professional knowing where to access sexual health resources to help inform CRaLD clients, yet no services were listed. A systemic barrier to engagement listed in the Toolkit was: "Services without a culturally sensitive environment" (2018, n. p.), yet the Toolkit did not offer links to culturally sensitive professionals who could advise how established practices could amend their service provision environment (Department of Health, 2018).

The *Australian National Women's Health Policy* (Department of Health, 2011) indicates that preventative sexual health issues and reproductive health are seen as "priority areas and targeted conditions" (n. p), the policy states:

> Women are not a homogenous group. They differ by factors such as ethnicity, geographic location, (dis)ability and sexuality.
>
> The Government is committed to continuing to reduce inequalities—this policy is one of a number of approaches to improving the health and wellbeing of all women in Australia, especially those at highest risk of poor health—and to promoting health equity between women" (n. p).

This policy (Department of Health, 2011) makes no mention of educational literature or sexual and gender-based programs in languages other than English, which can be presented in culturally appropriate ways to educate and encourage migrant women as new Australians, to engage in better sexual or overall health care. It also does not mention women's rights in terms of sexual pleasure, sexual therapies or diverse sexualities as part of what is sexual health, which the WHO (World Health Organization, 2013) and this researcher consider an integral part of a holistic definition of sexual health.

Most of the sexual health practice in Australia occurs within a clinical setting; either at a specialist medical professional's office, a general practitioner's office, a sex therapist's office, or another clinical setting in which sexual matters are discussed with clients (Utting et al., 2012). Such services keep confidential patient records which indicate a patient's sexual history, STI history, cervical screening testing, disclosed sexual difficulties and contextual information in regards to the client (Kahler, 2011). Only reportable conditions are reported to the Health Department. In hospital or government clinic settings, however, data from women's sexual health consultations, surgery or treatment are recorded, de-identified and kept by the Health Department, the data source for how Australia records women's health.

Data gathered in consultation may or may not include migration history, languages spoken, religious affiliation, support network, issues the client has poor knowledge of (e.g., anatomy, STI transmission, women's sexual arousal and response, contraception, etc.), religiously forbidden practices or if the patient has previously not taken medical advice previously, such as, for cervical screening testing. *The Standards for General Practice, standard 1.7* (Royal Australian College of General Practitioners, 2020b) on the content of patient records indicate:

> Recording cultural background: Practices in all clinical settings should work toward identifying and recording the cultural background of all patients since this background can be an important indication of clinical risk factors and can assist GPs in providing relevant care (p. 49).

If doctors recorded a client's cultural background, it could include information specific to the woman's sexual taboos, if a woman medical professional is preferred for gynaecological examinations, if religious beliefs forbid certain sexual practices, the use of contraception and what appropriate sexual health promotion material was provided to the woman, this will provide a better data source for research on women's sexual health.

4.3 Menstruation, abortion, contraception, and menopause

Historical research by London's King's College found that British and migrant women hold menstrual taboos or *rules* for hiding menstruation and not discussing it (Patton, 2005). This makes discussing sexual health with these women difficult when they find discussing a natural function like menstruation, taboo: discussion of genitals and sex become taboo by default. Some of the rules being:

> "5. A woman will talk to other women about periods only if she knows the other person well.
> 8. It is particularly important not to talk to men about periods; it is considered appropriate to inform sexual partners about menstruation.

> 9. The prohibition against entering certain places of worship during menstruation was recounted by interviewees who had grown up in Asia; the women reported that this was not openly discussed (p. 952)."

Migrant women from developing nations hold cultural or religious beliefs regarding menstruation, genital cleanliness, virginity, sexual activity, and discussion about women's genitals or the meaning of these things. Water and Sanitation and Hygiene (WASH) programs in developing nations are aiming to change the level of taboo and shame associated with a normal bodily function for a woman (WASH United, 2015).

The outcomes of this research may identify changes in attitude to menstrual taboo after women migrate to Australia, or it may identify that menstrual taboo still plays a part in migrant women's attitudes to their sexual health. For some Christian women, menstruation is understood theologically as part of the *curse of Eve*, evoking an *unclean*, shame-based punishing experience of menstruation as a daughter of sinful Eve, thus making problems related to menstruation difficult to discuss generally (Christina, 2017; R. Jha, 2014; Ussher et al., 2017). The following section examines menstruation, abortion, contraception and menopause in the six Asian nations of this study.

4.3.1. China

Chinese religious tradition about women placed them in a dependent role to their husband, father or male guardian. Women were traditionally inferior to men in the society, kept uneducated and the Confucian and Taoist religions enforced these ideals (Steinhauer, 2016; Zhiwen Xiao, Purnima Mehrotra, & Zimmerman, 2011). Menstruation was traditionally viewed as an unclean, unhealthy experience which released a woman's yang energy and made her behave in unbalanced ways. Sex with a menstruating woman would pollute a man or bring disease (Pinkston, 2010; Sridhar, 2016).

During Mao Zedong's regime and later, women were de-sexualised and menstruation was not an issue publicly discussed, despite the government providing gynaecological health checks on a regular basis and at times, enforcing abortion to force compliance with the one child policy (Ebenstein, 2010). Women were valuable as workers for the

economy. It has been a more recent development that younger Chinese women are now publicly discussing their period; this may be due to the influence of more information in the mass media and the role of some famous women publicly mentioning their period such as Fu Yuanhui, an Olympic athlete, and the actress Yueng Wing (Rannard & Allen, 2018). The taboo of discussing menstruation still creates a negative social reaction and yet, young Asian women are breaking this taboo (Crystal Tai, 2019).

Abortion in China was a procedure available during the 1979-2015 *One Child Policy* years and could be forced upon Chinese women (Moran, 2019). Intrauterine devices were the most common form of contraception until the turn of the century when other methods became available (Yuan et al., 2019). Selective sex abortion became illegal in 2005 due to the population imbalance between genders, however, it is still believed to be widely practiced as ultrasound can detect a fetus' gender and private clinics exist (Hesketh, Lu, & Xing, 2011). By 2008, abortion induction pills were available at government health clinics and pharmacies for married women, they are more widely used now as a form of birth control (eChinacities.com, 2010). Abortion is advertised as a form of contraception, which it is not.

Contraceptive pills are not widely used by younger Chinese women and older Chinese women prefer the IUD or sterilisation (Büchenbacher, 2017). Condoms are the most popular contraception with younger unmarried Chinese people who do not have to visit a government clinic to get free condoms then have their sexual activity information recorded (Büchenbacher, 2017).

China traditionally viewed the transition through menopause as a status elevator for women; Bulbeck stating (Bulbeck, 2001) the woman was now free from menstrual uncleanness as well as parental responsibility: "Rather than arguing that women gain status as they age, we might equally say that they lose the negative status of being a menstruating woman of reproductive age" (n. p.). This may reflect traditional Confucian and Taoist attitudes to women as less clean beings (Pinkston, 2010).

Health care of women increased during the Cultural Revolution, inclusive of annual gynaecological examinations, which detected changes to the woman's health,

inclusive of menstrual problems or menopause: this public healthcare scheme saw improvements in Chinese women's health. However, Since the commercialisation of China, the healthcare system collapsed, with Government spending on health significantly reduced as early as 2007 (L. Chen & Standing, 2007) and a new government plan legislated in 2009 to bring equity in health care for China (Kahler, 2011). This uncertainty about affording medical assistance leaves little option for menopausal women to better practice health care during menopause, especially women from rural areas. An economic variable being: women earn only about ¾ of a male's pay for the same work nationally (Xiu, 2013) and women make up most of the unskilled workforce.

4.3.2. India

India has not provided its women menstrual education via Government programs in schools. The BBC's *100 women* research project (R. Jha, 2014) investigated the experience of 100 menstruating women in India. Jah wrote "In India, there is generally a silence around the issue of women's health, especially around menstruation. A deep-rooted taboo feeds into the risible myth-making around menstruation: women are impure, filthy, sick and even cursed during their period" (p.1). Jha stated (R. Jha, 2014):

> A recent study by a sanitary towel manufacturer found that 75% of women living in cities still buy their pads wrapped in a brown bag or newspaper because of the shame associated with menstruation. They also almost never ask a male family member to buy sanitary towels or tampons (p. 1)

Trying to end the silence around the issue, *Goonj* is one of several groups that run campaigns to educate Indian people about menstruation and the myths around it (Goonj, 2019): Goonj works in 21 out of 30 states in India. The organisation is also making cheap sanitary towels from recycled cloths to help those 70% of Indian women who do not have access to safe and hygienic pads.

Rupa Jah mentioned *Menstrupedia* an Indian website dedicated to the menstrual health of Indian women. It has over 100,000 hits a month, anecdotal evidence of demand for

information about a topic many Indian women would never discuss publicly (Menstrupedia, 2018). Chandra-Mouli and Vipul-Patel reported (Chandra-Mouli & Vipul-Patel, 2017b): "Menstruation was considered a curse, disease, or representation of sin by some girls in five Indian states" (p. 3). Cultural taboo about menstruating girls or women's contact with kitchens or food remains in many areas of India. Chandra-Mouli and Vipul-Patel continued: "Daily activities are further limited by taboos related to what and who menstruating girls are able to come in contact with…. to ensure menstrual blood does not contaminate food or others" (p. 9).

Water Aid's WASH report on menstrual hygiene in South Asia indicated how taboo menstruation is in India, even in terms of access to water and sanitary products. Availability of privacy, sanitary products and water to wash during menstruation are key issues for most young women who may not know prior to menarche what is about to occur (Wang et al., 2015a):

> A key priority for women and girls is to have the necessary knowledge, facilities and cultural environment to manage menstruation hygienically, and with dignity. Yet the importance of menstrual hygiene management is mostly neglected by development practitioners within the WASH (water, sanitation and hygiene) sector, and other related sectors such as reproductive health (p. 1).

The risk of genital or urinary tract infection increases without adequate hygiene. Many Asian women have urogenital infections that are not being treated due to menstrual taboo, poor hygiene and access to water, poor education and low access to affordable, disposable sanitary products. India's Total Sanitation campaign (Hong, Fongkaew, Senaratana, & Tonmukayakul, 2010b), mentioned in the Water Aid report, ironically, does not include a section on menstrual hygiene education or available community resources. It is reasonable to assume that similar results would be found in the rural Philippines, Indonesia and in rural China.

Contraception is not widely utilised by Indian society due to the expense, regardless that the Indian Government funds the contraceptive production of injectable *Antara* and provides *Chaya* birth control pills through hospitals (Press Information Bureau,

2017). The pill is not commonly used in India as it is more expensive than condoms. The most common form of actual contraception as opposed to birth control, is female sterilisation at 75.3% of recorded data; condom use is at 11.7% and the contraceptive pill used at 8.7% (United Nations, 2020). Older and poorer women opt for sterilisation via tubal ligation after they have had their children; it is the most popular option as women are paid to be sterilised (Green, 2018). Sterilisation is performed in government clinics (Chaurasia, 2014) yet is losing popularity due to negative press about post-sterilisation deaths experienced in 2014 at Bilaspur. Indian males do not take responsibility for contraception and use condoms; this may be a cultural issue or not knowing how to correctly use them (Donta, Begum, & Naik, 2014).The pressure for male vasectomy is increasing due to the less invasive procedure (Green, 2018).

Abortion in India has changed as selective abortion of female fetuses is not allowed. This does not mean abortion does not occur (S. Singh et al., 2018):

> Since… the Medical Termination of Pregnancy Act in 1971, abortion has been legally available in India… including to save a woman's life, to protect her physical and mental health, in cases of economic and social necessity, and if contraception has failed between married couples. The act also requires abortion services to be provided by trained, certified doctors in registered facilities. In the case of medication abortions, a prescription is required (p. 113).

India does not record unofficial abortions or medication abortion, so no accurate figures are available. Singh et al. estimated that in 2015, "15.6 million abortions" were procured, with "12.7 million" of these being medication abortions used as a birth control method (p. 113): The research indicated abortion occurred to a third of pregnancies in India (S. Singh et al., 2018). A medication abortion is cheaper than a surgical one and does not require a woman to go into a clinic for an embarrassing gynaecological procedure; perhaps this explains the underestimated figures.

The Indian Menopause Society was started in 1995 by male doctors, Dr. Jah and Dr. Vaidya, in Mumbai. Female doctors and specialists joined the team soon after, sadly, this organisation meets the needs of medical and specialist staff and not the average

Indian woman ("Indian Menopause Society," 2018). *The Journal of Mid Life Health* is linked to the Society and indicates that there is little research on menopause as part of Indian's women's sexual health (Malik, 2103): "there is not much published Indian data on the subject of menopause" (p. 75). One research study by Viyalakshmi, Ramesh and Eilean (Vijayalakshmi, Ramesh, & Eilean, 2013) indicated that "According to Indian Menopause Society research there are about 65 million Indian women over the age of 45" (p. 74), which is a growing population demographic. All the women in the research indicated they had negative and distressing symptoms which affected their sexual function, such as tiredness (92.9%) and a dry vagina (36%). Government policy on women's health (*National Health Policy 2017.*, 2017) vaguely mentions menopause: "health needs of women beyond the reproductive age group" (p. 14), though no specific plan is listed to address needs of menopausal women with sexual health problems.

4.3.3. Indonesia

Indonesia has no Government program in place for women or girls' menstrual health management (MHM), or a mandated menstrual and health education program for girls within schools. Like India and the Philippines, many girls in Indonesia miss school due to menstruation and poor MHM facilities in schools. The Burnet Institute undertook research in Indonesia (Kennedy, 2016) and reported similar findings as those from India and the Philippines, their findings indicated:

> Menstruation can also contribute to school drop-out, absenteeism and other sexual and reproductive health concerns that can have substantial and long-term health and socioeconomic ramifications for adolescent girls"… Moreover, education settings may present an opportunity to reach adolescent girls to improve their knowledge, attitudes and practices in relation to MHM (n. p.).

One of the difficulties of utilising school based MHM or health education programs for girls in Indonesia is Indonesia is a socio-politically patriarchal culture, where the role of women in the dominant Islamic, culture is a subservient one, even in Christian communities. Nuranna and associates research evidenced this patriarchal power base (X. M. Chen et al., 1992): "due the culture of Indonesian society, wives have to ask

for approval in advance from their husbands in making the treatment decision" (p. 151).

Historically, Indonesian government policies regarding women are non-specific and vague (Department of Immigration and Border Protection, 2014; Stark & Wang, 2015): There is no women's policy overall (Department of Home Affairs, 2015b). Even though Indonesian law permits women two days menstrual leave each month, the stigma associated with menstruation and women overall, restricts women from applying for this leave (Doniger & Kakar, 2002).

> The two optional menstrual leave days are believed to be aimed at the tens of thousands of factory workers who cannot freely go to the restroom throughout the day… and work 10-15 hour days on a regular basis" (n. p.)

Women having to *prove* menstruation to employers who may be males, is a human rights discussion (Doniger & Kakar, 2002; G. Jha, 1920), especially as urogenital hygiene demands regular changing of sanitary pads: tampons are not commonly available in Indonesia. Indonesian research focusing on menstruation as a public health issue is difficult to find. Articles found on menstruation were old or focused entirely upon medical aspects of menstrual pathology (Wall, 2013). Little information was found in academic articles that discussed menstrual taboo and connections to urogenital health of women. The treatment of Indonesian women in this manner is discriminatory and breaches the United Nation's Universal Declaration of Human Rights. It is also in violation of the UN's Convention on the Elimination of All Forms of Discrimination against Women.

In Indonesia, contraception is on the rise with 50.6% of contraception being an injectable form, 21.1 % the contraceptive pill, implants 8.2%, female sterilisation at 6.2% and male condoms at 4.4% (Family Planning 2020, 2020). Like India, Indonesian males do not take responsibility for contraception. Contraception is also only available to married women. Funding family planning and affordable contraception is not easy in such a widespread nation. A *Kampung KB* plan to target the poorer and rural areas is being introduced (Family Planning 2020, 2020), though given cultural shame about

sexual matters for women is high, and men control finances to access medical or contraceptive services, it remains to be seen if this will work in villages (kampungs).

It is concerning contraception is not available to single Indonesians who are engaging in sexual behaviours without a comprehensive sexuality education (Emilia, 2019), as Emilia pointed out: "Knowledge of sexual intercourse, contraceptive methods, HIV/AIDS, pregnancy and (access to safe) abortion is very limited" (p. 10). Abortion is illegal and very restricted (ARROW, 2015). An example of abortion being restricted in Indonesia involved a case in 2018, where a 15 year old unmarried Indonesian girl was repeatedly raped by her brother and *she* was sentenced to 6 months in jail (Llewellyn, 2018). Abortion was perceived as illegal, yet in her case, the *Reproductive Health Law* allowed for abortion due to rape or if the mother's health or life is endangered (Llewelyn. 2018). Not many Indonesian women would know this. WHO made recommendations to the Indonesian government about access to safe abortion in Indonesia (World Health Organisation, 2017), such as increasing time limits for procuring an abortion, not criminalising unmarried women who seek abortion due to sexual assault, and "not requiring third party authorisation from a medical professional" (n. p).These recommendations have not been acted upon.

As part of the Indonesian Government's collaboration with worldwide research institutes, *The Family Life Survey 2014* (RAND Corporation, 2015) examined the health of Indonesian women. 1608 post-menopausal Indonesian women reported on their menopausal symptoms. Women reported vaginal dryness, continence issues and urinary tract infections; all of which affected their sexual health; no government program exists to assist women to manage distressing symptoms. Many Indonesian women would not be able to afford to pay for medication and they would have to ask permission of their husbands for the expenditure (Tanamal, 2018).

Indonesia's main population of women are aged between 15-64 years of age (Surbakti & Devasahayam, 2015). In the 2010 census (Surbakti & Devasahayam, 2015) "54 % of Indonesia's population over 6o years and above" (p. 27), were women: A lot of menopausal women are in that demographic. There is no government funded program that educates Indonesian women about menopause, let alone menstruation. One health website lists 5 Menopause clinics where Indonesian women can access hormone

replacement therapy (HRT); all are in Jakarta and fees are payable (What Clinic, 2020). As mentioned in previous sections, Indonesian women do not present for gynaecological checks and do not talk about their gynaecological problems (MAMPU, 2019a), the menopausal Indonesian woman will suffer in silence.

4.3.4. Malaysia

After the Beijing conference in 1995, Malaysia's Government responded to United Nations pressure to improve the status of women ("Ministry of Women, Family and Community Development.," 2016). Government departments specific to women's needs were established: *The Ministry of Women and Family Development* (MWFD), established in 2001; with *The National Population and Family Development Board*, established earlier, then sectioned into the MWFD. The Malaysian Government outlined: "Establishment of a full-fledged ministry that demonstrates the government's commitment to raise the status of women in this country" (n. p.), with the aim, "to achieve gender equality, family and community development as a caring and prosperous basis of a fairly developed country" (n. p.). Strategies mentioned by the Malaysian Government included: research into gender and development of programs to aid women, as well as expanding women's access to information, the dissemination of information and access to services specific to women; however, no mention of menstrual hygiene, gynaecological or reproductive health or sexual health are listed ("Ministry of Women, Family and Community Development.," 2016; *The Progress of Malaysian Women Since Independence 1957 - 2000.*, 2003).

Menstruation in Malaysia is not an openly discussed issue, despite related health, educational and social matters being promoted by the Government. Historically, some girls would miss school when menstruating (L. K. Lee, Chen, Lee, & Kaur, 2006). Lee et al's research indicated "Most (88.9%) of the secondary school girls had not consulted a medical doctor for problems relating to menstruation. However, it is interesting to note that of the 11.1% of those who had sought help for problems related to menstruation, 29.4% went for alternative or complementary medicine" thereafter (p. 870).

Plans to disseminate sanitation and menstruation education via school WASH

programs were discussed, with rural areas of Malaysia being at most need (WASH United, 2015). Cultural shame about menstruation and menstrual taboo were part of Malaysian culture in the 20th century and taboo remains (Chandra-Mouli & Vipul-Patel, 2017b). The authors reported: "girls in Malaysia... reported feeling ashamed, embarrassed and uncomfortable when inquiring about menstruation from adults" (p. 6). Shame about speaking to adults was also reported in similar ways when asked about consulting medical professionals (p. 10): "Consultation of health professionals for menstrual-related problems was minimal, generally reported by less than a fifth of girls (Chandra-Mouli & Vipul-Patel, 2017b). Menstruation in Islamic Malaysia is considered taboo and an issue related to uncleanness (L. K. Lee et al., 2006; Sridhar, 2016) thus little research was found about local women's experiences or knowledge.

Forms of contraception are diverse in Malaysia, with the pill and morning after pill available without a prescription at pharmacies. By 2015, 57.1% of Malaysian women used contraception and condoms, IUD's and contraceptive implants are also available for a fee (United Nations, 2015). Malaysia has specific women's clinics where IUD's can be free, with doctors to implant the IUD readily available in major cities. In rural or remote areas, mobile clinics assist women to access contraception (Ahmad et al., 2010). Contraception is available in pharmacies after discussion with the pharmacist; this is a disincentive to single, sexually active women in a conservative society (Gynopedia, 2020).

Women from Kuala Lumpur in Malaysia do not generally seek HRT or medical assistance with menopause (Wong & Nur-Liyana, 2007). Wong Et al.'s research reported, "Findings also revealed that most respondents suggested no definitive treatment for menopause. Only 45.6% (95% CI; 40.7 to 50.5%) of the respondents agreed on hormone replacement therapy as a treatment option. Nearly half (45.8%; 95% CI, 40.9 to 50.7%) believed in traditional remedies for treatment of menopause" (p. 25). Given that menopause can affect ones sexuality and health overall, it is interesting that Malaysian women seem disconnected from non-medically based sources of helpful information and source information from "magazines, family members, books, radio and television" (p. 27) (Wong & Nur-Liyana, 2007). This research did not however, measure rural women's behaviours or attitudes.

Other research by Abdullah, Moize, Ismail, Zamri, & Mohd Nasir involving 258 women aged between 45-86 years of age found (p. 94):

> Joint and muscular discomfort (73.3%) and fatigue (59.3%) were the most prevalent symptoms. Significant association with ethnicity were demonstrated with Malays was found to have 3.1 times higher incidence of sexual problems than Indians, (Odds Ratio (OR) 3.103; 95%CI 1.209, 7.967) and Indian had 2.6 times higher incidence of irritability compared to Malays (OR 2.598; 95%CI 1.126, 5.992). Fifty-two percent of women felt that menopausal symptoms affected their quality of life but there were only 2.7% who were severely affected (Abdullah, Moize, Ismail, Zamri, & Mohd Nasir, 2017).

Difficulty with health overall and painful menopause related symptoms would affect one's sexual health and attitude to sexual experiences called unidentified *sexual problems* in this study (Abdullah et al., 2017).

It is a crime to obtain or perform an abortion in Malaysia, with imprisonment for abortions after 4 months gestation and for infanticide post-birth. The only exceptions are to save the mother's life or for her health: the *Penal Codes 309, 312-316* detail this (Government of Malaysia, 2018). Yet, an estimated 90,000 abortions were performed in Malaysia in 2018, with Archer suggesting private clinics were not regulated and that women could get abortion pills via mail (Archer, 2018).

4.3.5. Philippines

The Philippines has historical taboo about discussing women's menstruation and sanitation requirements (Alcantara, 1994; Torralba-Titgemeyer, 1997). Even in urban centres, many girls miss school and engage in traditional ritual when they menstruate. Rodriguez mentions that in the Philippines, menstrual taboo and ritual includes pouring water over a girls head to make the duration of periods shorter, washing bloodied underwear, then wiping a girls face with them and the girl staying home from school for 3 days (F. Rodriguez, 2015).

> These are 'family rituals,' said the 63-year-old mother, for making

> one's skin and menstruation cycle 'smooth' – no pimples, no stink, no troubles… "Bawal humakbang sa labas, palipasin muna pagliyab." (Stepping out during menstruation is forbidden…).
> On average, Filipino women get their first period at 13, the 2013 National Demographic and Health Survey showed. It added that 10% of those aged 15-19 are already mothers (n. p.).

The Philippines menstrual hygiene issues are outlined by Rodriguez (Alcantara, 1994): "In 2012, UNICEF surveyed schools across Masbate and Manila, and identified the lack of 'knowledge, support, and resources' as key problems in menstrual hygiene management" (MHM) (n. p.). Primary concerns, even in urban areas were: access to water and privacy, community and school toilet facilities, affordability and access to sanitary products and easy disposal of sanitary products… on school or in community premises (Union for International Cancer Control, 2018); as Sommer (et. al., 2012) indicates:

> Across the Philippines, there are more latrines per school when compared with other countries… Toilets are often out of order, and even when functional, students avoid them because they are reported to be unclean, smelly and poorly lit. According to the WASH Situation Analysis in Poor and Under-Served Communities in the Philippines, 2011, 20 per cent of schools do not have access to water (p. 12).

The *Philippines Millennium Development Goals*, set by the United Nations regarding women have not yet been achieved (Wijngaards, 2014). Three of the eight goals for 2015 are as follows: the third goal is "gender equality and empowerment of women"; the fifth goal is "improve maternal health"; the sixth goal is "combat HIV/AIDS, malaria and other diseases" (n. p.). These goals relate to women and girls overall, yet not one of the criteria includes a specific education program the Government has agreed upon to target women's menstrual, reproductive or sex education throughout the Philippines; facilitated via schools or community health centres. This indicates there are financial and cultural constraints and a lack of structure across the Philippines for such programs on a large scale and that the status of women overall is not high.

Contraception options were available to married women until the 2009 ‘Magna Carta’ for women ("Republic Act No. 9710: An Act Providing for the Magna Carta of Women," 2009). This legislation, described by Tulali (Tulali, 2010) promotes the rights of women to “Comprehensive health services and health information and education covering all stages of a woman’s life cycle, and which addresses the major causes of women’s mortality and morbidity” (p. 6). However, there is no health care system, and its goals are unachievable without a funded health system with women’s clinics available to the female population.

Media influences women, with magazines like Cosmopolitan advising of contraceptive options, including ‘the pill, morning after pill, implants, IUD’s condoms and injections (Estella, 2017). The legal rights of Filipinas to contraception and sexual health are now legislated and publicised (Sastrillo & Babao, 2019), a large step forward.

A Government plan to assist women with menopausal health problems is non-existent. Filipina women generally access menopause information from women, magazines or websites rather than Government education (Gonzalez-Ventura, 2019; Ramoran, 2015). The Philippine General Hospital Menopause Clinic reported on common, menopausal complaints of women who could afford to attend their clinic, with 56.7% of women having hot flushes, 49.8% being irritable, 47.3% being nervous, 46.8% having palpitations, 45.9% having headaches, 44.6% experiencing night sweats and lower percentages experiencing other distressing symptoms (Gonzaga, 2019): No mention of sexually related problems was made in this article. A gynaecologist discussing menopause and problematic symptoms in the Philippines media (Ramoran, 2015) used pathologising language about menopause as an “oestrogen deficit” that will cause “irreversible” “damage” (n. p.). She advocated for HRT, despite it being unaffordable for most Filipina women whose access to a menopause clinic would be difficult. Menopause is a natural function of aging. The Philippines does not have a menopause management plan.

Procuring or performing an abortion is a crime in the Philippines. *The Penal Code’s* articles 256, 258 & 259 (Government of the Philippines, 1930) outline penalties that

are not commonly enacted. Abortion occurs in the Philippines, especially amongst the poor and by 2012, 100,000 women were hospitalised for unsafe abortions (Padilla, 2015). The influence of the Catholic Church upon parliament cannot be underestimated.

4.3.6. Singapore

Singapore's Ministry of Education (MOE) has a sexual education curriculum which is taught in all state schools: The curriculum includes information on menstrual hygiene and reproduction for girls within *The Growing Years* and *Empowered Teens* sections (Liew, 2014).

> Revised in 2012, the Singapore Ministry of Education's (MOE) Sexuality Education Program is part of the official curriculum in all government primary schools, secondary schools, junior colleges, and centralized institutes. The current sex education curriculum comprises two main programs: The Growing Years (GY) and Empowered Teens (eTeens) (p. 707)

Despite the Singaporean Government's provision of a women's health curriculum, Agarwal and Venkat report (Agarwal & Venkat, 2009) there are still some issues with menstrual taboo, cultural shame and ignorance about female anatomy, menstruation or help-seeking avenues "adolescent girls are reluctant to seek medical treatment, leading to delay in diagnosis and treatment. Appropriate health education measures need to be put into place to prevent this trend" (p. 365).

In the current Singaporean workplace, some women do not discuss problems with menstruation: "(n. p.) only a third (33%) of women in Singapore whose performance has been affected by period pain have ever admitted to their employer that this was the case. A quarter (25%) told their employer that troubles caused by period pain were down to some other reason" (YouGov., 2017). Menstrual taboo still exists in Singapore, despite education in schools about periods and reproduction. How taboo about women's natural bodily function influences Singaporean women's sexual health remains to be researched further.

A research program with women who attended the National University Hospital about their knowledge and use of contraceptive methods found Singaporean women do not know enough about contraceptive options: hormonal implants, injections, hormonal patches or intra-vaginal rings were not well known. Condoms were the most common contraception in Singapore in contrast to the contraceptive pill in Western nations like Australia (Gan & Chia, 2017; Gosavi, Ma, Wong, & Singh, 2016). Condoms are advertised in Singaporean media for safe sex and do not require a woman to visit to a doctor to discuss her sex life (Gan & Chia, 2017); not desirable if the doctor is male as this research validates.

Abortion is not illegal in Singapore and has been available since the Kuan Yew (1960-1990) era and thereafter (National Library Board, 2015). Recent statistics show 1 in 5 pregnancies are aborted in Singapore (Gosavi et al., 2016). Medical abortions in Singapore are ideally before 13 weeks gestation and performed in a medical facility or hospital via the use of Misoprostol: Surgical abortions are rarer and can be performed in hospitals into the second trimester (Chaudhuri, 2019). Singapore has a government funded website for menopause education, yet many women do not readily engage in accessing professional help with menopause, "(p. 1) Women… described an attitude of acceptance surrounding menopause and the changes associated with it. While they thought it was important to be informed, they did not seek out information about menopause and did not view health professionals as useful sources of information" (Mackey et al., 2014). However, in other research, a rise in Singaporean women's presentations for menopause treatment had been reported "(p. 8) the Menopause Unit at KK Women's and Children's Hospital (KKH) is seeing a 30 percent increase in women seeking consultation for issues relating to menopause" (Ang, 2014). Maybe, with better health information available, older Singaporean women are starting to access sexual health assistance as it has become normalised.

4.4 The language of reproductive 'function'

The literature reviewed for this review focused upon female biological function, reproduction and fertility, sexually transmitted infections and STI prevention. This indicates a widely held bias in academia as to what the concept of *sexual health* for women means: it is perceived as medically or pathologically based. Women's

sexuality becomes problematic to professionals when there is a diagnosable problem according to scientific reductionist criteria (Atkinson, 2015; Shainwald, 2011). Atkinson wrote about medicalisation of sexuality (n. p.):

> The expansion of medicine into areas of human life previously understood in other ways. Medical understandings of sex/sexuality being historically specific often serve to both reflect and reproduce social norms. By medicalising sexuality, we risk ignoring the social, cultural and relational causes of sexual problems (Atkinson, 2015).

Most literature reviewed from the six nations of this research used *reproductive health* terminology for describing research into women's sexual health; even in academic resources and peer reviewed journal articles sourced from Asia and other nations: 111 references on *Birth* (which only women can do). 98 Endnote reference keywords used described *reproductive health*, 88 references focused on *reproduction* and 62 on women's *fertility*. This language amplifies the perception of Asian women's cultural value being that of a childbearing function and the preservation of her fertility. This language use could be related to the cultural taboo about mentioning women's sexuality, genitals and pleasure apart from her meeting her husband's sexual needs, or, it could be that mentioning medically accurate terminologies for women's genitals is considered too confronting in nations where discussion of sexual matters for women, is taboo or shameful (Chu, 2017; Kaler, 2018; Ussher et al., 2017).

However, this language used by academics does not encompass women's sexual health, just a part of it. Regardless of the cause, the language of *reproductive health* is not helpful to women as not all women can have or do want children. This language mystifies women's sexual health and keeps women ignorant about their overall sexual health by depriving them of a language to describe: their anatomy, genital hygiene, pregnancy and sex, post-partum sex, painful sex, contraceptive methods, safe sex practices, sexual play, foreplay and erotica, sexual pleasure, masturbation, menopausal transition, same-sex sexuality, and asexuality or intersex conditions. Academia needs to change the language used for discussing women's sexual health.

4.5 Conclusion

Most of the academic and Government literature reviewed by the researcher focused upon *functional* problems related to Asian women's sex or sexual behaviours as determined by a medical practitioner: women's fertility, post-birth complications, sexually transmitted disease, cervical cancer, abortion and menopause, all of which affect women's sexual health (Blackwood, 2007; Tay et al., 2008; Williamson et al., 2018; Wu, Wan, Zhao, & Zhang, 2006; Xiao et al., 2011). However, this focus on the *functional* aspects of women and the sexual activity they engage, or do not engage in does not match the WHO definition of women's sexual health, which is a holistic thing within the power of the woman concerned (World Health Organization, 2013). Many Asian women have no idea of their sexual physiology or function, they may not have words to describe their genital structures; they have limited sex education or contraceptive choice, all which is wrapped-up within menstrual management discussion and focuses on reproductive function for marriage. Asian women exist within societies that have long standing male bias, where male entitlement to sex is evident and women are ill-informed about their bodies and sex.

The literature reviewed did not discuss at large women's sexuality or sexual health, women's physical pleasure, sexual *rights* like consent to sexual activity, sexual orientation and sexual behavioural diversity, sexual assertiveness and issues like asexuality, recovery from sexual trauma and managing menopause. This lack of knowledge can be addressed by a comprehensive sexual health education in Asian nations that encompasses these topics plus diverse sexual expressions or identities, outlining pornography as inaccurate sex education and promoting safe sex practices, which is only starting to emerge as necessary in Asia (Liew, 2014; Teng et al., 2016). There is no comprehensive sexuality education (H. Leung et al., 2019) provided to Asian women of the six nations that includes a female sexual health component. The incidence of women's cancers in Asia, specifically gynaecological cancers, cannot be reduced without providing Asian women the necessary sexual health information for them to protect their health in ways that reduce shame about discussing sexual topics and normalises the sharing of such knowledge as a positive thing for women and society.

Halting rising STI statistics in Asia due to unsafe sexual practices seen in pornography such as oral, anal and vaginal sex practiced concurrently is necessary and people need

safe sex information to avoid contracting STIs (Hesse & Pedersen, 2017). Condom use or the use of new condoms, dental dams or femidoms for each sexual activity is required to protect all sexually active Asians who are not exclusively monogamous in long-term sexual relationships (Jeffreys & Perkins, 2011; Teng et al., 2016).

This literature review has identified preventative sexual health education of all Asian women is a necessity for their lifetime sexual health. The unnecessary death of Asian women due to sexually related diseases is preventable with purposeful social health promotion normalising women's sexual health discussion. Comprehensive sex education needs to be provided by Asian Governments in schools as a positive thing; one that will protect all society members. As a point of choice for conservative, religious Asian parents who object, they could opt-out their teenager from a class. Breaking cultural norms which damage women's sexual health requires a positive approach, outlining to society all the benefits of engaging in women's health promotion. Getting the sociopolitical powers involved in the discussion to promote change is what Bandura's Social Cognitive Theory about societal change indicates works (A. Bandura, 2003a).

The chapter following this review discusses the research methodologies used for this dissertation, the rationale for the methods chosen, describes how the data was gathered, how data rigour was ensured and how ethical principles like informed consent and doing no harm to participants was adhered to.

Chapter 5: Research Design and Methods

5.1 Introduction

Researching the sexual health attitudes and behaviours of women from South Asian cultures was best suited to a qualitative method to acquire answers to the research questions and goals. An emic approach, using semi-structured audio interviews asking the women to discuss their personal and cultural narratives about sex and sexuality was likely to identify barriers to their engagement with sexual health services and identify how cultural or religious values affected their attitude and actions. The data would give voice to their sexual health service needs via identifying themed and interconnected "(n. p.) patterns of meaning" (School of Psychology, 2017) related to their choice to engage or not engage in sexual health services and describe their reasoning.

This research project focused upon Christian women migrants in Australia from six nations: China, India, Indonesia, Malaysia, Singapore and the Philippines. These nations are substantial migration sources to Australia identified by the Australian Bureau of Statistics (Australian Bureau of Statistics, 2017c). I am familiar with the nations and cultures, having travelled to all and lived in one. I chose to conduct the research with migrant women resident within Australia to gain a retrospective view of their sexual education and sexual health experiences in their nation of origin and to identify any changes since migration.

Asian women are an identified *at-risk* population group for poor sexual health care in Australia, due to the influence of socially learnt cultural and religious norms of their nation of origin. Social learning theory postulates that what a culture validates and enforces at large, becomes a cultural norm (A. Bandura, 2003a). This research investigates to identify what these norms are and how they act as barriers in influencing Asian Christian women's sexual health within Australia. The *Australian Women's Health Network* research identified risk factors for CRaLD women (p. 10):

> Women who have limited resources and lack the capacity to exert control over their lives are more vulnerable to experiencing sexual and

reproductive ill-health. In Australia, vulnerable women include culturally and linguistically diverse (CALD) women (Utting et al., 2012).

This research is the first of its kind to document the influence of cultural and religious worldviews upon the sexual health of Asian migrant women in Australia. Growing multiculturalism in Australia and migration by Asian populations specifically (Australian Bureau of Statistics, 2019) requires research about managing the risk of migrant women's non-engagement with available sexual health services as a public health priority.

5.2 Research Aims

This research was guided by two main questions:

1. How an Asian migrant woman's worldview defines what constitutes sexual health or *healthy* sexuality, affecting: a) her engagement with and b) use of sexual health services or sexual therapy practices within a secular culture which utilises a reductionist approach to medical and sexual health problems; and
2. How sexual health practitioners and sexologists in Australia can better engage with and meet the needs of Culturally, Religiously and Linguistically Diverse (CRaLD) women clients?

5.2.1 Objectives of the Study

1. To identify what Christian Asian migrant women from China, India, Indonesia, Malaysia, the Philippines and Singapore define as sexual health and sexually *healthy* according to their sexuality education.
2. To examine the sexual health practices of migrant women prior to migration to Australia to see if they change after migration.
3. To identify barriers faced by Asian migrant women hindering them from accessing sexual health treatment in Australia: and to identify their expectations of sexual health practitioners in Australia.
4. To identify what barriers restrict a secular sexual health practitioner engaging with their client's worldviews; inclusive of assessing the influence of a reductionist approach to human sexuality upon their own professional practice

(Atkinson, 2015; Douglas & Fenton, 2013)

5. To propose a basic framework for respectful, culturally humble (Foronda et al., 2016) and person-centred, sexual health practice aligned to further research.

The research findings will contribute to professional sexual health workers understanding Asian migrant women's worldviews, attitudes and actions better and inform health professionals about what is necessary to provide these women with culturally sensitive services in Australia. The text of this chapter will alternate between first and third-person narrative due to quotes and the researcher's description of methods.

5.3 Research Design

5.3.1 The methodology used for the study

This research program's methodology and epistemology were framed by anthropological inquiry, viewing sexual health within a sociocultural perspective and an emic and interpretivist paradigm (Holloway & Wheeler, 2010), this is the approach used by the Canadian medical system in its work with indigenous and migrant people (Dogra et al., 2010). The American Anthropological Association explains: "Sociocultural anthropologists examine social patterns and practices across cultures, with a special interest in how people live in particular places and how they organize, govern, and create meaning" (American Anthropological Association, 2013). The emic approach allows for participant's data to inform the researcher and reader of a first chain of evidence perspective; being the participant's ideas, beliefs and practices in regards to the research topic and questions (US Legal, 2019).

Social learning theory (Albert Bandura, 1971) is the foundational theory of intergenerational transmission of information and Bandura's social cognitive theory for personal and social change (A. Bandura, 2003a) is particularly applicable to this research because it investigates the cultural and religious influences of this specific community and requires their personal opinions. Bandura postulated that social conditioning and the behaviorist concept of "reinforcement" by self, family or culture operates in these systems (p. 5). What is desired by the family or community, modelled by the community leaders and is socially affirmed will be repeated and complied with by a member of the community who wants to belong to it: conversely, what is socially

undesirable, taboo or perceived as a threat to the community's status quo, will have negative social consequences such as shaming and exclusion from community. The "controlling influences" (p. 20) of a culture, religion or community are role-modelled and thus, taught to the people who are part of it (Albert Bandura, 1971).

The research aims to identify if what was socially learnt by the women in the past in the nation of origin regarding women's sexuality and sexual health, changes after migration and what barriers will impede change. It will identify the beliefs influencing their sexual health behaviours: via a retrospective view and inquire about changes in the now. Asian women experience poor sexual health, a gender bias to personal worth and poor health care overall (Ussher et al., 2017). Can traditional practices be adjusted in Australia by a change to women's cultural environment and exposure to new norms that value women, their health and their sexual health? It is anticipated the women's beliefs, influences and behavioural changes regarding their sexual health will emerge from the data and thematic analysis (Nowell et al., 2017).

5.3.2 Quantitative or Qualitative?

Quantitative questionnaires, surveys and examination of health statistics is one way to examine the sexual health practices of Asian migrant women, however, this method does not allow for women's narratives to be heard about what cultural or religious variables stop them from engaging in sexual health care in Australia for sexual health related issues such as: contraceptive consultation with a GP, Pap smear tests, STI testing, menopause advice or examination and therapy for painful sexual intercourse or anorgasmia (Ussher et al., 2017). A qualitative approach better matches answering the research questions as the participant data will explain why this group of women do not engage in the Australian health system for sexually related problems. Qualitative research examines the quality of a person's experiences, beliefs and actions upon their life (Reeves, Kuper, & Hodges, 2008). Christian Asian migrant women's narratives will be recorded; each answering identical open-ended questions plus clarifying or follow-up questions about their sex education and sexual health practices in the nation of origin and within Australia. Open-ended questions being questions that cannot be answered with '*yes*, *no*, or *I don't know'* answer; they are designed to open dialogue about a topic to gain a person's opinions, experiences, feelings, thoughts and explanations for actions (Farrell, 2016). A copy of the questions used is in appendix

B.

Dialogue in the audio interviews was continued until a point of participant narrative where no new information came forth; this is called *saturation* point (Mason, 2010). Mason outlines, "(p 8) There is a point of diminishing return to a qualitative sample, as the study goes on more data does not necessarily lead to more information" (Mason, 2010). The research designed in this case to facilitate discovery of the research participant's religious and cultural views about women's sex education and sexual health and how this affects their current health practices (Thomas & Harden, 2008).

Christianity is a subculture within dominant religious cultures in most of Asia; it is a majority religious influence in the Philippines, yet a large minority religion in India, Malaysia and Indonesia (Hackett, 2011). Singapore has a growing Christian population, reported in 2014 as growing at 18.4% (Philomin, 2014), the Center for Global Christianity reports that all six nations under this study will have increased the percentage of Christian population by 2020 (pp 36-40); China by 10.86%, India by 2.40%, Indonesia by 2.17%, Malaysia by 3.42%, the Philippines by 2.22% and Singapore by 4.12.% (Center for the Study of Global Christianity, 2013b). Christians have liturgical traditions, sacred music, religious ritual, arts, shared literature and shared norms in adherence to the doctrines taught within the religious communities, inclusive of beliefs taught about women and sexuality.

5.3.3 Qualitative interpretivist research

Conducting research into the beliefs, values and behaviours of a people group aligns with qualitative research methodology, anthropology and ethnography (Holloway & Wheeler, 2010). This research is more anthropologically based as it investigates the experiences and knowledge of a particular sample of people; it is not ethnography as that would have involved long-term immersion in the community (American Anthropological Association, 2013). Investigation of how women's sexual health is defined and understood within one culture and interpreting how this definition works within another culture is part of this qualitative research project. I conducted a Thematic Analysis of the data from 22 transcribed and coded face to face semi-structured interviews which asked questions of a purposeful sample of women, contextual to the research questions and goals. A purposeful sample being defined by

Palinkas and associates (Palinkas et al., 2015) as a group of data sources: “assumed to be selected purposefully to yield cases that are information rich” (p. 534).

I also utilised a key word and phrase search of the literature review’s Endnote references to identify common words and phrases about women’s sexuality and sexual health contextual to this research project. This provided a point of triangulating data to notice any similarities, differences or glaring inconsistencies between the academic and interview data, validating the rigour of the research process and research outcomes (Nowell et al., 2017). This Endnote word and phrase search outcomes comprises part of Chapter 2 and 3.

As a qualitative, emic based research project, I based the structure of the Thematic Analysis of participant interview data upon a process outlined by Nowell, Norris, White and Moule’s 6 Stage Model of Thematic Analysis (Nowell et al., 2017). The stages are as follows:

1. Familiarising yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report (p. 4-10).

Having a clearly outlined process for analysis means tracking the process will be easier and the structure ensures the process could be replicated if similar research were to be conducted. This process will be referred to in this chapter during the data gathering process and discussed more specifically within chapter 6, the analysis chapter, where points 3, 4, 5 will be outlined and point 6 will be produced as outcomes.

5.4 Recruitment

5.4.1 Participants

I had difficulty directly accessing women participants from churches in Australia which had a clearly identified Asian population. I anticipated churches with between 500 to 1,000 congregants would have a larger proportion of Asian women attending

who may be interested in the research program and willing to participate if confidentiality was guaranteed and informed consent obtained. A search of Perth churches was used to identify churches with Asian members, Asian leadership or which advertised they conducted religious services in Asian languages. A professionally printed information pack seeking participants was mailed to the Senior Pastor and women's leader of these churches. One hundred information flyers and 100 participant information letters were professionally printed in late 2014. Reply paid envelopes were provided for those women interested in participating who may reply via mail rather than email or phone myself to express interest. I developed an excel database for church information, aiming to post the research information to the churches, then afterwards, contact the leader of the church or women's ministry directly to ask if I could speak with the women's ministry leadership.

The initial mail-out was to 50 churches in Perth in 2015. Only one email response was received from a male pastor in 2015, saying his church would not promote the research, nor place the research notice on the church's notice board as it was deemed unsuitable. Follow-up phone calls to other churches asking to speak with the leader of the women's ministry were not successful; in some cases, comments were made alluding to research like "this is unnecessary" and "the church wanted nothing to do with private, sexual matters." A second mail-out to other churches was conducted in late 2016, with a cover letter requesting a face-to-face discussion with the leader of the women's ministry, providing opportunity to ask me relevant questions. Unfortunately, no responses were received: this unwillingness to respond evidenced sex as a taboo subject for church leadership.

I utilised Christian social and professional contacts I knew who were working in human services, health or counselling professions who had access to Asian women through their personal, professional or Church contexts as a different path to acquire research participants. The women I approached agreed to provide Christian women who they thought would be interested, with the research project's invitational package. This methodology worked well over a couple of years with 27 women in total contacting me to be interviewed, with 22 of those women, who met the research criteria and who gave consent for their data to be used, engaging in the program. The women represented the 6 Asian nations of this study: China, India, Indonesia, Malaysia, the

Philippines and Singapore.

University students were not targeted for participation due to the proportion of women students aged 18-25 years of age who are well educated and informed, which would constitute a biased sample. A broader sample for the research, inclusive of older women, women of differing levels of education with variety to the time of residence in Australia, would add to the richness of the retrospective and prospective participant narratives and identify common ideas or age-related or cultural differences.

5.4.2 Participant recruitment

Mason stated (Mason, 2010) “Samples for qualitative studies are generally much smaller than those used in quantitative studies” (p. 8). This is due to the intensive time taken to record each participant’s data on the same questions and the focus upon people’s meanings, not percentages of people experiencing a similar event. Mason’s description of an average sample size for qualitative research is as follows: “The most common sample sizes were 20 and 30 (followed by 40, 10 and 25)” (p. 292), within which this research sample fits.

The inclusion criteria for the participant recruitment were that:

- the women were aged over 18
- spoke English
- could travel to meet the researcher for an interview at a neutral, private location
- they would use an alternate name.

5.4.3 Difficulties in recruitment

Finding research participants was difficult. Church leaders did not respond to the information flyers and letters mailed out; even churches where the minister was a woman. Adding reply paid envelopes to the information packs sent, did not result in any responses. Forming connections with Asian women in churches became a word of mouth recommendation after I discussed these difficulties with Asian women and health professionals I knew, had professional association with, or through the *Western Australian Sexology Society* Facebook page ("About WASS," 2015). I provided these contacts with multiple research flyers and participant invitation letters and my contact details to distribute to Asian women they knew. All the women who participated in the

research, even those who later opted out, came via this networking method within their own workplace, social or cultural contacts. I did approach The Chung Wah Association of Perth in 2018 via email to ask about placing advertisements in their paper seeking Chinese research participants ("Chung Wah Association," 2020) but no reply was received.

Five women recanted their consent. In 2015, a Filipina woman in her 40's withdrew her consent due to concerns about her husband finding out she had participated. In 2016 an Indian woman in her 40's withdrew consent, due to fears she may be identified by her community. In 2017, 3 participants withdrew consent for their information to be used; an Indian woman in her 60's, a Chinese woman in her 50s and an Indonesian woman under 30; no reasons were provided, yet anxiety about being identified was most likely. These women are not listed in the participant demographic chart that follows.

5.4.4 Participant Demographics

Participants came from the six Asian nations of this research and were resident in Australia in compliance with Curtin University Ethics consent HR41/2014.

Table 3: Research Participant Demographics

Nationality	Name chosen	Age	Education level	Migration
Chinese	Sally	30's	Tertiary University	2007
Malaysian Chinese	Lauren	50's	Tertiary VET	2007
Indian	Jennifer	60's	Tertiary University	1971
Chinese	Lei Mai	30's	Tertiary University	2009
Singaporean	Mary 1	40's	Tertiary University	1986
Indonesian	Teleia	20's	Tertiary VET	2010
Indian	Joan	50's	Tertiary University	2000
Indian Sri Lankan	Rachel	60's	Tertiary University	1996
Indonesian	Hani	20's	Tertiary University	1999
Indonesian	Mei Lee	40's	Tertiary University	2011
Malaysian Indian	Tess	40's	Tertiary VET	2007
Filipina	Faith	40's	Tertiary VET	2015
Filipina	Jackie	40's	Tertiary University	2007
Filipina	Melanie	30's	Tertiary VET	2015
Indian	Elizabeth	60's	Tertiary University	1998
Singaporean	Caran	50's	Tertiary VET	1996
Singaporean	Nat	30's	Tertiary University	2017
Malaysian	Mel	40's	Tertiary VET	1995
Filipina	Rosa	50's	Tertiary VET	1982
Malaysian	Mary2	20's	Tertiary VET	2010
Singaporean	Marie	30's	Tertiary University	1991
Indonesian	Siti	30's	Tertiary VET	2007

5.5 Data Gathering

5.5.1 Open-ended interview questions

Holloway and Wheeler (Holloway & Wheeler, 2010) describe the interpretivist paradigm of emic research: "centres on the way in which human beings make sense of

their subjective reality and attach meaning to it" (p. 7). Open-ended questions are ones that cannot be answered with, *yes, no, I don't know* responses, they are commonly used in counselling by the person helper to get a fuller understanding of the client's meaning or put their experience into context (Farrell, 2016). *What? Where? When? How* and *Who?* are the most common starting words for an open-ended research question.

The participants all answered the same foundational open-ended questions which looked retrospectively at their country-of-origin experience compared to the in the *here and now* of being in a differing nation and dominant culture: Australia. Participants responses to the questions described how they interpreted, made sense, or did not understand their culture, religion, sexuality and sexual health. The participants could digress into deeper explanations to respond to any question. Audio recorded interviews averaged 1 hour per participant; only two interviews were less than 45 minutes. Audio recording meant less risk of breaching a participant's confidentiality if the contracted transcriber saw an audio-visual recording.

5.5.2 Face to face audio interviews

Audio recorded, in depth, semi-structured face to face interviews were utlilised to gather data from English speaking, adult, migrant Christian women who currently live in Australia. It was hoped some participants would be female medical or ancillary health personnel, female religious leaders within their communities and women who have had substantial contact with their nation of origin's subculture in Australia. A mix of tertiary and less educated women providing a more diverse data base for thematic analysis.

Audio interviews were conducted at community facilities or hired spaces in various suburbs of Perth or via Skype to other Australian States. Audio interviews were recorded on two separate devices, a laptop and a Phillips audio recording device; this ensured if one device failed, the recording would not be lost, nor the interviews require repeating. A transcriber was employed to produce verbatim Word documents of the audio interviews. External transcription meant that the interviewer was removed from the transcription process, reducing the risk of the interviewer adding to, or removing the participant's perspective on the subject at that time. The transcriber was asked to sign a confidentiality agreement about non-disclosure of information in the recordings.

I uploaded these Word documents into NVivo11 for coding, then read and re read each transcription prior to coding to familiarise myself with the data, the first stage of Thematic Analysis (Nowell et al., 2017).

The participants verbatim data is the measure of the depth of response to the research questions (Palinkas et al., 2015). Participants responded according to their life experience and knowledge; not according to what I expected. Some participants delved deeper into their narratives about sex education and their beliefs, some did not. This is a subjective part of qualitative data; participants respond as they will, and the depth of data relates to their collective narratives aligning with each other.

5.6 Data Analysis Structure

5.6.1 Coding

Saldana (Saldana, 2015) defines a code as follows: "A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (p. 3). This research focused on topical coding in NVivo11 because the questions asked of participants were the same and yet, responses varied for personal reasons of the participants. Saldana (Saldana, 2015) said "Coding is only the initial step toward an even more rigorous and evocative analysis and interpretation for a report. Coding is not just labelling; it is linking ideas" (p. 8). Organising the coded data into groupings of similar ideas reveals the key themes of the participant's responses to the research questions: Identifying patterns and key themes means that some initial codes could become a sub-code of a major key barrier theme. Saldana (Saldana, 2015) separates a code from a theme by saying, "A theme is an outcome of coding, categorisation, and analytic reflection, not something that is, in itself coded" (p. 13).

The most frequent topical responses by participants to the open-ended and clarifying research questions would identify the knowledge, beliefs, actions and attitudes of the participants and their responses would become the initial coding criteria for the thematic analysis process later. For this research, the coding related to topics and ideas the participant's conveyed as answers to questions in the interviews, such as participant's responses to the following general topics: sexuality, sexual health, sex education, menstrual education, women's sexual health, religious influence, cultural

influence, Government services, barriers to engaging with sexual health services, shame or taboo, contraception, STIs, gynaecological cancers, access to sexual health services, treatment preferences, financial cost, public health and media influence.

For example, participants were asked to define what they thought sexual health meant. Responses varied and included referrals to menstrual regularity, not having an STI, engaging in heterosexual sexual activities and not being in gynaecological pain. All these responses were coded under *Sexual Health*, but also under STIs, menstruation, healthy sex and poor sex education. Another example is the participants were asked, 'what women's health or sex education they received?' Responses varied from "none at all," to menstrual education, to how babies grew in-utero (without knowing how they got there), and to not to have sex before marriage (without knowing how sexual intercourse occurred). Coding in this case included criteria for poor sex education, a definition for sexual health, what sexual activity was sexually taboo, menstruation education, how females accessed sexual health services, barriers to help-seeking, religious influences about sex or family influence. Identifying patterns via interrelated codes is where the themes about barriers to their sexual health began to emerge, which is stage 2 of Thematic Analysis: "generating initial codes" (Nowell et al., 2017).

5.6.2 Thematic Analysis

Thematic Analysis is a research analysis methodology that: "is best thought of as an umbrella term for a set of approaches for analysing qualitative data that share a focus on identifying themes (patterns of meaning) in qualitative data" (School of Psychology, 2017). Thematic analysis examines individual audio interviews, focus group data, mass media, academic and government publications and legislation seeking connected or incongruent patterns. Thematic analysis of the participant interview transcriptions utilising NVivo11 software ("NVivo 11 Pro," 2017), involved coding the participant interview responses into similar ideas the participants gave to identical questions then separating out variations: Variations identify patterns or other themes in the coded data.

The emerging themes from the 22 participant's data were collated according to a particular topic of conversation. For example: asking participants to define what women's sexual health meant to them resulted in diverse responses. These were

subjective to the women's sex education in their nation of origin, family and culture. This area of exploration also evidenced linked ideas like taboo about discussing sexuality, shame or menstrual taboo. One theme that emerged early in the coding in NVivo11 was *sex education*: the lack of a comprehensive sexuality education for all participants, inclusive of medical professionals who participated was common. Another early theme emerged from asking the participants questions and coding the narratives was about having nobody to ask questions of about sex and their health, even in their family; nobody would talk with them about sex and women did not talk with other women about sex or health either. The amount of *silencing of women* imposed by culture, family and religion was a common theme. The process and outcomes of thematic analysis are discussed in more detail in the chapter 6 Analysis.

5.7 Ethical Considerations

5.7.1 Cultural sensitivity and competence

It was paramount to be able to relate well to the women who participated in the research interviews. Knowledge and respect of cultural, religious values and lifestyle behaviours that differ from my own is a practicality of speaking with women about so sensitive a topic. Cultural sensitivity or competence is required for participants to feel psychologically safe enough to answer such questions. True.org.au (True.org, 2018b) defines cultural competence as the following: "the ability to think and act appropriately and effectively when interacting with people from different cultures" (p.1). It was of great benefit that I grew up with Asian people, travelled extensively in Asia and lived short-term in an Asian nation.

Sensitivity to the cultural norms of the participants required I was familiar with Asian cultures, had knowledge of cultural practices, values and beliefs and be able to assure participant's that their identity would not be revealed. This constituted becoming familiar with where the data would come from: the women. Many Asian women are not used to talking about sexual matters (Ussher, 2017). Taking time to grow the depth of a conversation by talking about other women of their culture who may be experiencing a sexual health difficulty and asking participants what that woman would need, created psychological distance for participant's safety before beginning to ask them their personal opinions.

5.7.2 Informed Consent

The ethical principle of informed consent is required to apply to any research approved by a University (Ussher, 2017). Informed consent would be an issue if the participants did not have proficiency in English; hence a prerequisite of participation was conversational English proficiency as interviews were conducted in English. This requirement was noted on all marketing material distributed and discussed with every email, text or phone call inquiry. The research information flyer and letter outlined the topics of questions that would be asked in advance; only women prepared to discuss the matters contacted the researcher.

I verbally explained to each participant at the pre-recording conversation, the nature of the research, how they would be de-identified, the risk of being emotionally triggered by discussing such sensitive sexual topics, approximately how long the interview would take, how their data would be used, stored and later, destroyed. Each participant signed an informed consent form after discussion about the use of their de-identified data. The women all chose their own alternate name. All participants were advised of their right to withdraw from the interview at any time; including immediately prior to an interview and upon completion. Five participants who withdrew their consent to use the audio recording did so after the audio recording and after having signed the informed consent form. None of their information has been used and all their information has been destroyed. My conduct complied with the principles of informed consent according to the Australian Psychological Society (Australian Psychological Society, 2007).

This part of the research is vital in building trust with the research participants and beginning to understand the complexities of their world. Informing them of their rights and providing them with information about their data is like a prequel to stage one of Nowell et al.'s first stage of Thematic Analysis: "Familiarising yourself with your data" (Nowell et al., 2017), except in this case, you are familiarising the participants with what you will do with their data.

5.7.3 Confidentiality

The ethic of confidentiality was applied, as I explained it to all participants prior to recording an interview. All participants were informed on the research participation

information that if they participated, they would be de-identified and that the process would be private and confidential. The level of confidentiality was discussed in detail with each participant prior to recording the audio interview. I outlined to each participant that their confidentiality would only be broken in the case of distress or harm evidenced in the interview, which required calling an ambulance. Confidentiality was defined according to the Australian Psychological Society's Code of Ethics (Australian Psychological Society, 2007). Confidentiality of their audio interview was discussed in view of a transcriber hearing the participant's voices and answers as they transcribed.

The recruitment stage's ethical concerns included breaching a woman's confidentiality if interviews were conducted at a woman's church, her home or where others could overhear the recorded interview. If I visited a church and spoke to the women's ministry group, it could also breach women's confidentiality unless any interested women were clearly instructed to make direct inquiry to myself afterwards, rather than discuss participation in public. As such, research interviews were conducted at my expense, in rented office spaces in various suburbs and in rooms at local government community facilities. This stage of the research was part of familiarising myself with participants before gathering data.

Confidentiality of participant identity included asking each participant to choose an alternate name to be spoken at the interview and used in the transcription thereafter; Surnames were not used in any of the interviews and only exist on the participant consent form, which is securely stored in a locked facility. Demographic information, such as age, was put into categories such as: 18-25; 26-33; 34-41; 42-50; 50-60; 60+, to reduce the possibility a participant may be identified by her nation of origin or age. Applying the ethic of confidentiality meant that all the woman's data; her name, age, identifying information and current, exact professional status had to be de-identified to protect her (De Bord, Burke, & Dudzinski, 2014).

5.7.4 Causing no harm

Civil law applies to all research and human interaction, and it was incumbent upon me to advise all participants of the risk of participating in a dialogue which may potentially cause embarrassment or psychological harm. All participants were advised verbally

prior to audio recording that they did not have to answer questions if they did not want to. I regularly asked participants during interviews if they wanted to continue to answer the questions, which is normative behaviour for a person-centred professional counsellor (Sue et al., 2019). I intended no damage, harm or loss to any participant and if any participant seemed visibly distressed, I would ask what the participant wanted to do. No participant complained about the interviewing, nor refused to answer questions. No participant expressed distress in their interview. I also checked with each participant at the conclusion of the interview if she was OK, needed to debrief or wanted further assistance.

5.7.5 Benefits of participation

A positive ethical consideration I discussed with all participants was the benefit to themselves, their daughters or female relatives of participating in such research and the potential benefit to other Asian migrant women if the research inspired Australian health professionals and Sexologists to purposefully become more culturally sensitive to religious clients in their practice. One of the questions asked of participants inquired about how they would want sex education for their daughters to be different from their experience. Some participants had daughters and expressed how they had handled or would handle discussing sexual matters with their daughters differently than they experienced. Other participants with adult daughters described how their daughters having sex education in Australian schools had helped their daughters to make wiser sexual choices.

5.7.6 Dual relationships

Dual relationships were a concern due to the need to correspond with, visit churches and speak with religious leaders that potential research participants would attend. If a woman said she wanted to participate from a church, it could bring pressure from her religious leaders into telling them what was discussed in the interview if that was expected by the leader. I know health professionals, educators and friends, who were part of Asian churches and cultural groups: I asked these people to distribute marketing material in their religious or other social communities, this placed them in the dual relationship: being a church community member, yet marketing the research program of a friend or associate (Australian Psychological Society, 2007) who was not a part of their specific religious community. This ethical concern, as well as any perceived

conflict of interest was discussed with women who agreed to distribute marketing material for the research on behalf of the primary researcher (*Ethical practice for health professionals*, 2012).

5.8 Research rigour

5.8.1 Exclusions from research participation

Marketing to women at the same University of my research was not conducted due to the likelihood of a biased sample of younger, student women, who were not permanent migrants to Australia. Rather, I utilised Dattalo's approach (Dattalo, 2010) of "*deliberate*", or "*purposeful sampling*" (n. p.) principles to seek Asian Christian women with residential status within Australia as representative of a wider societal sample. I did not use participants from my professional counselling practice due to the ethical principles of *conflict of interest* and *multiple relationships*: I did not engage participants who are close friends for the same reasoning (*Ethical practice for health professionals*, 2012). These exclusions meant the participants did not feel obligated to participate due to the power imbalance of a request by a humanities professional they attended; nor feel obligated to a friend (*Ethical practice for health professionals*, 2012). As prior mentioned, I distributed research participation information to Asian Christian women I knew of who had agreed to promote participation in this research program to women within their own religious communities. The women participants contacted me directly via my email or business phone: this worked well and ensured that the sample remained purposeful, unbiased and more random (Dattalo, 2010).

5.8.2 Member Checks

Member checks were conducted during the interview process via questioning participants about consent to continue, receiving their verbal feedback and once recordings were completed when verbal feedback was sought from the participant to check she thought she was heard accurately. The use of paraphrasing, summarising and clarifying questions to check if the researcher understood what the participant meant, or had sought clarification for, were used with all participants, which was evident in the transcriptions of interviews (Farrell, 2016). No interviewee complained at the end of the interview that they had been misunderstood.

After the coding of transcribed interviews in NVivo11, I conducted a member check

with some of the women who had participated in the research interviews by emailing them a table of the most frequent codes that emerged in NVivo and asked them to respond by email to a few questions:

- Do the coded percentiles reflect Asian women's beliefs and experiences according to your knowledge?
- Do the codes accurately reflect your own experience and beliefs when in Asia?
- What issues did you think would code as more frequent, thus more important?

Their responses will be further discussed in Chapter 6, Analysis. Conducting a member check relates to moving into Nowell and associates stage 4 of Thematic Analysis (Nowell et al., 2017) by which you have already "become familiar" with the data, already generated "initial codes", already "searched for themes" and are now ready to "review" their accuracy before finally "defining" themes and "naming" them, then and reporting on them (p. 4-10). The member check responses are in Appendix E.

5.8.3 Audit trail

Transcribing the participant audio interview responses verbatim is a way for the data to be truly representative of the participant's responses to the open-ended research questions. Hiring an independent transcriber meant the researcher could not amend the verbatim transcriptions to suit her perspective. Coding, described later in this chapter, used the participants data within the context of the researcher's questions, which aim to answer the research questions, a logical process. Keeping all the interview transcriptions, invoices and payments for transcriptions, participant consent forms and member check responses in a secure, locked location or on an external hard drive ensures the safety of the data and for audit of the process if required, or if a researcher wants to replicate a similar research process.

5.8.4 Research rigour specifics

The open-ended questions each participant was asked in the audio interviews were designed to have a participant respond to the research questions and provide contextual information relevant to attaining the goals of this research program; this adds to "trustworthiness" of the data ("What is Scientific Rigor in Qualitative Research – a

definition," 2002-2019); the researcher's perspective is not added to transcription for coding. The list of questions used to open topical discussion with participants and key informants are in appendix C and D.

I hired a transcriber to prepare the audio recordings as Word documents for uploading into NVivo11. This ensured that the only changes made by the researcher to transcriptions were for spelling, grammar, or to enter words of other languages the transcriber did not know. This casual transcriber was not from the same University, nor related to me and signed a confidentiality agreement. I triangulated the participant data with the literature review content analysis data (Nowell et al., 2017). The comparison of themes from data analysis to the content analysis of literature review Endnote references is an important way to identify and validate if the issues and experiences participant's identified matches media and literature narratives. This will be discussed further in Chapter 6, Analysis.

5.9. Conclusion

This chapter has discussed how I set out the research process, ensured it could be replicated, evidenced how participants were recruited, how interviews were conducted and the ethical structures that underpinned the research methods chosen. My process and actions during the process have been outlined: how coding and Thematic Analysis (Nowell et al., 2017) was formulated, was conducted and describes how across chapter 5 and chapter 6 of this thesis, the flow of structural process towards analysis outcomes would be conducted. Description of the process of analysis of the data and discussion of the emerging patterns, themes and outcomes will follow in Chapter 6.

Chapter 6: Data Analysis

6.1 Introduction

Qualitative research relies upon the emic perspective of participants narratives to gather data about a research topic (Palinkas et al., 2015). In this case, this perspective is provided via semi-structured audio interviews of 22 Asian women I asked a set of questions about their sexual education and sexual health: from a retrospective view in their nation of origin and from a current perspective within Australia. The goal was to familiarise myself with the women and gather data that responded to the research questions and that identified patterns of meaning commonly held by the participants (School of Psychology, 2017): Familiarisation being the first step of the thematic analysis process (Nowell et al., 2017).

This chapter will discuss the analysis of the interviews dataset via the use of word queries, phrase searches and mapping of related concepts to explain the interrelated codes and underlying themes via Thematic Analysis (G. S. Guest et al., 2012; Nowell et al., 2017). The key themes that are identified across the data will be visualised in diagrams in this chapter showing the interconnected concepts influencing Asian women regarding their sexual health care and the barriers to them engaging in sexual health self-care. The text will shift between first person and third person because of quotations and my analysis.

6.2. Background

Twenty-two research participants were interviewed, and asked research questions designed to identify the retrospective influences on their sexual health from their nation of origin within the context of culture, religion, education, migration and relationships to find out what has changed, or not changed since migration to Australia. I aimed to examine if the socially learnt (A. Bandura, 2003a) lessons about women and sexuality from the original culture were actively influential on the women's sexual health practices within current Australian context and constitute barriers to engagement with sexual health services.

6.3. Coding and emerging themes

Coding is the second step of the thematic analysis process (Caulfield, 2019). The following table shows the primary codes and sub-codes from transcribed interview data.

Table 4: Primary and Secondary Codes

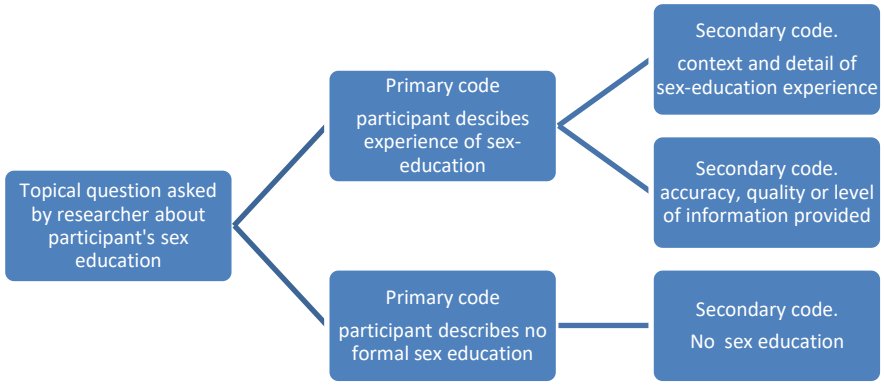
Code	Sub-code
Sex education	Religious sex-education
	School sex education
	Family sex education
Government & legislation	Women's health policy
Influence of culture	Influence of family
Sexual taboo	Shame & embarrassment
	Women's silence
Influence of religion	Doctrine & teachings
Gender-biased society	Male entitlement
Sexually transmitted infections	HPV
Affordability of services	Access to services
	Husband's permission
Health professionals	Women only
	Cultural sensitivity
	Treatment preferences
Sex	Sexual health
	Healthy sex
	Unhealthy sex
Changes since migration	
Barriers to sexual health	No information
Contraception	Family planning
Breast screening	
Women's cancers	Gynaecological cancers
Pregnancy & birth	Midwives
The media & sex	Pornography

The primary code *sex education* was formulated due to the topic of the questions the researcher asked to match the research questions. Every participant commented on their sex education, even if their narratives differed on some points. This primary code covered so many other ideas or beliefs the women held about sex than just the sex education they did or did not receive. Secondary codes emerged relating to the primary code yet showing a specific aspect of the primary code. For example: In the primary code *barriers to help*, a participant mentioned the *language* used by medical professionals her mother did not understand:

> *Some of the terms in English would be hard for them to understand because Indonesian language is so different to English. The way you frame the sentences completely has a different meaning… Imagine then explaining [laughs] anatomy or sex acts or sexual positions, or anything to do with sexual health… You would be misinterpreted.* Hani

Hani suggested a woman who spoke only Bahasa, would not have a word to identify her vulva and this would add to misinterpretation by a health professional in a sexual health consultation. The following diagram outlines an example of the process for primary and secondary coding undertaken for all primary codes, which is stage 2 of Nowell et al.'s Thematic Analysis process (Nowell et al., 2017).

Diagram 1: Coding Process Example



When participants described their experience of sex education, their responses included: no sex education, reproductive education, menstrual education, school-based sex education, misinformation or poor sex education. The path of coding inquiry could, for example, take the accuracy, quality or level of information provided and dependent upon common participant responses, develop a secondary code related to misinformation, thus poor sex education became a secondary code (verbalised 138 times by all 22 women).

In secondary coding for example, the women were clear in describing the poor sex education they experienced. Mei Lee describes her experience of a sex education lesson at Catholic school:

> *It's just only something with the tube on the right…and one on the left, and then something tube coming down in the middle, that's the picture. But they didn't tell where the penis comes from for the seed, they didn't tell that at all, no. Not how it happens.* Mei Lee

When asked if the presenter described women's external genital physiology Mei Lee continued, "So I have no idea, like ok… that's the inside, but where is the outside? No, no! Nothing." Mei Lee described having nobody she could go to ask further questions. Not an uncommon experience as Jackie, a Filipina, also describes, "I remember when I was um, I didn't know anything, even until I was 11 or 12. I didn't know how babies were made." She described something about sex she learnt from graffiti and friends.

> *On the wall of the building… drawings of… inappropriate drawings, and then I wouldn't understand, but then, my friends will tell us, what they were. What they were. Doing sex… That's how people have sex.* Jackie

Not that Jackie looked positively to sex after that. For other Filipinas, sex education is learnt from midwives pre or post-birth as until 2012, no state mandated sex education in schools was available. Faith, a midwife who worked in the Philippines, explained.

> *Explanations…you know, types of women and their bodies, so we teach them…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… No sex education.* Faith

Poor sex education was a common theme that emerged from the primary and

secondary coding of participant's narratives as they all described what little sexual information they learnt and how unhelpful this misinformation or lack of information was. The third stage of thematic analysis is via the process of looking for common connections across the data identifying common core schemas, attitudes and behaviours held by participants within their past and current context, these became the "generated" (n. p.) themes discussed in the following section (Caulfield, 2019).

6.4 Primary and secondary emerging themes

I compiled a table of primary themes based upon the topical questions asked and the responses of the participants. This comprised stage three of Thematic Analysis: identifying *emerging themes* from the data (Caulfield, 2019). Secondary themes were developed out of the participant narratives giving details of their shared experiences.

Table 5: Incidence of Primary Themes and Secondary Themes

Primary theme in **bold** Secondary theme underneath	Total mentions by 22 women interviewed
Sex education	
Poor sex education [quality/accuracy]	138 times by 21 women
Cultural taboo about discussing sex	62 times by 20 women
Religious sex education	73 times by 14 women
No sex education as children	43 times by 10 women
Media and sex education	25 times by 10 women
Sex education of men	21 times by 10 women
Government program	9 times by 5 women
Cultural influence	
Taboo about sex & women	127 times by 21 women
Cultural shame	86 times by 20 women
Male entitlement	74 times by 13 women
Gender bias	34 times by 15 women
Family influence	26 times by 12 women
Religious influence	
Religious shame	69 times by 17 women
Sexual health ignored	49 times by 17 women
Sexuality training	46 times by 10 women
Catholic influence	35 times by 9 women
Gender bias	29 times by 9 women
Forbidden sexually [acts]	24 times by 8 women

Women's value	
Taboo about women and sex	127 times by 20 women
Women not talking	117 times by 20 women
Male entitlement	74 times by 13 women
Bad attitude to women	37 times by 12 women
Male entitlement to sex	53 times by 16 women
Gender bias	34 times by 15 women
Women not valuing themselves	32 times by 12 women
Menstrual taboo	29 times by 13 women
Barriers to help: [women seeking help]	
Women not talking	117 times by 20 women
Cultural issues	79 times by 18 women
Shame and embarrassment	76 times by 14 women
Religious beliefs	45 times by 14 women
Gender of helper	39 times by 15 women
Poor education	25 times by 9 women
Partner / husband	23 times by 9 women
Trust and safety	23 times by 11 women
Professional helpers [desired qualities of]	
Cultural sensitivity	88 times by 18 women
Religious considerations	26 times by 12 women
Safe practitioner	26 times by 11 women
Women only	31 times by 16 women
Gender preference	23 times by 10 women
Sexual health training	15 times by 5 women
Changes after migration	
Change in attitude	36 times by 15 women
More education	26 times by 12 women
Sex education of children	25 times by 12 women
Sexualised society	18 times by 8 women
Better self-care	13 times by 7 women
Sexual health	
(what is) Unhealthy sexually	58 times by 14 women
(what is) Sexually healthy	40 times by 17 women
Menstrual taboo	29 times by 13 women
Pap testing	24 times by 13 women
Treatment preferences	19 times by 7 women
STIs	14 times by 9 women
Meaning of sexual health	14 times by 8 women
Medical practice	14 times by 6 women
Treatment preferences	
Cultural sensitivity	88 times by 18 women
Women only	31 times by 15 women
Religious considerations	26 times by 12 women
A safe practitioner	26 times by 11 women
Sexual health training	15 times by 5 women

It is important to note that not every participant responded to every question, as was her right. Some participants did not know how to answer some of the questions asked, even though they were pre-warned about the topics.

6.4.1 Member Check

A table of the primary codes and emerging themes above was emailed to 12 research participants to conduct a member check (Birt et al., 2016) and ask for feedback on accuracy. Questions the participants were asked and results are in Appendix E:

1. Do the code percentiles reflect Asian women's beliefs and experiences according to your knowledge?
2. Do the codes accurately reflect your own experience and beliefs when in Asia?
3. What issues did you think would code as more frequent, thus important?
4. Any other comments?

Feedback from the five member checks returned affirmed that the themes in the chart above accurately reflected Asian women's experiences. The respondents were all surprised that cultural influences, religious influences and the influence of male partners did not have a higher level of mention in the data. Member check feedback is Appendix E.

6.5 Thematic analysis

Nowell et al., (Nowell et al., 2017) described the purpose of thematic analysis: "thematic analysis… It is a method for identifying, analysing (sic), organizing (sic), describing, and reporting themes found within a data set" (p. 2). I analysed the dataset using word frequency queries, word tree searches and mind-mapping of words and phrases relating to a commonly held idea within or across primary and secondary codes, this process revealed underlying key ideas that connected across the dataset. Themes being defined as the underlying interconnected ideas, beliefs or values that are identified and summarised into larger topical ideas that a group of participants share (Caulfield, 2019; G. S. Guest et al., 2012; Nowell et al., 2017): this analysis was facilitated by NVivo11 software to find the common and interconnected threads ("NVivo 11 Pro," 2017). These emerging themes are listed in Table 6.

In the primary codes *Influence of culture* and *Barriers to sexual health care,* a shared concept was *women not talking*, this was evidenced numerous times by the participants when asked about how women in their culture discussed women's sexuality. Participant examples follow:

> *Oh my goodness! You should not discuss this kind of stuff, because this is so private, embarrassing and taboo and you better just shut up!* Lei Mai

> *I think… it happened to my mum, it happened to the neighbour, it happened to my aunty, they never talked about it, until, until they feel something so painful down there, and that's the time they went to the doctor for help and my aunty dies, because it's already too late.* Mei Lee

> *We don't… or even if we do, it's like an occasional classroom situation, or an occasional sort of a talk, uh given by the community or health expert, if you're interested - go join the talk. There's no discussion about it in public, it's not something you would openly discuss.* Mary 2

This commonly shared issue of women being unable to discuss sexual topics was coded across primary codes; *sex education*, *cultural influence*, *women's value* and *barriers to help* as well as in secondary codes. This common thread of meaning across the coding became the emerging theme *silence of women*.

The process of distilling coded data into a singular shared concept is how thematic analysis was conducted with the NVivo coded data as shown in diagram 2 below. Each primary and secondary code underwent the same distillation process. Diagram 2 shows the process of generating themes, which is step four of Thematic Analysis process. Thematic Analysis steps five and six, *defining and naming themes* and *writing them up* (Caulfield, 2019) comprises the next sections of this chapter (Nowell et al., 2017).

Diagram 2: Example of Process of Identifying Themes from Primary and Secondary Codes

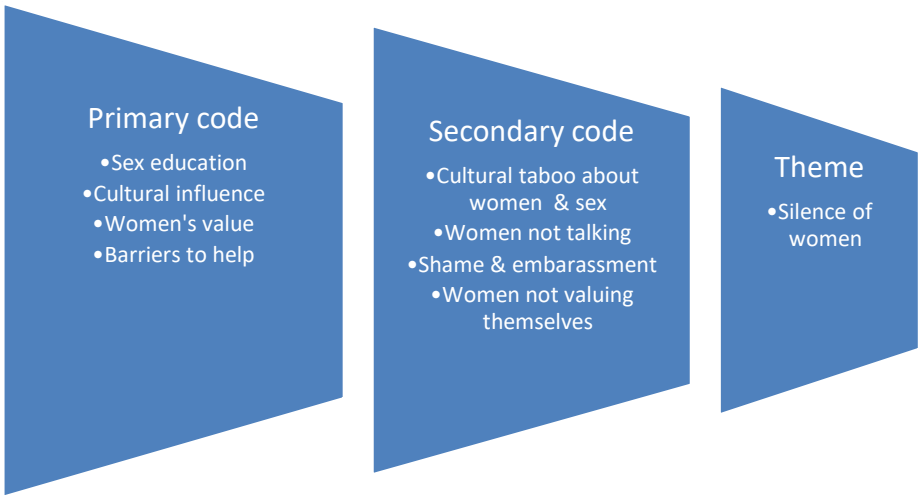
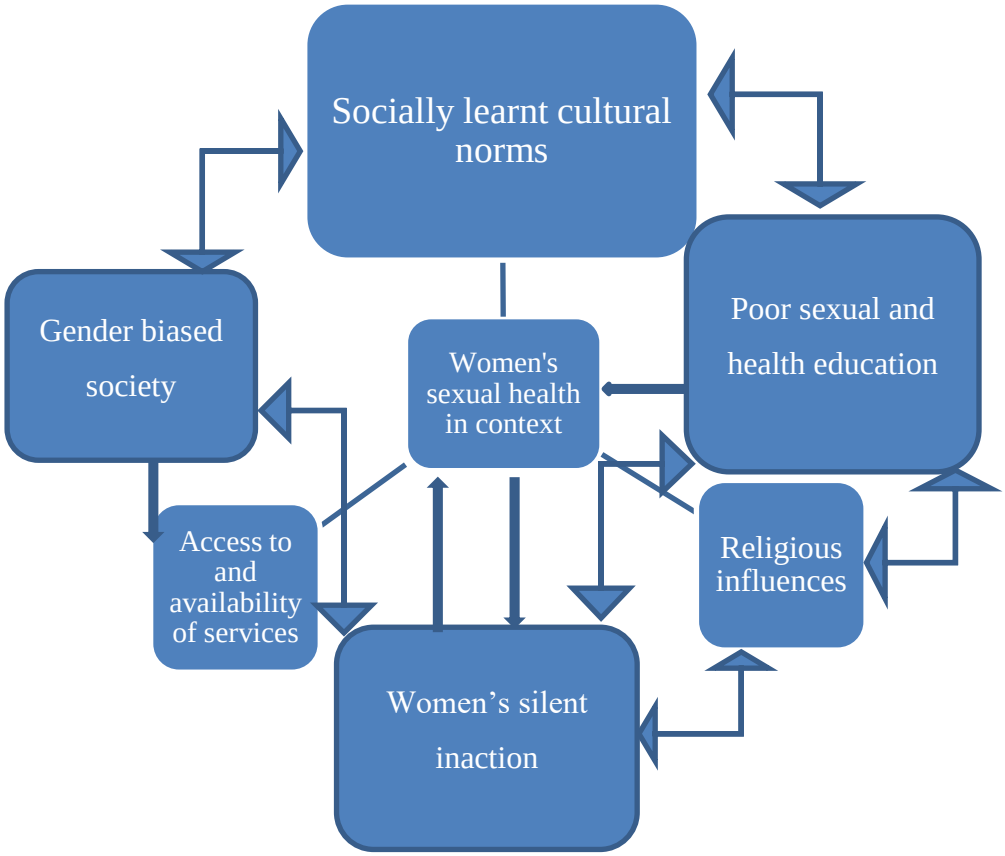


Diagram 3 illustrates how Asian women's sexual health exists within a complex context identified by the primary and secondary codes; no woman was separated from the context of her culture, beliefs and relationships. Asian women are generally from collective cultures where the individual is not as important as the cultural people group she is part of (A. K. C. Leung & Nakayama, 2017). Bandura's theory of personal and social change assumes that a woman from a collectivist culture may see her needs as secondary to those of community leaders (men) or her children (A. Bandura, 2003b), the analysis may validate this as a key barrier to migrant women's sexual health self-care. The key themes related to Asian migrant women's sexual health and the barriers to her engagement with sexual health services are interwoven within this social system.

Diagram 3: Participant's Sexual Health Within Context



The differing sized symbols represent the incidence of the mentions by a participant; the larger the symbol, the more it was mentioned. Further detail is provided in an article which is part of this chapter. The following sections describe the key themes emerging from the analysis.

6.5.1 Ignorance about sexual health

In the interviews, participants were asked what sexual health meant to them and how they would describe it. All but two of the women described sexual health as related to reproduction, the ability to have children, or not having problematic menstruation. This shared meaning or definition meant they had complied with the cultural norms of women's role and value defined primarily as wives and mothers, not as sexual beings, with a right to know about their physiology and sexual capacity. Bandura's theory (A. Bandura, 2003a) applied in this case as their narratives reflected the cultural taboo of the

primary code from their narratives: social 'taboo about women and sex' aligned with the code 'poor value of women.'

The participant definitions when compared to the WHO definition (World Health Organization, 2013) showed a restricted understanding of sexual health that did not encompass gender identity, gender expression, sexual orientation, sexual activity preferences, informed consent to sexual activity, gynaecological health, freedom from coercion for sex, sexual pain or sexual abuse, freedom from STIs, power to demand safe sex practices and a right to information about one's body and free-will to make choices about one's own sexual activity.

Examples of responses to a question asking them to define what women's sexual health meant to them follow: Hani, an Indonesian woman who has lived in Australia since childhood was the only woman with a reasonable definition of what sexual health meant to her:

> *Women's sexual health… I think it has a stigma of being just about sex… the sex side of things. For me personally it's more than that. It's the biological and anatomical side of my body that makes me a woman 'by the books' essentially… the reproductive health, things like menstruation, periods, um… all to do with the reproductive system, but more than just the sex side of things… to do with education of STIs and getting checked up on regularly.* Hani.

Hani's definition did not however, cover sexual orientation, gender issues or informed consent as the WHO definition does. Mei Lee, another Indonesian woman of an older generation described her version of sexual health: "If you're healthy sexually, it means you have kids. So, if you have no kids it's not healthy… Sexual health for Indonesian, it means having kids."

Caran, a Singaporean woman's definition ties into the Singaporean emphasis on population control: "Well I think they would think of birth control… They would think of, maybe sex education and general guidance in boy-girl relationship, I think that would be under sexual health."

Nat, a Malaysian Chinese woman's response evidences the cultural taboo about using

correct anatomical language in describing sexual health of women: “They might relate it back to physical health. And physical health of the private parts, I guess… because I think if it’s working fine we don’t do anything about it, if it’s not hurting we just assume things are ok.”

Teleia’s response described problematic gynaecological health issues:

> *Women’s sexual health, um I think my mum, or my grandmothers would think more in terms of do you have cancer, or like tumour or cyst, in you know, your ovaries, or um, uterus, that kind of stuff? So if you are clear of those things, then you’re healthy… Like, um, cyst or tumour found in their reproductive organs, um, yeah probably more in those areas, not so much um STD’s or anything like that.* Telieia

These quotes highlight that the women who participated in the study had a poor definition of what sexual health is. Physical or reproductive health and absence of pain or disease is what the majority suggested sexual health was. This is at odds with the WHO definition of sexual health which covers issues of pleasure, consent, sexual rights, diverse sexualities, contraception, family planning and gender identity (World Health Organization, 2013).

Using the process outlined in Diagram 2, ‘Ignorance about sexual health’ became a theme because women’s sexual health relies upon sex education within societies that value, educate and empower their women, having governments that facilitate access to funded women’s health services and provide accurate sexual health information. Asian governments need to address cultural issues of male entitlement and control of finance. Without such change to wider cultural norms, women will not value themselves enough to advocate for better sexual health.

6.5.2 Poor sex education

When participants were asked about their sex education, the majority explained a limited sex education, generally not provided by a parent, not even their mother or an aunt. What culturally approved sex education they received in school or church, focused upon abstinence from sex until they married, without any description of how a woman’s sexual arousal occurred, what to do if sexual activity was painful or how to have sexual

intercourse: safe sex was not discussed, nor was the risk of STIs. This constituted a sexual abstinence education, not a sex education. Women's sex education presented sex for women as a functional, reproductive thing, with sex being something their husband was entitled to, which if not given, could provide a rationale for him to have sex with somebody else.

Participant's sex education did not discuss genitals using correct biological names, when ovulation occurred, how sexual intercourse occurred, types of contraception or birth control, female pleasure, orgasm, safe sex, oral sex, non-penile-vaginal sex acts, how STIs are transmitted or sexual orientation or diverse genders. The Asian doctors and nurses who participated in the research interviews said they found out about sex and sexual health during their tertiary studies.

The secondary codes about sex education were: cultural taboo about sex and women, religious sex education, sex education of men, media and sex education, adult sex education, educating self, peer sex education, menstrual education and family sex education. All codes seemed based upon a deficit of accurate sexual information, or provision of sexual misinformation via pornography. 'Sex education' became an emerging theme with many related sub-themes.

Jackie, a Filipina woman described the lack of sex education within her family and the taboo of women speaking about sexual matters: "My mother never spoke *anything* to me. My grandmother never spoke *anything*. I was not told *anything*, even about my period. Not by my mother, neither my grandmother, nor my sister."

Hani described how a male high school teacher misinformed the students: "He didn't actually know… he didn't say yes or no… he didn't actually know that the clitoris wasn't part of the vagina [giggles]." This was in an Australian High School setting. Mei Lee's Catholic School experience was mis-informative too:

> *Uh, they just, um, show us a picture, of the women's reproductive organs, and then they explain: 'yes, this is the uterus and birth canal for the baby,' but they didn't explain, how could a man and woman make love, so I had no idea about where the baby comes from until I was about 28 years old… they didn't speak in detail about sex.* Mei Lee

Mei Lee further described her Indonesian experience of sex education: “Women treated like they don’t need to know… women have no sex or sexual health education.”

In Singapore, sex education seemed to have a differing focus, as Caran explained: “Maybe dating… maybe… maybe, family planning for marrieds…. yeah, in terms of uh, how you would respond to healthy dating, but not like the pleasure of sex, no, nothing.”

Sex education in these Asian women’s experience seemed focused upon sexual abstinence for women, without the women knowing how to have sexual intercourse. Sex education was often confused with menstrual education. The focus for women’s education was reproductive function and sex being an activity engaged in for male pleasure, with little knowledge provided of right to consent, safe sex practices, sexual orientation, gender diversity, women’s physiological function, sexual arousal or women’s pleasure.

6.5.2.1 Menstrual education. A lot of the participants seemed confused between menstrual education and sex education, often responding with menstrual information to a sexual education question. This may be due to the cultural shame assigned to discussing women and sex, even by women, compared to the reality of women having to deal with menstruation; this topic being the only discussion or information involving their genitals.

Jennifer, an Indian woman described how confusing and difficult it was for her to understand the menstrual education she received at school.

> *I just started bleeding once… uh one day, and I was wondering what the heck is going on, and I started wearing two and three panties… and in school, um, I think my uniform got stained, or something, and then my mother noticed it, and then she said to me, that you have to ‘wear this so and so’ thing, and I said why? And she said, you just wear it, you’re going to get this every month… That was my period’s education… That whole sex-ed thing was given for two hours in Marathi. The only reason I knew it was on sex-ed is because she flashed a sanitary pad at us.* Jennifer

Jennifer described a belief that menstrual hygiene education was sex education, an idea

held by eight participants who responded to sex education questions similarly as it was the only information about their gynaecology and bodily function they were provided.

What became evident was the lack of a basic sex education disempowered the women and put their sexual health at risk because they did not have the necessary knowledge about their bodies, safe sex practices, STI prevention and consent. Many had little knowledge of types of contraception or birth control that was available; inclusive of two retired Doctors. 'Poor sex education' became a theme due to the constancy of its mention in the data and its relevance within primary and secondary codes.

6.5.3 Cultural influence and shame

'Cultural influence' was a primary barrier code as the research questions were designed to identify the cultural influences acting as barriers for Asian women engaging with better sexual healthcare in Australia. The secondary codes developed out of participant responses were: Taboo about sex and women (127 mentions by 20 women), cultural shame, which included the influence of cultural leaders and cultural expectations (86 times by 20 women), male entitlement (74 mentions by 13 women) which included male entitlement to sex (53 mentions by 16 women) and gender bias (34 times by 15 women), family influence (26 mentions by 12 women) and changes to culture (18 times by 9 women).

When asked about the influence of their culture on themselves and their sexuality, a secondary code 'taboo about sex and women' became evident. The following participant quotes document the influence of cultural taboo about women and their sexuality.

> *Yeah, yeah. Oh, very much, I think uh, women have been raised like that, in the Asian culture*. Caran

> *I think you have to be very careful as to who you talk to and where you go… for the sake of, to preserve your reputation and the reputation of your family.* Hani

Faith, a Filipina midwife explaining difficulties of teaching pregnant women about their bodies and sex.

> *It's not, uh, different religion, but some sort of taboo. Sometimes when we*

were explaining about it, they're [patients] laughing at us… you know, the explaining of internals, sex and contraception. Faith

Other secondary codes regarding cultural influence were 'male entitlement' and 'gender bias' regarding women having sexual information or accessing sexual health assistance without a man's permission. This male control over women's health within cultural power structures like government, religion and family is dangerous for women in that they have no freedom to seek knowledge or medical assistance on for their own benefit. Examples follow:

Because that's what I learnt from my culture, women… asking for sex is a big, big NO, it's taboo, it's embarrassing, you're a maniac, and then the woman, it's not important when you have orgasm or not. Mei Lee

My husband wouldn't trust me with a male gynaecologist; he wouldn't want that… I was seen exposed by another male. He wouldn't trust the male doctor or wouldn't trust the situation. Nat

Jennifer described an Indian and Nepalese rural cultural context to women's initiation into marital sex.

The traditional, the indigenous Indian woman, the local woman, for example, she will marry, and they marry according to the stars… they will have intercourse in that marriage, the day of the marriage, and it's left up to him if it's important for her to know more, or if she's frigid, or whatever problem, that would come out later, and not even be spoken of. Jennifer

6.5.3.1 *The influence of family within culture.*

The secondary barrier theme of 'family influence' demonstrated how cultural influences are transmitted. It is important to note that Bandura's theory (A. Bandura, 2003a), places a lot of power in cultural and familial structures as transmitters of what is acceptable or unacceptable to know or do. For example, who talks to whom about sexual topics:

Because their level of sex education was very limited; it was not seen as essential self-care because the family was more important than self. Rachel

Hani, an Indonesian migrant explains the systems of power and influence in her family

of origin.

> *The boundaries and respect between generations there… There's this hierarchy with family and elders in Indonesia… But mum's side of the family is a trickier situation, there's this stern matriarch Grandma, if Grandma found out what I'd been doing, there'd be trouble*. Hani

> *The Indian women, it's very much so that, if grandma or the elder matriarch of the family says this is ok for me to do, then it's ok to do it. Its ok for me to go get a pap smear, breast check…. It's ok for me to talk about contraception, its ok for me to talk about sexual development with my daughter, but if my… the matriarch says no, it's not going to happen.* Elizabeth

The influence of culture on gender roles for the women participants seemed all-encompassing. It covered their attitudes and actions to self, other women, family structures, societal leadership and maintained the gender bias and male entitlement in the social and political arenas: most political representatives in Asian nations are male. The World Economic Forum's 2020 Gender Gap report indicated all the Asian nations of this study had poor or very poor political representation or contribution by women (World Economic Forum, 2020): The cultures are gender-biased to males.

Culture and family taught participants women were not to be assertive or independent, unless they were Singaporean. Women were silenced by cultural norms that those in societal and religious power, generally men, enforce. The culturally and religiously reinforced roles of women as child bearers and mothers who rely upon men, or elder women for permission to seek health care, to not to talk about themselves or ask about their health concerns keeps Asian women at risk of poor sexual health, death from gynaecological disease and ashamed of wanting to know more: 'Cultural influence and shame' silences women and was evidenced across the data, thus is a key barrier theme.

6.5.4 Low value assigned to women

The primary code 'women's value' grouped together how culture, religion, men and women valued women. Within their cultures, the participant's identified women were considered worth less than a man, silenced within society and socio-political realms. The secondary codes: '*bad attitude to women, male entitlement, gender bias, menstrual taboo*

and the link to *cultural taboo about women and sex'* meant it was not only the culture that silenced women, or the religion: the women stayed silent and did not ask questions amongst each other. When women participants in the research talked about their sexual health or were asked questions about it, the women said women do not talk with other women, even in families, thus the value of a woman's opinion, question or right to know was maintained at a low level in society, even by women, evidenced by the following comments.

Jennifer, an Indian woman outlined:

> *I wouldn't ask my mum that, like even like before I got married, I wouldn't really ask her about contraceptive, sex how-to or whatever.* Jennifer

> *It never gets discussed…. It's like… we women don't talk about it.* Mary 2

> *Because nobody would talk to me about that topic. Even like in the dormitory when… in the university, we don't really talk about, you know, things like that, even with our closest friends.* Jackie

Joan, an Indian migrant woman commenting on her mother and women in her family discussing sexual topics:

> *No not really. It, very interestingly, absolutely nothing, and what I had got, was um, statements like, 'keep yourself pure', um, yeah, they were random statements, there was never a sit down, 'I need to talk to you' thing. That never… that never even happened later.* Joan

Even in Singapore, it was not common for women to discuss sexual topics until recently. If you wanted information, you had to find it yourself.

> *We don't… or even if we do, it's like an occasional classroom situation, or an occasional sort of a talk, uh given by the community or health expert, if you're interested - go join the talk. There's no discussion about it in public, it's not something you would openly discuss… I've never had my mum talk to me about sex [laughs] even up until the time I got married. I've never had any discussion with mum.* Caran

How women valued themselves seemed linked to complying with cultural norms that their gender-biased society of origin reinforced. Apart from Singaporean women, the participants discussed being reliant upon their father or husband for finance and permission to access health care in their culture of origin. Hanna, a key informant said: "Because the men then make the decision, about 'will we go to the hospital or not, will we go to the doctor or not."

Elizabeth, a doctor who worked in Asia commented, "They won't have always told even their husband they are ill, in pain or the real reason for seeing a GP".

Jackie commented that a woman's value in her society and culture could also be defined by her ability to have children:

> *No, no they didn't get married, but now I can see that you know, when you're a spinster in the Philippines, it's a little bit, you know, you're a second-class citizen, you… like… something is not right… you know, and I… the main reason I see is because then she won't have sex or children.* Jackie

If a younger research participant asked anybody for sexual information, it would be a young woman and a peer. A problem with young women relying upon peers for sex education or sexual health information, is that peers can be misinformed themselves by media, pornography, gender stereotypes and religious ideology (Chu, 2017). As Yang (Hsing-Chen Yang, 2014) discussed: "Students view sexuality education classes in school as useless and 'nothing like real life' and they make up for this by learning about sex on their own, through their peers, mass media, pornography, and their own sexual experiences" (p. 50). This attitude is typified by the following comments.

> *I would say yes, I remember, because one of my roommates was a Filipina from Hawaii, she was there as a temporary intern and she had a boyfriend, so we would talk about dating.* Jackie

> *And my mum said to me, 'oh,' she like; paused for a long time and then she said, 'do you know, um, where baby comes from?' I'm like, 'yes I know!' My mum said, 'how do you know? I never told you!' So awkward…. I'm like, 'come on, friends do teach me things', and, and then she's like 'oh ok, good.'* Sally

Asian women did not talk to other women about sex, their sexual health, sexual problems, or ask mothers, aunts, sisters and especially men, questions about sex or sexuality, yet their value in society is defined by men, sexual availability and childbearing: it is contradictory. Women not talking with other women about sexual health matters that could cost a life is a deficit to a nation and culture; as is women dying from ignorance about their bodies and sexual health issues like STIs, breast and gynaecologic cancers.

An Asian woman's value seemed to be defined by anybody but herself. This pattern of not valuing women and women not valuing women is evidence Bandura's Theory of personal and social change principles apply within this cultural expectation of non-assertive compliance by women in Asian nations (A. Bandura, 2003a); cultural and religious pressure reinforcing that women are submissive to men, have less social power and be non-assertive and quiet, as Lau (Lau, 2016) wrote about poor sexuality education in Malaysia and Singapore: "Stereotyping was also common as women were depicted as passive, men as predatory" (n. p.). 'Low value assigned to women' is a barrier theme.

6.5.5. Sexual health in context of beliefs

The women who participated in the research found it easier to describe what was *unhealthy* sexually compared to what was *healthy* sexually. Of 22 participants, 4 women did not have an answer for what was sexually healthy: One of this research program's goals was to answer this question. A lot of the women's narratives linked to cultural or religious teachings that forbade certain sexual activities or sexual orientations which became secondary codes to the primary one. 'Healthy' or 'unhealthy sex' linked to coding within '*poor sex education, cultural influence, religious influence* and *women's value*.'

Examples of what participants described as 'sexually unhealthy' ranged from sexual play with a partner, self-pleasuring one's genitals, to sexual touch of someone's sexual organs, to sex outside of marriage, to same-sex sexual activity, sex using objects or with animals and included viewing pornography. These participant responses are important because they reveal the participant's beliefs and values about sex and if their religion of choice, Christianity, has been influential on their sexual activity. Their responses answer the question about cultural or religious influences on their sexual health; one of the research goals.

I don't have a great tolerance for same-sex because the bible teaches me it's not of God. Mary

Adultery, pornography, perverted sex not involving a man and his wife. Anything that is not between a male husband and a female wife is not sexually healthy. Rachel

Masturbation is absolutely a frowned upon thing: Absolutely. Because it is inciting… unpure thoughts [laughs]. Impure thoughts and sexual misconduct [laughs] you shouldn't do those things as a youth unless you're married. Hani

Nothing. Not allowed... it's taboo… do not let anyone touch your body, until you are married and only your husband can do that. Only your husband can do that… you mean touching yourself? NO, it's not done. Joan

Caran, a Singaporean Chinese woman described unhealthy sex as the following:

So, for example, premarital sex, adulterous relationships, um… all forms of sexual activity… And uh, homosexuality, behaviours and yeah, the other forms of uh, sexual expressions that are… that are unhealthy. Uh, sex between men and animals, I think there was a reference to that… all perverse sex acts… incest is forbidden. Caran

Mei Lee described unhealthy sex further:

Watching Porn is big no, touching, kissing, and doing masturbation… none of Indonesian woman talk about masturbation… Maybe there is no one, because I, myself, don't do it… But, since I came to Australia, I see a woman going to the adult store, and she buys a…a dildo, or a penis, a rubber penis, and she uses it for herself. That kind of behaviour is completely abnormal. Mei Lee

These descriptions of *unhealthy* sex are very heteronormative and do not conform to the WHO definition of what sexual health is (World Health Organization, 2013). The definitions are undergirded by what the participant's religious teaching permits as acceptable sexual activity, or what the society allowed as sex education. However, to be culturally and religiously sensitive practitioners, we need to respect the right of people to

adhere to their religious convictions, even if we do not believe them ourselves, this is a primary ethical concept; respecting the client's autonomy'(Australian Psychological Society, 2007).

The following participant narratives describe their definitions of what is 'sexually healthy':

> *Mm, for me it's just having one sexual partner. It's just having one sexual partner*. Joan

> *All to do with the reproductive system: but more than just the sex side of things… to do with education of STIs and getting checked up on regularly*. Hani

> *Uh, we are equal partners in a relationship, I have the right to be um, to have equal enjoyment, and I mean I want to.* Jennifer

> *Sex is for pleasure and its part of God's design for humanity, intended for women to enjoy... It's uh, a very intimate part of who we are, as a woman… Not just the reproductive part of life, but the whole.* Caran

Elizabeth, a Christian leader who lived and worked in India and Nepal described healthy sexuality as such:

> *You know, this is the way women are made. Humans we're made to fit together male and female… the creation mandate and people, we are male and female… I mean, if people are having um, struggles with sex and sexuality… To help the women to get over those problems, because... fulfilling one another sexually… is a good thing to happen. You need to be healthy for that.* Elizabeth

What was considered 'sexually healthy' was heteronormative and complied with conservative Christian teachings that sexual activity is restricted to marriage. Intersex, transgender and same sex attracted women exist and some identify as Christian or adhere to another religion. 'Sexually healthy' was defined in all cases as relationship based, even by two participants who were currently celibate. The celibate women expressed they felt *pathologised* by doctors in Australia when visiting for health matters because they were

not having sex and had chosen celibacy. Working with the 'contextual sexual health' of women to improve their sexual health is a theme.

6.5.6 Religious shaming of women

All the women in this research self-identified as Christian. The influence of religious teachings was important to identify in terms of meeting research goals. All participants were questioned about the religious influences on their sexual education or sexual health. The secondary codes revealed the most common influence women received from their religion was 'shame' or 'religious sex education.' Poor sexuality training was also reported. Religious influence was not positive for the majority.

> *The way we were taught about sex in church is that we have sex to bring God's children to earth... But you don't talk about sex unless you are abstaining from it, or you are talking about it as a means of having children.* Hani

> *With uh, religious point also, um, the influence that sex is 'no-no' until you are married, until you are married. I have to marry to have sex.* Joan

> *We do not talk about pleasure or sexual pleasure in the Mormon Church… not in youth. We don't talk about pleasure in the Mormon Church. Just don't masturbate, you don't have those sexual thoughts, you abstain… you abstain.* Hani

Mei Lee described the Catholic sex education she received in Indonesia:

> *They didn't speak in detail about sex. And when they taught/talked about the man's sex organ, they just said, "because God… maybe God is tired, or God is felt… feeling sleepy, that's why the organ of a man, it looks just like a number 1." Said like that, "because God is sleepy," and yeah, that makes no sense… that's what I learnt from the church.* Mei Lee

Lauren, a pastor advocated for better training of religious leaders about sex within the context of their faith.

> *"I think it'd be very useful if pastors… if this subject is part of a pastoral training... Because we have to acknowledge the fact here is that sex is part*

of the human need and of God's design… and if so important, why is it not taken out, it's not even taught." Lauren

Only Caran, a Singaporean woman had a positive experience of sex education in church:

Mm, I was in church early, when I was 16… and so, I think the church was surprising at that time, they did get doctors to come and speak to us so we… we actually get a bit of understanding… the dating, the sexual health issues were raised by some of the Christian doctors in the church. Caran

When asked about their specific teachings from the bible about sex in church, examples follow:

The most I did learn as a teenager was boy-girl relationships, in peer group. They didn't talk about sex, because… no. We talked about temptation, so they said temptation, but they didn't go down to it. Nat

Hani, an Indonesian described her church's teachings about sex from the bible:

They don't really preach much of the details about sexual intercourse or sex acts. Um... the only thing that comes to mind is the women who are ostracised for having sex before marriage [giggles]. The story of Jesus and Jesus saying: 'those who are without sin cast the first stone' because they were stoning a prostitute in the street… the connotation taught to us… that she was impure. Hani

For Indonesian Christians engaging in premarital classes, the Catholic Church forbade discussion with others:

A nun, a priest, pastor or an elder from… from the church [taught]. But basically, none of them is having like a degree in medicine, health or is a doctor, they know nothing, they just know all the Catholic theory… the people are not allowed to tell outside of the class, that's why I don't know… I asked my friend, she said they're not allowed to speak of it outside of the [premarital] class, so I don't know what… what they're being taught about sex. Mei Lee

Women's sexual purity was promoted in church, yet the participants' said the same rules

did not apply to men; this linked the code 'gender bias' to church culture:

> *Yes (laughs)… and it's more forgivable for men to break that virtue… it was something taught to the boys as well... but… you know, when a girl had sex… she too carried that stigma and the reputation attached to it.* Siti

In one church, a participant described how men's sexual sin was minimised and the woman's complaining faced blame:

> *I actually know of somebody… who went to the bishop to report a rape by someone within the church… and they told her they could guide her through the steps of repentance… She's at fault for inciting him to sexual thoughts. Yeah, they questioned her. 'What were you doing? What were you wearing? How did you get yourself into a situation like this?' It was very shaming for her. He was counselled through repentance process. He was never excommunicated: He's still in the church… Some of the things they taught girls are very dangerous… like 'you're in control of the way a man looks at your body.' It's actually a very dangerous way of teaching who is responsible for what.* Hani

The analysis highlighted that although Christian religion bases its value for humanity on all humans being created "in the image God and He created them, male and female" (Genesis 1:27) with *both* being told to have dominion over the Earth (Genesis 1:28), women are not treated as if they do carry that Godly image and are shamed within the church and not included in a gender-biased ministry. Specific criticism targeted the Catholic Church with more than 1/3rd of the women mentioning gender bias in churches and promotion of submissiveness to men. The 'Religious influence: shaming women' was a constant theme from participants.

Some secondary barrier codes were commonly shared across the primary codes, especially within *sex education, cultural influences, religious influences* and *women's value* and the emerging themes are examined in the following sections.

6.5.7 Gender bias in culture and church

Asian nations have a gender bias: a preference for male children and it is males that dominate the socio-political leadership in the cultures under study (United Nations

Development Program, 2018). India and China, specifically, have gender imbalance reflected in their population demographic. China as a result of the preference for sons and one child policy, with 713 million males to 682 million females in 2018 (Textor, 2018). India's gender demographic is changing too, with more males under 24 years of age compared to females (Knoema, 2019). Indians, like Chinese, have preference for sons with both nations permitting sex-selective abortion. India banned sex-selective abortion in 1994 (Parliament of India, 1994).

Even amongst Asian migrants to western nations, gender stereotypes persist (Guo, 2019). The church, as previously mentioned has this gender bias too. This was evident across all primary and secondary codes apart from in the code 'changes after migration' to Australia. Some of the women's responses discussing gender bias and male entitlement follow:

> *In Philippines, boys are more important than girls. The thing is girls can't say no to the father, brothers or husbands… so little power*. Faith

> *So the system, the culture of India seems to… go in favour of the male… women in the dark... of their rights in this regards*. Jennifer

Joan, an Indian woman described the gender bias in her religious culture:

> *Ah, that's something drilled into you from a very young age… however it is a known fact that boys go off and do whatever they want, they might be into pornography, they might be um, they might have several girlfriends and be doing whatever sexual, and it just it's kind of just accepted... families don't make a song and dance about it for boys*. Joan

Elizabeth commented on an Indian practice of blaming women for not bearing sons and what might be a consequence:

> *If you don't present the son, you know, you might get away with it a second time, but to… have not presented a son, is pretty shameful for the woman… and so, women would be put aside for a time, or divorced, um, in the hope that she would get better and give a son. The man might marry again, you know,*

they'd get a better outcome, by having a son, and that first wife, then would be not valued, but devalued in the family. Elizabeth

6.5.7.1 Sex is for men.

A secondary sub-code that emerged from 'gender bias' and 'male entitlement' was that *sex is for men* and men are entitled to it. All but one of the research participants seemed socially and religiously conditioned to agree with this theme. This was evidenced by their narratives in response to questions about the meaning of sex. Participant responses follow:

> *I think that woman are still quite oppressed, despite this ability… this seemingly, uh, equal status that we have in society, and all that sort of stuff, I still feel that woman are still expected to be subjected, you know, we're still expected to pleasure the men*. Mary

> *I would say I've had that from non-Christians… and from Christians as well, like and then the consequence if you don't keep your husband happy is that he'll find another woman*. Nat

The influence of religious teaching about submission and obedience to the husband impact the sexual activity of Indonesian, Catholic women:

> *Um, this is what I know from my country… you have to obey what your husband tell you… if he wants to have sex anytime, you have to say yes… woman should say yes as well, because it's just like part of being obedience toward God, and then, your husband, because the husband is the head of the family, and then so you have to serve, you have to serve your husband, and whether you are ready or not.* Mei Lee

Mary, a Malaysian woman described verbatim the entitled attitude that her brother-in-law, a Christian medical professional had to sex and the attitude of her sister, his wife:

> *I have a sister whose husband; she's older than me… and until today, her husband demands sex every night. And she is like, a grumpy old lady because that is one thing that really pollutes her marriage. She said that even when she had breast cancer and she was in hospital, and she just had this breast taken*

out and she was still on a drip, and her husband was a medical doctor, he signed a release form to bring her home so that he… So that he could have sex. He couldn't bear not to have her. Mary

Rachel, a retired medical doctor, commented about sex in Christian marriage. "Wives must submit to their husband's sexual needs and be unselfish." When asked about stopping sex due to the husband's infidelity, she responded "That depends upon if his sexual needs had been met." This response is an example of religious beliefs overruling a professional's impartial professional judgement. Importantly, if acted upon, a belief that could also put a woman's sexual health at risk. The burden of a woman's husband's fidelity was based upon her sexual performance to please him. Rachel evidenced a socially learnt bias to male entitlement and sexual power that her tertiary education and expertise dismissed.

The narrative of Mary, whose sister's husband, a medical doctor, took her out of hospital when she would have been medicated and in pain, so he could have sex with her for himself, showed that gender bias and entitlement are evident amongst well educated Asian professional men. What societal gender bias does, is reinforce to women that they are of less value than a man and that their role in culture or the church is to meet a man's needs: their health and sexual needs are incidental and under the power of a man to agree to pay for. Cultural 'gender bias' is a key barrier theme.

6.5.8 Money and access to services

Many Asian women live in cultures where they have to ask their husband or father for money to attend medical screening or medical appointments (Carteret, 2016; Hach, 2012; MAMPU, 2019a). This is a deterrent to accessing sexual health or screening services because many women are too embarrassed and ashamed to discuss their genitals, breasts or ask for money especially from their husbands. The quotes shared below from key informants demonstrate this financial dependency.

They're not likely to engage, because they won't know the language used, they won't know the system and they'll be relying often on the husband, who has the job, money and gives consent. Elizabeth

She might try or might not tell her spouse if it would embarrass or shame him. It depends on the level of intimacy in the marriage and if he will listen. Rachel

Asian women who migrate to Australia with husbands and family members retain cultural traditions and social systems within this nation (Mengesha et al., 2017). Practically, this means migrant women living in Australia may not access medical screening or treatment for sexual health issues because their husband or family say no to the finance, or they are too embarrassed to speak about their need with their spouse. Males have a lot of societal power over women accessing money, thus 'access to finance' is a theme linked to cultural 'gender bias.'

6.5.9 Specific treatment preferences

When asked what kind of treatment preferences they wanted, participants evidenced clear ideas about sexual health treatment services as secondary codes. The most significant issue mentioned by the women were *cultural sensitivity* in health practice, with the health practitioner respecting client religion and being a *safe* practitioner to talk with. A woman practitioner was preferred for cultural reasons. The quotes below portray the issue of cultural safety and sensitivity in sexual health practice.

I'm just shy, and I would go to a female doctor only. I would not see, but otherwise my doctor is, my GP is a male doctor. Rosa

Not a man to examine my breasts and my vagina, I'd be going to a female doctor. Jackie

Uh, I would prefer if I have to see a doctor, I would still prefer a female, I wouldn't be comfortable to go with a male. A man only has the knowledge; they don't know how to empathise, because they don't… they are not, they do not have female genitals. Mary 2

But for a skilled professional, I would expect this person to be able to, be sensitive towards our culture and also maybe our orientation, ideas towards sex and then be able to make talking a lot more approachable. Caran

Hanna, a key informant, described how culturally insensitive health practitioners can speak with CRaLD patients in Australia can be a problem. “I’ve seen patient’s go back to their countries for treatment, or non-treatment, rather than stay in Australia, where it’s too confronting.”

Elizabeth, a retired medical professional commented on working with Asian women.

> *You definitely need to be sensitive to that, you know, to go ‘they’re not going to be wanting the same information as I’m expecting an 18 year old Australian girl to want to know, or even a 24 year old.’ Yeah, it’s different… Oh I think um, it’s who makes the decisions. So, so we talk lots in Australia about women’s own autonomy, you know, “it’s your body”. But that’s not the way Asian women work... uh, this is a decision I need to take home, and this… must be talked about, and if the grandmother says “no,” or “yes.” ... What will happen? Yeah, so, that… it will go through the older women to then influence the husband… Or what his mother thinks, it’s often the mother-in-law who decides.* Elizabeth

The influences across secondary barrier themes: ‘poor sex education, cultural shame, religious shame and taboo about women and sex’ and embarrassment about one’s genitals makes Asian women prefer female health professionals if they need treatment, but they want ones who understand the whole context of their lives, inclusive of their religion. This section links with next section and the theme discussed covers both needs of Asian women and sexual health practice and practitioners.

6.5.10 Need for culturally sensitive practitioners

With key informants, I interviewed three medical professionals, all trained as general practitioners; two who worked specifically in Asia and they are retired. One doctor trained in the United Kingdom is still practicing in Australia with multicultural clients. I also interviewed two Filipina midwives and three nurses, all resident in Australia, who are Asian and have worked in Asia.

The questions asked of the key informants related to their observations about Asian women’s attitudes and actions about their sexual health, sexual health screening and how they dealt with cultural or religious barriers Asian women had to coming for

treatment for sexual matters. The open-ended questions asked are all included in the appendices. The themes ‘treatment preferences’ and ‘professional helpers’ had many identical codes.

The most desired quality in a professional helper was cultural sensitivity. Australian medical professionals do not have mandatory cultural sensitivity training, yet this is of vital importance if shy, embarrassed and sexually uneducated women are to engage with Australian health services after they find a *safe* practitioner then they can encourage other women of their communities to engage with a respectful practitioner. Examples of what qualities a research participant desires in a health professional are below:

> *This female doctor based at the campus… at university. I see her if she’s available. She’s incredible. She talks about… I think I could tell her every single detail… about my body or sexual experience… and she’d just explain it to me… She’s one of these people.* Hani

> *Because I’m in Australia… as I told you that this is my body, they don’t really have to respect me and look at me from a religious perspective, but I need them to respect me as a client. And explain well. As …the way the professional, the code of ethics for them, to treat me just like the way they treat any other people, whether Christian or non-Christian. Because that’s what I need… I deserve to be treated in… with the respect*. Mei Lee

> *I’d probably need to know that the male had some specific training or experience in gynaecology… had trained in it or had some speciality or experience in that field… If he can’t align with that experience, he’d have to have studied it. I’d want to be confident that he knew what he was talking about. Would also trust that what I’m telling him is real; trust that the level of pain was what I was experiencing was real: I’m not making it up*. Jennifer

5.5.10.1 *Cultural sensitivity in health practice.*

The following section provides verbatim quotes from the key informants as health professionals describing difficult dialogues and experiences with Asian women patients in their practice. This section is important in that it can evidence discrepancies

between what the research participants say they want from a sexual health professional and what the health professional's attitude, action and service provided was.

It is important to note that cultural sensitivity training is not a key part of medical training in Australia, it is a post graduate training (Royal Australian College of General Practitioners, 2020a) and only for working with Aboriginal or Torres Strait Islander people. The English trained doctor, Hanna did not receive any cultural sensitivity training at medical school, it was only after 2000 that it became an issue of discussion in the United Kingdom's medical training (Dogra et al., 2010). The Sri Lankan trained doctor, Rachel, did not receive cultural training, nor did the Australian trained doctor, Elizabeth.

> *(Consultations) Probably might be faster with me as a woman. It might be 5 minutes into a consultation but… but often I would be quite direct, about that, just say, I hear these things that are happening to you, I wonder if you are having some problems with your periods, or perhaps your having some gynaecological pain'… to go to that point, and if I was comfortable about it, and them accepting that that was something we could talk about, then they were usually fine, then, yes, women would talk about it with me*. Elizabeth

> *People would come in with an issue because somebody else within that community has already felt safe… a little community they talk to each other, one person comes in, they eventually feel safe enough to have a pap smear, have a breast check, go for a mammogram… They find that they are heard, accepted, can be helped, and then they will talk to other people within their community, and who may then also come in.* Hanna

> *I would say that they would need to know, that the place they were coming to was safe, that they could be heard, um, that nothing would be done to them without their consent and with good explanation, that they were in charge, and could disengage at any point that they wanted to… and knew that. That they would need to be educated that the information that they're given be kept private, between them and the health professional… and isn't shared with their family, because that gives some safety… in actually being able to talk about things. Um, but also that IF they wanted the family involved under permission, um, that the*

professional would be willing to allow the family into the conversation. Hanna

Rachel, a retired Asian doctor, commented about the need for Asian women patients to feel safe in a consultation. “It would be safe for Asian women to be with familiar people and people who knew their culture. I think longer than standard Medicare funded appointments would be required to build trust.”

Overlooking the importance of the cultural and religious considerations of the client is short-sighted practice in a migrant nation like Australia. A benefit of being a migrant nation is that overseas students are training as health professionals in Australia in large numbers, 398,563 total overseas tertiary students in 2018 (Ferguson & Sherril, 2019), some who before 2018 became graduate visa workers and applied for permanent residency (op cit., 2019); their stories could be extremely valuable to tertiary training institutions. There is a great need for health professionals to train in cultural sensitivity and various religious sub-cultures to understand why migrant women do not present for sexual health screening or treatment services easily and why if offended by an Australian health professional, they will not return. Male health professionals need to not be insulted by migrant women’s reluctance to see them for treatment, regardless of their expertise. ‘Need for culturally sensitive practitioners’ is a barrier theme.

6.6 Barriers to sexual health self-care

This section continues the sixth stage of Thematic Analysis (Nowell et al., 2017) by reviewing and further analysing the themes that emerged from the data (Caulfield, 2019). The participants were asked what barriers to Asian women engaging with medical or sexual health professionals they could identify and what things would discourage them from going to get professional advice for their sexual health. *‘Women not talking’* was the most frequent barrier, followed by ‘cultural issues, shame & embarrassment, religious beliefs, gender of helper,*’* societal *‘*attitude to women, women not valuing themselves and trust and safety.’ The statistics are outlined in Table 5.

The primary codes of initial barriers to women engaging with sexual health services are outlined in Table 5. The barriers to engaging with sexual health services in

Australia that the participants identified will be grouped into key themes thereafter. The primary codes are as follows:

6.6.1 Women not talking with family or friends

The data revealed a common theme across all the women's narratives. They did not engage in discussion about sex, sex education, sexuality, sexual health issues or raise questions about sex with mothers, grandmothers, aunties or sisters. Women did not talk amongst themselves, even intergenerationally about anything sexual they considered taboo or embarrassing. The only exception was amongst younger women under 40 who discussed sexual issues with peers. The older women participants displayed a compliance with the cultural and religious 'taboo about women and sex' that was culturally and religiously reinforced in their nation of origin's social structures and politics. Of note: none of the nations in this study had a Government Women's Policy with a sexual health action plan other than the Philippines and Singapore. Bandura's Theoretical principle of negative reinforcement applied to these women and they complied with behaviours that will damage their sexual health (A. Bandura, 2003a). Examples of participant narratives follow:

> *I think my mum knows I am sexually active, but we don't talk about it in any detail: There's this underlying assumption: don't discuss that, even though I am happy*. Hani

> *Because nobody would talk to me about that topic. Even like in the dormitory when… in the university, we don't really talk about, you know, things like that. Even with our closest friends*. Jackie

> *There's no discussion about it in public, it's not something you would openly discuss… I've never had my mum talk to me about sex [laughs] even up until the time I got married. I've never had any discussion with mum.* Caran

6.6.2 Shame and embarrassment about women's sexual issues

The women who participated in this research and the key informants all mentioned the shame, embarrassment and anxiety Asian women faced when discussing menstruation, menstrual problems, sexual pain or pain in their genitals, their sexual activity or sexual topics and questions related to these. The women would never discuss such issues in

public, at work, or with a man, even if he was their husband. The social taboo and negative cultural conditioning about women, menstruation and sex made a strong deterrent, increasing the anxiety about help-seeking for sexual health problems.

WASH programs in developing Asian nations are working at a grass-roots level with Asian communities to remove stigma for women and girls about menstruation and hygiene (UNICEF, 2016). This is a start, however, motivating Asian women to not be ashamed of menstruation and sexual issues will take time as the comments below will outline.

> *No one spoke about it… It was… yeah, I mean no one openly said anything, but it's… shame.* Rosa

> *She says, 'that you know, uh, I feel very rejected, I feel very embarrassed, I feel that I'm worthless woman… because my husband can't perform with me [laughs]. Because my husband… can't do sex.'* Lauren

Joan describes her experience after a female GP in India found out she had had sex before marriage:

> *There was nothing else to it anymore, all it did was attach more and more shame and guilt and drove me into a corner… I will safely say that those Asian… 50 and above, who were educated back in Asian countries… it's sin; it's shame. I would say at least 70% are very secretive, are very, you know, uh, shameful, or embarrassed to share in family about such things like sex, yeah.* Joan

Elizabeth, a key informant commented on shame: *"But for the women to actually… to specifically talk about it, women seem quite embarrassed… It's not something the women would talk about easily to anyone."*

6.6.3 Cultural issues about women discussing sexual matters

This section reiterates aspects of the previously mentioned issue of the 'influence of culture' on how Asian women do not discuss their sexuality, sexual activity or sexual health easily. This section identifies what some of those cultural issues are; religious tradition, the low cultural value of women, the cultural reinforcement of women to

prioritise for men's needs first, for women to act quiet, not act demanding and not talk about sexual issues or seek help without their husband's permission. Most of the women who participated also felt they needed to look or act sexy for their husband, yet without any sexuality education to know what that might look like for them; this is a paradoxical situation for disempowered women with little sexual knowledge.

> *They also put it on the back burner... not a priority for the women. They put it on the back burner, they always... even… not only to do with sex, even it's their… even if it's their health. They always put it on the backburner.* Teleia

> *Uh, for the older ones, for the Christian, are very conservative, because we traditional Asians, but today I must say that many of them, I mean the younger ones, is like, ah you know, quite open (about sex), 'ok, it doesn't matter anymore.'* Lauren

> *Asian women of my generation are not very demanding. Maybe they do not like to make a fuss or cause a problem by complaining?* Joan

> *They don't talk about sex openly in Asia. Ok, uh, but they will uh, but they know that they need to bring out their sensuality, they need to… they need to present themselves… but talk about sex, in particular and all those things, is… we Asians don't do that*. Lauren

> *Um, their husbands won't want them to be seen by a male doctor, either, you know, they'll be very unhappy about that*. Elizabeth

The cultural barriers to Asian women discussing their sexual health, even with each other or female sexual health professionals impacts them deeply due to these socially reinforced traditional norms transmitted via family and religion. Asian women who comply with the cultural tradition of not speaking about sexual issues remain ill-informed about their bodies, their need for sexual health checks and are stuck with the man in their life choosing if they can access health checks and have this paid for.

6.6.4 Shaming and silencing religious beliefs

The Christian religious experience of the research participants was varied by denomination and how women in church leadership roles were either accepted or rejected. Only the participants who came from evangelical or Pentecostal church backgrounds attended churches which had women in leadership positions. I had assumed this would be a key to whether the participants expressed the shaming or silencing of women occurring in their religious experience: Not so. The data evidenced that most of the participants and key informants had experienced or witnessed the silencing and shaming of women in their religious organisation. This religious influence affected their ability to speak about sexual health issues, ask for help or speak with a sexual health professional.

> *The older women are less likely to do that, unless um, no, I'll say yeah, they're… They struggle with speaking out.* Rachel

> *Before, as a Catholic, if I can put from scale 1 until 100%) I would put my scale would be 90% disgusted and ashamed about the way religious teaching really shaped me, with what I believe, religion really shaped me with my way of bad thinking*. Mei Lee

Joan, an Indian divorcee who chose celibacy for religious reasons discussed how she felt shamed by medical professionals for that choice:

> *It would be nice to have a doctor who doesn't faint on sight when you tell them you haven't had sex for 20 years. Because mostly, you get that very strange expression: People look at you like 'is there something wrong with you?... people just assume that if you're single, that doesn't matter; you're having sex … I'm extremely weary about telling even a doctor, that I have not had sex for about 20 years*. Joan

6.6.5 The gender of the health professional

As indicated in the above-mentioned sections, the gender of a health professional is a big issue for the research participants, as being vulnerable and embarrassed in front of a woman is more culturally and religiously tolerated for women from CRaLD backgrounds, and more acceptable to their husbands. This barrier reinforces how important it is for sexual health services in Australia to pay attention to the needs of

CRaLD women and provide appropriate services staffed by women. Only one participant, a younger Singaporean, had no problem with a male sexual health professional.

> *I personally would be happier with a female doctor*. Hani

> *It's ok both genders now…[laughs] when I was younger, yeah maybe I would like the female gender*. Caran

Elizabeth, a retired doctor spoke about how women presented in her medical practice.

> *Women tend to like to see women in India or Nepal, so, I got a lot of women patients... And the cultural shame of going and actually having a pap smear, and… and being seen… God forbid by a male, uh, it's… unthinkable*. Elizabeth

6.6.6 Women manifesting women's low status

One of the primary tenets of Bandura's 'social cognitive theory of personal and societal change' (A. Bandura, 2003a) by which a society can change a problematic issue is via developing social platforms, inviting key people from community to bring their thoughts into a forum for discussion about new ways of thinking about that problem issue, then to find new ideas to fix that problem and formulate plans to deal with that problem in society. The outcomes of the forum's discussion must be achievable using the new actions, which when enacted, become the start of social change over time if the political powers of that society act upon recommendations and positively reinforce and promote them. An example is Singapore's 1960 first family planning campaign, which used media propaganda to make contraception and family planning acceptable to many of Singapore's culturally and religiously diverse population (National Library Board, 2015) and involved women engaging with 'reproductive' health checks they would never engaged in previously. The following narratives evidence how the participants discussed or complied with cultural norms detrimental to their sexual health due to low value of females.

> *The thing is, girls can't say no to the father, brothers or husbands, so little power… if you don't have kids, then you're more like, you know, second class citizen.* Mel

> *This is a very common thing… back in those Asian countries, they will tell you, 'Oh, you pick her up from the garbage bin' [a girl child].* Lei Mai

> *They're so used to keeping their mouth shut as Chinese women… and they feel they're… helpless… they feel it's no use to talk about it with their husband.* Mary 2

Elizabeth, a retired health professional, spoke about how cultural value placed upon women, reflects in their value of themselves:

> *In parts of India… is a poor country. People aren't well educated, their own cultural background devalues women… Some women are ashamed of their bodies, their genitals… some women appear to be ashamed of their bodies, or repulsed by their bodies, or think that um, touching themselves in certain places, like breasts, is to be frowned upon.*

Lauren, a religious leader from Malaysia, talks about how she now encourages women to see a doctor. "I tell them this thing… I say that… you know this is here. I say, the past 15 years, I've never heard so much of cancer. Go do it!" (pap test).

Hani, a young Indonesian woman was the only participant who seemed to challenge the value of women in her religion.

> *Some of the things they taught girls… are very dangerous… like 'you're in control of the way a man looks at your body.' It's actually a very dangerous way of teaching who is responsible for what.* Hani

Changing women's sexual health in Asia will require changing how women are perceived in society and developing lobby groups to formulate plans to change women's status by pressuring governments to enact changes to provide sexual health education and health services for women. When women's status is elevated in socio-political arenas, the trickle-down to wider culture can occur, this is what the Global Gender Gap Report (World Economic Forum, 2020), postulates. Nations where women who are statistically equal in political, economic, education and health arenas have more societal value and better health outcomes.

6.6.7 Issues of trust and safety

As evidenced in previous sections, it is difficult for Asian women to trust and feel safe in arenas where they have little knowledge. Asian women exist in cultures where menstrual and sexual taboo regarding women is widespread and they have little power to act for their own concerns because the cultural norms and gender roles make seeking sexual health care exceedingly difficult. For most, it relies upon permission from a man they are uncomfortable talking to about sexual issues. Adding cultural and religious taboo about women talking about sex and there is little space for trust in sexual health professionals to develop or be normative.

A positive thing from the data was the women ministers of religion who encouraged their female parishioners to engage in mutual relationships of trust in which women started to talk about problems they had.

> *And then she says this, you know 'I'm sharing this because I know you for 8 years, you know, yeah, please do not tell anybody, don't even tell my husband.'* Lauren

> *So as a pastor, you know, you sort of visit them and talk to them, and then they, of course they don't open up immediately, but as we talk, you know, as they submit their story once or twice, they trust, they start to open up, you know… This and that, then they start to say ok, 'oh I have this problem'.* Rose

The importance of an Asian woman being able to trust in a health professional or religious leader and having a safe, confidential place to talk about their health and life issues cannot be underestimated.

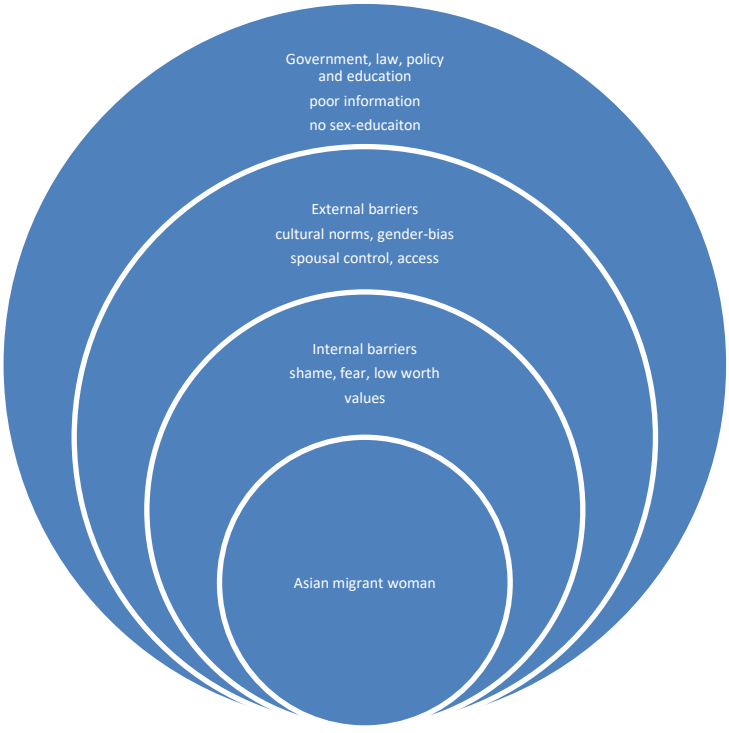
6.6.8 Internal and external barriers

The amount of 'internal' to self and 'external' to other people or society barriers Asian women face when considering accessing sexual health services combine into strong deterrents to engagement with the Australian public health system. 'Internal' barriers such as a woman's anxiety, lack of trust, embarrassment, or ignorance of what may be required of her keep her avoidant of engaging in health services. 'External' barriers like religious or cultural influences, the control of her spouse, financial constraints, and knowledge of or access to women's health services are all negatively powerful.

‘Internal and external barriers’ to engaging with sexual health services are strong deterrents for Asian women (Ussher et al., 2017), thus, are barrier themes.

The cultural norms and values of Asian cultures which devalue women, silence them and discourage women’s independent access to health services without the permission of a male family member are strong, controlling and induce ‘shame.’ Without the time taken to earn an Asian woman’s trust, she is unlikely to easily tell a health professional what her health issue is in 10 minutes, which is the standard medical consultation in Australia (Department of Health & Human Services, 2015). She is also more likely to tell a woman health professional her problems as it is culturally inappropriate to discuss sexual matters with a male, as well as more embarrassing. This raises the question of the time allowed for Medicare funded appointments in Australia for women’s sexual health consultations when the public health system plans for 10 minute consultations (Hach, 2012; Mengesha et al., 2017). There are multiple layers of internal and external barriers to engaging with sexual health services as shown in diagram 4.

Diagram 4: Levels of Barriers to Asian Migrant Women’s Sexual Health Care



6.6.8.1 Internal barriers.

'Internal barriers' are the attitudes, beliefs and actions of the woman regarding her sexual health; these are psychological, belief based and behavioural. These are listed on Table 6.

Table 6: Internal Barriers

Psychological	Actions
Poor attitude to own sexual health	No action to engage in sexual health ca
Poor knowledge of sexual health	Not discussing or seeking knowledge
Negative belief about what might happen	Avoidance
Fear and anxiety	Not attending /avoidance of sexual heal services
Shame and embarrassment	Not attending /avoidance of sexual heal services
Religious beliefs	Not specified

Not discussing sexual matters is a choice, as is ignorance, yet both are driven by 'external' barriers and negative reinforcement. Fear, anxiety and shame are included in this list and these are fed by influential 'external' barriers.

6.6.8.2 External barriers.

'External barriers' include relational, social, political and religious influences, all are powerful influences on the woman's behaviour.

Table 7: External Barriers

Relational	Societal
Husband's permission	No Government women's policy on sexu health
	or sexual disease prevention
Parental permission	Lack of funding for women's health
Family norms & values	Lack of Government provided services
Lack of finance	Societal menstrual taboo

Lack of somebody to talk to	Cultural taboo about women and sex
No person to talk about sex with	Lack of sex education/sexual health educatio
	for women to protect their own sexual health
Relational	**Societal**
	Gender-biased culture/poor political representatio
	Repercussions for women who do not compl
	with cultural norms
	Religious taboo about sex and women makin
	help-seeking in churches unlikely
	Low cultural value of women

Societal and cultural barriers were more numerous than relationship-based barriers. This may be because if a woman's relationships are determined by her family, husband and religion, she may be socially isolated from wider range of social relationships that could be helpful such as women's clubs, support or information groups which are more common in Australia.

6.6.8.3 Government and societal barriers.

'Government barriers' identified in Table 7 can be rectified with planned and implemented women's health policies and practices which cover women's sexual health, not just their reproductive health. The education systems of the Asian nations of this study do not provide comprehensive sex education, or preventative women's sexual health education in secondary schools: thus, it does not appear to be a priority. Asian Governments, other than Singapore and the Philippines do not value women by legislating to ensure women's rights to sexual health despite the lobbying of powerful religious groups. The Philippines initiated government policy, which covers aspects of women's sexual health called the Magna Carta of Women in 2009 (Sastrillo & Babao, 2019), so despite poor infrastructure to meet the Magna Carta's goals, the Philippines has its sights set on women's rights.

6.7. Triangulation with Literature Review data

In the literature review of this research, the key word and phrase search of the Endnote references were initially formulated into a table of key topical women's sexual health issues from 637 references. Early in the research, *men* were mentioned 554 times: At this later date, 712 references were accessed, with *men* mentioned 627 times. Initially, *Women* were mentioned 388 times in the 637 references: later, 442 references mentioned *women*. Given the literature accessed was meant to be focused upon women and their sexual health, the poor mention of women correlated to the participant data in agreeing men have more social, religious and political power in Asia than women because they are mentioned more in women's sexual health articles. The government, cultural norms and religious values of the Asian nations under review keep men's status maintained; thus aligning with Bandura's theory (Albert Bandura, 1971; A. Bandura, 2003a) in which socially transmitted and reinforced values become acted-out by society; in this case, women are not considered as important as men, therefore the society acts that way.

In the early content review, STIs were mentioned 481 times out of the 637 sources. Later, of 712 references utilised, 549 mentioned STIs. Sadly, most of the women interviewed in this research study, some being nurses and midwives, had poor knowledge of STIs, the health consequences and safe sex practices. Australian and United Kingdom trained women had much better knowledge.

Governments of Asian nations other than Singapore, play a large part in reinforcing social taboos about women's sexuality and sexual health. In the initial content analysis, 234 mentions for government (influence or legislation) were found, later, this increased to 263 mentions from 712. Governments have a duty of care to their citizens, women included, yet other than in Singapore, the nations did not have a long-term plan for women's sexual health. They all had 'reproductive' or 'family planning' programs; however, reproduction is not a woman's only function in society: women's sexual health is more than biological function and childbirth. The women did not access sexual health services and were ashamed and embarrassed by their body and its functions. The literature review and participant data align in that without sex education, women's sexual health in Asia is not likely to improve.

‘Sex education’ in Asia was not mentioned a lot in the more recent review of 712 references, rating only 100 mentions in the literature reviewed. This lack of a comprehensive sex education in Asia meant many of the participants disliked sex, endured it without pleasure, believed it was for men and gave sex as a service to their husband. Sexual health was mentioned 131 times in the research resources, yet not understood well by the research participants, even by two of the Asian doctors and some of the nurses who were key informants. The WHO definition is my baseline for comparison; no participant’s description came close: academic references also did not come close, nor did government media.

The silence on Asian women’s sexual health at government, academic and social levels does not normalise the importance of women’s sexuality or health. This silence mirrors the silence of and lack of sex education of the women in this research.

6.8 Summary

The largest influence on women’s sexual health is the cultural context she finds herself in and has been socially conditioned to accept and comply with. Bandura’s theory of social and cognitive personal and social change (A. Bandura, 2003a) negatively applies to Asian nations represented in this study and to the women because they have been socially conditioned to comply with values, attitudes and behaviours of a gender-biased society which are harmful to their sexual health and life expectancy. The women do not have the information to know this or question this. It was evident from the data that religious influence was vastly secondary to cultural influences: A sad narrative for the church was the women’s Christian religion reinforced the gender bias to males of their society; also affirming the sexual taboo about women and devaluing women’s worth.

Any society that devalues women, allows minimal sex education, has few or no women’s health services where sexual health services are provided in an affordable way places its women’s health at risk. A society with the systemic barriers identified in this analysis will evidence high levels of sexual health problems, female specific

cancers and related deaths. In many Asian nations this is the case (Ginsburg et al., 2017; World Health Organization, 2018a, 2020a). Societies that shame women, keep women ignorant of crucial health information, objectify women and treats them as secondary creatures to men and men's sexual needs, abuses women. Women are foundational to the family and nation and need to be valued as such. Without women, you have no nation.

Socially learnt values and norms are not easy to shift even after migration to a new nation (Ginsburg et al., 2017). Australian evidence from research with migrant women by Mengesha et al., concurs with this research program's outcomes that cultural influences are is the largest influence on migrant women's health overall (p. 7):

> *Because they came from different health system(s), where health preventative is not available, (they) normally go to health services when they get sick' (Sam, Nurse). This implies that the individual level experiences of being a migrant can compromises refugee and migrant women's participation in preventive services such as cervical and breast cancer screening despite these services being freely available in Australia* (Mengesha et al., 2017).

This relationship-based view of women's sexual health in Asian nations represented by this research does not allow for women to *own* their bodies, decide what sexual activities they will explore or consent to, choose what contraception or birth control they use and explore pleasure, sensuality and the role of fantasy for self. Sexual health as defined by the WHO (World Health Organization, 2013) is diverse and defining sexual health within a woman's context is vital; it is not just reproductive function or relationship based. Non-heteronormative women exist, some are Asian and some are in the church. This research data did not identify scope for women on the Gay, Lesbian, Bisexual, Transgender Intersex or Other [GLBTIO] identifying sexualities to be well represented. Intersex women were not mentioned at all. Women's genital structures correct names were not used by many academic sources and not by the women participants easily. Some women did not have a word for parts of their genitals in their original language. This language issue needs to change. How can women identify where a problem exists if they cannot name it?

Migrant women do not know what is available for their sexual health, or do not access sexual health services in Australia because they are not used to such information or services being promoted, funded and spoken about without shame. Three levels of barriers get in the way: the *internal*, the *relational* and the *societal*: all must be considered and addressed in any sexual health service provision in Australia for the change to start. Asian Australian women need to have the same access to health services as anybody else; it is a basic human right.

The following two articles for publication reflect aspects of data analysis and outcomes of chapter 6: one article examining barriers to sexual health from the perspective of the participants and the other article examining barriers from the perspective of the key informants.

Publication 3. Chapter 6a

Asian migrant women identify barriers to engagement with sexual health services.

This article has been submitted to Journal of International Women's Studies

6a.1 Abstract

Asian nations are the largest migration source to Australia in the past 15 years. This research examined barriers to engagement with sexual health services by women from China, India, Indonesia, Malaysia, the Philippines and Singapore. Semi-structured audio interviews were conducted with 22 women asking open-ended questions about sex education and sexual health practices. Thematic analysis was conducted with data to identify barriers to engagement with sexual health services. Barriers to engagement with sexual health were socially learnt and reinforced. Taboo and shame about women's sex, sex education and lack of sexual health information in the nation of origin was reinforced by societal gender-bias maintaining the low status of women who did understand sexual health.

Sexual health professionals must adapt to Culturally Religiously and Linguistically Diverse (CRaLD) clients in service provision. A rights-based, person-centred service, connected to cultural groups could help migrant women engage in preventative sexual health practices.

Key words: Asian women, migrants, sexual health, health practice, cultural sensitivity

6a.2 Introduction

This article reports on outcomes of a qualitative research program which is a chapter in a doctorate in public health. This research was approved by Curtin University's Ethics Review Committee. One research goal was to identify, from an emic perspective, what barriers Asian migrant women identified needing addressing before they connected with sexual health services in their nation of origin and within Australia.

Another goal was to use the data and outcomes of thematic analysis to inform Australian sexual health professionals about the barriers the Asian women identified so sexual health professionals could amend their practices to meet Asian women's in culturally and religiously sensitive ways. Mengesha, Perz, Dune and Ussher (Mengesha et al., 2017) indicate change is reliant upon the service provider's

willingness to adopt aa person-centred way of practice.

Semi-structured interviews (Caulfield, 2019) of twenty-two Asian migrant women were conducted using identical open-ended questions to identify barriers to sexual health they faced and what would help them to engage with sexual health services in Australia. Thematic analysis of the data distilled the barriers to core variables discussed in this article.

6a.2.1 Background

Other than Singapore, the five other Asian nations in this study: China, India, Indonesia, Malaysia and the Philippines, do not prioritise government funding for services for women's sexual health education or health screening services. As Asian people are the largest source of skilled migration to Australia within the last 15 years (Australian Bureau of Statistics, 2019), this makes this research timely in terms of developing preventative public health programs targeting migrant populations. Culturally, Religiously and Linguistically Diverse (CRaLD) women for Asia are current Australians.

Asian nations are conservative in literature or mainstream media presentations of women and their sexuality, with censorship of sexual information about women common (IMDA, 2020; Siddharta, 2017). Academic literature from Asia or about Asian women discusses women's *reproductive function, fertility* or STI risk (Chu, 2017; Emilia, 2019; United Nations, 2020) rather than sexual health as defined why the World Health Organization (WHO)(World Health Organization, 2020b). Migrant women normalised to poor education about women's sexual health, having little knowledge of their bodies are unlikely to engage in sexual health services within Australia (Asif, 2018; Mengesha et al., 2017) thus, not be represented in the government statistics on screening for women's cancers or STIs. CRaLD women do not present for sexual health consultations in Australia without great anxiety and shame (Mengesha et al., 2017) due to culturally embedded taboo about women and their sexuality (Hach, 2012).

6a.2.2 Aims

- For Asian women residing in Australia to identify barriers existing to themselves

or women of their culture engaging with sexual health services in Australia.

- To use the outcomes of thematic analysis to inform Australian sexual health professionals.
- To promote amendments to sexual health service delivery to meet Asian women's needs in culturally and religiously sensitive ways.

6a.2.3 Theoretical framework

Bandura's *cognitive and social theory of personal and social change* (A. Bandura, 2003a) was hypothesised to operate in the society of origin via negative reinforcement of women's sexuality within cultural context, resulting in a socially reinforced lower status of women. Negative social reinforcement maintaining the cultural taboo about women's sex education, resulting in a society overlooking women's sexual health. It was hypothesised that the barriers to sexual health participants identified operating in their nation of origin would align with their current barriers to engagement with sexual health services in Australia because the negative reinforcement they had experienced within culture, media and education became normalised and internalised (Francesca & Stevens, 2018; Multicultural Women's Health Australia, 2016a). Bandura's theory postulates changing the status quo occurs when the culture or society makes a desired change the focus of media and marketing to normalise something new as beneficial to all (A. Bandura, 2003a).

6a.3 Methods

Qualitative research investigates the lived experiences of people, Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood would say a 'purposeful sample' (Palinkas et al., 2015) of people are being studied. This research topic is best suited to the emic approach, seeking rich descriptions and narratives from women to explore and analyse their experience, rather than a quantitative survey with no options for participant responses not matching the researcher's scales or questions.

In qualitative research, Nowell, Norris, White and Moules (Nowell et al., 2017) say a sample size of 20-25 people is considered a reasonable sample size to gain 'rich descriptions' of participant data and reach data 'saturation' (Mason, 2010), by which no new information is forthcoming. This research program's sample matched these qualitative criteria. The participant data being the foundation for 'Thematic analysis'

(G. Guest, K. M. MacQueen, & E. E. Namey, 2012), to interpret the data and identify the common themes and patterns of meaning the participants held about their retrospective and current barriers to engagement with sexual health services in Australia (Liamputtong, 2019).

Open-ended questions for semi structured audio interviews (Caulfield, 2019) were developed and participants received notification in advance of the question topics so they could give informed consent, a vital ethical practice in sexual health (IWHC, 2019). Questions were designed to facilitate discussion about the participant's sex education experience, cultural or religious taboo about women and sex in their nation of origin, observations and experiences of sexual health problems within women of their social circle, problems with access to sexual health services in their nation of origin, what cultural taboos they could identify hindering women's sexual health, their physiological knowledge, their personal beliefs about sexual issues related to women and if their sexual health practices had changed since migration to Australia. Ethics approval was provided by Curtin University and the Australian National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research was utilised as a standard of practice framework (NHMRC, 2018). All participants were deidentified.

Semi-structured interviews (Caulfield, 2019) of twenty-two Asian migrant women were conducted using identical open-ended questions to identify barriers to sexual health they faced in their nation of origin and what factors would help them engage with sexual health services in Australia. English speaking migrant women from six Asian nations, four being substantial sources of migration to Australia (ABS, 2021) were recruited and consented to participate. Semi-structured audio interviews were conducted with 22 women from China, India, Indonesia, Malaysia, the Philippines and Singapore. The women ranged in age from 19 to 65 years of age, with the majority between 30 and 50 years of age. To enhance the de-identification of participants, they were divided into age groups. For example, 18-25, 26-35, 36-45, 46-55, 56-65 and over 66 years of age. As a purposeful sample (Palinkas et al., 2015), the women who agreed to participate shared a religion, spoke English and gave written consent to de-identified recorded audio interviews and de-identified transcriptions being used as data for thematic analysis (Caulfield, 2019).

6a.3.1 Ethics

All participants were advised that they could withdraw from the study at any time and their data not be used, or to not answer a question (NHMRC, 2018). Open-ended and clarifying questions (Farrell, 2016) gathered data about their beliefs and experiences about sex education, sexual health practices past and present, gaps in their knowledge about their bodies and sexual function, what they deemed sexual health to be and what was sexually permissible or was sexually taboo. The recorded interviews were transcribed verbatim by a hired assistant who signed a confidentiality agreement. The recordings are stored securely in a locked facility on password protected external hard drives and participants were informed the audio recordings would be destroyed at the completion of the thematic analysis (NHMRC, 2018). The interview transcriptions are held on a password protected external hard drive in a secure location (NHMRC, 2018). The researcher kept analogue and digital records of the process of the research for an audit trail in case of replication of similar research, this information is also stored securely (NHMRC, 2018).

6a.3.2 Coding

A member check (Nowell et al., 2017) of initial coding of transcribed data by research participants was conducted to verify the accuracy of initial coding and ensure the researcher's coding and initial analysis was truly reflecting the participant data and cultural nuances (NHMRC, 2018). Small grammatical changes were made to verbatim transcriptions to reduce speech stutters and verbalisations like repeated 'um's, 'er's or sounds participants made that had no meaning, participants gave consent to minor changes like these (Birt et al., 2016).

Transcriptions were uploaded into NVivo 11 ("NVivo 11 Pro," 2017) for coding of words and phrases each participant gave in response to questions, grouping similar ideas into primary codes related to a specific issue (Saldana, 2015). Primary codes about barriers were *poor sex education, defining sexual health, cultural influences, religious influences, shame, women's silence* and had they had a *Pap test.* Secondary codes were formed where patterns of similar ideas, attitudes or actions were expressed by the participants (Saldana, 2015), some secondary codes about barriers were: *ignorance, fear, bad experiences, male control of finance, poor access to services and gender bias in society and religion.* Thematic analysis is a qualitative research analysis

methodology (Nowell et al., 2017) allowing data to be organised into patterns of meaning commonly held by research participants and summarises the key issues participants collectively into core concepts or 'themes' (Liamputtong & Serry, 2013).

6a.4 Results

Coding evidenced interconnected patterns of commonly identified barriers to these women engaging with sexual health services in their nations of origin and Australia. Thematic analysis (Nowell et al., 2017) of the data revealed the following key barriers all the participants identified: *'socially learnt cultural taboo about sex and women'* which was connected to *'poor sex education'* and *'women's silence and inaction'* about sexual health matters due to *'shame and embarrassment'. 'Cultural influences'* about the role and status of women in male dominated societies aligned with *'religious influences'*, the *'gender of the helper'* and *'partner control'* of finance and healthcare. These were the interconnected key barriers to women engaging with sexual health services in Australia. All were normalised in the nation of origin.

6a.4.1 Cultural influences

The influence of culturally validated norms about women's worth compared to men's negatively impacted the women's care for their health overall. Sexual discrimination is common and men can control the access to healthcare and finances (Asian-Pacific Resource & Research Centre for Women, 2015). Sex discrimination was mentioned by the research participants, not as much by the content analysis. Some of the women were aware of it yet resigned to it as Mary's quote reveals.

> *I think that women are still quite oppressed, despite this ability… this seemingly, uh, equal status that we have in society, and all that sort of stuff. I still feel that women are still expected to be subjected, you know, we're still expected to pleasure the men.* Mary

The women evidenced inadequate sex education, few practiced sexual health screenings like mammograms or Pap tests in their nation of origin ort in Australia. Most expressed shame and embarrassment about menstruation, their genitals and sexual activity inside and outside of marriage. When asked about the cultural influence

of sexual taboo for Asian women, Caran commented: "*Yeah, yeah. Oh, very much. I think women have been raised like that in the Asian culture."*

Sexual discrimination has led to poor sexual health care by women. This is an issue that requires urgent advocacy and funded health promotion in Asian nations to change poor sexual health outcomes like STI's (Rastogi, 2016b)

6a.4.2 Government inaction

The '*inaction of government'* in Asia to provide all citizens with a comprehensive sex education and women with sexual health information is a key issue more frequently in the content analysis, yet all the research participants said they wanted a better sex education than they received. Singapore does have a restricted sex education program (Ministry of Education, 2018), however it does not promote nor normalise sexual health issues such as safe sex practices in detail, provide information on what sexual health actually is, contraception options, promote Pap tests for sexually active women, mammograms, STI symptoms or testing, sexual arousal patterns, sexual communication and consent, nor discuss diverse sexualities, genders, or male sexual health checks.

6a.4.3 Lack of information

The largest barrier to Asian women engaging with sexual health services that thematic analysis and content analysis agreed upon was *'women's; lack of knowledge or information'* about sex, their body and sexual health; primarily due to the cultural taboo about sex and lack of comprehensive sex education or women's sexual health information being available in their nation of origin. Governments of the six nations did not provide comprehensive sex education or easy public access to women's sexual health information. This needs to be addressed. Caran, a Singaporean woman provide an example of her limited knowledge when asked to define sexual health:

> *I think they would think of birth control… they would think of, maybe sex education and general guidance in boy-girl relationship. I think that would be under sexual health.* Caran.

The lack of women's sexual health information available in their nation of origin kept women ignorant of how to manage their own sexual health. Mei Lee described what was a societal gender-based belief that Asian women did not need to know about their sexual health: *'Women treated like they don't need to know… women have no sex or sexual health education.'*

6a.4.4 Female only health workers

The *'cultural sensitivity of a health worker',* or *'the gender of a health worker',* preferably female, were a key theme. The following quotes provide examples of the common narratives about the gender of a health worker.

> *I'm just, I'm just shy, and I would go to a female doctor only. I would not see a man. But otherwise, my normal doctor is, my GP is a man.* Rosa

> *Not a man to examine my breasts and my vagina. I'd be going to a female doctor.* Jackie

6a.4.5 Shame

The silence of women about sex evidenced in the coding was related to the shame they felt about discussing taboo women's sexual matters. The *'shame and embarrassment'* women felt about discussing sexual matters was a large influence on the research participants. Both thematic analysis and the content analysis identified this barrier. *'Shame and embarrassment'* were mentioned directly 76 times in the 22 interviews by 14 women. The research participants rated *shame and embarrassment* much higher than content analysis did. The research data was emic; from the participant's view and member checks (Birt et al., 2016) confirmed this. The content analysis data was etic, observational data held by academics and medical professionals showing a bias to the scientific method and reductionism (Lawrence, 2020). The following quotes outline this commonly held belief.

> *I will safely say that those Asians… 50 and above, who were educated back in Asian countries… it's sin; it's 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, yeah.* Lauren

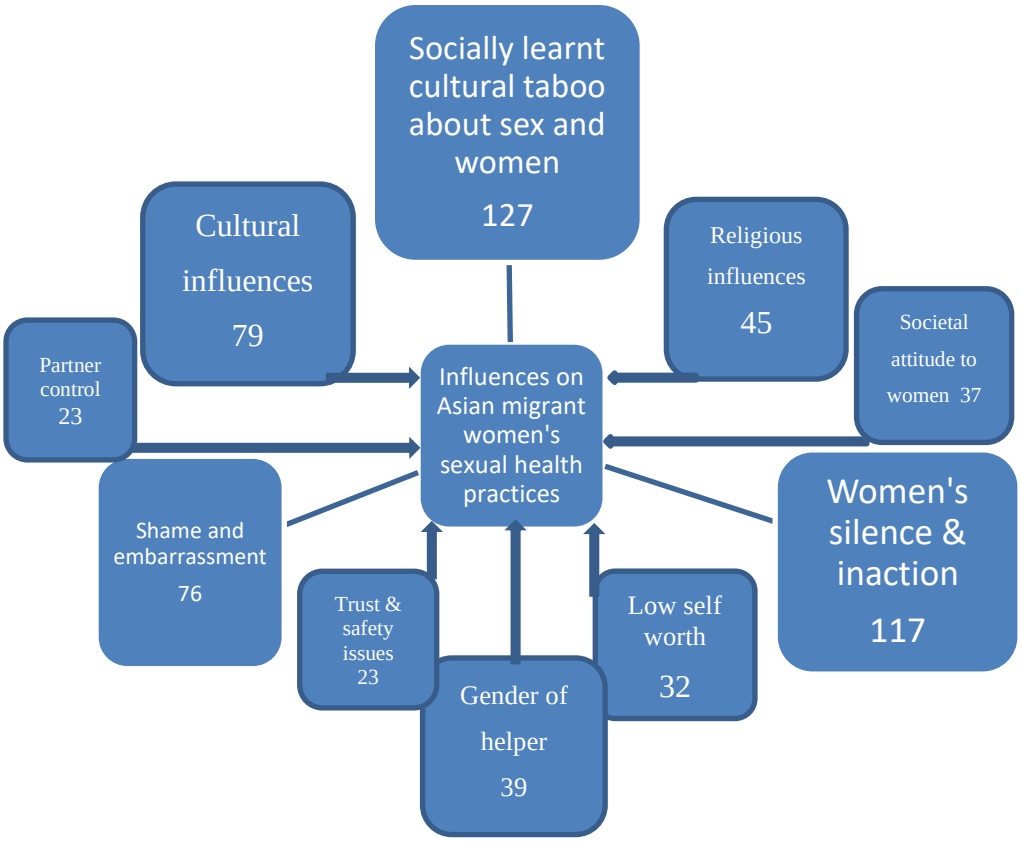
We just never had that kind of talk, and I always just get the impression, yeah sex is dirty and yucky, and… embarrassing. Teleia

Hani, a young Indonesian woman described how carefully women navigate sexual discussions because of social norms: *"I think you have to be very careful as to who you talk to and where you go."*

6a.4.6 Other barriers

Less influential barriers were: *'Fear and mistrust' (12), 'Religious influence' (11), 'A bad experience' (10), 'a language barrier' (9)* or *'lack of time' (5)* to see a professional. Diagram 5 shows the incidence of barriers research participants identified; evidencing a system of interconnected concepts commonly held and alluded to in their narratives. Diagram 6 reveals barriers from the content analysis as a point of triangulating data.

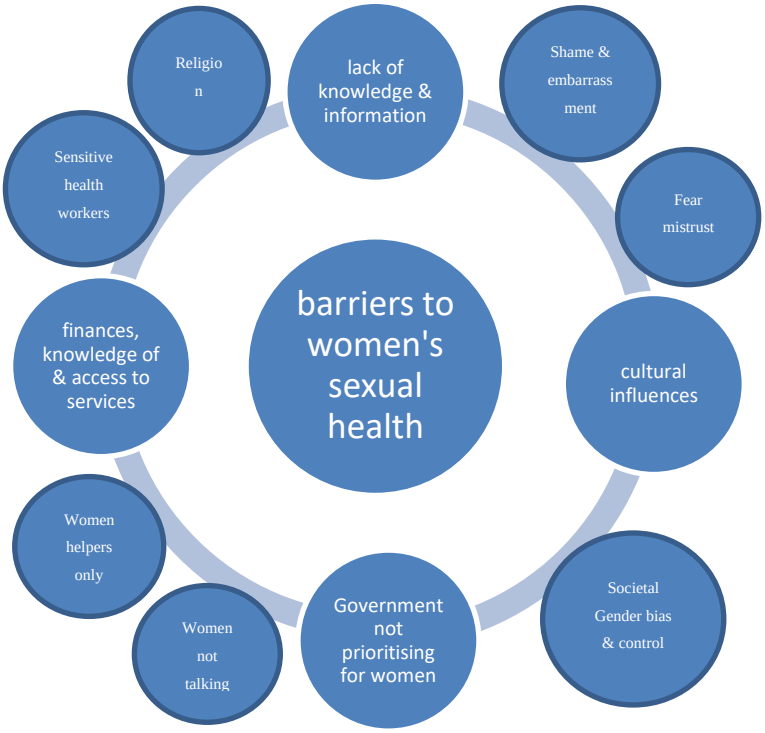
Diagram 5: ***Incidence of Barriers to Sexual Health Identified by Research Participants***



6a.4.7 Content analysis triangulation

A content analysis (Bengtsson, 2016) of 712 Endnote references (Web of Science Group, 2020) was conducted to compare barriers identified by academics with thematic analysis outcomes. Similarities would validate the research data. 95 sources where 'barriers' to women engaging with sexual health services for Pap tests, contraceptive or family planning advice, mammograms, STI testing, problems with having sex and sex education were mentioned in key words and phrases of research references. Of the 95 mentioning barriers to Asian women engaging with sexual health services, the most common barrier was the *'lack of knowledge or information'* women had (46 mentions). *'Cultural influences'* rated highly (360 as did women *'not having access to money'* because males controlled it (35). The Asian governments *'not prioritizing for women'* or sexual health services (34) meant women having *no knowledge or access* to sexual health services (34). Asian *'social gender bias to men'* meant women needed a male's consent to treatment (30). Women's *'shame and embarrassment'* (29) continued as *'women not talking'* (21) with anybody about their sexual health maintained their silence.

Diagram 6: Barriers to Asian Women's Sexual Health Identified in Content Analysis



6a.5 Discussion

It is important to note that the Endnote references were primarily located in academic journals, health professionals' articles or government documentation. All these sources were *etic*, observational and involved commentary about women (Lawrence, 2020). They were not written from the participants viewpoint of need or experience. *Etic*, quantitative research is structured to quantify large sample data on a specific issue, not analyse personal narratives. The barriers identified by the content analysis differed from the research outcomes because the level of knowledge about women's sexual health differed. Academic authors had more knowledge and access to more information. The 'expert' position is not the most accurate way to identify Asian women's sexual health needs.

6a.5.1 Theoretical link to barriers

All barriers identified interconnected within the context of the women's life within culture and society. The culture of origin's systemic gender bias reinforced the low status of women, women acting out of these internalised norms after migration to Australia even after many years. What had been socially learnt, normalised and reinforced remained intact despite migration, which is what Bandura theorised (A. Bandura, 2003b)

6a.5.2 Unusual outcomes

A *language* barrier was only focused upon by one research participant, who explained that not having a sexual health worker or translator who understood the woman's language could lead to misinterpretation if English was relied upon in consultation. All the research participant's spoke English, this was not identified as a major barrier; research with non-English speakers may have differing results. The content analysis did not identify language as a major barrier, this is significant as English may be a second or third language for Asian migrants and misunderstandings could occur.

A *'bad experience'* with a sexual health or medical worker was mentioned by 8 research participants; most often due toa painful procedure or the beliefs of the patient not being respected. This issue was not found in the content analysis, perhaps because

the focus of those writing was not to criticise their peer's work, yet a bad experience with a health worker led to research participant's avoidance of further treatment.

6a.5.3 Commonalities

A degree of commonality existed between the thematic analysis and content analysis with the barrier of *'religious'* influences concerning women and sex. According to 14 participants, religious influence was negative, with churches not providing any sex education, nor teaching about sex in a positive way. Discussion about sex occurred only if it related to premarital sessions with a religious leader discussing the function of sex in marriage; not to discuss pleasure, sex acts, consent or agreed boundaries for sexual activity. An example of this barrier is as follows:

> *The way we were taught about sex in church is that we have sex to bring God's children to earth... But you don't talk about sex unless you are abstaining from it, or you are talking about it as a means of having children.* Hani

The gender bias to male leaders in religious leadership was evident within this barrier. Only two women participants had a positive experience of learning about sex in their religion; they were from Singapore.

6a.5.3 Differences

The barrier of the *gender* of a sexual health worker was mentioned 31 times by 15 research participants; yet the content analysis did not identify this as a major barrier. This could be explained by the differences in status and knowledge between the research participants and the health professionals. Academics know more about sexual health and were predominantly from Western nations where the gender of health professional is not necessarily a major determinant of women accessing services. 14 research participants said this preference for a female health professional was because it was less embarrassing, they trusted women more than men and 9 women said their husbands did not want another male looking at their body. Nat provided an example of this attitude:

> *My husband wouldn't trust me with a male gynaecologist; he wouldn't want that…I was seen exposed by another male. He wouldn't trust the male doctor or*

wouldn't trust the situation. Nat

Utting et al.'s research with migrant women in Melbourne also identified this barrier (Utting et al., 2012). Cultural and religious norms about sex and women cannot be dismissed in provision of services.

6a.5.4 Shame gets in the way

It's easy for health professionals to dismiss or minimise migrant women's shame and embarrassment about sexual health, yet it is a reason they will not present, nor return for services. Taking time to build trust with clients and explain reasons and benefits for the sexual health service is essential if CRaLD women are to engage in screening tests like Pap or breast screening.

6a.5.5 Lack of government provided information

Both data sources agreed that *'cultural influences'* such as gender bias to male political, social and religious power kept the control of women's health under the power of men, inclusive of husband's permission to access or have finance for sexual health services. This key barrier links to the *culture* barrier research participants identified, because if the government does not provide sex education or clinics for women's sexual health screening and education, then that government is inactive in promoting women's health and status overall, resulting in maintaining social norms disadvantaging women. The *cultural and religious taboo* about women and sexuality both data sources identified is a result of a lack of relevant, accurate sexual health information and education provided in Asia.

6a.5.6 Pornography for information

Pornography is available the nations, despite censorship; however, this is not a realistic or safe sex education for women as it does not show safe sex practices, informed consent nor depict a realistic sexual arousal pattern for women. It can normalise violent sex acts and the myth that woman who says 'no' to sex does not mean it (Lau, 2016; Park et al., 2018). Ill-informed women are more likely to feel shame about normal body functions like menstruation and engage in dangerous sexual behaviours (Ussher et al., 2017).

6a.5.7 Cultural sensitivity required

Of the 22 women interviewed, 18 women expressed a desire for cultural and religious sensitivity by a health practitioner. Their shame, embarrassment, lack of knowledge, poor sex education and their dependence upon a partner or family member's consent to treatment cannot be underestimated; all barriers are interrelated. Mei Lee outlines how she wants to be treated by a health professional:

> *As I told you that this is my body, they don't really have to respect me… from a religious perspective, but I need them to respect me as a client and explain well… the way the professional… the code of ethics for them. To treat me just like the way they treat any other people. Because that's what I need… I deserve to be treated in… with the respect*. Mei Lee

Some participants had bad experiences with the insensitivity of a health professional and would not return. Interestingly, in the content analysis, about a third (30) of the references mentioned *'cultural sensitivity'* in research or practice, yet only seven references discussed how to be culturally sensitive in practical ways.

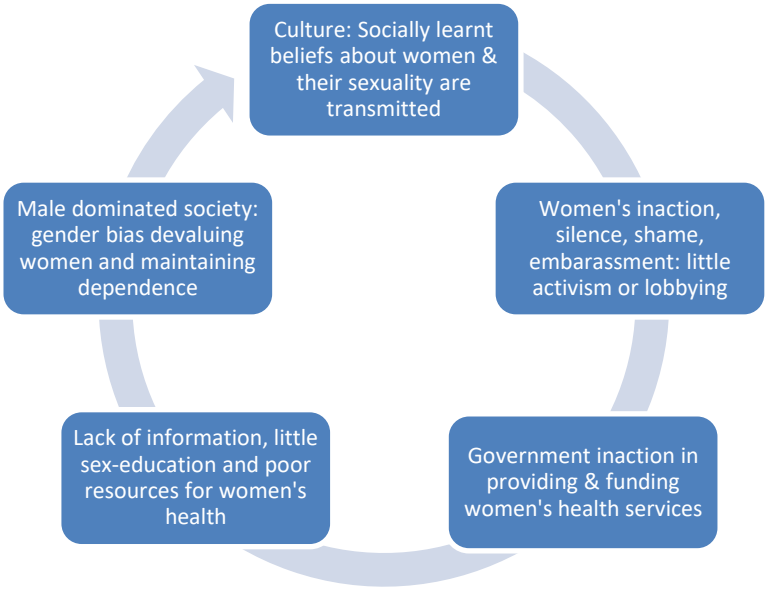
6a.6 Research contribution

This research importantly contributes to growing awareness of the need for Australian health professionals to engage in further training in sexual health, sexology and women's human rights. Ethical and respectful practice with CRaLD women who are reluctant to engage in services and who will not return if they are shamed for their lack of knowledge requires a practitioner who views within her context (Shainwald, 2011). This research has shown that Asian migrant women resident in Australia have specific sexual health needs that a change to Australian service delivery models and CRaLD training of staffs can meet. Diagram 7 shows how all barriers operate systemically.

This sensitivity is imperative because migrant women are not represented in Australian Health Department statistics about cervical cancer, breast cancer and sexually transmitted diseases (Department of Health, 2018) because they have not and do not present for treatment due to the barriers to their sexual health the participant data from this study identified. The following diagram shows how barriers to sexual health identified by the research participants operate systemically within the woman's life

context within the nation of origin and within Australia. Each barrier flows into and out of another. Addressing the barriers will require a systemic approach.

Diagram 7: Systemic Barriers to Asian Women Engaging with Sexual Health Services



6a.6.1 Dangerous assumptions

Migrant women are not always aware of State funded sexual health services in Australia: some research participants did not know this. Apart from three participants, the women in this research did not regularly have mammograms or attend Pap screening; some had never had a Pap test, or only had one after childbirth. Only three participants visited a GP for sexual pain or difficulties. Two of the participants were retired doctors, two were midwives, three were nurses and yet they did not maintain their sexual health in Australia, a common practice for Australian women (Willis, 2019). Being a professional health worker is no guarantee of preventative sexual health care as this research has shown.

6a.7 Research required

Both data sources identified *shame* as a barrier to women engaging with sexual health services. The nations and cultures of origin can amend sexual health taboo by

normalising women's sexual health via health promotion, something Bandura theorised (A. Bandura, 2003b) and reduce cultural shaming of women. All barriers identified by this research need further qualitative investigation with purposefully sampled and/or random samples of CRaLD women residents as part of similar research. Qualitative research *can* be generalisable to a larger population when similar research validates the outcomes, this is welcomed.

6a.8 Conclusion

What maintains barriers to Asian migrant women's engagement with sexual health in Australia are the same barriers that existed in the nation of origin: the barriers migrate with the woman who is normalised to them, aligning with Bandura's theory that what is reinforced by a society is normalised, tolerated and acted-out over time until the society promotes the benefit of change (A. Bandura, 2003b). Asian governments need to do this for their women's health.

This research showed Asian migrant women have specific health needs that a change to health service delivery model could address. Migration is no guarantee of change in women's sexual health behaviours. Qualitative research is recommended in how to increase uptake of sexual health services by Asian migrant women (Multicultural Women's Health Australia, 2016a) provided it is conducted with Asian migrant women and meets a need they express. CRaLD trained female professionals positioned within sexual health promotion programmes linked to Asian migrant communities and offering longer than 10 minute Medicare consultations (Hach, 2012) could build trust and safety and facilitate generational change.

6a.8.1 Two perspectives

Overall, the barriers have two key themes: *the client's* and *the systems*. To address the systemic barriers in Australia, cultural sensitivity training for all medical practitioners, nurses and sexologists in Australia should be mandatory, currently it is not mainstream training for doctors (Royal Australian College of Physicians, 2019) nor sex therapists. To meet the need of CRaLD women's sexual health requirements, medical and sexology professionals need this training as women's sexual health is a human rights issue, as is equitable health service for all Australians.

The following section is an article for publication which examines the perspective of health professionals in Australia identifying barriers to Asian women's engagement with sexual health services in Australia.

Publication 4. Chapter 6b

Health professionals identify barriers to Asian women's sexual health.

This paper has been submitted to Journal of International Women's Studies

6b.1 Abstract

This research article reports on results of thematic analysis of semi-structured interviews of 10 key informants of a larger study about barriers to Asian migrant women's sexual health from their perspective. 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; professional *health workers practices* and the *health system service models*. Key informants agreed 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. Asian women, women's sexual health, health professionals, thematic analysis, cultural humility

6b.2 Introduction

It is obvious to health professionals in Australia that migrant women resident in Australia do not easily present for screening tests like breast screening or pap tests (Department of Health, 2018) and some recent studies with Asian migrant populations are exploring reasons why Asian women do not (Mengesha et al., 2017). An assumption that bulk billed Medicare services incentivise migrant women to present to sexual health services or sexual therapy in Australia are 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).

6b.2.1 Gender bias in Asia

Asian developing nations like China, India, Indonesia, Malaysia and the Philippines have a history of culture being gender biased to and largely governed by males. Cultural tradition and religion reinforce the lower status of women (United Nations

Development Program, 2018). Women are shamed and disempowered for non-compliance to the status quo via violence (Thomson Reuters Foundation, 2018), a censored media, no state provided sex education and poor political representation (Shah, 2016). Singapore's traditional society also had this gender bias. This societal gender bias manifests in poor sex education for girls, little sexual health information being available to Asian women (Khoo, 2016c; Steinhauer, 2016) and politics dominated by men. Educated empowered women are not idealised in Asia.

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., 2019) and in some developing nations the teen pregnancy incidence continues to rise (ARROW, 2015; Khoo, 2016c) 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 normalised by positive reinforcement (A. Bandura, 2003a), there is no logic to believing women migrating from these cultural contexts change what has been normalised for them in a new nation.

6b.2.2 Australian context for women's sexual health

Australia aims to make cervical cancer a thing of the past due to HPV vaccination and cervical screening tests ("Cervical cancer could be eliminated in Australia within 40 years, experts say.," 2018a), to catch breast cancer at early stages via the free mammogram program (Breast Screen Australia, 2021) and doctors can provide bulk-billed medical assistance for sexual difficulties, yet these goals may be unachievable if a portion of the population remains not represented in the health statistics because they do not present for available services or treatment due to lack of knowledge or information and cultural reasons which migrated with the woman (Asif, 2018; Mengesha et al., 2017).

Australian medical systems do not generally work in client-centred ways as they are focused upon the professional expertise of staff, services offered and a fast turnover for client sessions with 10 minute consultations the average (Department of Health & Human Services, 2015). Financial management of health organisations 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 if staffs 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, 2020a), 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 female community leaders have a valuable perspective on reasons why Asian female clients struggle with sexual health issues or treatments. This article presents the results of thematic analysis of semi-structured interviews conducted with 8 female health professionals and 2 religious ministers serving Asian communities in Australia. The results identify barriers the key informants identified, the core themes of the barriers from thematic analysis (Castleberry & Nolen, 2018) and the informant's ideas for best practice in engaging Asian migrant women in sexual health services.

6b.3 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 utilised in the research (World Health Organization, 2020b). This definition includes broad categories about gender diversities, sexual identity, sexual orientation differences, and sexual behaviours, sexual pleasure and informed consent as part of sexual health. Current research of the six Asian nations of this research evidences 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, Benard, King, & Thomas, 2016), researching why they do not is vital for public health. Reasons may include: Cultural taboo about women and sexual matters being discussed (Ussher et al., 2017), male

control of finances for health (Shah, 2016) or religious restrictions on sex education or decision making (Bhartiya, 2013). These are common in Asia where women's sexual health is not state funded (United Nations, 2019).

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 professional's perspectives as a point of comparison to the research participant's 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 such as a history of sexual trauma.

6b.4 Theoretical framework

The appropriateness of using reductionist medical methods utilised in western medical and health practice with culturally, religiously and linguistically diverse (CRaLD) migrant clients is questionable. 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 the women's ideas of what is normal practice within the one dominant culture and what language they speak, hence, religion is an influential variable as well as culture and language and will influence women's ideas about sexual health (Bhartiya, 2013).

A medical anthropological method espoused by the Canadian Medical Protective Association (CMPA) (Canadian Medical Protective Association, 2014) is a foundation for engagement with migrant communities, health promotion and effective sexual health practice with migrant women. The CMPA espouses health practitioners 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).

Cultural humility is a concept underpinning this paper (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 the professional retains an *expert* position without necessarily having to reflect upon their own “lifelong learning”, “self-reflection” about their “openness” to new ideas and influences and show awareness of “power imbalances” in the therapeutic relationship with “institutional accountability” (e. 125) for ethical practice over a lifetime (MacKenzie & Hatala, 2019). Cultural humility in practitioners is manifested by working with the client in person-centred, 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 need (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 the migrant communities (A. K. C. Leung & Nakayama, 2017).

6b.5 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 analyse it (Palinkas et al., 2015). A goal being to use the “information rich” (p. 534) interviews to find “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.

6b.5.1 Methodology

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).

6b.5.2 Recruitment of participants

The key informants were a 'purposeful sample' (Palinkas et al., 2015) of ten 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 for the researcher about participating in the research in a key informant capacity (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 within large Asian communities within churches that advertised and marketed to an Asian community 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.

6b.5.3 Inclusion and exclusion

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.

6b.5.4 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.

6b.5.5 Interviews

A recognised qualitative methodology is audio interviews (Castleberry & Nolen, 2018). Semi-structured audio interviews of 8 health professionals and 2 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 they were or had been part of in their professional practice. Identifying barriers from Asian migrant women is one perspective on reasons why they do not engage: professional health workers and religious perspectives can identify other barriers to women's engagement with sexual health services from a service provider perspective. The average interview was for 1 hour when *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.

6b.5.6 Ethics

The National Statement on Ethical Conduct in Human research was complied with by the researcher (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 they could rescind their participation at any stage prior to and after the interviews, and none did. All informants provided written consent for their de-identified data to be used for Thematic Analysis and for the thesis. Key informants were de-identified to protect their privacy during transcription and in the thesis and 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.

6b.5.7 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 ensuring an audit trail is possible and that similar research could be duplicated (Nowell et al., 2017)

6b.6 Data collection

Data was gathered from 10 audio recorded semi-structured interviews with 8 health professionals and 2 ministers of religion who serve Asian communities. The demographics of the key informants are included in Table 8 below.

Table 8: Demographics of Key Informants

Background	Profession
Rachel	Sri Lankan. 55-65yo.
	Medical doctor. Retired
Elizabeth	Australian. 55-65yo
	Medical doctor. Retired.
	Minister of religion
Faith	Filipina. 25-35yo
	Nurse/Midwife.
Mary	Singaporean. 35-45yo
	Nurse
Melanie	Filipina. 35-45yo
	Nurse/Midwife
Tess	Malaysian 45-55yo
	Nurse
Hanna	English-Australian 55-65yo
	Medical doctor in practice
Ann	Australian 45-55yo
	Nurse. Incontinence specialist
Lauren	Chinese Malaysian 55-65yo
	Religious minister
Rose	Australian 35-45yo. Minister

6b.6.1 Coding

Interview transcriptions were uploaded into NVivo 11 software for coding based upon topical responses to questions asked of all key informants. Coding being the process of categorising 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 9: Primary and Secondary Barrier Codes

Primary codes	Secondary codes
Low cultural sensitivity of professional worldview	Health professional imposes their own
Client wants female professional	Asian women not trusting male health professionals
Client's cultural taboo & shame	Women not talking about sexual topics easily: embarrassment
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 gynaecology/physiology
Health workers not explaining what is required and why	Client anxiety
Asian women ignoring pain	Asian tradition. Women look after others first

6b.7 Analysis

6b.7.1 Thematic analysis

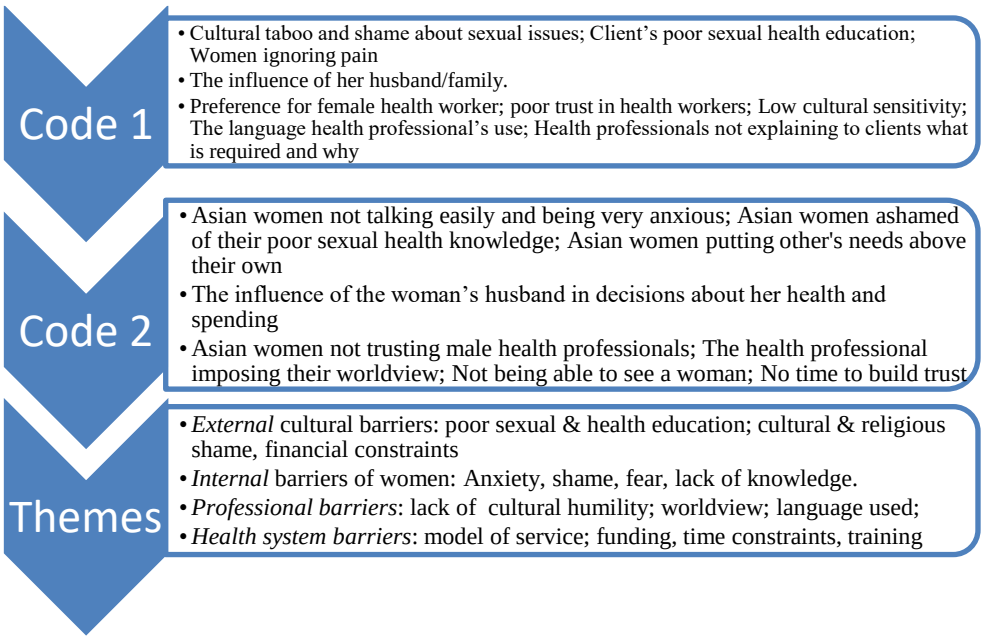
Thematic Analysis (Nowell et al., 2017) of the data was utilised to analyse the coded data by looking for shared patterns of ideas, meanings or concepts that interviewees identified:

1. Shared barriers the key informants identified *blocking* Asian women 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 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 Diagram 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 undergirding 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* she received in her nation of origin was an *external* barrier socially learnt, reinforced and internalised (Bandura, 2003). The *bad experience* an Asian woman had with a health professional was a *professional* barrier and 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). Diagram 8 shows the distillation process from coding to identifying core barriers.

Diagram 8: Thematic Analysis Process to Identify Barriers



6b.8 Results

Thematic analysis revealed four types of core barriers. Barriers *external* to the client 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 and body and genital shame.

Professional barriers identified were: Male health workers; health workers who used 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 analysis identified were, focus on the professional's capacity not the client need; service models emphasising short consultations and service models focused upon high patient turnover. A lack of women's health services is a common reality for women in Asian developing nations (IWHC, 2019). A lack of government provided sex education; governments not prioritising policy and funding for women's sexual health and poor sexual health service provision in Asia (other than Singapore).

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

6b.8.1 External barriers

The *external* barrier of *lack of knowledge and information* Asian women had about their body structures, sexuality and health was identified by the key informants as a major barrier. The 22 research participants also identified this barrier which was contextual to their culture, religion and the lack of sexual health education their nation

of origin provided in school or via public health programs. 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 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 boyfriend." The phenomena of pornography being a source of information about sex for women in Asia and the issue of sexual practices being modelled that could damage a woman's sexual health because no safe sex messages are shown is for another paper.

'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 and her worldview leaked into 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 sexual health information that is necessary for women is an *external* barrier to the women. Asian governments are responsible for sexual education and health programs in their nations, from the key informant's perspective, the nation's 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." A fatalistic comment about being disempowered, ill-informed and resigning herself to not having information about her own body and health.

6b.8.2 Internal barriers

Internal barriers were the associated emotional and psychological results of the influence of external barriers which became reinforced and normalised (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 gynaecological 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.

Internalised anxiety about the social taboo of discussing or asking for sexual information also stopped the women discussing sexual health or asking about it. '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, is 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.

6b.8.3 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 facilitating informed consent. This affected the women's ability to trust health professionals thereafter. 'F', a Filipina midwife described how she has had only one Pap test in Australia: "Once, it was bad." 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.

6b.8.4 Health system barriers

The health system barrier of the *gender of a sexual health worker* was mentioned by all the female key informants as a major barrier and they identified this issue as contextual to the women’s husband not wanting a male health worker involved. This barrier was not emphasised 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 emphasising the expertise of the health professional, the treatment required and not considering the needs of the client first (Atkinson, 2015).

‘A’ described how her role as a nurse specialist 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: an *internal* barrier, yet the gender of the health worker 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 empathise, because they don’t have the female genitals.*

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

6b.9 Discussion

It was evident during the interviews, reading the verbatim transcriptions and analysis, that the influence of medical model service delivery focusing upon 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: they did not have the time. 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 engagement of Asian women; it is a barrier *external* to the Asian women and can be rectified by changes to the health service delivery models used in Australian practice.

The health professionals as key informants all aspired to be culturally sensitive yet did not have the training to understand various ethnic women, differing religious, cultural values or taboos and worked within systems focused upon a fast turnover, 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, 2020a), which ignores the large migrant populations of Asians in Australia who collectively are the largest non-European ethnic people groups (Australian Bureau of Statistics, 2019). This *professional and health systems 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 upon "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) and the client's trust rests in the professional's respect of their whole 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 cultural context. The key informants all agreed cultural sensitivity was a requirement, yet only 5 of the 8 described how they did this in practice. Interestingly, in the content analysis (Columbia Public Health, 2020) of references for the analysis chapter of the doctorate, 34 research references mentioned *cultural sensitivity* or *cultural competence*, yet only seven references discussed *how* health professionals could practically do this: 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 barriers plus the *internal* barriers the women had become normalised to mean the barriers to the women engaging in sexual health services in Australia covered multiple arenas of their lives. *External* issues from their original culture and society which minimised empowering women to have sexual health information that could benefit their life or save it, became *internal* psychological barriers involving shame, fear and avoidance of discussing sexual health topics. Socially learnt and reinforced norms that aligned with Bandura's Social Cognitive Theory for Social and Personal Change (A. Bandura, 2003a). 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 for them to risk change in personal behaviour.

The differences between the literature review information, the research participant's data and the key informant data were obvious. The research participant and key informant data was *emic* data; from the participant's perspective and member checks with the participants which 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.

The lack of mention of *shame and embarrassment* as a patient barrier in academic references could be explained by the differences between the professionals and academics and the research participants. Academics and professionals are more educated about sex and health, and are predominantly from developed nations, or trained in scientific reductionist methods where the gender of a sexual health professional is not a major determinant of access to services: for Asian women it is. Utting and associates also identified this barrier in their research of migrants (Utting et al., 2012).

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 upon 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' was a barrier, yet they worked within a system where only the patient needs to be informed for the professional to gain consent to 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). The researcher agrees with that statement and this study's outcomes agree. Of the key informants, only two maintained their own sexual health within Australia, which is a common practice (Multicultural Women's Health Australia, 2016b) 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 not structured to cultural diversity; nor does it provide the training.

6b.9.1 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 put meeting the needs of migrant populations and their cultural and religious norms as a priority in practice, with research conducted in how to increase uptake of services by Asian women (Lu et al., 2012), so best practice does not remain an unrealised ethical aspiration.

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

6b.10 Conclusion

The four core barriers identified by this key informant study, the *external*, *internal*, *health professional* and *health system* barriers and the doctoral 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 arenas of barriers in their practice and 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 because they migrate to a nation with available, publicly funded sexual health services. Models of service delivery not considering the multiple levels of barriers those women face 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; not seeing her within cultural context (Shainwald, 2011).

Chapter 7

Publication 5

Generational differences in sex education and sexual health practices of Asian, migrant women in Australia

This article has been submitted to Journal of Migration and Health

7.1 Abstract

Generational differences exist between Asian migrant women's sexual health attitudes and practices in Australia. Migrant women are underrepresented in health statistics due to non-presentation for sexual health screening. 22 deidentified research participants were interviewed about sexual health beliefs and practices prior to and after migration. Interviews were transcribed and coded for thematic analysis. Analysis revealed surprising results related to women's age and migration timing. Women over 50 years of age refuse change. Women over 40 years of age resist changing their sexual health beliefs or practices. Women under 40 years of age changed their sexual health beliefs and behaviours. This article provides valuable information for sexual health professionals and epidemiologists to devise targeted sexual health promotions.

Key words: sexual health, health screening, age differences, cultural influence

7.2 Background

This article outlines the generational similarities and differences in attitude and action between different ages of Asian migrant women regarding sexual health practices in Australia. Generational differences emerged from thematic analysis of data from 22 de identified transcribed interviews (Caulfield, 2019) of Asian women representative of six Asian nations: China, India, Indonesia, Malaysia, the Philippines, and Singapore. The analysis revealing that women under 40 years of age are more likely to change their sexual health behaviours, women over 40 unlikely to change and women over 60 years of age refusing change.

7.2.1 The gender gap in Asia

It is important to know the Asian women's culture of origin context for women prior to migration for this study: In China, India, Indonesia, Malaysia, the Philippines and Singapore, the political representation of women is low and cultural structures and norms discourage women from being assertive. The World Economic Forum's Gender Gap Report (World Economic Forum, 2013) indicated it will take 71.5 years to achieve gender parity in South Asia.

1. China is ranked at 106 of 153 nations because of gender inequality in society, despite better education for women.
2. India is ranked 112 due to poor political and corporate representation by women, though women's education is improving.
3. Indonesia ranked at 85 with the poorest political and corporate representation by women of the six nations and the poorest health.
4. Malaysia ranked at 104 due to poor political and business representation by women.
5. The Philippines ranked 16 due to poor political and corporate representation by women, poor education, poor health systems and poor economic contribution by women.
6. Singapore ranked 54 due to the poor political and corporate representation by women.

The six nations are male dominated societies in political representation, business, and economic or social power. Males in power positions make decisions about women's health.

7.2.2 Asian nations of this study

Asian cultures socially reinforce the tradition of the secondary status of women: women being passive partners where male preference and entitlement is normalised by cultural or religious values (Malavi, 2016; Sahu, 2018). In a culture where women's sexual health is not prioritised for by the government, women do not demand or access sexual health services because of social taboo, maintains the poor sexual health of its women and their difficulty in discussing sexual matters (Ussher et al., 2017).

The Asian academic, medical and sexual health literature reviewed used language focused upon women's *'reproductive'* health, '*fertility*' or *'prevention of sexually transmitted infections'* (Domingo et al., 2009; Liew, 2014; Williamson et al., 2018; Wu et al., 2006; Xiao et al., 2011) rather than *sexual health* according to the World Health Organization (WHO) definition (World Health Organization, 2013). This definition includes gender constructs, sexual diversities, informed consent, pleasure, and rights to sexual safety and contraception and health of genitals. Government literature of the six nations focused upon *'reproductive health'* of women or sexually

transmitted diseases rather than providing holistic sexual health information or sexual health services available as a human right (Asian-Pacific Resource & Research Centre for Women, 2015; Government of Malaysia, 2019; United Nations, 2020). The power of holding the knowledge of women's sexual health rested with medical experts and academics. Vital sexual health knowledge, such as safe sex practices, the benefit of HPV vaccination, the benefit of Pap screening and regular breast checks, which could save a woman's life, were not publicly promoted, nor part of any sex education in schools apart from in Singapore (Awang, Loh, Tong, & Tan, 2019; Geronimo, 2016; Ismail, Shajahan, Sathyanarayana-Rao, & Wylie, 2015).

7.2.3 Worldwide feminist movements

In the context of worldwide feminist movements (Global fund for women, 2021), human rights lobbying (Amnesty International, 2021), not-for-profit group health research (World Health Organization, 2021b) and the social conditioning power of Asian media (Jackson, Cai, & Chen, 2020), one could expect more women's representation in Asian politics and business with pressure applied to Asian Governments to provide better health services for women: Not so. Despite the growth of women's advocacy groups to end family violence, women's advisory groups for women's health and social groups lobbying for women's education and political rights being on the rise across Asia, change is slow. For example, Water and Sanitation and Hygiene (WASH) programs in developing Asian nations (UNICEF, 2016) promote women's and girls' menstrual hygiene and educate women about issues like basic sex education, family planning and STIs only if they are permitted to by local legislation.

Feminist messages are transmitted in Asian media targeting women (E. Chen, 2016); in China for example, women's magazines now promote "power femininity" (p. 2831), a move away from traditional roles for women. In India the influence of some Bollywood movies encourages women's education and promotes their rights (Rasul & Raney, 2016). Indian feminism is in its third phase (Arnand, 2018) and has influenced legislation about domestic violence, rape and sexual harassment (Parliament of India, 2013), though change to the male dominated society is slow. It is slower change in Indonesia.

In Indonesia, women's groups like MAMPU (MAMPU, 2019b) work in 27 Indonesian provinces building local women's groups to raise the profile of women leaders with the goal of reducing family violence, improving women's health and promoting women's health services. MAMPU works collaboratively with other women's groups like Institut KALPAL Perempuan, BITRA and Bakti Bursa to advocate for better services and health for women (MAMPU, 2019a). Legislation is currently proposed against domestic violence which includes a sexual violence component (Dunstan, 2019). Indonesia aims for 30% female political representation, though this has not occurred. However, women's socio-political or lobby groups in Indonesia report to the oversight of male dominated political parties: this socio-political bias prevents women's sexual health being at the forefront of health policy and planning.

In Malaysia, progress for women's rights is occurring. The Ministry of Women and Family Development legislated for gender equality and promotes women in politics (Government of Malaysia, 2019); not that this has occurred. In 2018, 3 women were on the 14 seat Federal Cabinet (Beh Li Yi, 2018), with 32 women representatives in the 322-seat parliament. Women's advocacy groups like 'Sisters in Islam' lobby for women's equal rights and an egalitarian society (Sisters in Islam, 2020). Malaysian women's access to sexual education in schools is restricted, with sexual health information having a reproductive focus, not a sexual health focus (Economic Planning Unit, 2015).

In the Philippines, the lobbying of human rights groups and not-for-profits resulted in the 'Magna Carta of Women' (Sastrillo & Babao, 2019), which guarantees Filipinas the right to sex education and sexual health information and services. However, implementing the legislation will require the government spending on developing services and training health professionals and educators. Filipinas have not had such protection of their rights in law previously and the legislation extends to how women and children are portrayed in media.

Singapore's government planned for a society in which women were key economic participants and thus, their *'reproductive health'* has been catered for via clinics that provide contraceptive advice, screening for breast checks and Pap testing and abortion on demand (SingHealth, 2014) since 1960. Assisted reproduction and sexually focused

clinics now operate privately ("Gleneagles: Sexual Health," 2019). However, Singaporean women still avoid sexual health screening or help for gynaecological pain (YouGov., 2017).

7.2.4 Theoretical foundation

Bandura's *Social and Cognitive theory of Personal and Social Change* (A. Bandura, 2003a) indicates that a society will not change the existing status quo on a culturally embedded issue if there is no perceived positive benefit by those in power and the issue is viewed negatively due to tradition. This means society members will conform to unhealthy practices if they are ostracised for speaking out about change or seeking more knowledge. The shaming of Asian women about their gender, menstruation and sex is a common cultural practice in developing Asian nations (R. Jha, 2014; Kennedy, 2016) which negatively reinforces (A. Bandura, 2003a) women's compliance with cultural taboo and harms their sexual health. This compliance contributes to Asian women's lack of knowledge of the importance of their sexual health and their shame about sex. Bandura's theory postulates to change the cultural taboo about Asian women's sexual health, it would need to be positively reinforced and normalised in society via health promotion in media (A. Bandura, 2003a).

7.2.5 Research aims were

1. To identify generational differences in attitudes and actions to sexual health in Australia.
2. To identify changes to sex-education attitudes and practices.
3. To link these practices to sociological theory.

7.3 Materials and methods

7.3.1 Qualitative framework

Qualitative methods producing emic data gain personal narratives about attitudes and beliefs because they allow for detailed descriptive responses to open-ended, rather than survey-based questions (Farrell, 2016). This qualitative research was conducted via recorded semi-structured audio interviews (Caulfield, 2019) of research participants, with recordings transcribed into Word documents for coding in NVivo11 ("NVivo 11 Pro," 2017). Interviews are a recognised qualitative method (School of Psychology, 2017) for gaining emic data about shared human experiences of a 'purposefully

sampled' (Palinkas et al., 2015) group, in this case, 22 Asian migrant women resident in Australia and 10 key informants.

Research participants were interviewed, asked about sex education and sexual health for women of their culture, to describe their experience of sex education prior to migration and if they had had consultations for sexual health issues like pap testing or breast screening. They were asked if they had a daughter, what sexual health education would they want provided for her in comparison to their own experience? What did they wish they had been told or provided information about sexuality or sexual health? Participants were asked how they would educate a daughter about sexual health and whom they expected to provide this information. Their responses are described further in this article. Ten key informants who worked with Asian women's sexual health were invited to comment on the sexual health beliefs and practices of Asian women they had worked with for triangulation of data and research rigour (Nowell et al., 2017).

Coding of interviews (Saldana, 2015) was conducted via a topical word and phrase search in NVivo11, by which shared ideas from the group data were collated into key concepts about a topic from responses to a question. For example, being asked about what sexual health or sexuality information the women wished they had received in their nation of origin, their responses were coded into *poor sex education* as well as *lack of access to sexual health information*. The coding revealed a pattern within the original cultures of withholding vital sexual health information from women, for example, the importance of Pap tests, breast checks and gynaecological checks. Lack of information about women's cancers, safe sex, and contraceptive options was common in their society of origin. Codes related to the research questions: *sex education* experience, *source of sex education*, *pap testing*, *breast screening*, *sexual difficulties*, *contraception* knowledge, *advice seeking* about sex, *pornography*, *access to services*, *bad experiences* with health services, *shame and embarrassment*, *husband's influence* and *sex education of daughters*.

Thematic Analysis (Nowell et al., 2017) of the codes was conducted to distil the codes into core concepts or themes revealing the core themes about beliefs, attitudes, values, and behaviours related to their sexual health. One commonality across participant generations was the women wanted their daughter's sex education and sexual health

to be what they had not experienced. However, analysis also identified generational differences existed between research participants under or over forty years of age about their sexual health attitudes and actions in Australia. These age specific differences in attitudes and actions about sexual health and sexual activity related to their attitude to discussing sexual topics, willingness to seek sexual health information and participate in sexual health screening such as pap tests and breast checks. These differences will be examined in the results section.

7.3.2 Participant background

The 22 research participants were adult women who migrated to Australia between 1970s and 2015, the majority migrated after 2000. Three participants were in their 20s, six in their 30s, six in their 40s, four in their 50s and three in their 60s. All spoke English with 20 of the 22 having tertiary education qualifications from overseas or within Australia and their qualifications were health or education related. The youngest participant was 23, the oldest was in her late 60's. Those who had been educated in Australia were under 40 years of age. Two of the participants did not have biological children.

All research participants were recruited via professional and social contacts and sent information packs outlining the research topic, research questions and level of confidentiality. All contacted the researcher directly and discussed participation. Students from the researcher's university were excluded so the sample would have less age bias. Inclusion criteria required participants spoke English and gave written consent to participate after reading the information. Ten key informants who had experience in working with Asian women or were Asian themselves (six of the ten) were recruited via professional contacts. They participated in semi-structured interviews about Asian women's sex education and sexual health practices to provide a secondary emic perspective for the research to strengthen its validity. All were de-identified and signed consent to participate and for publication with ethical conduct aligned with approved standards (NHMRC, 2018).

7.3.3 Ethics

All participants were de-identified in transcriptions and audio recordings were destroyed at the completion of analysis. Participants who did not want to answer a

question could refuse or refuse their data to be used. All participants gave written consent for their de-identified interview transcriptions to be utilised for analysis and for publication. The researcher's process complied with the National Statement on Ethical Conduct in Human Research (NHMRC, 2018) and Curtin University Ethics Committee approved the research project.

7.4 Results

7.4.1 Reflections 40 plus years of age

Analysis revealed older the woman, she would never attend any sexual health checks. Rachel, a retired doctor in her 60's, practiced medicine in Asia being one; her professional knowledge not overruling her shame, she had not had a Pap test for over 25 years. Elizabeth, a retired medical professional in her 60's validated this generational avoidance of older women.

> *Older women often present with tingling in the head, tingling in the fingers, burning in the top of the head, all sorts of those somatic feelings, which really are just an indicator that they are worried about other health related things… I'll say 'women's problems' was the reason they had presented, but it's not something they could talk about easily.* Elizabeth.

> *Women of my generation from Asian cultures were taught to be modest about their bodies and this meant they did not always know about their gynaecological structures, nor about how sexual acts happen, conception occurred, nor were concerned these matters are very important…* Rachel.

The participants over 40 avoiding sexual health checks, or not knowing what one was, were: Mei Lee from Indonesia, Jackie from the Philippines and Marie from Malaysia. The following quotes outline this pattern of avoidance.

> *I think… it happened to my mum, it happened to the neighbour, it happened to my aunty, they never talked about it, until, until they feel something so painful down there, and that's the time they went to the doctor for help and my aunty dies, because it's already too late. The neighbour dies later... she didn't tell anyone, it's embarrassing.* Mei Lee.

I just went to the GP, and the GP said "are you sexually active?" I said, "Yes." He said, "Have you had a pap smear?" I said, "What's that?" He told me then did one. Marie.

7.4.2 Higher education did not change over 50s

Professionally educated women in their 50s avoided sexual health checks in their nation of origin and since migration to Australia. Jennifer and Joan from India, Lauren and Mary from Malaysia and Caran from Singapore; all were tertiary educated professionals' resident in Australia and admitted they avoided sexual health checks like Pap testing and did not discuss such issues with their husband. Joan did not know what a Pap test was, as indicated below.

I didn't know. I've never had one... India or here. Joan.

And I was in my late 30's, just before I turned 40. That was the first I heard of and encountered a pap smear (in Australia) … *There's no such thing as a regular pap smear.* Mary.

7.4.3 Reflections by under 40s

The participants less than 40 seemed more knowledgeable about the need for Pap tests, even if they did not get one and were more open to going to a female doctor for sexual health related issues as indicated below. Hani, an Indonesian tertiary student and Mary 2 from Singapore, both in their 20s, were the only participants who had a mother who role-modelled or discussed sexual health practices, even if they were given no detail of what occurred.

We were really lucky because our family doctor was a gynaecologist before he became a GP. We'd go to the doctor with mum sometimes and she'd tell us sometimes, 'go out now, because I'm having a check-up'... It was a normalised thing for us. Hani.

Yeah my mum would talk about pap smears, um, she also had, if I'm not wrong, two miscarriages... and um, yeah she talk about pap smears, but for the life of me, I never knew what it was. I had no idea... I knew nothing. Mary 2.

Because I think if it's working fine we don't do anything about it, if it's not hurting we just assume things are ok... I've seen a few shopping centres where they put up 'free pap smears' or 'free sexual health checks, come talk to us, here's our number, so it makes me think. Nat.

The participants under 40 years of age evidenced a growing knowledge about sexuality and sexual health they discussed amongst friends, other women or siblings. This was despite a lack of comprehensive sex education in their nation of origin and not having a family culture within which sexual conversations occurred, even with their mothers. Hani, Teleia, Sally Nat, Mel, Siti and Mary 2 were all aged between 20 and 35 and found sexual information via the Internet, books, magazines or discussion with peers. The younger the woman, the more likely she was to find knowledge about sex, use contraception and expect sexual pleasure.

I was preparing to get married… I had a vague idea of what sex was… my mum and grandmother never discussed sex openly, if they did discuss it, it would be something that's kind of a bit uncomfortable to talk about or almost demeaning… and then I found this website, that's I think, mainly designed for teenagers, like 15 years old, and when I was reading it, I learnt… Teleia.

In school with friends, and we found the secret book and magazines, and we read about it behind mum and dad's back, and that's how we learnt things… And my mum said to me, 'oh,' she like, paused for a long time and then she said, 'do you know, um, where baby comes from?' I'm like, 'yes I know!' My mum said, 'how do you know? I never told you!' So awkward… I'm like, 'come on, friends do teach me things' and then she's like 'oh, ok, good.' Sally.

In Australia… I think my first conversations about sex were with friends from university and conversations about it in school with curriculum and friends. Yeah. We had sex-ed lessons in year 7 in primary school (in Australia). Hani.

The curiosity about sex and the search for sexual information was common to the younger women; Faith, Jackie, Mary 2 and Nat who trained as nurses received education about women's bodies, human sexuality, contraception, sexually transmitted diseases and safe sex as adult tertiary students.

I know that they certainly did cover venereal diseases. Use of condoms and the further explanation of venereal diseases that was… to my best of my knowledge, I only remember it in diploma level. In nursing diploma and anatomy, then did I know that that was called clitoris, and that was called labia, and labia-minora, labia majora, vulva… as an adult. Mary 2.

Hani found out about sexual issues at university.

It wasn't until university… and meeting people from different departments and they're talking about sex toys and different positions and all that kind of stuff I'm like "wow!" Hani.

Caran found out about sexuality at her church young adults' group.

There was this pleasure of sex talk, and some of the issues involving the Christian approach to sex and all that. Caran

Those younger women under 40 who found sex education information seemed willing to discuss sexual topics with peers, women of their culture they met in their educational institution or in professional practice. Mel, a midwife originally from the Philippines, spent time in her practice in Manila, educating the women who came to the birthing clinic she had worked at.

We already give them ideas about birth and organs. I would show posters about women's parts and tell how it works. Explanations, but they are different you know, types of women and pregnancy and birth, so I would discuss with them. They're not aware of it, how it happens and what sex really is. They know bits, but do not understand. Mel.

She was also someone from church, I knew since I was a little girl, so uh my husband and I, we both went to her, and her husband was there for part of it, before he excused himself, maybe half to one third through, so they shared about what sex is like... Um, how woman's bodies are attuned compared to guys… ways in which we could love each other, and contraception. Nat.

The longer an Asian migrant woman had been in Australia from a young age, the more likely she was to have had some sex education and know about sexual health issues

like contraception, consent to sexual activity, sexual pleasure and safe sex. Hani, an Indonesian woman in her 20s who came to Australia as a child commented:

> *If I grew up in Indonesia, I would be a very different person. Probably I would have no idea what the reproductive system does; I wouldn't know if I was having healthy period or not (laughs) I wouldn't know how to track my own cycle and I'd have no idea who to turn to talk about sex or my health.* Hani.

7.4.4 Sex education problems

All participants, apart from one, Hani, who went to high school in Australia, had poor sex education focused on menstrual management and hygiene, sex for reproductive purposes and sexual abstinence until married. Given the incidence of unwed pregnancy rising specifically in Malaysia (Khoo, 2016c) and the Philippines (Asian-Pacific Resource & Research Centre for Women, 2015) and high teenage pregnancies in Indonesia (Rohmah et al., 2020), this lack of necessary sexual health, contraceptive and sexual rights-based information, sets-up young Asian women to become pregnant without them knowing how not to. Also, if they or their sexual partner do not know about, nor practice safe sex, they may become infected with an STI like chlamydia, which could affect their future fertility. If contraceptive options are not available to sexually active youth, unwanted pregnancy and STIs will occur (Llewellyn, 2018; Padilla, 2015).

Rose, a key informant who is a pastor, spoke about the generational differences in sex education for younger Filipinas in her congregation.

> *Of course, cause they… they've been you know, both in the Philippines and in Australia… So, they do have this, I guess an education from the schools here, so they have a higher education in that… in that sex field.* Rose.

An issue identified by analysis that is dangerous to a younger woman's sexual health was the use of internet pornography by some participants to learn about sex. There are no safe sex messages in pornography, no informed consent and it can depict relational violence and normalise it (Harvard University, n.d.; Lau, 2016; "More Malyasian women watch porn using mobile devices," 2017). Lauren, an older participant from Malaysia who pastors a church, counselled premarital couples about pornography not being a useful reality.

> *Pornography? No, you're having too much info that's wrong. What you saw, the… whatever you saw on the thing and then you expect to do the same thing on the bed, and you'll get disappointed. Because they're not taught you know, by the parents, or sex education. So, they're taught that to teach themselves any way and end up watching pornography*. Lauren.

Jackie commented about educating her children early about pornography.

> *Preparing her, then I would be educating her about, you know, pornography…with her iPad, and my son too, so I think just making them really aware of the stages… I would tell them, you know, it's bad. Like with my son, my husband talks to him more than me.* Jackie.

Marie commented on a younger friend she found viewing anime pornography.

> *I saw that she was looking at some anime type sexual stuff that she stumbled upon, I said to her, "are you are aware that that is porn?"* Marie.

Marie said the young person was not aware that the anime they were watching was pornographic as it was fantasy based and not real. Anime and manga are visual art forms accessed by younger Asian people and have become popular amongst worldwide youth. These art forms, easily available via the Internet, now have pornographic versions of common anime and manga series available called Hentai (Hentai, 2020). Much of this is violent and shows forced sex acts focusing on teenage female schoolgirls, having unrealistic bodies, showing sexual content that is non-consensual and male dominated (McLelland, 2011, 2013). This is what young people watch if they are part of the anime, manga or cos-play culture, so it may become normalised if they cannot separate sexual fantasy from sexual reality: this is not safe.

For the participants who were health professionals, it appeared that if they had not been studying medicine or nursing, the likelihood of them gaining the necessary sexual health information was low within family or a culture where women did not discuss sexual topics (Lau, 2016; Mengesha et al., 2017).

7.4.5 Sex education for daughters

Research participants wanted a better experience of sex education for a daughter. Women under 40 were already talking with daughters. Women over 40 said it was not *them* who told their daughters. Some of the older participants were relieved their daughters had sexual education in Australian schools and more health information available to them they did receive. The difficulty in talking about sex with a daughter related to the participant's age as over 40s were anxious about saying anything to daughters because their daughter may know more than them.

> *My daughter, from my observation is a very good educator. The way she brings up her daughter; she explains everything to her… how she's feeling, the emotions... in fact, I learn from her.* Mary.

> *They learnt everything in school... So, I didn't have to teach them a lot, and uh I did speak to them about their relationships, and to abstain from having sex until they are of a certain age and with certain responsibilities.* Jennifer.

> *Educate in stages I believe, you know, now we just talking to her about preparing her for her period... And things like you know, you know your hormones, you know, things change, so stage by stage…* Jackie.

Two participants of the over 40 age group broke the cultural taboo they grew up with and discussed sexual topics directly with their daughters.

> *I think I'd be explaining things in stages, as, as she grew up, so I wouldn't be explaining everything to her at the age of 10. But I think from a young age, I'd be teaching my child to be careful about who got close, and how they got close. Being as well, aware of how sexual abuse takes place.* Joan.

> *I have had a chat to my daughter about it, and sort of said to her, "you know, these are… this is what happens between a man and a woman, but it is also very important for a female to feel like she is being respected", you know. I think that's very important…. I've always been very open… honest and upfront with her about it… when I used to see sort of, her exploring herself, I would just say to her "can you just do that in your bedroom?* Marie.

The research participants in their 60s stayed silent on sexual topics, conforming to the cultural norms and taboo about not discussing sexual information.

7.4.6 Female health worker preference

All the women preferred a female health worker for sexual health checks, with only one woman from Singapore, Caran, having seen a male doctor for a sexual health consultation and another participant, Marie, having been asked by a male Australian doctor if she was sexually active and if she had ever had a Pap test, said yes, then allowed him to perform one: However, her preference was for a female thereafter. This was a shared key theme.

7.4.7 Avoidance of screening

The younger women who had more sexual health information than their mothers did not readily access Pap testing freely available in Australia or see a doctor about gynaecological pain. Hani, Sally and Teleia had accessed a Pap test in Australia, Mel, Mary 2, Nat and Siti, had not. Nat indicated she would only access a Pap test if she were in pain. Mary 2 said she did not want another Pap test as she found it painful.

The participants of *all* age groups avoided sexual screening tests like breast checks or Pap tests. Avoidance was a key theme. This is problematic for the Australian health system which aims to eradicate cervical cancer. If women do not present for screening, they are not measured in the statistics ("Cervical cancer could be eliminated in Australia within 40 years, experts say.," 2018b; Garland et al., 2018) there is a gap in the system epidemiologists work with. This shows a need for a targeted sexual health promotion by Australian health service providers to older Asian women migrants: advocating within their communities for pap tests, breast checks and menopause management to prevent serious health problems.

7.5 Discussion

Key themes identified in the analysis follow.

7.5.1 Women over 40 comply with taboo

Asian women over 40 comply more with taboo about discussing sexual issues and with cultural or religious norms about the role and status of women in their culture of origin (Sam, 2012; West, 2020). Most of the research participants evidenced poor sex education, minimal sexual health knowledge and shame about menstruation, gynaecology, and sexual matters (Louie, 2014). Most had not had sexual health checks like a Pap test or breast check for years and only accessed medical assistance if pain was unbearable. This aligns with Bandura's theory about social and personal change only occurring if it is positively marketed as desirable and normalised (A. Bandura, 2003a) which is it not in Asia.

The differences across the age groups were more specific. Participants over 40 years of age did not seek sexual health checks in Australia even if they knew they were freely available. Some had not had a breast check or Pap test for many years and were negative about the idea of having one, even if they were experiencing pain. They did not actively seek sexual health information for their own benefit as they considered their sexual pleasure and health not as important as their husband or family. 40 years ago was 1980 and sexual health information was not easily accessible in Asian nations via media, and censorship of sexual content was common (ARROW, 2015) this may explain the lack of sexual education or sexual health information of the women over 40 and the negative attitude.

7.5.2 Women under 40 risk change

The younger women under 40 were more likely to seek out sex education and sexual health information for their own benefit. Younger women more likely to access pornography to learn about sex because other sexual education information was unavailable in their nation of origin, even when pornography did not promote safe sex or provide realistic information about female sexual arousal and the time it may take (Suschinsky, Bossio, & Chivers, 2014). These younger women were also more likely to speak with peers about sexual topics than family members and more likely to reluctantly seek sexual health checks. These younger women have adapted to the social norms of Australia by speaking more about sexual topics and researching sex. The Internet has been publicly used for 30 years and young people have found sexual information they want, even if it is not accurate (Dennis, 2020).

7.5.3 Cultural adaptation issues

A generational and cultural shift in attitude to sexual information occurring more easily for those who are under 40 (Sorenson & Harrell, 2020). Older women appeared to value others more than self which would have been socially learnt and reinforced in their nation of origin (A. Bandura, 2003a) and not challenged in Australia.

7.5.4 Lack of sex education

The Asian nations represented in this study do not provide comprehensive sex education and women's sexual health education programs (ARROW, 2015). This is a discriminatory as the lack of information places women's health at risk (IWHC, 2019), especially older women. All women who participated in this research wanted a better sex education and sexual health experience for their daughters, their concern for the health of their daughters is leverage for change.

7.5.5 Health screening avoidance

This research reinforces the low presentation by Asian migrant women of all ages for screening for breast and gynaecological health (Asif, 2018; Mengesha et al., 2017). The women participating in this research were all well-educated, yet still avoided sexual health consultations or screening whether over 40 or below 40 years of age.

7.6 Recommendations

The researcher advocates for comprehensive sexuality and sexual health education for all women as a human right. The World Health Organization and human rights organisations can lobby governments to provide this (World Health Organization, 2021a) as a way of reducing STIs and female cancers. The researcher recommends similar research with migrant populations of all educational levels to identify culturally appropriate ways to engage migrant women groups. No change will occur to screening numbers if targeted health promotion does not occur within a framework respecting culture and the time necessary to engage migrant women within services staffed by women (Mengesha et al., 2017). Research into identifying pathways for Asian migrant women to make necessary adaptations to their healthcare is recommended. Such research could focus upon sources of sexual information in the last 40 years as a way of contextualising the generational differences.

7.7 Conclusion

The generalisability of this research is limited due to the sample size, which is not to say it is not representative of Asian migrant women's experiences due to the richness of the data and the results and recommendations are transferable (Caulfield, 2019). Women who are not represented in Australian sexual health screening statistics can present for treatment of cancers or disease at a late stage of disease: a developing and costly public health issue needing to be addressed early (Department of Health, 2018). It is recommended the Australian public health system engages with key female cultural informants to develop culturally appropriate health promotions. The 4-Domain Cultural Adaptation Model (Sorenson & Harrell, 2020) and a cultural humility approach (True.org, 2018a) used as a framework to research under-screened, Asian migrant women with poor sex education and little sexual health knowledge about the benefit of sexual health checks for themselves and for the benefit of their family. This would over time, normalise sexual health care, inform and empower women about the sexual health and change sexual health behaviours due to positive reinforcement by health promotion and media (A. Bandura, 2003a). Asian migrant women would then receive the same health benefits as any other Australian.

Chapter 8
Discussion and Recommendations

8.1 Introduction

The rising demographic of Asian migration to Australia, the high incidence of women's cancers in Asian nations and the historical poor presentation of Asian women for sexual health screening tests such as Pap testing and mammograms inspired me to conduct qualitative research into Asian women's rationales for not engaging in preventative sexual health care. I wanted to identify barriers to Asian women engaging with sexual health services in Australia from their perspective, considering the women's social context, culture, religion and health education. However, getting Asian migrant women to talk about sexual health was not easy, with 5 participants dropping out of the research because they feared problems if they were found out. The barriers to engagement with sexual health services participants identified revealed a growing women's public health problem needing a preventative plan structured on addressing these barriers. The barriers identified by research participants and key informants provide a challenge to professional health worker practices in Australia in terms of person-centred, culturally humble work with CRaLD women. As such, this research has met its informative aim.

8.2 Responding to research aims and questions

As shown in Chapter 6, thematic analysis identified patterns of interrelated concepts like a web of social barriers to women's sexual health by which research participants were stuck between complying with cultural norms about women being passive recipients of restricted sexual knowledge or risked being labelled as immoral. Traditional gender roles exist in their nations of origin where male power and entitlement was and is played out in the control of women's health; women overseen by socio-political regimes dominated by men having cultural traditions which devalue women and restrict information specific to women's sexual health. The shame, fear and embarrassment women experienced in wanting better sex education, sexual health knowledge or asking for money for treatment from their spouse when to do so was culturally inappropriate, keeps Asian women powerless to improve their sexual health.

8.2.1 Linking outcomes to aim 1

The first research aim was addressed via the research participants clearly describing what was sexually healthy and what sexual health meant to them: participant definitions are included in chapter 6. Any discrepancy between the participant's definition and the WHO definition (World Health Organisation, 2020) was used as a benchmark by the researcher to identify *gaps* to their knowledge: these gaps were identified in analysis as a barrier to their sexual health practices in Australia. The participant's definitions of *sexual health* were limited to reproductive function, childbirth, sex in a monogamous marriage and not suffering from an STI or UTI. Their definitions of sexual health clearly identified the culturally systemic lack of sex education and women's sexual health information they had access to in their nation of origin at a socio-political level, school level and societal level: a major barrier to women's sexual health overall.

8.2.1 Linking outcomes to aim 2

The second aim: to identify if women's sexual health practices changed after migration to Australia had a mixed, age-related response. The outcomes indicated that sexual health practices from their nation of origin migrated with the woman if she was over 40 years of age: Challenging these beliefs and practices took time. Women over 60 years of age rigidly adhered to traditional norms from their country of origin and would not change. Their negative social conditioning was entrenched in agreement with Bandura's theory about negative reinforcement (A. Bandura, 2003a). Overall, the major barriers identified were barriers like cultural norms of internalised shame for menstruating and being unclean, plus external cultural, socio-political and legal barriers in Asian societies that restricted women's rights to their health, proving that a gender bias to males was acted-out on all levels of Asian societies of this study.

Continuing with addressing this aim; the major barriers identified by the participants and key informants to women accessing sexual health services in their country of origin were due to cultural shaming of women about menstruation, their gynaecology, poor sex education, the lack of information about women's sexual health and few women's services being available or affordable. The need of a spouse, father or male guardian's consent to access and pay for sexual health services was commonly mentioned and due to cultural taboo about women discussing their sexual health with

men, the women did not ask, so screening like Pap testing or mammograms did not occur.

The lack of sex education or sexual health knowledge in their nation of origin was the major barrier that was tolerated, especially if the woman was over 40; only the women under 40 actively sought out sexual education or sexual health information for themselves in Australia and had expectation of a pleasurable sex life; most of these were tertiary educated and some were nurses or midwives who learned about women's sexual health during training. These socially conditioned barriers from the nation of origin still influenced new Australian Asian women's behaviours. Change occurred only for the younger women under 40.

8.2.3 Linking outcomes to aim 3

The third research aim was addressed by the research outcomes revealing the barriers participants identified within Australia: a gender preference for a female health professional, personal anxiety and shame, little time to build trust, difficulty in talking about sexual issues due to lack of knowledge, not knowing what services were available, fear of pain and the control of their spouse or a bad prior experience with a health professional. Participants, who had experienced a bad experience with a doctor or health professional in a sexual health consultation, were highly unlikely to attend again, even for years, unless their problem became very painful: their embarrassment became internalised and their mistrust and fear of health professionals increased.

The outcomes clearly indicated cultural influences were more powerful barriers in influencing Asian women's health choices than religious influences. This outcome addressed the third aim of the research: identifying barriers to sexual health practices and what foundation the barriers were built upon: culture or religion. The women, especially women over 40 years of age, complied with restrictive social norms from their nation of origin regarding women's gender roles and women's sexuality being taboo to discuss, even if the lack of information was harmful to their health or female family members' health. They knew little about sexual health screening or safe sex practices. Some of the participants discussed deaths of grandmothers, mothers, aunts and community members from preventable female cancers: yet the women refused to seek medical assistance until it was too late because of cultural taboo and shame about

women discussing sexual matters. This compliance with negative, socially reinforced social norms is an example of Bandura's theory of how a negative status quo is maintained in which change does not occur for a known problem (A. Bandura, 2003a).

It was unanimous the participants wanted a female health professional if they did present for sexually related health problems including pain, a Pap test or sexual difficulties. They wanted a *trusted and safe* female health professional respectful of their culture, considerate of their religion and who took time to earn their trust by explaining the benefit of screening tests and who provided information without using technical language. They wanted to build a relationship of trust over time, which does not fit with the Australian public health system's preference for 10 minute medical consultations (Carteret, 2016). Having a health professional who spoke an Asian language, or who was Asian, was considered helpful, though it was not a key barrier. This may be because the research participants all spoke English.

8.2.4 Linking outcomes to aim 4

The fourth research aim was addressed via gaining another perspective on barriers from Australian health professionals as key informants as a point of data triangulation to compare to the participant data. The barriers key informants identified restricting an Asian woman attending sexual health consultations in Australia were focused on cultural shame, patient anxiety and fear about discussing sexual and intimate issues, language barriers if the patient did not speak English or have terminology to describe their problem or the bodily structure involved in the problem, the patients ignorance about sex, their body and women's sexual health, their ability to afford services and patients wanting a female health professional they trusted. Barriers key informants identified were aligned with those participants identified yet did not express the intensity of the barrier to the same degree as the research participants did. This indicates health professionals *minimised* the *internal* and *external* barriers Asian women face. The key informants were, however, aware that the Australian health system did not work well for Asian women who had cultural shame issues and low trust in health professionals.

The key informants identified the Australian health system is time-pressured, focused upon brief consultations and not focused on the gender of the service provider; rather,

their qualifications or knowledge: it is power based not viewing the client as an equal partner in consultations about their health. The key informants identified cultural sensitivity training was important, yet it was not prioritised for by their employers, nor was funded training part of the practices they worked within. The barriers they identified had two levels: *external* to their professional practice and related to the patient or *internal* to the health system they were part of which did not operate the way the patients needed. To engage Asian women, the approach of Australian health professionals needs to change.

8.2.5 Linking outcomes to aim 5

The response to the fifth research aim was founded upon examining the barriers from three perspectives: the participants, the health professionals, and the academic literature review. Data triangulation can verify or dispute research findings in small sample bases like this one (Nowell et al., 2017); in this case, the triangulation evidenced the participant data and key informant data showed research participant barriers differed in intensity to the academic perspective provided by the literature review. Medical and academic perspectives used in the literature review *minimised* the intensity of *internal* and *external* barriers the research participants identified they faced: this is Australian health professionals 'missing the mark' on what is occurring for Asian women and shows a lack of connection to the women's experience. The research outcomes are important for health professionals to pay attention to: theory and expertise does not help the client who does not understand what is going on, nor the need for an intervention and who may not have the basic knowledge of physiology and sexual health the professional does.

The literature review discussed menstrual taboo; shame and lack of sex education, yet did not utilise an *emic* perspective, rather an *etic* observational one which is distanced from people's experiences, descriptions and meanings. This 'distance' results in providing services that women do not engage in because it does not address their needs. Only two research papers found discussed barriers from the women's perspective and suggested how barriers to CRaLD women's engagement with health services could be addressed (Department of Health, 2018; Mengesha et al., 2017); however, the department of health document does not suggest a framework for addressing barriers they identified other than longer appointment times with doctors.

Thus, devising a basic framework for working with Asian CRaLD women required focusing upon what the research participants said they want in a sexual health service and what the key informants said would meet the women's needs.

Informing sexual health service providers of the web of systemic barriers to engagement migrant women face means they can propose ways to meet migrant women's sexual health needs by amendments to their service structure. A framework for 'culturally humble' (MacKenzie & Hatala, 2019), person-centred sexual health practice by Australian health professionals is outlined later in this chapter. This framework addresses the fifth research aim and the second research question.

In summary, the outcomes from this research addressed the five research aims and the two research questions listed in Chapter 1. Asian women's worldviews about their sexual health, what is sexually healthy and whether they will engage in sexual health practices are heavily influenced by traditional cultural values from male dominated societies, where shame for being a woman is reinforced and avoidance of sexual discussions and behaviours, other than in monogamous marriage is also reinforced. Sexual health professionals in Australia need to engage in cultural humility training (MacKenzie & Hatala, 2019) to adapt their practices so Asian women will feel safer in engaging with sexual health screening, sexual therapies and not be afraid of health professionals.

The next sections will summarise how this research identified unexpected research outcomes, address research limitations and make recommendations for Australian sexual health professional practice.

8.3 Linking outcomes to theory

The theoretical principles of Bandura's *Social and Cognitive Theory of Personal and Social Change via Societal Negative or Positive Reinforcement* (A. Bandura, 2003a) applied to the women of this research program and their sexual health practices. The theory explained how historical, cultural norms and societal structures in Asian nations regarding the role of women, their social status and the amount of sexual information they could access was moderated by male dominated socio-political and religious

structures that constrained women's right to their sexual health. The long-term negative social conditioning of women to accept cultural norms that caused them and other women harm, was proven to exist in older women of this research who indicated they will not change their behaviours. One key informant, Hanna, a doctor, said she believed some older Asian women "would rather die than shame themselves or their family by having a known sexual disease," regardless of what it was, or what it was caused by.

This research outcomes evidenced that all Asian nations represented in this study, including Singapore, had poor political or corporate level business representation by women and that the cultural and moral rules about modesty, sexual chastity and submissiveness applied to women more than men. To change this imbalance in Asian nations, it will be imperative for Asian Governments to plan for future women's health services, promote women's status in society, promote the benefit to a society of women's health overall and use marketing to the husbands and fathers of Asian nations to influence the men about the benefit of a wife or daughter who is valued for more than her reproductive or sexual capacity. Bandura's theory promotes the use of the media to achieve social change by normalising the change as beneficial to the whole society (A. Bandura, 2003a). The story of Singapore's Government's family planning media program success proves that social conditioning using media can result in positive change to society: Singapore is a wealthy, well-educated nation whose women have better status than many Asian nations as they are valued for their contribution to society (National Library Board, 2015), not that Singaporean women easily connect with sexual health services despite their higher status.

A more recent issue the researcher identified is the sexual misinformation and lack of safe sex messages provided by online pornography which will harm Asian women's sexual health and keep them ill-informed about women's sexuality, informed consent and contraception: Asian governments need to provide an alternate source of sex education and sexual health information for their women as a human right.

8.4 Unexpected findings

8.4.1 Religion is not a major influence

The women's religious experience concerning doctrine taught about women and sex, in the majority were as shaming as the cultural influences were and left the participants confused about their worth. This was surprising because Christian doctrine indicates women bear the image of God, yet the participant data indicated the opposite; women were worth less than men and had to submit their lives to the permission of a man. Religious influence was identified as a minor barrier compared to cultural and gender-based barriers socially learnt in the women's nation of origin; this was a surprising outcome as the researcher's expectation was religious influences would be far more influential considering the strict moral code of Christianity regarding sex. Asian culture amended the Christian religion, not the other way around.

8.4.2 Review data and participant data differences

The differences between barriers identified in the literature review and participant data was of particular interest. The academic literature focused upon barriers like economic considerations, lack of available services, cultural shame and lack of sexual information being available. Some literature reviewed mentioned language as a major barrier, yet the participant data did not indicate this to be the case; perhaps because all the women who were part of this research spoke English. The literature reviewed did not however, identify the depth and intensity of the systemic cultural, social, educational and socio-political barriers Asian women face to improve their sexual health identified in chapter 6. Most of the academic and medical literature focused upon the reproductive role of Asian women, their fertility and STI prevention without outlining practical steps women could take to take charge of their bodies or sexual health. The literature reviewed did not use language or terminologies in describing women's sexual health or genital structures using anatomically correct terminology; if academics do not use accurate language, how are people adequately informed?

Discussion of issues like informed consent to sexual activity, women's sexual pleasure or menopausal issues were not communicated in a positive way in the literature review; a lot of the language about women and sex was pathological and deficit based, which is not helpful to women who already feel ashamed if they do have access to sexual health information. The Asian mass media marketed damaging products like vaginal

whiteners, tighteners and feminine sprays which cause damage to the sensitive genital tissues (Saraogi, 2013) and have no health benefits.

8.4.3 Key Informant outcomes

The key informant data had a surprising outcome. Cultural sensitivity training was mentioned by all key informants as something desirable and necessary for working with CRaLD women; however, this training is not included in medical training within Australia. The only cultural training is in Indigenous health (Royal Australian College of General Practitioners, 2020a). The medical professionals indicated that CRaLD sensitivity or cultural humility training was not part of their experience in employment either, neither was it funded. I considered this an alarming deficit in training given Australia is a migrant nation; with the largest migrant growth from Asia (Australian Bureau of Statistics, 2019; *Migration to Australia: a quick guide to the statistics*, 2017).

8.4.4 Ignoring LGBTQIO women

Importantly, Lesbian, Bisexual, Transgender, Intersex, Asexual or other non-binary, non-heterosexual sexualities of people identifying as women were hardly discussed in academic or government literature about women, sexual health and sexuality. The sexual health of women who identify with these non-heterosexual groupings seemed invisible in the Asian nations of this research; it could be that conservative Asian cultures focus on the heteronormative family and conformity to cultural norms, not those people considered deviations to the social norm. In the age of international human rights, this is a major issue that will need to be addressed.

8.5 Significance of outcomes

The research outcomes are significant and especially useful for sexual health workers who have poor cultural knowledge and little training in cultural sensitivity. The participants identified health professionals as a barrier to their engagement with sexual health services because of the lack of time taken in consultations, the technical language used, bad experiences participants had experienced with interventions like Pap tests and breast screening without adequate explanation of the benefit and what process would be used and who used an authoritative approach which shamed the women about their lack of knowledge.

Significantly, the models of service that Australian health clinics use focused on high turnover, Medicare funded 10-minute consultations and use an *expert* power stance by staffs need amendment if migrant women's populations are to be afforded the same quality of health care provision as Caucasian Australians. This is a matter of discrimination. Cultural and religious differences in what is viewed as appropriate service from a migrant women's perspective is not a small matter for the woman involved: they are huge barriers and a health system which minimises these will keep the migrant women's avoidance of sexual health self-care in place. Bandura's theory of negative reinforcement and maintaining the status quo can continue, even in Australia (A. Bandura, 2003a).

This research will encourage researchers to investigate Asian and other ethnic population's sexual health in Australia from a qualitative perspective so that information identifying barriers new Australians face in engaging with their sexual health occurs and the Australian system can adjust to culturally sensitive models of health service provision to meet the needs of all the population. This is also important research because the financial cost to the Australian economy of not identifying specific pathways for preventative public health promotion could become high if Asian migrant women do not undergo screening and present at late stages of disease or cancers.

8.6 Research limitations

The sample size of qualitative research can be criticised by quantitative researchers in terms of the generalisability of data outcomes to a larger population. Qualitative research samples are generally 20 participants or less; this research had 22 participants, thus meets an acceptable standard for research of this type (Mason, 2010). With smaller samples and an emic perspective, the depth of the data that emerges from qualitative methods can be high. The use of a purposeful sampling, key informants, member checks and triangulation with other sources of relevant data adds to the veracity and richness of qualitative research (Nowell et al., 2017; Palinkas et al., 2015). This research program utilised all the above methods and its outcomes addressed all the research aims and questions.

This research was limited to Asian migrant women who spoke English and were resident in Australia, thus cannot represent all Asian women who do not speak English from the six nations of origin: Singapore is an exception as English is a national language. I focused upon Australian Asian migrant residents as research participants for ease of access to participants, to meet ethical standards for human research, to reduce research costs and because it is the Australian public health system that will deal with Asian migrant women who present for sexual disease when it is at a late stage and expensive to treat.

Another limitation to the research is that all the participants self-identified as Christians. This excluded Islamic, Hindu, Sikh, Buddhist or other Asian religious women from the research sample. However, to answer the research question about what the predominant influence on Asian Christian women is, their culture or faith, it was necessary to make the sample purposeful and restrict participants to Christians. Similar research could be conducted using the same methodology with other Asian religious women migrants whose data could replicate the results or be a point of contrast to this research; this would be welcomed.

8.6 Implications for Australian sexual health practice

This research provides an important perspective on Asian women's sexual health in Australia and what influences their engagement or non-engagement with sexual health screening and therapeutic services. The three perspectives on barriers to Asian women's engagement with Australian sexual health services provides information useful to sexual health service providers to consider in terms of how they deliver culturally appropriate services and for health departments to consider for targeted health promotion within specific ethnic communities.

Key informants' ideas about how services could best serve CRaLD women were diverse; the older Asian health professionals did not expect Asian women to engage well with sexual health services due to the controlling influence of spouses and Asian women's shyness about sexual matters, which they evidenced by not attending sexual health screening for years themselves. The key informants identified the current

Australian health system does not focus on removing these external barriers for CRaLD women because the system is focused upon a wide service provision for economic reasons, within short consultation time, provided by whomever is trained without a focus on the gender of the provider meeting the need of the client. This evidences a *system focus* not a client focus within service delivery.

The key informants evidenced varied responses to an Australian sexual health practitioner engaging with their client's worldviews in a 'culturally humble' way as best practice (MacKenzie & Hatala, 2019). Some of the key informants who were medical professionals were not aware of 'cultural humility' (Clabby, 2017) practices and thought the CRaLD women should adjust to how sexual health services are conducted within Australia despite how the research participant women viewed abrupt and time-short appointments as very confronting and avoided them. Other key informants, predominantly nurses, already practiced cultural humility principles based upon their own experience rather than training.

8.8 Recommended research

Further research into larger groups of Asian migrant women from the six nations will be required to reinforce the validity of the research outcomes. Other nations who have been or are large sources of migration to Australia, like Vietnam, Pakistan, Cambodia, Myanmar and Thailand could also be part of a similar qualitative study to replicate, challenge or validate this research program's outcomes (Australian Bureau of Statistics, 2017c).

In terms of childbearing migrant women to Australia, educational material for migrant women (in their own language) unaware of the risk in this culture to their sexual health or the risk to their future fertility if their current sexual partner did not emigrate with them is especially a concern related to the increase in chlamydia and gonorrhoea (World Health Organization, 2018a). Child Health Clinics could be used to inform and distribute information about safe sex and contraception in other languages to migrant women due to the long-term relationship that is formed with a child health nurse which builds trust: an important need the research participants identified.

Longitudinal research focused upon the 'culturally humble' (Foronda et al., 2016) way to providing sexual health services is required to test the Framework for sexual health practice suggested by the researcher in response to barriers identified within the Australian health system. This would involve adapting an existing women's health service to utilise the framework, one that is staffed by women trained in the cultural humility approach. Having staff that speak an Asian language could be beneficial unless translators know the woman or her family and this would reinforce shame. A clinical practice that engages with female community leaders, measures new engagements with the service, notes the source of referrals, notes return visits, performs non-shaming follow-up on did-not-shows, shows evidence of women's screening tests over a couple of years and ensures that sexual health information is available in many Asian languages.

Research into Asian male attitudes to women's sexuality and sexual health are strongly advocated; the outcomes showed Asian husbands strongly influence their spouse's access to and use of health services as fathers and husbands control financial expenditure. It behoves researchers to find out what Asian men think about women's sexual health and if men would welcome change via comprehensive sex education being available in their nation and if not, why not? Research into Asian government's planning and budgeting for women's health services and the rationale for not funding wider health services to their female citizens is advised; is it that Governments run by men do not see the importance of women's health? Discussing with Asian men the benefit of political representation by women if it meant their wives and daughters lived longer, healthier lives and couples benefited by having mutually satisfying sex lives could be a start point. Asian men need to value women as economic contributors, academics, politicians, commercial leaders and agents of social change too.

8.9 Recommendations

8.9.1 Safe sex education

Safe sex education (Laverack, 2009) is imperative: presented in a culturally or religiously respectful manner and emphasising preventative self-care rather than imposing worldviews contrary to those of the participants. The role of female cultural professionals with the first language of the woman migrant in this case cannot be underestimated in terms of teaching sexual health practices such as safe sex. Benedicta

(Benedicta, 2014), at The Third National Sexually Transmissible Infection strategy noted in the section on targeting priority populations: “Peer education and support have played important roles in reducing the risk of STI transmission and in connecting with some hard-to-reach populations. Peers are credible, trusted sources of information and can assist in overcoming physical and sociocultural barriers" (p. 17).

8.9.2 Health promotion

From a preventative public health perspective, The Australian public health system will need to identify culturally respectful ways to engage migrant women of other cultures into using the health system for reproductive and sexual health self-care and monitoring: This is preventative medicine. Normalising women’s sexual health promotion within culturally diverse populations within Asia and Australia requires serious consideration: Engaging cultural or religious leaders and media organisations may provide avenues for formulating appropriate promotional material in languages other than English (Committee on Health Care for Underserved Women, 2011). This information needs to indicate where CRaLD women can access culturally sensitive sexual health checks or receive sexuality education information, which could result in better engagement by CRaLD women who have not presented for health checks if the service utilises the advice provided by the framework presented.

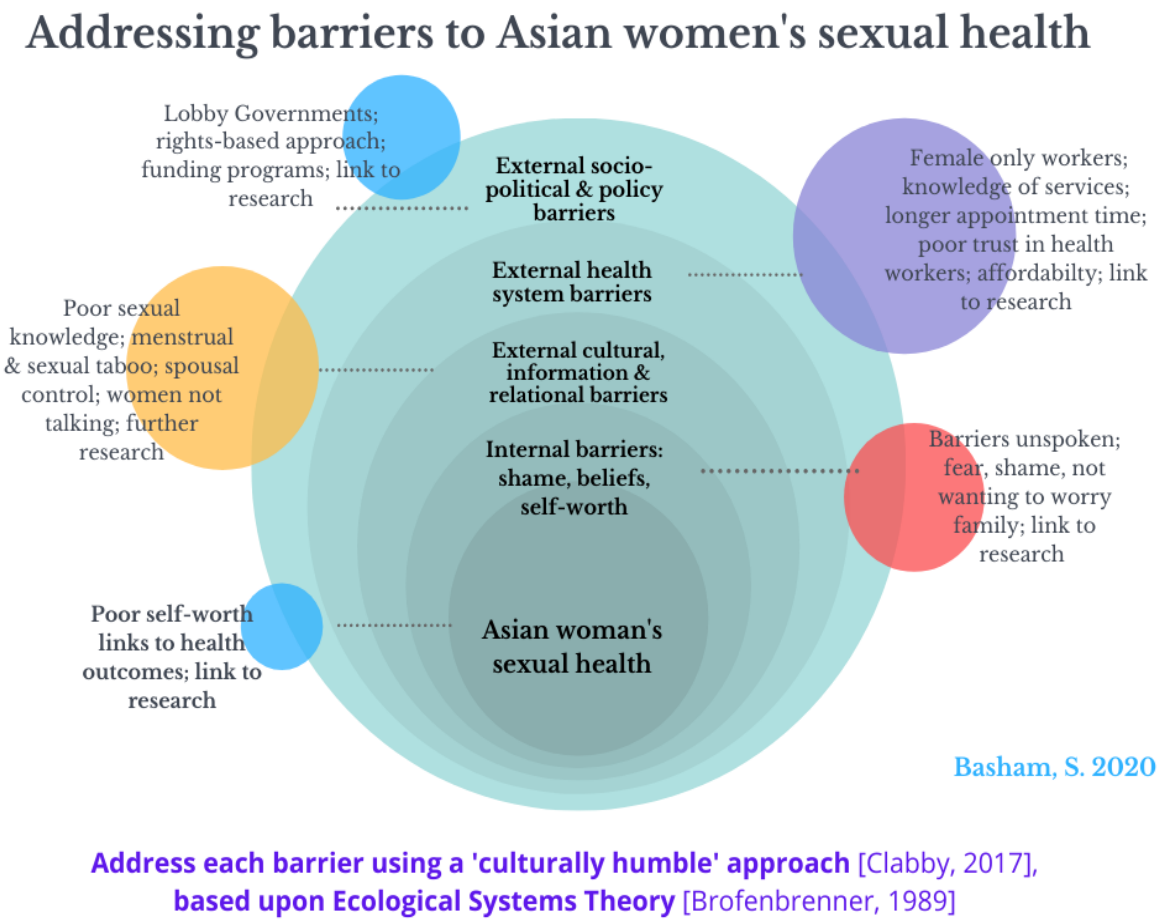
Another consideration is if the level of access of Asian women to sexual health services in Australia is not marketed in their first language and marketed within their communities as necessary, available via culturally or religiously respectful clinics and funded by the Medicare system, they may continue to not practice sexual health self-care, even if it is available. Australia cannot rely on assuming that women migrants will readily engage with Western based ideals of preventative healthcare when they have no history of engaging in their own culture or nation or origin (Department of Home Affairs, 2015a, 2015b; Ismail et al., 2015). Considering the multiple variables like culture or religion which influence these women’s sexual health practices is vital, as is health promotion outreach into culturally diverse communities.

8.9.3 CRaLD service facilitation

Changes at training and facilitation level of health services to become CRaLD inclusive is required (Committee on Health Care for Underserved Women, 2011;

Department of Home Affairs, 2015a, 2015b; Ismail et al., 2015). This change could save the public health system in Australia substantial monies from future intensive medical treatment when women's sexual health issues become seriously pathological or life threatening due to lack of knowledge about service availability, cultural shame or other values inhibiting migrant women from engaging in valuing their sexual health (i.e., regular breast checks, pap smear tests, gynaecological check-up's and STI testing when required and consultation for sexual difficulties). The following framework summarises the powerful influences and barriers to Asian women engaging in sexual health care and provides a basis for engaging in dialogue with Asian women clients to build rapport and trust.

Diagram 9: Framework to Address Barriers to Asian Migrant Women's Sexual Health



Address each barrier using a 'culturally humble' approach [Clabby, 2017], **based upon Ecological Systems Theory** [Brofenbrenner, 1989]

8.10 A framework for practice

The framework is similar in structure to Brofenbrenner's Ecological Systems Theory (Brofenbrenner, 1979), in which a person is not separated from the whole context of their culture, religion, socio-political society and relationships. Bandura's Theory of Cognitive and Social Change, however, explains how people cannot change their behaviours if the structures of the system which block change are not changed first: change must be viewed by those with societal power in a positive light with the benefits of change outweighing the system remaining the same (A. Bandura, 2003a). Women's sexual health in Asian nations can only change if the Government and culture see the value of the change and promote it.

The Framework is useful to summarise the powerful systemic influences and barriers to an Asian woman engaging in sexual health care within Australia. It is not proposed that changes to the socio-political and policy barriers can be achieved by discussions with a female client in consultation using the Framework as a discussion starter. That socio-political and policy arena of change requires transforming the political structures and representation of a nation via an increase in women's political representation and lobbying by human rights organisations to governments of Asian nations.

The framework is a brief of thesis outcomes and could be used to provide a foundation for further research into specific aspects of Asian women's sexual health due to barriers that have been identified. For example: Further research could be conducted using focus groups to identify what sexual health information Asian women wish they had known earlier and the benefit of women speaking about sexual health with other women. Other research could be conducted into the rationales for the control Asian men exert over their wife's health. Research could be conducted in women's health clinics to check the efficacy of a culturally humble approach to women's sexual health care practices over years, by measuring attendance, word of mouth referrals, if there is an increase in screening testing and whether community engagement with female elders improves practice attendance.

8.10.1 Using the Framework

Health professionals can use the Framework to guide their engagement with a client, initially asking questions about *external* socio-political and cultural influences on the client's life which are less threatening or embarrassing for the woman to discuss. Using open-ended, curious questions (Farrell, 2016) about their culture, beliefs and eventually about 'secret women's business' in a way that will build trust over time and show respect to the woman. It is advisable for a clinician to begin with the middle areas of the framework, asking about *external* barriers to build rapport:

- What it was like to grow up as a girl where they used to live?
- What was the status of women in their nation of origin?
- What did she learn at school about girl's health? What health services were available to women in her nation of origin?
- What did her mother or female elders tell her about being a woman? If the woman is married, what does her husband think about her health problems?
- Who in her family knows about her health issues?
- Who does she confide in or ask for advice from?
- What support network does she have in Australia?
- Who manages the finances in her family?

Having a background to the woman's life context can identify her specific barriers. After trust is built, a health professional could ask about the *internal* barriers the woman must overcome, initially using a third-person perspective and open-ended questioning style (Farrell, 2016). Examples being:

- If a woman from your culture had painful sex, who would she talk to?
- If a friend thought she had a sexual disease, what would she need to feel safe enough to talk about it?
- If you had a friend who found she was pregnant and did not want to be, who would she ask for help?
- If a woman from your culture was touched in a sexual way by a male when she was a child, who would she tell?

By using a third person questioning technique it can provide you a woman's opinion without her having to talk about herself in detail, which is less shaming and threatening. Directly asking first-person questions can come later when the woman is more comfortable with the health professional. For example:

- Is this how you would want to be treated too?
- How long has your vulva been irritated (using a diagram to show where that is)?
- What do you know about the benefit of Pap tests?
- Are you ready to have a Pap test now you know the benefit?
- Do you want a support person to go to the mammogram test with you? Who would that be?
- What kind of person would you be comfortable talking to about treating painful sex?

8.11 Conclusion

This research identified Asian migrant women need targeted sexual health information in other languages as part of comprehensive sex education which could save their life. It informs medical professionals and government bodies on barriers to engagement with sexual health services and what culturally humble, best practice could look like. This is significant as what the participants identified they needed to risk engaging in the Australian sexual health system means that changes to service delivery and professional conduct which need to be made from a training level to a practice and service delivery model level. Australian sexual health practitioners need to amend their practice models to meet client need; they also need to train in cultural humility (Clabby, 2017).

The research aims and questions were clearly addressed by the research outcomes: The barriers Asian migrant women identified in their culture of origin and within Australia were systemic, negatively reinforced by culturally powerful norms, validated by key informant data and in contrast to the academic perspective about barriers from the literature review. The influence of Christian religion was identified as not as powerful as cultural influences, even though the influence by Christian teachings on how the participants viewed their worth and body was largely negative and reinforced negative

cultural norms. Importantly, the research identified a generational split. Women over 40, and especially those over 60 were less likely to change their sexual health practices in Australia, thus they need to be targeted in health promotion.

The barriers identified by this research provide a platform to conceptualise how sexual health services in Australia could better meet the needs of CRaLD women within a basic framework of culturally humble, long-term engagement facilitated by women and connected to female leaders of identified sub-cultures as a forum for health promotion to women of their communities (Clabby, 2017). The Framework in this dissertation outlines how a longer-term plan to engage and service Asian migrant women's sexual health can be facilitated by some changes to the existing Australian system: however, this will require associated research and funding. Making the change will evidence investment in the multicultural women of Australia and evidence non-discriminatory service provision. It is highly recommended.

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Appendix A. Ethics approval

Curtin University

Memorandum

To	A/Prof Jaya Earnest, Nursing and Midwifery - Centre for International Health
From	Professor Peter O'Leary, Chair Human Research Ethics Committee
Subject	Protocol Approval **HR 41/2014**
Date	5 May 2014
Copy	Sandra Alsion Basham Nursing and Midwifery - Centre for International Health

Office of Research and Development
Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for providing the additional information for the project titled "*Asian female migrants who identify with Christian worldviews about healthy sexuality: Implications for sexual health interventions in Australia*". The information you have provided has satisfactorily addressed the queries raised by the Committee. Your application is now **approved**.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 41/2014.** *Please quote this number in any future correspondence*.
- Approval of this project is for a period of four years **05-05-2014** to **05-05-2018**.
- Your approval has the following conditions:
  i) Annual progress reports on the project must be submitted to the Ethics Office.
- **It is your responsibility, as the researcher, to meet the conditions outlined above and to retain the necessary records demonstrating that these have been completed.**

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **Progress Report** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development annually.

Our website https://research.curtin.edu.au/guides/ethics/non_low_risk_hrec_forms.cfm contains all other relevant forms including:

- Completion Report (to be completed when a project has ceased)
- Amendment Request (to be completed at any time changes/amendments occur)
- Adverse Event Notification Form (If a serious or unexpected adverse event occurs)

Yours sincerely

Professor Peter O'Leary
Chair Human Research Ethics Committee

Appendix B. Invitational flyer

Asian? Female? Living in Australia? What about your sexual health?

If you are an Asian woman, over 18 years of age who identifies with Christian values, you could assist sexual health professionals in Australia to provide more culturally and religiously respectful services to persons like yourself: Chinese, Indian, Indonesian, Malaysian, Filipina, and Singaporean women are sought for a confidential Ph.D. research project.

The research will involve confidential one-on-one, audio recorded interviews with a Ph. D student from Curtin University's Centre For International Health; School of Nursing.

Topics to be discussed are personal without seeking detail about your sexual practices: Your culture of origin's view of women, women's sexuality and their sexual health: Your sexuality education; The influence of your religious beliefs upon your sexuality; What you consider to be sexual health or 'healthy' sexuality. Your use of services: What would stop you going to a sexual health professional? And what considerations Australian sexual health professionals could provide for better services to Asian women?

It is essential that you speak English, are willing to have your voice recorded (not name) and that you sign a consent form agreeing to the use of your information.

Further information can be obtained from the researcher (below).

Sandra Basham Ph.D student
Centre for International Health
School of Nursing
Curtin University

Phone: 0447 130563
Email: sandra.basham@postgrad.curtin.edu.au

Phone: 0447 130563 Phone: 047130563 Phone: 0447130563

Phone 0447130563 Phone: 0477130563 Phone: 0447130563

Appendix B. Information letter

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Participant Information & Invitation Sheet

I am undertaking a study that aims to examine the influence of Christian beliefs upon Asian migrant women accessing and utilising sexual health services in Australia. My name is **Sandra Basham** I am the lead investigator for this project under the supervision of **Associate Professor Jaya Earnest from the Centre for International Health,** and **Associate Professor Maryanne Doherty Poirer, from the Sexology Department in the School of Public Health.**

The **main aim** of this research is to identify religious and cultural factors that affect Asian Christian migrant women engaging with sexual health or sexological health services within Australia. A secondary aim is to inform sexual health practitioners in Australia how they could better understand and meet the needs of Asian, Christian migrant women in sexual health practice.

I am seeking Christian Asian women from China, Philippines, Singapore, India and Indonesia, to participate in private face-to-face interviews at which, the interviewer will specifically ask questions related to the effect of your Christian faith and culture upon your sexuality and sexual health care within Australia. Your written consent will be required and you will be de-identified to protect your privacy. The verbatim (de-identified) data will be thematically analysed for key themes to write a doctoral dissertation.

Topics to be discussed are personal: Your culture of origin's view of women, their sexuality and health in general; your sexuality education; the influence of your religious beliefs upon your sexuality; What you consider to be sexual health, healthy sexuality and acceptable sexual behaviours? What would stop you going to a sexual health professional? And what considerations Australian sexual health professionals could provide for better services? The interviews will take 90 minutes at the most.

Secondarily, I am seeking to interview professional health workers who work with women as key informants about how migrant women's sexual health practices can be influenced by their worldview, culture of origin and religion within Australia and what options can be utilised for better engagement with such women.

I would be most grateful if you could spare the time to assist in this project. The importance of your thoughts and personal experience is welcomed in terms of providing better future services.

Any information you share will be treated in the strictest confidence and you, or your specific religious affiliation will not be identified in the resulting report. You are free to stop participating in the project at any time or to decline to answer any particular questions: There is no intention to offend. A copy of the report and results will be shared with you.

Please feel free to contact the researchers, if you have any questions or anything further you would like to add.

THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO US

Jaya Earnest
Associate Professor
Centre for International Health
Faculty of Health Sciences
Curtin University of Technology
Perth, Western Australia
Tel | +61 8 9266 4151
j.earnest@curtin.edu.au

Sandra Basham
Ph. D student
Centre for International Health
Faculty of Health Sciences
Curtin University of Technology
Perth, Western Australia
Sandra.basham@postgrad.curtin.edu.au

This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR41/2014). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Appendix B. Consent form

Asian Christian female migrants and cultural or religious barriers to their sexual health in Australia: Implications for sexual health practice.

Consent Form for Participants

Interview date ……..

Sandra Basham, Ph.D. student from the Centre for International Health is the lead researcher for this project under the supervision of: Associate Professor Jaya Earnest from the Centre for International Health & Associate Professor Maryanne Doherty-Poirer Head of the Sexology program, School of Public Health.

- I have read the information sheet for this project and have agreed to participate in the above-mentioned study.
- I am participating voluntarily and understand that I can withdraw from the study at any time and/or not answer any question if I participate.
- I am sharing information with the understanding that my answers will be kept confidential and that my name will not be associated with my answers
- I am able to ask questions of the project at any time

I understand that my answers will be added together with answers from other participants and our answers may be used in reports and publications and I agree to this as long as my name or any other information that identifies me is not used.
I am happy for this Focus Group Session/Interview to be audio recorded.
YES □ NO □

Signed …….

Print Name……

Date……/……/

Appendix C. Demographic information

Asian Christian female migrants and cultural or religious barriers to their sexual health in Australia: Implications for sexual health practice

DEMOGRAPHIC INFORMATION

Name: (use name you choose)

Age group: (please circle) 18-25 26-35 36-45 46-55 56-65 66-

When did you migrate to Australia?

Country of origin:

What was your religious background?

Do you have family in Australia?

What is your current religious adherence?

Level of schooling before coming to Australia:

Do you have a G.P. for women's health issues?

When is the last time you visited a G.P. for women's health issues?

Contact details (phone and e-mail):

Appendix C. Participant questions

Semi-Structured interview

A. Background and Demographics

1. Language spoken
2. Age group
3. Religious background
4. Arrival in Australia
5. Country of origin
6. Family structure & religion
7. Level of education
8. What their culture would think 'sexual health' means.

B. General Analysis – Women's sexual health in culture

1. In your culture, how do women discuss women's sexuality?
2. What women's health or sex education did you receive?
3. Who educated you in women's sexual health issues?
4. How satisfied were you with the sexuality education you received?
5. In your culture, where do women go with sexual health or sexual problems?
6. Who would you not talk to about sexual health matters?

C. General Analysis –Religious influence

1. In your religion, what was taught about women's health or sexuality?
2. Who led the discussion or training? Their background?
3. What did you learn?
4. What does sex mean to you?
5. What specific religious beliefs affect how you view your sexual health or function?
6. What do you understand to be religiously prohibited sexual behaviours?
7. How much would your religion affect your decision about who you'd see for help?

D. Problem analysis – Current needs

1. What kind of professional would you discuss a sexual matter with?
2. If you had a sexual health problem now, what would you need from a professional to trust them?
3. If a woman from your religion or church had a women's sexual health problem, where would the church advise her to go for help?

E. Religious Sex Education

1. What do you think your religion says about the role of women?
2. What does your religion say about women and sex?
3. What have you been taught?

F. Health in Australia

1. How common is it for a woman of your culture to access specific women's health services in Australia?
2. What women's health issues do you think women like yourself have to deal with?
3. What are your suggestions to improve women's and sexual health services to migrant women like yourselves?
4. If you knew a woman from your faith/culture had to go to a sexual health service for a private matter, who do you think she'd prefer to see?

G. Sexual Health Education

1. What do you think Asian women like yourself needed to know about women's sexual health earlier in life?
2. What is the source of sexual health information for women like you?
3. What would you suggest that could help professionals in Australia working with women's sexual health and education with women from your faith or culture?

Appendix D. Key Informant questions

KEY INFORMANT INTERVIEW QUESTIONS

Inform the KI about the research being conducted (discuss handout)

Alternate name:
Professional background:
Date of Interview:

1) Please tell me something about your background and work with Asian women's sexuality.

2) What has been your experience working with Asian migrant women? Describe what you have done and heard.

3) What patterns of behaviour or barriers have you noticed in terms of female migrants accessing professional sexual health services?

4) How do Asian migrant women present for sexual health consults and how do they mention the importance of their culture or faith in consultations?

5) What do you think Asian women have as specific cultural or religious needs that need to be considered in professional work? What health system issues get in the way?

6) How do you work with a person's faith issues if they aren't yours? How do you overcome religious resistance?

7) If an Asian female client said she was a Christian and had sexual problems, what would you assume to ask her?

8) How do you broach sexual health matters (ie breast self-exams; pap smear tests; STI testing or treatment; safe sex; sex education; sexual techniques, behaviours or sexuality education matters) with Asian female clients generally?

9) If an Asian Christian client told you "she couldn't do" what you suggested as treatment due to her religious beliefs, how would you handle this?

10) Describe your training in working with diverse cultures

Appendix E. Member check questions and responses

Member check questions the research participants were asked to check the veracity of 'Barrier' codes from thematic analysis (chapter 6):

1. Do the code percentiles reflect Asian women's beliefs and experiences according to your knowledge?
2. Do the codes accurately reflect your own experience and beliefs when in Asia?
3. What issues did you think would code as more frequent, thus important?
4. Any other comments?

Participant responses

Question 1.
[R]. "Yes "
[M]. "It looks reasonably close to what I would expect about Asian women's beliefs and experiences"
[L]. "I think all the codes are OK"
[E]. "I would say all your categories seem appropriate
[C]. "To a large extent, migration to Western countries and countries that embrace the emancipation of women, their beliefs and experiences have been shaped to be more open to discussions towards sex and help-seeking. Though poor sex education is cited as the most mentioned words (138 times) in the survey, both the countries I reside in all of my life, Singapore and Australia, have ample and adequate sex education programmes and materials in the circulation. The Government made it their responsibility to inform the public about these issues. Asian women in these countries I believe are more well-informed. As a result of the poorer communication of these sexual matters and the patriarchal systems in certain countries, the value of women may be undermined. This can be seen in the influence of culture section where the taboo about sex and women scored so high. It is a lack of information and the pervasive culture that women are inferior that society sees women in that light. Where women are esteemed as merely sex objects, there's a higher male entitlement to sex (53 times). Cultural sensitivity is mentioned 88 times in this survey. It behoves the professional helpers to be culturally sensitive to the differences above and to tailor their therapy to address the issues relevantly"

Question 2.
[R] "Yes"

[M] “It broadly reflects the beliefs and experience of most women I know – my own was a bit more unique as my parents were more liberal in educating me”
[L] nil comment
[E] Nil comment
[C] “Singapore is an affluent country and its modern education and culture have enabled both men and women to accomplish equally. Sex education is well taught in schools and equal opportunities in education and employment have enhanced the role of women in society. There is little gender bias (34 times in your survey) in the public sphere. However, psychologically this is not something that was inculcated in us since young. Being raised by Builders and Baby Boomer parents where the role of women is very much played down, low self- esteem, low self-worth and shame are issues that continually confront women in our society.”

Question 3
[M] “I expected gender bias and partner barrier to code more frequently”
[R] “Influence of culture”
[L] nil comment
[E] nil comment
[C] “I would code influence of religion as more important. Rather than driving up religious shame and ignoring sexual health and sexuality training, the church can step up and help change culture. The ability to teach women that they are valuable is ingrained in biblical teaching so the church has authority to help women and their self-esteem. The influence of culture is also important. Media is a powerful tool to influence culture. Healthier values regarding women can be reflected in the media. With the boom of Zoom and other video conference tools, it’s the right hour for agencies that believe in the upholding of the value of women to spread their philosophies.”

Question 4
[M]“This research is really important to ensure that professionals and teachers understand that familial influence needs to be considered when teaching kids about this subject”
[R]“No”
[L] “No questions”
[E] “I don’t have anything else to note”
[C] “Just a personal note to say how happy I am for you. Almost done”