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Men’s sexual health: understanding the individual and community perspectives of South Asian men in Brent and Leicester, United Kingdom.

MOHAMMED SHAIKH

A thesis submitted in partial fulfilment of the requirements of
University of West London for the degree of Doctor of Philosophy

14 May 2018

Declaration

I, Mohammed Shaikh, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I can confirm that this has been indicated in the thesis.

Signed:

Date: 14 May 2018

Abstract

Background: South Asian communities are increasing in the UK and there is a significant growth of this population from the 2001 and 2011 Censuses. In Brent and Leicester more than 30% of the population are from a South Asian background. South Asian men make a significant proportion of this population (Office for National Statistics (2012). In general men's health is under-researched and there is little research that focuses on the health of men from ethnic minorities in the UK. The sexual health of men is well researched particularly in the field of Human Immunodeficiency Virus (HIV) but this largely focuses on men who have sex with men and there is little UK research that examines the issues surrounding the sexual health of men in the South Asian community. This thesis focuses on producing a better understanding of South Asian men's perspectives on sexual health through participatory research and dialogue.

Methods: A South Asian men's participatory action research group (PAR) was established to collectively explore South Asian men's sexual health in Brent; followed by ten semi-structured and five in-depth one-to-one interviews with South Asian men in Leicester. The data from the three phases was thematically analysed using a qualitative descriptive method and key themes identified in relation to the perspectives of South Asian men towards sexual health. .

Findings: This study uncovered deep seated cultural and religious issues that are important for those working in the field of men's sexual health to understand. The themes emerging from the data highlighted that talking about sexual health carries connotations of stigma and shame that are largely associated with non-acceptance

of homosexuality and what South Asian communities consider to be western or 'white' liberal culture. Generational differences and the strong influence of first generation immigrants and religious leaders emphasised the theme of shame and stigma. Misconceptions about what is meant by sexual health were evident, with participants focusing on infection and promiscuity rather than health and suggesting that culturally sensitive information was lacking. Themes focused on how services could be more accessible and culturally acceptable also focused on the need to 'be private and discreet' and to some degree 'hidden' to prevent stigma and shame.

Conclusion: South Asian men's sexual health cannot be understood without understanding the wider local South Asian community which encompasses religious and cultural influences which impact South Asian men's perspectives on sexual health. These perspectives have been shaped by cultural and geographic origins, patterns of migration, religious and family expectations, generational and marital status. These issues result in a lack of engagement amongst South Asian men and sexual health services.

The findings of this study suggest that services should target South Asian men at an individual, cultural community and service level to build trust and provide services that are accessible and culturally acceptable. There is also a need to create greater understanding about the nature of sexual health and align it with men's health issues more generally. Establishing forums and creating information sources that facilitate open discussion among men in South Asian communities to de-stigmatise sexual health would also assist in reducing stigma.

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Glossary of abbreviations and definitions

AIDS	Acquired immune deficiency syndrome
BME	Black and Minority Ethnic
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CCG	Clinical Commissioning Group
CVD	Cardiovascular disease
DH	Department of Health
GP	General Practitioner
GRIPP	Guidance for Reporting Involvement of Patients and Public (University of Warwick)
GUM	Genitourinary medicine
HIV	Human immunodeficiency virus
IoT	Internet of Things
LGBT	Lesbian, gay, bisexual and transgender
LBB	London Borough of Brent
MBE	Member of the Order of the British Empire
MSM	Men who have sex with men
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NHS	National Health Service
NPL	Naz Project London
ONS	Office for National Statistics
OSML	Ottaway Strategic Management Limited
PAR	Participatory action research

PHE	Public Health England
PiiAF	Public Involvement Impact Assessment Framework (Lancaster University)
POST	Parliamentary Office of Science and Technology
PPIE	Patient and Public Involvement and Engagement
PROCESS	*PR*Ostate *C*ancer in *E*thnic *S*ubgroup*S* study
QRC	Quick Response Code
SRE	Sex and relationship education
STI	Sexually Transmitted Infections
UCLCEH	University of Central Lancashire Centre for Ethnicity and Health
UK	United Kingdom
UWL	University of West London
WEMWBS	Warwickshire and Edinburgh Mental Health Well-being Scale
WHO	World Health Organisation

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Overview of the thesis

This thesis provides a unique insight into the community and individual perspectives South Asian men in Brent and Leicester and suggests that cultural, religious and generational influences create barrier to men discussing sexual health and associated services. This knowledge is central to developing culturally acceptable approaches to engaging and informing South Asian men in recognising sexual health as a personal and community priority.

The rationale for researching sexual health derives from the personal and professional observation that there is an absence of dialogue about sexual health in the male South Asian community and that this may create health inequality in an important aspect of men's health.

Accounts of inequality in health care suggest that in the United Kingdom (UK) along with other Westernised nations, those who are not from the indigenous population experience poorer health outcomes across many indicators, compared to the indigent population (POST, 2007). Inequalities in health outcomes are attributed to difficulty in accessing services, cultural barriers, racism, prejudice and health care provider's cultural incompetency (Gunaratnam, 2003). Greater understanding of these inequalities is required and can only be resolved by engaging with Black and Minority Ethnic (BME) communities on issues related their health. There is a complex interplay of factors affecting health amongst BME communities in England such as the long-term impact of migration, racism and discrimination, poor service delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility. Understanding these processes is important for the

development of effective health policies to reduce the health disadvantage experienced by people of BME communities in England (POST, 2007).

Engaging with BME communities on health issues and services can be challenging due to the complex nature of those communities mentioned above. There has traditionally been a low uptake of health services among BME communities, especially those from the UK's South Asian populations (Stuart, 2008). Men from BME populations and South Asian populations have traditionally been less involved in health services and health research.

1. Chapter 1 describes the development of the South Asian community in the UK over the past 70 years. It highlights issues of migration, race and ethnicity and considers health inequalities faced by BME communities and South Asian men.

2. Chapter 2 critically discusses the research and healthcare policy that focuses on sexual health in BME communities and discusses how communities can be involved in collaborative research.

3. Chapter 3 provides the rationale for the use of participatory action research (PAR) and qualitative description in this research and describes the methods used to collect and analyse the empirical data for the study, including the recruitment of the PAR group in Brent and individual participants in Leicester.

4. Chapter 4 describes the findings of the participatory and qualitative descriptive phases of the research and draws them together to provide a rich picture of how South Asian men perceive and address the issue of sexual health individually and as men in the community.

5. Chapter 5 provides a critical discussion of the perspectives of South Asian men in relation to sexual health from a community, individual and service viewpoint. The three overarching issues discussed in this chapter include misconceptions, stigma and shame associated with sexual health and sexually transmitted infection (STI), homosexuality from the perspective of South Asian culture and religion and the role that sexual health services have in promoting sexual health amongst men within the South Asian community.

6. Chapter 6 discusses the strengths and limitations of this study, and concludes with the implications of the findings for sexual health services/ policies and future sexual health research involving South Asian men.

Chapter 1 South Asian men in England

This chapter describes the development of the South Asian community in the UK taking a historical and contemporary perspective. It considers the concepts of migration, race and ethnicity providing a cultural context for this research. The issue of health inequality in BME South Asian communities is discussed in the context of national and local demographic data in Brent and Leicester with a particular focus on men's health.

1.1 Ethnicity and race in the context of being South Asian

Understanding the concept of ethnicity and race in the context of being South Asian enables this research to (a) highlight why the focus of this research was targeted to South Asian men and (b) recognise and acknowledge the issues related to their ethnicity which may influence and impact on the views of participants in relation to sexual health.

1.1.1 Defining ethnicity and race

The term ethnicity cannot be explored without initially exploring the term race. Ethnicity and race are both major components in relation to this study. Race and ethnicity are terms commonly used in health care literature, often interchangeably and without clear definition and explanation and are interconnected through complex historical and political threads and have been socially constructed through dynamic processes over time (Gunaratnam, 2003). In research that focuses on issues associated with being a member of a particular ethnic group Guanratnam (2003, p.7) urges "researcher's to examine and trace how research is entangled with wider social and historical relations in order for these relationships and formations to be

exposed". Our current understanding of race and ethnicity is shaped by history and is important because this understanding influences social policy and the ability of ethnic communities to engage with these policies.

Banton (1987) suggests that the word race was rarely used either to describe people or in accounts of differences between them in an examination of the literature of the 17th and 18th centuries. This term changed from its inception in 19th century. The origins of the term and concept of race are controversial, although Malik (1996) shares a convincing argument that the discourse of race did not arise out of the categories of enlightenment discourse, but arose out of the relationship between European thought and the social organisation of capitalism. Therefore, the concept of race emerged from the domination of one group over other groups. The word race and related concepts such as 'racial' and 'multiracial' now seem to imply the existence of discrete, naturally separate, population groups and less of domination (Bonnett, 1993).

Race was previously referred to as biological and physical characteristics, but race does exist outside of this representation. Race is also related to historical and contemporary social and political power struggles (Bonnett, 1993; Malik, 1996). In Britain, the historical formation of race is one of power and subordination (Barker and Jane 2016). Race is now subjected to categories of nationality and often described in polar dimensions such as black or white. This is further categorised into ethnic groups such as Black African, Black American and South Asian Indian, South Asian Pakistani and so forth. In doing so, individuals and groups of people are represented by a certain characteristic, although race categories can vary across the globe. This

understanding provides a concept whereby race was used to describe the 'origin' of people across the globe and has over the years been shaped influences that have their roots in power, struggle and capitalism. In addition, the overlaying of religion has led to race being used as an umbrella term to describe people with geographical, cultural and religious heritage. Therefore, the term South Asian may be described as a term for race, which encompasses a mixture of ethnic backgrounds and traits.

The above understanding of race is appropriate for use in this study and this is aligned to the understanding of race within contemporary British society. In doing so, understanding race within the context of British society requires also acknowledging the struggles associated concerned with race in this country and an understanding towards the series of legislation to support the agenda for race such as the Race Relations Acts (1965; 1976; 2000) which is now superseded by the broader Equality Act (2010). My personal view of collapsing race into one act can help demonstrates how race is equally important as the other acts related to gender, sexual orientation, and disability. Yet folding race into an overall category, rather than a distinct legislation means this removes the historical conations of the power and struggles which were once related to this term. This removes the historical struggles of populations from across the globe that has migrated to Britain and lessens this to simply a category of difference rather than of structural power domination and capitalism.

Race and terms such as ethnicity are concepts sharing a single centre, or core with some notable and important differences at the periphery. Common to all is an idea

of descent and ancestry and very closely implicated in all understandings do we find ideas about culture. These notions of culture will typically include past, beliefs, ideas that define a group constituted by language, dress and custom (Fenton, 2003). The vast majority of studies of race and ethnicity pay little, if any, attention to questions of masculinity, often discussing developments in, and patterns of, colonialism, imperialism and racial discrimination in un-gendered terms while placing more emphasis on wider patterns of social construction, deviance and identity (Edwards, 2006). This is important as this provides some context to working with specific BME groups who have migrated to the UK and understanding the movement of BME communities to certain cities in the UK. This also potentially provides the perspective concerning their health and the perception they have on the health of communities other than their own.

Health research needs to take on board the issue related to the terms of race and ethnicity, particularly when considering in whose interest the research is being undertaken and the issue of race needs to be considered at all stages of research. Race and ethnicity are issue which are not going to be pertinent to all research studies but when considering research with BME communities then race and ethnicity are components which cannot and should not be ignored (Gunatram, 2003). Health service providers and health researchers have been accused of reluctantly adopting a critical approach to the needs of BME clients, particularly when acknowledging the effects of race and racism on the health and the life chances of BME populations. As a result, the wider health implications resulting from the interplay of ethnicity, class or gender on sexual health have received little attention

(Serrant-Green and McLuskey, 2008; Balsa and McGuire, 2003; Culley, 1996; Gerrish et al, 1996).

Therefore, race in the context of this study is used to describe a collective group of people whom may share geographical heritage, religious beliefs, common language and common cultural and family perspectives towards everyday social matters and practices and have experienced an imbalance of power and domination as well as importantly sharing some biological and physical attributes.

1.1.2 Ethnicity

The term race is also associated with the term ethnicity. Prior to the introduction of ethnicity population categorisation, the term race was mainly used in Britain. However, ethnicity and race are terms that are often used interchangeably and confused, dependant on the context in which they are used. In the UK, the national census did not record race or ethnic origin at all until 1990. The question of a non white presence became a public issue in the 1960s when the number of immigrants from Britain's former colonies in the Caribbean and Indian became the focus of political and public debate (Fenton, 2003). This started the momentum of recording data on race and ethnicity.

Ethnicity is something that is self-defined and is subjectively meaningful to an individual (Fenton, 2003). In Britain, ethnicity emerged as the preferred term to race to highlight the differences between populations from the 1960's. Ethnicity now plays an important part in the sociological imagination, in policy and political discourses (Fenton, 2003).

As with race, ethnicity is not a neutral term and has come to embody language, religion, culture, nationality and a shared heritage (Fenton, 2003). Ethnicity was used and is used to associate population groups with the country of origin. It is important to note that previous understanding that classify people according to their country of origin seems no longer to be sustainable, particularly since nearly forty percent of what we regard as minority ethnic population are now actually born in Britain (Modood et al, 1997). Furthermore, ethnicity has increasingly been seen as a political symbol, defining not just exclusion by a powerful majority but also a source of pride and belonging, in other words mobilising resource which enables populations to celebrate their differences and make legitimate demands as UK citizens (Fenton, 2003). In relation to this study ethnicity is a factor which combines a set of people from a continent which includes a number of countries and cultures; South Asian.

Simply understanding ethnicity within the context on national origin is not sufficient. Ethnicity is a cultural concept centred on the sharing of norms, values, beliefs, cultural symbols and practices. The formation of ethnic groups relies on shared cultural signifiers that have developed under specific historical, social and political contexts (Barker and Jane, 2016). There is also evidence that ethnicity is related to the positive and negative health outcomes and health experiences of certain groups in the UK (POST, 2007).

There is increasing evidence that socio-economic status, age and gender are as important as ethnicity in making sense of a person's health and social care needs. Ethnicity is only one contributing factor along with key related factors that one must

take into account when undertaking research on a particular ethnic group of people, but ethnicity is an important factor. For the purpose of this study ethnicity is considered as a major factor as this research is focused on one distinct group of men represented from a one broader ethnic group. Therefore, the use of ethnicity in this respect helps to focus on matters related to this particular group of men as they are under-represented in health research in comparison to other ethnic groups.

Understanding the ways in which relationships between socio-economic status, ethnicity and health are mediated remains poor (Asthana and Halliday, 2006). Ethnicity is a complex, dynamic characteristic whose properties can pertain to individuals, families and larger groups. The context-dependent, unstable nature of ethnicity means that a single policy to ameliorate all deficits associated with ethnicity is unlikely. There are two problems that affect minority ethnic groups disproportionally and never trouble the British ethnic majority; the lack of a common language for communication with professionals and discrimination based on racialised ideas of difference.

There is a need to recognise the complexity associated with ethnicity in relation to difference and diversity. This means acknowledging differences between and within different ethnic populations, generations, as well as accepting that ethnicity is not always the only explanation for disadvantage and discrimination. Diversity and difference, therefore, needs to be understood within a broader context in which socio-economic status, age and gender, generational group may be equally as important as ethnicity in making sense of a person's health and social care needs (Ali et al, 2006). The understanding of ethnicity in the context of health and how UK

health policy or the lack of health policy addresses the needs of the BME population and particularly South Asian men's health is required. Ethnicity in this research is therefore required to be understood within the context of recognising the differences and diversity of a particular ethnic group as well as the socio-economic factors to that particular group such as age, gender, health, wealth and religion and migration rationale as well as the specific generation in question.

1.1.3 Defining South Asian in the context of this study

South Asian encompasses in the UK context means many groups and cultures as well as generations which have migrated and been born in the UK. This study focuses on men from a South Asian ethnic origin, hence in addition to understanding race and ethnicity there was a need to understand the term South Asian in the context of British society and health research in the UK. Ironically, the term South Asian is an invented one and was introduced in Britain during the 1970's as another ethnic label to divide and rule in line with a neo-colonial perspective (Nasta, 2002). The use of South Asian fails to distinguish between a diverse range of backgrounds which stem from complex religious, linguistic and regional histories (Nasta, 2002). The term South Asian only makes sense when viewed in the context of Britain as this is a term unique to Britain and British history (Nasta, 2002).

The term South Asian is not one which people who are of South Asian descent chose to be described. South Asia was subsequently shaped by colonial influence and projects and the term South Asian was part of a re-ordering of the world according to European terms. Therefore, this term is essentially Western and there is no equivalent word in any South Asian language (Ali et al, 2006). So, when we

discuss South Asian in this context it refers to people who have been labelled as South Asian but people who might not necessarily identify themselves as South Asian, particularly those who migrated from the Indian sub-continent.

In Britain, South Asians have been described as coloured, black and Indian in different contexts, different constituencies, or at different times (Ali et al, 2006). The inescapable conclusion is that both the language used (races, ethnic groups) and the actual classifications which are deemed to be important are a consequence of embedded social practice coming from historical circumstances (Fenton, 2003). Government census data use ethnic categories to determine population figures to help the government understand the multicultural mix in the UK and support establish and review policies and health policies. The South Asian term can be viewed in both a positive and negative light. Positive in the sense that it enables groups to be distinguished under umbrella terms and negative as it does not accurately categorise populations at a micro level (Ali et al, 2006). There is an assumption that South Asian refers to all people with origins from the Indian sub-continent and although there are many similarities amongst this population there are also many differences amongst this population, particularly in regards to religious and cultural influences.

One way to overcome confusion on using the term South Asian is to simply not use this term. Ali et al (2006) suggests using a different term altogether. There should be exploration on terms which South Asian communities would like to be identified as with South Asian people. Ali et al (2006, p.5) suggest that “we should instead use the term ‘BrAsian’ (British-Asian). The BrAsian term is recognition of the need for a

category that points one in a direction away from established accounts of national identities and ethnicised minorities".

Using the term BrAsian is only one suggestion. The point of discussing BrAsian is not to confuse matters further regarding the term South Asian, but rather look at the complex issues related to the use and appropriateness of the term South Asian in relation to health research. The continued use of the term South Asian continues to follow the history of British dominance over people from the Indian sub-continent. New ways of identifying groups from the Indian sub-continent is required. However, the point of using an identified term associated to men with origins to the Indian subcontinent is to relate this research back to British society and the wider population. Using unidentified terms, which may be chosen by South Asian men, is not the purpose of this study, however important this issue may be.

Consequently, young South Asian people, who are second and third generation South Asians in the UK, are beginning to redefine their identity by adopting such terms as British Muslim or British Asian or even British-Indian (Ali et al, 2006). Young South Asian people are increasingly using religious affiliations, such as Muslim, or Hindu or Sikh, to describe their cultural and geographical. This indicates the important role of religion in regards to identity of South Asian men and South Asian communities. The religious identity of people with origins from the Indian sub-continent can be in some way provide a better identity as religion continues to play a pivotal role in the South Asian population of Britain. This difference of identity representation also represents fundamental differences in how young people and the older generation of South Asian communities make sense of their own identities and

in the context of British society (Ali et al, 2006). Young South Asian people will use terms they determine appropriate rather than being labelled a term they do not recognise and this means being less influenced by a term associated with historical colonial power relationships.

The term South Asian in the context of this study is used in ethnic context to describe people whose origins are from the Indian sub-continent which include India, Pakistan, Bangladesh and Sri Lanka. The rationale being this is line with government census data that describe ethnic origin of people from the Indian sub-continent and a term which South Asian men who will be approached to participate in this study will be familiar with.

1.2 Migration of South Asian communities to England

This section describes how people who are considered to be South Asian arrived in the UK. Immigrants from South Asian communities have been part of the British population for many years, with the earliest being recorded over 400 years ago (Nasta, 2002) People from the Indian Sub-continent came to Britain when trading with the continent began and migration increased in the 19th and 20th centuries (Visram, 2002). South Asian communities have experienced many challenges settling in Britain. South Asian migrants were initially relegated to the margins of society within labour and housing and this was demonstrated through social policy and the need for legislation towards equality (Herbert, 2008).

South Asian communities in Britain mainly have origins from the distinct geographical areas of the Punjab, Gujarat and Sylhet. Each of these geographical

areas has a range of difference in terms of religion, caste, class as well as by urban-rural distinction. In addition, South Asians from the Indian sub-continent also arrived in Britain by the way of East Africa; mainly Kenya and Uganda (Barker and Jane, 2016). The presence in Britain of people from the Indian sub-continent did not only begin in the 1950s when the post-war labour demands of the British economy encouraged their arrival (Nasta, 2002).

Post-Second World War era heralded a new phase in the history of immigration (Herbert, 2008). South Asian communities have figured most prominently in these migration processes and by the last quarter of the twentieth century, from India, Pakistan and Bangladesh due to the demand for more labour in Britain in an era for post-war reconstruction and economic expansion. As indigenous white workers progressed from menial jobs to the white collar sector, the numbers of Irish and Eastern European migrants could no longer fill the gap in labour shortages, so Britain turned to its former colonial territories, including the Indian subcontinent (Herbert, 2008). South Asian views on being a member of British society will differ amongst different generations of South Asians and this will impede on the perspectives on health which are based in the UK and of those which originate from the provinces of the Indian sub-continent.

The initial influx of South Asians composed mainly of sailors who worked for the East India Company, as well as servants and nannies who accompanied their imperial adventurers and administrators on their return from India to Britain. In the first half of the twentieth century, migration continued as South Asians employed on British merchant lines decided to settle in seaport cities such as Newcastle, Liverpool and

London. Similarly, a small number of Indian soldiers were recruited mainly from the Punjab and were expected to return home after the wars but stayed on in Britain (Herbert, 2008). Therefore, South Asians were never understood to be settlers in Britain, rather a population which support build the UK and return home. This will be different from those South Asians who are born in this country and only have connection to the Indian sub-continent through relations to the earlier South Asian generation.

The majority of early South Asian migrants in the 1960's had rural origins and belonged mainly to the poorer sections of the community. In the early phases of migration there was an under-representation of women amongst the South Asian population as the majority of South Asian men came without female relatives. They came primarily with the idea of accumulating sufficient savings and then returning home (Ali et al, 2006). Indian and Pakistani communities migrated to Britain during the 1950's and the mass migration of Bangladeshi people occurred in the 1980's.

The main influx of migrants was from India and Pakistan between 1965 and 1974 with 134,000 Indians and 68,000 Pakistanis entering the UK. The arrival of East African Asians was particularly rapid, rising from 6,000 in 1965 to 31,600 in 1967, with a further 27,000 entering Britain in 1972. The peak of arrivals from Bangladesh was from 1980 to 1984 when a total of 23,000 arrived in Britain (Herbert, 2008). East Africans settled mainly in Leicester and Northwest London, whilst Indians were most numerous in the northwest Midlands, London and West Yorkshire. Pakistanis clustered in the northern mill towns such as Bradford and Manchester, whilst Bangladeshis tended to settle in Inner London Boroughs (Herbert, 2008). An

important point to note is the locations where many South Asian migrants settled and reside in relation to where this study was undertaken. Leicester and London are two cities with a significant population of South Asian people and both cities have a significant South Asian male population.

East African, mainly Kenyan and Ugandan migrants in Britain differ from those migrants from the Indian sub-continent in several aspects. First, they are mainly, though not exclusively, of urban background. Second, Punjabis constituted the largest single linguistic group; the East Africans were predominantly Gujarati speaking. Third, as a group, they had comprised the largest component of the emerging middle classes of East Africa. Many of the Gujarati population from both Indian and East Africa settled in Leicester and London (Ali et al, 2006).

South Asian people who migrated to the UK came primarily as economic migrants to help build the infrastructure of Britain and economy. This meant moving home and building a new home thousands of miles away from the culture they had been born and raised into. Creating a home in another country involved making choices and compromises. It meant discarding some elements of Indian culture such as agriculture and spending much of the day outdoors. Indians inhibited a dual world and saw themselves as having a plural identity. Westernised, and immersed within their local communities, they also retained a sense of their Indian-ness and community solidarity, seen in the existence of social networks and emergence places of worship as early as the nineteenth century, and the growth of religious infrastructure in the inter-war years (Visram, 2002).

This plural identity of two cultures is evident in earlier first and second generations of South Asian migrants in England and less so with younger members of the South Asian populations who have more inclination towards Western culture and towards a single 'British' identity rather than 'dual identity. This is similar to the dual identity issues of Africans and now African-Americans who reside in the United States (Edmondson-Bell in Reason and Bradbury, 2006). Being part of two distinct cultures can both be beneficial and problematic. There will be moments when one culture is preferred over the other and a compromise on a specific trail of thought or an issue will be required. Dual identity of an individual is particularly interesting when considered to health and sexual health. South Asian men do not simply represent a group who have migrated to the UK, but a significant proportion of South Asian men are now born in the UK (Census, 2011) and their conceptualisation of sex and sexual health may differ from the that of men with men who possess 'dual identity' as a result of earlier migration patterns.

Providing a brief overview on the migration pattern of South Asian people to Britain helps to contextualise this study and provides insight into where South Asian men's understanding and attitudes towards sexual health may originate. Influences from the cultural and geographical heritage of the Indian sub-continent, as well as the post-war western liberal concept of sexual health in British society have shaped a unique sexual health culture and identity in South Asian men. Researching the community and individual perceptions of sexual health in South Asian men needs to take account of migration and how cultural heritage may influence this among South Asian men in England.

1.3 National and local South Asian demographics

The 2011 census in England and Wales has five broad categories (White; Mixed/Multiple; Asian/Asian British; Black African/Caribbean/Black British and Other ethnic groups) (ONS 2015). The South Asian population make up a small proportion of the current population in Britain but consist of a large ethnic minority group. The 2011 census figures show that Indian was the largest ethnic group of the South Asian population with 1.4 million people followed by Pakistani. This is consistent with census findings on international migration, which found that South Asian countries (India, Pakistan and Bangladesh) continued to rank highly within the most common non-UK countries of birth (ONS, 2012).

The South Asian/Asian British ethnic group categories had some of the largest increases between the 2001 and 2011 Censuses. People identifying as Pakistani and Indian each increased by around 0.4 million (ONS, 2012). High proportions of residents who were Kenyan, Tanzanian and Ugandan born identified as Asian (ONS, 2015). Half of those who identified with a Bangladeshi ethnicity arrived between 1981 and 2000, during a period of instability in the country following the Bangladeshi war of independence (1971) and military coup (1975) (ONS, 2015). Muslims are the second largest religious group of foreign-born residents. Previous published data has shown that 9 in 10 residents identifying as Pakistani and Bangladeshi ethnicity also identified as Muslim. Over half of Sikhs arrived before 1981 and the numbers have continued to fall over more recent periods (ONS, 2015).

1.4 South Asian culture

South Asian culture is so vast that no amount of literature can capture the richness of this culture. There are however, some key factors which shape South Asian culture within the context of British society. Clarity is required whether this research concerns the culture of South Asian population living in Britain who have migrated from the Indian sub-continent and East Africa, whether that be first or second generation migrants or whether this study is regarding the South Asian culture of people born and raised in Britain. There was no specific target age range and in terms of generation for this study; therefore a brief overview of culture in relation to all South Asian men was undertaken.

Minority ethnic groups have to contend with inappropriate generalisations of cultural practices and the use of simplistic explanations to explain their behaviour. Such explanations tend to present a static and one dimensional view of cultural norms and values, which are devoid of context and allow no room for individual interpretation (Ali et al, 2006). South Asian culture seems to have collapsed into an overall category and this will have an impact on the delivery and outcome for this research. Understanding South Asian culture requires understanding more than one culture and means understanding a whole set of cultures within cultures. It is impossible to understand all South Asian cultures during the period of this research, but one way to begin to understand this culture is to understand the South Asian household. The South Asian household provides an insight on South Asian men's role in the family and community and what are the key influences on their everyday lives.

1.5 South Asian household

The dimensions of the South Asian household of South Asian migrants differed to the dimensions of the white households in Britain. The country of origin was integral and at the heart of the South Asian household (Herbert, 2008). It is also better to understand the importance of religion in making sense of the lives of South Asian populations and religion is influential in the South Asian household (Modood, 1997). The principal aim of the South Asian household was to ensure the welfare of all family members and so individuals were guided by family duties and expectations of reciprocity. In conjunction with this, the principle of hierarchy was paramount. Family members were situated within strict hierarchical relationships which were expressed through ritual codes and behaviour and demanded covert displays of sub-ordinance and compliance to elders. Within this system, wives were expected to be submissive to men, to alleviate family tensions and ensure the harmonious working of the family. As a result, South Asians were not socialised to conceptualise themselves as autonomous individuals but viewed themselves in relation to the family and they were also acutely aware that their public behaviour was inextricably linked to the family's good name and reputation. Of course, this has changed since the early days of migration to England. Many South Asian families now resemble a Western or British family way of life and are less influenced by the family ideals which are stem from the Indian sub-continent. However, many issues in relation to the culture of South Asian families since the initial influx of migration still remain today in South Asian families such as the importance of religion and role of elders in the South Asian community. This also includes the role of gender and importance of shame and honour on individuals and families in the South Asian communities. The

importance of the family, elders, and religion and gender roles and expectations will inevitably influence the culture of South Asian men's sexual health.

The second-generation and third-generation since the 1970's witnessed the emergence of young Asians with a formal education acquired mainly, if not entirely, in British schools (Ali et al, 2006). This means there is a significant South Asian population in Britain who have a dual culture within the South Asian household. Understanding this issue of dual culture helps to understand the South Asian male population. South Asian men consist of men who have migrated, regarded as earlier generations and those born in the UK. Many young South Asian men are now educated in Britain and speak fluent English and this differs to migrant generations. The emergence of the youth population marks the coming of age of a new form of Asian political and cultural agency. It is not that this younger population is more 'progressive' than the parental age group; rather having grown up in Britain they articulate a home grown British political discourse. (Ali et al, 2006). This younger generation of the South Asian population in Britain are exposed to two cultures, one at home and the other at school (Ali et al, 2006). These two home-grown cultures are different to the culture South Asian male migrants brought with them from the Indian sub-continent. This further shows the complex nature of identifying South Asian culture in the context of this study. South Asian men's sexual health views will differ and very much depend on the perspectives they represent and the culture they are exposed to and represent.

South Asian culture as with culture of any community is complex. However, there are some key factors in relation to understanding the South Asian culture which

broadly include the importance of family amongst South Asian populations, the influence of religion, gender roles within the South Asian household. These broad factors only represent some of the issues in relation to South Asian culture but are essential when discussing South Asian culture. Religious and cultural beliefs are known to have great influence on individuals' health and behaviour (Wylie, 2015) and this is no different in South Asian communities. In fact, religion and cultural influences have a great emphasis on health and how health issues are promoted in the South Asian communities. To better understand this, we must understand some of the health issues and health inequalities present in BME communities and South Asian communities.

1.6 Brent and Leicester

The locations for this study were Brent and Leicester as they both represented a significant South Asian population and the area where I lived during the time of undertaking this study. A brief analysis on the key demographics of the London borough of Brent and city of Leicester was undertaken to further understand the environment of South Asian men who participated in this study. This demographic analysis demonstrated key differences but importantly the similarities between the two locations where South Asian men who participated in this study. In doing so, similar attitudes and behaviours towards sex and sexual health may be demonstrated amongst South Asian men.

The resident population in England and Wales in March 2011 was 56.1 million. This population is divided into 311,215 for Brent and 329,839 for Leicester. The borough of Brent has approximately 20,000 fewer people than Leicester. The gender

breakdown between Brent and Leicester show that both areas have a fifty percent male/ female split which is very similar to the national average of forty nine percent male and fifty one percent female split.

Leicester has a diverse population in comparison to the national average. Fifty percent of Leicester's population are from BME groups; most of whom represent a South Asian ethnic background. Leicester's diverse population is now marked by a higher number of younger people and a lower number of older residents (NHS Leicester and Leicester City Council, 2012).

Brent also has a diverse population and the area of Wembley in Brent has the largest South Asian population in London (Brent Council, 2001). Brent is one of only two local authorities serving a population where the majority of people are from ethnic minorities; London borough of Newham being the other authority. Brent's population is growing and figures indicate considerable numbers of BME people moving into the borough creating new communities, as well as a considerable transient population (Bowen and Fogarty, 2008). Data from the Census 2011 shows the ethnicity profile of England in comparison with Brent and Leicester. The following graph shows that Brent has an Asian/ Asian British population of thirty three percent and Leicester's Asian/ Asian British population of thirty seven percent compared with the national average of seven percent Asian/ Asian British population figure (1.1).

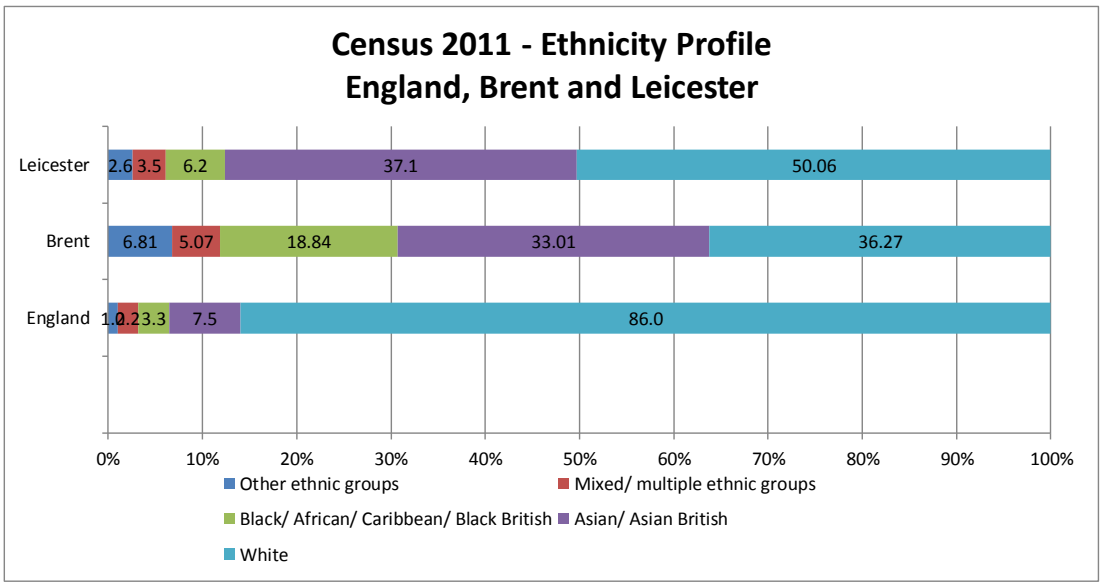
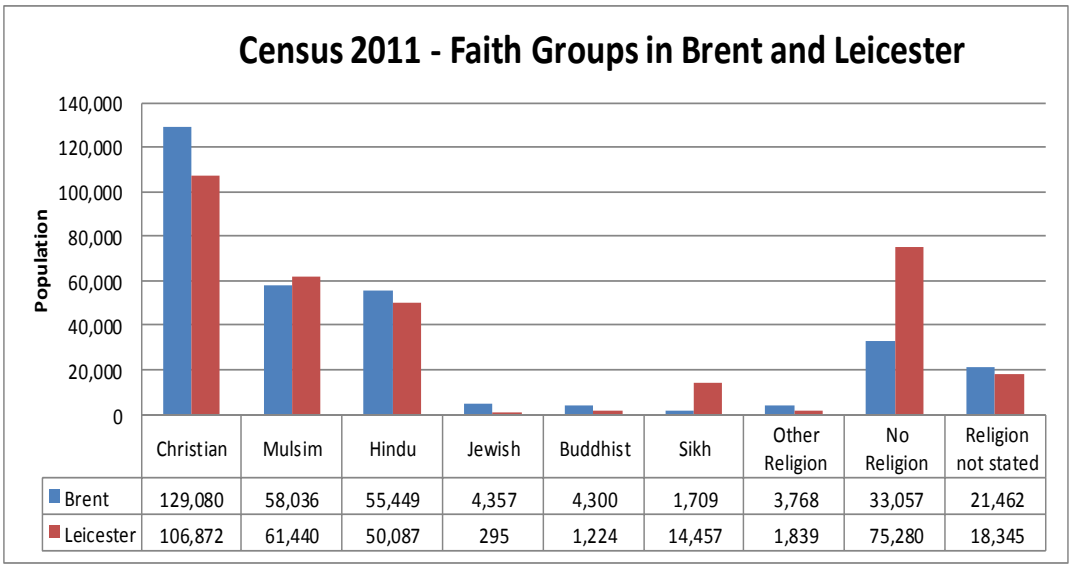


Figure 1.1: Census 2011- Ethnicity profile in England, Brent and Leicester

In addition to the breakdown in ethnicity, a breakdown of religious groups was undertaken to compare the population of Brent and Leicester. The following figure (1.2) shows that Brent and Leicester have a significant Christian, Muslim and Hindu population. Leicester also has a large Sikh population and a population consisting of no religion.



	Christian	Mulsim	Hindu	Jewish	Buddhist	Sikh	Other Religion	No Religion	Religion not stated
Brent	129,080	58,036	55,449	4,357	4,300	1,709	3,768	33,057	21,462
Leicester	106,872	61,440	50,087	295	1,224	14,457	1,839	75,280	18,345

Figure 1.2: Census 2011- Faith groups in Brent and Leicester

Brent and Leicester share many characteristics rather than differences. The population figures, gender proportion, ethnic breakdown and religious association resonate between the two areas. South Asian communities and South Asian men share many attributes in both Brent and Leicester (ONS, 2015).

1.7 Research aim and questions

The overall aim of this study is to:

- Understand how community and individual perspectives of South Asian men in Brent and Leicester influence concepts of sexual health and acceptability of sexual health services.

This research aim is broad and therefore a set of research questions were developed to help focus the study. The research questions are as follows:

1. What are South Asian men's individual and community perspectives of sexual health?
2. How are these perspectives influenced by cultural and family heritage?
3. What barriers do South Asian men believe exist in relation to raising the profile of sexual health amongst South Asian men in communities?
4. How can local sexual health services better engage with South Asian men regarding sexual health?

Chapter 2 Literature Review

This chapter critically discusses the policy and research literature that focused on sexual health in BME communities and considers the ways in which communities or the public can be involved in research as more than simply subjects or participants. The process undertaken to identify relevant literature is described. The literature review focused on the epidemiology and experiences of South Asian men's sexual health and public involvement in research.

2.1 Search Strategy

The search for relevant literature was undertaken in a systematic manner to identify key resources related to the involvement of South Asian in sexual health related research. A review was undertaken of electronic bibliographic databases, systematic reviews, journals and examination on the resource lists of articles and grey literature such as NHS research and guidance reports.

The literature review was undertaken in two phases. The first phase of the review focused on research which may have engaged with South Asian men in research related to sexual health, ideally of a qualitative nature and epidemiological data. The second phase of the review focused on South Asian men taking part in any form of research regarding health and sexual health care services in England. Therefore, the 'overarching' search terms used for this review included research, involvement and sexual health. Specific terms were used to narrow the search and identify relevant documents and studies were also used. A criterion was developed for documents which would enable the review to locate the appropriate literature

reflecting the research aim and research questions. This criterion is demonstrated in Table 2.1.

	Research	Involvement	Sexual Health
Overarching Terms	Research and Sexual Health	Public Involvement in Research	Ethnicity and Men's Sexual Health
Specific Terms	Research and BME communities	South Asian men and public involvement	Sexual Health and BME communities/ BME men
	Research and South Asian men	South Asian men, public involvement, sexual health	Sexual Health and South Asian men

Table 2.1: Criteria for literature search terms

It is important to note that the use of terms in the literature review will vary outside England and terms such as BME in the UK means Black and Minority Ethnic communities and in locations within the Indian Sub-continent this term is less recognisable. In addition, the term BME has been historically used to encompass all the ethnic minorities and racial groups in England and as discussed earlier, the term 'South Asian' is referred to people with origins from the Indian sub-continent which includes a wide population group. As this study targets South Asian men, the term BME and South Asian was used for this review to locate specific studies and documents concerning South Asian men and sexual health.

The initial literature review was carried out during November 2009 – July 2011 and was regularly updated during the study research period with a final search being carried out in May 2017 to ensure relevant studies informed the final thesis. Literature selected in this review was based only on studies undertaken in the UK to ensure relevance to the research target group of South Asian men living in Brent and Leicester. There was a particular emphasis on locating studies undertaken in England as the experience of diverse communities differs to the experience of minority communities in other countries, particularly with regards to the rationale and patterns for migration, community interaction and community infrastructure. Literature which was identified included reports on the impact of Government social and health policy, experience of being involved in research and public and user involvement with NHS and other local health providers. The NHS is a unique health care provider in the world and the voluntary and community infrastructure and policies in England differ from the third sector infrastructures of countries across Europe and beyond. The review was particularly keen to locate material from Brent and Leicester as they were the two locations for the research fieldwork but broaden the focus to England and UK as focusing on only two geographical locations limits the review to studies which may be relevant and undertaken elsewhere.

The literature review accessed material from national organisations including INVOLVE, Kings Fund, National Institute for Health Research (NIHR) and the Department of Health (DH). Electronic search engines totalling 23 databases were used and material was obtained (Appendix 1). This resulted in identifying 644,600 documents. Clearly, most of this material was irrelevant and search filters were used

on each of the databases to help identify potential documents related to the research aim and research question. As a result 76 documents were identified (Appendix 2).

The inclusion and exclusion criteria used for the literature review is shown in figure 2.1 and demonstrates how material was further refined and selected for analysis.

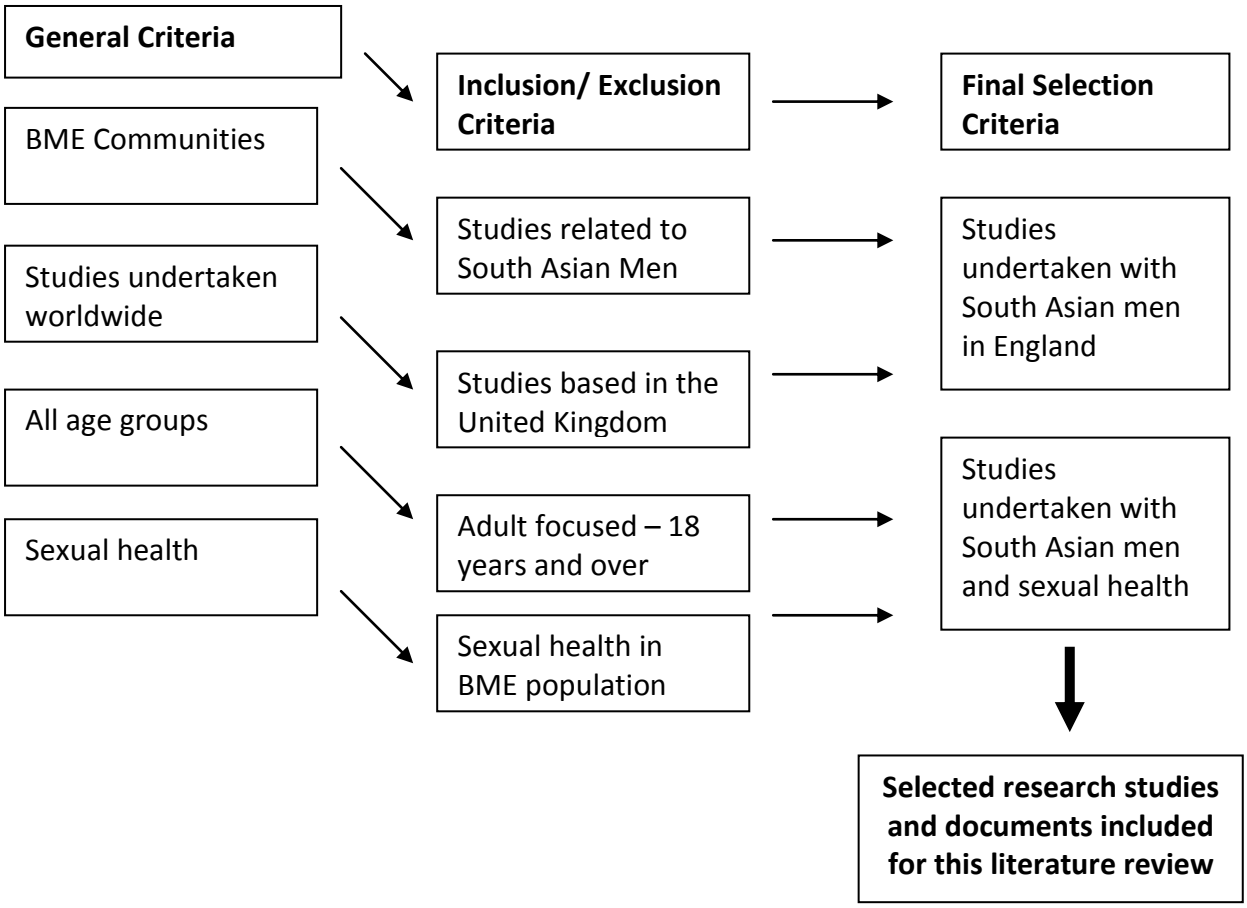


Figure 2.1: Literature review inclusion and exclusion criteria

2.2 BME health inequalities

This section provides a description on some of the health inequalities faced by BME communities and inevitably this will include health inequalities faced by South Asian communities and South Asian men. Inequalities in health in relation to BME

communities are well documented in the UK, but this is less evident for South Asian communities are less well documented.

Health inequality is defined as; an inequality regarding health in comparison to different population groups in relation to access to services, experience and needs being addressed. Identification of health inequalities in the UK is important to ensure that disadvantaged individuals and populations improve their health in relation to disease, illness and improve general health and well-being.

Understanding health inequalities from a BME perspective is important as this provides a platform to further understand health inequalities prevalent to South Asian men. At the end of the 1990's the UK government acknowledged the importance of providing accessible and appropriate health and social care to minority ethnic populations living in Britain (Acheson, 1998). Since then there has been considerable activity aimed at reducing health inequalities and establishing equitable health services. Ethnicity health has been considered at national and local policy levels. However, what this has actually meant for South Asian population is less clear. Nonetheless, the translation of this understanding into improved health outcomes and better service support has been slow. The disadvantages experienced by South Asian communities and the process of what can sometimes be described discriminatory health service delivery are now reasonably well understood such as recognising cultural and religious matters in relation to health professionals recognising the issue of gender preferences and dietary requirements in acute settings (Acheson, 1998).

2.2.1 Diversity and health

Those working in public services and local communities need a critical understanding in their practice that will enable them to tackle, rather than be overwhelmed by, the problems of providing accessible and appropriate health care in an ethnically diverse society. There is a need to take into account diversity and differences when planning and delivering health services to BME communities (Ali et al, 2006). Serrant-Green and McLuskey (2008, p.112) add that "improving the health of men from BME communities is a complex task. It involves engaging with many difficult subjects and integrating a clearer understanding of the cultural and ethnic diversity within and between communities".

Ignoring diversity and difference is only one element of providing inadequate health services. Occurring simultaneously and equally important is the misrepresentation on the healthcare needs of South Asian people. When the differences of South Asian populations are recognised by health and social care agencies, it is often to their disadvantage. Sometimes this is the consequence of ill-informed views about the cause of problems presented by South Asian populations; at other times it is the use of inappropriate myths and stereotypes, which although purporting to explain the behaviour and beliefs of South Asian populations, do little more than falsify their experience (Ahmad, 2000). Consequently, South Asian communities are held responsible for their problems and are frequently characterised as in some way to blame for their need because of their so-called deviant unsatisfactory and pathological lifestyles (Ahmad, 2000). An example is where language is an issue and the lack of translation and interpretation may be the option and required. Often

the case that is required is a culturally sensitive approach rather than a supply of material and support provided in various South Asian languages.

The issue of men's sexual health and South Asian men's sexual health is less documented in the literature of BME health inequalities. Health literature which is available is focused towards the sexual health of gay men. This is important, but health research and literature needs to go beyond sexual orientation and understand how external influences impact on South Asian men's sexual health. Better understanding regarding the culture surrounding South Asian men's sexual health prevents this lack of understanding to occur. There is also a need to recognise the complexity associated with ideas such as ethnicity, difference and diversity. This means acknowledging differences between and within different 'ethnic' populations as well as accepting that ethnicity is not always the only explanation for disadvantage and discrimination. Diversity and difference needs to be understood within a broader context in line with socio-economic status, age and gender which are all equally important as ethnicity in making sense of a person's health and social care needs (Ali et al, 2006).

2.2.2 South Asian health inequalities

Interestingly, many of the problems faced by South Asian people who use health services are similar to those faced by other minority ethnic communities in England, although there are differences in access to care and treatment and in the way people are treated within services. There is also a difference in the perception of health and of health services within South Asian communities but there are also significant

similarities and differences in regards to socio-economic status and health status amongst each South Asian group (Ahmad, 2000).

At the beginning of the 1990s it was possible for health and social policy to present South Asian populations as a discrete group. There is now recognition on the differences in both socio-economic positions and cultural values among Indian, Pakistani and Bangladeshi populations (Nazroo, 1997). Low socio-economic status seems far more likely than ethnic origin or cultural difference to be responsible for ill-health among South Asian populations (Ali et al, 2006). There is a history of defining health problems faced by South Asian populations in terms of cultural deficits, for which the main solution offered are towards a 'Western' lifestyle (Ali et al, 2006). We need to acknowledge that South Asian populations may not be all that different from the general population, particularly in relation to health.

Focusing on the needs of South Asian populations is not the same as responding to those needs. Using the available evidence to make improvements in service delivery is a far from straightforward process and in the past, policy and practice has seemed overwhelmed by the difficulties of responding to the needs of South Asian people (Ali et al, 2006). Health policy and practice needs to shift its focus and ensure the present evidence base is used more effectively to improve outcomes for South Asian populations (Ali et al, 2006). The sexual health of South Asian men was considered for this study because of an absence of sexual health research beyond the sexual health disease, sexual health of gay/ bi-sexual related to South Asian men. This study attempted to understand the culture of sexual health in a broader context irrespective of South Asian men's age, sexual preference and ethnic category and

contextualises sexual health within a framework which recognises identity, migration and religious and cultural influences. The focus of this research is on South Asian men's sexual health and therefore before exploring men's sexual health it is also useful to understand issues related to men's health.

2.3 Men's health

Before discussing men's sexual health it is important to put men's health into some context. There has been a rapid increase of interest in the health of men (Men's Health Forum, 2014). Men's health has moved from complete silence to now being recognised as an area of almost equal importance to women's health (Robertson 2007). Men have equally the need for physical and emotional health issues to be addressed as women. Suicide, depression, binge drinking, violence, heart disease and drug taking: each is significantly higher among men than among women in most western contexts and each is highly problematic for men's health and wellbeing (Broom and Tovey, 2009). In addition:

- The average male life expectancy at birth is currently under 75.
- Heart disease and stroke are together the biggest single cause of male deaths.
- Nearly 22,000 men in the UK are newly diagnosed with prostate cancer each year and about 9,500 die, the number of new cases is expected to treble over the next 20 years as the population increases.
- The incidence of testicular cancer has doubled in the past 20 years.
- Indian, Bangladeshi and Irish men have higher rates of heart disease, and African-Caribbean and Bangladeshi and Indian men have higher rates of stroke.
- Sexual problems are common among men, almost one-fifth of men in their 50's experience erectile dysfunction (Peate 2003, p.49).

Men on average, die six years younger than their female contemporaries, even though there are more males born each year (Peate, 2003). Women engage in far more health-promoting behaviours than men and have healthier lifestyle patterns. Little is known about why men engage in less healthy lifestyles and adopt fewer health-promoting beliefs and behaviours (Broom and Tovey, 2009). It is widely recognised that men do not access family doctors to the same extent as women (Peate, 2003). They are not frequent attendees on the majority of services related to health. This may be due to men's bodies remaining static, meaning men's bodies are relatively unchanging with regards to physical and hormonal changes in comparison with women's bodies. Men who do not use health services come primarily under two categories. The first being not wanting to waste time of services and secondly men tend to deal with health matters on their own (Conrad and White, 2007). Conrad and White (2007, p.22) mentions "research that shows men are reluctant to seek help and delay in seeking help. If men are not coming forward to use health services then services must go to men".

Men's health is unnecessarily under resourced than it needs to be and men are reluctant users of health services due to the difficulty of access, cultural norms and false perceptions of services being mainly orientated towards women and children (Wlikins and Baker, 2004). There is a need to identify effective ways of involving men in issues related to health and there is a need to capture the different experiences of health amongst diverse groups of men in our society (Luck et al, 2000). Men's health is also an area under researched, despite many men being part of a great deal of research studies as participants within cardiovascular health, drug and alcohol misuse, diabetes and prostate cancer (Wilkins and Baker, 2004).

Health research often assumes that males are a homogenous group (Bhopal, 1997; Gunaratnam, 2003). Bhui et al (2002) suggests men's health is studied less due to the stigma associated with research, an unwillingness to participate in studies, the ideas about men's roles and the expectations in the community.

The views of men on their experiences regarding health is less documented than women. There is a striking absence of knowledge relating to men's health that is grounded in the everyday experience of men themselves (Robertson, 2007; Watson, 2000). There are significant bodies of material and data that relate to male medical conditions, epidemiology and gender differences in disease profiles, psychological measures of masculinity and their relationships to health outcomes (Robertson, 2007; Watson, 2000). However, there is less comparative body of qualitative empirical data relating to men's health experiences. Furthermore, this health experiences is less available on BME men and South Asian men.

2.3.1 Defining men's health

There are many views on what is meant by men's health but few precise definitions and no one universally agreed definition of what is meant by men's health. Men's health is complex and involves many associated factors such as age, social class, ethnicity, marital status, sexuality, employment status, social network, genetics, health behaviour and these are all also relevant to women's health. The difference is that many of these factors are taken into account when discussing women's health but many factors are absent when discussing men's health. Men's health is usually associated with disease alone. We now know men's health exceeds disease and

illness and in this respect men's sexual health will need to be discussed (Men's Health Forum, 2014).

Previous understanding whereby men's health is understood from a disease perspective alone is changing. It would be foolish to relegate the issue of men's health to disease association alone (Harrison and Dignan, 1999). Men's health is a complex subject based on differences related to age, social class, marital status, sexuality, ethnicity, employment status, personal health beliefs and behaviour which all can be significantly influenced by education and life experiences. Therefore, in line with the above definition, and in context of this study, men's health is understood to encompass physiological, psychological, social and environmental factors. Similarly, this study needs to take on board all these factors when exploring the issue of sexual health. There is no one universally agreed definition of what is meant by 'men's health' and this may be one of the barriers for health professionals discussing or taking up men's health as an important issue for the male population. In their policy document *Getting it Sorted* (2004) Wilkins and Baker provide a view of defining men's health:

> …male health issue is one arising from physiological, psychological, social or environmental factors which have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level (Conrad and White, 2007, p.10).

Better understanding of men's health is required. Better understanding of BME and South Asian men's health is also required. South Asian men's health is normally associated with diabetes and cardiovascular related disease (CVD). South Asian

men's sexual health is of a less importance compared to diabetes and CVD, despite sexual health being a national priority in England (Men's Health Forum, 2014).

2.4 Sexual health

Improving sexual health is considered a national and international priority (WHO, 2006, 2010. The Department of Health (DH) (2013) *Framework for Sexual Health* makes it clear that sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. Ensuring access to appropriate sexual health information, interventions and services can have a positive effect on population health and wellbeing as well as individuals at risk (Murphy and Rodrigo, 2014).

In England there is no direct national health policy related to the sexual health of South Asian men. However, in the DH (2001) *Better Prevention, better services, better sexual health – The national strategy for sexual health and HIV* there is recognition of developing targeted sexual health information for BME groups and that sexual health disease and HIV diagnosis is not equal amongst the different BME communities. There is no particular reference towards the sexual attitudes, behaviours and experiences of South Asian men in national sexual health policy. This suggest either there is no need for a specific policy on the sexual health of South Asian men and that South Asian men's sexual health needs not to be considered any differently to the sexual health of men from BME communities or all men in England. It also suggests that there is not enough information is available on South Asian men's sexual health. What is required is an understanding at a local level where South Asian men reside and that sexual health services take into

account local influences and infrastructure to meet the sexual health needs of South Asian men. Information which is widely available is usually related to rates of sexually transmitted infection (STI) amongst South Asian men or in reference to sexual health services aimed at South Asian gay men.

Improving sexual health is a national priority that was also made explicit in the *'Healthy Lives, Healthy People', White Paper 2010, Health and Social Care Act 2012* and the *Public Health Outcomes Framework 2013-16*. There has been a steady increase in the incidence of STI across the UK in recent years (OSML, 2013). The first National Strategy for Sexual Health and HIV (DH 2001) addressed the growing incidence of STI's and HIV and aimed to modernise sexual health and HIV services. A clear link between sexual ill health, poverty and social exclusion was identified, as well as the unequal impact of HIV on gay men and certain BME groups. The DH (2013) published the *Framework for Sexual* Health Improvement in England setting out the nation's ambition and objectives and as shown in the figure below (2.2):

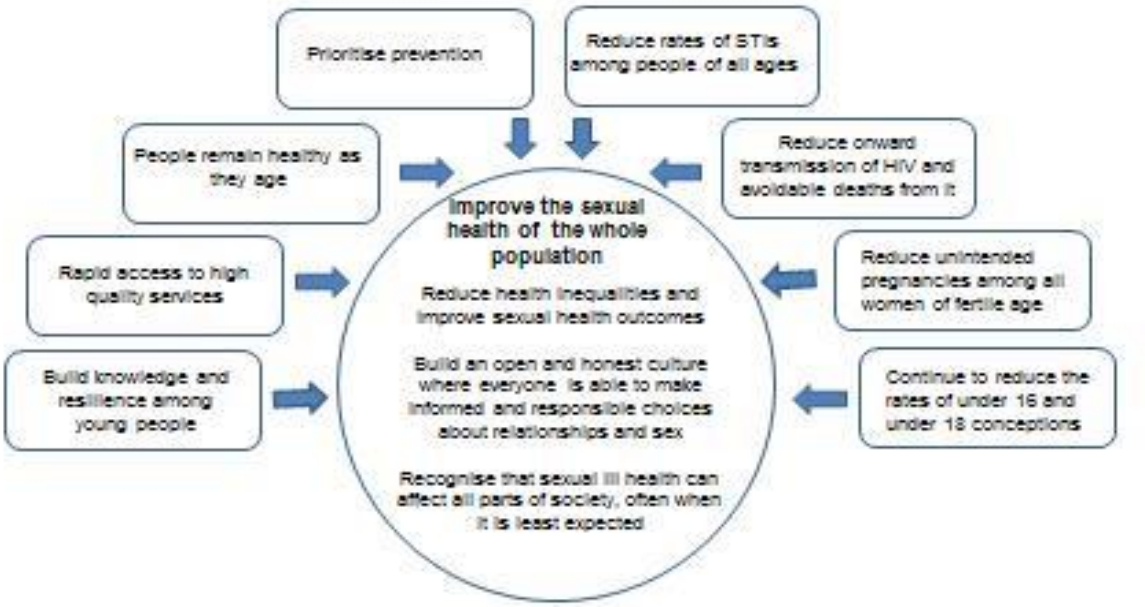


Figure 2.2: DH framework for sexual health

The DH (2013) framework is clear that sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. However, while individuals' needs may vary, there are certain core needs that are common to everyone. There is ample evidence that sexual health outcomes can be improved by:

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health
- preventative interventions that build personal resilience and self-esteem and promote healthy choices
- rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times
- early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk; and joined-up provision that enables seamless patient journeys across a range of sexual health and other services and this includes community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings (DH, 2013).

2.4.1 Sexually transmitted infections (STI)

There has been a steady increase in the incidence of sexually transmitted infections (STI) across the UK in recent years (DH, 2013). The first national strategy for sexual health and Human Immune Deficiency Virus (HIV) (DH, 2001) addressed the growing prevalence of STIs and HIV and aimed to modernise sexual health and HIV services. In this strategy there is a clear link between sexual ill health, poverty and social exclusion as well as the unequal impact of HIV on gay men and certain BME groups (DH, 2001). Despite this acknowledgement, South Asian men's sexual health is less at the forefront of -sexual health research and sexual health services.

The Health Protection Agency and The UK Collaborative Group for HIV and STI Surveillance (2005) states that:

> .....sexually transmitted infections are the greatest infectious disease problem in the UK today. Each year more than 1.5 million new episodes are seen in UK clinics for GUM. The morbidity and associated mortality is substantial, and disproportionately affects gay men, marginalised communities and young men with high risk sexual lifestyles". (Conrad and White, 2007, p.47).

The Department of Health (DH, 2013) state sexual behaviour is a major determinant of sexual and reproductive health. Certain behaviours are associated with increased transmission of STIs and HIV which include:

- age at first sexual intercourse
- number of lifetime partners
- numbers of concurrent partnerships
- payment for sexual services
- alcohol consumption and
- substance misuse.

Despite the strengthened national focus, rates of STIs continue to rise, with genital Chlamydia and Gonorrhoea being the most common infections locally and nationally

(DH, 2013). People with STIs which may include HIV, may be unaware that they have a disease and may remain undiagnosed. If it is not diagnosed because there are no symptoms, then by definition this is not considered a disease which is a potential source for further transmission. This not only affects their overall health and wellbeing but increases the risk of onward transmission in the population (Murphy and Rodrigo 2014).

2.4.2 Sexual health and BME communities

Research and statistics on the sexual health of BME communities in Britain is still in its early stages. There are many studies on African communities and HIV, but less around other BME groups besides African communities and this tends to be small pockets in and around London (Serrant-Green and McLuskey, 2008). Research needs to expand to different BME groups and across the country (Serrant-Green and McLuskey, 2008). Improving the sexual health of men from BME communities is a complex task. Furthermore, it requires an understanding of the cultural and ethnic diversity within and between communities (Serrant-Green and McLuskey, 2008). Peate (2003) concentrates on five areas in relation to men's sexual health such as men's health epidemiology, testicular cancer, erectile dysfunction, definition and prevalence, prostatic disease and sexually transmitted infections. However, Peate (2003) fails to consider how ethnicity may impact on South Asian men's sexual health. The needs of men's sexual health vary amongst BME groups due to awareness on sexual health, differential patterns of migration, age, gender roles (Luck et al, 2000).

Serrant-Green and McLuskey (2008, p.96) state “views about sexual health vary amongst BME communities, although there is general consensus amongst these groups that sex outside of marriage is viewed as wrong and discussions about sex are taboo”. Sexual health is a sensitive topic to discuss at both a community and individual level. Undertaking sexual health research is also sensitive as this move to the intimate and private thoughts of an individual and brings those voices into the public sphere. It is important to undertake research on sensitive health topics because it illuminates the darker corners of society and brings them to the forefront of society and explores methodological debate on how these topics can best addressed (Lee, 1993). Research on South Asian men’s sexual health means exploring cultural and religious ideals and values which may prevent discussing sexual health amongst South Asian communities. The lack of discussions on South Asian men’s sexual health in the South Asian community demonstrates the level of sensitivity on this health issue.

Dialogue on sensitive health issues in the community means discussing related matters which are of importance to the community. This means understanding and recognising the different disadvantages amongst different populations. Health service providers and researchers have been accused of being particularly reluctant in adopting a critical approach to the needs of BME clients, particularly in acknowledging the effects of race and racism on health (Gunaratnam, 2003). As a result the wider health implications resulting from the interplay of ethnicity, class or gender on sexual health have received little attention (Balsa and McGuire, 2003; Culley, 1996; Gerrish et al, 1996; Serrant-Green and McLuskey, 2008). Sexual health promotion and prevention work aims to help people make informed and

responsible choices with an emphasis on healthy decisions. Effective health promotion and research addresses the prejudice, stigma and discrimination that can be linked to sexual ill health (Department of Health, 2013).

The concepts of sexuality and sexual health have produced much debate over the years and they have also proved problematical for many health professionals in attempts to define the concepts of men's sexual health (Peate, 2003). The Department of Health (2001; 2004; 2006; 2007; 2012) recognised the need to develop targeted sexual health information for BME groups. Sexual health interventions in England aimed at men are few compared to sexual health interventions aimed at women. This is partly due to sexual health services in England initially being developed out of the need to provide effective sexual health services for women such as ovarian and cervical screening and prenatal/ post-natal care (Peate, 2003). Historically, the rise of breast and ovarian cancers in women has been more acknowledged in mainstream health policy in comparison to men's cancers such as prostate and testicular cancer (Peate, 2003). Specific health concerns for men such as prostate cancer have fallen behind in the world of scientific research and men's health is unnecessarily poorer than it needs to be and men are reluctant users of health services due to the difficulty of access, cultural norms and false perceptions of services being mainly orientated towards women and children (Wilkins and Baker, 2004). Health policy, public health campaigns and the focus of community health organisations are still strongly biased towards addressing women's health issues (Broom and Tovey, 2009).

2.5 Influences on sexual health

Currently a public health approach toward sexual health is used and this is typified by the following characteristics; the focus is on the health of populations, rather than that of individuals and the emphasis on prevention of ill health and promotion of wellbeing rather than on cure and treatment (Wellings et al, 2012). Sexual health presents particular challenges for public health because the behaviours involved are not only for the most part personal and private, but may be stigmatised and discriminated against. Morals, taboos, laws, and religious beliefs employed by societies influence the sexual behaviour of individuals (Wellings et al, 2012). A useful framework with which to understand the different influential levels of sexual health is provided (Cullmbien et al in Wellings et al, 2012). See figure below (2.3):

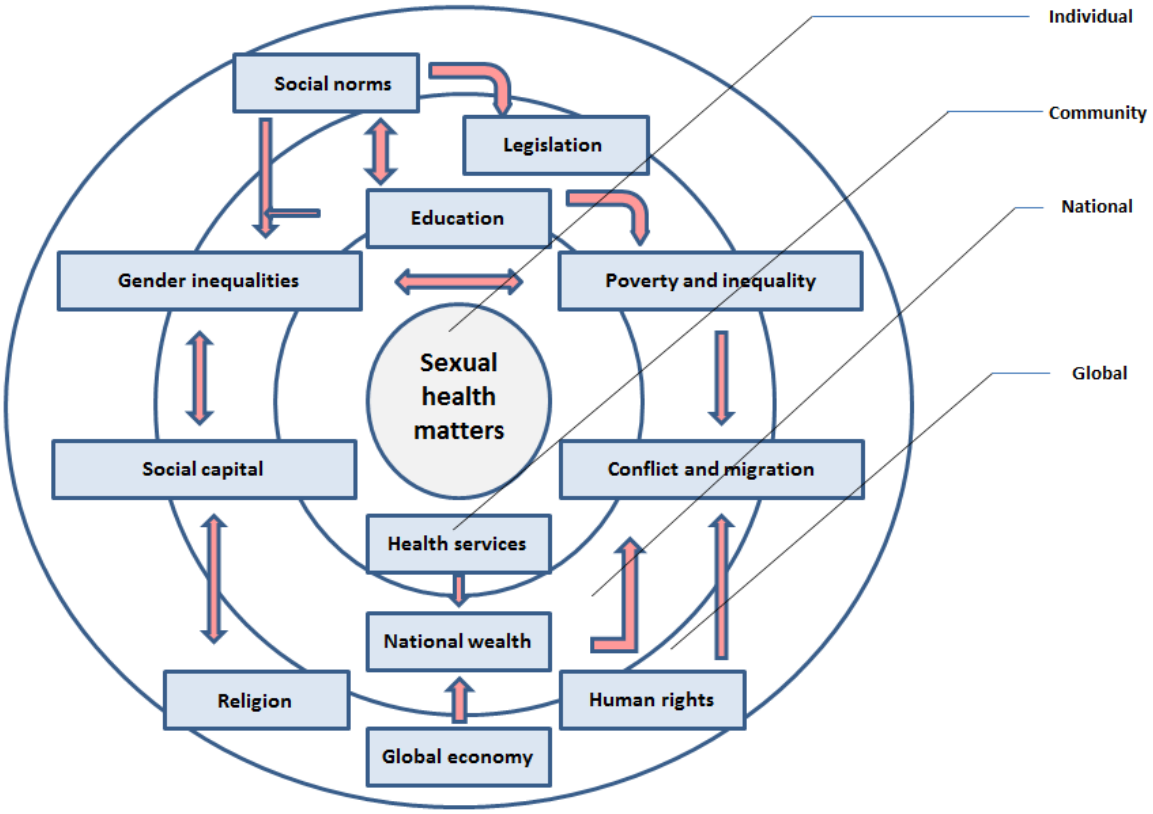


Figure 2.3: Influential levels of sexual health

Increasingly, public health recognises the role of the broader structural factors in relation to sexual health (Cullmbien et al in Wellings et al, 2012). At the heart of social structural perspective is the recognition that behaviour is more than merely a personal choice. Social structure, institutions, and norms provide the potential for, and impose limitations on, human agency and action (Cullmbien et al in Wellings et al, 2012). Central to this model is the recognition that factors external to the individual, such as inequitable power structures, absolute and relative poverty and differential access to resources, social isolation and discrimination restrict an individual's ability to achieve positive health outcomes or to facilitate change (Cullmbien et al in Wellings et al, 2012). These factors create 'risk environments' that disproportionally influence the health outcomes of the poorest and the most vulnerable (Cullmbien et al in Wellings et al, 2012).

Operating at greater distance from individual action are macro-level factors such as the national and global economy, levels of development, political organisation and systems of governance, and social norms often underpinned by laws. Public policies are included in macro-level influences, which encompass provision of education and healthcare services, transport and housing. At a more proximate level, community-based inequalities foster differentials in sexual health status. They include inequalities in wealth, income and availability of resources, relative and absolute area-level deprivation, population density, adequacy of transport systems and access to public health interventions and healthcare facilities, and social organisational factors such as cohesion (Cullmbien et al in Wellings et al, 2012). In the more immediate context on the lives of individuals, living conditions, personal

relationships, and financial resources have the potential to influence health (Cullmbien et al in Wellings et al, 2012).

Wellings and Johnson (2013) signpost that resistance to a broader approach to sexual health may include that the focus on adverse biomedical outcomes is more comfortable for practitioners and less controversial for policy makers. Clinicians and researchers alike find it easier to ask about matters that relate to safer sex than to raise sensitive issues of pleasure, power, and exploitation. A life course approach is another important part of a broader perspective on sexual health. A narrow conceptualisation of sexual health (Cullmbien et al in Wellings et al, 2012) excludes the sexual health needs of large subgroups of the population.

2.6 Sexual Health in Brent and Leicester

NHS Brent Clinical Commissioning Group (NHSBCCGLBB) and London Borough of Brent (NHSBCCGLBB) (2014) state that in 2011, there were 4,413 diagnosed cases of STI's in Brent, a rate of 1,413 per 100,000 of the population; this is considerably higher than the England average of 804 per 100,000 populations. NHS Brent CCG and LB Brent (2014) also state that in 2012 there were 886 people aged between 15 and 89 living with diagnosed HIV in 2013. Late diagnosis of HIV is associated with a worse prognosis and an increased risk of onward transmission. In Brent, 56% of HIV diagnoses are at a late stage, compared to 52 percent in England and 50 percent in London as a whole.

Sexual heath is a critical issue particularly for young people under-25 in Brent (Brent Primary Care Trust, 2010). There is an overall increase in the diagnosis of STIs,

particularly Chlamydia predominantly amongst the under-25 age group. The increase is in part due to better diagnostic techniques and a Brent Primary Care Trust (2010). Consultation with young people highlighted the need for access to sexual health information and services as high priority. Brent Primary Care Trust (2010) found a lack of awareness on local sexual health services, lack of sexual health awareness and lack of publicity targeting men and particularly targeting men from BME groups. A sexual health service to target BME communities was commissioned by Brent Primary Care Trust, although emphasis was not towards South Asian men at the time (Brent Primary Care Trust, 2010).

Brent Primary Care Trust (2010) identified the low uptake of sexual health services by South Asian men. It is important to note that this report only used data which was made accessible through local Genitourinary Medicine (GUM) clinics, primary care and local acute trusts and therefore did not provide information regarding the evaluation of local sexual health programmes and activities that may have been undertaken with South Asian men in the borough. There is an overall lack of evaluation capturing the impact of sexual health interventions targeting men from BME communities in this assessment.

Sexually transmitted infections continue to be an important public health problem in England. In 2012, Brent ranked 21 out of 326 local authorities in England for rates of STIs. Ottaway Strategic Management Limited (OSML) (2013) mention there was targeted work undertaken in Brent with BME population and this is delivered by services such as the Community Health Action Trust (CHAT) and The African Child organisation. All other providers in the borough are reaching strong proportionality of

these targeted BME communities in their patient profiles. CHAT and the African Child have a clear mandate and are commissioned to target work with these communities. Both services operate with slightly different client groups. CHAT targets adults particularly in the African communities and the African Child targets young African men and women. Currently there is no targeted service in Brent to engage with young or older South Asian men on sexual health.

A stakeholder survey undertaken in Brent by OSML was completed by 49 respondents (OSML, 2013). Results of this survey suggested that sexual health issues are affected by a wide range of social, cultural and economic factors including:

- Education and awareness about sexual health and availability of services
- Proactive outreach work, especially in educational settings, such as schools, community groups and youth groups
- Support for integrated services, combined sexual health and contraceptive services
- Sharing of information between services, including audience information (information for patients and members of the public) and the referral pathway
- Targeting specific high risks groups, including particular BME communities such as men who have sex with men (MSM) from BME groups, sex workers, looked after children and children leaving care
- Services need to be available during evenings and weekends
- Greater involvement of GP practices
- Normalise the management of sexual health amongst the whole population in order to reduce stigma and shame
- Website to include up to date service listings, and use of other web and video based tools such as Twitter and Facebook.

This work suggests that there is a recognised need to promote positive sexual health messages and prevention of sexual disease in BME communities of Brent (OMSL, 2013). The lack of specific information on South Asian men's sexual health suggests that there is a need to begin collating local knowledge on South Asian men's sexual

health to better understand and ensure sexual health services effectively work with this group to plan better sexual health prevention campaigns and interventions. Leicester continues to be an area with significant sexual ill health as evidenced by the high rates of acute STI's and HIV compared to the national average (Murphy and Rodrigo, 2014). Leicester is the sixth highest prevalent area for HIV outside of London (Murphy and Rodrigo, 2014). New diagnoses are made every year both in clinical and in non-clinical services. Black African and MSM communities are the two population groups in Leicester who are most affected by HIV given their relative proportions within the population.

NHS Leicester and Leicester City Council (2012) state sexual health in Leicester is similar to the national picture with rising numbers of STI's. Chlamydia is the most common STI in Leicester. The overall number of new STI diagnoses increased in Leicester between 2009 and 2012 with young people under the age of 25 being disproportionately represented in these figures (Murphy and Rodrigo, 2014). Greater emphasis needs to be placed on targeting areas where the likelihood of a positive result is increased, that is those areas with a considerable BME and South Asian populations.

It is clear sexual health is a national priority and a priority across the country including Brent and Leicester. Sexual health is equally a priority amongst men as it is amongst women. Key issues in relation sexual health and sexual disease are important factors such as demographics, population, age, gender, ethnicity and socio-economic status when understanding the culture of sexual health. What is

evident is the lack of information associated with the South Asian men's culture at a national level and in Brent and Leicester.

2.7 Sexual health research and South Asian men

This section will focus on sexual health literature related to BME communities, particularly in relation to the research aims and research questions for this study. There was vast literature identified regarding the sexual health of South Asian men in England but much of this was within a clinical research context and mainly concerned with STI. As mentioned earlier, the emphasis of this literature review was aimed at obtaining 'qualitative' and epidemiological data regarding sexual health research. Therefore, the review focused on data and information which supported the research aim and questions.

Bradby and Williams (1999) study on the behaviours and attitudes of young British South Asians on sexual health was undertaken in Glasgow. This was a cross sectional study of sexual behaviour using self-reported measures in a self-complete section of a social survey administered in 1996. 824 14 – 15 year olds recruited of which 492 Asians (primarily the South Asian Punjabi community) and non-Asians subsequently traced through general practitioner registration in 1996.

Bradby and Williams (1999) study found that South Asians were far less likely to report having had heterosexual intercourse. South Asian men were less likely than non-South Asian men to report condom use. South Asian sexual abstinence was reported to be for religious reasons, which the study found was less important for non-South Asians. The higher level of sexual abstinence among South Asians has

implications for the delivery of sexual health services to the minority who are sexually active before marriage (Bradby and Williams, 1999). By using individual questionnaires for this study it allowed participants to share experiences and views openly possibly in comparison within a group situation. Although, the disclosure of sexual related information and confidentiality was also a major concern for participants in this study. Bradby and Williams (1999) highlighted the lack of research into the social epidemiology and sexual behaviour in any one ethnic group of South Asian origin. This issue has developed greatly since this study in the 1990's (Bradby and Williams, 1999).

Importantly, Bradby and Williams (1999) study points out that British Asians are good candidates for preventative services as they use general practitioner services as much or more than other ethnic groups. Their article discusses the political and practical difficulties of sexual health research with any social group, and particular difficulties with ethnic groups which may be influenced by stereotypical and racist overtones of undertaking research. Bradby and Williams (1999) concludes by suggesting that sexual health services (primarily in Glasgow) would benefit from public relations work with young South Asians and target both married and non-married men, particularly encouraging condom use as the under reporting of condom use may not be the best indicator of sexual relations amongst South Asian men (Bradby and Williams, 1999).

Cultural and religious influences are highly important in the South Asian community (Bradby and Williams, 1999). Understanding the role of religious and cultural influences is important for sexual health services as this can help develop better

public relations with South Asian communities in order to improve sexual health within the South Asian community. However, Bradby and Williams (1999) do not provide a method of understanding religious and cultural issues, particularly in relation to sexual health and how sexual health services can begin to address religious and cultural sensitive issues within the South Asian community.

Weston (2003) paper on 'Public honour, private shame and HIV: issues affecting sexual health service delivery in London's South Asian communities' argues that communally held concepts of honour and shame within South Asian communities create a framework of social control with significant implications for HIV/AIDS transmission. Weston (2003) paper is focussed on BME, South Asian men who have sex with men (MSM), using international and national data on HIV. HIV transmission occurs in South Asian countries and is one of the fastest growing areas for HIV infection in the world. Weston (2003) paper focuses on how this epidemic impacts on British MSM and how sexual health services need to provide effective support for British Asian MSM. The Weston (2003) paper describes how stigma associated with HIV/AIDS is powerful in the South Asian communities in the UK as this is closely related to public and family honour. The role of the family in South Asian communities is paramount. Sexual health services need to understand this socially constructed view of public and family honour to tailor sexual health services.

There is a need for researchers to pay more attention to BME health in general if disparities in the quality and quantity of health services available to different ethnic groups are to be addressed. Only a limited amount of quantitative data is available for use in establishing a baseline from which to measure the success of sexual

health interventions, and to identify areas of priority in intervention design. Quantitative evaluation of ethnic differences in sexual attitudes and behaviours is also essential if the consequences for sexual health promotion are to be fully understood. More significant though is the lack of qualitative research addressing the health beliefs and behaviours of the various BME groups in the UK. Those engaged in research with BME communities need to address the question of how to access BME groups in order to facilitate their participation in the study process and ensure that the research is an enabling rather than an extractive process.

Weston (2003) suggests that not only ethnic specific agencies are capable of providing culturally sensitive services to BME communities but that generic agencies too can develop the capacity to meet the needs of some BME individuals and this is also recently reflected in the DH (2013) sexual health objectives. Therefore, there is a place for both ethnically specific and generic sexual health service provision to meet the needs of BME communities. Finally, there remains an almost total absence of research addressing the sexual attitudes and behaviours of British South Asians, and the effectiveness of existing health service provision for these groups. This needs to be addressed.

Sinha et al (2007) study explored the sexual behaviour and relationships amongst BME teenagers in East London. The study examined how sexual behaviour and attitudes are shaped by culture, gender, peer norms and religion and how this has implications for sexual health policy and practice in urban, multicultural areas. This was a mixed method study amongst 126 young people aged 15 – 18 years in the London boroughs of Hackney, Newham and Tower Hamlets. The experiences of

teenagers in London may vary to the experiences of BME teenagers across the UK. This study is unique in the sense that the focus was on the influences of sexual health rather than reliance on sexual health data. The study focused on religion, culture and family using 30 qualitative focus groups across 15 young and community centres. The Sinha et al (2007) study found that culture, gender, religion and youth influence BME teenagers in aspects of sexual relationships and that these social markers may have different contextual meaning for individuals. This is no different for teenagers from non BME backgrounds. The study concludes by suggesting BME teenagers requires sexual health services to provide contraceptive services, counselling, screening and sex education, only delivery patterns of such interventions need to take into account local demographics and local culture.

Sexual behaviour and relationships of BME teenagers are influenced by culture, gender and religion. However this study (Sinha et al, 2007) points out that knowing and individuals ethnicity and/or religion does not mean one can assume their sexual health needs. Sexual healthcare providers need to deliver services flexibly in relation to groups and individuals. Therefore, sexual health services need to understand the cultural and emergent values of the community and individuals to provide contextual sexual health services.

Public Health England (2016) and DH (2013) both report a rise in STI's amongst Asian or Asian British people in England, with HIV being of concern amongst BME men. Estimates suggest that 62,880 MSM are living with HIV in the UK. Data from PHE (2016) indicates that men of white ethnicity comprise 84% (38,429 of 45,679) of cases of newly diagnosed MSM with HIV in the UK. By comparison, 14.6% of the total (6,654 of 45, 679) are among BME men who are exposed in this way. In

addition to clinical data there is data on available on the attitudes towards sexual health in the UK in the form of the National Survey of Sexual Attitudes and Lifestyles.

2.8 National Survey of Sexual Attitudes and Lifestyles (NATSAL)

The aims and content of National Survey of Sexual Attitudes and Lifestyles (NATSAL) is to understand national trends in sexual health and sexual behaviour. NATSAL-1 charted not only generational changes in sexual behaviour, but also changes in HIV risk behaviour during the 1980s. NATSAL-2 captured the resurgence in risk characterised by increasing numbers of sexual partners, increasing proportions of men paying for sex, and increases in risk behaviour among men who have sex with men since 1990 as treatments for HIV became available and the widespread fear of AIDS in the 1980s diminished (Wellings and Johnson 2013).

Griffiths et al (2011) state some studies such as NATSAL 2 have been characterized by convenience samples and/or work in specific geographical locations. The NATSAL-2 is a large national probability sample survey of the British population, which oversampled the four largest ethnic minority groups in the UK; this enabled a robust estimate of key behavioural and attitudinal parameters to be identified for those of Pakistani, Indian, Black Caribbean and Black African origin. The survey describes attitudes towards sex, experiences of learning about sex and first heterosexual intercourse, among people of Indian and Pakistani origin resident in Britain (Griffiths et al, 2011). After adjusting for socio-demographic differences over half of the respondents of Pakistani origin (64.6% of 365) reported that they considered religion as ‘very important’ to them and were more likely than other respondents to report premarital sexual activity and abortion as wrong. This finding

is consistent with qualitative studies (REFS), and may reflect how premarital sex and abortion are disapproved of and/or forbidden in Islam, the predominant religion reported by the Pakistanis sampled (Griffiths et al 2011). Reported attitudes towards sex before marriage, indicated that approximately three-quarters of Pakistani respondents reported this as 'always, mostly or sometimes wrong', in contrast to less than half of Indians, and less than a sixth of respondents from other ethnic groups (Griffiths et al 2011).

NATSAL-2 (Griffiths et al, 2011)shows Pakistani men and women and Indian women were more likely than other respondents to report that they did not discuss sex with their parents during adolescence (Mercer et al, 2013). In addition, NATSAL-2 (Griffiths et al, 2011) shows approximately two-thirds of Pakistani and Indian men reported being in non-marital relationships at first sexual intercourse, suggesting that attitudes are not necessarily consistent with behaviour, which has also been observed in qualitative studies (Mercer et al, 2013).

A limitation to NATSAL 2 is the collation of those of Pakistani, Indian and Bangladeshi origin under the broad term 'South Asian' which excludes the Sri Lankan ethnic origin. Indians and Pakistanis are the largest ethnic minority groups in Britain, representing 28% and 16% of the non-white population, respectively. However, relative to other ethnic minority groups, a paucity of sexual health research has been undertaken among Indians and Pakistanis (Griffiths et al, 2011). This may, in part, be due to the reluctance of researchers to explore issues that are culturally taboo among South Asian communities and thus extremely sensitive.

NATSAL-2 (Griffiths et al, 2011) shows many findings consistent with reports of other groups for a desire towards more sexual health information among these ethnic groups, despite cultural taboos surrounding sex and sexual matters. These data have implications not only for the UK's sex and relationship education (SRE) curriculum in general, as discussed previously, but also when planning and delivering SRE specifically for Pakistanis and Indians for whom lessons at school were more likely to be reported as their main source of sex education relative to their male counterparts and women of other ethnic groups. This is also important because Indians and Pakistanis were less likely than respondents of other ethnicities to report that they had found it easy to talk to their parents about sexual matters during their adolescence (Griffiths et al, 2011).

NATSAL-2 remains the most reliable source of sexual behavioural and attitudinal data available for Pakistanis and Indians in Britain (Griffiths et al 2011). While NATSAL-2 collected data for those of Pakistani and Indian ethnic origin separately authors acknowledged that this approach is relatively crude and may mask heterogeneity of behaviours, cultures and beliefs found within these ethnic groups. This is a limitation of quantitative analysis, but the insights that have been gained from this study will complement the findings of qualitative studies to better understand the interplay between attitudes, culture, faith and sexual behaviour.

NATSAL-3 used WHO's definition of sexual health, mentioned earlier, to frame the design, analysis, and interpretation of the study. This approach views sexual health as not merely the absence of disease but recognises the importance of having pleasurable and safe sexual experiences that are free of coercion, discrimination,

and violence. The case for adopting a more holistic approach to sexual health has generally been made on the grounds of the benefits for control and prevention of STIs, HIV, and unplanned conception (Wayal et al, 2013).

Improving sexual and reproductive health remains a public health priority in Britain (England, Scotland, and Wales) (DH, 2013) as it does globally and the large changes in sexual lifestyles that have occurred in the past 60 years have been captured by the three NATSAL studies (Mercer et al, 2013). Field et al (2013) states on the basis of the 2011 census data, the NATSAL-3 sample was broadly representative of the general population of Britain in terms of self-reported general health, marital status and ethnic origin and key socio-demographic characteristics. Field et al (2013) also state no other large population survey of sexual lifestyles has investigated whether people felt that a health condition affected their sexual activity or enjoyment.

Sexual behaviour has been surveyed worldwide; sampling strategies, question standardisation, and computer-assisted methods of data collection have improved data quality, and biological measures, such as prevalence of STI's and hormonal status, have been added to behavioural measures (Field et al, 2013, Wayal et al, 2013). The results of NATSAL-3 in provide extensive data from a large, representative population sample collected with the aim of better understanding sexual lifestyles and improving sexual health. NATSAL-3 highlighted the need for sex education, health policy, and practice that recognises and responds to increased sexual diversity in the population (Field et al, 2013; Wayal et al, 2013).

A resistance to a broader approach to sexual health could be that a focus on adverse biomedical outcomes is more comfortable for practitioners and less controversial for policy makers (Wellings and Johnson, 2013). Clinicians and researchers alike find it easier to ask about matters that relate to safer sex than to raise sensitive issues of pleasure, power, and exploitation. A life course approach is another important part of a broader perspective on sexual health. A narrow conceptualisation of sexual health excludes the sexual health needs of large subgroups of the population.

One study identified was in relation to prostate cancer of South Asian men. The Metcalfe et al (2008) investigation on whether South Asian men in the UK are at lower risk of being diagnosed with prostate cancer in a UK-based retrospective cohort study and to examine possible reasons that may explain this. The PROstate Cancer in Ethnic SubgroupS (PROCESS) study is a population-based retrospective cohort study. The South Asian group included this study are men of Indian, Bangladeshi and Pakistani origin. The PROCESS study provides evidence of a lower incidence of prostate cancer amongst South Asian men living in England, in comparison with their White counterparts. If anything, South Asian men presented with clinical features of earlier disease suggested that the reduced risk is unlikely to be an artefact of poorer access to health care. This retrospective cohort study conducted in southern England in the late 1990s provided evidence of lower rates of prostate cancer diagnosis in South Asian men compared than in White men.

2.9 Economic costs

The cost implication of South Asian men not accessing sexual health services early can be considered an important rationale why this study was considered. The overall cost of sexual health promotion is minor compared to the costs of treating STIs and unintended pregnancies (Murphy and Rodrigo, 2014). Murphy and Rodrigo (2014) explain the cost of treating STIs nationally (excluding HIV) is estimated at £170 million. There is evidence demonstrating that spending on appropriate sexual health interventions and services is cost effective. For example:

- Every £1 spent on contraception, £11 is saved in other healthcare costs
- The provision of contraception saves the NHS £5.7 billion in healthcare costs that would otherwise have been spent if no contraception was provided
- Early testing and diagnosis of HIV reduces treatment costs from £12,600 per annum per patient compared with £23,442 with a later diagnosis
- Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person with consequential cost savings
- Early treatment of STIs and partner notification are cost effective interventions
- Screening strategies targeting high risk populations that lead to early identification and treatment are cost effective as they avert future costs of dealing with complications and onward transmission
- Interventions that are evidence-based and lead to behaviour change are cost effective (e.g. free condom provision, assertive outreach health promotion, needle exchanges, and sex and relationship education targeted at specific groups) (Murphy and Rodrigo, 2014).

Robertson (2007) states the cost of the problem in men's health spreads wide, with implication across the whole of society. Robertson (2007) states that we need to look to a health service that supports men to make better life choices and that have a positive effect on their health and well-being. Murphy and Rodrigo (2014) add that there is evidence that preventative interventions that focus on behaviour change and are based on behaviour-change theory have been effective in promoting sexual health. The National Institute for Health and Clinical Excellence (NICE) (2011) in Murphy and Rodrigo (2014) recommend helping people to work through their own motivations by encouraging them to question and change their behaviour can form a

key part of preventative interventions in reducing STIs (including HIV) and reducing the rate of under 18 year old conceptions, especially among vulnerable and at risk groups. Behaviour change is not the purpose of this study but plays a key role to understand the culture and understanding of men's sexual health of South Asian men in Brent and Leicester in regards to understanding their attitudes towards sex and sexual health.

There is a steady increase in STI's amongst South Asian groups in England. NATSAL 2 and 3 is regarded as one of the most reliable available data on sexual behaviour and attitudes. This data shows that South Asian groups consider sex before marriage as wrong, particularly Pakistani groups. NATSAL also shows that discussing sexual health is easier for non-South Asian communities and that there is a need for sex education and for health policy and practice that recognises and responds to increased sexual diversity in the population. Interestingly, the PROCESS showed that there is a lower case of prostate cancer amongst South Asian men. This review shows the remarkable cost implication in relation to sexual health and that this impacts across the whole of society. An efficient health service is one that supports men to make better life choices that have a positive effect on their health well-being. For this to happen there needs to be discussions with men from various ethnic groups to determine the best way to share information, prevention approaches and interventions which will be effective amongst their ethnic groups.

Understanding South Asian men's religious and cultural issues in relation to sexual health are important for sexual health services. Religious and cultural issues

encompass family and public honour, shame and respect (Weston, 2003). These are issues which should not be underestimated when discussing sexual health in the South Asian communities. Weston (2003) points out the lack of research with South Asian men on their sexual attitudes and behaviours. In addition, work targeting South Asian men can be undertaken by generic health providers. Overall, the key message captured from the literature review is the need for sexual health service providers and professionals to understand the context of work. This means understanding the religious, cultural and community background and influences of a specific population. In the context of this study, this means understanding the culture of sexual health of South Asian men.

2.10 Public involvement in research

Patient and public involvement and engagement (PPIE) in the planning and delivery of healthcare has been a recurrent feature of government policy and exhortation since the early 1990s (Ali and Atkin, 2004). PPIE comprises involving, consulting and listening to patients and the public in order to make services responsive to patient needs, improve clinical outcomes and patient experience, add value to services and support good governance.

There is an increasing emphasis to promote active public involvement in health research (INVOLVE, 2012; NIHR, 2015 from the shaping of research questions to being co-researchers. PPIE presents particular challenges for sexual and reproductive health services due to stigma and confidentiality issues (DH, 2013) and is a key issue when undertaking culturally sensitive research with South Asian men about men's sexual health.

Additionally, this review focused on public involvement in research rather than patient involvement as patient involvement tends to predominantly be undertaken within a health service improvement setting and in clinical trials and research with patients tends to reflect NHS based clinical reviews and clinical studies associated with people taking part in research as participants or subjects. This review also intended to capture the involvement of public members amongst the voluntary and community sector and capture health research undertaken outside the NHS domain as research in such a context is structured towards the principles of community engagement, community empowerment and community development in relation to supporting South Asian men through research to highlight the challenges and the solutions on the culture of sexual health.

Public involvement in research refers to situations in which members of the public are involved in decisions about what research is prioritised, how research is designed, how research is delivered and how recommendations of research is disseminated and implemented. The term ‘members of the public refers here to a broad range of groups including users of services, patients, carers, members of a group who share a particular interest or a condition, for example, people with disabilities or residents of a particular demography. In the case of this research the target group is finding research whereby the culture of South Asian men’s sexual health has been explored. Recently, members of the public have been increasingly active in research topics in many different ways across the spectrum of research by sharing experiences and opinions in clinical research settings, contributing human tissue or the testing a particular intervention, treatment or medicine. Research is language now exposed to the mass public in England (NIHR, 2015).

Generally, ethnic minorities including those from South Asian heritage have not been active or engaged in the development or conduct of healthcare research in England (INVOLVE, 2012). Ann-Kemp (2009) studied the understanding of user involvement within the context of the NHS. She found that a typical active volunteer in Britain is a white, middle-aged, married female, who attends a place of worship, has a good level of education and has some form of employment. Ann-Kemp (2009) acknowledges that ethnic minorities in the UK were underrepresented in the study and that there is a need for research to determine whether or not the motives for involvement would be applicable to all ethnic groups. Munro (2008) has a similar view and states that active user involvement and volunteers tend to be from middle-class, well-educated and articulate backgrounds. Munro (2008) further mentions that research with BME communities can be very challenging due to the educational levels of poor and disadvantaged communities. This creates challenges for researchers wishing to explore culturally sensitive topics and issues and engage members of these communities in shaping the research.

The Healthcare Commission (2009) studied how well healthcare organisations engaged local people when planning and improving services. A total of 172 NHS and independent sector organisations, 106 community and user organisations and 64 patient and public representatives were involved in face to face interviews, telephone interviews and workshops for this study. All agreed the need to engage local people and that there was no national data on the quality and impact of patient and public engagement. Patient and public engagement remains largely locally focused and flexible to a particular area or population (Healthcare Commission, 2009). The Healthcare Commission (2009) paper suggests establishing national or

local benchmarked data would support organisations to assess patient and public engagement and its impact. This audit used examples of patient and public engagement with health planning, delivery and service reviews but there were no examples of patient or public engagement in qualitative healthcare research or engaging with South Asian men on sexual health besides data from within an acute and primary care clinical setting.

Staley (2009) peer reviewed a number of papers, systematic searches of electronic databases and grey literature related to the NHS and health related organisations on public involvement. The findings from this review indicate that public involvement has a variety of impact on all levels of research which include impact on public members, researchers and community organisations. The Staley (2009) report mentions the difficulties of assessing the impact of involvement and predicting where and how involvement will have the greatest impact with public members. The Staley (2009) report describes several studies where members of the public have been involved during various stages of research and mentions that the impact of public involvement includes research design and carrying out the research which is described as research delivery. Health researchers tend to focus on health problems and health needs whilst the public focus tends to be towards the strengths of a community such issues which are important in the neighbourhood as crime and safety and infrastructure. Staley (2009) suggests involving the public in determining and reviewing research methods is beneficial for research development and delivery and states different people will draw different conclusions based on their particular interest, experience and expectations within qualitative research.

Public involvement in research is a complex social process and it is unlikely that public involvement carried out in the same way would be generalised to achieve the same impact. This makes it difficult to generalise from the methods used in one area to another. It is also difficult to generalise about the findings of studies on the actual impact of public involvement in research. The public who are involved and the context for involvement make it hard to predict where involvement would have the greatest impact that is the added value PPIE bring to research. The complexity of the interactions between the 'active components' such as the researcher and people involved makes the attribution of specific impacts to the involvement process in general or to different types of involvement problematical. These factors also make it difficult to identify empirical evidence about how the factors shaping public involvement and its impacts are linked. Positively this complexity adds value to the richness of information of public involvement in research and this complexity should not be seen as a deterrent for 'involving' public members in research; rather it suggest the need for research to provide clarification of the value of PPIE.

There is a growing interest in assessing the impact public involvement in research on both researchers and members of the public. There is relatively little research in this field i.e. on the metrics of impact on public involvement in research. Much of the research that does exist indicates that this level is not of high quality and the quality measures or criteria of success on impact in research vary significantly amongst public members involved in research studies. Validated measures of the impacts of public involvement in health research are needed.

Staniszewska et al., (2009, 2011; 2012; 2013) developed the Guidance for the Reporting of Patient and Public Involvement in Research (GRIPP) checklist to support research capture the impact of public and patient involvement in research studies. This checklist is intended to be an internationally recognised checklist of involving patients and members of the public in research to support guidance on a wide range of patient and public involvement techniques and approaches. In addition, Popay and Collins (2014) produced the Public Involvement Impact Assessment Framework (PiiAF). The PiiAF is primarily aimed at researchers who wish to design an assessment on the impact of public involvement in research and encourages research teams using the PiiAF to involve relevant members of the public in the development of their plans to assess the impact of public involvement. This framework involves patients and members of the public not only as participants in research studies but also highlights the impact of their involvement and determines the difference actually made by public involvement to the study. This framework does not dwell into the domains of working with under-represented groups, sometimes described as 'hard to reach groups' in research such as BME communities, and particularly South Asian men. Therefore, the suitability of this framework is of questionable value with South Asian men on such a sensitive topic such as sexual health. There is no evidence to suggest that GRIPP and PiiAF have been undertaken with men from any ethnic minority group with regards to understanding their sexual health.

Barber et al (2011) conducted a systematic and structured examination on the process and impact of public involvement in a qualitative study to develop principles and indicators for effective public involvement based on the consensus of a wide

range of stakeholders. The study advisory group worked with three consumer advisors who had informed the methods and interpretation of findings. Two consumer advisors and three academic researchers took part in structured reflective discussions after three advisory group meetings. The evaluation of this study found positive public impact on the design, interpretation and dissemination of research findings and there was mutual learning for both service users and academic researchers.

Oliver et al (2009) attempted to identify the contribution and influence of public members of an advisory panel in setting the research agenda for a national research programme. The public involvement approach they examined was of a consultative nature. Oliver et al (2009) used mixed methods including document analysis, interviews and structured observations of advisory panel meetings in order to assess the impact of public involvement. They were able to identify the unique contributions of public members on the panel specifically towards the research agenda setting process.

Brown et al (2006) reported their collaboration with people with diabetes which led to the formation of a focus group to identify research priorities of people with diabetes living in inner-city communities. Two members of the focus group became members of the research team and contributed to the data analysis process. The research priorities generated in the focus group were compared with the research priorities identified by a Research Advisory Committee for the DH and the Medical Research Council. This identified the similarities and differences between the research priorities of members of the public and healthcare professionals with an interest in

diabetes. Brown et al (2006) raises questions as to whether undertaking research with South Asian men would be better suited to a health topic such as diabetes, which is an accepted health condition, rather than sexual health which has a strong taboo in the South Asian community and in the general population.

Williamson et al (2010) explored the impact of public involvement in a qualitative research study into older adults and the prevention and management of loneliness. This study focused on two lay researchers who were involved in the development, implementation, data analysis and dissemination stages of the study. A case study using a range of methods including interviews, reflective diary and conference papers was used to demonstrate the impact of public involvement. The case study was co-authored by an academic researcher and two lay researchers. Impacts on the lay researchers primarily increased the confidence and lay members expressed a sense of personal achievement.

Slade et al (2010) examined the process and impacts of public involvement in a five-year research programme to develop and test a complex intervention for adult mental health services. The research programme established three advisory groups, two of which included service user representatives and the third was a mental health service-user only advisory group. The research programme comprised several linked studies; a systematic review, a national survey and a multi-centre randomised controlled trial. The authors recorded recommendations made by all advisors during the first seven months of the project. They examined the recommendations according to contributor and the numbers of recommendations that were or were not implemented. Positive impacts on the research included improving the relevance of

the study design; negative impacts included the increased costs and time taken to develop research involving members of the public.

Health service providers need to ensure patients and members of the public are valued. Service providers need to stop taking the time of patients and the public input for granted. Service providers need to plan around people and not engage patients and members of the public solely for policy and organisation agendas (Andersson et al, 2006). Patient and public involvement needs to be flexible to adapt to people's lives rather than expecting the public to fit into the processes which are normally set up by professionals without the public input. Crucial to the success of future public involvement in any area of public health care service provision will be the need to focus more on issues that interest the public to create processes which help public participation (Andersson et al, 2006). The Andersson et al (2006) research study ultimately, due to its nature being an academic study has the research aim and research questions agreed before approaching the public, therefore, this will inevitably influence the research approach direction and the outcome of this study. Andersson et al (2006) also state development teams in organisations need to be established in order to undertake essential activities such as accumulating evidence, collecting good practice and gathering findings from formal research to ensure the effective and required approaches and methods that can be used. This raises the question on the capacity of NHS organisations to place the agenda of public involvement in research as a priority.

The Thompson et al (2008) study was undertaken using semi-structured telephone interviews with a sample population of fifteen university health researchers. This

study found that involving the public in research is about readjusting the balance of power between the researcher and research participants. Thompson et al (2008) emphasise the importance to engage users of health services in such a way that their 'experiential expertise' of illness and services is afforded greater consideration alongside professional health care expertise. They also state that there are difficulties in obtaining adequate funding, cost in both time and money as well as the lack of skills of both the researcher and the public in carrying out research, in addition to the use of unfamiliar research language and jargon with public members. Researchers and the public need training on all of these issues. Research with the public is undertaken, but genuine improvement rather than tokenistic involvement in this area takes time and requires greater institutional support structures for this to be effective. Thompson et al (2008) also support Williamson (2007) who argues that in order for public involvement in research to be effective there needs to be a shift in power from researcher to the public. A study with nurse and patients found that nurses need to examine their reasons for accepting or rejecting the views of patients or members of the public in research, particularly when these differ from theirs. This often takes place in the experience of patients in health care.

Blackburn et al (2010) found that building and strengthening relationships with those who you involve shows that you are seriously taking their views on board. The issues of honesty, being sensitive and being aware on practical issues such as investing time and taking extra care when dealing with public will encourage successful service user involvement.

Mir (2007) state there is evidence that poor communication has a negative effect on access to services and on relationships between service users and health care professionals. Problems in communication include language barriers and poor existing channels of communications and networks used by BME groups. Mir (2007) agrees with Chiu (2008) that there is evidence on a lack of confidence and willingness on the part of service providers and service users to discuss cultural issues relevant to the way services are provided. Engaging with BME individuals and families is important to gain an accurate understanding of their circumstances and cultural values but BME communities and South Asian communities (Mir, 2007; Chiu, 2008) may require support in order to contribute meaningfully with health providers and services.

The main areas in which service users and carers found involvement difficult were in overcoming professional language barriers, emotional issues and power imbalances between public and professionals (Hitchen et al, 2009). Hitchen et al (2009) developed job descriptions for service users and co-researchers. All co-researchers were given an honorary contract and paid an hourly rate. Twelve people were recruited which included mental health trust staff and managers. One of their key findings is that the use of professional language discouraged service user and carer involvement. Agreeing an acceptable language before meetings is paramount. Involvement for service users meant their emotions and experiences were involved. Professionals may lose sight of this and usually distort this contribution to anger, illness and frustration or inappropriate contribution. Service users are initially invited to be involved in service development and research, and this often loses momentum resulting in service users becoming disengaged and disempowered. Issues such as

communication, emotional impact and power relations are important areas that need to be resolved if user involvement in research is to improve and be effective.

Robinson and Lorenc (2010) studied extensively the issue of effective patient and public engagement with sexual health services in London. Their study used four methods of data collection including a literature review of 59 documents, journals, websites plus an email survey targeting Primary Care Trust's in England. An online survey of 72 stakeholders and detailed interviews with 25 stakeholders was undertaken which included commissioners, voluntary and community organisations, clinicians and patients. They found that the most important challenge for effective patient and public engagement on sexual health was the lack of organisational commitment and a lack of dedicated staff and resources. Ideal engagement methods should be innovative, flexible, validated and importantly co-designed between professionals, researchers and the community.

Interestingly, Robinson and Lorenc (2010) mention participatory action research (PAR) (Morton-Cooper, 2000; Reason, 2001; Waterman et al, 2001; Baum et al, 2006) as a specific research design which they consider as an ideal involvement technique on the issue of sexual health. They also highlight patient and public motivation as a key factor on effective involvement in sexual health projects and services and that this cannot be controlled by the research lead or the research team but, instead rather relies on the expertise and communication skills of the research facilitator. They found that effectively involving at-risk groups such as men, older people, BME groups and those with disabilities should be a priority for sexual health services where there is a lack of research. The stigma of sexual health, reproductive

health and HIV/ AIDS, especially for BME communities, is a major barrier to patient and public involvement in sexual health studies. One way of overcoming this barrier is to involve and collaborate with well-established local voluntary and community organisations. Using community friendly organisations not only helps to support the spread of key health messages but also starts constructive dialogue and builds trust between services and marginalised communities. Robinson and Lorenc (2010) recommend the need for training and information on patient and public involvement in sexual reproductive health and HIV/AIDS. Their report includes a case study of community researchers working to access hard to reach groups. This case study suggests using community researchers as an effective method of engaging disengaged groups and in combination with financial incentives.

My own research study did not have the resources and incentives to pay participants to be involved as this is part of a university research degree programme and this may be problematic to approach and engage with South Asian men. A key point from the Robinson and Lorenc (2010) report is that effective patient and public engagement in sexual health is primarily based on the individual views of professionals from the statutory and voluntary sector. The Robinson and Lorenc (2010) study make no reference to direct public involvement in their own study and only mention two in-depth interviews undertaken with service users. Thus, it appears that a study focused on public involvement with sexual health services, ironically demonstrated greater engagement with health professionals and their organisations, both in the NHS and voluntary and community sector, rather than with patient and public members.

Any public involvement in research needs to consider the power relations between researchers and the researched and the methods of communication. The method and approach of communication is important when engaging with public members who are less represented in research. Engaging with under-represented communities in research is best undertaken working with local voluntary and community organisations. Importantly, motivation of participants in research on sexual health should not be under estimated.

2.11 Literature review summary

The literature review for this study demonstrates that men's health and men's sexual health, particularly South Asian men's sexual health is under-researched. Inevitably, there will be small scale research being undertaken in clinical settings which concerns South Asian men and research of a qualitative nature targeting specific populations on their sexual health. What this literature review demonstrates is that, in addition to national data such as NATSAL, undertaken in 1990; 2000 and 2010;2012 respectively) there is still much to learn about the 'culture' of South Asian men's sexual health. This is not only pertinent due to the cost implications to the health service but also supports address the growing need for an appropriate sexual health service which includes meeting the needs of South Asian men. In order to for this to take place, further research is required to understand the perspective of South Asian men's sexual health using research approaches and techniques to closely compliment the language used by South Asian men.

Some of the key issues identified in this review are the importance of understanding South Asian religion, families and culture in order to provide sexual health services

that are sympathetic to these values while meeting public health priorities and addressing health inequalities. The use of greater public involvement in research that builds relationships, understands the power relations of services and public members may provide a platform for participatory research approaches.

The literature review highlighted the limited research focusing on the perceptions and experiences of sexual health and sexual health services on South Asian men. The literature review showed that STI's were shown to be rising amongst South Asian communities in England (Public Health England 2014). South Asian men rarely report having extra marital sex, regular use of condom is less frequent than in other community sectors, factors influenced by religious and cultural influences on sexual behaviour and attitudes (Bradbury and Williams, 1999). Lack of knowledge concerning STI transmission and strong stigma associated with HIV/ AIDS in South Asian communities inadvertently towards prejudice views of gay culture and gay men. Qualitative research of sexual health belief regarding the origins of negative attitudes towards sexual health and sexuality is associated with the South Asian culture, family and religious belief systems. The findings in this chapter will indicated where some of this culture and attitude stem from within South Asian men. There is also powerful stigma associated with HIV/AIDS in South Asian communities (Weston, 2003). However, it is evident that there is a lack of qualitative research addressing these health beliefs in South Asian communities (Bradbury and Williams, 1999; Sinha et al, 2007). GPs are ideal to offer guidance to South Asian communities about preventative sexual health services (Bradbury and Williams, 1999). The role of GP's in South Asian communities is important and carries a level of influence other practitioners may not necessarily possess.

Chapter 3 Methods

This chapter discusses the philosophical stance take in this research, the iterative development of the study design and the methods used in each of the three phases of data collection and analysis.

3.1 Theoretical framework

This research is situated within a qualitative paradigm as it concerns the views and experiences of people (Denzin and Lincoln, 2005). My role as a community development worker heavily influences the way in which I view the world and how knowledge is generated. My belief is that knowledge is socially constructed and contextualised by the people involved. In essence, community development work leans itself towards research that responds to the needs of communities and how research should be developed and delivered in and with communities. This stance assumes that researchers and communities should be partners in research and power differentials and dynamics minimised and if possible, removed. The use of an approach which is participatory in nature facilitates a collaborative generation of knowledge and associated action.

3.1.1 Qualitative research paradigms

A paradigm provides a framework within which particular worldviews and approaches to generating knowledge can be undertaken. Ontology is used to designate the nature of reality and relates to debates about the existence of one or more realities and how these realities are represented (Koshy et al, 2011). Epistemology is used to designate the theory of knowledge and it presents a view and justification for what can be regarded as knowledge, what can be known and the

criteria that knowledge must satisfy in order to be called knowledge rather than beliefs (Koshy et al, 2011). Epistemology provides the means by which the researcher can explore the relationship between the issue being researched and the researcher. As a researcher I contend that the world and knowledge is not distant to me, rather my world is an active part of me and that knowledge is created, shaped and influenced by the people around me. This ontological and epistemological stance underpins my preference for undertaking research that is collaborative and emancipatory whereby there is closer interaction with participants as partners in the research than as distant research subjects.

Four major interpretive paradigm structures in qualitative research were identified; positivist and post-positivist, constructivist-interpretive, critical enquiry and feminist post-structural. Guba and Lincoln in Denzin and Lincoln (2005, p.195) provide a table on the major paradigms in social science research their ontology, epistemology and methodology alignment (table 3.1).

Basic beliefs of alternative inquiry paradigms (updated version)

Issue	Positivism	Postpositivism	Critical Theory *et al.*	Constructivism	Participatory
Ontology	Naive realism – "real" reality but apprehendible	Critical realism – "real" reality but only imperfectly and probabilistically apprehendible	Historical realism – virtual reality shaped by social, political, cultural, economic, ethnic, and gender values; crystalised over time	Relativism – local and specific co-constructed realities	Participative reality – subjective-objective reality, co-created by mind and given cosmos
Epistemology	Dualist/ Objectivist; findings true	Modified dual/ objectivist; critical tradition/ community; findings probably true	Transactional/ subjectivist; value-mediated findings	Transactional/ subjectivist; co-created findings	Critical subjectivity in participatory transaction with cosmos; extended epistemology of experiential, propositional, and practical knowing; co-created findings
Methodology	Experimental/ manipulative; verification of hypotheses; chiefly quantitative methods	Modified experimental/ manipulative' critical multiplism; falsification of hypotheses; may include qualitative methods	Dialogic/ dialectical	Hermeneutical/ dialectical	Political participation in collaborative action inquiry; primacy of the practical; use of language grounded in shared experiential context.

Table 3.1: Basic beliefs of alternative inquiry paradigms (updated version)

In conventional quantitative research designs there is a linear process and a sequential relationship between question or hypotheses formulation, research activity, research findings and changed practices. In qualitative research this linear process is fluid as the research direction is very much dependent on the source of the data, how data is obtained and this may not follow a predetermined research process which is static. This flexibility enables qualitative researchers to be flexible in their methods. Qualitative research is concerned with meaning and how people's experience and events make sense of their world. Researchers who adopt the qualitative approaches are concerned with the quality and texture of experience, rather than with the identification of a cause-effect relationship. Charmaz (2006, p.14) states "qualitative researchers have one great advantage over our quantitative colleagues. Qualitative researchers can add new pieces to the research puzzle or conjure entirely new puzzles, whilst gathering data that can even occur late in the analysis". Qualitative researchers exemplify a common belief that they can provide a 'deeper' understanding of social phenomena than would be obtained from quantitative data and they are not constrained by pre-existing hypotheses (Bausell and Yu-Fang, 2002). Researchers using a qualitative approach therefore pursue lines of inquiry which may not have been envisaged or anticipated.

The overall aim of this study was to understand how community and individual perspectives of South Asian men in Brent and Leicester influence concepts of sexual health and acceptability of sexual health services which include questions around exploring the South Asian men's individual and community

perspectives of sexual health, how are these perspectives influenced by cultural and family heritage and what barriers do South Asian men believe exist in relation to raising the profile of sexual health amongst South Asian men in communities. As a result this should provide local sexual health services better approaches to engage with South Asian men regarding sexual health. Table 3.1 show two paradigms highlighted which seem relevant for this study; critical theory and participatory.

Critical theory stands out due to its nature of challenging the status quo. There are many forms of critical theory research and the ones which initially stand out in relation to this study and research aim and questions are critical social theory. Critical social theory is concerned in particular with issues of power and justice and the ways that the economy; matters of race, class, and gender; ideologies; discourses; education; religion and other social institutions; and cultural dynamics interact to construct a social system (Kincheloe and McLaren in Denzin and Lincoln, 2005, p.306). Critical theory is never static; it is always evolving, changing in light of both new theoretical insights and new problems and social circumstance and therefore critical enlightenment also can be appropriate to positions this study as this concerns competing power interests between groups and individuals within a society (Kincheloe and McLaren in Denzin and Lincoln, 2005, p.307). My community development influences draws me towards another form of critical theory research; critical emancipation. Critical emancipation is used in setting for those who attempt to gain power to control their own lives in solidarity with a justice-orientated community. Here, critical research attempts to expose

forces that prevent individuals and groups from shaping the decisions that crucially affect their lives (Kincheloe and McLaren in Denzin and Lincoln, 2005, p.308).

The participatory paradigm stands out for this study as this can be used to explore critical debates and adopt a critical theory approach such in the case of critical action research or emancipatory research. In this context research is used as a way of understanding how particular people and particular settings are shaped and re-shaped discursively, socially, culturally and historically. It aims to connect the political with the personal within a collaborative setting (Kemmis in Reason in Bradbury, 2006, p.93). However Kemmis in Reason in Bradbury (2006, p.92**)** point out much of action research was and is of a technical form. It is orientated towards functional improvement measured in terms of its success in changing particular outcomes of practices rather than social settings. The inclination to set this study towards critical theory and participatory is that they encourage collaboration and dialogue with research participants in a form comfortable for all participants.

3.1.2 Paradigms concerning Critical Theory and Participatory Research

Critical theory is a reality created and shaped by social, political, cultural, economic, ethnic and gender-based forces that have been reified or crystallized over time into social structures that are taken to be natural or real. People, including researchers, function under the assumption that for all practical purposes these structures are real. Critical theorists believe this

assumption is inappropriate. Critical theoretical approaches tend to rely on dialogic methods; methods combining observation and interviewing with approaches that foster conversation and reflection. This reflective dialogic allows the researcher and the participants to question the 'natural' state and challenge the mechanisms for order maintenance. Therefore, researchers using a critical theory approach are required to discuss the meaning and implications of the concept developed and this relies on community consensus for social change (Kemmis in Reason in Bradbury, 2006).

Within the participatory domain, action research is recognised as one of the leading research approaches. Although, action research can locate itself to a number of research paradigms, the nature of action research means it breaks from a positivist and empiricist science and leans itself towards a participatory worldview because it is context-bound and involves an action element within the design in order to improve a situation. The origins of action research can be found in different geographical contexts and amongst professional communities (Charles and Ward, 2007). The conceptual and philosophical roots of action research have been reviewed by Reason and Bradbury (2006) who trace its diverse origins from philosophy, social science, psychotherapy, critical theory, systems theory, education, spiritual practices, indigenous cultures, liberationist thought and complexity theory. Action research which sometimes can also be known as community-based study, co-operative enquiry, action science and action learning is an approach commonly used for

improving conditions and practices in a range of healthcare environments (Koshy et al 2011).

Action research is commonly associated with the 'European' social psychologist Kurt Lewin whose central interest was in social change. Although the development of action research has been attributed to Lewin It is important to note in Lewin's own work, participants were not involved in setting an agenda or making decisions (Koch and Kralik, 2006). Prior to the work of Lewin, action research had been noted to take place on work with women in 20th century Vienna (Denzin & Lincoln, 2005). The Tavistock Institute is responsible to bring Lewin's work on action research from America to the United Kingdom (Greenwood, and Levin, 1998).

Action research is practical, participative, emancipatory, interpretive and critical (Wisker, 2008). Some action researchers borrow from Marx's position that local people need to engage in critical reflection about the structural power of dominant classes in order to take action against oppression (McIntyre, 2008). Similarly, Gramsci's participation in class struggles and his belief that economic and self and collective actualisation can alleviate the uneven distribution of power in society has contributed to the belief among practitioners of action that people themselves are, and can be, catalysts to change. Action research draws on the paradigms of both critical theory and constructivism and therefore may use a range of both qualitative and quantitative methods (Baum et al, 2006; Wisker, 2008).

Ontology associated with participatory action research (PAR) means that human beings are dynamic agents capable of reflexivity and self-change, and an epistemology that accommodates the reflexive capacities of human beings within the research process (Greenwood and Levin, 1998; Kindon et al, 2007). To undertake PAR, researchers must adopt a participatory perspective which 'asks to be both situated and reflexive, to be explicit about the perspective from which knowledge is created, to see inquiry as a process of coming to know, serving the democratic, practical ethos of action research' (Reason and Bardbury 2006).

The theme of catalysts for change is central to the work of empowerment rhetoric and this can be seen in Camilo Torres's work with disempowered groups in Colombia, Freire's work in Brazil, Ghandi's work in India and Neyerere's work in Tanzania (Savin-Baden and Wimpenny, 2007). Ideally, the work and philosophical approach of non-Western thinkers such as Gandhi would be ideal to adopt as this would be relevant in undertaking research with South Asian men. However, due to the lack of available research information regarding the work of Gandhi and action research in this context was not considered and Freire's view of action research was considered.

There is resemblance to the work of Freire in education with oppressed people in South America that is certainly ideal for this study. One of the main reasons includes recognising Freire's work is supporting people not to be oppressed. Freire (1972a, 1972b), like feminists, provides a rationale for the development of alternative forms of progressive social and political thought,

including an Afro-centric conception of the social world, of knowledge and of culture, related both to Africa itself and to the African Diaspora, populating both Latin America and North America. With this in mind, there was thought towards a need for this research to relate back to a South Asian perspective and of a South Asian concept on the social world, knowledge and culture. This study of South Asian men's sexual health therefore needed through the lens of Freire to provide a platform to better understand the sexual health culture of South Asian men help to engage in critically dialogue and construct their own meaning of sexual health.

3.1.3 Research paradigms relevant for this study

Any research undertaken on the issue of men's sexual health needs to incorporate an understanding of sex, masculinity and the concept of sexual health. A key influential figure with regards to sex, sexuality and sexual health is the French author and community activist Michel Foucault who aligned with himself with those excluded by mainstream institutions (Alix-Fingham, 1993; Barker, 1998; McNay, 1994), such as minority and disadvantaged communities and his understanding of sex and sexual health was heavily influenced by his own sexuality. Foucault's writing challenged the notion of how society in general viewed sex and sexuality in an accepted and 'normal' manner. His perspectives supported marginalised communities and groups and for those excluded by mainstream standards (Gutting, 2005).

Foucault deserves our attention if for no other reason than that health and medicine were major themes in his enquiries and was used to illustrate his

broader theories about the relationship between power and knowledge (Foucault 1981). A Foucauldian perspective argues that it is impossible to remove power from members of the medical profession and transfer it to patients. This discussion of power is precisely the debate which as a novice researcher and community development professional I found challenging during the course of this research. Aligning a community development paradigm to a traditional medical paradigm i.e. PAR and sexual health in this case, meant a constant struggle to between different paradigms and methodologies. A critical theory perspective seemed more relevant for this study.

Using critical theory perspective enabled this study to explore issues of power, oppression and vulnerability faced by South Asian men, although this is not the primary purpose of this research. This does however help to acknowledge the culture of inequalities faced by South Asian communities and South Asian men in England. Focusing on the relationships among culture, power and domination; critical theory research argues that culture has to be viewed as a domain of struggle where the production and transmission of knowledge is always a contested process (Kincheloe and McLaren in Denzin and Lincoln, 2005).

Critical theory research assumes that it is important to understand a situation in order to change it. Social situations are created by people, so can be deconstructed and reconstructed by people. Research underpinned by critical theory is best situated in the context of the 'empowerment' of individuals

(McNiff and Whitehead, 2006). Critical theorists use critical reflection on social reality to take action for change by radically calling into question the cultures that they study. This critical lens is also central to PAR (Baum et al, 2006) as it requires that those collaborating in the research attend to how power in social, political, cultural, and economic contexts informs the way in which people act in everyday situations (McIntyre, 2008).

Therefore, a combined approach of critical theory in a participatory paradigm enabled South Asian men to share their views on the culture on men's sexual health in their own perspectives and importantly in the language they choose and attempts to bring some of the 'closed' and unspoken culture to the forefront. This meant identifying research paradigms and research methodology and methods which enabled a critical dialogue and provided an opportunity to implement meaningful change where it was possible for me as a research and for South Asian men who were participants in this study. Following a struggle to locate a suitable research paradigm it became clear that a critical participatory action research paradigm and approach would best fit this study. Therefore, a critical participatory action research was used for the first phase of this study.

3.2 Participatory Action Research (PAR)

Participatory action research (PAR) emerged in the latter half of the twentieth century through the work of Paolo Freire (Freire, 1972a; 1972b). Freire was an adult educationalist in the 1970's and is considered to be the founder of PAR. He broke with the tradition of gathering data on "the oppressed" co-

researched with participants, placing capabilities in the hands of people to transform their lives through action (Koch and Kralik, 2006). The theoretical basis of PAR is also attributed to liberal writers such as Marx, Engels, and Gramsci (Koch and Kralik, 2006). The concept of hegemony (associated with Gramsci) which is regarding the state and ruling capitalist class and sue of cultural institutions to maintain power in capitalists societies, is also important to the approach in PAR (Koch and Kralik, 2006). Gramsci's argument is similar to that of Freire, in that it is only through self-awareness on the ways in which people contribute to their own oppression can people begin the empowerment process (Freire, 1972a, 1972b, 1974; Reason, 2001). The importance of helping disadvantaged people to develop critical thinking so that they are able to understand the ways in which they are disadvantaged by political, social and economic conditions is central to PAR, together with the focus on developing self-organised actions to address inequalities experienced by disadvantaged communities (Freire, 1972).

The use of PAR in healthcare research is focused on bringing people together with a common purpose to undertake collaborative enquiry that results in community lead research priorities and change in healthcare needs (Viswanathan et al, 2004). Community-based PAR cannot be delivered effectively unless the following three barriers are resolved; sufficient funds, academic incentives and staffing (Viswanathan et al, 2004). Central to PAR is the need to understand the historical contexts, social practices, cultural forms, and ideologies that give the language of everyday life in disadvantaged communities shape and meaning (McLaren & Leonard, 1993).

Freire's philosophy confronts the essentially "Eurocentric" nature of dominant traditional social and political thought. In his argument for the deconstruction of the category of 'the oppressed' and the acknowledgement of diversity, Freire, provides a rationale for the development of alternative forms of 'progressive' social and political thought (McLaren & Leonard, 1993). This perspective provides the opportunity for this study to consider how a South Asian male perspective on the nature of sexual health is shaped by the social world, knowledge and culture of the South Asian community.

Working with South Asian men requires an understanding of their culture, lifestyle and values as well an understanding of their experiences of living in England. This means recognising the oppression they face both within and outside of the South Asian community in England and include understanding issues such as faith, caste systems, origins of birth, economic status, profession, employment status, educational attainments, community networks and family institutions. As a member of the South Asian male community this has helped me to have an insight towards some of the possible multiple oppressions this group face as well as the opportunity to apply the principles shown by Freire in supporting communities to recognise and harness the potential to help themselves. I agree with Freire (1974, p.12) who states "it is important to help men help themselves, to place them in consciously critical confrontation with their problems, to make them the agents of their own recuperation and success". Therefore, the initial approach of this study was based on the underlying principles of Freire to work with South Asian men rather than to simply impose a research approach whereby they are regarded

as subjects as this goes against my ontology and epistemology viewpoint. Creating the opportunity for South Asian men to contribute and shape this study ensures they are in a position of power.

Working with communities using the principles of PAR and with ideas about empowerment and representation for those who are marginalised and powerless can leads to many challenges. Some of these challenges may be practical, such as restricting participation among those upon whom domestic duties burdens fall. Some challenges may be associated from a conflict of interests provoked by the demands of a democratic agenda. Therefore, professionals using PAR should enter into communities to learn from, rather than to teach people and open up spaces for dialogue and realise that people are not only knowledgeable but also capable of generating their own solutions and working together with local people (Cornwall, 1996). Generating spaces for genuine dialogue challenges deeply held prejudices about the poor, vulnerable, oppressed and disadvantaged groups and how the contribution of participants in research is considered given equal importance to the researcher.

The use of PAR has primarily been undertaken with working with oppressed groups of people, whose issues include inaccessibility, colonisation, marginalisation, exploitation, racism, sexism and cultural disaffection. Utilising a PAR approach within this context is explicitly political whereby the aim is to restore to oppressed people the ability to create knowledge and practices which are in their own interests. Many disadvantaged groups-communities of colour, disabled people, feel that they not only have been exploited in the

research process but that the outcome of most research has always been used against their interests (Crabtree & Miller, 1999). Although challenging the dynamics of political, social and community disadvantages is appealing to me in my capacity of a community development professional, it is not the purpose of this study, However, it was important to acknowledge political, social and community disadvantages South Asian men face as this will impact on addressing the research aim and research questions. It is important that participants who took part in this study are not simply subjects of research but valuable stakeholder of this study. It was paramount South Asian men were given a voice during this study and this voice is expressed how South Asian men consider appropriate. One approach to capture the voice of participants is the use of qualitative description.

3.3 Qualitative description theory

Sexual health research requires researchers to attend to the social and cultural fabric of a community to understand the extent to which that cultural fabric influences individual sexual behaviours and attitudes. It necessitates that researchers acknowledge the diverse range of sexual norms, values, and behaviours of communities and commit to exploring, discussing, and debating topics related to the manner in which individuals and groups construct their sexual attitudes and outlook (Reece and Dodge, 2004). Using a qualitative descriptive approach enabled this study to analyse the direct words of South Asian men. The use of qualitative description as an approach in health services research is limited (Neergard et al, 2009). Researchers may endorse such a call for a more holistic approach on sexual health research, they may

be faced with the need to use innovative research methods and approaches in order to overcome complexities associated with designing and conducting studies consistent with such an approach (Reece and Dodge, 2004).

The growth in qualitative health sciences research has led to the introduction of a vast array of qualitative methodologies, resulting in what Sandelowski (2000) calls methodological acrobatics. ‘Methodological acrobatics is when researchers sometimes feel obliged to designate their work as phenomenology, grounded theory, ethnography or a narrative study when in fact it is not. This may result in 'posturing' and does not make any valid methodological or theoretical contributions to research. Furthermore, it may neglect the benefits of an alternative approach (Neergard et al, 2009). The goal of qualitative descriptive studies is a comprehensive summary in everyday terms, of specific events experienced by individuals or groups of individuals. Novice qualitative researchers feel they have to defend their research approach by giving it ‘epistemological credibility. Qualitative description supports novice researchers to break that barrier and deliver meaningful research without challenges of getting into the methodological debates of research (Lambert et al, 2012).

Sandelowski (2000) argues that researchers can unashamedly name their method as qualitative description. If their studies were designed with overtones from other methods, they can describe what these overtones were (i.e. in the case of this study PAR with underlying principles of Freire and Foucault with paradigms of constructivism and critical race theory), instead of

inappropriately naming or implementing these other methods. The aim of qualitative description is neither a thick description (ethnography), theory development (grounded theory) nor interpretative meaning of an experience (phenomenology), but a rich, straight description of an experience or of an event (Neergard et al, 2009).

3.4 Use of action research and qualitative description in this study

It was also evident during PAR group phase that sexual health is not a health topic which is considered a health priority by South Asian men. There are many reasons why the PAR approach lost its impetus and therefore the PAR group ceased to continue and a change in direction was required. The lack of direction as well as the challenge to effectively implement the reflection and action stages of PAR meant PAR became inappropriate for this specific group of South Asian men to explore the culture of South Asian men's sexual health. McIntyre (2008, p.46) mentions that "an important aspect of PAR is that participants do not take action on everything that is brought to light in a collaborative project". Thus, there are times when people are energised and feel a deep need to act on a particular issue. There are also times when people are less enthusiastic about taking a particular action. Sometimes, that is because an action requires a degree of energy that participants either do not possess or choose not to use at a particular historical moment. Other times, participants hesitate to act on an issue because they are uncertain of the implications the action might have for them and their communities. This participant uncertainty clearly was being demonstrated in this study.

The topic of men's sexual health was placed at the forefront of this research allowing the data which was generated and analysed to shape the research direction and outcome. PAR in this instance was not ideal to explore the culture of South Asian men's sexual health. Hence, a decision to use a different research approach which was (a) flexible and not prescriptive of theoretical positioning (b) put the views of South Asian men at the core of this study and (c) less emphasis of undertaking any practical form of action. Therefore, a qualitative description approach was considered and finally chosen as the research approach to replace PAR during the study.

Qualitative description was chosen as this allowed the data generated directly from South Asian men to maintain an influence on the direction of this study. In qualitative description the research direction is shaped from the data generated. A qualitative descriptive approach moves away from the traditional linear process of undertaking qualitative research. Qualitative descriptive research is the method of choice when straight descriptions of phenomena are desired (Sandelowski, 2000). Qualitative description is also better used in relation to small independent research projects (Neergard et al, 2009). Neergard et al (2009, p.3) shows the qualitative description design approach as proposed by Sandelowski (2000) (table 3.2):

Design Issues	Design Specifics
Philosophy	Pragmatic approach
	Overtones of other qualitative approaches (phenomenology, grounded theory, ethnography or a narrative study
Sample	Purposeful sampling
	Maximum variation sampling especially pertinent
Data Collection	Minimally to moderately structured open-ended interviews with individuals or focus groups
	Researchers are interested in the 'who, what, where and why' of the experience

	Observation of specific occurrences
	Review of documents or other pertinent materials
Analysis	Qualitative content analysis using modifiable coding systems that correspond to the data collected
	When appropriate 'Quasi-statistical' analysis methods are added using numbers to summarize the data with descriptive statistics
	Stay close to the data – low level interpretation
	Goal of the analysis strategy is to understand the latest variable (useful for concept clarification and instrument development)
Outcomes	Straight description of the data in a way that "fits" the data (chronologically by topic, by relevance etc.)

Table 3.2: Qualitative description design model

The above diagram shows the philosophical stance, sampling and data collection and analysis research design specifics when using qualitative description. The overall outcome in qualitative description as proposed by Sandelowski (2000) is a straightforward description of the data organised in a way that fits the data to form key themes, key topics and matters of importance.

3.5 Data generation procedures

There is no fixed formula for designing, practising and implementing PAR projects. Nor is there one overriding framework that underpins the PAR process and so can be flexible and adaptable to the needs, priorities and preferences of the community, the composition of a group, the research topic and environment (McIntyre, 2008). A PAR study needs to take account of key principles which include the research being an endeavour of equal partners, taking part in constructive and critical dialogue and making small changes which make a difference to social justice and changing the dynamics of power (McTaggart et al, 1988).

Using PAR with communities is not easy. It is important not to raise expectations in communities which cannot be addressed whilst undertaking PAR (Cornwall, 1996). The complex issues involved in this revolve around not only the responsibility of the researcher but also on the 'response-ability'. This is the ability for the community to respond and to change. Conventional structures may be entirely inadequate to cope with the implications of PAR practice (Cornwall, 1996). PAR is not something that is easy for those researchers who like to have a sense of control. It requires flexibility and a willingness to deal with uncertainty (Brydon-Miller, 2002). This notion of uncertainty which requires flexibility in research can be a challenging concept for a novice researcher, particularly as PAR has a reliance on participants supporting research. During times of the PAR group phase a lack of control to facilitate prevented effective cyclical actions to occur. This lack of control was difficult to lead on as on one hand communities are expected to lead and on the other hand a novice researcher such as me was expected to lead. My lack of knowledge and experience of delivering PAR was apparent.

PAR challenges traditional or 'expert' knowledge and legitimise the experiences and knowledge of community members (Thomas, 2000). PAR challenges the traditional model of 'legitimate research knowledge' in order to consider whose interest and knowledge research serves. One of the limitations of PAR is gaining entry to a target group, developing trust and not simply selecting people not to participate in PAR projects as the topic may seem irrelevant to local people, and whether they have the technical skills to be required or not selecting people who may have additional or other priorities. It is necessary to listen to local people and their priorities, which in

some cases may not be the priorities of the research issue. Listening to people grants access to acquiring trust with local people and provides a platform to work effectively with them. With this in mind, PAR ideally, needs to evolve from the community; South Asian men. PAR in this study was an idea which was imposed and despite a short training workshop on PAR delivered to South Asian men, this was not sufficient for clarifying whether PAR was the appropriate research method. Delivering PAR requires extensive preparatory work with communities and this was under estimated for this study.

Phase one used a participatory action research approach in Brent, London, to capture a collective view on South Asian men's sexual health. Phase two used semi-structured interviews with ten men in Leicester. Phase Three used in-depth interviews with five men in Leicester. This is demonstrated in the following figure (3.1). The preparatory PAR group meeting was used as sample data (Appendix 10, 11, 12). Qualitative description allows the use of any of the purposeful sampling techniques in qualitative research. The use of maximum variation sampling is a useful approach to gain a broad insight into a particular subject for qualitative description (Sandelowski, 2000). Data generation from the PAR was challenging to obtain. A major limitation in this approach on the subject matter was the requirement of undertaking agreed individual and collective actions which this particular group failed to apprehend. Therefore, data at the PAR group phase was generated in the form of observations and audio recording of meetings which was transcribed.

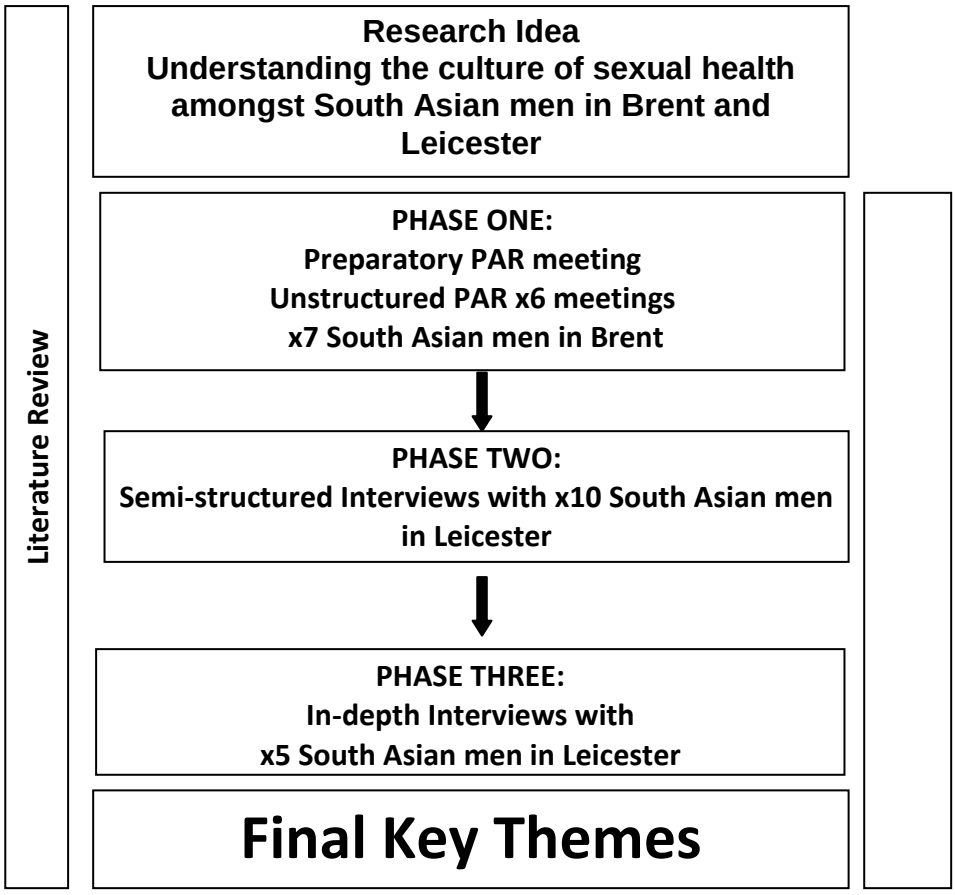


Figure 3.1: Research design

3.6 Ethical considerations for all research phases

An ethical code of practice in research is a common requirement. The University of West London (UWL) has its own ethical policies and principles to adhere for academic research. Ethical approval for this study was obtained at the initial stage of the study for using PAR which involved establishing and forming a group of South Asian men in Brent. Further ethical approval was obtained as the research evolved and changed direction from using a PAR approach to ten semi-structured interviews and five in-depth interviews. Ethical implications for both the PAR group and the individual interview phases ensured all participants were provided with the participant information

sheet, participant s completed consent forms and were offered the opportunity to obtain further information or ask questions regarding the study before and during the study. All participants were informed that they had the opportunity to withdraw their consent at any time without giving reasons. In addition, all participants were provided with my contact details and contact details of my research supervisors before any interview procedure was undertaken.

During the data generation phases, particularly the transcription phase, all participants were referred throughout the study by using a unique reference number rather than their name in order to ensure confidentiality. I transcribed all the interviews myself, and no one else, apart from my university supervisors had access to this data until it was in the form of a transcript that was unidentifiable.

Participants were not placed at risk of physical harm during this research, but there was a possibility that participants may have become distressed and emotional as they discussed sensitive issue related to sexual health. Discussions may also have the possibility to uncover issues such as sexual orientation and private sexual experiences and attitudes. Research which intrudes into private spheres or delves into some deeply personal experience can be potentially distressing and emotive for some (Lee and Owens, 2002). In order to minimise risk of upset or distress interviews were undertaken in a sensitive manner and ensured all participants were comfortable and only continued the interview if they remained to do so. If for any reason observation was noted that that showed participants were uncomfortable or

they displayed an unwilling desire to continue then interviews would immediately cease. Fortunately this did not occur at any phase of this study. In the event of any criminal activity or other disclosures, this would have been discussed with my research supervisor and appropriate actions would have been have taken following UWL research regulations. Fortunately, no such criminal activity or other harmful disclosures occurred during the data generation stage.

The same ethical considerations was given to phase two and phase three interviews as obtained from phase one of this study. Further ethical approval was granted from the university's research ethics committee to undertake semi-structured and in-depth interviews for phase two and phase three with South Asian men.

3.7 Data analysis procedures

Qualitative data analysis is the process of bringing order, structure, and interpretation to the mass of collected data (Denscombe, 2010). It is important to note that Crabtree and Miller (1999, p.146) state "the fundamental task of any qualitative data analysis is to make sense out of or bring some comprehensible and illuminating order to the complex set of human practices and interrelationships that are usually the object of inquiry". Data analysis in qualitative description requires the analysis to stay as close as possible to the data (Sandelowski, 2000). This was important to understand the actual views of South Asian men on sexual health in the manner which is described by them. This is referred to as low level interpretation and with minimum interpretation. Data analysis using a

qualitative descriptive approach required all the data generated to be coded, categorised and merged into themes and groups. The analysis of all PAR group meetings and individual interviews was undertaken in a systematic manner and all the data generated was manually transcribed and analysed using thematic analysis shown by Braun and Clarke (2013).

Data analysis for this study was undertaken using computer assisted qualitative data analysis software (CAQDAS). The use of CAQDAS was undertaken to help determine the key themes and patterns. A number of reputable CAQDAS was considered for this study such as Framework analysis and Atlas-ti. Atlas-ti is internationally recognised qualitative data analysis software and has the ability to be used to link themes in data sets as well as allow viewing various data fields, categories and themes on a single screen.

Data analysis from the interviews and group interviews enabled this study to identify a number of key issues which were systematically categorised. There is no one correct way to analyse qualitative data, but one important factor that makes all data analysis effective is the need to be systematic (Koshy et al, 2011). A clear criterion about the selection of data needs to be highlighted and this is usually relates back to the research aim and research questions (Miles et al, 1994). The analytical process was undertaken with the intention of exploring the key issues related to the culture of South Asian men's sexual health. This can be viewed as selective analysis, although the words, phrases

and languages used in qualitative description takes precedent over the researchers view of what should be highlighted.

Using a qualitative descriptive approach enabled the analysis not to be confined to a particular theoretical research framework as the primary source throughout the data analysis process is the data. Qualitative content analysis using modifiable coding systems that correspond to the data collected was used for data analysis. Neergard et al (2009, p.3) shows the six analytic strategies of qualitative description proposed by Miles et al (1994) in the following table (3.3):

a.	Coding of data from notes, observations or interviews
b.	Recording insights and reflections on the data
c.	Sorting through the data to identify similar phrases, patterns, themes sequences and important features
d.	Looking for commonalities and differences among the data and extracting them for further consideration and analysis
e.	Gradually deciding on a small group or generalisation that holds true for the data
f.	Examining these generalisations in the light of existing knowledge

Table 3.3: Analytical strategies of qualitative description

Table 3.4 describes the process used for undertaking data analysis in this study. Content analysis is the overarching approach in qualitative description data analysis. Content analysis in qualitative description requires the need to stay close to the data and describe informants experience in the language similar to the informants. This meant the identified topics, subjects and themes was based on what South Asian men described.

This analytical process required coding all data, identifying key phrases, patterns, commonalities and themes. Data analysis for this research used

codes to help determine themes. Open coding or initial coding is when the codes are descriptive and involve the labelling of chunks of data in terms of their content. The participants own words are often used to open code at the initial stages. Axial coding or focused coding as it is usually referred to occur after several interviews and the open coding stage has progressed.

Denscombe (2010, p.98) states:

> "As the codes take shape, the researcher will look for relationships between the codes; links and association that allow certain codes to be subsumed under broader headings and certain codes to be seen as more crucial than others"

The themes amongst all sets of data was further analysed for commonalities and differences which helped to identity the emerging groups. The preparatory PAR group meeting was transcribed and analysed. This set of data was used as the sample data to help support the study. This data will be shown as one example of how the data was analysis process was undertaken for this study in the tables 3.4 (Appendix 3). Phrases from the data, patterns, themes and groups from the preparatory PAR group meeting and PAR group meetings was jointly analysed into overall themes and groups. This provided a collective view on South Asian men's sexual health perspective.

Participant Data/ Phrases/ Quotations	Codes; patterns, sequences, commonalities and differences	Themes/ Groups
Participant Six (PAR Group Session One): "Yes, you won't see Asian people sitting amongst each other discussing sexual health in their house. White communities will talk about sex. In [South] Asians it's a shame thing. You don't talk about sex in front of your parents, even if it's positive, you don't. It's out of respect"	*"You **won't see Asian people** sitting amongst each other discussing sexual health in their house"*	Lack of discussion in South Asian families
Participant Two (PAR group): "I personally wouldn't talk to family and friends if I did have any concerns; it's just something you don't discuss in an open way with family and friends. I'm a personal person so it would be private"	***"White communities will talk about sex**"*	Misconception regarding non-South Asian communities
	*"In [South] Asians it's a **shame** thing"*	Shame
Participant Two (PAR Group Session Five): "The biggest barrier is that our parents and we as parent fail to have this conversation on sexual health issue because this is not done within [South] Asian families, because sex outside of marriage is not acceptable"	*"You don't talk about sex in **front of your parents,** even if it's positive, you don't. It's out of **respect**"*	Respect/ stigma
	*"I personally wouldn't talk to family and friends if I did have any concerns; it's just something you don't discuss in an open way with family and friends. I'm a personal person so it would be **private**"*	Privacy
Participant Two (PAR Group Session Five): "The main thing is that it is the way we are brought up. Even though we are born and bred here, it's not part of our culture; this is not something we talk about. I can't say I have had these conversations with my parents, or my parents have sat me down and discussed this. It's probably done in non-[South] Asian families, probably White families, when they say use protection. It's not done in our culture and our society. Obviously this is something new for me"	*"The biggest barrier is that our **parents** and we as parent fail to have this conversation on sexual health issue because this is not done within [South] Asian families, because sex outside of marriage is not acceptable"*	Parental influence Respect
		Stigma and shame
Participant Three (PAR Group Session One): "White communities are more open to talk in their families, it runs in their culture"	*"The main thing is that it is the way we are brought up. Even though we are born and bred here, **it's not part of our culture**; this is not something we talk about. I can't say I have had these conversations with my **parents**, or my parents have sat me down and discussed this. It's probably done in **non-[South] Asian families, probably White families**, when they say use protection. It's not done in our culture and our society.*	Stigma and shame
Participant One (PAR Group): "It's not discussed in the open arena; it's always behind closed doors. There's less taboo in the Western community"		Parental influence Respect
		Misconception of non-South Asian communities

	Obviously this is something new for me" *"White communities are more open to talk in their families, it runs in their culture"* *"It's not discussed in the open arena; it's always behind closed doors. There's less taboo in the Western community"*	Misconception of non-South Asian communities Stigma and shame
Participant Two (PAR Group Session Five): "I think the issue of sexual health is more relevant for the younger community than the older community as they are the ones more sexually active. Older people won't discuss a sexual health issue which is a key barrier. Some young people I spoke to are more tuned to the issue. They know about the general stuff. Some young people said they have no need to visit a sexual health services as they are not sexually active. They said in our religion we can't have sex before marriage. The conversation with them stopped"	*"I think the issue of sexual health is* ***more relevant for the younger community than the older community as they are the ones more sexually active****.* ***Older people won't discuss a sexual health i****ssue which is a key barrier. Some young people I spoke to are more tuned to the issue. They know about the general stuff. Some young people said they have no need to visit a sexual health services as they are not sexually active. They said in our* ***religion we can't have sex before marriage****. The conversation with them stopped"*	Sexual attitudes and behaviour vary amongst different age groups Religious influences

Table 3.4: Sample of developing codes and themes

Themes were developed following the identification of key phases and issues from the data. The following table shows how groups were combined and themes allocated to demonstrate significant issues (Table 3.5):

Data Patterns	Overall Themes
• Misconception of non-South Asian communities • Shame • Respect/ stigma • Privacy • Parental influence • Respect • Misconception of non-South Asian communities	**Family relations**
• Sexual attitudes and behaviour vary amongst different age groups • Religious influences	**Generational differences**
• Stigma and shame • STI • Misconception of non-South Asian communities • Respect	**Stigma**
• Awareness of services • Stigma associated to using sexual health services • Discretion • Outreach services • Confidentiality • Role of GP • Multi-agency approach • Sexual health information • Community locations	**Sexual health awareness**
• Community leaders	**Community engagement**
• Acceptable health topics in the South Asian community • Multi-agency approach • Trust building • Multi-lingual services/ information • Language	**Culturally appropriate interventions**
• Sexual health associated with gay men • Sexual health associated with HIV/ AIDS • Homophobia • Stigma and shame • Stigma • Sexual orientation irrelevant	**Homophobia**

Table 3.5: Data themes

The data analysis of phase one was replicated for phase two and phase three. This required all data generated to be analysed and identify codes, patterns, themes and overall groups.

Qualitative description requires that that the outcomes of analysis be examined in light of existing knowledge (Sandelowski, 2000; Neergard et al, 2009). Therefore, the findings from the three phases of data generation will be discussed in the context of the literature review, national and local data and reports on sexual health related to South Asian men in the UK (Public Health England, 2018). In addition, The influential levels of sexual health model of Collumbien et al (2012) (figure 5.1) will be the key component to align my discussions in chapter 5 on the themes identified. Collubmbien et al (2012) suggest a number of research design approaches to use on

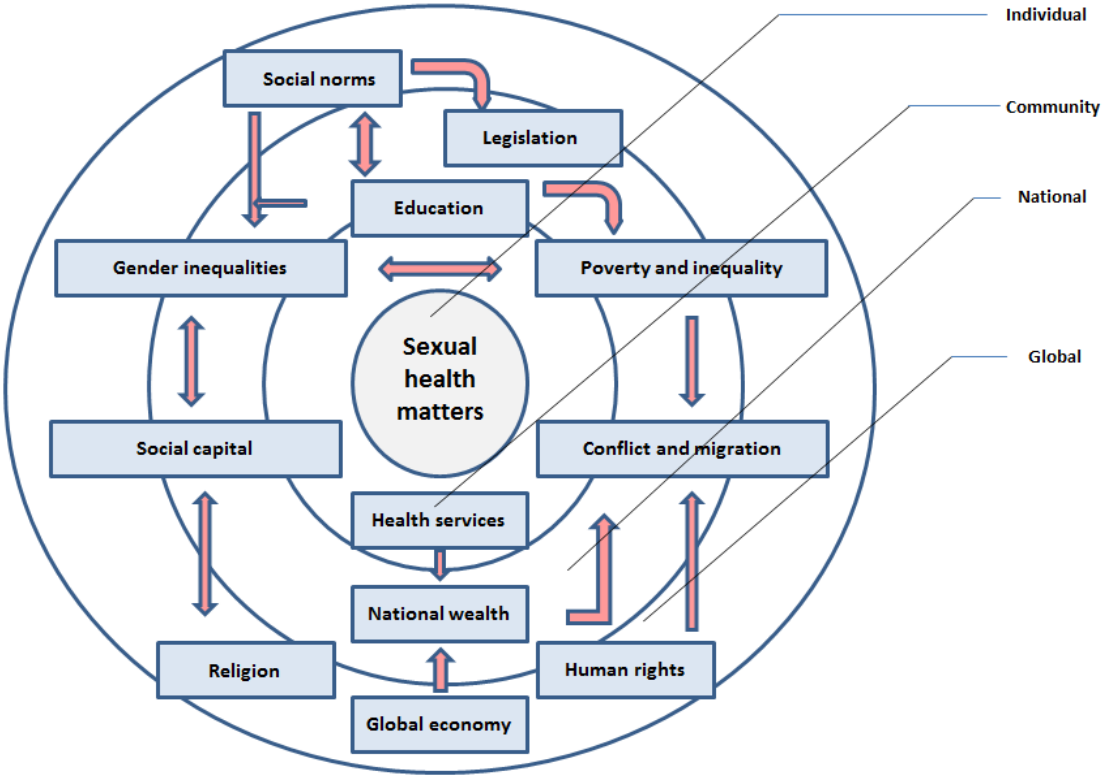


Figure 3.2: Influential levels of sexual health

sexual and reproductive health and one which is a participatory approach. Collubmbien et al (2012) asserts that sexual health research should come under the following broad objectives, research on magnitude, determinants, and consequences of sexual/ reproductive behaviour and ill health, research for promoting behaviour change (health promotion), research on preventative and curative reproductive health services and research on policy, social, and legal arenas of sexual and reproductive health. Using the framework of Collumbien et al (2012) (figure 5.1) helped simplify all the key issues identified under three main headings related to the individual, community and sexual health services. All three levels are interlinked as they all require equal attention.

The framework of Collumbien et al (2012) (figure 5.1) indicates positive sexual experiences are good for us and our health and negative sexual experiences are bad for us and ultimately impact negatively on our mental and physical health (Wellings and Johnson, 2013). There is a need to build sexual lifestyles and the quality of sexual experience and relationships into the overall framework of human wellbeing across the life course as an essential first step.

The framework of Collumbien et al (2012) (figure 5.1) further indicates structural influences on sexual health include a range of social, economic, and political factors operating at a number of levels, from individual action to global policies. The way in which structural factors interact to wield an influence on sexual health status is highly context dependent. The recommendation is that comprehensive multi-level, multi-partner interventions are needed that take into account of the social context in mounting individual-level programmes, attempt to modify social norms to support uptake and maintenance of behaviour change, and tackle the structural factors that

contribute to risky sexual behaviour. Because the relationship between structural factors and poor sexual outcomes is complex, efforts by public health agencies to address them need to be in collaborative partnership with different sectors and agencies, and supported by political leadership and attention to human rights (Collumbien et al, 2012).

Behaviour is more than merely a personal choice. Social structures, institutions, and norms provide the potential for, and impose limitations on human action and thoughts. Power structures, absolute and relative poverty as well as differential access to resources, social isolation and discrimination restrict an individual's ability to achieve positive health outcomes or to facilitate change (Collumbien et al, 2012; Wellings and Johnson, 2013). The Collumbien et al (2012) model (figure 5.1 Influential levels of sexual health) helps to understand the different levels at which structural influences operate and situates individuals within a nest of social circles. However, this model is predominantly based upon poverty and sexual health. In the case of many South Asians in the UK, absolute poverty is a thing of the past in the UK and relative poverty to wealthy is argued to be adequate (Cabinet Office, 2018). Despite the usage of this model, this will be the appropriate model to align data analysis of all three phases and the critical discussions later on in this thesis.

In, addition, The DH (2012) states the NHS Constitution belongs to the people, it sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. This constitution ensures that the NHS provides a comprehensive

service to all irrespective of race, gender, sexual orientation, disability, age, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The NHS should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. It states the NHS is accountable to the public, communities and patients that it serves. Therefore, there are implications for NHS providers who do not shape local sexual health services to meet the needs of all communities they serve and this includes South Asian men.

3.8 Data validation

Qualitative data analysis can be a time-consuming affair and sometimes does not proceed in a linear fashion (Denscombe 2007). Denscombe (2007, p.302) states "qualitative researchers need to come to terms that it is not feasible for them to present all the research data collected and analysed and only selected data need to be presented. They need to act as a transparent editor. Therefore, the researcher does not need to show the 'messy' process of qualitative data analysis but only show the most important data findings". This was the approach undertaken for the data analysis for this study. Using a qualitative description approach requires analysis to be as close as possible to the language used by those taking part in the research however 'messy' that may be. Milne et al (2005) in Neergard et al (2009, p.4) demonstrate strategies to enhance rigour in qualitative description. This is demonstrated in the Table (3.6) below:

Strategy	Techniques
Authenticity	The informants are free to speak • Purposeful, flexible sampling • Participant-driven data collection The informants voices' are heard • Promoting richness rather than superficiality of data • Conducting focus group interviews to diminish the role of the researcher

	Informants' perceptions are accurately represented • Accurate transcription • Content analysis (ensuring data-driven coding and categorising_
Credibility	Capturing and portraying a truly insider perspective
Criticality	Reflection on the critical appraisal applied to every research decision
Integrity	Reflecting on researcher bias • Dual role (clinician/ researcher/ interviewer) during the interview • Dual role in the process of analysing Informants' validations/ member checking Peer review/ researcher triangulation

Table 3.6: Rigour in qualitative description

Milne and Oberle (2005) state rigour in qualitative description requires informants perception to be accurately represented, reflection on the researchers bias (i.e. ontological and epistemological stance and agenda for the research) and importantly validation with participants in the form of triangulation. Validating the findings with South Asian men in the form of in-depth interviews at the third phase provided the study confirmation on the identified patterns, themes groups for understanding the culture of South Asian men's sexual health.

This validation process provided an opportunity to determine whether the findings on understanding the culture of sexual health amongst South Asian men is (a) the same as the sexual health culture in men from non-South Asian communities (b) useful to share with sexual health commissioners (c) useful to share with South Asian focused community organisations and faith establishments working with South Asian men and (d) identify possible solutions by South Asian men from all the data collected and analysed from all three phases.

The data generated and analysed from phase one and phase two required validation. The PAR group meeting data provided a collective view of South Asian men's sexual health culture and the semi-structured and in-depth interviews provided an individual perspective. Therefore, phase three is considered a validation process to ensure the overall key themes and groups shared by South Asian on the culture of sexual health reflected the overall view of all South Asian men who participated in this study.

This chapter demonstrates the challenge of locating an ideal theoretical research framework for this study. A community-orientated research approach was chosen to deliver a sensitive research topic of sexual health with a group of South Asian men. Community development influence blurred the initial approach and there was a struggle of theoretical positioning for this study to align itself towards an appropriate and suitable theoretical research framework. As a result of iterative changes the study adapted to a more suitable framework from PAR to interviews. The theoretical positioning arrived to choosing a qualitative description research approach which was about the data being the fundamental instrument and not aligning the research to a particular framework. Qualitative description allowed the language, words and often clear and silent voices of South Asian men on sexual health at the forefront of this study.

3.9 Limitations of action research and qualitative description

I have mentioned some of the limitations of using PAR during the course of the study and this resulted in a change in direction to use qualitative description. Some of the limitations experienced of using PAR in this study include the difficulty in establishing

the PAR group comprised of local South Asian men to explore the issue of men's sexual health, the lack of experience of me as both a researcher and facilitator to adequately deliver PAR, the lack of focus on behalf of all PAR group member to recognise the 'action' element of PAR, the difficulties on PAR group members defining and agreeing the term 'sexual health, PAR group members commitment, attendance and punctuality and PAR not being a sensitive approach to explore men's sexual amongst within the South Asian community. PAR is best delivered as a shared responsibility amongst researchers and the community but as the subject of 'sexual health' within South Asian communities is sensitive there was reluctance of South Asian men from the PAR group to be known to be associated with this study. As a result the data generated from PAR was used to inform phases two and three of this study; ten semi-structured interviews and five in-depth interviews.

Using a collaborative research approach, however favourable may not necessarily be the ideal research approach to investigate South Asian men's sexual health as experienced during this study. Consultation needs to be undertaken with any target group and in this case South Asian men to determine the best research approach for undertaking sexual health research. A pre-research consultation would have helped consider the ideal age group, sexual orientation, faith or no faith belonging, specific South Asian ethnic origin, language, as well as choosing the location. It is beneficial for research in communities to have closer links with clinicians working on men's sexual health to maximise research exposure and impact.

Community development and community engagement are tools which can be used to work in communities who are deemed marginalised and this requires building trust

and personal relationships with communities. These tools can also hinder relationships between services and communities. Therefore, it essential when working in communities and in this case working with the South Asian men that a considerable attention is required to build trust and relationships. The importance of developing trust and relationship in Brent was underestimated during the PAR group establishment phase of this study. Research exploring sensitive health topics such as South Asian men's sexual health requires time and resources to support the research progress effectively. Resources can help in the form of incentives for community members to take part in a study and providing training and material to help undertake the research. Food, refreshments and support with travel costs are also key issues which were raised by the PAR group and were provided during the PAR phase of this study.

One barrier of using PAR was creating a superficial community of South Asian men to explore the culture of sexual health. PAR is effective when there is an established group of people or community that are passionate about a topic of importance in the community. South Asian men's sexual health is not a topic at the forefront of the in the South Asian community in Brent and Leicester. An established community or group with motivation on a particular topic will use PAR effectively and recognise the importance of undertaking such an approach.

This study faced the gravity of South Asian men's sexual health as a taboo topic within the South Asian community. Further research was required on simply choosing the appropriate research approach to undertake research between groups of South Asian men in relation to sexual health. Men's sexual health in this country

is generally understood from a Western Eurocentric context and to some degree is relevant to South Asian men as certain men's health issues encompasses all men, but there is clearly a difference on how this topic is perceived in the South Asian community and what sexual health means within a South Asian male context. However, qualitative description also has its limitations. Its strength lays in its ability to be a standalone approach without the need to be 'fixed' towards a particular theoretical research framework. As a result, qualitative description can be seen to lack rigour and recognition. In addition, qualitative description is a lesser known qualitative inquiry in comparison to the major inquiry field such as phenomenology, grounded theory, narrative and ethnography and this means social researchers are less familiar with the qualitative description approach (Sandelowski, 2000; Neergard et al 2009; Lambert and Lambert, 2012).

Chapter 4 Findings

This chapter commences with a profile of all participants from the three phases in this study and describes the findings from all phases of this study in two sections; collective and individual. The findings from this study sought to develop an understanding towards the individual and collective views of sexual health and sexual health services from South Asian men. The themes identified from all three data phases are presented in line with Collumbien et al's (2012) framework to better understand the different influential levels of sexual health. The reason for choosing this particular sexual health framework as an appropriate model for understanding was to (a) demonstrate the findings from this research in a simplistic manner and one which described the views of South Asian men and (b) this was a model which reflected the holistic understanding of sexual health. Presenting the findings in this manner helped the study to develop a potential model to better understand the influences of South Asian men's sexual health and culture which is further discussed in the next the chapter.

4.1 Phase One: PAR group

In order to commence this process a group of South Asian men was established and recruitment activity was undertaken in Brent, London. There are four key areas around recruitment in research; initially finding a knowledgeable informant, getting a range of views, testing emerging themes with new interviewees, and choosing interviewees to extend results (Seale et al, 2004). These are valuable ideals; however, the actual practice may deviate from these, and like many things, recruitment in a research study routinely happens on an ad-hoc and chance basis. This was certainly the case to establish a PAR group for this study.

4.1.1 Phase One: PAR group recruitment

The detailed components of this study are described in chapter four. Initial focus of this study was to acquire a 'collective' perspective of South Asian men's sexual health. PAR group participants were recruited through outreach work undertaken in Brent, London. Following the provision of participant information and providing consent forms, all the participants attended a preparatory meeting was scheduled to help build a personal rapport and explore South Asian men's initial thoughts on sexual health and extract individual perceptions about being involved in a PAR study. This process was used to develop a plan for the facilitation of all the PAR group meetings.

Extensive outreach work and networking with local community organisations and groups in Brent was undertaken to promote the research and find suitable participants to join the initial PAR group for this research study (Appendix 4, 5, 6). South Asian men aged above 18 and over were targeted. A recruitment strategy was developed to include a communication plan, appropriate community targeted publicity in the form of a poster, community friendly presentation developed on the research project designed specifically to target community groups and organisations, organising community based discussions and meeting and undertaking informal interviews with potential participants through word of mouth approaches. Participants were recruited from the local voluntary and community sector following an extensive outreach recruitment programme. Recruitment was primarily successful by using 'word of mouth' techniques.

During the PAR group recruitment phase established gay men's group in London were approached Dost (South Asian and Middle Eastern gay and bisexual MSM group, NAZ Project London (NPL) and the North West Lesbian and Gay Group (Brent). The research aim and research questions together with the approach of PAR were shared with both groups with the aim to recruit participants. Men from both groups generally expressed how such a study was required and likely to be beneficial for South Asian men. However, no members from both these groups were recruited. Men from both these groups expressed either that the study be undertaken with either straight or with gay/ bisexual men but not collaboratively due to confidentiality issues regarding sexual orientation. It was reiterated that the focus of study is not on the sexuality *per se* of South Asian men, but acknowledged that this issue was needed to be handled sensitively during the study delivery phase. This showed the additional level of complexity of research to explore the culture of South Asian men's sexual health. It is fundamental for any research; along with thorough ethical approval to consider the logistics of undertaking research on men's sexual health in the South Asian community bearing in mind members from both the gay and straight communities (Appendix 7, 8).

PAR group meetings were held in Brent, London, during April 2011- June 2012. The first meeting undertook ice breaking activities, present the research aims and questions and provide opportunities for participants to discuss their thoughts on being involved in this study. This complying with the Ethical Standards of University of West London is imperative that research clarifies the principal aim of a study which in this case was for an academic doctorate purpose.

Meetings were initially planned to be weekly but this had to be changed to hourly meetings once a fortnight to the needs of members of the PAR group. The PAR group initially decided to meet for an hour fortnightly on Saturday mornings as this enabled participants who were in employment or in education to attend PAR group meetings.

4.1.2 Phase One: PAR group profile

Seven local South Asian men were identified to become participants in this study. The initial aim was to recruit South Asian men to represent various cultures, faith groups and ethnicities of the South Asian male population. The South Asian community in Brent is predominantly of Sri Lankan origin and belongs to the Hindu faith. It became apparent early on during the outreach work that recruitment for representation was highly challenging as men from the local community did not seem forthcoming to join this study. This was due to a number of reasons that mainly included the social stigma associated with sexual health in the South Asian community which is also common in other communities. Therefore, an early decision was made to recruit South Asian men who would be willing to take part, commit to the study attend a series of PAR group interview meetings. Therefore, a stringent inclusion and exclusion criteria was not developed for the development of the PAR group due to the lack of response in the Brent from the local South Asian male population. The research aimed to recruit 8-12 local men (which is in line with undertaking effective focus group work (Wilkinson, 1994; Barbour and Kitzinger, 1999; Bloor et al, 2001). However, only seven South Asian men came forward to take part in the study. The profile of all seven group members is as follows (table 3.7):

Participant Number	Age	Gender	Ethnicity	Language Spoken	Employment Status
One	36	Male	Indian/ British Asian	Gujarati	Employed
Two	51	Male	Indian	Guajarati	Employed
Three	29	Male	Indian/ British Asian	Hindi	Employed
Four	28	Male	Indian/ British Asian	Hindi	Employed/ Student
Five	35	Male	Indian/ British Asian	Gujarati	Unemployed
Six	71	Male	Indian	Punjabi	Retired
Seven	20	Male	Indian/ British Asian	Gujarati	Student

Table 4.1: Profile of PAR group members

The age range of PAR group members was between 20–51 years, all whom mainly spoke the language of Gujarati. Therefore, the origins and heritage of this group of South Asian men was North India. There was a mix of men employed, unemployed as well as a student and a retired member.

An informal discussion was undertaken with each member to discuss the research aim and PAR methods and this provided the opportunity for each participant to ask questions around the involvement and commitment required. It is also important to point out that none of the members of the group had previously participated in research or undertaken any form of professional or academic training in research. Research was generally understood by this group to be delivered and managed by so called ‘outside’ experts. Therefore, it was important to facilitate group meetings using appropriate language and not use professional jargon in order to enable the

PAR group to move at a comfortable pace. It was also important to support the confidence and self-esteem of PAR group members, thus allow all members constructively and critically contribute during PAR group interview meeting. Following the recruitment stage of the PAR group, an opportunity was provided to the PAR group which shared the principles and background of men's sexual health, an overview of sexual health, sexual health disease and sexual health services (Appendix 9, 10). The purpose of this particular workshop was not to influence the group should discuss or manipulate towards a specific issue, rather it was to enable participants the confidence to commence discussions and critical dialogue. In addition, a second workshop was designed and delivered to all PAR group members that provided an overview of PAR (Appendix 11, 12). Following the two workshops a series of meetings with the PAR group was organised. In total six PAR group meetings with South Asian men in Brent were undertaken.

4.1.3 Phase One: PAR group preparatory meeting

In order to capture the collective views of South Asian men's sexual health a PAR group preparatory meeting was organised. The PAR group preparatory meeting schedule focused on the themes highlighted from the literature review such as sexual health knowledge and awareness of local sexual health services (Appendix 13). The findings from this questionnaire helped commence discussions to explore a range of issues related to the culture of South Asian men's sexual health. Key themes that emerged from the PAR group preparatory questionnaire highlighted:

1. **Lack of awareness**: Lack of awareness of sexual health services. Sexual health services should be available in discreet locations and open all hours for South Asian men.

2. **Definition of sexual health**: Sexual health is associated with sexual disease, activity and performance. Myth busting work on sexual health needs to be delivered South Asian communities.
3. **Research**: South Asian men are rare involved in research concerning men's sexual health.
4. **Trust**: Importance of building trust between sexual health services and South Asian men. South Asian men are reluctant to be volunteers with local sexual health services due to the fear of personal information might be disclosed in their community.
5. **Language:** Sexual health information should be made available in South Asian languages.
6. **Community related issues:** Sexual health is a sensitive topic in the South Asian community. The profile of men's sexual health can be raised in the community by associating sexual health to 'community acceptable' topics such as cancer, diabetes, heart disease etc. South Asian men are not comfortable discussing sexual health with family and friends, but would are comfortable discussing sexual health amongst men.

These themes helped South Asian men to commence discussions on a range of sexual health issues in future PAR group meetings and ensure the group remained focused on the research aim and research questions. A set of observation/ fields notes and transcripts were undertaken during all PAR group meetings (Appendix 13, 14)

4.2 Phase Two and Three: Individual interviews

The PAR group ceased to operate due to the inactivity of actions amongst all PAR group members which prevented effective PAR cycles to occur. Therefore, during the final PAR group meeting participants agreed on a set of questions to be used for the second phase of the study. The second phase of this study resulted in undertaking ten semi-structured interviews which was introduced to add to the data obtained from the PAR group 'collective' interview phase. The questions chosen reflected were generated from the overall themes and groups which emerged from the PAR group phase.

4.2.1 Development of interview questions

The interview questions for phase two developed out of themes and groups from phase one and the interview questions for phase two and three developed out of themes and groups from phase one and two. The rationale of developing interview questions from subsequent phases/ themes and groups was to ensure that discussions and the direction of data remained on course to explore issues highlighted by South Asian men in regards to sexual health. Interview questions used were open ended questions and this in line with qualitative description data generation.

4.2.3 Phase Two: Semi-structured Interviewee profile

Recruitment to undertake ten individual semi-structured interviews was undertaken by engaging and accessing a local South Asian football club in Leicester (Appendix 14, 15, 16). The reason for choosing a local South Asian football club was due to the ease of obtaining data from a captive and willing audience. In addition, due to

relocation to Leicester during the course of this study meant accessing a local establishment in Leicester would save time on travel to and from London. As in the PAR group phase the recruitment focused on South Asian men above the age of 18. The age of second phase interview participants ranged from 33- 46 years, all of whom were in employment and all spoke the Gujarati language. The profile of all South Asian men taking part in semi-structured individual interviews is as follows (3.8):

Participant Number	Age	Gender	Ethnicity	Language Spoken	Employment Status
One	34	Male	Indian/ British Asian	Gujarati	Employed
Two	35	Male	Indian/ British Asian	Gujarati	Employed
Three	46	Male	Indian/ British Asian	Gujarati	Employed
Four	37	Male	Indian/ British Asian	Gujarati	Employed
Five	37	Male	Indian/ British Asian	Gujarati	Employed
Six	37	Male	Indian/ British Asian	Gujarati	Employed
Seven	35	Male	Indian/ British Asian	Gujarati	Employed
Eight	35	Male	Indian/ British Asian	Gujarati	Employed
Nine	34	Male	Indian/ British Asian	Gujarati	Employed
Ten	33	Male	Indian/ British Asian	Gujarati	Employed

Table 4.2: Profile of semi-structured Interviewees

4.2.4 Phase Three: In-depth Interviewee profile

A third and final phase was introduced to further analyse the themes and groups which emerged from the data generated from the PAR group and individual semi-structured interview phases. This final phase consisted of five in-depth interviews. In-depth interviews were used to enable participants to discuss the identified themes further. Probing questions were used in the in-depth interviews to enable participants to discuss issues a flexible manner. Recruitment to undertake five in-depth interviews was undertaken via accessing members from South Asian men from the second phase (Appendix 17, 18, 19). The recruitment also focused on South Asian men above the age of 18. The age range of members during the in-depth interviews was from 37- 59 years, all of whom were in employment and all who also speak Gujarati. The profile of all South Asian men taking part in-depth interviews is as follows (3.9):

Participant Number	Age	Gender	Ethnicity	Language Spoken	Employment Status
One	37	Male	Indian/ British Asian	Gujarati	Employed
Two	39	Male	Indian/ British Asian	Gujarati	Employed
Three	48	Male	Indian/ British Asian	Gujarati	Employed
Four	59	Male	Indian	Gujarati	Employed
Five	58	Male	Indian	Gujarati	Employed

Table 4.3: Profile of in-depth Interviewees

4.3 Phase One: PAR group – A community perspective

The findings from all three phases was demonstrated through the lens of the Collumbien et al (2012) framework to better understand the different influential levels of sexual health. This enabled the data analysis process to identify key themes from the PAR group phase (Appendix 20, 21). The key issues raised in the PAR group phases ranged from across individual, community, national and global levels and they are demonstrated below:.

4.3.1 Linguistic issue

One of the main themes which became apparent from the phase of this study was the use of the term 'sexual health'. This was an unfamiliar term amongst South Asian men and when they did come across this term it generally was in a negative context:

> *Participant Two (PAR group session two): "I think it's the terminology that is used. If you are talking about sexual health, it's automatically associated with the actual deed; it's not associated with all the other problems you can have"*

> *Participant Two (PAR group session two): People are not confident discussing these issues in the open, that's the main thing"*

South Asian men insisted they are not comfortable to use 'sexual health' and this meant raising matters concerning South Asian men's sexual health would be required to be undertaken using culturally sensitive and acceptable terms:

> *Participant One (PAR group session six): "Maybe we need to move away from using the term 'sexual health' altogether and rephrase it differently. The minute you say sexual health it's all about sex"*

South Asian men are comfortable to discuss health issues in the community which are acceptable in the South Asian community and one approach suggested by

members of the PAR group was to discuss sexual health under the acceptable health issues within the South Asian community:

> *Participant Seven (PAR group): "Not being direct, going round other issues like diabetes and then [introduce] sexual health issues"*

> *Participant Seven (PAR group): "Talk about other issues blood pressure, cancer, diabetes and other health issues. Win over people, build trust and confidence first and then talk about sexual health issues"*

4.3.2 Construction and perception of sexual health

In addition to the term and use of 'sexual health' it was evident there was uncertainty on the definition and understanding of what constituted sexual health amongst South Asian men in the PAR group. There was understanding that sexual health was a very broad concept and usually was associated to negative matters such as STI:

> *Participant Four (PAR group session one): "'Sexual health is quite broad"*

> *Participant Two (PAR group session six): "'Sexual health has negative connotations and consequences"*

Discussing sexual health meant an individual or group was involved in promiscuous affairs and this was frowned upon amongst South Asian men:

> *Participant Seven (PAR group): "Negative, there must be something wrong or [they must be] doing something wrong to use [sexual health services]"*

> *Participant Two (PAR group): "From a cultural point of view these kinds of things shouldn't be happening if an individual is in a marital relationship"*

As a result of negative connotations towards the terminology of sexual health, South Asian men did discuss whether such an issue can be discussed in a positive context and brought to the forefront of South Asian people's health:

> *Participant Two (PAR group session two): It's not something we are comfortable with discussing with family and friends or groups. If we did want to address the issue how do we do it?"*

Issues concerning sexual health and the term was absent from South Asian's men vocabulary due to less or no experience of discussions around this issue within the South Asian family and community:

> *Participant Two (PAR group session five): "The biggest barrier is that our parents and we as parent fail to have this conversation on sexual health issue because this is not done within [South] Asian families, because sex outside of marriage is not acceptable"*

> *Participant Two (PAR group session two): "It's like a taboo subject, how do you bring it to the forefront of discussion, by discussing it in this kind of way, people are becoming more open to different views and different ways of addressing certain problems. In that sense it's constructive. They feel more confident to talk about it"*

There was an impression amongst South Asian men in the PAR group that non-South Asian men and communities used the term 'sexual health' frequently and this was due to an open sexual health culture amongst non-South Asian communities:

> *Participant One (PAR group): "There's less taboo in the Western community"*

> *Participant Six (PAR group session one): "White communities will talk about sex. In [South] Asians it's a shame thing. You don't talk about sex in front of your parents, even if it's positive, you don't. It's out of respect"*

4.3.3 Sexual connotation

The term men's sexual health was such a taboo amongst PAR group members that they refrained from being externally associated with this study and being linked with any activities regarding positive sexual health messages:

> *Participant Two (PAR group): "Personally I wouldn't want to be involved, if I went out in the community and promoted men's MOT sexual health, people might think I had one of the illnesses and label me and this can affect my kids at school"*

In addition, older members of the PAR group and some young members of the group mentioned that men's sexual health discussions and interventions are targeted for the young population and irrelevant for the older generation. It was as if PAR group

members suggested sexual health research and interventions for older South Asian men is not required:

> *Participant Two (PAR group session five): "I think the issue of sexual health is more relevant for the younger community than the older community as they are the ones more sexually active"*

4.3.4 Privacy and confidentiality

A major issue which was raised during the PAR group meetings was regarding privacy and confidentiality. South Asian men lacked confidence in family, friends and local health services of maintaining confidentiality if an issue regarding their sexual health was discussed due to exposure amongst the South Asian community. There clearly was a requirement building trust regarding the discussion associated with South Asian men's sexual health:

> *Participant Two (PAR group): "I personally wouldn't talk to family and friends if I did have any concerns; it's just something you don't discuss in an open way with family and friends. I'm a personal person so it would be private"*

> *Participant Two (PAR group session five): "Not everyone's comfortable about going to a GP. Some people find the GP receptionist intimidating as they ask what the problem is. This kind of thing is personal and intimate and sensitive and can be a deterrent. That was the first barrier"*

> *Participant Two (PAR group session five): "They [South Asian men] would not be comfortable discussing this with a GP as the GP may know the family"*

However, South Asian men suggested a male health professional would be ideal for them to approach and discuss sexual health matters. They also suggested, if there was assurance towards confidentiality that their local GP would be an ideal health professional for them to raise sexual health matters:

> *Participant Two (PAR group session five): South Asian men feel more comfortable talking to men, so when there is a female at the [health] clinic, they can feel embarrassed and shy"*

> *Participant Two (PAR group session four): "G.P's would be in a better position to guide us, as they have first-hand experience [of sexual health issues]"*

4.3.5 Honour and respect

In addition to terminology and association to men's' sexual health, privacy and confidentiality the issue of family and community honour was highly important amongst PAR group members. South Asian men from the PAR group mentioned sexual health is not discussed because this is disrespectful to discuss in the family and community. They also implied the lack of respect amongst non-South Asian families and communities enabled conversations regarding sexual health to take place:

> *Participant Seven (PAR group): "In our [South Asian] community there are things like culture, family, honour, respect that will hold a person back from being open"*

> *Participant Two (PAR group session five): "The main thing is that it is the way we are brought up. Even though we are born and bred here, it's not part of our culture; this is not something we talk about"*

> *Participant Two (PAR group session five): I can't say I have had these conversations with my parents, or my parents have sat me down and discussed this. It's probably done in non-[South] Asian families, probably White families, when they say use protection. It's not done in our culture and our society"*

4.3.6. Sexual orientation

One issue which was regularly raised within the PAR group phase was concerning sexual orientation and homosexuality. Discussing sexual health was initially understood to be of concern to gay men within the PAR group. There is an impression that men's sexual health is only of concern to gay men and this was a concern:

> *Participant Two (PAR group session two): "As soon as you said sexual health, people stigmatised, relating it to homosexuality or men having sex with men….you know about AIDS and HIV"*

> *Participant Four (PAR group session two): "Most people commented on sexual health and came up with sex or homosexuality. It's not just about sex, it's not just about homosexuality, and there are other aspects to sexual health as well"*

Discussions within the PAR group often focussed around homosexuality and occasionally discriminatory language and homophobic viewpoints was highlighted:

> *Participant Six (PAR group session one): "Being gay is not accepted, it's not going to be accepted in wider society"*

It must be noted that not all PAR group resembled this viewpoint and challenged this discriminatory language and perspective within discussions:

> *Participant Four (PAR group session two): "Homosexuality is more about sexual orientation than sexual health or disease"*

> *Participant Five (PAR group): "At the end of the day it's all the same thing, men are men, no matter what sexuality or culture you come from"*

4.3.7 Sexual health awareness

Discussions regarding local sexual health services were limited within the PAR group setting. It was evident that South Asian men who participated in the PAR group were unaware of the location and services provided by local sexual health services:

> *Participant Three (PAR group): "No, I don't think they [sexual health services] are widely known….no one talks about them"*

> *Participant Seven (PAR group): "Clear messages about what [sexual health] service[s] do, what sort of service it [sexual health] provides and where it is"*

Sexual health services need to be discreet to enable South Asian men the confidence to access these services. Discretion ensures South Asian men have assurances on privacy and confidentiality matters:

> *Participant Two (PAR group session one): "People want a discreet [sexual health] service"*

> *Participant Two (PAR group session two): "Everybody wants a discreet service; no one wants to be seen going somewhere, or going to see someone to discuss this [sexual health] issue. It's a confidentiality thing"*

> *Participant Three (PAR group session two): "People say they want a 24 hour service, because they don't want to be seen, they can book an appointment or go at night and go freely"*

An approach to raise the profile of local sexual health services amongst local South Asian men is to distribute publicity in locations where South Asian men congregate and this constant reminder would help reduce the stigma of using sexual health services amongst South Asian men and communities:

> *Participant Four (PAR group): "I think it [sexual health publicity] should be everywhere, until you don't have a sexual health issue; you're not exactly going to look out for it. If you only use hospitals and health centres, you are only going to get those people [who go to hospital or health centres]"*

> *Participant Seven (PAR group): "It should [sexual health information] be available everywhere. You might hesitate to pick up a leaflet in a GP waiting area so if you had leaflets in other places there are many people who would feel more comfortable and people will not know what you are taking"*

> *Participant Two (PAR group session five): "There's not enough [sexual health] information out there. You can have adverts in weird places like public toilets. You can have a poster in a public place"*

> *Participant Five (PAR group): "I think it would be good [sexual health information] in various places like local gyms"*

> *Participant Three (PAR group): "I think it [sexual health information] should be in all community locations as it raises awareness in the community"*

Social media were discussed as a useful platform for sexual health services to engage with South Asian men as this provided anonymity if effective governance and management was assured:

> *Participant Two (PAR group session four): " It [social media] can be done from your mobile phone nowadays, you don't even have to go somewhere like a doctors surgery or anywhere like that, from your laptop at home, from your PC, work, anywhere. So you're not going to be stigmatised by going to a clinic or event, or display stand. This can be an on-going thing"*

> *Participant Two (PAR group session four): "The Facebook and the internet thing is good because people can read other people's comments and might give people the confidence to speak up themselves and talk about different issues and issues affecting you. Also, you can remain anonymous"*

Building trust with local South Asian men should be considered a priority for local sexual health services in order to develop appropriate sexual health publicity and interventions in the South Asian community. Sexual health services need to engage with South Asian men to identify approaches which are suitable for South Asian men. South Asian community organisations and community leaders can help promote the issue of South Asian men's sexual health:

> *Participant Six (PAR group): "South Asian people are a wider range of groups, religiously; you need to see it as a multi-cultural thing and approach community leaders"*

> *Participant Four (PAR group session two): "Community leaders can talk about it [sexual health] as a stepping stone or door to open to get other things in as well"*

Culturally appropriate approaches specific to South Asian communities and South Asian men were identified during PAR group meetings. South Asian men mentioned a number of innovative approaches to promote South Asian men's sexual health that should be explored by sexual health services. One approach is for local sexual health service to work in collaboration with local drug and alcohol services and learn from those services on overcoming issues which are associated with stigma and taboo in the community:

> *Participant Four (PAR group session two): "Services like drug and alcohol services try to go out there and work with the community and they try different approaches. There's a possibility to work alongside different services [like these] to see what barriers they face and what could work or not work"*

4.4 Phase Two and Phase Three: Semi-structured and In-depth interviews – An individual perspective

The introduction of the second phase semi structured interviews and in-depth interviews was to add further understanding around the individual perspective of South Asian men's sexual health to compliment the collective findings from the PAR group. Ten semi-structured interviews were undertaken with members from a local South Asian football club in Leicester using questions identified as a result of the themes identified from the PAR group phase one of this study. Interviews were organised at suitable dates and times for each participant and each interview lasted approximately for 40 – 60 minutes. All interviews were audio recorded, transcribed and analysed. In addition, the third and final phase involved undertaking in-depth interviews with five South Asian men in Leicester (Appendix 22, 23). Phase three provided South Asian men an opportunity to elaborate on the themes from the previous two phases. South Asian men who took part in phase two were approached to be further interviewed for phase three in as well as approaching South Asian men who had not previously participated in his study. The rationale to combine phase two and phase three interviews into the analysis and findings was they reflected an 'individual' perspective' of South Asian men's sexual health which was the intention of introducing the two phases. The findings from both interview phases are as follows:

4.4.1 Construction and perception of sexual health

The findings from all interviews showed a wide range of perspectives on men's sexual health and often intentionally and unintentionally exposed some of the origins

of this perspective on sexual health. Sexual health is often associated in negative context such as STI's:

> *Interviewee Five: "Men's sexual health means sexually transmitted diseases such as HIV, unprotected sex, [and] not using contraception"*
>
> *Interviewee Six: "It's about the sexual health of men such as diseases. Sexual health is important, you would not want to catch any diseases or pass any disease to anyone"*
>
> *Interviewee Eight: "I put it down to men possibly having problems, sexual health problems. I think I see it as a negative thing straight away, on the basis of sexually transmitted diseases and that kind of stuff and people not aware what precautions to take"*

Sexual health was generally discussed to be problematic for an individual in regards to sexual performance and function:

> *Interviewee Three: "I think about whether I am capable of having sex, is my sexual genitals in order, have I got any diseases or anything"*

It must be pointed out that occasionally sexual health was mentioned in a positive context usually in relation to sexual activity and wellbeing:

> *Interviewee One: "Something to do with sex, that's all"*
>
> *Interviewee Nine: "I think of our general wellbeing and your sexual life"*

Men's sexual health matters tend not to be discussed amongst South Asian communities and there was a misconception that non-South Asian communities discuss sexual health openly as they have a culture of sexual activity outside of marriage and this makes it easier to discuss sexual health related matters within the home and amongst parents and children:

> *Interviewee Two: "In England the culture is about freedom and being open, and that's the right way for this issue"*
>
> *Interviewee Nine: "The culture is different. In the White community it is acceptable. You can have a boyfriend, you can have a girlfriend, you can have sex before*

marriage, you can do all of those things and you can start at the age of fourteen. Families know about it and it's quite open. Whereas in the South Asian community those things just don't happen, although it does go on… it's not open and families will not accept it. Maybe that's the problem"

Interviewee One: "In the White community I don't think there's much of a barrier and the Black community. They are a bit more open than the Asian community, I can't tell you exactly why, but they are, more open, and go back to their parents, open to their friends and families"

In-Depth Interviewee Four: "I think in the Western world this kind of discussion is taken more openly rather than being a taboo. I haven't actually come across anyone who in the Western world considers discussions about sexual matters to be a taboo"

Interviewee Seven: "In the [South] Asian community we don't talk about it, but you would hear about it in the wider community because it's more open and it's more acceptable"

In-Depth Interviewee Two: "Sex outside of marriage is not acceptable within our culture and that's going through all communities within the Indo-Pak...people from the Sub-Continent. These things are not the normal things"

Due to sexual health considered a private matter in the South Asian community, discussions on sexual health will always remain at the peripheral of the South Asian community:

In-Depth Interviewee Two: "I think that sexually related topics regardless of whether you talk to men or women will always remain a taboo subject within our (South Asian) community and I think specifically more in the Indo-Pakistani community and Bangladesh community"

However, South Asian men did point out that discussions around sexual health are also not as open in non-South Asian groups as some men may suggest:

In-Depth Interviewee Three: " Well, I think even in the English (White) communities a man would(not) really want to discuss if there's something wrong with his sexual health ...you know what I mean, sexuality or sexual organs. Even a white male wouldn't feel free to talk about it amongst white people unless it's someone in the medical field that he's actually made an appointment to go and see but I don't think openly people would want to talk about it if they had some form of sexual disease or problems or anything like that"

There was also an indication that discussions around sexual health have advanced in the South Asian community and this is expected to improve in the future with the younger generation:

> *Interviewee Seven: "I personally think it is possible, because now the generations have moved on and generations have got older. This generation is grown up in Britain and is more open. Talking about sex is not that bad. Before it would have been, you wouldn't even talk about it, but now it's like you have a laugh and a joke about it"*

> *Interviewee Three: "We won't get South Asian men coming forward, we are reserved. I think in another 15-20 years we will have South Asian men and women happy to discuss sexual health, sex and sexually transmitted diseases. I think it's in the process, but for the future. We have not adjusted just yet"*

4.4.2 Stigma

South Asian men are not comfortable to discuss matters related to sexual health due to privacy issues and the South Asian culture of having an accustomed culture on the abstinence of mentioning sexual health within the family and community settings:

> *In-Depth Interviewee Five: "Nobody discusses this [sexual health]. People discuss spiritual matters, people discuss other things but nobody discuss this because people think this is private"*

> *In-Depth Interviewee Four: "I think culturally people just don't discuss anything sexual. It's something people just don't find comfortable discussing"*

> *In-Depth Interviewee Four: "I think it's more like a cultural thing. You know what I mean. Sexual health is considered to be a subject or a topic people avoid discussing as a matter of their culture. You know it's considered to be a taboo subject. People don't feel comfortable discussing anything sexual amongst family or friends"*

> *In-Depth Interviewee Four: "It's just not done. It's one of those things that is just not discussed in the South Asian/ Indian family....men or women"*

> *In-Depth Interviewee Two: "You have to understand that we have a strong culture and traditional belief relating to sex and sexuality as a whole and these would be rarely discussed in the family circle. I don't think you can go to any household from the South Asian background where you can find and happily discuss these things"*

Stigma around sexual health was also associated with implying an individual was partaking in inappropriate sexual behaviour according to the local South Asian community:

> *Interviewee Ten: "The big problem you have is someone willing to speak about their problem. People will assume such and such person has done this and that is why they have got this"*
>
> *Interviewee Eight: "I feel in the [South] Asian community and culture, if I was to discuss this issue they would be worried and concerned and imply I am dirty"*
>
> *Interviewee Two: "In the [South] Asian community if they [people] are going out and sleeping around it's frowned upon"*
>
> *Interviewee Eight "They see [STI and AIDS/ HIV] it as people being stupid and ignorant and over sexually active, inappropriately taking part intercourse with the wrong people. I think that view will always remain"*
>
> *Interviewee Eight: "I would still see this as being frowned upon from a cultural point of view. God, if I was to say I was doing a run for breast cancer and joining my sister that would be great. If I was to say I am doing a run to prevent AIDS I think the Asian community would frown upon it and say it's a man-made disease, so it's self-inflicted"*

As with the phase one PAR group stage findings, the interviews suggests sexual health is as issue that is not discussed in South Asian communities due to an overwhelming association to embarrassment and shame:

> *In-Depth Interviewee One: "That's one of the things people are reluctant to talk about and sometimes it's embarrassing because (South) Asian males are quite private and people with pride and they don't want to talk about sexual health"*
>
> *Interviewee Nine: "I think embarrassment, expectations, peer pressure. It's a close knit community"*
>
> *Interviewee Six: "I don't think many men would openly discuss sexual health, they may be embarrassed"*
>
> *Interviewee Seven: "It's a bit of a taboo subject in [South] Asian men because you wouldn't really talk about sexual health in general, especially with men"*
>
> *In-Depth Interviewee Three: "I think the reason is because they are too embarrassed to talk about it. That's one of the main reasons"*

Interviewee Seven: "Being a bloke you wouldn't think how is your sexual health because that's a conversation you would not want to have with any other male, not unless you were in a formal interview or having a meeting or discussion with your doctor or something on a professional level"

Stigma around sexual health is also associated to an individual's religious belief system:

In-Depth Interviewee One: "I think there are a lot of cultural barriers, prejudices and a lot of religious beliefs and it's like a taboo subject where people don't want to discuss it openly"

An individual's respect is highly important within the South Asian community, therefore, discussing men's sexual health can be viewed as disrespecting the existing and historic South Asian culture and traditions of elder members of the community which is abstain from discussing this sex and sexual health:

Interviewee Five: "With the Indian community it's very rare and it's never open, there's always been a barrier. It's always been more due to respect and whether it will be bad if I asked them kind of questions or talk about it with the elders"
Interviewee One: "Again…..it comes down to the shame element. Families don't want to hear no shame about their families"

In-Depth Interviewee One: "I don't think that parents are open enough or willing enough [to talk about sexual health] because of shame or respect"

Interviewee One: "I won't go back to my mother or father. It's shameful and disrespectful and it won't happen"

Interviewee Three: "Sexual diseases caused by sexual activity is regarded shameful and Indian people are concerned with shame and honour and you need to consider other members of your family such as wives, children and parents. The community we live in is not broad minded. We may live in a western world but we still are not very broad minded"

Interviewee Five: "I don't know, with the Indian community it's very rare and it's never open, there's always been a barrier. It's always been more due to respect and whether it will be bad if I asked them kind of questions or talk about it with the elders"

Interviewee One: "In the Asian community men don't really speak about sex with their families, I think because of shame and disrespect"

4.4.3 Family relations

The role of families and the role of parents play a major role in shaping the culture of South Asian men's sexual health as discussions regarding sexual health continue to be absent within the home environment:

> *In-Depth Interviewee Five: "I think one of the reasons is that this topic, right from childhood, is never discussed in the home amongst children and parents"*
>
> *Interviewee Four: "I think the cultural barriers would be the family. Families only discuss this within and not want to discuss outside of this setting or speak to other people about this issue"*
>
> *Interviewee Seven: "It's quite weird, especially being an Asian man myself, we don't really grow up with that in your home and you always shy away from it. It's more of an ethnic, more of a cultural thing"*
>
> *In- Depth Interviewee Two: "You wouldn't even dream of discussing these things with your parents or you peers or other family members. So this is why it's a bit difficult in that sense to discuss these things on that level"*
>
> *Interviewee Five: "I think different people can always speak to parents about sexual health, whereas in my experience South Asian [parents] people do not do that"*

South Asian men suggest sexual health services should work with South Asian families to help raise the profile of sexual health and of local sexual health services:

> *In-Depth Interviewee One: "Awareness needs to be undertaken in the family setting because it's kind of embarrassing talking about this to your father, mother or brother or sister about sexual health and that's where the barriers start from"*
>
> *Interviewee One: "If you can break the barrier with their families, then they will open up to everything else"*
>
> *Interviewee Three: "My parents could not talk about girls and boys. I talk to my children about boyfriends and girlfriends and the first thing we do is talk about sex and contraception. We need to be open and who better to give advice about sexual health information than parents"*
>
> *Interviewee One: "Work needs to be done with families of South Asian men, which will make it easier to be accepted"*

There was a view against raising the issue of men's sexual health with South Asian families as this would be an inappropriate approach due to the culture of privacy and respect within South Asian families and communities.

> *In-Depth Interviewee Two: "All I am saying is that this sexual health thing is not something you can discuss in an open setting, within a South Asian family setting. You need to understand that. As much as you might want it to happen...it's not going to happen. You got to understand that we got a strong tradition, strong culture...I have said this throughout my interview and a lot of this stops us from coming out with information and discussions taking place in a formal setting"*

Despite work being undertaken in schools on sex and relationship education (SRE), South Asian parents and families continue to be reluctant on conversations regarding sex and sexual health with their children:

> *Interviewee Seven: "In mainstream schooling they do have sex education, even though, that still is a taboo subject within the [South] Asian community. Parents know that's there but won't talk about it"*

4.4.4 Religious doctrine

In addition to the role of families in South Asian men's culture, the role of religious beliefs of individuals and groups play a major role on attitudes and behaviour towards, sex, sexuality and sexual practice in relation to endorsement and disapproval on sexual practice and sexual health amongst South Asian men.

> *Interviewee Eight: "I don't think the South Asian culture is backwards. It's a forbidden matter in the [South] Asian culture and goes back to whichever is the belief system for people"*

> *In-Depth Interviewee Two: "I mean just having a relationship of boyfriend and girlfriend will be bringing dishonour to the family. People are opening up and being Westernised within our society, the society we live in, these are the normal things happening...that does have an influence, but I still think the majority of people are still holding on to their cultural beliefs and I state this is more mainly in the Indian, Pakistani and Bangladeshi community because we hold strong beliefs. We have religion; Islam, and these things are like a no go area. No way is sex before marriage is going to be accepted or tolerated within a Muslim family unit"*

Interviewee Nine: "Imagine if you come back and had a sexually transmitted disease and you tell the community pray for me. They would react and say hold on a minute you have just done something totally forbidden so you just don't announce those things. This door will never be open and accepted"

Interviewee Nine: "Religion plays a big part. If someone was promiscuous and slept with three different women and caught sexually transmitted disease, you know questions would be asked such as how, when, why, with whom. It's just forbidden. You just cannot sleep outside of marriage and have sex with a female outside of marriage.

In-Depth Interviewee One: "Depends how educated the family is. How religious the family"

In-Depth Interviewee Two: "I'm not saying it doesn't happen but it's less likely to happen within Muslim culture or someone from a Muslim background to someone from a non-Muslim background. I mean if you look at the Hindu religion or people from Sikh backgrounds...in their religion its totally acceptable to drink and you know socialise and go out clubbing and pubs. I'm not saying it doesn't happen in the Muslim community but it's more accepted (in their community). Whereas, in the Islamic culture these things are totally forbidden"

Religious beliefs of South Asian communities prevent discussions on men's sexual health in the South Asian community to occur as this was an issue which is considered to be discussed in privacy:

In-Depth Interviewee Two: "From my own observation people from the Muslim community, no matter what part of South Asia they are from are very entrenched in their beliefs and values and have systems in place. They hold on firm to these things. For them to openly discuss sexual health and sexual relationships within a family setting or informal and formal setting...these things I don't think it's going to happen because it's all about traditional beliefs and honour and respect"

4.4.5 Knowledge of STI's

There was a significant lack of understanding of South Asian men interviewed regarding STI, STI symptoms and treatment for STI's.

Interviewee Two: If people say there's Chlamydia and there's a cure for it, or its easily fixed, people won't be so frightened to seek help for it, whereas if somebody has something they would be scared, even I would be scared to seek help"

Interviewee Three: One of the main reasons of getting sexually transmitted disease is because other communities are not circumcised. Men with circumcisions have a less chance to get sexual diseases"

There is a clear need organise sexual health educational session in the community by local sexual health services:

Interviewee Three: "If we educate people now, we can reduce sexual disease in the future"

Interviewee Ten: "There should be more professionals helping the community. The public does not have an understanding if it has a problem. Hence, people can find out if they have something wrong with them and get treated for it. People can carry something [STI] and not know at all"

4.4.6 Homophobia

South Asian men who took part in the interviews reiterated with some of the homophobic discriminatory views as with South Asian men from the PAR group which were based on religious beliefs and cultural influences of individuals:

In-Depth Interviewee One: "There is a lot of homophobia because most divine religions are against homosexuals so a lot of people from South Asian communities believe in religion and to say (religion) has positive conations towards homosexual is a lie. People generally think because you are gay, for example in Islam, you should be stoned to death. People have that automatic hatred towards them kind of people. They got lack of understanding about homosexuals. Having a relationship with someone of the same sex is non-existent, although it exist, but people think it is non-existent and you can't be normal and homosexual at the same time"

Some men interviewed challenged the view that South Asian men are homophobic and there exist an anti-gay culture in South Asian communities:

In-Depth Interviewee Two: "I don't think there's a lot of homophobia amongst the [South] Asian community than the White community. If there is, we all hold these views and certain individuals will all hold these views. I don't think you should be saying that South Asians are more homophobic than the non-South Asians"

In comparison to the views from phase one findings, South Asian men who took part during the interviews acknowledged that being gay was normal and acceptable. South Asian men expressed South Asian communities now seem to accept gay men and gay culture, irrespective of ethnicity:

> *In-Depth Interviewee Three: "I think a lot of (South Asian) men are happy to come out of the wardrobe, come out of the closet and tell people that yeah…we are gay. [South] Asian men are (now) open to come out and say I am gay. I think living in this country it's got to be acceptable regardless of what faith would say"*

The issue of sexual orientation was raised frequently during all three phases of this study. However, South Asian men mentioned sexual orientation should not be discussed in relation to sexual health matters:

> *In-Depth Interviewee One: "You see I don't think that could work because there are two different sections; one is about your sexual orientation and the other things is your sexual health. I know some of this can overlap in certain aspects but if you start talking to somebody about sexual health and you turn to homophobia, being gay or your views about being gay is going to make people back off. It's a very, very sensitive subject"*

There was discussion during interviews whether STI was prevalent amongst gay men or straight men. STI was generally understood to be an issue for all men irrespective of sexual orientation:

> *In-Depth Interviewee Four: "I mean one thing in general, and people need to be educated about is that STI's are not associated with gay men. It is not a gay man's problem. It is a problem that affects everybody. This is something people have got to get straight in their head"*

4.4.7 Sexual health awareness

South Asian men interviewed were unaware of how to access local sexual health information and of local sexual health services in Brent and Leicester. Interviews highlighted the need for local sexual health services and sexual health information to be promoted in the South Asian community:

Interviewee One: "I'm sure there are services out there that do these kinds of things and help people, but, they need to advertise and let people know about it as people might not know this service is available. I don't think South Asian men know about these services"

Interviewee Nine: "Sexual health services need to promote their [own] services for all men, not just predominantly white men"

Interviewee Eight: "I think should there be a billboard in a highly populated South Asian community. If the service was multilingual then I think that would work"

Interviewee Eight: "I think if the South Asian community associate themselves in a certain area or place I think billboards and signage with phone numbers which are discreet and confidential would encourage people to come forward and call"

Interviewee Nine: "Awareness needs to come first then engagement and spread key messages"

4.4.8 Community engagement

As with the earlier phase of this study South Asian men who were interviewed expressed the need to involve South Asian men with discussions related to developing local sexual health services and interventions. There was suggestion to use community engagement with South Asian men on sexual health using individuals who may have previously been diagnosed with an STI and been treated to dispel myths around sexual health, STI and help start discussions about the importance of sexual health:

Interviewee Three: "I think the best thing is to have people who have first-hand experience of sexual disease or illness and say to South Asian men to come down to a meeting and listen to people who have experienced these issues. This may help people to open up and discuss these issues. This can also be an opportunity to ask questions we may not necessarily ask our doctor. You can ask questions about symptoms"

Interviewee Six: "You can set up a session to talk about it or produce leaflets so people are aware. You may even get a few people coming forward to say they have had something (STI's) and may be interested"

South Asian men mentioned the possibility of establishing a men's sexual health forum in the community which may provide an effective approach to engage with South Asian men:

> *Interviewee Five: "I think holding regular forums and keeping information online, so if people cannot attend they can still access the information. I think it's important to hold regular meetings and holding activity days and interactive days"*

> *Interviewee Four: "South Asian men will [be] comfortable talking to other South Asian men rather than talking to a stranger that they have never met or spoken to before"*

However, a South Asian men's sexual health forum would need to find an alternative to using the term sexual health. The term sexual health is considered a major barrier and may prevent South Asian men from participating:

> *Interviewee Five: "I think you can set a group up, maybe even change the name, so people can talk about it openly, and not mention the sexual health aspect. If you were getting a group together and renamed the group, you may get the attendance, such as Men's Health Forum. That would attract men and encourage them to speak about health issues"*

> *In-Depth Interviewee Five: "It depends on how you name it. That's very important because if you name it anything sexual. I mean even now, I'm speaking the words slowly (low) that somebody will listen to it. In South Asian men it's not the norm and where they discuss it loudly and the word itself creates problems"*

South Asian men who were interviewed stated a men's health forum need not to be exclusively for South Asian men, but rather for all men as this would encourage cross-cultural learning on sexual attitudes and behaviours from a wide range of perspective and thus prevent stigma towards one section of the male community:

> *Interviewee Nine: "You don't want a separate group just for South Asian men because you will create the divide even more and that can hinder progress in the field or research in the field. You got to keep them [all men] together"*

> *In-Depth Interviewee Four: "A health problem is a health problem. It doesn't matter where you come from. There is no need to focus on just one particular community leaving aside everybody else because this is just not a problem with one particular*

community. This is a problem amongst all communities and all ages of men. This should in fact be treated like a problem of men rather than a problem of South Asian men"

In-Depth Interviewee Four: "I mean human beings are human beings and everyone will suffer if they are suffering with any health issues...be it sexual or other health issues"

The discussion around a men's health forum uncovered many matters such as who leads and facilitates such as group:

Interviewee Seven: "If it comes from a professional it has more respect and understanding, but if it comes from a general conversation with your friends it wouldn't work"

There were reservations on who would attend a local men's health forum and fear of being exposed in the community:

Interviewee Eight: "People will only openly discuss their sexual health issues with people they know and are comfortable with, although people may be reluctant to go because they may know someone else may be there"

South Asian men highlighted some issues to consider establishing a local men's health forum to include South Asian men and this involved working with local faith organisations and local religious leaders, and undoubtedly there was some reservations towards engaging with local faith organisations and religious establishments:

Interviewee Two: "I think faith establishments should play a key role. Places of religious worship only concentrate on religious things. Life is not about just that, it's also about other things"

Interviewee Eight: "There was this huge awareness of testicular cancer, and all the lads discussed this, if you have a lump check yourself and everyone did that openly but that's not a manmade diseases or the result of sleeping with too many women"
Interviewee Ten: "The easy one you can keep point to is religious backgrounds. Religion will be used to solve their problems by approaching a religious leader to confide and speak to them"

Interviewee One: "I think the older generation don't want to see this kind of thing in a faith establishment. For example, if you are sitting in a mosque, listening to a

speech, and you're sitting with 90 per cent of people who are young and the Imam was talking about sexual health, I wouldn't see it as a problem"

4.4.9 Young people

Younger members of the South Asian community are considered to be open-minded in comparison to elder members of the community to discuss sexual health matters. This is due to many younger members of the UK South Asian population being born and raised in Britain, hence adopting a more relaxed Western and open attitude towards sex and sexual health:

In-Depth Interviewee Two: "I think it's more important to work with the younger generation because they are the ones who are more likely to be open and honest with you. If you look at the older generation who may have not necessarily gone through the schooling system or the structure here and basically... a lot of their cultures or their beliefs are from back home. So they are going to be a bit more reluctant to open up to someone"

In-Depth Interviewee One: "I think it's better to work with the younger generation because they are more aware of a lot of things in general. It's like when you see the people of the older generation they are living the life of back home and where(as) the younger generation have a bit of both. Bit of the British inside of them and with the cultural and religious beliefs that's embedded in them"

In-Depth Interviewee Three: "I think if you are young and you have been brought up in this country then you would know better that if there's anything wrong with you then you need to go and see a doctor"

Thus, sexual health services need to target younger members of the South Asian male population to achieve meaningful impact in the South Asian community for future generations:

In-Depth Interviewee Two: "To get a true picture you would have to do this with the younger generation because I don't think the information that you are looking for, especially the qualitative information... you're not going to get that from the older generation. They are not going to be as open. They're going to be shy and say "oh no...we don't discuss these things", whereas with the younger generation you are going to get a more true and real picture of what's happening on the ground level because their approach to life is going to be different to how it was for the older generation"

Educating young people around sexual relationship education (SRE) was seen as an ideal way forward and this meant local sexual health services work children and young people in a school setting, although this approach also had some reservations:

> *In-Depth Interviewee Five: "What I think is that the first thing that needs to be done is that it should be started within the schools"*
>
> *In-Depth Interviewee One: "Education is the key. The younger you get them the better it is for you. If you educate them at a younger age then that will hopefully have a knock on effect when they grow up. When they have kids, their kids will become aware of it and so on. It's like creating a cycle"*
>
> *In-Depth Interviewee Two: "You got to remember that when our youngsters go through schools a lot of their knowledge is what they have learnt from friends or discussed in the playground or discussed over social networking. It's not real information and they may have not had it in a classroom setting because a lot of Muslim parents withdraw their children from sex education when it's taught in schools. If it's not compulsory, they are not going to allow their children to go and take part in these discussions even though they are in an informal environment, in a school setting"*
>
> *In-Depth Interviewee Five: "So once it starts in the schools and the parents come to know that it is there in the schools then maybe it will be easier for the parents and maybe a short (video) version is shown in school assemblies. Nothing too much and in detail but some awareness because now there has to be some awareness amongst the children that there are people who are different and that it's OK to be different "*
>
> *In-Depth Interviewee Five: "Yeah, especially secondary school children where you can discuss it a bit more because at primary you might get some issues. You might get some parents refusing, because you have to have permission nowadays. So they might refuse. These topics can be discussed in details at secondary school"*
>
> *In-Depth Interviewee Two: "We know that within our (South Asian) community girls are having abortions or girls going for contraception or boys going for contraception. It's not something we're oblivious to or turn a blind eye to. In reality these things do happen but we as parents don't want our children exposed to this. We think if you start teaching this in schools and telling them about sexual activities and sex duration and sexual relations creates a thing for them to pursue these things. There is this lack of knowledge possibly within a certain community, especially within the Muslim community because they are being withdrawn from these classes and settings and that there is a lack of knowledge in certain aspects"*

One solution provided by South Asian men interviewed regarding SRE in a school setting was to establish health clinics and drop in opportunities for young people located in areas where young people congregate:

> *In-Depth Interviewee Two: "One way may be...a possible way around this, maybe if you had clinics that were located in places where young people frequented. I don't know. Youth clubs...places where young people hang around or spend time. It might make it more easier for them to access the services but if they was to go to a clinic at the surgery it might be a bit more difficult for them to kind of turn and say "look I need to speak to someone" because they might think someone might see them or see them visiting a STI clinic"*

4.4.10 Culturally appropriate interventions

As with phase one, phase two and phase three findings highlighted various culturally appropriate interventions South Asian men raised to support raise the profile of men's sexual health in the South Asian community. South Asian men suggest sexual health information and publicity should be promoted in the South Asian community as there is an overall lack of sexual health information and publicity in the South Asian community:

> *In-Depth Interviewee One: "There's not a lot of information which is structured out there for [South] Asian men to access. Another thing is the language barrier as well. Having different information in different languages or having people from the community to educate people within the community about sexual health. There are very limited resources"*

Sexual health services should use effective sexual health marketing campaigns targeting South Asian men in the community:

> *In-Depth Interviewee One: "South Asian men's needs are different to men from other communities like White British men. So I don't think one size fits all is going to work for everyone. So you have to tailor it to meet the different needs to different communities. So, South Asian men needs are different and services need to be different from what is to other communities"*

Sexual health information and services should be made available in discreet locations which will support South Asian men to access without being exposed in their own communities:

> *In-Depth Interviewee Two: "You got to understand that traditions, culture and taboo are all intertwined and sometime it's difficult for people to overcome these barriers. So, you need these [sexual health] services and if they are to be accessible they need to be in places which are easier for them to go to in discretion"*

However, most men interviewed mentioned sexual health campaigns and interventions should include men from all ethnic groups and cultures to promote positive sexual health messages and awareness of local sexual health services to prevent stigmatisation towards South Asian men:

> *In-Depth Interviewee Five: "I think the needs for everybody should be the same because after all we are human beings. All men and women, psychologically, physiologically....we are all built the same way"*
>
> *Interviewee Nine: "I think it's a good to use South Asia media but it goes back to the divide issue. Sexual health help is for everyone regardless of race, colour and culture. So if you start going down that route you will start to exclude certain groups and certain communities…you don't want that"*
>
> *Interviewee Eight: "I think it should be treated in the same way men from other communities are being treated. I think there is a system in place and it works for a very large population so I think if there was awareness then I think people would come forward and take up the relevant service"*
>
> *In-Depth Interviewee Two: "Why do I have to go to a South Asian men only clinic? If I have got an issue and something's not right with me I should drop in to any clinic. You know...I don't care who is visiting it whether they are Black, Asian, White and European. Why do you have to have a specific one for South Asian men? It's not like we got different sexual health issues to what they have"*
>
> *In-Depth Interviewee Two: "They [sexual health] don't need to be targeted to specific groups because then you have labelled them. They should be open for everyone. Listen everybody has sex, some people might have it in different ways but it's the same action. You're not going to suffer from something different to your non-South Asian men. If you have got issues, health issues, then you have got issues"*

In-Depth Interviewee One: "Target men from all communities, you can have a drop in session for South Asian men or appointments (allocated) for them"

In-Depth Interviewee Three: "We can have sort of like meetings or sexual awareness clinics. You know and it's just based on men or from (South) Asian backgrounds where everyone can just come and talk and they can talk and give questions and they don't have to say it's me and be referred to as a "Frank""

In-Depth Interviewee Two: "If you are going to be sexually active and have unprotected sex and experience different things then there's always a chance that at some point in your life you are going to have to use the sexual health service. I don't think that within different communities there is a different need. I think the need for all the South Asian community will be same. I don't think there would be different demands from different community groups or different South Asian men"

The potential use of mainstream media and South Asian media was mentioned by South Asian men as a useful platform to raise the profile of South Asian men's sexual health, although some interviewees regard this approach would not be ideal:

Interviewee Two: "I think media, internet coverage would be massive. The [South] Asian media will have a lot of older people listening and watching, so I think that would be a good. I don't mean to sound cruel, but the older generation are too set in their ways to change their mind set, but I think 20, 30, 40 and 50's age group can be educated for future generations"

In-Depth Interviewee Four: "Let me just try and explain it a little more. If I had a problem, a sexual health problem...and because of the taboos we have talked about, because of embarrassment, and not looking for help, yet I would like to get help but my stigma is stopping me. If I saw a programme like that on the TV, people discussing about it (men's sexual health)...number one...it will enhance my understanding of the problem...number two....It'll point me to where I can get help"

Interviewee Five: "One way is to use [South] Asian channels such as Zee TV and Star Plus as they have millions of subscribers. You have many adverts on there and spread the message nationally"

Interviewee Seven: "I think men's sexual health messages in South Asian media would make a difference but I can't actually see a [South] Asian channel doing this. They will start losing viewers. They would want to move away from that"

In-Depth Interviewee Four: "TV programmes geared up specially to highlight any sexual problems or difficulties with a whole spectrum of people.....English, African, Asians and things are brought to surface and an open discussion can take place"
In-Depth Interviewee Three: "Radio. Nowadays we have a lot of people listening to the Sabras (local South Asian station). On radio they have all sorts of issues so I

think radio would be a very good one because I think you are behind the phone and not in front somebody and you don't have to say your name but you can talk about your problems and on a radio station you can have a medical professional who can give medical advice"

Interviewee Ten; "I don't think it would make a difference using South Asian media because not everybody reads newspapers or read magazines. It's up to an individual to seek out the knowledge and they would only do this if they had something wrong with them"

All South Asian men interviewed agreed that social media and the development of digital technology as useful platforms to help raise the profile of South Asian men's sexual health:

In-Depth Interviewee Two: "You can have websites. You can do that on the go. You don't have to necessarily visit some place or go to the city centre or out of the city. You can be doing anything and still be online and you got to remember when you do this online over the internet then this is a personal thing. You don't have to worry or be thinking someone's going to see me pick this leaflet up or someone's going to see me read this"

In-Depth Interviewee Three: "Today we live in the day of the internet and Facebook pages where people can openly ask admin and see what kind of questions and answers people are looking for. Yeah, Facebook or social media would kind of help as well"

South Asian men suggested using digital technology such as developing applications for South Asian men's sexual health as this would enable a private and discreet approach to raise the profile of sexual health and local sexual health services:

In-Depth Interviewee One: "Twitter, Facebook, Snapchat. Different apps [applications]. That's a really good way, effective way to get to people. Create an app as well and make it private"

The use of social media does not come without its challenges, particularly towards information management and governance. There was also some scepticism towards using social media to raise the profile of South Asian men' sexual health in relation to personal information exposed.

In-Depth Interviewee Four: "I have never used social media to be quite honest. If someone sent me a message on Facebook I wouldn't know where to find it. The only thing I do know a little about is social media is that it can open up access for people, people that know you, people that don't know you and if there is a taboo topic then it would be difficult for people to participate in if there's embarrassment then you wouldn't actually go on there and discuss things"

Culturally appropriate interventions suggested by South Asian men include the use of arts based interventions. However, any arts based interventions would require diligent community engagement and planning to ensure culturally sensitive issues are addressed in relation to the target group:

In-Depth Interviewee One: "People from middle class communities may think a play about sexual health is open and easy and other communities might find it a bit offensive or disrespectful. It's a good idea but you need to see where it fits within the community and within the perception of sexual health for South Asian men"

South Asian men mentioned the pivotal role GPs can play in promoting South Asian men's sexual health. South Asian men regarded the GP as the one appropriate health professional to communicate men's sexual health messages as well as refer South Asian men to local sexual health services.

In-Depth Interviewee Two: "I mean discussions about sexual health within the South Asian community; I'm not saying you can't discuss them but I think you have to have the right setting; the right kind of environment for these things to be discussed. I mean if it was a setting which was private. For example in a clinic or in some doctors surgery where it was on a one to one basis you will probably more likely to get a realistic or more honest answer or discussion that can take place. I think in that kind of environment you would get more out of it. You know it's a personal thing"

Interviewee Three: "GP's are the right place to raise this issue, rather than going to a sexual health clinic in medical centre which may make people ashamed to visit and sitting in the waiting area. I don't think anyone apart from your doctor should be involved in your sexual health. I don't think we need extra services"

Interviewee Three: "Doctors need to raise awareness about men's sexual health. They should engage with men and discuss sexual health awareness, diseases and symptoms. Doctors need to be proactive not reactive"

In-Depth Interviewee Two: "I think a lot of this should be done through the local GP. This is the best time...when you go to see your GP you have an open and honest discussions with them if you are suffering from illness or health problems. You already have that relationship with your GP. So, I think the person to have these talks with would be through your GP surgeries because you know you have that one to one confidentiality and you know if you go to see your GP no one will know you are dropping into a STI clinic. In terms of targeting the South Asian community and in terms of accessibility the GP services would be the best services to go through"

Interviewee Eight: "When a GP meets their patients, they should give them a leaflet and tell them if you have any problems and want to discuss sexual health. I think this is the only person that an individual can breakdown with their barriers. So my first point would be by my GP and ask me questions on sexual health, but they would need to do this to all men on their patient list, not just South Asian men"

However, not all South Asian men regarded the GP as the appropriate health professional to discuss men's sexual health as there was concern related to the fear of personal health information being exposed in the community and this prevents South Asian men discussing sexual health with their local GP:

Interviewee Seven: "I think the other cultural barrier is that most [South] Asians have a [South] Asian G.P. That can be embarrassing and prevent people from talking. It's a really difficult situation to be a [South] Asian man and deal with this as it's very embarrassing and due to the community being close knit"

South men also suggested an approach to overcome barriers such as the fear of confidential information being exposed in the community was target all men on the patient register as would ensure anonymity and support South Asian men feel less polarised and help support the confidence to discuss matters related to sexual health with their local GP. South Asian men would be comfortable to discuss sexual health matters issues if they were invited to a men's health screening programme which included sexual health at their local GP surgery:

Interviewee Seven: "I think [sexual health] services would need to try and make it easier for men to feel less embarrassed to speak. [Sexual health] services need to set up health appointments for certain generations for a health check and within that health check a discussion can take place with your GP about sexual health. When you are put in that position you are likely to discuss it"

Interviewee Three: "Men don't have anything such as women's smear test and this should be available"

Interviewee Two: "Recently, I have seen things on blood pressure, heart conditions which has made me aware of common disease amongst [South] Asians and now I am thinking about those a little more. If that was the same for sexual health it would help open up the topic"

Interviewee Seven: "There's a lot that has happened for the gay community to help them understand their sexual health and they probably use sexual health services a lot more than heterosexual men. The way to overcome it is to have a screening; a general health check for men which would include sexual health. This would help break the barrier to speak to your doctor and make men think it's actually not that bad speaking about my sexual health with my G.P"

South Asian men mentioned an effective approach to raise the profile of men's sexual health is to engage with local sports clubs, particularly South Asian football clubs in the community:

Interviewee Two: "It would be good to approach [South] Asian football clubs, approach the committee and have a word with them. They can pass leaflets on"

Interviewee Two: "I think it's important to aim at groups such as football clubs, so if you have the coach or manager on board who can provide access to more men"

4.4.11 Sexual health research

South Asian men recognised the need for sexual health research to explore issues regarding sexual health with South Asian men f and men from all communities:

In-Depth Interviewee Two: "To get the real picture of what's going on you need to do this [sexual health research], I think you need to do this with the younger community as well as Indian and Pakistanis and Bangladeshis and the Muslim and non-Muslim communities"

In-Depth Interviewee Four: "Unless people are approached, by people like you, and go out into the field, in the South Asian community to bring these things out in the open, until that's done, that stigma is still going to remain there and people are not going to talk freely and this is probably one benefit of a research"

Research on men's sexual health should target all men and not only South Asian men. Undertaking research which is inclusive of all men would help to reduce the stigma associated with sexual health and further polarisation of South Asian men on sexual health issues:

> *In-Depth Interviewee Two: "I think you should research on them (South Asian and non-South Asian groups) together because you would get a better flavour of what's happening within the two communities. You would think "Yo...these guys are the same as these guys! There's no difference. So maybe that might stop.....rather than doing two separate studies and there's no difference, that there's no different need"*

South Asian men mentioned that research on South Asian men's sexual health should also not be undertaken as an isolated health topic and that research would gain a better recognition in the South Asian community if the topic of sexual health was combined with prevalent and culturally acceptable health issues in the South Asian community:

> *In-Depth Interviewee Five: "(Research should take place) with other diseases because when you are doing that people will be made aware, and not feel like they are being targeted of this (sexual health)"*

> *In-Depth Interviewee Five: "Doing research through diabetes, they (South Asian men and women) will be more receptive and will be able to answer questions more. They will understand that you (research) is not trying to pry because the topic will scare them"*

4.5 Overall findings –Community and Individual perspectives

There are many individual and community perspectives South Asian men highlighted regarding sexual health such as linguistic issues, construction and perception of sexual health, stigma etc. These issues are demonstrated in the following figure (4.5):

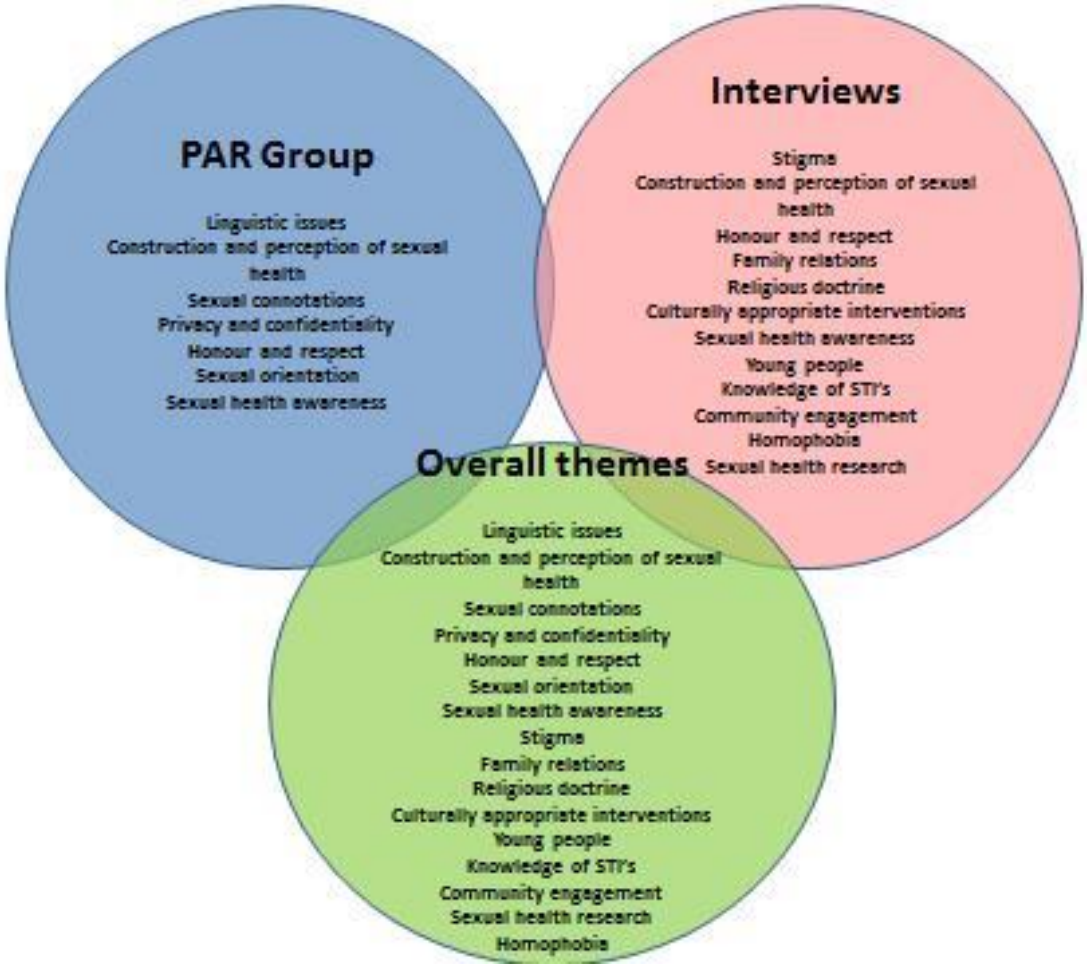


Figure 4.1: Overall Individual and Community Themes

Themes from the PAR group and interviews are shown in the figure above and they are combined to display the overall themes to show all the key issues which were raised in all phases of this study. Some of the major themes will be critically

discussed in the next chapter under the three broad headings of; construction and perception of sexual health, preconceptions and sexual health services as they encapsulate the individual and community perspectives of South Asian men's sexual health from participants in this study.

Chapter 5 Discussion

This chapter critically discusses some of the overarching issues and themes which have been identified in this study by South Asian men in relation to their individual and community perspectives on sexual health.

5.1 Emerging themes

As highlighted in the previous chapter there are a number of sexual health themes amongst South Asian men which to some extent are also relevant for non-South Asian men. These include stigma and social taboos, issues regarding sexual orientation, attitude towards gay men, awareness of local sexual health services, and the role of the GP and using culturally appropriate interventions. For the purpose of this study three overarching issues are selected and critically discussed in this chapter in line with the research aim and research questions, literature review findings and from the results of South Asian men who took part in this study that identified them as of concern and highly important (Table 5.1):

Individual Level	Community Level	Service Level
Construction and perception of sexual health	Preconceptions	Sexual Health Services
Defining and understanding sexual health	Homophobia	Culturally Appropriate Interventions
Knowledge of STI's	Tension between religion and sexuality	Sexual Health Research

Table 5.1: Three key themes identified by South Asian men regarding sexual health

The overarching issues are discussed in relation to the influential model of sexual health as demonstrated by Collumbien et al (2012) (figure 3.2). The rationale behind this approach is to highlight the findings of this study in a manner acceptable

and relevant to understanding sexual health amongst sexual health researchers. This chapter will be discussed in three sections; Individual level, Individual to Community level and Community to Service level. It must be noted that all three themes and levels are interlinked and many of the issues are also related to more than one level and theme.

Individual sexual health matters include sexual behaviour, sexual preference, sexual orientation, risk taking, sexual performance and polygamy. Community matters include the understanding of sex as an intimate and private experience as opposed to an open, transparent and emotional act. South Asian men regard family respect and public honour as very important. Religion and faith organisations have a major role to play in the South Asian community. Religion, faith leaders and faith organisations influence South Asian men's view on sexual health and upon discussion on their sexual health and this can both be a positive and/or negative influence. It would be interesting to understand more about South Asian men's sexual health, particularly the role of religion and faith organisations in England and their influence on attitudes towards sexual health. The majority of participants in this research were from a particular section of the South Asian male community, namely form the Muslim Gujarati (North Indian) community residing in Brent and Leicester and this view of sexual health is therefore limited to this specific cohort. Service matters include the awareness and locations of sexual health services and opening times of sexual health services. There was a view that current sexual health services in England, particularly in Brent and Leicester where this study was delivered did not meet the needs of South Asian men's sexual health. This view is clearly open to dispute as there are a growing number of South Asian men who do

use local sexual health services. Furthermore, South Asian men who took part in this research had no experience (or did not mention any experience they may have experienced in using sexual health services) of using local sexual health services, therefore were more likely to be unaware of the sexual health services that are available and how sexual health services are currently being delivered to meet the needs of all men and possibly the needs of South Asian men.

5.2 Individual Level –Construction and perception of sexual health and STI

The first level is focussed at the individual level of South Asian men. The findings from this study suggest that knowledge of sexual health, particularly defining sexual health is problematic amongst South Asian men and a lack of knowledge on STI and STI transmission subsequently negatively influenced their understanding on sexual health and sexual lifestyles.

5.2.1 Defining and understanding sexual health

One of the major issues whilst conducting this study was in relation to South Asian men's use of language, terminology and understanding and defining what constitutes as men's sexual health.

> *Participant One (PAR group session six): "Maybe we need to move away from using the term 'sexual health' altogether and rephrase it differently. The minute you say sexual health it's all about sex"*

All South Asian men in this study were more than comfortable to understand what constitutes as men's health but there was never a general consensus amongst South Asian men on the term men's sexual health. This hindrance was evident during all three phases of this study; PAR group preparatory interviews/PAR group meetings, semi-structured interviews and in-depth interviews. Defining and

understanding South Asian men's sexual health meant often South Asian men would share their views and perspectives from an individual perspective to sharing which they believed were community perspectives and this was dependent on the experiences from community discussions, or lack of discussions in the family and information obtained from the media on men's sexual health as well as information accessed from health professionals such as the GP. This transient understanding and perspective of men's sexual health changed in light of where discussions were taking place. Considerable attempt over the course of the last few years was used to capture a consensual understanding on defining South Asian men's sexual health in the language and perspective considered by South Asian men but this was never achieved. This links back to the earlier findings from this study which showed that South Asian men and South Asian communities find the term sexual health unacceptable and would prefer the issue of sexual health be mentioned as a secondary health term due to stigma. Stigma is still associated with poor sexual health (Elliott et al, 2015; DH, 2013).

5.2.2 Sexual health as a secondary term/ issue

As mentioned earlier, a major issue identified in this research was the need to promote and raise South Asian men's sexual health as a secondary and not primary health issue for men in the South Asian community. There was a view that prevalent health issues in the South Asian community such as diabetes should be used to promote the topic of South Asian men's sexual health.

> *Participant Seven (PAR group): "Not being direct, going round other issues like diabetes and then [introduce] sexual health issues"*

This research demonstrated that South Asian men would be far more willing to engage in discussions on the issue of South Asian men's sexual health if discussed alongside other more acceptable (less taboo and stigma associated) health subjects affecting South Asian men such as diabetes, high blood pressure, cholesterol and coronary heart disease.

South Asian men mentioned the importance to distinguish the culture of South Asian men's sexual health from health issues that are prevalent amongst South Asian men's health issues such as diabetes; high blood pressure and high cholesterol. Some level on understanding the culture of South Asian men can help to better understand the culture of South Asian men's sexual health. Research into less taboo health issues in the South Asian male community can provide methods to build trust in the South Asian community to further explore the culture of South Asian men's sexual health. Therefore, consideration is required on how prevalent health issues and men's sexual health issues can be combined and seen as an overall important health issue in the South Asian male community. As a non-clinician, this is not an area of my expertise; however, one approach would be to organise dialogue amongst community health clinicians, community researchers and community leaders such as local councillors and community organisations leads regarding South Asian men's sexual health. This may be one approach to discuss the best way to raise the profile of South Asian men's sexual health in the community.

Another factor to this issue was an overwhelming view that sexual health should be discussed within a private and confidential closed setting, ideally between a patient and health professional. South Asian men regarded the patient and health

professional setting would provide a platform for South Asian men to be transparent and discuss confidential and personal matters related to men's sexual health which they would not do otherwise. South Asian men expressed concern regarding confidentiality discussing their sexual health and this from the close knit culture of many South Asian communities which many family and members are linked. The issue of confidentiality is underestimated and is important when engaging with South Asian men on sexual health, even within a discreet sexual health clinical environment (Parker et al, 2014). Promoting reassurances on confidentiality is very important to South Asian men.

In South Asian communities there is a strong emphasis on the importance of protecting the public honour of families and communities and this is embedded in the cultural and social fabric of South Asian communities in the UK. What occurs privately should remain private and this includes the discussions on sexual health and sexuality and sexual activity (Weston, 2003). There is a need to develop new perspectives on men's health and illnesses which are inclusive of South Asian men and culture in the UK.

During the research delivery stage reference was made to issues concerning men from other BME communities and white communities in respect to the openness of dialogue, matters of sex and health. It was apparent that South Asian men who participated in this study regarded sex and sexual health to be more of an open topic amongst men in non-South Asian communities. The concept of sexual health amongst black families is related to healthy sexual behaviour. BME communities believe young people should not be sexually active until they get married or are

adults (Ochieng and Meetoo, 2017). This is similar to the views of South Asian men in this study who regard sexual health to be a private affair and a matter only discussed when married. BME families promote sexual abstinence during adolescence to delay sexual activity, and thought abstinence was positive and desirable. Promoting abstinence means young people are protected from STI's, HIV and unwanted pregnancy (Ochieng and Meetoo, 2017).

There is a need for understanding community-specific cultures and racial and ethnic composition of sexual networks (Jewkes and Dunkle, 2017). Better understanding of sexual health disparities requires interrogating the meaning of sexual health indicators in different communities, and ensuring that we understand the context in which certain outcomes occur. Only through the use of more robust and representative sampling of ethnic minorities can we maximise the value of investing in population-based data collection, and ensure that we have the data necessary to properly inform efforts to eliminate sexual and other health disparities in the UK.

5.2.3 South Asian men's and women's sexual health

Another key issue South Asian man in this study failed to acknowledge or make any reference to was how men's sexual health may somehow be associated with that of South Asian women's sexual health. Surprisingly, the issue of South Asian women's health appeared to be invisible. This invisibility of South Asian women's sexual health suggests that South Asian men consider the sexual health needs of South Asian women to be met by sexual health services. This research did not obviously explore the culture of South Asian women's sexual health and it would be interesting

to research cultural sexual health issues which are relevant for both South Asian men and women as parallel studies focused on specific demographics.
It was clear from the literature review that there is a lack of research into understanding the culture of South Asian men's sexual health particularly of South Asian men in Brent and Leicester. This may be due to men's health and men's sexual health considered less in comparison to that of women's health and women's sexual health. In addition, there are societal issues such as shame, respect, privacy, knowledge, expectation of gender roles, and gender based behaviour and attitudes towards health and sexual health.

In chapter 1 the view that men's health has historically had less priority than women's health in England and internationally was put forward. This view is reflected within the South Asian community who consider men's health to be less important than women's health due to fewer body transformations.

> *Interviewee Three: "Men don't have anything such as women's smear test and this should be available"*

It was not the intention of this research to suggest that men's health should now be at the forefront of all health discussions in the community and within the South Asian community in comparison to women's health. Rather, this study attempted to bring the discussion about men's sexual health and in particular South Asian men's sexual health to a level where it maybe as comfortable as discussing prevalent men's health issues in the South Asian community is acceptable as women's sexual health issues. Whether this research provides impetus for that discussion to take place is debatable.

Researchers in the field of men and masculinities studies in general, and men's health in particular, often remain wedded to crude, modernist conceptions to society and fail to engage with recent theoretical debates within feminism and social science about the workings of politics and power in contemporary societies (Broom and Tovey, 2009). Often researchers fail in their research and writings to engage with many strands of thought that characterise contemporary feminism, anti-racist/ post-colonial studies, and gay and lesbian scholarship). There is a need for more historically informed research and genealogical work along the lines proposed by Foucault and his followers which challenges the self-evidence of our current ways of thinking and action. A more critical, historically orientated and theoretically informed approach to men's health would give acknowledgement to the often powerful interests underlying specific definitions of men's health problems and South Asian men's sexual health.

5.2.4 Cultural influence

An important influence on understanding sexual health is related to understanding sexual health which originates from the Indian sub-continent. This requires an understanding on the local South Asian population and infrastructure of family and community, gender roles of men and women as well as understanding the migration patterns of South Asian communities in England (Sinha et al. 2007). An understanding on the migration patterns of South Asian people in England which encompasses the different generations and how this culture has adapted to the culture and communities in England is important to gather a better view of how sexual health is perceived. Understanding the culture of first generation South Asian communities in England provides an insight into the South Asian culture. In turn, this

enables a better on how sexual health is perceived by second and third generation of South Asian communities and South Asian men.

Older South Asian men hold views towards sex and sexual health from the Indian subcontinent. It must be pointed out that a high number of South Asian men who participated in this study were born in the UK and only a few members were born in the rural villages of North India. During the PAR meetings and interviews sexual health was discussed in what was considered acceptable amongst older South Asian men. It would have been interesting to explore how men's sexual attitudes and behaviours differ of men from urban and rural areas in the Indian subcontinent because these influences have an impact on the first generation migrants of South Asian men in England and influences South Asian men born in the UK.

> *Interviewee Three: "Sexual diseases caused by sexual activity is regarded shameful and Indian people are concerned with shame and honour and you need to consider other members of your family such as wives, children and parents. The community we live in is not broad minded. We may live in a western world but we still are not very broad minded"*

5.2.5 Knowledge of STI's

During the literature review it became evident that data on the relationship between South Asian men and sexually transmitted disease derived principally via the use of GUM clinics. This data demonstrates trends both in Brent, London and in Leicester where this study was carried out and shows the need for use and diagnosis of men from South Asian origin (Ottaway Strategic Management Limited, 2013; Robbins et al, 2015). These trends may simply be due to an increased awareness of sexual health services by South Asian men or alternatively demonstrate a trend of increased sexual relations amongst South Asian men. PHE (2014) shows that STI's amongst South Asian men are on the increase but this pattern is no different to the patterns from men of BME communities. In fact, STI's amongst South Asian men

are lower in comparison. This does not suggest STI is less prevalent amongst South Asian men, rather South Asian men may be reluctant to be tested at sexual health services. Therefore, STI data needs to be understood from a perspective of how many South Asian men are being tested and diagnosed with STI.

> *Interviewee Two: If people say there's Chlamydia and there's a cure for it, or its easily fixed, people won't be so frightened to seek help for it, whereas if somebody has something they would be scared, even I would be scared to seek help"*

5.3 Individual to Community Level - Preconceptions

The second level moves from an individual level to a community level. The purpose of linking the individual and community level is work around preconception and prejudice vies work needs to be undertaken within South Asian communities where sexual health research with men may occur and this may require delivering messages through established community communication channels such as faith and religious establishments and community organisations.

5.3.1 Homophobia

A number of observations were recorded during the PAR group and interview phases. Observations on the language used by South Asian men to define the term sex, understanding what they regard as men's sexual health and attitudes of sexual behaviour towards women and men who were not considered to be straight.

> *In-Depth Interviewee One: "There is a lot of homophobia because most divine religions are against homosexuals so a lot of people from South Asian communities believe in religion and to say (religion) has positive conations towards homosexual is a lie. People generally think because you are gay, for example in Islam, you should be stoned to death. People have that automatic hatred towards them kind of people. They got lack of understanding about homosexuals. Having a relationship with someone of the same sex is non-existent, although it exist, but people think it is non-existent and you can't be normal and homosexual at the same time"*

During the PAR group stage the use of inappropriate language was evident which can only be considered discriminatory towards gay men. This use of language was challenged by other members in the PAR group. There needs to be awareness and acknowledgement towards men with differences in sexual orientation in research on South Asian men's sexual health. Homophobic attitude and behaviour is of great concern, regardless of which community this takes place (Stonewall, 2013). In the UK, four in five LGBT people had experienced hate crime (Antjoule, 2016) and one in ten experienced a homophobic hate crime or incident was physically assaulted (Guasp et al, 2013). This issue of homophobic attitude was not considered during the conceptual phase of this study. Although the requirements to ensure approval by the university's research ethics committee was fully adhered to it was apparent that careful planning is required when undertaking research on sexual health with a group who reflect strong religious and cultural views towards homosexuality. This is not suggesting all factions of the South Asian male community are homophobic, rather, it suggests that any conversation on men's sexual health will inevitably engage with conversations about sexual orientation and researchers are required to be ready for such dialogue taking into account people's strongly held religious and cultural views. The sexual health of gay men is as important as the sexual health of straight men. In fact, the sexual health of gay men is considered more important due to the homophobic attitudes they may face in society.

Weston (2003) insists a need to move research into the health of BME communities from a narrow biomedical focus and address the role of social, cultural and behavioural practices in explaining ethnic inequalities in health. Sexual health interventions specifically targeted at South Asians in the UK are limited. Beyond a

loose network of individual South Asian workers in mainstream HIV and sexual health agencies, Naz Project London (NPL) is the only agency working specifically with South Asians in the UK. NPL grew out of recognising a different need of South Asians from the current models of sexual health services which are based on Western models of sexuality, identity and biomedicine. South Asian lives share and also differ in social and cultural norms to non-South Asians in the UK.

5.3.2 Prejudice views towards gay men

There was no overall South Asian men's sexual health definition. This varied from relating sexual health to sexual disease to community and family matters such as honour and shame. This also varied amongst an individual's sexual orientation, what was considered as acceptable dialogue on sexual health within the South Asian communities and how the role of religion and faith leaders and organisations influence sexual health understanding within the South Asian community. Men's sexual health and the sexual health of women were two issues which South Asian men in this study regarded as separate matters. South Asian men understand sexual health to be less important than other acceptable health issues in the South Asian community due to cultural influence and acceptability. One issue which produced strong opinions and heated discussion in the PAR group was the issue of being gay.

During the PAR group stage there was an impression that local sexual health services are geared towards gay men rather than straight men. There was a view that no research is available specifically concerning heterosexual South Asian men's sexual health. Therefore, South Asian men who took part in this study felt that

sexual health research needed to be inclusive of all South Asian men and not just towards gay men. South Asian men who participated in this study regarded this research as the first time they had come across a study for straight South Asian men's sexual health within two highly South Asian populated cities in England. Therefore, a wealth of learning had been achieved, particularly towards how research with this specific group on men's sexual health may need to be conceptualised and delivered. This view of sexual health services are only for gay men added to the negative view that gay men undertake wrong sexual activity and therefore sexual health services are required. This was often raised in the PAR group.

Prejudiced views towards gay men and gay culture predominantly stem from religious beliefs amongst South Asian men who participated in this study. Therefore, work regarding gay culture and sexual orientation needs to be addressed jointly by individuals and communities. Prejudice views against homosexuality are both culturally and religiously sanctioned (Siraj in Ouzgane, 2006) and this requires work jointly to be targeted at an individual and community level with South Asian men. In doing so, individuals and communities may commence dialogue on homosexuality and the struggles gay men and South Asian gay men face on a daily basis. Projects such as the NAZ Project London (NPL) can provide expertise around the area of dealing with prejudice views towards South Asian gay men. This prejudice view towards homosexuality impacts on the relationship between men who have sex with men (MSM),

5.3.3 Men who have sex with men (MSM)

South Asian men in this study regard sexual health services geared towards men who have sex with men (MSM) and not tailored to meet their needs. This is, according to South Asian men in this study due to (a) no requirement for such services as sexual activity should only occur in a marital relationship (b) confidentiality issues (c) sex and sexual health is a private topic and not be discussed in the wider community, particularly with South Asian young people. This is ironic as the MSM population is increasing and this is also reflected in the South Asian gay population (Rainbow Asian Project, 2011).

Gay, bisexual and other MSM constitute an estimated 5.5% of the UK male population (Public Health England, 2014). This equates to 45,000 MSM. In London, 1 in 11 MSM are HIV positive. There is a need for more general information on HIV in MSM and non MSM communities. There is also need for further research on South Asian MSM (Public Health England, 2014).

One in twenty MSM are living with HIV in the UK with up to one in 12 in London. This compares to one in 667 in the general population. The number of MSM living with a diagnosed HIV infection has doubled from 16,180 in 2003 to 33,960 in 2012; this rise is due to the availability of Anti-Retroviral Therapy which increases life expectancy and continuing HIV transmission. The number of MSM newly diagnosed with HIV each year continues to rise. Between 2011 and 2012, the number of new HIV diagnoses increased by 10% from 2,960 and in London by 14% from 1,400 to 1,600. Trends in new HIV diagnoses are influenced by HIV testing patterns, migration as well as underlying transmission. The number of MSM that had an HIV test in sexual

health services in England increased by 13% (from 64,270 in 2011 to 72,710 in 2012), while in London, the increase was 19% (from 28,640 in 2011 to 33,980 in 2012) (PHE, 2014). Often, the issue of HIV and AIDS occurred during interviews with South Asian men. As with society in general, there was stigma associated towards individuals and groups with HIV/AIDS and this requires effective communication amongst South Asian men, South Asian communities and all communities.

MSM continue to experience inequalities related to their health, wellbeing and socio-economic circumstances compared to the rest of the population. MSM have higher rates of cardio vascular disease (CVD), asthma and diabetes and may be more likely to be in receipt of housing benefit and income support. There is a need to increase the understanding of South Asian MSM's cultural, family and religious issues. A need to increase the accessibility and promotion of sexual health services to South Asian MSM. Importantly, work with the wider South Asian community to promote positivity and inclusivity about South Asian MSM (Rainbow Asian Project, 2011). Extensive work on South Asian MSM or discussions on sexual orientation and homophobia was not undertaken during this study. However, as this issue arose during the interviews it was important to mention this issue. The rationale for this study is to raise the profile of South Asian men's sexual health by better understanding the culture which surrounds South Asian men's sexual health. This study acknowledges going beyond the research aim and research questions and take into account the sexual heath culture of South Asian gay men who are more polarised within the South Asian community and non-South Asian communities. As the MSM community to increase so does the discrimination they face. The findings

from research suggested the need to challenge this form of discrimination amongst South Asian men and within the wider South Asian community.

Sexual health services need to be aware that some BME MSM, particularly those from South Asian communities has heightened concerns about confidentiality and visiting sexual health clinics in England in comparison with white MSM (McKeown et al, 2012). An evaluation was undertaken on a series of sexual health interventions targeting BME MSM in the UK. There is a need for further research into interventions targeting BME MSM populations. Importantly, there is a need to focus on providing sexual health information in languages preferred by BME groups. Cultural and linguistic sensitive approaches should be paramount when targeting BME MSM. It is vital to engage with faith communities, organisations and community leaders. (Jaspal et al, 2016). Research into the mechanisms and underpinnings of future sexual health interventions is urgently needed in order to reduce HIV and other STI among BME MSM in the UK. Importantly, the design of local sexual health interventions should be informed by BME MSM, or members of a group the interventions are designed and targeted to ensure cultural and linguistic sensitivity (Fish et al, 2016).

5.3.4 Tension between religion and sexuality

Religion and sexuality was highlighted during the recruitment of establishing the PAR group. South Asian gay men who took part in this research regarded themselves as religious and those with Muslim backgrounds consider themselves as equally Muslim heterosexual men. The majority of South Asian men who took part in this study were from a Muslim background. In the PAR group setting one individual openly shared

his view that South Asian men who are gay are not Muslim and was considered as being out the fold of Islam. This was challenged in the PAR group setting at the time but it showed that South Asian men who took part in this study held negative views towards homosexuality regardless of which faith group are a part of. This was another issue that was not anticipated at the conceptual and planning stage of this research. Future research with South Asian men on sexual health, sex and related topics need to ensure there is investment and prior work with participants on all forms and levels of discrimination.

An issue which was raised by South Asian men was on the important role of faith leaders and faith organisations in the South Asian community. South Asian men state such organisations and groups have a well-established and reputable position in the South Asian community and can support and promote key health issues in the community which sexual health services may face challenging.

> *Interviewee Two: "I think faith establishments should play a key role. Places of religious worship only concentrate on religious things. Life is not about just that, it's also about other things"*

Maxwell (2006) claims arguments about being Muslim and South Asians in the UK are exaggerated and in fact Muslims and South Asians are almost as likely as Whites to identify themselves as British. In addition, factors such as socio-economic difficulties and ethnically and religiously segregated networks that supposedly contribute to Muslim and South Asian alienation have been shown to be insignificant. Muslims and South Asians have built integrated networks and consider themselves part of the larger British community.

Qualitative fieldwork suggests complex contextual relationships between culture, ethnicity, gender, age and religion (Sinha et al, 2007). Culture and religion are

contextual, and this carries implications for healthcare (Ahmad, 1996). Sinha et al (2007) argues the multiplicity of factors affecting sexual understanding, attitude and behaviour require a range of flexible approaches to cater for the entire community. This would then provide options for underrepresented groups to access information and services in the manner regard as appropriate which would depend on local ethnic, religious demographics

Generations of migration of Muslims to Britain and migration from various parts of the world means being British and Muslim has many definitions. The Muslim mix in Britain forces Muslims to determine what is centrally Islamic and what is considered a culturally relative expression of Islam (Coward et al, 2000). Participants in this study assumed they observed genuine Islam in comparison to South Asian Muslim gay men who they assume as not abiding to the central tenets of Islam.

Homosexuality in Islam remains a largely an unexplored area, principally because the Qur'an, Ahadith and Shari'a, are used as heteronormative sources determining sexual morality and have stifled debate about the topic. Homosexual Muslims, until recently confined to a 'culture of invisibility' are beginning to speak out to re-claim their identity and to reconcile their faith with sexuality (Siraj in Ouzgane, 2006).

There is no definitive work on homosexuality and Islam, merely a series of cross-references that stress the 'abnormality' of homosexual individuals and their relations. The proscription of homosexual acts is grounded in the Islamic view that heterosexuality is natural and essential, and heterosexual marriage the only path to religious and personal fulfilment (Siraj in Ouzgane, 2006).

Jaspal (2010) states the dominant view among many Muslims is that homosexuality is forbidden and incompatible in Islam and the Holy Scripture and teachings of the Prophet Mohammed (Peace Be Upon Him) explicitly outlaw homosexuality. Consequently, for Muslim gay men this may mean identity complications which will impact of their mental and physical wellbeing. Muslim men may be reluctant to accept they are gay and have gay tendencies as they view their own sexuality through a religious lens and this will always keep stigma and taboo towards gay men and culture within the South Asian Muslim community. Greater awareness of Muslim gay men within South Asian communities is required along with scholarly inquiries into the psychological experiences of being gay and Muslim.

Siraj in Ouzgane (2006) shares his work with homosexual Muslims from London organisations who participated in qualitative, semi-structured interviews to share their experiences of being gay and Muslim. This study was conducted with 8 men and participants were aged between 25 and 47 years. All participants had a reasonably high level of education attained at least an undergraduate degree level of education. All participants identified themselves as homosexual and stressed an importance to their Islamic faith regarding being gay did not exclude them from being identified as Muslim.

5.4 Community Level to Service Level – Sexual Health Services

The final level is specifically related to sexual health services. The purpose of linking the community level and the service level was to emphasise that sexual health services need to understand the local demographics and South Asian culture it

serves and accordingly develop appropriate interventions. To support sexual health services better understand local communities and South Asian sections of communities' services can now use the Government's newly established Ethnicity Facts and Figures website (Cabinet Office, 2018). There are many issues local sexual health services need to consider in relation to South Asian men's sexual health such developing culturally appropriate interventions, consider whether there is a need for ethnic specific sexual health services, delivering meaningful community engagement, using innovation and research to engage with South Asian men.

5.4.1 Culturally appropriate interventions

The final major theme is sharing some of the ideas and solutions South Asian men who took part in this study believe can (a) help raise the profile of men's sexual health amongst South Asian men and South Asian communities and (b) help sexual health services to effectively engage with South Asian men. These ideas which are shared are considered culturally appropriate as they regard the influences of religious and cultural beliefs amongst South Asian men to be uncompromised and help promote trust in community using approaches whereby confidentiality is paramount. These ideas and solutions are derived from the findings using data in the terms used by South Asian men. Many of the solutions are currently undertaken by existing sexual health services and therefore this is not a section on new innovative solutions. Rather, this section provides how sexual health resources can be amended and the use of existing resources to help better engage with South Asian men on sexual health in Brent and Leicester.

Service level issues also include the availability of sexual health information and publicity that specifically targets South Asian men. South Asian men who took part in this research had not been exposed to any literature about sexual health which was aimed at South Asian men and this suggested sexual health literature should be used as an initial approach to reach South Asian men. This would help South Asian men better understand sexual health. There may be a vast amount of literature and references on sexual health for both men and women of South Asian origin but this resource is not at the forefront of academia in England and maybe lays within the South Asian sub-continent. Research needs to include theoretical perspectives of key South Asian sexual health activist and authors. There needs to be a rethinking in sexual health literature in relation to South Asian men in Brent and Leicester (Hasan et al, 2015).

5.4.2 Specialised services for South Asian men

Sexual health services need to consider whether developing a specialised service for South Asian men is feasible and required. Despite South Asian men in this study acknowledging the lack of knowledge on local sexual health services they recognise there is a need to provide adequate sexual health services for men from all ethnic backgrounds. The in-depth interviews overwhelmingly demonstrate that South Asian men prefer not to be an isolated group and targeting all men would in fact help South Asian men believe that this is an issue that is common amongst men from all communities. Hence, this would reduce the stigma and taboo associated with men's sexual health in the South Asian community.

There are many creative means to promote sexual health amongst South Asian men and ways sexual health services in Brent and Leicester can better engage with local South Asian men. South Asian men shared many ideas whilst discussing sexual health and exploring the barriers which prevent South Asian men to discuss sexual health in the South Asian community. By default, solutions to some of the discussed barriers were uncovered. As mentioned above, these solutions are not indicating further resources need to be channelled towards South Asian men's sexual health. Rather, engage with local voluntary and community organisations; most importantly engage with South Asian men to determine the localised preferred approaches. Ideas such as training, small scale research into the use of digital technology and social media, volunteer schemes, use of arts, financial incentives and telephone helpline are all existing approaches which need to be carefully adopted for use in the South Asian communities to target South Asian men.

An important issue highlighted during the course of this study was whether there were any international and national guidelines to undertake research on the sexual health concerning men. Research needs be undertaken and delivered in accordance to any research ethics committee. One outcome from this research would be to consider whether developing standardised research guidelines on how to undertake research on men's sexual health, particularly men from BME communities in England.

This research suggests stakeholders and local sexual health services need to commence dialogue and work towards the development of a set of guidelines that support the promotion of South Asian men's sexual health. Developing a men's

sexual health or a sexual health framework for South Asian men can help local sexual health services to deliver a culturally appropriate and meaningful service. This requires undertaking a needs analysis in the South Asian community with regards to men's sexual health. A potential set of guidelines, developed with South Asian from the local community can help to promote and ensure key messages in the South Asian community and further determine if sufficient resources is required. The Warwickshire and Edinburgh Mental Well-being Scale (WEMWBS) developed by Coventry and Warwickshire Partnership NHS Trust and the universities of Edinburgh and Warwick (2007) is an example of how mental health of a patient is measured using a validated scale developed by mental health practitioners with mental health service users. This scale suggests that men's sexual health can develop a scale to determine the general sexual health wellbeing of men and particularly the sexual health of South Asian men to help provide baseline data and also develop a tool to compare the sexual health wellbeing of men from all communities in England. This scale would need to be developed to cover a range of men's sexual health issues and by using this approach would help engage men on sexual health related issues such as prostate and testicular cancers and sexual risk taking behaviour.

This study shows that there is no need for a major overhaul of local sexual health services to understand the culture of South Asian men's sexual. Rather, simply acknowledging key issues related to this specific group which can help sexual health interventions be delivered effectively and efficiently. Key issues such as the language and words used for sexual health is important, the low of acceptance of gay culture amongst South Asian communities which may results into homophobic

attitudes and behaviours, issues to consider if undertaking research on South Asian men's sexual health and seeking innovate ways deliver culturally sensitive sexual health research and sexual health interventions to South Asian men. None of these issues and ideas is new. They have and are being used to engage with sexual health research and interventions with non-South Asian communities. The point made by South Asian men is that underlying religious and cultural issues require more emphasis when working with South Asian populations in comparison to non-South Asian population.

5.4.3 Community engagement

Innovative approaches are required to work with South Asian men in relation to sexual health. Clear messages are required on what constitutes men's sexual health. South Asian men in this research often confused men's sexual health with sexuality and although both issues can be related they are distinctly different. Therefore, research needs to engage with South Asian men and agree the language and definition of men's sexual health. This would ensure that messages portrayed in the South Asian community are culturally sensitive and appropriate. Discussions in the South Asian community on South Asian men's sexual health are not prominent. South Asian men in this study mentioned that the lack of discussions on sexual health often made this issue difficult to discuss in the South Asian community. South Asian men suggested dialogue in the community can be achieved through the use of culturally sensitive material.

The University of Central Lancashire's Centre for Ethnicity and Health (UCLCEH) (2007) provide a community engagement model for health services and

communities. UCLCEH previously covered sensitive health issues such as drug use and mental health and provided a framework for making an effective change within BME communities. This model was initially considered to be adopted for this research with South Asian men on sexual health. However, fundamental to implementing this community engagement model is funding and resources as well as a direct link to health services to make improvements. In addition there needs to be engagement of key stakeholders such as local sexual health services and community organisations. The issue of men's sexual health carries a stigma in the South Asian community and there was considerable attempt to engage with stakeholders during the PAR group recruitment stage. Another factor was that this research, particularly participants were not a part of a local health or sexual health service. The lack of visible change or improvement played a major factor in structuring and motivating PAR group meetings.

The third sector plays an important role, particularly when it comes to engaging with health issues regarding BME communities and under-represented communities. Diverse areas such as Brent and Leicester have long established community infrastructures for South Asian people in comparison to many towns and cities in UK. An initial attempt was made to engage with key community organisations and groups in Brent. Despite all acknowledging the need for research on South Asian men's sexual health, there was a lack of interest.

Organising discussion opportunities in the South Asian community would help to engage with a wide range of South Asian men. The use of various approaches has no doubt a cost implication. In this modern day of financial scrutiny, financial

governance and reducing cost there would need to be consultation to determine the best approaches to use in South Asian communities to promote South Asian men's sexual health.

One suggestion from this research is to establish a confidential telephone helpline to target South Asian men. A helpline service would require health professionals with knowledge and understanding of sexual health issues and local sexual health services to help signpost South Asian men. Establishing such a service may not require considerable changes to existing local sexual health services. This could possibly be delivered by local sexual health services for a few hours a week or fortnightly using existing resources. Community consultation with South Asian men would determine if such a service is required and be of benefit to South Asian men.

Incentives to promote men's sexual health, particularly to South Asian men and men BME backgrounds could be through a bonus scheme whereby BME community organisations can undertake culturally sensitive work in their own communities. This approach can be cost effective to local sexual health services in terms of promoting innovative sexual health approaches in the community and promote the effective use of culturally specific interventions. Sexual health services require capacity and specialist community based knowledge which through robust governance and management can be ideally delivered through community based charities and organisations.

The use of a mentor scheme or a buddy up scheme would also help local sexual health services to support local volunteers to take a proactive role in promoting

men's sexual health. Creating a 'health volunteer' role i.e. 'sexual health ambassador role' for local health services would be one method of engaging with the community and enabling local South Asian men to promote key men's sexual health messages in the South Asian community. This can be achieved by engaging with local health charities and groups that are based in the community and have a specific focus to improve the health of BME communities. A scheme such as this requires incentives for community organisations to take part and effective collaboration can only be achieved if benefits are demonstrated to both parties. A method to determine the impact of such partnership work would be to use public health epidemiology to demonstrate the cost saving to the local NHS from such schemes.

A suggestion by South Asian men from this research is that training for South Asian men regarding sexual health issues should be made available. This could be in the form of short workshops and courses in community settings that provide the opportunity for South Asian men to learn about men's sexual health in a group setting. The use of webinars would provide the platform to deliver men's sexual health training to South Asian men in the privacy of their homes. Faith organisations can take a lead on courses and help deliver the courses in the local community in a method suited to the South Asian community. Delivering courses in this manner by established community networks can help build better understanding between the community and sexual health services.

5.4.4 Innovation

Innovation encapsulates many approaches such as using digital technology to using creative forms of communication illustrated as performing arts, drama and theatre. Innovation within the context of health is defined as transforming healthcare for patients and the public by developing and spreading new ways of working, using new technology and new leadership. This is a broad definition and fundamentally innovation in the healthcare is using existing ideas and new ideas to make meaningful impact for patients and the public to meet their needs. Of course, any innovation needs to be tried and tested before it can be considered an effective approach. Some suggestions from South Asian men within this study are mentioned below as innovative approaches to raising the profile of sexual health and undertaking sexual health research with South Asian men:

5.4.4.1 Performing arts

A key approach which was not considered during this research was the use of innovative methods in research such as the arts. The use of performing arts as a way of engaging with communities in research is not common. Issues such as mental health and palliative care have used interventions such as the arts to promote health messages in the South Asian community. Although there is a debate on the impact of using such an approach and whether the impact measures (if any), can be demonstrated, needs to be validated. The arts use various methods of measurement in comparison to the clinical domain which bases its understanding on sexual health on clinical data. It would be ideal to use information and data from the arts to complement existing national and local sexual health clinical data to provide a better understanding on South Asian men's sexual health.

5.4.4.2 Media

The use of mainstream media and South Asian media in the form of community based radio channels is also considered an ideal approach by South Asian men who took part in this research. The production of radio community talk shows would enable a wider audience participation and help share key messages in regards to men's sexual health as well as discuss controversial issues related to sex, extra marital relationships, sexuality, STIs, living with HIV/ Aids, sex education in schools, homophobia and cultural barriers, stigma and taboos related to sexual health in the South Asian community. Radio would also help reach a wide audience to both South Asian and non-South Asian families.

> *Interviewee Two: "I think media, internet coverage would be massive. The [South] Asian media will have a lot of older people listening and watching, so I think that would be a good. I don't mean to sound cruel, but the older generation are too set in their ways to change their mind set, but I think 20, 30, 40 and 50's age group can be educated for future generations"*

5.4.4.3 Social media

During the in-depth interviews there was reference on using social media to share information and messages on South Asian men's sexual health. Discussions with South Asian men included privacy and anonymity, the opportunity to engage with members of the public and directly with sexual health professionals and the ease to access information. These reasons are valid and it raises the question on why the initial social media platforms established for this research such as Facebook and Google Groups failed to engage with South Asian men. This issue raises questions whether six years ago South Asian men were not prepared to use social media and possibly now ready to engage through social media who took part in this study. Facebook and Google Group social media used at the beginning of this study were

relatively new concepts for this research and this group of South Asian men and - hesitation and lack of familiarity with social media and particularly for sensitive health issues prevented this to take place. Nowadays, many health organisations and renowned health charities use social media and therefore now South Asian men would be comfortable to use this method. There is growing confidence of the public in social media.

> *In-Depth Interviewee Two: "You can have websites. You can do that on the go. You don't have to necessarily visit some place or go to the city centre or out of the city. You can be doing anything and still be online and you got to remember when you do this online over the internet then this is a personal thing. You don't have to worry or be thinking someone's going to see me pick this leaflet up or someone's going to see me read this"*

5.4.4.4 Digital technology

Innovative ways are required to engage with South Asian men on sexual health issues. During the literature review phase of this research obtaining information on South Asian men's sexual health was virtually non-existent and only a small number of sources were useful. The possibility of using digital technology, particularly with the development of a men's sexual health application for mobile phones would be ideal as this would provide an opportunity for sensitive issues to be explored and ensure issues such as privacy, confidentiality and engage men in the comfort of their personal environment at convenient times. A mobile phone application would provide an opportunity to promote key issues and distribute meaningful men's sexual health messages, information on homophobic discrimination, information on local sexual health services and ongoing collection of valuable data and information to discover develop new approaches. Developing such an application with South Asian men would be an ideal platform to develop appropriate resources. Rowe (2017) argues that healthcare is perhaps the best place for Internet of Things (IoT)

applications. IoT is changing the process of clinical trials, making them more efficient and cost-effective, and speeding up the time it takes to research new treatments. IoT helps significantly with research study recruitment and study management, although questions remain in relation to patient privacy and the security of devices and networks.

The use of a Quick Response Code (QRC) is another alternative of digital technology that is used to promote health issues and could also be used for the dissemination of sensitive health research such as South Asian men's sexual health. Simply adding a QRC code to posters in locations where underrepresented groups congregate would be an easy method for South Asian men to find out information on sexual health and sexual health research. QRC can also involve sharing information on what services are provided by sexual health services, sexual health information as well as promote opportunities to take part in future research.

5.5 Research

The subject of men's sexual health is delicate amongst health professionals and researchers. If men's sexual health is not systematically addressed it is predicted that this will have cost implications to health service in the future (Robertson, 2007). There needs to be discussions on social science research and its role to complement biological sciences. Science and social science research need to be delivered in conjunction with each other to provide a holistic view on the sexual health of South Asian men. It is important to understand the limitations of social science research particularly with regards to new treatments and clinical advances.

Nevertheless, social science research can play an important role with regard to approaches at the community macro and micro levels.

It is evident that there are differences and similarities in the culture between South Asian communities and non-South Asian communities. This cultural difference is often celebrated. The similarities include the important role that religion and faith have in communities. South Asian communities encompass a wide range of communities and undertaking research on South Asian men's sexual health is only meaningful if this category is further narrowed to focus on specific age, community, faith group and sexuality. Only then can meaningful research be focused and delivered. Small scale research such as this study can help to bring a taboo subjects to the forefront and provide opportunities for better understanding on South Asian men's sexual health. There is a need for research on a larger scale which encompasses a wider South Asian male audience and different locations. However, small scale research allows deeper insight into the reasons certain views are held and shared on sexual health by South Asian men. One must take into account that it is not easy to do sexual health research with any group, even if South Asian men consider a GP setting more comfortable (Llewllyn et al, 2012).

There is a need for innovative approaches to raise the profile of sensitive health issues such as South Asian men's sexual health. This research used PAR. However, it was clear there is a need to use a format and languages which are relevant for South Asian men and the use of theatre and arts may provide a culturally sensitive approach to raise men's sexual health issues. The topic of men's sexual

health research needs to be undertaken in collaboration with acceptable health issues in the South Asian community and certainly not as an isolated health issue.

> *In-Depth Interviewee Four: "Unless people are approached, by people like you, and go out into the field, in the South Asian community to bring these things out in the open, until that's done, that stigma is still going to remain there and people are not going to talk freely and this is probably one benefit of a research"*

Wayal et al (2017) mentions the need for interventions targeting ethnic groups at risk of poor sexual health. Further research is required how influence of family plays on sexual health in South Asian communities. Currently, there is further research being undertaken on the factors contributing to ethnic inequalities in sexual health for England's National Institute for Health Research's (NIHR) Health Protection and Research Unit in Blood Borne and Sexually Transmitted Infections. This research will contribute to the development of interventions to reduce ethnic inequalities in sexual health in line with the DH (2013) *Framework for Sexual Health*. The International Network for Public Involvement and Engagement in Health and Social Care Research was also recently launched to help understand global perspectives on public involvement in research and this would mean understanding different research perspectives and research lenses (Cochrane, 2018).

Importantly, as South Asian men in this study indicated, there is no requirement to provide ethnic specific sexual health services for South Asian men. Sexual health researchers also need to think about the rationale and approaches of undertaking research with South Asian men. Re-directing research endeavours away from questions of 'difference' to questions of 'sameness' is important. Men and women are more similar in respect to their genetic make-up and everyday material needs and experiences than they are different. Research tends to be preoccupied with questions of difference (Broom and Tovey, 2009). In addition, issues concerning

equality, equity and diversity respect differences but research should be inclusive for all unless research concerning specific conditions or situations is required.

The recent *Race Disparity Audit* (Cabinet Office, 2018) mentions the new Ethnicity Facts and Figures website and this data envisages to be reliable in comparison to data collected using self-reporting means and the Census. Understanding ethnic disparities in health is complex and involves considering a range of factors, including socio-economic, demographic and cultural factors. This website will begin to collect various ethnicity related data and the recent audit mentions that most Asian groups express lower levels of satisfaction and less positive experiences of NHS services than other ethnic groups. Research to understand lack of and less positive experience of sexual health services is a way forward. In addition, Hunn (2017) mentions a survey which comprised of over 1,000 people across the UK states that 52% of White respondents were confident that they would be treated with dignity and respect if they took part in a health research study in the UK compared with only 35% of ethnic minorities. However, only 14% from this survey were non-White.

Far more important than the issue of ethnic or gender specific sexual health research is the need to understand local culture and local operating powers of influence at the individual and community level. There is a need to place questions of power relations and unequal access to the conditions that shape health and wellbeing firmly on the agenda of men's research. Greater recognition needs to be paid to the historical and cross-cultural variability in constructions of gender and in conceptions of the body, health and illness (Broom and Tovey, 2009).

The NIHR (2018) recently introduced the *National Standards for Public Involvement in Research*. The standards are to provide people with clear, concise benchmarks for effective public involvement alongside indicators which improvement can be monitored. The standards are intended to encourage approaches and behaviours which will support flexibility, partnership and collaboration, a learning culture, sharing of good practice and effective communications. However, the standards are not a recommendation for any particular approach or method for public involvement in research, or about one way of doing public involvement. Rather, the standards are areas research involving the public need to address which requires a reflection on the research design and approach used. Sexual health researchers can now use these standards to ensure equity in research delivery and importantly that issues of power are being addressed.

Chapter 6 Conclusion

This chapter summarises all the key points from this study. The strengths and limitations of this study are shared, although this it is important to note this is primarily reflected from my perspective as the researcher and not necessarily the perspective of South Asian men who participated in this study. The implications for sexual health services and sexual health research will be shared in this chapter. In addition, clear action points on the way forward will be presented and this chapter concludes by suggesting the next steps following on from this study and how sexual health research with South Asian men in the future can possibly be influenced from the learning and outcomes of this study.

6.1 What was learnt/ reflections

Undertaking this study for the course of several years was both a positive and negative experience. Some of the positive experiences include embarking on a new research experience and meeting many people (participants of this study) learning about research theories and methodologies and learning the potential significance research plays in the development of health culture and attitudes towards sexual health. Some of the negative experiences include how undertaking research can be a time consuming affair, challenging at the best of times and ensuring research analysis and findings does justice to those who contributed such as the academic supervisor, stakeholders and importantly the participants of a study.

Research is dependent on the perspective and outlook of the researcher as the study findings are viewed through the lens of each researcher. This perspective influences the research paradigm for each study. This was evident in the case of

this study as my community development background and influence played a role during the research conceptualisation stage and the initial delivery of this study. It was not until the research had reached the fieldwork stage that I realised how much this influence was impacting on the delivery of this study. Initially, there was less focus on the study target group (South Asian men) and health topic (sexual health. My community development influence was considered inappropriate for South Asian men who participated in this study and was an obstacle during the course of this study. As a result, the study changed its approach and direction which better suited South Asian men to undertake research on the subject of sexual health towards an individualistic approach using semi-structured and in-depth interviews due to concerns related to confidentiality and exposure in the South Asian community.

Sexual health is not an easy subject for research as experienced in this study. This does not mean qualitative sexual health should not be prioritised. Rather, due to the sensitive nature associated with sexual health, particularly South Asian men's sexual health, there is a requirement for significant preparatory work with South Asian communities and South Asian men before commencing any research on sexual health. The stigma associated with sexual health in the South Asian community was underestimated for this study and the findings show the influential role of stigma associated with sexual health.

One key issue which was not taken into account during the research proposal stage was the issue of providing incentives such as financial rewards for participants in this study. Incentives should have been allocated due to the sensitive nature of this research topic and the fact South Asian men are less represented in social science

based sexual health research. Research with people who have experience of taking part in research and on topics openly discussed in the community is and can be delivered without the need for financial incentives. However, research with underrepresented groups and on topics carrying stigma in the community such as sexual health requires some form of incentives to recruit participants and retain participants. This is where working with local volunteering agencies and local community organisations can make a positive impact regarding participant recruitment and provide a study the necessary platform to progress.

Therefore, the experience from this study suggests undertaking sexual health research with South Asian men using a qualitative approach requires preparatory work to understand the local demographics and local South Asian culture of the community targeted. In doing so, researchers will build trust and relationship with people from the local community and this can be detrimental to the success of sexual health research undertaken with South Asian men. Liaising and building relationships with local voluntary and community organisations who engage with South Asian men would be an ideal platform for sexual health researchers and sexual health services to collaborate with in order to begin developing trust in the community. The possible introduction of incentives may generate interest amongst under-represented group to take part in sexual health research that may historically refrained to do so.

6.2 Strength and limitations to the study

There are many positive and negative elements of this study. The first being that a study to explore the culture of South Asian men's sexual health, in accordance to

the literature review undertaken for this study, has not been previously undertaken with South Asian men in Brent and Leicester. Sexual health of South Asian men in comparison to non-South Asian men is generally under-represented in qualitative research and much of the information that is available is based on STI data derived from GUM settings undertaken in England. The NATSAL 2 and NATSAL 3 (Field et al, 2013; Mercer et al, 2013; Wayal et al, 2013) does provide data on the sexual attitudes and lifestyles of South Asian men but the NATSAL surveys lack details on the origins of sexual health related views, attitudes and behaviours of South Asian men and recommendations on what support should be made available for South Asian men about their sexual health.

Using a qualitative descriptive approach in this study provided a needed understanding on sexual health related terminology and language used by South Asian men themselves and enabled this research to remain close to the descriptions of sexual health used by South Asian men. Researchers tend to shape a study towards a particular research paradigm which is influenced by the researchers' outlook and this influences the journey of the research and the outcome (Sandelowski 2000). Qualitative description, in its nature, minimises the researchers influence and allows for participants to dictate the research data contributed and findings without the pressure of actively being involved.

Using a collective approach such as PAR and moving towards an individual approach as in semi-structured, in-depth interviews) demonstrated an attempt to locate an ideal research approach which was effective for South Asian men to contribute from a collective and individual perspective. PAR was found to be

inappropriate for South Asian men in this study due to the stigma associated with sexual health in the South Asian community. PAR was also inappropriate as South Asian men in this study failed to grasp the 'action' element of an action research study. The lack of taking part in the action element of PAR meant South Asian men regarded research to be delivered by research professionals and be treated as research subjects and not research participants in a study. This issue was challenging for me to comprehend during the implementation of this research as this relates back to my personal understanding as a community development worker on the culture of research and breaking the power dynamics between community members and research academics and professionals.

This study initially adopted a PAR approach to engage with a group of South Asian men. This changed over the course of this study. The use of PAR or action research would have been better suited if this study was designed to improve practice of sexual health professionals. Direct links with practitioners and services would have enabled the ability of this research to deliver successful action research cycles. Working with a group of South Asian male volunteers, most of whom had not used local sexual health services or sexual health professionals made delivering action research cycles challenging. Research adopting an action research or PAR approach needs to engage with members connected to local sexual health providers and work to determine the best suited research approach to use with local South Asian men on sexual health related issues.

The overall findings of this study resonate with the findings from the sample data of this study. The sample data showed six key areas South Asian men's sexual health

culture: awareness of sexual health, defining sexual health, knowledge of sexual health services, language and community related issues. All of which were further elaborated during the collective and individual fieldwork phase. A grounded theory approach to better understand one of the six issues from the sample data may have allowed this study to be focused and deliver meaningful recommendations. Keeping a 'broad' approach meant this study only explored a specific area to understand the culture of South Asian men's sexual health.

The findings from this study show the importance of better understanding a local community in order to help shape a meaningful local sexual health service. In relation to South Asian men this meant understanding the specific ethnic origin, generation, migration purpose and experiences and religious and cultural influences. By doing so, sexual health services can use approaches which are better suited to a particular group of people belonging to the wider 'South Asian' community. Simply providing a sexual health service for all South Asian men is not adequate. Effort needs to be geared towards understanding the demographics of each community to better understand the community and determine which section of the South Asian community is being targeted.

During the course of this study it was also clear that my limitation on how to deal with issues regarding the sexual orientation of South Asian men was apparent. South Asian men who participated in this study regarded the sexual health of gay men and the sexual health of non-gay men to differ. The sexual attitudes, behaviour and practices of heterosexual, bisexual and homosexual men all differ, but sexual health is an important matter for all men regardless of sexual orientation. Cultural barriers

are major issues which prevent the disclosure of South Asian gay men's sexuality to South Asian families. South Asian families expect South Asian men to marry and have children in heterosexual environment (McKeown et al., 2010). By not defining a specific sexual orientation to this study meant that a section of South Asian men, namely South Asian gay/ bisexual men, to be unintentionally excluded from this study. Thus, the views and experiences of sexual health are limited to heterosexual, religiously inclined married South Asian men. This links in with challenges of not having a clear objective of sexual health research (Collumbien et al, 2012).

In addition, this study lacked a focus on how sexual health relates to issues of masculinity and how the issue of masculinity impacts on the South Asian community. This study would have benefitted from undertaking a focus on how South Asian men regard masculinity and this would have helped the research a deeper understanding on the origins, beliefs and attitudes related to the sexual health culture of South Asian men. Work on the theories of sex, sexuality, sexual identity and sexual health would have been beneficial for this study. As a result, this study lacked the rigour of linking the data generated by South Asian men to recognised sexual theories. However, the lack of South Asian male sexual health theorists was also recognised during the implementation of this study and literature review.

Another major issue for this study was recognising the migration patterns and rationale of South Asian men in Brent, Leicester and England. There were a number of references by South Asian men towards sexual attitudes and understanding between the different generations of South Asian men and that 'cultural baggage' related to sex, sexuality, sexual identify and sexual health was often associated with

views whose origins are from the Indian sub-continent. This study lacked the detail on how those views exist amongst South Asian men who are not born and raised in England to those of South Asian men who are born and raised in England.

The age of South Asian male participants was another major issue for this study. This study would have achieved more of an impact if a specific age range of South Asian men or young people was pre-determined. Age specific research would have helped focus the study at the implementation stage, particularly at the questionnaire development stage in order to develop age specific recommendations. Focusing on South Asian men eighteen years old and above meant the study dealt with a wider range of sexual health experiences and influences across a broad age range. A broad overview of South Asian men's sexual health was obtained, but this study lacked how addressing the need of South Asian men's sexual health can be appropriate to specific age groups of the South Asian male population.

Focusing on only one group of South Asian men, rather than all men actually added to the stigma surrounding South Asian men's sexual health. The choice of undertaking research with only South Asian men was supported by the literature review for this study and the lack of research available to explore the individual and collective perspectives of South Asian men's sexual health. Therefore, a rationale to choose South Asian men as the research target group was agreed. In doing so this narrowed the sexual health experiences and attitudes to South Asian men and excluded non-South Asian men. Men from all communities share similar and different views of sex and sexual health. This study would have benefited by understanding how the culture of South Asian men's sexual health is different to men

from non-South Asian communities. In addition, this study engaged mainly with men in Brent and Leicester whose ethnicity originates from North India; Gujarat. This specific group of South Asian men does not represent the views of all South Asian men from these two locations and in England. Rather only represents a small section (although significant) of South Asian men. Therefore, this study is considered to explore the sexual health culture of South Asian 'Gujarati' speaking Muslim men rather than South Asian men.

6.3 Implications for sexual health services and future research

Sexual health services need to understand South Asian men's sexual health from an individual and community perspective of South Asian men. Understanding some of the main issues from an individual and community perspective enables sexual health services to view issues which are important regarding sexual health from the lens of South Asian men. It can be argued that using a qualitative descriptive approach as used in this study is the ideal approach to understand South Asian men's sexual health as this research approach is embedded within the words and views of participants. This study developed a framework for better understanding South Asian men's sexual health (figure 4.5, Chapter 4). This framework demonstrates some of the key issues which need to be considered when delivering sexual health services and undertaking sexual health research with South Asian men in Brent and Leicester.

As mentioned earlier in this thesis, this study had no direct link developing this research proposal with local sexual health services in Brent and Leicester. Therefore, sharing the findings of this study to local sexual health services in Brent

and Leicester in order to make practical changes on how they engage with local South Asian men may not be appropriate. The rationale for this study to remain independent from any local sexual health services was to adopt a community-led research approach and allow South Asian me to influence this research and its outcomes rather than be guided by an organisations agenda. The experience of this study shows that sexual health research needs to be delivered in conjunction with local sexual health services to generate credibility and impact in the community. Linking research with local sexual health services allows ownership of research and encourages responsibility for sexual health providers to make meaningful changes to its services. The *Framework for Sexual Health Improvement in England* (DH, 2013) and *Public Health England's Strategic Action Plan 2016 - 2019* (PHE, 2015) both identified a need to improve the sexual health provision to BME communities in England. Both these documents should be used to drive the need for sexual health services to develop strategies and plans to engage with and meet the specific sexual health requirements of BME men and particularly, but not exclusively, South Asian men.

Interestingly, South Asian men who participated in this study mentioned that there was no need for any major reconfiguration of local sexual health services and that there is no need for a ethnic specific services as this further alienates South Asian men to engage with local sexual health services. Rather, generic sexual health providers can develop roles and activities to engage with South Asian men using some of the culturally appropriate approaches shared by South Asian men in this study. Sexual health services need to develop local culturally appropriate initiatives to improve healthcare pathways for South Asian communities (Dhar et al 2010).

This can be further strengthened by aligning sexual health providers with generic health providers. Understanding the stigma associated with sexual health in the South Asian community is paramount. South Asian men's sexual health stigma is associated to the use of GUM clinics and therefore a preference for sexual health services to be delivered within a primary care setting. There is no one ideal setting to deliver sexual health services. Effective sexual services are dependent on the meaningful engagement of all stakeholders in the community (Griffiths et al, 2008). Meaningful engagement can only be achieved by engaging with all members of the community which includes South Asian men to develop sexual health services.

This study did not explore the impact of national sexual health policy in England on South Asian men in Brent and Leicester. This study shows the absence of sexual health policy for South Asian men. South Asian men who participated in this study believe sexual health policy and policymakers need to engage with all men collaboratively and not solely with South Asian men. The interviews with South Asian men show that sexual health concerns men from all communities and directing sexual health policy towards South Asian men can be a disservice for South Asian men. National and local sexual health data suggest sexual health policies need to be targeted for all men in England.

Sexual health research with South Asian men requires clarity on what the research is attempting to achieve. As Collumbien et al (2012) mentions sexual health research comes under the following broad objectives; research on magnitude, determinants, and consequences of sexual/ reproductive behaviour and ill health, research for promoting behaviour change (health promotion), research on preventative and

curative reproductive health services and research on policy, social, and legal arenas of sexual and reproductive health. This study was unclear from its conception where its focus should be in relation to sexual health and sexual health services for South Asian men. The research aim and questions provided a platform to commence the research fieldwork but this study lacked any impetus into making any meaningful change to sexual health policy and practice due to it unclear objective. Future sexual health research with South Asian men requires sexual health research objectives to be concretely determined before the delivery of any sexual health research with South Asian men.

The topic of only undertaking research on sexual health as a stand-alone topic, prevented many South Asian men to participate in this study. South Asian men indicated that using sexual health as a secondary and not primary subject would have engaged a larger proportion of South Asian men. Associating sexual health with prevalent health topics in the South Asian community would have helped this study receive a more positive response in the South Asian community and demonstrate the impact on sexual health as a result of linking this research with an acceptable and open health issue in the community. Recent figures show prostate cancer is now a bigger killer than breast cancer in the UK (Prostate Cancer UK, 2018). Figures show that 11,819 men now die from prostate cancer every year in the UK, compared to 11,442 women dying from breast cancer. It means the male-only disease is now the third most common cancer to die from, after lung and bowel cancer. There is a valid purpose to link sexual health to prostate cancer and this should be a rationale for sexual health services and sexual health researchers to consider if meaningful engagement with South Asian men is required.

As mentioned earlier in this chapter, qualitative sexual health research with South Asian men is effective when aligned to a health topic which is prevalent to a local community. This may mean aligning sexual health with a health topic such as cardiovascular disease or diabetes which is prevalent within the South Asian communities in the UK. At this moment in time, sexual health research with South Asian men as a standalone topic is challenging to pursue. Using a research approach which targets individuals rather than groups, unless a distinct group is required, is the preferred approach by South Asian men. Determining the sexuality, age and specific ethnicity of South Asian men is important along with understanding the local demographics and South Asian culture.

6.4 Concluding remarks: What are the next steps and unanswered questions?

Initially, this study commenced to answer less explained and less explored issues regarding the individual and community perspectives of South Asian men's sexual health. In doing so, more questions than answers arose on issues which included the impact of migration on South Asian men's sexual health, differences of sexual attitudes and behaviours amongst South Asian men in England and the Indian sub-continent, the sexual health status of South Asian men in comparison to men from non-South Asian backgrounds, South Asian men's sexual health in relation to specific ethnicity, age and sexuality, comparison of South Asian men's sexual health culture amongst urban populations in England, the role of religious and cultural influences on sexual health, homophobia within South Asian communities, finding an appropriate sexual health theory/ research methodology to deliver research on sexual health with South Asian men, South Asian men and sexual activity and contraception, etc. There are a number of unanswered questions from this study

which were not anticipated at the research conceptual stage of this study. In my opinion, this study answered the initial research aim and questions but in doing so uncovered many areas which had not been initially considered.

Fundamentally, what this research shows is that there is a need to understand the impact of migration on sexual health as demonstrated by Mole et al (2014). There is an importance to understand the local environment of South Asian men and contextualise research and using a research approach to suit South Asian men's local environment. It is important to understand the social environment of South Asian men and understand the educational attainment and income levels of those South Asian men who are targeted in sexual health research. Qualitative research on South Asian men's sexual health in the future needs to take the above factors into account as well as understand the local demographics and South Asian culture.

This study shows that South Asian men are willing to take part in sexual health research, but only if researchers can provide a safe environment for individuals to engage which ensures privacy and non exposure in their own South Asian community. Sexual health research needs to have clear objectives and determine a distinct target group. Sexual health researchers require undertaking preparatory work the target community to help individuals from the community to meaningfully contribute to sexual health research and aligning sexual health research with acceptable health topics in the South Asian community will result in a positive impact amongst South Asian men and the South Asian community.

This chapter demonstrates the complexity of undertaking sexual health research, whether this is with South Asian men or men from non-South Asian communities. There was an interest for this study to focus on South Asian men due to the literature review undertaken and identifying the lack of information on the individual and community perspectives of South Asian men's sexual health. Interestingly, South Asian men mentioned that undertaking research on South Asian men's sexual health in isolation from other communities further detaches them from the wider population. Delivering sexual health research with South Asian men requires an understanding on the role of South Asian men in the South Asian community and the wider community. South Asian men need to be involved in discussions on identifying the appropriate research approaches to be delivered in their local community. The success of sexual health research with South Asian men depends on identifying the appropriate research approach which recognises South Asian men's religious and cultural influences, local South Asian culture and relevance of sexual health to other health matters prevalent in the South Asian community.

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Appendix 1

Literature Review – search results

Key Search Terms	Academic Search Elite (EBSCO host)	ACP Journal Club	BioMed Central	CINAHL/ Medline/ PscyARTICLES/ PsyInfo	Cochrane Controlled Trial Register (OVID)	Cochrane Database of Systematic Reviews (CDSR) (OVID)	Embase (OVID)	Ethos: Electronic Theses Online Service	Evidence-Based Medicine Reviews (OVID)	Health Technology Assessment Database (OVID)	Intermid/ Internurse	Journal TOCs	NICE Evidence Search	SAGE Premier Journals	Social Care Online	Social Policy and Practice	TRIP Database	Web of Science	ZETOC Search	Total
Research																				
Research & sexual health	8,309 (320) (41)	1	11,494	12,323 (223)	162	109	7,319 (60)	72	142	7	4,200 (38)	671	10,850	1,59,444 (120,835) (14,974)	16,188	568	508,022 (419)	24,392	4,670	85,081
Research & BME communities	26 (13)	0	139	52 (15)	0	0	20	13	0	0	74	2	1,609	505	8,976	113	194,834 (309)	64	42	11,894
Research & South Asian men	82 (20)	0	2,064	103 (19)	0	1	73	12	1	0	194	0	1,669	24,903	3,785	1	426,593 (241)	1,242	67	34,292
Involvement																				
Public involvement & research	1,009 (140)	0	35,835	1,369 (167)	19	10	502	36	10	3	6,504	364	12,211	355,834	9,857	84	45,333 (271)	7,636	1,962	431,445
South Asian men & public involvement	0	0	428	0	0	0	0	0	0	0	86	0	943	16	2,166	0	1,500 (18)	37	0	3,694
South Asian men, public involvement, sexual health	3	0	131	0	0	0	0	0	0	0	32	0	514 (335)	6,885	1,149	0	35	3	0	8,541
Sexual health																				
Ethnicity & men's sexual health	11	0	11	18	0	0	7	3	0	0	450	0	19	28,228	4,087	0	28,809 (93)	4	0	32,931
Sexual health and BME communities/ BME men	1	0	10	2	0	0	3	0	0	0	31	0	1,183	167	18,087	6	9,324 (172)	3	2	19,667
Sexual health & South Asian men	4	0	377	8	0	0	2	0	0	0	99	0	752 (483)	9,740	5,815	0	22,191 (147)	372	8	17,055
Total	233	1	50,489	452	181	120	667	136	153	10	7,508	1,037	29,302	441,252	70,110	772	1,705	33,753	6,751	644,600

Appendix 2

Literature Review – study relevant documents

Database	Document Number							
Academic Search Elite (EBSCO host)	1	2	3	4	5	6	7	8
Author	Dhar, Jyoti. (2010) How and why do South Asians attend GUM clinics? Evidence from contrasting GUM clinics across England.	McKeown, E. et al. (2010) Disclosure, discrimination and desire: experiences of Black and South Asian gay men in Britain.	Cremin, M. (2015) Meeting the unmet needs of BME men with prostate cancer.	Sass, B. et al. (2009) Enhancing pathways to care for BME populations: A systematic review.	Chitembo, A. (2012) Towards an HIV-free generation: getting to zero or getting to rights?	McKeown, E. et al. (2012) The experiences of ethnic minority MSM using NHS sexual health clinics in Britain.	Mercer, C. et al. (2015) Examining the potential public health benefit of offering STI testing to men in amateur football clubs: evidence from cross-sectional surveys.	Saggurti, N. et al. (2011) The interrelationship of men's self-reports of sexual risk behaviour and symptoms and laboratory-confirmed STI status in India.
Summary	South Asians report low levels of sexual ill health, few data exist regarding their use of genitourinary medicine (GUM) services. South Asian men who attend GUM clinics were reported to attend as they wanted HIV test. Sexual health services need to develop locally-delivered culturally appropriate initiatives to improve care pathways.	Cultural barriers prevent the disclosure of sexuality to family amongst Black and South Asian gay men in Britain. Among South Asian gay men, a major theme was regret at being unable to fulfil family expectations regarding marriage and children. Importance of social location, particularly education and income, when examining the	Men with prostate cancer from BME communities have reported many unmet information and support needs. Not enough is known about the psychosocial effects of a prostate cancer diagnosis on men from BME communities in the UK. Health professionals should look beyond the physical effects and consider the psychosocial	Improving pathways to care is an important part of UK Government policy on delivering equitable treatment for black and minority ethnic (BME) patients. However, there is little guidance on how this can be achieved. This systematic review aimed to evaluate research studies reporting initiatives to enhance	Paper discussing a global plan towards tackling HIV. Recommendations include supporting women and babies in prevention of HIV.	To compare the experiences of ethnic minority and white British men who have sex with men (MSM) who attend sexual health clinics in Britain. Sexual health clinics need to be aware that some ethnic minority MSM, particularly those from and Indian, Pakistani or Bangladeshi background, have heightened concerns about clinic attendance	In Britain, young people continue to bear the burden of sexually transmitted infections (STIs) so efforts are required, especially among men, to encourage STI testing. The SPORTSMART study trialled an intervention that sought to achieve this by offering chlamydia and gonorrhoea test-kits to men attending	This paper describes the interrelationship among men's self-reports of symptoms, unsafe sexual behaviour, and biologically tested sexually transmitted infections (STIs). Results suggest that the self-reported STI-like symptoms and unsafe sexual behaviour taken together as a predictor of confirmed STIs improve the sensitivity to a

		intersection of ethnicity and sexuality in future research.	effects of such a diagnosis when assessing the needs of BME men.	pathways to mental health care for BME groups. Consequently, there is currently a dearth of information on which to build evidence-based guidance for service development. Evidence that is available is mainly not from the UK and hence needs to be treated with caution.		and confidentiality compared with white British MSM.	amateur football clubs between October and December 2012. Offering STI testing in amateur football clubs may widen access to STI testing and health promotion messages for men at higher STI risk, which, given the minority currently testing and the popularity of football in England, should yield both individual and public health benefit.	significantly greater degree as compared to the sensitivity of self-reported STI-like symptoms or unsafe sexual behaviour alone as a predictor of confirmed STIs.
	Document Number							
	9	10	11	12	13	14	15	16
Author	Schensul, S. et al. (2004) Responding to Men's Sexual Concerns: Research and Intervention in Slum Communities in Mumbai, India.	Griffiths, C. et al. (2008) Are one-stop shops acceptable? Community perspective on one-stop shop models of sexual health provision in the UK.	Logie, C. et al. (2000) Adapting the minority stress model: Associations between gender non-conformity stigma, HIV related stigma and depression among men who have sex with men.	Herbert, K. et al. (2016) The prevalence of erectile dysfunction in heart failure patients by race and ethnicity.	Same, R. et al. (2014) Sexual and reproductive health care: Adolescent and Adult Men's willingness to Talk and Preferred Approach.	Connell, P. et al. (2004) Investigating ethnic differences in sexual health: focus groups with young people.	Weston (2003) Public honour, private shame and HIV: Issues affecting sexual health services delivery in London's South Asian communities.	Dougan, S. et al. (2005) Epidemiology of HIV among Black and Minority Ethnic men who have sex with men in England and Wales.
Summary	This paper reports on multi-year,	Traditionally, GUM and	Study on stigma and mental	Study in United States to	Research to examine	Focus group study with young	Paper considers how socio-	Examines the epidemiology of

	multi-level research and intervention project to assess men's culturally based sexual health concerns to utilise those concerns in the development of HIV/STD risk reduction and treatment programmes in urban communities in Mumbai, India.	contraceptive services have been provided separately. Providing these services on one site, as a one-stop shop, has been suggested as a way of improving access to care. Knowledge of one-stop shops was limited. The concept was acceptable to participants. South Asians associated stigma with GUM, preferring instead a general practice one-stop shop. In terms of acceptability there can be no blue print one-stop shop model. Local assessments should decide whether a one-stop shop should have public health benefit and if so how best one should be set up to maximise access.	health among men who have sex with men (MSM) in India.	examine erectile dysfunction (ED) in male patients with heart failure.	participant's willingness to talk about 11 sexual and reproductive health topics. Study undertaken with 346 men aged between 16 - 35 years. All men were willing to talk about all SRH topics. Findings indicate that adolescent and adult men are willing to discuss a wide range of SRH topics with their healthcare provider.	people investigating the differences in sexual health. The study identified ethnic differences in terminology, awareness of sexually transmitted infections, non-exclusive sexual relationships, and experience of sexual health services. Gender had a greater influence on normative beliefs.	cultural factors affect the provision of HIV and sexual health services to South Asians in London. It argues that communally held concepts of honour and shame within South Asian communities create a framework of social control with significant implications for HIV/AIDS transmission.	HIB among BME men who have sex with men (MSM) in England and Wales, using ethnicity data from two national HIV/AIDS surveillance systems (1997, 2002). BME MSM accounted for just over 1 in 10 new HIV diagnosis among MSM in England and Wales.
	Document Number							
	17							

Author	Hasan, MD. K. (2015) Rethinking Gender, Men and Masculinity: representations of Men in the South Asian Reproductive and Sexual Health Literatures.	
Summary	Paper explore the issue of relatively little research to date has focused to gender and health on men in South Asian contexts. Paper argues the need to rethink men, gender and sexual health in South Asian contexts.	
Inclusion/ Exclusion		
Database	Document Number	
ACP Journal Club (Ovid)	1	
Author	Sacks, H. (2015) Preexposure tenofocir-emtricitabine reduced HIV infection in men who have unprotected anal sex with men.	
Summary	Randomised Control Trial of men who have anal sex with men (MSM).	

BioMed Central	Document Number				
	1	2	3	4	
Author	Greenwood, N. et al. (2014) The influence of ethnic group composition on focus group discussions	Green, G. (2016) Power to the people: To what extent has public involvement in applied health research achieved this?	Iqbal, G. et al. (2012) UK ethnicity data collection for healthcare statistics the South Asian perspective.	Fish, J. et al. (2016) Equality in sexual health promotion: a systematic review of effective interventions for Black and Minority Ethnic men who have sex with men.	
Summary	Paper to explore the impact of relative ethnic homogeneity and heterogeneity of focus group participants on the group discussions; improve understanding of homogeneity and heterogeneity in focus groups; suggest ways to operationalise concepts such as being 'more comfortable' with other focus group participants. Considerations around focus group participant demographic homogeneity and heterogeneity are complex and these terms may	Paper examines what extent public involvement has been achieved in applied health research. The National Institute for Health Research (NIHR) has succeeded in ensuring patient and public are a key part of the applied health and social care research infrastructure. Paper suggests that a consumerist approach is still predominant and that in reality the public voice has limited impact upon the research design or upon with	Study used five focus groups, 36 South Asian volunteers on ethnicity data. The study confirmed that the collection of patients' ethnicity data is deemed important by potential patients but there remains uncertainty and unease as to how the data may be used.	Systematic review of effective interventions for BME men who have sex with men. Research into the mechanisms and underpinnings of future sexual health interventions is urgently needed in order to reduce HIV and other sexually transmitted infections among UK BME MSM. The design of such interventions should be informed by the members of these groups for	

	be most usefully applied only in relative terms.	research gets funded. The biomedical model would appear to dominate in research decision-making despite the participatory rhetoric.		whom they are targeted to ensure the cultural and linguistic sensitivity of the tools and approaches generated.				
CINAHL/ Medline/ PscyARTICLES/ PsyInfo	Document Number							
	1	2	3	4	5	6	7	8
Author	Lleywellyn, C. et al. (2012) What is it about STI research that is unappealing? An experience of conducting sexual health research in general practice in England.	Parker, H et al. (2014) How important is confidentiality in sexual health clinics? A survey of patients across 51 clinics in England.	Mole, R.C. et al. (2014) The impact of migration on the sexual health, behaviours and attitudes of Central and East European gay/ bisexual men in London.	Adolescence Education Newsletter. (2009) Needs assessment report for a young people's sexual health project in West Bengal.	Hawkes, S. (1998) Providing sexual health services for men in Bangladesh.	Bojko, M.J. et al. (2010) Sexual health, marital sex, and sexual risk in urban poor communities in India.	Pryce, A. (2004) "Only odd people wore suede shoes". Careers and sexual identities of men attending a sexual health clinic.	Elliott M, N et al. (2015) Sexual minorities in England have poorer health and worse health care experiences: a national survey.
Summary	Developing sexual health services in primary care is recommended as a way of improving patient choice and increasing the capacity of testing services. This is a survey study of sexually transmitted infection (STI) testing service users' preferences for STI testing	Survey stressing the importance of patient confidentiality when using sexual health service clinics in the UK.	Study found that the sexual behaviours with gay/bisexual male migrants from Central and Eastern Europe have been significantly influenced by the process of migration itself.	Study on the sexual health problems and information needs of young people in urban and rural West Bengal. Study in 1997, targeting both male and female adolescents aged between 12 - 19 years. A lack of sexual awareness of	Paper studies male sexual health services in Bangladesh in the 1990's.	Article explores marital sex and its link to men's extramarital sexual behaviour in 3 economically marginal communities in Mumbai, India.	Paper concerned with the ways in which men construct and explain sexual identity.	Study to compare the health and health experiences of sexual minorities with heterosexual people of the same gender, age, race/ethnicity, and socioeconomic status. Survey sent to 5.56

	services.			sexual health issues and knowledge of the human anatomy.				million randomly sampled adults registered with NHS general practice. Sexual minorities suffer both poorer health and worse healthcare experiences. Efforts should be made to recognise the needs and improve the experiences of sexual minorities.
	Document Number							
	9	10	11	12	13	14	15	16
Author	McCarthy, O et al. (2012) What young people want from a sexual health website: design and development of Sexunzipped.	Prah, P. et al. (2015) Asking about sex in General Health Surveys: Comparing the methods and Findings of the 2010 Health Survey for England with those of the Third National Survey of Sexual Attitudes and Lifestyles.	Mason, L. (2005) Knowledge of sexually transmitted infections and sources of information amongst men.	Gerressu, M. et al. (2009) Sexually transmitted infection risk exposure among Black and Minority Ethnic youth in Northwest London: Findings from a study translating a sexually transmitted infection risk-reduction intervention to the UK setting.	Edelman, N. and Barron, D. (2016) Evaluation of public involvement in research: time for a major re-think?	Brett, J. et al. (2014) Mapping the impact of patient and public involvement on health and social care research: a systematic review.	Oliver, S. et al. (2015) Public Involvement in research: making sense of the diversity.	Staley, K. et al. (2014)'The missing links': understanding how context and mechanism influence the impact of public involvement in research.
Summary	Study to explore	While a relatively	Study to	Study amongst	Paper suggests	This study	Paper presents	Paper

	young people's views on what elements of a sexual health website would be appealing and engaging, and their views on what elements of a sexual health website would be appealing and engaging, and their views on the content, design, and interactive features of the 'Sexunzipped' intervention website. It is challenging to meet all of young people technological and design requirements; consultation with the target audience is valuable and necessary in developing an online sexual health intervention.	high response to sexual health questions in HSE 2010 demonstrates the feasibility of asking such questions in a general health survey, differences with NATSAL-3 do exist.	investigate men's awareness of sexually transmitted infections and sexual health services amongst men aged 16 and over in two primary care trust regions in the North-west of England. Men's knowledge of STI is limited, particularly in relation to the symptoms. Best way of providing information according to respondents is through their GP.	young people in aged 13 - 27 years. Knowledge of STI and condom use skills is not enough to equip young people with the means to reduce STI risk. Young men made conscious decisions regarding sex and condom use, whereas young women experienced persuasion, deceit and difficulty in requesting condom use.	the need to revisit the purposes and values that underpin public involvement in research in each stage of the research process.	provides the first international evidence of patient and public involvement that has emerged at all key stages of the research process. However, much of the evidence base concerning impact remains weak and needs significant enhancement.	a coherent framework for designing and evaluating public involvement in research by drawing on an extensive literature and the authors' experience.	emphasises the need for intentional and explicit exploration of the links between context, mechanism and outcome, applying the principles of realistic evaluation to public involvement in research help towards positive outcomes.
	Document Number							
	17	18	19	20	21	22	23	24
Author	Haguire, K. et al. (2014) Valuing patient and public involvement in	Staniszewska, S. (2009) Patient and public involvement in	Chambers, E. et al. (2009) Patient and public	Staniszewska, S. (2013) Patient and public involvement in	Ashcroft, J. et al. (2016) Impact on the individual: what do patients	Hall, V. (2009) Reflections on engaging in participatory	Samangaya, M. (2007) Access to sexual health services for	Tariq, S. et al. (2007) Sexual health services for South Asians

	research.	health services and health research: a brief overview of evidence, policy and activity.	involvement in community research.	research: future challenges.	and carers gain, lose and expect from being involved in research?	research.	young BME men.	in London, UK: A case-control study.
Summary	An article that provides recommendations for meaningful patient and public involvement in research. Recommendations include using both electronic and traditional media to disseminate messages among the research team and to the public about the research that is taking place, giving participants an opportunity to provide feedback and recognising the range of expertise that patients and the public have, including lived experience of medical conditions, service use, experiences as research participants and understandings of different social and cultural	Paper which encourages the use of quantitative measures alongside qualitative measures to strengthen the impact evaluation of PPI in research.	Unable to locate document	This paper suggests that whilst PPI activity has increased, the evidence base underpinning PPI activity remains relatively weak, primarily because of poor reporting with many studies only providing partial information. More PPI information and measures are required.	Study on how and why patients and carers have been involved in research and its impact on them. Results show that benefits included the provision of a life focus and an improved relationship with illness, that there were less positive experiences on time, money, and lack of acknowledgement. Need to promote patient and public involvement in research.	Paper describes the recent growth of service user or public involvement in health research and aligns it to the emergence of a new paradigm that provides a framework to underpin this type of participatory research. Paper concludes by proposing that working in this way requires the researcher to personally address power differentials and to acknowledge and embrace the potential for cross-cultural challenges.	Study using questionnaires at a nurse-led sexual health drop in services among men aged 16 - 25 years. Attendance from BME men was lower than of white men. Embarrassment was the major factor hindering the use of services. Sexual health services are needed in places frequented by young people from BME groups.	A case-control study was undertaken in 2 London GUM clinics. South Asians less likely to have sexually transmitted infections. South Asians were significantly more likely than controls to have been referred by other medical services rather than self-referred which is in keeping with poorer access to GU medicine services in London.

	issues.							
	Document Number							
	25							
Author	Elford, J. et al. (2012) HIV infection among ethnic minority and migrant men who have sex with men in Britain.							
Summary	Examines HIV infection among men who have sex with men (MSM) from different ethnic and migrant groups living in Britain. Highlights the importance of health promotion targeting MSM from all ethnic and migrant groups in Britain.							
	Document Number							
Cochrane Controlled Trial Register	1							
Author	Bailey, J. V. et al. (2016) The men's safer sex project: intervention development and feasibility randomized controlled trial of an interactive digital intervention to increase							

	condom use in men.		
Summary	Report details the development of the Men's Safer Sex website and the results of a feasibility randomised controlled trial and qualitative evaluation.		
Cochrane Database of Systematic Reviews (CDSR)	Document Number		
	1	2	
Author	Anderson, L. et al. (2015) Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations.	Shefer, G. et al. (2013) 'Our community is the worst': the influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London.	
Summary	Study to assess the effects of community coalition driven interventions in improving health status or reducing health inequalities. A definitive	Existing knowledge about the cultural beliefs of black and minority ethnic (BME) communities in the UK regarding stigma and	

	answer as to whether a coalition-led intervention adds extra value to the types of community engagement intervention strategies described in this review remains unattainable.	mental illness is limited. Thematic analysis identified that cultural beliefs regarding mental illness reflect four different voices present within the BME communities. The study revealed that cultural beliefs influencing both relationships with family and, consequently, help-seeking for individuals with mental illness must be considered in the development of anti-stigma interventions and when engaging communities around mental health.	
	Document Number		
Evidence-Based Medicine Reviews	1		
Author	Bailey, J. et al. (2010) Interactive computer-based interventions for sexual health promotion.		

Summary	Interactive Computer Based Interventions (ICBI) are effective tools for learning about sexual health and they also show positive effects on self-efficacy, intention and sexual behaviour. More research is needed to establish whether ICBI can impact on biological outcomes, to understand how interventions might work, and whether they are cost-effective.							
Intermid/ Internurse	Document Number							
	1	2	3	4	5	6	7	8
Author	James, P. (2009) National Policy and sexual health of men who have sex with men	Barber, C. (2015) Men's health, article 10: sexual health and men.	Enson, S. (2013) Analysing issues in sexual health outreach provision	Ochieng, B. and Meetoo, D. D. (2017) Sexual-health beliefs among minority ethnic families in the North of England	Croghan, E. (2013) Sexual health: is it different for young ethnic minority people?	Cremin, M. (2015) Meeting the unmet support needs of BME men with prostate cancer	Singh, I. et al. (2013) Health and health care in South Asian communities in the UK.	Peate, I. (2013) Support workers and the challenges for men's health
Summary	Article on the role of nursing to help deliver the Department of Health's 10 year National Strategy	Article discusses male sexual health and highlights a number of ways in which	Article on systematically reviewing sexual health outreach provision for young people.	Study to explore beliefs and attitudes regarding sexual health among minority ethnic	Article on study to discover the sexual health service needs of young people, particularly those	A literature review was undertaken to identify the challenges specific to caring	Paper highlights the ethnic health differences between populations and the role of race	Article on men's health in the UK. Men's health is influenced by differing factors to women's

	for Sexual Health and HIV (2001) and the Government's White Paper, Choosing Health (2004). Government policy if failing to significantly reduce the transmission of HIV and STI's among MSM, despite a £300 million cash boost. Sexual health of MSM needs responsible funding alongside more robust and effective evidence-based preventative strategies to help nurses.	healthcare assistants can offer support and help.	Involving young people into all aspects of service provision is paramount.	families. Participants' description of sexual health education fell into three broad themes; Black families' concept of sexual health, sexual disclosure in the home and the need for culturally appropriate sexual health promotion.	from BME groups. Study concludes with recommendations on the characteristics of an ideal service, staff characteristics, service location, opening times, encouraging use by BME groups and sex and relationship education.	for men with prostate cancer from BMR communities in the UK. Men with prostate cancer require information and psychosocial support. There needs to be further understanding on the attitudes and cultural beliefs of men from BME communities towards healthcare.	in the delivery and experience of healthcare.	health and it is necessary to convince men to change their behaviour in order to improve their levels of health. This is a complex area that must be explored further.

	Document Number		
	9	10	
Author	Peate, I. (1997) Testicular cancer: the importance of effective health education	Barber, C. (2014) Inside the male psyche: men and healthcare	
Summary	Article on testicular cancer amongst men in the UK. Health education programmes concerning	This article suggests social attitudes around what it is to be a man are likely to have a major impact on how	

	testicular cancer need to take into account complexities such as cultural diversity, if patients are to heed vital and in some case life-sustaining advice.	men view themselves and any healthcare issues that they may experience. Most of these attitudes are deep-rooted and are likely to be manifest from birth onwards.	
Journal TOCs	Document Number		
	1	2	
Author	Pui-Hing Wong, P. et al. (2017) Understanding the sexuality and sexual health of Muslim young people in Canada and other Western countries: A scoping review of research literature	Baptiste-Roberts, K. et al. (2016) Addressing Health Care Disparities Among Sexual Minorities	
Summary	Muslim communities comprise one of the fastest growing populations in Canada and other Western countries. Healthcare providers and educators point to the lack of relevant and inclusive sexual health information as a major barrier	There is evidence of health disparities between sexual minority and heterosexual populations. Although the focus of lesbian, gay, bisexual, and transgender health research has been human immunodeficiency virus/acquired immunodeficiency	

	in promoting Muslim young people's sexual health. This paper reports on the major themes identified through the review: (1) sexual health knowledge and perspectives on sex education; (2) socialisation and conflicting values about sexuality; (3) gender, risks and sexual practices; and (4) sexual health information and service needs. The study concludes that the lack of research on sexuality and sexual health of Muslim young people poses a challenge for policy-makers, service providers, sex educators and other stakeholders to gain sufficient understanding to guide the development of effective and inclusive sexual health programming for Muslim young	syndrome and sexually transmitted infection among men who have sex with men, there are health disparities among sexual minority women. Using the minority stress framework, these disparities may in part be caused by individual prejudice, social stigma, and discrimination. To ensure equitable health for all, there is urgent need for targeted culturally sensitive health promotion, cultural sensitivity training for health care providers, and intervention-focused research.	

	people in Canada and other Western countries.			
NICE Evidence Search	Document Number			
	1	2	3	
Author	Johal, A. et al. (2012) Invisible men: engaging more men in social projects	Boourne, A. et al. (2014) The chemsex study: drug use in sexual settings among gay and bisexual mean in Lambeth, Southwark and Lewisham	National Prostate Cancer Audit(2016) Prostate cancer Audit 2016 Annual report	
Summary	Report explores the barriers that exist which prevent from engaging with social projects at a beneficiary level and looks at how to overcome these barriers to ensure effective engagement. Report findings include men are more resistant to seek help from others than women, men's reluctance to engage with certain types of projects can be due to social stigma, men from	Report on drug use in sexual settings among gay and bisexual men in Lambeth, Southwark and Lewisham. Report does not recommend social marketing campaign on the dangers of chemsex. Instead, the report recommends ensuring access for men to gay-friendly drug and sexual health services, co-ordinated work with managers of commercial sex-	Third annual report demonstrating the results of the National Prostate Cancer Audit and Patient Survey. Prostate cancer is the most frequently diagnosed solid cancer in men and the second most common cause of cancer-related death in the UK.	

	BME backgrounds are hard to reach and addressing the needs of society avoids examining problems in terms of gender and focus on cultural background, age and economic situation instead.	on-premises and co-ordinated engagement with commercial companies and gay media.		
SAGE Premier Journals	Document Number			
	1			
Author	Tong, S. E. and Low, W. E. (2012) Public Health strategies to address Men's health needs			
Summary	Study on South Asian men's health needs in Malaysia. A better understanding of Asian men's health needs and their health-seeking behaviours is needed.			
Social Care Online	Document Number			
	1	2	3	
Author	Samangaya, M. (2007) Access to sexual health services for young	Khan, S. (1994) Cultural contexts of sexual behaviours and	Gatter, P. (2005) Sexual Health	

	BME men	identities and their impact upon HIV prevention models: an overview of South Asian men who have sex with men		
Summary	Study using questionnaires at a nurse-led sexual health drop in services among men aged 16 - 25 years. Attendance from BME men was lower than of white men. Embarrassment was the major factor hindering the use of services. Sexual health services are needed in places frequented by young people from BME groups.	Paper stressed the need to understand the dynamics of sexuality and the psychosocial aspects of sexual behaviour on the South Asian framework so as to develop appropriate strategies to counter AIDS and STD's.	Paper on HIV transmission and prosecution.	
Social Policy and Practice	Document Number			
	1			
Author	Samangaya, M. (2007) Access to sexual health services for young BME men.			
Summary	Study using questionnaires at			

	a nurse-led sexual health drop in services among men aged 16 - 25 years. Attendance from BME men was lower than of white men. Embarrassment was the major factor hindering the use of services. Sexual health services are needed in places frequented by young people from BME groups.						
Web of Science	Document Number						
	1	2	3	4	5	6	
Author	**Weston, J. (2003) Public honour, private shame and HIV: issues affecting sexual health service delivery in London's South Asian communities**	Hossain, SMM. Et al. (2004) Community development and its impact on health: South Asian experience	**Sinha, S. et al. (2007) 'People make assumptions about our communities': Sexual health amongst teenagers from black and minority ethnic backgrounds in East London.**	**Bradby, H. and Wlliams, R. (1999) Behaviours and expectations in relation to sexual intercourse among 18-20 year old Asians and non-Asians**	Tariq, S. et al. (2007) Sexual health services for South Asians in London, UK: a case control study	Doemer, R. et al. (2012) Sexual mixing and HIV risk among Ethnic Minority MSM in Britain	
Summary	**Paper focused on how socio-cultural factors affect the provision of HIV and sexual**	Most South Asian governments have concentrated on emulating a Western style of	**Study to explore sexual behaviour amongst BME teenagers in East London**	**Study to map the reported behaviours and attitudes of young British South Asian**	A case-control study was undertaken in 2 London GUM clinics. South Asians less likely	A cross-sectional online survey of men who have sex with men (MSM) living in Britain in	

	health services to South Asians in London. The paper argues that communally held concepts of honour and shame within South Asian communities create a framework of social control with significant implications for HIV/AIDS transmission.	healthcare service, with the result that an elite few are over medicalised whereas the majority are neglected. However, community participation in the development of local health services could provide a solution	**examining how these relationships are shaped by culture, gender, peer norms and religion. The multiplicity of factors affecting sexual attitudes/ behaviour requires a range of contraceptive, counselling, screening and sex education services available for all teenagers, although delivery patterns may differ in response to differing needs.**	**people in Glasgow that may have implications for sexual health. South Asian men were less likely than non-South Asian men to report using a condom.**	to have sexually transmitted infections. South Asians were significantly more likely than controls to have been referred by other medical services rather than self-referred which is in keeping with poorer access to GU medicine services in London.	2007-2008.	

Appendix 3
Sample of developing codes and themes

Participant Data/ Phrases/ Quotations	Codes; patterns, sequences, commonalities and differences	Themes/ Groups
Participant Six (PAR Group Session One): "Yes, you won't see Asian people sitting amongst each other discussing sexual health in their house. White communities will talk about sex. In [South] Asians it's a shame thing. You don't talk about sex in front of your parents, even if it's positive, you don't. It's out of respect"	*"You **won't see Asian people** sitting amongst each other discussing sexual health in their house"*	Lack of discussion in South Asian families
	***"White communities will talk about sex**"*	Misconception regarding non-South Asian communities
Participant Two (PAR group): "I personally wouldn't talk to family and friends if I did have any concerns; it's just something you don't discuss in an open way with family and friends. I'm a personal person so it would be private"	*"In [South] Asians it's a **shame** thing"*	Shame
	*"You don't talk about sex in **front of your parents,** even if it's positive, you don't. It's out of **respect**"*	Respect/ stigma
Participant Two (PAR Group Session Five): "The biggest barrier is that our parents and we as parent fail to have this conversation on sexual health issue because this is not done within [South] Asian families, because sex outside of marriage is not acceptable"	*"I personally wouldn't talk to family and friends if I did have any concerns; it's just something you don't discuss in an open way with family and friends. I'm a personal person so it would be **private**"*	Privacy
Participant Two (PAR Group Session Five): "The main thing is that it is the way we are brought up. Even though we are born and bred here, it's not part of our culture; this is not something we talk about. I can't say I have had these conversations with my parents, or my parents have sat me down and discussed this. It's probably done in non-[South] Asian families, probably White families, when they say use protection. It's not done in our culture and our society. Obviously this is something new for me"	*"The biggest barrier is that our **parents** and we as parent fail to have this conversation on sexual health issue because this is not done within [South] Asian families, because sex outside of marriage is not acceptable"*	Parental influence Respect
		Stigma and shame
	*"The main thing is that it is the way we are brought up. Even though we are born and bred here, **it's not part of our culture**; this is not something we talk about. I can't say I have had these conversations with my **parents**, or my parents have sat me down and discussed this. It's probably done in **non-[South] Asian families, probably White families**, when they say use protection. It's not done in our*	Stigma and shame
Participant Three (PAR Group Session One): "White communities are more open to talk in their families, it runs in their culture"		
Participant One (PAR Group): "It's not discussed in the open arena; it's always behind closed doors. There's less taboo in the Western community"		Parental influence Respect
		Misconception of

	culture and our society. Obviously this is something new for me" *"White communities are more open to talk in their families, it runs in their culture"* *"It's not discussed in the open arena; it's always behind closed doors. There's less taboo in the Western community"*	non-South Asian communities Misconception of non-South Asian communities Stigma and shame
Participant Two (PAR Group Session Five): "I think the issue of sexual health is more relevant for the younger community than the older community as they are the ones more sexually active. Older people won't discuss a sexual health issue which is a key barrier. Some young people I spoke to are more tuned to the issue. They know about the general stuff. Some young people said they have no need to visit a sexual health services as they are not sexually active. They said in our religion we can't have sex before marriage. The conversation with them stopped"	*"I think the issue of sexual health is* ***more relevant for the younger community than the older community as they are the ones more sexually active****.* ***Older people won't discuss a sexual health i****ssue which is a key barrier. Some young people I spoke to are more tuned to the issue. They know about the general stuff. Some young people said they have no need to visit a sexual health services as they are not sexually active. They said in our* ***religion we can't have sex before marriage****. The conversation with them stopped"*	Sexual attitudes and behaviour vary amongst different age groups Religious influences
Participant Two (PAR Group Session Two): "It's like a taboo subject, how do you bring it to the forefront of discussion, by discussing it in this kind of way, people are becoming more open to different views and different ways of addressing certain problems. In that sense it's constructive. They feel more confident to talk about it. Even amongst us when we first started the training session, looking at it on a deeper level it generated debate, it opened things up; people started understanding the issues. We identified what the barriers are for South Asian people. It's not something we are comfortable with discussing with family and friends or groups. If we did want to address the issue how do we do it?" *Participant Two (PAR group): "Personally I wouldn't want to be involved, if I went out in the community and promoted men's MOT sexual health, people might think I had one of the illnesses and label me and this can affect my kids*	*"It's like a taboo subject, how do you bring it to the forefront of discussion, by discussing it in this kind of way, people are becoming more open to different views and different ways of addressing certain problems. In that sense it's constructive. They feel more confident to talk about it. Even amongst us when we first started the training session, looking at it on a deeper level it generated debate, it opened things up; people started understanding the issues. We identified what the barriers are for South Asian people. I****t's not something we are comfortable with discussing with family and friends or groups****. If we did want to address the issue how do we do it?"*	Stigma and shame

at school" *Participant Two (PAR Group Session Six): "'Sexual health has negative connotations and consequences"* *Participant Four (PAR group): "Taboo, we don't think we are associated with sexual health or related to STI's, the negative sides, disease, and sexual ill health"* *Participant Two (PAR Group Session Two): "I think it's the terminology that is used. If you are talking about sexual health, it's automatically associated with the actual deed; it's not associated with all the other problems you can have. It's the way it's worded. If you used terms like 'men's health' then response and the input from different people will be completely the opposite"* *Participant One (PAR Group Session Six): "Maybe we need to move away from using the term 'sexual health' altogether and rephrase it differently. The minute you say sexual health it's all about sex"* *Participant Four (PAR group): "Barriers which are accepted and not accepted by the community. Unfortunately sexual health is not accepted in the South Asian community. As soon as you mention sex… they back off, and this stops me, it's like banging your head against a brick wall"* *Participant Seven (PAR group): "Yes, in other communities it's more open, flexible and there is more understanding in this area. In our [South Asian] community there are things like culture, family, honour, respect that will hold a person back from being open. A lot of these problems arise when you are messing about, sharing partners, or different activities, experimenting different things"*	*"Personally I wouldn't want to be involved, if I went out in the community and promoted men's MOT sexual health, **people might think I had one of the illnesses and label me** and this can affect my kids at school"* *"'Sexual health has **negative connotations and consequences**"* *"Taboo, we don't think we are associated with sexual health or related to STI's, the negative sides, **disease, and sexual ill health**"* *"I think it's the terminology that is used. If you are talking about sexual health, it's automatically associated with the **actual deed**; it's not associated with all the other problems you can have. It's the way it's worded. If you used terms like 'men's health' then response and the input from different people will be completely the opposite"* *"Maybe we need to move away from using the term 'sexual health' altogether and rephrase it differently. The minute you say sexual health **it's all about sex**"* *"Barriers which are accepted and not accepted by the community. **Unfortunately sexual health is not accepted in the South Asian community**. As soon as you mention sex… they back off, and this stops me, it's like banging your head against a brick wall"* *"Yes, **in other communities it's more open**, flexible and there is more understanding in this area. In our [South Asian] community there are things like culture, **family, honour, respect** that will*	Stigma and shame Stigma and shame STI Stigma and shame Stigma and shame Misconception of non-South Asian communities Respect

	hold a person back from being open. A lot of these problems arise when you are messing about, sharing partners, or different activities, experimenting different things"	
Participant Three (PAR group): "No, I don't think they are widely known….no one talks about them"	*"No, I don't think they are widely known….**no one talks about them**"*	Awareness of services
Participant Four (PAR group): "No, not at the moment because I have never used the services in the past"	*"No, not at the moment because I have **never used the services** in the past"*	Awareness of services
Participant Six (PAR group): "No awareness, because I never had the need to use one"	*"**No awareness**, because I never had the need to use one"*	Awareness of services
Participant Seven (PAR group): "Clear messages about what service[s] do, what sort of service it provides and where it is"	*"Clear messages about what service[s] do, **what sort of service it provides and where it is**"*	Stigma associated to using sexual health services
Participant Seven (PAR group): "Negative, because it's for helping people who need help and there must be something wrong or [they must be] doing something wrong"	*"Negative, because **it's for helping people who need help and there must be something wrong** or [they must be] doing something wrong"*	Stigma associated to using sexual health services
Participant Two (PAR group): "It means there's something wrong. From a cultural point of view these kinds of things shouldn't be happening if an individual is in a marital relationship, but these things do go on in the society we live in. Sexual health within the Asian community is quite a sensitive subject"	*"**It means there's something wrong**. From a cultural point of view these kinds of things shouldn't be happening if an individual is in a marital relationship, but these things do go on in the society we live in. Sexual health within the Asian community is quite a sensitive subject"*	Discretion
Participant Two (PAR Group Session Two): "Everybody wants a discreet service; no one wants to be seen going somewhere, or going to see someone to discuss this issue. It's a confidentiality thing. People are comfortable having anonymity. It's about having some kind of service where you want to use the service and having discretion, where you could go to a drop in centre or use of a telephone line. People are not confident discussing these issues in the open, that's the main thing"	*"Everybody wants a **discreet service**; no one wants to be seen going somewhere, or going to see someone to discuss this issue. It's a **confidentiality** thing. People are comfortable having anonymity. It's about having some kind of service where you want to use the service and having discretion, where you could go to a drop in centre or use of a telephone line. People are not confident discussing these*	Discretion
Participant Two (PAR Group Session One): "People want a discreet service"		
Participant Three (PAR Group Session Two): "It's about times, which are why people say they want		

a 24 hour service, because they don't want to be seen, they can book an appointment or go at night and go freely" *Participant Four (PAR Group Session One): "'Maybe outreach work as well, go to people's houses and work with them one to one"* *Participant Two (PAR Group Session Four): "Would you really want [sexual health services] to come into a marital home and share that you have a sexual transmitted disease and discuss it?"* *Participant Two (PAR Group Session Four): "Visiting people can back fire because men's family can find out about their sexual health issues, if they live on their own then it's ok"* *Participant Two (PAR Group Session Five): South Asian men feel more comfortable talking to men, so when it's a female at the clinic, they can feel embarrassed and shy. So gender is important of the health professional"* *Participant Two (PAR Group Session Four): "G.P's would be in a better position to guide us, as they deal with these issues on a day to day basis, and have first-hand experience. Whereas we as a group haven't had any experience on dealing with these issues"* *Participant Two (PAR Group Session Five): "The first point of call is usually the GP, but not everyone's comfortable about going to a GP. Some people find GP receptionist intimidating as they ask what the problem is. This kind of thing is personal and intimate and sensitive and can be a deterrent. That was the first barrier"* *Participant Two (PAR Group Session Five): "They all said there are not enough awareness of services, and how to book themselves and visit these services. They would not be comfortable discussing this with a GP as the GP would know the family. They said having a sexual health clinic connected to ad-hoc services like Connexions where they can access a range of services at the same time. Youth clubs are important, in comfortable environments"* *Participant Two (PAR Group Session Five):*	*issues in the open, that's the main thing"* *"People want a **discreet service**"* *"It's about times, which are why people say they want a 24 hour service, because they **don't want to be seen**, they can book an appointment or go at night and go freely"* *"Maybe **outreach** work as well, go to people's houses and work with them one to one"* *"Would you really want [sexual health services] to come into a marital home and **share that you have a sexual transmitted disease** and discuss it?"* *"Visiting people can back fire because **men's family can find out** about their sexual health issues, if they live on their own then it's ok"* *"South Asian men feel more comfortable talking to men, so when it's a female at the clinic, they can feel embarrassed and shy. So **gender is important** of the health professional"* *"**G.P's** would be in a better position to guide us, as they deal with these issues on a day to day basis, and have first-hand experience. Whereas we as a group haven't had any experience on dealing with these issues"* *"The first point of call is usually the **G.P**, but not everyone's comfortable about going to a GP. Some people find GP receptionist intimidating as they ask what the problem is. This kind of thing is personal and intimate and sensitive and can be a deterrent. That was the first barrier"*	Discretion Outreach services Confidentiality Confidentiality Confidentiality Role of GP Role of GP

"There's not enough [sexual health] information out there. You can have adverts in weird places like public toilets. You can have a poster in a public place" *Participant Seven (PAR group): "It should be available everywhere, some people might not want to go doctors to get this [sexual health] information. You might hesitate to pick up a leaflet in a GP waiting area so if you had leaflets in other places there are many people who would feel more comfortable and people will not know what you are taking"* *Participant Four (PAR group): "I think it should be everywhere, until you don't have a sexual health issue; you're not exactly going to look out for it. If you only use hospitals and health centres, you are only going to get those people [who go to hospital or health centres]"* *Participant Five (PAR group): "Yes, I think it would be good in various places like local gyms"* *Participant Two (PAR group): "There should be a lot of exposure in different places and not [just] the places you normally would put information"* *Participant Three (PAR group): "I think it should be in all community locations as it raises awareness in the community"*	*"They all said there are not enough **awareness of services**, and how to book themselves and visit these services. They would not be comfortable discussing this with a GP as the GP would know the family. They said having a **sexual health clinic connected to ad-hoc services like Connexions** where they can access a range of services at the same time. Youth clubs are important, in comfortable environments"* *"**There's not enough [sexual health] information** out there. You can have adverts in weird places like public toilets. You can have a poster in a public place"* *"It should be **available everywhere,** some people might not want to go doctors to get this [sexual health] information. You might hesitate to pick up a leaflet in a GP waiting area so if you had leaflets in other places there are many people who would feel more comfortable and people will not know what you are taking"* *"I think it should be **everywhere,** until you don't have a sexual health issue; you're not exactly going to look out for it. If you only use hospitals and health centres, you are only going to get those people [who go to hospital or health centres]"* *"Yes, I think it would be good in **various places** like local gyms"* *"There should be a lot of **exposure in different places** and not [just] the places you normally would put information"* *"I think it should be in all **community locations** as it raises*	Awareness of services Multi-agency approach Sexual health information Sexual health information Sexual health information Community locations Community locations Community locations

	awareness in the community"	
Participant Two (PAR group): "The challenges from a service point of view are bringing people in to use services, how to target individuals in the community, what messages and tools [to] use to engage with people" *Participant Six (PAR group): "South Asian people are a wider range of groups, religiously; you need to see it as a multi-cultural thing and approach community leaders and people from high positions and distribute pamphlets, information"* *Participant Four (PAR Group Session Two): "Community leaders talk about it as a stepping stone or door to open to get other things in as well"*	*"The challenges from a service point of view are **bringing people in to use services, how to target individuals in the community**, what messages and tools [to] use to engage with people"* *"South Asian people are a wider range of groups, religiously; you need to see it as a multi-cultural thing and **approach community leaders and people from high positions** and distribute pamphlets, information"* *"**Community leaders** talk about it as a stepping stone or door to open to get other things in as well"*	Community engagement Community leaders Community leaders
Participant Seven (PAR group): "Not being direct, going round other issues like diabetes and then [introduce] sexual health issues" *Participant Four (PAR Group Session Two): "I think you need to look at different avenues, some services like drug and alcohol services try to go out there and work with the community and they try different avenues. Sometimes the community does not want to know and what do you do then? There's a possibility to work alongside different services to see what barriers they face and what could work or not work"* *Participant Seven (PAR group): "I would think a workshop should not be open, hold back. Talk about other issues blood pressure, cancer, diabetes and other health issues. Win over people over a few sessions, build trust and confidence first and then talk about sexual health issues"* *Participant Three (PAR group): "Try [not] to go against their belief, taking a softer approach, better understanding and communication"* *Participant One (PAR group): "No, it's not ever raised in various languages, only in English which will reach out to young people but not older people, depends how you sell it and if you use various linguistic techniques"*	*"Not being direct, **going round other issues like diabetes** and then [introduce] sexual health issues"* *"I think you need to look at different avenues, some services like drug and alcohol services try to go out there and work with the community and they try different avenues. Sometimes the community does not want to know and what do you do then? There's a possibility to work alongside different services to see what barriers they face and what could work or not work"* *"I would think a workshop should not be open, hold back. Talk about other issues blood pressure, cancer, diabetes and other health issues. Win over people over a few sessions, build trust and confidence first and then talk about sexual health issues"* *"Try [not] to go against their belief, taking a softer approach, better understanding and*	Acceptable health topics in the South Asian community Multi-agency approach Acceptable health topics in the South Asian community Trust building Trust building Multi-lingual services/ information

Participant Six (PAR group): "Language barriers"	*communication"* *"No, it's not ever raised in various languages, only in English which will reach out to young people but not older people, depends how you sell it and if you use various linguistic techniques"* *"Language barriers"*	Language
Participant Four (PAR Group Session Two): "Most people commented on sexual health and came up with sex or homosexuality. I think you could have done a Power Point presentation [of] what is actually sexual health, so people get a clear picture, it's not just about sex, it's not just about homosexuality, there's other aspects to sexual health as well" *Participant Two (PAR Group Session Two): "As soon as you said sexual health, people stigmatised, relating it to homosexuality or men having sex with men….you know about AIDS and HIV. By going on [about] one thing (homosexuality), it's had a negative impact, there's so many issues related to the same subject and not related to sex, those needed to come out more"* *Participant Six (PAR Group Session One): "Being gay is not accepted, although the Church of England has accepted it, it's not going to be accepted in wider society"* *Participant Six (PAR Group Session One): "'If you were gay would you tell your friend you're gay?"* *Participant Four (PAR Group Session Two): "Homosexuality is more about sexual orientation than sexual health or disease"* *Participant Five (PAR group): "At the end of the day it's all the same thing, men are men, no matter what sexuality or culture you come from"*	*"Most people commented on sexual health and came up with sex or* ***homosexuality.*** *I think you could have done a Power Point presentation [of] what is actually sexual health, so people get a clear picture, it's not just about sex, it's not just about homosexuality, there's other aspects to sexual health as well"* *"As soon as you said sexual health,* ***people stigmatised, relating it to homosexuality or men having sex with men….you know about AIDS and HIV****. By going on [about] one thing (homosexuality), it's had a negative impact, there's so many issues related to the same subject and not related to sex, those needed to come out more"* *"Being* ***gay is not accepted****, although the Church of England has accepted it, it's not going to be accepted in wider society"* *"If you were gay w****ould you tell your friend you're ga****y?"* *"****Homosexuality is more about sexual orientation than sexual health or disease****"* *"At the end of the day it's all the same thing****, men are men****, no matter what sexuality or culture you come from"*	Sexual health associated with gay men Sexual health associated with HIV/ AIDS Homophobia Stigma and shame Stigma Sexuality irrelevant

Appendix 4
Research poster (1)

Appendix 5
Research poster (2)

Appendix 6
Phase One - Study Advertisement

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Are you interested in sharing your views of local sexual health services? If the answer is yes then we want to hear from you

- Would you like to share your views in an exciting research project?
- Are you comfortable to be interviewed?
- Would you like to make a difference in your community?
- Are you a member of the South Asian population interested in improving access for men to use local sexual health services?
- Would you be interested in challenging the view that South Asian men do not use or require sexual health services?

If the answer is yes to most or all of the above then contact the following student for more information on this research project in your area:

Mohammed Shaikh
Tel: 07854 263 178
Email: 21087472@student.uwl.ac.uk

You will be interviewed by a researcher who will use a set of questions to explore the views of South Asian men on engaging with local sexual health services. You will be supported throughout this interview and this interview will be undertaken in private. You will be free to withdraw from the research project at any time and confidentiality will be maintained throughout.

This can be an ideal opportunity to share your 'real' views and opinions!

Don't hesitate and find out more about this opportunity

Thank you for reading this

Appendix 7
Phase One - PAR group Participant Information Sheet

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PARTICIPANT INFORMATION SHEET

1) Participatory action research as a means to engage South Asian men in local sexual health services

Barriers to health care services exist for many people and that those barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities. Fountain *et al* (2007) state community engagement takes the view that the community itself has the greatest ability to access its own members and develop local services in order to meet the needs of their community. This research uses action research to work with a group of South Asian men during to explore the culture of sexual health. .

Thank you for reading this.

2) What is the purpose of the study?
South Asian men do not appear to use sexual health services. The purpose of this study is to support South Asian men in Brent and Leicester to access local sexual health services. The project will consist of meeting with a group of South Asian men to explore knowledge on sexual health matter and whether local sexual health services are meeting their needs. The study will also involve understanding the use of participatory action research with South Asian men on sexual health.

3) Why have I been chosen?
You have been asked to participate either because you have some experience or an interest in improving access to sexual health services. Your views and opinions are important to this research and could influence future service developments.

4) Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even if you decide to take part you are still free to withdraw at any time and without giving a reason.

5) What will I be asked to do if I take part?
You will be asked to participate in a series of meetings with South Asian men and help identify problems and solutions in the community. This may result in

individual and collective actions to raise the profile of South Asian men's sexual health.

It is important that we keep an accurate record of your opinions and therefore we will be recording the discussion. We will only use first names during the discussion and no names will be attached to comments that may be used in the final report. You will be sent a copy of the focus group report to comment on its accuracy and the conclusions drawn by the researchers.

6) **What will happen to the results of the research study?**
The results on this phase of the research findings may be shared with academics in the form of a report, journal or verbal presentations. This research will be completed in May 2013 and at this time all findings will be made available.

7) **Who is organising and funding the research?**
The research is being supported and funded by the College of Nursing, Midwifery and Healthcare at University of West London.

8) **Who has reviewed the study?**
This study has been reviewed by the College of Nursing, Midwifery and Healthcare Sciences Research Review Committee at University of West London.

9) **Contact for Further Information**
If you would like any further information please contact any one of the Lead Researchers listed below:

Mohammed Shaikh
Tel: 07854 263 178
Email: 21087472@student.uwl.ac.uk

If you have any complaints about the conduct of this research project and you wish to discuss them with someone other than the researcher, please contact the Lead Academic Supervisors:

Professor Heather Loveday
Tel: 020 8209 4110
Email: heather.loveday@uwl.ac.uk

Professor Kathryn Mitchell
Tel: 020 8231 2468
Email: kathryn.mitchell@uwl.ac.uk

Thank you for reading this

Appendix 8
Phase One - PAR group Consent Form

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CONSENT FORM

Title of Project: Participatory action research as a means to engage South Asian men in local sexual health services in Brent

Name of Lead Investigators: Mohammed Shaikh

Please tick box

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my response may be recorded. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

4. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 9
Phase One - PAR group sexual health workshop plan/ programme

Lesson Plan – Sexual Health Training 2010/11

Programme	PhD Research
Research Title	Participatory action research as a means to engage South Asian men in local sexual health services in Brent
Student Researcher	Mohammed Shaikh
Date/ Time	Saturday 9th April 2011 10.00am – 12.30pm (2.5 hours max)
Activity	Community based training/ group discussion
Level/ Class Profile	Community Based Research Training 8 – 12 South Asian Men
Resources	Teaching Room Projector/ laptop for power point presentation Handouts Refreshments

Aims	To assist research participants in gaining:- • An understanding of Sexually Transmitted Infections (STI's) • Knowledge of several methods of contraception • Knowledge of specialist local support agencies.

Learning Outcomes
By the end of the training session, participants should have learnt: • About the sexual health patterns of the local Brent community and national population. • About sexually transmitted infections, particularly those most relevant to South Asian communities in Brent. • About various methods of contraception • About local and national campaigns supporting positive relationships and sexual health • How to make referrals to appropriate local and national support services • A variety of methods for engaging South Asian men on sexual health issues and topics

Healthy and Safety Considerations
Adhere to standard TVU Health and Safety policies and procedures required when teaching and learning and Community Health Action Trust policies and procedures.

Time	Student/ Researcher Activity	Participant Activity
10.00 - 10.05	**Welcome & introduction**	**Welcome & Introduction**

10.05 – 10.15	**Ground Rules**	Group Activity; Ground Rules (10 mins)
10.15 – 10.20	***Presentation; Introduce the session overview and outline (5 mins)***	
10.20 – 10.40		Activity One; Joe Blogs
10.20 – 10.40	***Presentation; Sexual National and Local picture (20 mins)***	
10.40 – 10.50	**Break**	**Break**
10.50 – 11.10		Group Activity; Sexual Transmitted Infections and Contraception (20 mins)
11.10 – 11.25	***Presentation; Key Sexual Transmitted Infections and Contraception (15 mins)***	
11.25 – 11.45		Group Activity; South Asian Men and Sexual Health/ Services (20 mins)
11.45 – 12.00	***Presentation; Sexual Health and South Asian Men in Brent (15 mins)***	
12.00 – 12.05	***Video; Sexual and Men (5 mins)***	
12.05 – 12.15	Question and Answer Period	Question and Answer Period
12.15 – 12.20	**Session Evaluation**	**Session Evaluation**

Evaluation/ Learning Assessment
• Session Evaluation Sheets • PAR – 2nd Session Sheets

Teaching Reflection

Appendix 10
Phase One - PAR group sexual health workshop presentation

Medicalisation of Sexuality

- To attempt to directly translate medical terms such as homosexuality into other languages without an understanding of the languages and cultures within such translations are being attempted is a futile exercise.
- By discovering the history of sexualities in different cultures, the social and personal context of the words that the different languages use it is more possible to create a dialogue.
- This requires training, self exploration, the meaning and context of words and the social contexts in which they operate. This is especially true in the arena of private sexual experiences.
- In a translation of 'oral' sex one translator wrote 'verbal' sex.

Medicalisation of Sexuality

Group Activity/ Video

http://www.youtube.com/watch?v=il3RbTVC6Ik

Brent Data

Sexual Health Needs Assessment June 2010

"Sexual Health is an important part of physical and mental health. It is a key part in our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease"

National Strategy for Sexual Health and HIV[1]

[1] Department of Health (2001) Better prevention, better services, better sexual health – The national strategy for sexual health and HIV

Sexual Health Needs Assessment June 2010

Brent has an approximately 280,000 resident population, of which almost 43% are under the age of 30. It has a significant Black and Minority Ethnic (BME) population with almost 55% of the population in this category. Brent is ranked the 53rd most deprived borough in England.

There are significant variations in deprivation within each ward of the borough with Stonebridge, Harlesden, Kensal Green and Kilburn having the most deprivation and the highest burden of sexual ill health

Sexual Health Needs Assessment June 2010

Significant findings are:

- High prevalence of Sexually Transmitted Infections particularly Chlamydia
- High prevalence of HIV 4.4:1000 (aged 16-59 year olds)
- High percentage of late diagnosed HIV (CD4 count <200 cells/mm3) representing 36% of all new diagnoses
- High prevalence of HIV in BME groups particularly Black-African and Black-Caribbean
- Poor uptake and use of Long Acting Reversible Contraceptives (LARCs)
- Low LARC prescribing, high Emergency Hormonal Contraceptive (EHC) Prescribing
- High rates of <18 conceptions
- High number of Terminations of Pregnancy (TOPs) in <18 conceptions

Sexual Health Needs Assessment June 2010

From the outcome of the SHNA the strengths of tackling the burden of sexually ill health in Brent are:

Good GUM services

- Easily accessible
- Good reputation
- Good internal structure – electronic records
- Able to impact on STIs prevalent in the community as well as onward transmission with partner notification
- Good uptake of HIV testing when offered
- Already working towards "One Stop Shop" format as currently providing contraceptive services as well

Sexual Health Needs Assessment June 2010

HIV management

- Strong links in acute sector for management of people living with HIV
- HUB provides a single point for people living with HIV to access a number of different organisations
- Multitude of community based voluntary organisations geared to catering to the psychosocial needs of BME communities living with HIV/AIDS both in and out of borough

Sexual Health Needs Assessment June 2010

18 Conceptions and TOP services

- Good referral system between various sexual health services and TOP services, in particular GPs
- Good access to TOP services
- High level of NHS funded TOPs
- High percentage of TOPs performed <10 weeks gestation

Sexual Health Needs Assessment June 2010

The National Strategy for Sexual Health and HIV highlighted significant inequalities in sexual health. Sexual ill health particularly affects teenagers and young adults, gay men, and black minority ethnic groups. There is also a strong link between social deprivation and STIs, termination of pregnancy (TOP), and teenage conception.

Sexual Health Needs Assessment June 2010

Ethnicity

Brent is one of only two local authorities in London serving a population where the majority of people are from ethnic minorities, and these groups are growing faster than any other. The chance of two people in Brent being from different ethnic groups is higher than anywhere else in the country, making Brent the most heterogeneous borough in England.

Black and Minority Ethnic (BME) groups make up the majority of the population at 54.7%; including 18.5% Indian, 10.5% Black/Black British Caribbean and 7.8% Black/Black African[1]. Approximately 130 languages are spoken in schools in Brent and it has the highest proportion of people born outside the EU in England and Wales.

[1] ONS, 2001, UK Census

Sexual Health Needs Assessment June 2010

The numbers of new STIs have risen steadily over the last 10 years. The highest rates have been recorded in young people, men who have sex with men (MSM) and BME groups. It has been reported that 16-24 year olds account for nearly half of all STIs diagnosed in GUM clinics. The Black –Caribbean population continue to have a high incidence of STIs and account for almost 17% of gonorrhoea diagnoses despite comprising 1% of the UK population.

Sexual Health Needs Assessment June 2010

The first National Strategy for Sexual Health and HIV was published in 2001, and was a key instrument for placing sexual health firmly on the national agenda. It set out an ambitious 10-year programme to tackle sexual ill-health and modernise sexual health services in England, and focused on achieving its aims listed below, through enhanced prevention, improved commissioning, modernised services and better support for people with HIV and Sexually Transmitted Infections (STIs). The stated aims of the strategy were to:

- *Reduce transmission of HIV and STIs*
- *Reduce prevalence of undiagnosed HIV and STIs*
- *Reduce unintended pregnancy rates*
- *Improve health and social care for people living with HIV*
- *Reduce stigma associated with HIV and STIs*

Sexual Health Needs Assessment June 2010

In 2005 Brent developed a Sexual Health Strategy which looked at the approaches needed to develop and commission services for sexual health and people living with HIV over 2005-2008. Some of the seven standards set out by the London-wide sexual health framework (above) were incorporated and six key objectives were identifiedfor Brent:

- *To reduce the transmission of HIV and STIs and reduce the prevalence of undiagnosed HIV and STIs*
- *To ensure appropriate levels of service and service uptake for high risk and under-served groups.*
- *To improve health and social care for people living with/affected by HIV*
- *To reduce the stigma associated with HIV and STIs and normalise access to sexual health services*
- *To reduce unintended pregnancy*
- *To improve the sexual health of young people*

Sexual Health Needs Assessment June 2010

London has the highest number of sexually transmitted infections (STIs) in England, compared with any other region. In 2007, around two in five diagnoses of infectious syphilis and gonorrhoea, more than one in five diagnoses of genital Chlamydia and genital warts, over quarter of genital herpes diagnoses and half of HIV diagnoses were made in the capital.

Mens Health

Men's Health

- Men's sexual health remains marginalised within research, policy development and service provision around sexual health
- Men's health is predominantly associated with physical functioning and reproductive ability
- A more holistic approach to research, policy and service delivery is needed in order to advance the sexual health of men
- Sexual health is not equally distributed across the male population
- Sexually transmitted infections have continued to increase since 2000, but they are easily treatable in most men

Serrant-Green, L. (2008) The Sexual Health of Men. Oxon: Radcliffe Publishing Ltd.

Men's Health

- Across their adult years men can potentially encounter a diversity of difficulties affecting their sexual health and sexuality
- Men require an open, genuine, therapeutic relationship with healthcare providers in order to address their concerns
- Men's sexual behaviour is usually described from a hegemonic masculinity viewpoint
- Men tend to view their sexual behaviour in terms of action rather than emotion
- Men will take risks in their sexual behaviour despite having the knowledge and ability to protect themselves

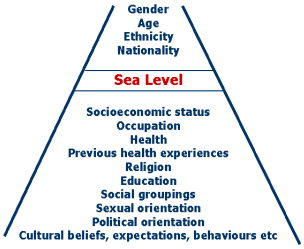
Men's Health

- Black and minority ethnic men are shown to be disproportionately higher risk of sexual ill health
- Addressing the sexual health needs of black and minority ethnic men requires a contextualised approach which includes the recognition of diversity and difference of experience
- Community-based initiatives which local stakeholders and community organisations provide a positive example for developing an integrated approach to sexual health
- A range of innovative, culturally appropriate and co-ordinated approaches are required to provide accurate service provision for men
- Sexual health services should empower and involve male service users in decision making
- There is a need for better information about the range of sexual health services available to men, with male targeted media playing a major role.

Sexual Health Practice

Health Messages.....?

The Iceberg Model



Communication Difficulties

- Language
- Attitudes, feelings and expectations
- Non verbal signals:
  - Eye contact
  - Head and body movements
  - Touch
  - Dress
  - Facial expressions
  - Gestures
  - Proximity
  - General appearance

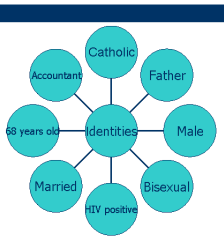
Communication Difficulties

- Paralinguistics:
  - Tone of voice
  - Loudness
  - Speed
  - Stress
  - Rhythm and pitch
- Role Uncertainty
- Role non correspondence
- Definition disparity
- Goal disparity

A few other issues.....

- Power and status differences
- Situations where the definitions others impose on people impact on them in ways that are detrimental
- The burden of representation
- Attempts by clients to get health professionals to support them when they are in conflict with their family and culture
- Internal conflict over an aspect of identity because of stigma
- Relevance of culture at some times and not at others

An Ideographic Approach



Contraception across Cultures

Group Activity

List contraceptives methods used in the UK

Contraception across Cultures

Technological facts but also mental constructions
What definition of contraceptions contain and what they leave out:

a) human agents
b) beliefs
c) relationships
d) institutions and power structures within which they operate.

Contraception across Cultures

Methods of contraception can be categorised by:
1) mode of operation – traditional or modern
2) provider or user dependent.

As a social construct:

1) Works at both biological and social levels
2) Can be studied at different levels from pharmaceutical companies, to policy makers and planners, to providers and recipients.
3) Different levels have different interests and values
4) Practiced within local systems of economic values, ethical concerns, political and religious ideologies, kinship structures and dyadic relationships

Contraception across Cultures

5) Different groups will ascribe different meanings to contraception depending on their beliefs, social situation, political and economic circumstances and history
6) A disadvantage of the medicalisation of family planning is that where other primary health care services are poor quality it makes people less likely to seek family planning from the same source
7) As a consequence of not taking into account perceptions of the quality of service offered, conclusions were drawn that the 'problem' of lack of uptake of services was to do with women's failure, behaviour and irrationality.

Contraception across Cultures

8) Contraceptive use takes place within intimate heterosexual relationships. In many cultures women are expected to defer to their husbands, or work behind their backs if they wish to use contraception.
9) Women in Bangladesh and Mexico are alike in that to deceive their husbands in this way runs the considerable risk of male violence, and in such circumstances, contraceptives that can be administered clandestinely and infrequently are the contraceptives of 'choice'.
10) Fluid boundaries between contraception and reproductive control. In the former Soviet Union abortion is an acceptable method of reproductive control.

Contraception across Cultures

11) Different ideas about the body and how it works
12) In Uzbekistan midwives expressed the view that the 40 days of 'jhilla' following childbirth were unsuitable for inserting an IUD but felt it was unnecessary anyway as sexual intercourse is not supposed to happen during this time.
13) Amongst Ethiopian Jewish immigrants a belief in the fertility depressing, long term effect of hormonal contraceptives and a cultural concern about their role in restricting blood flow during menstruation makes long term use of oral contraceptives unlikely.

Contraception across Cultures

18) Do not just function as fertility regulators but as symbols and metaphors of other culturally salient issues. Often symbolise (not necessarily positively) progress, development and modernity.
19) In Uzbekistan using contraceptives is seen as contributing to the establishment of the country in the ranks of world nations.
20) For Palestinians in Galilee reproduction (or rather the lack or control of reproduction) has become a source of self identity and a means of evaluating others. Making mistakes and getting pregnant is therefore judged harshly.

Russell, A., Sobo, E.J., and Thompson, M.S. (YEAR) Contraception across Cultures. Oxford:Berg.

Case Study (A)

A Community Engagement Project to Assess Sexual Health Needs of Young People of South Asian Heritage in Blackburn and Darwen (2003)

This research was conducted by a group of young people of South Asian Heritage who wish to remain anonymous with the help and support of:
Blackburn and Darwen Teenage Pregnancy Partnership Board
Blackburn with Darwen Racial Equality Council
Centre for Ethnicity and Health, University of Central Lancashire

Some of the findings

- Most (57%) said that they had received sex education at school and found the information useful
- Most (55%) said they did not know how to access sexual health information of services. Concern about confidentiality was high and about the security and safety of the location of the service
- Most (89%) were aware of contraceptive methods. 36% said they would not use contraceptives.
- Most were not, and never had been sexually active and thought that their religion and culture forbid them from having sex unless they were married. 25% said they were currently engaged in sexual activity and 36% said they had been at some time in their lives.

Contraception across Cultures

15) In Japan oral contraceptives are seen as contravening 'nature' and hence are rarely used.
16) Fear of side effects are often ignored or derided by planners as ignorant and wild.
17) In Mexico fertility and menstruation regulation are regarded as part of the 'female sphere of influence and knowledge'. Women fear female sterilization in case they will not be able to do the same amount of work afterwards, while men fear male sterilization seeing it as culturally unthinkable to dispense with virility in this way. A perception that women will be put off using contraceptives because of side effects bodes ill for the principle of informed consent.

Case Studies

Research Method

The research was undertaken because concern was expressed that young women of South Asian heritage accounted for 1 in 8 of all requests for terminations of pregnancy, yet made up only 1 in 20 of those accessing general sexual health information or contraception

10 young people of South Asian heritage were recruited to undertake the research
281 respondents completed questionnaires

Only one focus group took place of an established group of male friends. Others were reluctant to discuss sexual matters openly with people they didn't know, fearing that comments they made would be reported back to the community. They were particularly frightened of family members finding out that they had taken part in the research

Some of the findings

- 3 females indicated they could have a sexual relationship with a man or woman and 3 indicated they would be most likely to have a sexual relationship with another woman only
- 3 males indicated that they could have a sexual relationship with a man or a woman and 1 indicated that he would be most likely to have a sexual relationship with another man only
- The majority thought that same sex relationships were unacceptable within the South Asian community. On a personal level, however, respondents were more tolerant and 41% expressed positive views about same sex relationships.

Some of the findings

- In the focus group discussion, however, the following comments were made, and 9 out of 10 were against gay men, lesbians and bisexuals:

'My religion doesn't allow it, my culture doesn't allow it and I don't allow it'

'We've known someone since the age of 2 and when I found out he was gay I went home and couldn't eat.'

'If I found out my friend was gay I would help them to die.'

'Being gay is bad it's worse than a pregnant Asian girl who isn't married.'

'You are not a man if you are gay.'

Some of the findings

- An Asian GP in a northern town in the UK reported that out of 100 Bangladeshi married men he questioned privately 90 of them stated that they had sex outside of their marriages
- Several pieces of anecdotal research in India indicate that 60% of sexually active men have sex with men. The majority of these men are married. Others have given a higher estimate.
- In Karachi, Pakistan, it has been estimated that there are probably more male prostitutes than female.
- There is a rapidly rising number of young South Asian girls in the UK attending abortion clinics and family planning clinics.
- Amongst a group of 20 South Asian boys with an age range of 16-18, 12 of them stated privately that they had gone to prostitutes in the last six months.
- In a small survey (200 men aged 18-21) of South Asian young men in the UK, 40% said that they had some form of male to male sex leading to orgasm, while 70% of them had sex with a women. Condom usage was only 10%.

Some of the findings

- Genital hygiene amongst Hindu men is very low. The main reasons appear to be that boys are not taught about cleaning under their foreskins, since touching the genitalia is considered shameful by their mothers.
- In one research paper in India, 90% of married women stated that they did not enjoy sex with their husbands.
- It has been estimated in India that some 40%-50% of married men have anal sex with their wives.
- There are very significant levels of anal and vaginal tearing amongst married women (and prostitutes) in India, higher that 50% in some research studies.
- Two of the major problems reported to 'sexologists' in India are impotence and premature ejaculation.

Any questions……?

Thank You

Case Study (B)

Some anecdotal reports on sexual behaviours amongst South Asians (1994)

Khan, S (1994) Contexts. Race Culture and Sexuality. London:The Naz Project.

Some of the findings

- In a variety of research work in India, it was found that the average age for first sexual encounter was 14.
- In one condom workshop consisting of 50 young South Asian men living in the UK, over 60% used the condom incorrectly which would have led to condom failures in a real situation.
- It has been estimated that some 25% of the sexually active male population in India has an STI.
- In India the estimated average time for the sexual act to be consummated is five minutes. The sexual act is performed in the dark with the clothes on.
- Very often neither partner will see the other without clothes.
- Knowledge of the sexual organs of each gender is extremely low.

Video Clip

Youtube Clip

http://www.youtube.com/watch?v=59l3fMwRgCU

Appendix 11
Phase One - PAR group PAR workshop plan/ programme

Lesson Plan – Participatory Action Research Training 2010/11

Programme	PhD Research
Research Title	Participatory action research as a means to engage South Asian men in local sexual health services in Brent.
Student Researcher	Mohammed Shaikh
Date/ Time	Saturday 2nd April 2011 10.00am – 12.30pm (2.5 hours max)
Activity	Community based training/ group discussion
Level/ Class Profile	Community Based Research Training 8 – 12 South Asian Men
Resources	Teaching Room Projector/ laptop for power point presentation Handouts Refreshments

Aims	To assist research participants in gaining:- • Knowledge of research and the use of research • Knowledge of quantitative and qualitative research approaches • Knowledge of research methods • An understanding of Action Research/ Participatory Action Research methods • Identify challenges and issues of working on a research project

Learning Outcomes
By the end of the training session, participants should have learnt: • The difference between qualitative research and quantitative research • The difference of participatory action research in relation to other qualitative research techniques • Some of the challenges of working on a participatory research project • Identified examples of making a difference through the use of action research • Process of working on a participatory action research project.

Healthy and Safety Considerations
Adhere to standard TVU Health and Safety policies and procedures required when teaching and learning and Community Health Action Trust policies and procedures.

Time	Student/ Researcher Activity	Participant Activity
10.00 – 10.10	**Introduction**	**Introduction**
10.10 – 10.15	***Presentation; Introduce the***	

	session overview and outline (10 mins)	
10.15 – 10.30		Group Activity; What is Research? (15 mins)
10.30 – 10.40	***Presentation; 'Research' (10 mins)***	
10.40 – 10.55		Group Activity; Different Types of Research? (15 mins)
10.55 – 11.15	***Presentation; Research, Qualitative and Quantitative Research, Research Methods (20 mins)***	
11.15 – 11.30	**Break**	**Break**
11.30 – 11.50	***Presentation; What is Action Research, PAR (20 mins)***	
11.50 – 12.05		Group Activity; Advantages and Disadvantages of PAR (15 mins)
12.05 – 12.15	***Presentation; Key Issues on using PAR (10 mins)***	
12.15 – 12.25	Questions and Answer Period	Questions and Answer Period
12.25 – 12.30	**Session Evaluation**	**Session Evaluation**

Evaluation/ Learning Assessment
• Session Evaluation Sheets • PAR – Initial Session Sheets

Teaching Reflection/ Observation

Appendix 12
Phase One - PAR group PAR workshop presentation

Using Participatory Action Research to engage South Asian men to improve sexual health services in Brent

UNIVERSITY OF WEST LONDON

Mohammed Shaikh
Saturday 9th April 2011
CHAT

Session Overview

1. Research
2. Qualitative Research
3. Research Process/ Methods
4. Action Research/ Participatory Action Research
5. Research Outline
6. Interviewing
7. Qualitative Data Analysis

Research

What is Research?

ACTIVITY

In groups compose a short definition of research.

Research – A Definition

Research is a systematic process of collecting, analyzing and interpreting information (data) in order to increase our understanding of a phenomenon about which we are interested or concerned.

from Leedy PD & Ormrod JE (2010) **Practical Research Planning and Design.** 9th ed. Boston: Pearson, p.3.)

Research – The Characteristics

Research:
- originates with a question or problem.
- requires a specific plan for proceeding.
- usually divides the principal problem into more manageable sub problems.
- is guided by the specific research problem, question or hypothesis.
- accepts certain critical assumptions.
- requires the collection and interpretation of data in an attempt to resolve the problem that initiated the research.
- research is, by its nature, cyclical or, more exactly, helical.

from Leedy PD & Ormrod JE (2010) **Practical Research Planning and Design.** 9th ed. Boston: Pearson, p.3.)

What Research is Not

ACTIVITY

In groups make a list of things that research is not.

What Research is Not

Research is not:

- mere information gathering
- mere transportation of facts from one location to another
- merely rummaging for information
- a catchword for getting attention

from Leedy PD & Ormrod JE (2010) **Practical Research Planning and Design.** 9th ed. Boston: Pearson, p.2.)

Qualitative Research

What is Qualitative Research?

Qualitative inquiry broadly means that it aims at understanding the meaning of human action **(words and images)**

Many researchers use the phrase 'qualitative' as a blanket designation of all forms of social inquiry that rely on data primarily in the form of words.

Qualitative methods are procedures including unstructured, open-ended interviews and participant observation that generate qualitative data.

Iterative; the analysis tends to be an evolving process in which the data collection and data analysis phases occur alongside each other.
Inductive; from the detailed study of localised data, the analysis attempts to arrive at more abstract and generalised statements about the topic.
Reseacher-centred; the researchers 'self-identity' is treated as significant in relation to the analysis.

Schwandt (2007) The Sage dictionary of qualitative inquiry.
Denscombe (2010) The good research guide for small scale social research projects.

Qualitative Research

Qualitative research is carried out when we wish to understand meanings, interpretations and/or to look at, describe and understand experience, ideas, beliefs and values (Wisker, 2008, p.75)

Qualitative research can no longer be viewed from within a neutral or objective positivist perspective. Class, race, gender and ethnicity shape inquiry, making research a multi-cultural process (Sage, 2005, p.20)

However, there is often a presumption among many researchers that choosing qualitative methods will enhance the potential for participants' own voices, can provide a more informative picture of culturally based processes and practices and a depth to context (McKie, 2002, p.263).

McKie (2002) states it is also important to note that not all Qualitative methods promote participation (p.264).

What is Quantitative Research?

Quantitative data take the form of numbers. They are associated primarily with strategies of research such as surveys and experiments, and with research methods such as questionnaires and observation.

Quantitative is often used as a synonym for any design (e.g. experimental and survey) or procedure (e.g. statistical) that relies principally on the use of quantitative data.

'Every researcher can and should use numbers in their research' (Gorard, 2006:2). Quantitative data can be used very effectively without the need for complex statistical analysis.

Schwandt (2007) The Sage dictionary of qualitative inquiry.
Denscombe (2010) The good research guide for small scale social research projects.

Differences between Qualitative and Quantitative Research

Perhaps the clearest use of the adjective is to distinguish between qualitative data (non numeric) and quantitative data (numeric)

Quantitative	Qualitative
Experiment	Case Study
Test	Interview
Statistical Analysis	Content Analysis

Research Process and Methods

The Research Process

An Analytical Framework

Ontology

The ontological orientation of the researcher, in terms of his or her beliefs about reality, determine their epistemological perspective on knowledge.

Epistemology

The epistemological orientation of the researcher is determined by his or her beliefs about reality and influences their choices of research methodology.

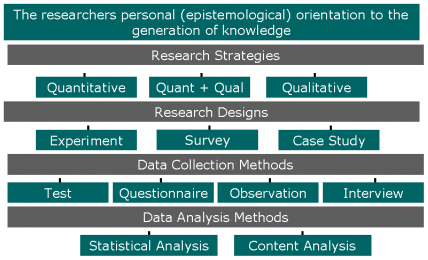
Methodology

The methods used by the researcher are determined by his or her ontological and epistemological orientation

The Research Process

- Deciding on the research question
- Locating and searching the relevant literature
- Planning the project
- Preparing a proposal
- Getting approval
- Collecting and storing data
- Analysing and interpreting data
- Drawing conclusions and making recommendations
- Writing and presenting findings

Research Methodology



Action Research

Participatory Action Research

Origins and Historical Developments

Action research began in the USA during the 1940's and came to use in the UK during the 1970's and by the 1980's it was making an impact particularly within education.

Action research is associated with the social psychologist Kurt Lewin whose central interest was in social change. Koch and Kralik (2006, p.12) mention although the development of action research has been attributed to Lewin, it is important to note Lewin's work participants were not involved in setting the agenda or making decisions. Prior to the work of Lewin, action research had been noted to take place on work with women in 20th century Vienna.

The Tavistock Institute brought Lewin's work on the concept of natural experience and action research from America to the United Kingdom.

Action research accounts are complex. Its roots can be found in different geographical contexts and in different professional communities. The conceptual and philosophical roots of action research have been reviewed by Reason and Bradbury (2001) who trace diverse origins form philosophy, social science, psychotherapy, critical theory, systems theory, education, spiritual practices, indigenous cultures, liberationist thought and complexity theory.

Action Research

Action research has been around for some 70 years. It has always been linked with social change for social justice. Noffke (1997) says that the term 'action research' appeared in a 1961 speech by Martin Luther King. (McNiff & Whitehead, 2006, p.36)

Lawrence Stenhouse wrote (1983) that 'research is systematic enquiry made public.' Action research lends a new dimension because it is about processes of improvement, and making claims that something has improved (McNiff & Whitehead, 2009, p.11). Brydon-Miller (2002) echoes a similar view that the wider purpose of action research is to contribute through this practical knowledge to the increased well-being; economic, political, psychological, spiritual of individual and communities, and to a more equitable state.

Morton-Cooper (2000) further mention action research can be categorised roughly into four kinds; experimental, organisational, professionalising and empowering. Greenwood and Levin's (1998) version of action research have characteristics that refer to the combination of three elements; research, action and participation. O'Brien (1998) defines action research as simply as learning by doing.

Action Research Principles

Fals Borda (1995) identified 36 strands of PAR represented at the World Congresses. Contemporary action research might be characterised within three broad groupings; action research in organisational change, in education research and participatory action research. (Charles & Ward, 2007, p.8)

- Hall (cited in Hagey, 1997) suggests seven key characteristics of PAR
- Kemmis and McTaggart (2003) name eight key features of PAR
- McTaggart's (1989) list of 16 tenets of PAR presented to the Third World encounter on Participatory Research in 1989

(Charles & Ward, 2007, p.10)

Action Research and Controversy

Charles & Ward (2007) states some of issues related with action research include:

- The positionality of the researcher and ownership of research
- Research quality and validity
- Power dynamics
- Use of action research
- Transferable knowledge

Key Researchers/ Theorists

Reason (2001) state the theoretical root of what has come to be called action research is attributed to liberationist writers such as Marx, Engels, Gramsci.

John Dewey in the 1920's. Dewey's concern for participative democracy and the generation of knowledge by all members of society through action and experimentation have provided foundation for action research.

The work of the social psychologist Kurt Lewin (1890 – 1947) provides the first well documented example of an explicit action research programme. He produced a theory and practice of action research that included the now widely used 'iterative spiral' of planning, acting, observing, and reflecting, which can be employed by groups to undertake their own research and solve problems.

Key Researchers/ Theorists (b)

Paulo Freire is also widely recognised as influential in the development of action research. Freire worked in adult education, particularly with the disenfranchised. He developed an educational methodology designed to enable previously illiterate people to understand and articulate a critical view of the world, what is called critical pedagogy. (Charles & Ward, 2007, p. 4)

Action in the UK was invigorated in the 1970's by Lawrence Stenhouse, an educational researcher at the University of East Anglia. He promoted the idea of the 'teacher as researcher' as opposed to the conventional model of research being undertaken by the outside expert.

Peter Reason is Director of the Postgraduate Programme in Action Research at the University of Bath.

Hilary Bradbury is an Associate Professor of Organisational Behaviour at Case University in the US.

Cyclical Process

The process of observe, reflect, act, evaluate, modify move in new directions is generally known as action reflection, this process tends to be cyclical.

- Action research aims to be a disciplined, systematic process. A notional action plan is:
- Take stock of what is going on
- Identify a concern
- Think of a possible way forward
- Try it out
- Monitor the action by gathering data to show what is happening
- Evaluate progress by establishing procedures for making judgements about what is happening

(McNiff & Whitehead, 2006, p.8, 9)

Participatory Action Research

Participatory action research is a process in which 'researchers' and 'participants' systematically work together in cycles to explore concerns, claims or issues that impact upon or disrupt people's lives.

Its purpose is to assist people in extending their understanding of their Situation and thus resolving issues that confront them.

In modern, democratic social contexts, it is seen as a process of inquiry that has the following characteristics;

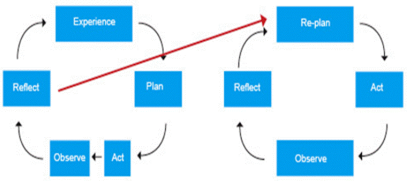
- It is democratic, enabling the participation of all people
- It is equitable, acknowledging peoples equality of worth
- It is liberating; providing freedom from oppressive, debilitating conditions
- It is life enhancing, enabling the expression of peoples full human potential.

Action research is likely to be interpretative, constructivist, and using qualitative rather than quantitative methods (Wisker, 2008, p.231)

Action researchers can employ both qualitative and quantitative research techniques (McNiff, Lomax and Whitehead, 1996, p.15)

Arnstein's Ladder of Participation (1969)

PAR Methods



PAR Issues

Lofman et al, (2004, p.333) have written an article describing ethical issues specifically on PAR. The ethical issues they highlight are

- on the importance of informed consent
- confidentiality and anonymity
- protecting an individual from harm
- the role of the researcher
- power dynamics in PAR
- and the ownership of the research
- All data needs to be recorded onto a secure laptop, which will be stored in a secure lockable cupboard.
- All work will be transferred and stored on a password protected computer.
- All transcripts will be recorded and documented anonymously
- All issues discussed in group interviews and individual interviews during the two parallel phases of the research will adhere to strict confidential guidelines.

Research Outline

Introduction - Background

The proposed study is an **evaluation on the use of participatory action research (PAR) as a means to engage South Asian men in local sexual health services in Brent**. The aim will be to undertake research with this target group in order to highlight the key issues of using PAR with South Asian men through a combination of individual and group interviews, ensuring all stages of the PAR process is evaluated.

It is important to note that Brent has a very diverse population (Bowen & Foggarty, 2008) and amongst BAME communities in England there is a complex interplay of factors affecting health such as the long-term impact of migration, racism and discrimination, poor service delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility (POST, 2007).

Research Question

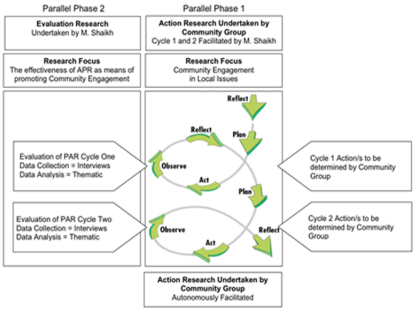
The general aim of this study will be to:

- **Explore Participatory Action Research as a means to actively engage South Asian men in shaping local sexual health services in Brent.**

To further understand this general research focus and question, two specific questions have been identified to support the research study. They are as follows:

1. **What influence on local sexual health services in Brent can be achieved by local South Asian men using participatory action research methods?**
2. **What are the key issues which help or hinder the process of using participatory action research with South Asian men?**

Question one and two will reflect study phases one and two respectively.



Methods

Set up group (8-12 south Asian men)

Cyclical process of group interviews

Group Interview for 6 – 12 weeks using participatory action research principles, conducting semi-structured interviews, exploring different engagement activities with them and asking their responses on the use and suitability of methods.

Issue ***semi-structured questionnaires*** to local community members via voluntary and community sector

This process will enable the group to focus on the experience of local people, identify a possible areas, production of a general action plan, formation of group tasks and questions to 'trigger' focus group.

Carry out a number of questionnaires with support of group, analyse with group, and evaluate with group, then, decide with the group which participatory action research method to focus upon of sexual health

Data Collection, Analysis & Storage

As a result, my research methods will use qualitative methods. Mainly using a group interview throughout the research process and using semi-structured interviews in the form of questionnaires at the beginning stage of my research within the community.

Koch and Kralik (2006) recommend; One to One in-depth interviews, Group interviews (10-12 people) (p.31 35)

Quantitative measures are likely to use questionnaires for data collection, particularly when obtaining data from large number of respondents, as they can be counted, measured and statistically analysed. (Wisker, 2008, p.187)

Action research uses triangulation; that is uses at least two and probably three methods to gather data (Wisker, 2008, p.231)

Hart and Bond (1995) multi-methods data collection; for action researchers it is essential to facilitate the engagement and cooperation of others, individually and collectively in the research enterprise and pave the way for the implementation of improvements (p.77)

Data Collection, Analysis & Storage

The process of qualitative data analysis is fundamentally a non-mathematical analytical procedure that involves examining the meaning of people's words and actions (Morton-Cooper, 2000 p.82)

There are several ways of tackling data analysis in qualitative research, not all of them are suitable or appropriate to the particular collaborative nature of the action research process. (Morton-Cooper, 2000 p.81)

Use of Content Analysis; Transferability
Data Storage; protection

Unlike qualitative analysis in non-action research, it is not a question of putting it all together in one place and sorting it into appropriate categories for analysis. The analytic process in action research begins from the moment you start to develop your original research question. Every activity thereafter is part of a continuous process of analytical refinement. (Morton-Cooper, 2000, p.75)

Interviewing

Traditional Types of Interview

Fontana, A. & Frey, J.H. (1998) Interviewing: The Art of Science, in *Collecting and Interpreting Qualitative Materials*, Denzin NK & Lincoln YS, (eds.), Thousand Oaks: Sage Publications, pp. 47-78.

Traditional types of Interview

The Structured or Closed Interview

The Semi structured Interview

The Unstructured or Open Interview

Traditional Types of Interview

The Structured or Closed Interview

- The structured interview uses closed questions, i.e., questions that require either a yes or know answer or require a choice of answer to be made.
- This approach is commonly used in survey research and hardly ever in qualitative research. It is useful for deductive exploration of a clearly defined research question.
- The interviewer controls the process in structured interviewing as well as the direction of the interview.

Traditional Types of Interview

The Unstructured or Open Interview

- The unstructured interview uses open questions, i.e., questions that encourage the interviewee to offer in depth information.
- This approach is commonly used in qualitative research and hardly ever in quantitative research. It is useful for inductive exploration of loosely defined research questions or even as a means to develop research questions.
- The interviewer controls the process in unstructured interviewing but has little control over the direction of the interview.

Traditional Types of Interview

The Semi-structured Interview

- The semi-structured interview may use both open and closed questions
- This approach is commonly used in qualitative research and sometimes in quantitative research. It is useful for deductively exploring research questions but allows for inductively derived new perspectives.
- The interviewer controls the process in semi-structured interviewing and the overall direction of the interview but allows the interviewee some control over the direction of the interview.

Non-Traditional Interviewing Two Examples

Holstein, J.A. & Gubrium, J.F. (1997) Active Interviewing, in *Qualitative Research Theory, Method and Practice*, D. Silverman, (ed.), Thousand Oaks: Sage Publications, pp. 113-129.

Miller, W.L. & Crabtree, B.F. (1999) Depth Interviewing, in *Doing Qualitative Research*, 2nd edn, Crabtree BF & Miller WL, (eds.), Thousand Oaks: Sage Publications, pp. 89-107.

Conversation

(Clandin and Connelly)

".... conversations are marked by quality among participants and by flexibility to allow group participants to establish the form and topics important to their inquiry. Conversation entails listening. The listener's response may constitute a probe into experience that takes the representation of experience far beyond what is possible in an interview. Indeed, there is probing in conversation, in-depth probing, but it is done in a situation of mutual trust, listening, and caring for the experience described by the other." (Clandin and Connelly, p.168)

Active Interviewing (Holstein and Gubrium)

Active interviewing puts the interview at the heart of the interpretive process.

The interviewer and interviewee generate meaning and understanding together actively rather than the researcher, post interview, trying to extract meaning from data that has been collected in a supposedly objective way
(Holstein and Gubrium 1997)

Depth Interviewing (Miller and Crabtree)

Depth Interviewing is seen as a "partnership, as a communicative performance, and as a conversational research journey". (Miller and Crabtree 1999, p.91).

The interview is perceived as a highly complex exchange between participants which is influenced by their multiple social roles, motivations and goals.

Practicalities of Interviewing

Interviewing is a highly skilled activity, regardless of its format, and attention needs to be paid to:

Preparation

Resources

The Interview Setting

Practicalities of Interviewing

Interviewing is a highly skilled activity and

Preparation

- Select participants / interviewees / sample.
- Contact prospective participants and explain the purpose and conduct of the interview / research verbally and in writing.
- Explain the participants ethical rights verbally and in writing.
- Allow time and opportunity for prospective participants to ask for clarification.
- Obtain verbal and written consent from participants.
- Prepare interview schedule (if appropriate).
- Get to know your technical equipment.

Practicalities of Interviewing

Interviewing is a highly skilled activity and attention needs to be paid to:

Resources Required

- Sufficient time.
- An appropriate room and a "do not disturb sign".
- A good quality recording device and microphone.
- Sufficient media if appropriate, e.g. tapes, disks.
- A reliable power supply, e.g., spare batteries.
- "Food and drink".
- Spare information sheets / consent forms
- Interview schedule.
- Sensitivity

Practicalities of Interviewing

Interviewing is a highly skilled activity and attention needs to be paid to:

The Interview Setting

QUESTION: What is an appropriate room / setting?

- One that is the appropriate size.
- One that has appropriate seating.
- One that has appropriate work surfaces.
- One that is heated / ventilated appropriately
- One that has refreshments available.
- One that is exclusively yours for the required time.

Practicalities of Interviewing

QUESTION: How long should an interview be?

- It depends on the interview type.
- It depends on the motivation of the participants.
- It depends on available time.
- It depends on the complexity of the issue being explored.
- It depends on how well the interview is going.

Qualitative Data Analysis

Qualitative Analysis

Qualitative data usually consists of the words or actions of research participants, gained through interviews, observation, documents or diaries.

Qualitative analysis involves bringing order, structure and meaning to this mass of information so that conclusions can be made and communicated.

Qualitative Analysis

There are as many different approaches to qualitative analysis as there are qualitative researchers (Tesch 1990)

Qualitative Analysis

Crabtree and Miller (1999) describe the interpretation of qualitative data as a "complex and dynamic craft" and compare it to a "dance":

"Interpretation is like a night at the big dance. The dance begins with an invitation to attend. These invitations state the intent, establish the context, determine the guests, suggest what to bring and wear, and propose boundaries for what to expect. It's a senior high school prom or a community contra dance. This is the initial describing phase of interpretation....."

Qualitative Analysis

".....Once at the dance and with the fun under way, however, the dance often changes. New partners appear, the music shifts, the unexpected happens, you and some of your closest friends change, and new relationships form. You must keep re-describing and adjusting, gathering new information; this is the iteration between data collection and interpretation. There is an opening dance that sets the tone for the evening, much as the initial organizing style frames the interpretive possibilities. The big dance event ends with a closing dance that, one hopes, resolves the evenings tensions."

Qualitative Analysis

The process of qualitative interpretation is described by Crabtree and Miller as having five phases "through which one iteratively spirals and shifts". The five phases are:

- Describing
- Organising
- Connecting
- Corroborating and Legitimating
- Representing the Account

These five phases should not be seen as linear or sequential but rather as parallel, overlapping and interweaving processes.

Qualitative Analysis

Organising and Connecting

Crabtree and Miller describe 3 organizing styles:

- The Editing Style
- The Template Style
- The Immersion and Crystallization Style

Key Texts/ Websites

Publication of the *Handbook of Action Research* (Reason and Bradbury, 2001).

www.actionresearch.net
www.jeanmcniff.com
http://www.scu.edu.au/schools/gcm/ar/arhome.html
http://www.did.stu.mmu.ac.uk/carnnew/
http://research.edu.uea.ac.uk/care

Any questions….?

Appendix 13
Phase One - PAR group preparatory questionnaire

UNIVERSITY OF WEST LONDON

‘Barriers to engage South Asian men in sexual health/ services’ (PAR group preparatory interviews) - Phase one

Title of Project:
Participatory action research as a means to engage South Asian men in local sexual health services in Brent

Name of Investigator
Mohammed Shaikh

Interview Brief
Brief outline of research
Interview brief
STI’s in South Asian are increasing in the Borough.
There is no dedicated Sexual Health Prevention for Men role in Brent.

Interviewee details
Are you in employment? What kind of employment?
What is your role in your organisation?

Question Theme One – ‘Issues related to personal views about sexual health and how these are reflected in the wider male South Asian population?’

What do you think of when the words ‘sexual health for men’ is mentioned?

Do you think there is a difference on the understanding of sexual health for men amongst South Asian communities and men from other communities? What do you think are these differences?

Are you comfortable talking about sexual health issues to family and friends? Why?

Are you comfortable talking about sexual health issues to other men? Why?

What do you think would encourage South Asian men to talk and improve their sexual health?

Question Theme Two – ‘Issues related to service provision and how it may or may not meet the needs of South Asian men?’

Do you know what sexual health services are in available for men in Brent?

What do you think are the major challenges for local sexual health services to effectively engage with South Asian men?
How do you think sexual health services should engage with South Asian men in Brent?

Do you think sexual health information in community locations would be useful for South Asian men in Brent? Or do you think sexual health information should be only available in health related premises?

What are the best times, days and location you think local sexual health services should use to engage with South Asian men?

Question Theme Three – 'Issues related to research and raising the awareness of sexual health in the male South Asian population.'

How do you think the media (radio, television and newspapers) portray men's sexual health issues? How does impact on the South Asian community?

What issues prevent you from volunteering or playing a role in supporting local sexual health services to engage with South Asian men?

What do you think are the barriers for South Asian men to engage with research on the issue sexual health for South Asian men?

AOB
Is there anything you would like to add with regards to barriers for South Asian men to engage with local sexual health services?

Thank you for your time

Appendix 14
Phase Two – Semi Structured Interview Participant Information Sheet

UNIVERSITY OF WEST LONDON

PARTICIPANT INFORMATION SHEET

10) Participatory action research as a means to engage South Asian men in local sexual health services (*Phase Two*)

Barriers to health care services exist for many people and that those barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities. Fountain *et al* (2007) state community engagement takes the view that the community itself has the greatest ability to access its own members and develop local services in order to meet the needs of their community. This research used action research to work with a group of South Asian men during the Phase One of this study. This is the ***phase two*** element of the research study and will interview South Asian men to explore the degree to which South Asian men are engaged with sexual health services.

Thank you for reading this.

11) What is the purpose of the study?

South Asian men do not appear to use sexual health services. The purpose of this study is to support South Asian men in Brent and Leicester to access local sexual health services. The project will consist of a survey in the community and interviews with South Asian men to find out whether local sexual health services are meeting their needs. The study will also involve interviews with all participants to capture their experience of being involved in this research.

12) Why have I been chosen?

You have been asked to participate either because you have some experience or an interest in improving access to sexual health services. Your views and opinions are important to this research and could influence future service developments.

13) Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even if you decide to take part you are still free to withdraw at any time and without giving a reason.

14) What will I be asked to do if I take part?

You will be asked to participate in a semi-structured interview. The interview will last for approximately an hour. If you agree to participate you will be shown a briefing sheet that will outline the areas that will be discussed at the interviews.

It is important that we keep an accurate record of your opinions and therefore we will be recording the discussion. We will only use first names during the discussion and no names will be attached to comments that may be used in the final report. You will be sent a copy of the focus group report to comment on its accuracy and the conclusions drawn by the researchers.

15) What will happen to the results of the research study?

The results on this phase of the research, along with the result of the ***phase one*** findings may be shared with academics in the form of a report, journal or verbal presentations. This research will be completed in May 2013 and at this time all findings will be made available.

16) Who is organising and funding the research?

The research is being supported and funded by the College of Nursing, Midwifery and Healthcare at University of West London.

17) Who has reviewed the study?

This study has been reviewed by the College of Nursing, Midwifery and Healthcare Sciences Research Review Committee at University of West London.

18) Contact for Further Information

If you would like any further information please contact any one of the Lead Researchers listed below:

Mohammed Shaikh
Tel: 07854 263 178
Email: 21087472@student.uwl.ac.uk

If you have any complaints about the conduct of this research project and you wish to discuss them with someone other than the researcher, please contact the Lead Academic Supervisors:

Professor Heather Loveday
Tel: 020 8209 4110
Email: heather.loveday@uwl.ac.uk

Professor Kathryn Mitchell
Tel: 020 8231 2468
Email: kathryn.mitchell@uwl.ac.uk

Thank you for reading this

Appendix 15
Phase Two – Semi-structured Interview Consent Form

UNIVERSITY OF WEST LONDON

CONSENT FORM

Title of Project: Understanding the culture of South Asian men's sexual health: Using a qualitative description approach

Name of Lead Investigators: Mohammed Shaikh

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions. ☐
2. I understand that my response may be recorded. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
4. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 16
Phase Two - Semi-structured Interview Questionnaire

UNIVERSITY OF WEST LONDON

Semi-Structured Interview
'Barriers to engage South Asian men with sexual health/services' – Phase two

Title of Project:
Participatory action research as a means to engage South Asian men in local sexual health services in Brent

Name of Investigator
Mohammed Shaikh

Interview Brief
This interview is to determine whether the individual views of South Asian men on the use or lack of access to sexual health services corresponds to the views of the PAR South Asian men's group during the first phase of this study.

This interview is related to research activity undertaken with a group of South Asian men in Brent who used participatory action research on exploring the barriers of using sexual health services.

Some of the findings from the group highlighted the key issues they regarded as the main reasons why South Asian men do not access sexual health services. The aim of this interview is to find out whether individual interviews will demonstrate the same findings regarding the barriers and allow the researcher to find out whether the information gathered through participatory action research with South Asian men on sexual health issues is regarded as an effective research approach with this particular group and with this specific group. Therefore attempting to seek whether the information gathered through individuals' interviews is richer than the information gathered through PAR.

1. Individual and Personal Level
Can you tell me what you think about first when I use the phrase 'men's sexual health'?

What do you think are the other issues you would associate with men's sexual health?

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?

2. Community Level

Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?

3. Service Level
What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?

4. Research related
Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

Thank you for your time

Appendix 17
Phase Three – In-depth Interview Participants Information Sheet

UNIVERSITY OF WEST LONDON

PARTICIPANT INFORMATION SHEET

Understanding the culture of South Asian men's sexual health: Using a qualitative description approach **(*In-depth interview*)**

The Department of Health (DH) (2013) states that sexual health promotion and prevention work aims to help people make informed and responsible choices with an emphasis on healthy decisions. Effective health promotion addresses the prejudice, stigma and discrimination that can be linked to sexual ill health. In England, there are no requirements for sexual health providers to target Black, Asian and Minority Ethnic (BAME) communities.

Serrant-Green and McLuskey (2008, p.96) state views about sexual health vary amongst BAME communities, although there is general consensus amongst these groups that sex outside of marriage is viewed as wrong and discussions about sex are taboo. Serrant-Green and McLuskey (2008, p.112) also state improving the health of men from BME communities is a complex task. It involves engaging with many difficult subjects and integrating a clearer understanding of the cultural and ethnic diversity within and between communities. This study is about better understanding the culture of South Asian men's sexual health.

Thank you for reading this.

What is the purpose of the study?
The purpose of this study is to better understand the culture South Asian men's sexual health. This project consisted of a focus group and semi-structured interviews with South Asian men to find out more about the culture of South Asian men's sexual health.

Why have I been chosen?
You have been asked to participate either because you have either taken part in stage one or stage two of this study during the focus group or semi-structured interviews. Your views and opinions are important to this research and could help highlight the key issues regarding the culture of South Asian men's sexual health.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even if you decide to take part you are still free to withdraw at any time and without giving a reason.

What will I be asked to do if I take part?
You will be asked to participate in an in-depth interview. The interview will last for approximately an hour. If you agree to participate you will be shown a briefing sheet that will outline the areas that will be discussed at the interviews.

It is important that we keep an accurate record of your opinions and therefore we will be recording the discussion. We will only use first names during the discussion and no names will be attached to comments that may be used in the final report.

What will happen to the results of the research study?
The results on this stage of the research, along with the result of the stage one and stage two findings will be shared with academics in the form of a report, journal or verbal presentation. This research will be completed in March 2017 and at this time all the findings will be made available.

Who is organising and funding the research?
The research is being supported and funded by the College of Nursing, Midwifery and Healthcare at University of West London.

Who has reviewed the study?
This study has been reviewed by the College of Nursing, Midwifery and Healthcare Sciences Research Review Committee at University of West London.

Contact for Further Information
If you would like any further information please contact any one of the Lead Researchers listed below:

Mohammed Shaikh
Tel: 07854 263 178
Email: moe0@hotmail.co.uk

If you have any complaints about the conduct of this research project and you wish to discuss them with someone other than the researcher, please contact the Lead Academic Supervisor:

Professor Heather Loveday
Tel: 020 8209 4110
Email: heather.loveday@uwl.ac.uk

Thank you for reading this

Appendix 18
Phase Three – In-Depth Interview Consent Form

UNIVERSITY OF
WEST LONDON

CONSENT FORM

Title of Project: Understanding the culture of South Asian men's sexual health: Using a qualitative description approach

Name of Lead Investigators: Mohammed Shaikh

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions. ☐
2. I understand that my response may be recorded. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
4. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 19
Phase Three - In-depth Interview Guide

UNIVERSITY OF WEST LONDON

In-depth Interview Guide
'Understanding the culture of South Asian men's sexual health - Phase three

Title of project
Understanding the culture of South Asian men's sexual health: Using a qualitative description approach.

Name of Investigator
Mohammed Shaikh

Date:
Location
No. of Interview:
Age:
Phase One or Phase Two participant:

Interview Guide
Brief outline of research
Brief outline on findings from previous interviews
Rationale for undertaking In-depth interviews
Questions
Thank you

Introduction
This interview is the last data collection phase to help understand the culture of South Asian men's sexual health. Two methods of data collection have been used; focus group (PAR) and individual semi-structured interviews. The two methods used provided valuable insight and helped produce key themes regarding the culture of South Asian men's sexual health. The purpose of in-depth interviews is to further explore the identified key themes and also help validate the key themes through engaging in deeper conversation to better understand the culture of South Asian men's sexual health.

Interview questions

Why do you think South Asian men' sexual health is not discussed in the South Asian community?

How do you think discussions about South Asian men's sexual health can be encouraged amongst family and friends? Do you think this discussion should take place within the family setting?

Do you think South Asian men's sexual health issues should be discussed alongside South Asian women's sexual health issues?

Do you think men's sexual health is different amongst South Asian men from across South Asian communities? Can you identify commonalities and differences?
Do you think that South Asian men's sexual health needs are different to that of men from non-South Asian communities?

Do you think there is a need to work with young South Asian men in regards to their sexual health and sexual practices?

Do you think there is a need for research to undertaken with South Asian men on their sexual health? Why?

Do you think South Asian men's sexual health research should take place with research of men's sexual health from non-South Asian communities?

Do faith organisations and faith leaders have any role in promoting sexual health among South Asian men? Are any networks/ groups that would be more effective?

What kind of health promotion/ education would support better dialogue and recognition of sexual health issues among SA men/ communities?

What information or campaigns would you like to see available if mainstream media and South Asian media suddenly promoted South Asian men's sexual health?

Which social media platform would be effective to promote South Asian men's sexual health in the South Asian community and why?

Do you think there is more homophobia amongst South Asian men and South Asian communities in comparison to non-South Asian communities?

Do you think sexual orientation should be or not be a part of South Asian men's sexual health discussion?

Do current sexual health services meet the needs of SA men? If not how could they be reconfigured/ made more relevant to SA men?

Who do you think should be making decisions about sexual health policy and sexual health services to improve the sexual health of South Asian men?

What would encourage or prevent you from engaging with sexual health services to discuss sexual health policy and services for South Asian men?

Do you think men's sexual health should not be focused for only South Asian men but for all men? Explain why?

Thank you

Appendix 20
Phase One PAR group meeting observation/ field notes

PAR Group Meeting – Observation Notes

Meeting Number: One
Date: Saturday 29th October 2011

Introduction/ Background
Prior to this session, extensive recruitment was undertaken to establish a group of South Asian men who were willing to take part in the research study. A number of recruitment approaches was undertaken which included outreach work, changing publicity to ensure the message was culturally appropriate and visiting a number of local groups, professionals and community leaders in Brent.

Initially the aim was to establish a group which represented a number of men from various South Asian communities in Brent, although the aim was not set up a representative sample group of South Asian people in Brent as this was not the purpose but to initiate participatory action research (PAR) which relied on a qualitative research approach. Recruitment to the PAR group was not easy. Members who showed an interest in Brent found the research to be unclear and complex. Therefore a simplified poster was produced and distributed at key locations and sent to key community groups and organisations in Brent. No single community group or organisation approached the researcher for further details. Therefore, recruitment focused on individuals using 'word of mouth' techniques.

Individuals who expressed an interest were approached and invited to informal meetings at Community Health Action Trust in Brent or arranged telephone meetings. A total number of seven South Asian men expressed an interest and were keen to be involved in the research project. The men, who all live in Brent, ranged from men who are between twenty and seventy one. The group comprised of individuals who are students, unemployed, in employment and retired members of the community. A key indicator of the group was that it reflected a number of different generations of South Asian men living in the UK who would have similar and different views to each other regarding research, sexual health for men and understanding, knowledge and experience of sexual health services in Brent. Group participants represented different cultures and different sections of the South Asian male population in Brent. It is fair to note not all South Asian male communities are represented within the group as the South Asian community is vastly large, representing all faith groups, multiple of languages, caste systems, beliefs, economic status, educational background to name only a few. In addition, family and community influence and experience of living in the UK, particularly in London and Brent is a distinguishing factor. Two members of the group are also first generation South Asian communities who migrated to the UK, whilst the remaining five group members have been born and raised in London.

In order to commence the research and remain focused on the research aim and questions it was important to provide information to the group on PAR and sexual health for men. As a result brief workshops were organised each reflecting research and PAR and men's sexual health. The aim was to use PAR which would enable the participants to have an equal platform of dialogue as co-researchers and not research subjects. PAR means the group leading and deciding on the direction of the research from collective and individual actions, observations, reflections and planning. Therefore, a workshop on research was organised and delivered which highlighted the aim of the research study and explored the differences between qualitative and quantitative research, qualitative research methods and action research and PAR. A second workshop was organised and delivered to the PAR group

which explored men's health, men's sexual health and sexual health terminology and diseases. One member did suggest sharing a table with group members on what counts as sexual health and what does not to prevent the group discussions distracting on sexual orientation and gay South Asian men. Sexual health for men is a broad subject, therefore the sessions focused on three areas. A 1996 review of men's health by Lloyd (1996) in Davidson & Lloyd (2001, p.5) identified three prominent definitions of men's health; men's health as biological e.g. prostate, disease, secondly in terms of risk and risk taking and finally about masculinity. Both sessions were well received and all members of the PAR indicated they were useful to commence discussions on exploring South Asian men engaging with local sexual health services.

McIntyre (2008, p.3) states there is no one fixed formula for designing, practicing and implementing PAR projects. Nor there is one theoretical framework that underpins PAR processes. Some researchers borrow from Marx's position that local people need to engage in critical reflection about the structured power of dominant classes in order to take action against oppression. Some researchers take Gramsci's position on class struggles and his belief that economic and self and collective actualisation can distribute power evenly in society. However, McIntyre (2008, p.3) points out the major influence in the field of PAR is from the work of Paulo Freire. Freire's conscientisation theory is his belief in critical reflection for disadvantaged individuals and communities as essential for individual and social change. Similarly, Freire's development of counterhegemonic approaches to knowledge construction within oppressed communities has informed many of the strategies practitioners use in PAR projects.

Prior to this meeting individual semi-structured interview was undertaken with all group members. This was undertaken to support the group analyse and explore the views of all members towards sexual health, local sexual health services and barriers for using sexual health services amongst the South Asian male population in Brent. This was undertaken to support the PAR group start to discuss and explore a number of themes relating to South Asian men and sexual health services in Brent. Morgan (1998, p.31) Mentions one way of linking of focus groups to individual interviews is to conduct focus groups as a follow up to individual interviews. This would allow the researcher to explore issues that came up only during the analysis of the interviews. It would also to help clarify areas in which there seemed to be a number of different viewpoints from individual responses. Each interview was undertaken at the homes of each participant and was analysed using content/ thematic analysis.

A number of meeting dates was suggested to all members of the PAR group. One meeting date was agreed, but due to the Cricket World Cup Final between Pakistan and India only one PAR group member attended. This point reminded me to organise meetings which would be convenient days and times for South Asian men to attend. All group members had indicated Saturday mornings to be the best time to meet as this would not exclude them from their personal and professional circumstances and commitments. The other six members did not send their apologies and suggested meeting at a later date. This prompted me to agree a set of ground rules for the group which not only takes on board the group meetings and conduct amongst group members but also ensuring members of the group are notified if individuals cannot attend future PAR group meetings. Another key aspect is that no member of the PAR group is provided with payment or an incentive to be involved with this research study. Therefore, this PAR study relies solely on the motivation, commitment and generosity of time of each individual member. As a researcher this needs to be reminded point when undertaking the research, particularly when the research is not being driven in the manner the researcher requires it to do so.

The training facility at Community Health Action Trust was chosen as the meeting venue as this was available to use at no cost and the office was located in a building which

accommodated a number of health related organisations, projects and charities. This would enable members of the PAR group to access the research group without being identified as being involved in a sexual health research study and maintain discretion and anonymity.

Meeting/ Outcome
This session was the first session following the two training sessions on PAR and men's sexual health, and the individual interviews with all seven PAR group members. Refreshments were provided and helped the group wait for members who arrived late. This session was used to briefly look at the data findings from the group interviews of all members and findings.

It is still evident through observation the group did not seem fully confident on the role of the group, the role of each individual member and what difference they can make as a result of being involved with this study. Although the group have only previously met twice on the brief PAR and sexual health training sessions, they seemed familiar with each other and comfortable to communicate with each other. One specific member seems to be more vocal than the rest of the group and at times can be dominant with his attitude and views of sexual health within the South Asian male population.

Nearly all of the group members are supportive of the research proposed and value the efforts of establishing a group to focus on the issue of men's sexual health within the South Asian community in Brent. I started to explore the findings of the PAR group member's interview findings and this was very much one sided in the sense I was doing all the talking. I started the meeting by sharing the findings from the individual semi-structured interviews and group members shared their opinions on the results.

All of the group members agreed that sexual health is an area which is a very sensitive topic to discuss within the South Asian community. Participant Four summed the topic of sexual health by stating "sexual health is quite broad". Participant Two supported this view by stating "you can talk with your mates, but to talk with your family is not a cultural thing we do." Participant Six mentioned "you won't see Asian people sitting amongst each other discussing sexual health in their house. White communities will talk about sex. In Asians it's a shame thing. You don't talk about sex in front of your parents, even if it's positive, you don't. It's out of respect". Participant Six further mentioned "It's something what people need to work on. People are not familiar and comfortable with this thing. When something's new that's always going to be the reaction. When you work on something and they realise the benefits then it passes on one by one. You have to work on it; it's not going to happen overnight". They all held the views South Asian communities in Brent are traditionally more conservative than people of the White population living in Brent on sexual health issues and generally on the view of sex. Participant Six reflected this view by stating "white communities are more open to talk in their families, it runs in their culture".

It also appears some of the members, in particular two members have strong views against the gay community and in some cases this can be seen as discriminatory and homophobic. Participant Six said "being gay is not accepted, although the Church of England has accepted it, it's not going to be accepted in wider society". This can be as a result of childhood upbringing, religious interpretation and understanding and belief systems and general lack of knowledge towards people who have different views and outlook on life and sexual orientation. The issues of homophobia can certainly be an issue to explore with the group; although the members with homophobic views would disagree they have homophobic views and use religion as a way to justify their views. Participant Six mentioned "being gay is not accepted, although the Church of England has accepted it, it's not going to be accepted in wider society".

It is also worth mentioning one group member prior to joining has indicated he is bisexual and is married and has children. He has indicated to me confidentially that he has had sex with men in the past and his family are unaware of his attraction towards men. He has also confidentially shared within me he intends to openly share his sexual orientation to his family and is waiting for the appropriate time and circumstance to do so. During the group discussion Participant Six strongly expressed "confidentiality is the biggest thing" amongst the South Asian community. This is an issue I would not share with any members of the group under any circumstance, however as the group facilitator I need to be aware of homophobic discussions and views and steer the group towards non-discriminatory language and views.

This meeting also explored the issue of sex within the Asian community, and some members of the group maintained their view sexual health is strongly related to the physical function of sexual activity and sexual orientation.

Four of the group members represent the Islamic faith and it is apparent from the discussions of the group they hold views which can be considered very conservative and male dominated. Participant Four informed "using established centres like mosques, community centres and work with the community would be good". My role as the facilitator reminded the group the South Asian population is made up of various faith groups, communities, language and cultures. This is an important issue that the group needs take on board when planning any group interventions within the Brent community. The issue of what constitutes the South Asian community in London and in the UK can be a discussion in another chapter.

The group supported the view from the interviews findings in that local sexual health services need to offer a service which is discreet, confidential and anonymous. As the first meeting of the PAR group, although the groups focus is still unclear some of the discussion, including the rather controversial discussions and views can be used as a platform to discuss a number of sexual health topics and views for the male South Asian community of Brent.

Group Dynamics

It was apparent that two individuals seem to be more vocal than the other group members. Participant Six managed to comment on all the discussion taking place. Participant Four and Participant Two were also vocal in comparison to the other group members. This can be due to a number of reasons. One which is both Participant Two and Six are the older members of the group and they felt it was their place to share a South Asian viewpoint on men's sexual health. They felt the others would not be strong enough and can be easily influenced by the group discussions. Overall, the group agreed the findings from the interview reflected their individual views and the views of the local South Asian male community. It is worth noting the majority of the group are members of the Gujarati speaking community whose origins are of North India. Brent's predominant South Asian population is the Sri Lankan community. The group does not have a Sri Lankan male member.
All the group members looked relaxed and comfortable. I think this was due to the two prior workshops which enabled the group the start bonding and demonstrated all the group members are approaching this research at the same level of knowledge on men's sexual health and research.

As both the researcher and facilitator it was challenging to lead the discussion and allow the group take the lead. A number of prompts were used to begin discussions with the group. At times this would result in an informative discussion on the views of individuals towards men's sexual health and at other times there would be a group consensus on a specific topic such as homosexuality. The group clearly require time to form and I think individuals in the group are not comfortable to share their 'real views' to the group. Koch and Kralik (2006,

p.100) mention the facilitators role in PAR is to stimulate, rather than change, encouraging participants to change issue which are of concern to them, focus on the process rather than the results, ensure that the process starts from where people are rather than where they should be and assist participants to analyse their present situation and what they would like to plan. This will take time and require building trust amongst the group. As a facilitator this is the phase I think a group building activity may support the individuals to bond and trust one another. I also think PAR is a challenging research method to use on a sensitive topic such as sexual health amongst South Asian men, but this research approach challenges the power structures in society which can look at issues such as education and discrimination. McIntyre (2008, p.4) explains there is what he calls a 'cross-fertilisation' of research traditions that characterise PAR. He states critical action research, rapid rural approaches, community-based participatory research and participatory community research all focus on the breakdown of power structures which are present in a particular community.

Key Themes
The key themes which have emerged from the meeting include:

- ***Service Level***; discreet and confidential sexual health services, outreach sexual health services, wider men's sexual health issues
- ***Community Level***; culture & religion, perception of other communities, faith and community role
- ***Individual and Personal Level***; stigma, shame, respect, homophobia; sexual activity & practice

Agreed Action
Having dual roles as researcher and facilitator and with an additional role as an observer was challenging to maintain. At times information prompts from the interview analysis was used to lead the discussion and then I would enable the group to lead and direct the discussion. It appears some members of the group are not as vocal as other members of the group and I was keen to engage them in group discussions. I also think not knowing enough about men's sexual health prevented individuals to speak up as they feared they may share something which was wrong or culturally inappropriate.

Agreeing an action was an unclear process for the PAR group. Group members appeared unclear whether the action was for me as the researcher or for them as individuals. The PAR workshop was delivered to ensure the group understand PAR is a collective process. Yet this was not fully understood by all members of the group. As the facilitator I was aware of not imposing my thoughts on what actions the group should implement. I ensured I enabled the group to discuss amongst each other their own ideas and suggestions. I also questioned my role as a researcher and facilitator as it is important to allow the group to organically grow and direct themselves where they want to go. This means stepping back and giving the PAR group control, but I am also part of the group so I questioned myself on whether directing is seen to be a researcher or a member of the group. In PAR you will always have a lead facilitator, even if the topic originates fully from the group, you will always have one member leading the group so this makes me think whether PAR is a truly collective process or is it participant led process.

Plan for next Meeting
To continue to discuss interview findings and agree the first action research cycle.

References
Davidson & Lloyd (2001) Promoting men's health: A guide for practitioners. London: Harcourt Publishers Limited.

Koch, T. and Kralik, D. (2006) Participatory Action in Health Care. Oxford: Blackwell Publishing Limited.

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Appendix 21
Phase One - PAR group meeting transcript

Final PAR Group Session Selected Transcript
Facilitator – Purpose of today's meeting to finalise the action research process, we are clearly the action research cycles have not been going to plan, there has not been actions as a result of our groups discussions, not say they haven't been useful or constructive, it's just a case of what we do at the next stage of research and one of the ideas and my research supervisor has come up with is to undertake further individual interviews in the near future to look at sexual health far more closely around South Asian men and to look at action research in more detail. One of the key things of today's meeting is to identify key questions I can use for my interviews and some ideas from the group members of what questions to ask South Asian men, particularly around the barriers for sexual health services and possibly action research. So I will go through sexual health questions, action research questions for interview questions.
(Papers of questions circulated and data analysis findings diagram circulated which shows findings from all PAR group discussions and PAR interviews)
These questions are based on some of the findings which emerged from the PAR group discussions.
Facilitator goes through research findings paper with group.

- Stigma; shame, sensitive topic, respect, homophobia
- Sexual practice; sexual health understanding and information, wider men's sexual health issues such as prostate and testicular cancer
- Culture and religion; generational factors, faith and community, perception of other communities
- Services; discreet and confidential services, outreach sexual health services
- PAR; attendance and punctuality of individuals, understanding and action, group dynamics

Sexual Health Issues/ Services

- What do you think is the definition of sexual health men?

P3 – Yes its different now, before I thought sexual health for men was something that you just do probably with your partner. I know now it's something to do with diseases, aids and other things related to sex, not just intercourse.

P4 – What (P3) had just more or less said? I think most people link sexual health to do with sex

P1 – People associate sex with illness

Facilitator – So does everyone think their understanding on the definition of sex is clearer from this group?

P2 – It's come a long way from where we initially started because we kept focusing on the sexual aspect, we didn't talk, didn't understand that something like impotency can be related to men's sexual health. We weren't linking sexual health to testicular cancer or any other cancers or illnesses associated with sexual organs, whether it was with men or women such as cervical cancer. For us its different because we

keep focusing on the male aspect of it, as this group is dominated by males, we weren't looking at both the sexes; we just kept on concentrating and focusing on the men's bit. You can be celibate but be struck down with testicular cancer. It gives us a better understanding of the illnesses related to your sexual organ.

- Was sexual health for men clearly defined during the research?

P2 – Maybe I think you could have, it's not necessarily your fault, but when you put the word sex into anything you're always going to be talking about sex, you could have used information on sexual health. It keeps relating to sex because it had the word sex in it. Either you spelt it out for us or you think we would understand what you are trying to get at. It could be that it wasn't clear for everybody, whereas some people may have had an indication or an idea that it's not only related to sex, even though moist of our conversations kept revolving around sex. As the group went on, we had more discussions we had a better understanding or we started to understand its not only to do with the sexual aspect but other conditions as well. Maybe it wasn't clear to start with, or maybe you might have made it clear, the group focuses on the word that sticks in your head. The groups understanding got better with meetings getting frequent, that it's just not about the same thing that we were going on about, but has a wider implication.

P5 - I agree with him

P4 – I think maybe if we had a presentation on what is sexual health would have helped. It's a learning process. You as a researcher want to see what kind of perception people of men's sexual health.

P3 – It took longer than expected; the first meeting was used to explain what sexual health is?

P2 – But that might work in our favour, because it show what perception South Asian men have of sexual health? You look at sexual health for men differently to how we are looking at it. You know what it's all about or you know what kind of research looking for and the information you're looking for, but you can see when you say sexual health people jump on the bandwagon and kept on hammering on about the same thing. Maybe some of the view that came across could have been homophobic. It show our lack of understanding and knowledge when it comes to this kind of thing, is that related to the way we think or is it culturally bedded into us.

P1 – It's still a taboo subject no matter what.

P2 – It's not something we are comfortable talking about or discussing.

Facilitator – Do you think the sexual health presentation I presented at the initial phase helped or made the issue a lot more complicated, rather than simplifying the issue? Do you think a basic definition hand-out would have been useful?

P1 – I think however you tackle the subject would have been difficult and the same thing; it will always go back to sex side of it. No one ever seems to think beyond that, as time has gone by we have a better understanding that it's just not sex.

- Do you think there are cultural barriers preventing South Asian men to access and local sexual health services and discusses sexual health issues in the community?

P1 – It's a taboo, if you were to do this same research with South Asian women, how would they respond? I think it would be the same.

P2 – You see media and there's stigma in the community related to this issue, such as people can't conceive, you're labelled. In the community we always label the woman, anything sexual health is never the man's fault.

Facilitator – Do you think this taboo is the same in other communities, especially other BME communities in the UK?

P1/P5 – No

P1 – They are more open and adapted to western culture, whereas groups like Muslims this isn't the case.

Facilitator – What about other South Asian communities?

P5 – I think it would be? Asian men don't come forward

P2 – It's still a taboo, but they go out there and search for information and support groups or clinics where they can get their help, whereas within the Muslim community it might not be the same thing and might not be willing to get that help. I think people from other ethnicities are much more opened minded.

P1 – It's about fear and embarrassment, it's difficult to answer.

Facilitator – So ethnicity and faith are key indicators

- Can the communities overcome these barriers?
- Are these the same barriers for other communities? Other BME communities?
- How real are the barriers to engage with local sexual health services?

P2 – I personally think it's generational, depends which generation you talk and deal with will I think will be different. Someone who has been born and bought up here will differ to their parents and grandparents who have not been born over here. Someone born here will know there's help available whereas older generational wont accesses help. We born here will be more proactive about getting help.

Facilitators – Do you think the South Asian young generation are more open to find out about local sexual health services.

P1 – I think if you just look at what you have tried to achieve by getting people to talk about sexual health is a first step, maybe the next generation you won't need to talk about it as they'll know about it. It is about generations.

P4 – I'm not sure, there's community pressure on local schools not to talk about sex and sexual health. Parents make complaints if sex is openly discussed. Some South Asians have the same mentality as their own parents, such as core values.

- Are health topics such as cancer more acceptable in the South Asian male population?

P1 – I think cancer is quite common now, you wouldn't word it like someone's got testicular cancer, you would just say so and so has cancer. End of.

Facilitator – So is it easier to talk about serious health topics, so is sexual health disease not serious?

P2 – It comes down to taboo again. Sexual health disease means you have been banging someone and might be against your religion.

P2 – He's having extra activities!

Facilitator – why that is a problem to the community, surely that's an issue for the individual and people involved and not the community.

P2 – It's a problem because guys doing something he's not supposed to be doing

P5 – Community needs to go with the times

P1 – When you say community it's not about one person, it's about everyone and that's how it works with South Asian communities. No one's ever isolated. You would be isolated if someone found you had Gonorrhea. From that conversation it would escalate, like a grapevine effect. Someone will spread one rumour before you know it everyone knows about it.

P2 – We're a close knit community, like you're going to meet in the temple or the mosque or in the wedding, birthdays, some kind of get together. Conversations going to evolve to have you heard about so and so.

P1 – Look at the Pandit who died, no one ever knew he was gay. He got tarnished after that

Facilitator – So cancers are a lot more open and acceptable in the community rather than sexual health diseases and sexual health issues?

- What would help South Asian men take up services?

P2 – I think the internet and getting people to talk about it, breaking the taboo. Once you get people talking about it like our group. Encourage people to talk to raise awareness.

Facilitator – So organising awareness events at community locations on sexual health, would this go down a treat within the South Asian community. Do you think this would face community resistant? What would be the reaction?

P2 – The reaction would always be there. First you need to get and use statistics relevant to the South Asian community. Gender issues regarding health professionals. Mortality rates might wake the community up.

Facilitator – What about sexual health practice? Sexual health disease is increasing amongst South Asia men in Brent. Do you think it's still a good idea to share statistics?

P2 – Why not? It gets people thinking. We can't keep going on about the taboo thing; it might be a matter of life and death.

P1 – You might get yourself checked and sorted, but you still wouldn't tell anyone and not even share this to the nearest and dearest to you

- What would enable South Asian men openly discuss sexual health issues in the community? Is this possible?

P4 – Some men find it comfortable talking to religious leaders, so maybe educating religious leaders would be a start. Educating key figures in the community highlighting the key services in the community and raising awareness of those services in the community.

P3 – If they say it then it might open up.

- Do you feel more confident looking at sexual health for men issues in research?

All – Yes

P2 – It's given us more of an insight. There's a wider implication, not only associated with sex.

- Do you think the subject of sexual health for South Asian men is adequate to be covered using PAR?

P1 – I think it was worthwhile, if you have more of this then you can be more informative to other people

Facilitator – So you think action research and sexual health was a good combination.

All – Yes

P2 – It was a good combination, but I thought it would be even better if there were people from different ethnicities and different backgrounds, not only South Asian which would have given you more different views and experiences.

P1 – I think they would have similar views!

P1 – Aids is still a taboo, and that's in every culture

P2 – It's a good tool, but it's one of many you need. It's a good tool to engage people, but I think it needs to be supported by other methods.

Participatory Action Research

- Do you think the PAR training was appropriate for the research?

P4 – It told us what it was all about, the different methods?

All – Yes

P2 – Some just had the same conversations, maybe you as the researcher should have nipped it in the bud to keep people on track

- Do you think PAR meetings were appropriately planned and facilitated?

P1 – I think it was adequate

P2 – It would have been more resourceful if you had one or two points to focus on each meeting.

P1 – I think we were all reserved to begin with

P2 – No one wanted to sound stupid

- Meeting time, length?

P4 – Less frequent

P2 – Shorten the meetings, would encourage constructive discussions

- Is PAR an easy research approach to use?

P1 – With stats you can mess with the figures, it's harder to mess with this kind of research

P2 – Challenge for PAR group has been getting everyone together, being on time.

- Is PAR an effective approach for South Asian men to use on sensitive health issues

P1 – Yes, it's discreet

P2 – It's comfortable to talk when other people are talking about the same thing, and encourages people to open up. I wouldn't otherwise be comfortable talking about this at the mosque or anywhere else

- What would you do differently if you were involved in a research project using PAR?

P1 – I would have an incentive for people to take part in the research

P2 – I was involved in other research which gave £15-20 for an hours work and it showed that not only the regulars attended, but other people started to attend the meetings as well.

- Why do you think PAR is not working? Not worked?

P1 – Yeah, I think so

P2 – The research might not have an impact outside, but it definitely has had an impact on our group, the taboo amongst us has been broken. It's proved you can get a group of South Asian men to discuss sexual health issues and services. There has been something positive come out.

- What are the barriers for South Asian men to use PAR?
- Do you feel more confident to use PAR?
- What do you think prevented the group implement action cycles during the research process?

P1 – Time, volunteering time for meetings and work takes up a lot of time

Facilitator – Would it be a good idea to incentivise actions from good discussions?

All – That would have been much better

- How could the group have worked more effectively?

P2 – I you buddy upped people to work in pairs. So people would have worked with each other and bounced ideas off each other.

Interview Questions

- What are the key questions to interview South Asian men on the barriers of sexual health?

P1 – First question is to ask if they are comfortable talking about sexual health

P2 – What is your understanding of sexual health? This would let you know if you get the same reaction as the PAR group.

P2 – List sexual health conditions

P1 – Ask if they have been affected

P4 – Find out if they know where they can get help from?

P2 – Ask none South Asian men about sexual health issues

P1 – What would be really interesting is if you can get South Asian males and females in a room together! I don't think it would be that open.

- Which questions do you think would are important to ask South Asian men?

P2 – Do they know where to get help on sexual health issues?

P1 – Would South Asian men they are happy to talk about sexual health to family and friends?

P1 – If it was a White male asking question about sexual health, maybe they would have been more receptive.

Facilitator – Would it have been easier if this topic was undertaken with South Asian men by a researcher from another ethnicity?

Appendix 22
Phase Two Semi structured Interview transcripts

Interviewee Number: xxx

1. Individual and Personal Level
Can you tell me what you think about first when I use the phrase 'men's sexual health'?
Something to do with sex, that's all". Something to do with minds and something to with sex, that's the first thing that came to my head

What do you think are the other issues you would associate with men's sexual health?
I don't know how to answer that question, because I don't understand the question clearly.
In the Asian community men don't really speak about sex with their families, not as much, I don't think because of shame and disrespect.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?
No, I discuss sexual health with my friends, not with the family. With my friends it's a normal thing.
We talk about sexual health in an all-round manner, we talk about normal sex, friendship and that kind of stuff, and we talk about it all the time

2. Community Level
Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?
The community we live in now….maybe the next generation I think might be coming into it more, whereas the generation before, or shall I say the older generation won't discuss this kind of thing. To them it's shameful to talk about at the time.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
Again…..it comes down to the shame element. These people, families don't want to hear no shame about their families, so it's like me for example, I won't go back to my mother or father and say I'm gay. It's shameful and disrespectful and it won't happen.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?
I think it's the same, as I have different kind of friends. I personally have White friends, Black friends and Asian friends, so if we have this conversation of sexual health, it's normally the same kind of level.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?
Well, if it's available, and people wanted to come to it, then I don't see a reason why not. Only if it is available to them and known to them, then they might want to come…me personally I would not go. I don't think I need it and go sit in a room and

talk to a group about sexual health. I think I am perfectly fine with my friends or my girlfriend, but some people they might not have them kind if people to talk with, they might not have that lifestyle and they might need people to go and talk to about it.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?
I don't really see this kind of thing on the television, so I can comment about something that I haven't seen. If there was something about men's sexual health then I think it would be quite good. It might make people a little open minded a little bit more, but I haven't seen anything like that.
The community now, the younger generation are a little open minded now, and I don't see why they can't portray these things in the media, so people can see these kinds of things and see there is a problem and know where to contact people for help if things need to be done.
I think the older generation don't want to see this kind of thing in a faith establishment. For example, if you are sitting in a mosque, listening to a speech, and you're sitting with 90 per cent of people who are young and the Imam was talking about sexual health, I wouldn't see it as a problem. I think there have been occasions when I have heard this by a preacher, but with the older generation this would not work.
I don't think an older person would listen to it, they would probably get and up and go and would not be bothered about it, but at least it's getting through to the younger generation and they can relate to it.

3. Service Level

What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?
I'm sure there are services out there that do these kinds of things and help people, but, they need to advertise this and let people know about it as people might not know this service is available. I'm sure there loads of publicity such as in doctor surgeries and hospitals, but I don't think South Asian men know these services.
It comes down to the fact they feel ashamed going to see a doctor about this; sexual health. They think shall I go or shall I not, when they should feel like this.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?
In the White community I don't think there's much of a barrier and the Black community. They are a bit more open than the Asian community, I can't tell you exactly why, but they are, more open, and go back to their parents, open to their friends and families, this is the situation and probably go to the doctors and see the right person. They will be open about it. The Asian community are more discreet about this.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?
They need to be open to their families, if they can open up to their families that are the most important thing. If they can pass that barrier, I don't know what can be done to overcome this barrier. Something needs to make them feel secure, so when

they do speak to their families it's not going to be a problem. Right now, I don't see any avenue they can do that.
Work needs to be done with families of South Asian men, which will make it easier to be accepted.

4. Research related
Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?
Yes, the younger community will definitely take part.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?
Well some kind of security with their families. If you can break the barrier with their families, then they will open up to everything else. Right now this is the most disrespectful thing you can do. Young Asians will do all kinds of things, but when it comes to their parents they are scared to tell them and discuss sex with them.
I don't think paying people would work. I think people need to come to make a difference and want to make a difference, otherwise I don't think it's worth paying people.

Interviewee Number: xxx

1. Individual and Personal Level
Can you tell me what you think about first when I use the phrase 'men's sexual health'?
I think it's sort of diseases, which are the sort of thing I am thinking about, diseases and looking after you…along that line, possibly cancer.

What do you think are the other issues you would associate with men's sexual health?
I think sort of cleanliness and the way you go about looking after your own health and your own genitals and keeping check of signs of things and visiting doctors. Keeping a check on you….anything abnormal in the body particularly around the genital area.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?
Not as much as it should be. It is a bit of a taboo subject unless something was really worrying me, I would be sceptic to even go to the doctors. I suppose it's not a good thing. I don't discuss it as much as I should, and leave it to the last minute if I was a worried about a lump or something.
I'd say if I was worried I wouldn't go to the doctors so easily.

2. Community Level
Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?
I think there should be a little more awareness about it. If it's out there, at the surgery, people would feel more comfortable. I don't see much about it. Recently, I

have seen things on blood pressure, heart conditions which has made me aware of common disease amongst Asians and now I am thinking about those a little more. If that was the same for sexual health it would help open up the topic.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
I think it's not the 'norm' thing. In the Asian community if they are going out and sleeping around it's frowned upon. I don't know much about it myself. If people say there's Chlamydia and there's a cure for it, or its easily fixed, people won't be so frightened to seek help for it, whereas if somebody did have something they would be scared, even I would be scared to seek help.
I would be panicked, I would think this shouldn't be happening to me and people have been through this I think wow, how did they do it. I don't see information about this.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?
I think with other communities they are open about these things. I think we (not all South Asian community), but certain groups, religious groups it's just never been an open discussion. Our parents, my parents have never explained sexual health to me. We learnt from cousins and going along with life. I think things will change, my sons coming to adolescent age and I will at least ask him if he needs information about this.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?
I think there should be one. If anyone is struggling with this they have somewhere to go to and if you put them in that predicament it will be easier for them or some sort of a confidential helpline, men feel at ease. I just think there should be more information, you can't prevent cancer, but other diseases you can if you have the knowledge for it. Prevention rather than cure. The other side of the spectrum is that until you don't face it you won't research it. So it's a difficult one on how to put it in people's faces.

It would be good to approach Asian football clubs, approach the committee and have a word with them. They can pass leaflets on. If it's a random leaflet through your letterbox you will throw it away, but if they distribute it you will take it on board.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?
I think media, internet coverage would be massive. The Asian media will have a lot of older people listening and watching, so I think that would be a good. I don't mean to sound cruel, but the older generation are too set in their ways to change their mind set, but I think 20, 30, 40 and 50 can be educated for future generations.

I think faith establishments should play a role, places of religious worship only concentrate on religious things, but I think they need to. Life is not about just that, it's also about other things. I think there should be help groups within the faith groups

3. Service Level

What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?

I think there needs to be awareness, and train people in religious groups to know about these services.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?

I think if somebody has Chlamydia, its frowned upon, even with HIV, people will say he's done wrong. If you got HIV people automatically assume your gay, but it's not necessarily transmitted like that. If people are aware then they are more compassionate about these things. I think the main thing is education. If people are educated on this subject, then they won't want to hide. Other cultures are more open and supportive.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?

Education.

I mean don't know about other communities, but I think the Black community are the same in the sense people are more reserved and stay within their own community. It's only now I see people interacting with different cultures and adapt. In England the culture is about freedom and being open, and that's the right way for this issue.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

I think on an individual basis it will be hard. There's always going to be some people who ready to participate and others who are not. I think it's important to aim at groups such as football clubs, so if you have the coach or manager on board who can provide access to more men. Group basis would be better and accepted.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

Money.

Numbers or statistics usually help, such as the amount of people suffering would gain compassion from people and take it away from the money side of things. This would prompt people to do something about it. If you can explain, horror stories or case studies of individuals then it will help. It can happen to anybody. There's no harm in checking yourself.

Interviewee Number: xxx

1. Individual and Personal Level

Can you tell me what you think about first when I use the phrase 'men's sexual health'?

I think about whether I am capable of having sex, is my sexual genitals in order, have I got any diseases or anything I am ashamed of are the main things that springs to mind.

What do you think are the other issues you would associate with men's sexual health?
Sexual health can be about any form of activities, but also such as erection problems, impotence due to alcohol and drugs. Some people might have the urge to have more sex whilst on drugs. Drugs and alcohol can be a good thing for some people and bad for some people in relation to sex.

If people are not under influences, they might not be able to perform well, or perform at all or might perform event better, when using or not using drugs.

Sexual health is also about mental health, people may assume every time you have sex you pass on disease, when that's not the case in terms of prostate cancer or testicular cancer.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?
I wouldn't say we talk about sexual health, but as a person I do talk about issues such as continence, it's not related to my sexual activity, buts it's related to the part of my body I have sex with. I question why I need to go to the toilet so often, but it's been explained as you get older bladders become weak and it's hard for people to hold their urine.

I would not discuss hard core sex, such as sexual moves. We might talk about sexual problems to do with our bodies, but we would not talk about sexual health itself.

2. Community Level
Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?
No. I don't think it's possible. We are very conservative about things like that. When it comes to sexual problems, we like to keep it to ourselves. If there was any other form of illness, we would be happy to share it with everyone and tell everyone to pray for me. As soon as it comes to sex, we feel reserved talking about it and maybe you may talk to your good mates who may end up taking the 'mickey' out of you. If you talk, you would keep it between you and the doctor. Asian people take a long time before we actually go and see a doctor for a problem.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
I think the reason is because cancer is not something you have due to sexual activity, so it's easier to say it. When you say you have gonorreah or Chlamydia it's through actions of sex you have it. Its most likely people may say I can help you, or people will say it's your fault, you went around dipping here and dipping there, so when it's part of the problem cause by actions then you are reluctant to talk about. In life you may get cancer, you think and people think it's no fault of your own, and

want people to pray for you and that's why you come out in the open about those health topics.

Sexual diseases caused by sexual activity is regarded shameful and Indian people are concerned with shame and honour and you need to consider other members of your family such as wives, children and parents. The community we live in is not broad minded. We may live in a western world but we still are not very broad minded.

I think now there's second and third generation South Asians, we have a western way of thinking, not to say we become westerners, but willing to talk about these issues, this can happen to anyone of us, let's talk about it.

As generations will pass it will become easier to talk about sexual health in the future.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?
This is what research can help out with. Do South Asian men have more sexually transmitted disease, are there more HIV positive men or are other communities, due to lifestyle, have higher rates of sexually transmitted diseases and infections. I think it does, South Asian people are regarded to be clean, wash before and after sexual activity whereas other communities would not. One of the main reasons of getting sexually transmitted disease is because other communities are not circumcised. Men with circumcisions have a less chance to get sexual diseases. The other thing is washing regularly. Regardless of your faith, people from South Asian communities use water, as it's a cleaner method and toilet paper is expensive.

I think South Asian men think they would be less likely to catch sexual transmitted infection than men from other communities.

However, I don't live in South Asia and therefore do not know what South Asian men generally do.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?
No. If there's already a group for other men, we should use that group. This way would help us understand each other's sexual health and transmission of sexual diseases. If you stick just to your own community you will not know what's going on in other communities. We need to know what happening everywhere. We may form a group for South Asian men and still have men reluctant to talk, you go to a group of non-South Asian men and you will see people talking and give you courage to speak. As Asians we are very conservative and don't want to be the first one to stand and talk about our sexual health and voice our problems. Yet if we had a couple of people who came in and broke the ice would be very helpful.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?

At the moment all you see on television is sexual health adverts for people who are of teenage age and make them aware of what can happen which I think is a good thing for the future. If we educate people now, we can reduce sexual disease in the future. To have anything for older men is a bit too late because older men would not even act upon it.

I see an advert for prostate cancer. I feel I have the same problems and symptoms, yet I won't phone up and act on it, because I think it's either this or that, and hoping all is well.

Start educating people now for future generations who will be well educated on sexual health and practice safer sex.

3. Service Level

What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?

What we need to do is raise awareness of services. I think it's hard because your GP is the first point of contact. Sometimes having clinics everywhere are helpful, whilst your own GP can help you much better. GP's are the right place to raise this issue, rather than going to a sexual clinic in medical centre which may make people ashamed to visit and sitting in the waiting area. I don't think anyone apart from your doctor should be involved in your sexual health. I don't think we need extra services. Economically speaking we are taking certain money from certain budgets for these services or start up a project when we can use primary care services much effectively. Your doctor should be the best person. We are just using the services already provided.

I think our GP's need to check people for certain illnesses and disease in accordance to your age. Do we need to only see a doctor when we are ill, can we not go and speak to him about our problems and family health. Doctors should speak to patients about their health, and it's confidential.

Doctors need to raise awareness about men's sexual health. They should engage with men and discuss sexual health awareness, diseases and symptoms. Doctors need to be proactive not reactive.

Men don't have anything such as women's smear test and this should be available.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?

Simple one word….ignorance, until they have left it too late. South Asian people ignore a lot of health issues until it becomes to a point we cannot ignore it and need to do something about it. It's only then we are happy to go and see somebody about it. When the lumps got big on your penis, not when it's small and started.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?

I think the best thing is to have people who have first-hand experience of sexual disease or illness and say to South Asian men to come down to a meeting and listen

to people who have experienced these issues. This may help people to open up and discuss these issues. This can also be an opportunity to ask questions we may not necessarily ask our doctor. You can ask questions about symptoms.

We won't get South Asian men coming forward, we are reserved. I think in another 15-20 years we will have South Asian men and women happy to discuss sexual health, sex and sexually transmitted diseases. I think it's in the process, but for the future, today we are still ignorant. It will also get easier for Asians coming in to the country in the future. We have not adjusted just yet, but in 10 - 15 years this will happen.

In the future you may get South Asian men talking not only about 'banging' but about what you can get from sexual activity, such as lumps and discharge, soon people will start talking more.

My parents could not talk about girls and boys, I talk to my children about boyfriends and girlfriends and the first thing we do is talk about sex and contraception. We condemn it but if things are going to happen let it happen in the right. We need to be open and who better to give advice about sexual health information than parents.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

I think it would be good to have it, but not sure about the attendance. We can say let's have a sexual health initiative or meeting. On your face they may say yes to attend, but won't as they are conservative about this issue.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

Biggest incentive would be privacy, not sitting under a board about sexual health, not a free drink or sandwich. Like me and you, in privacy it would be much better, they can go into detail.

Interviewee Number: xxx

1. Individual and Personal Level

Can you tell me what you think about first when I use the phrase 'men's sexual health'?

I think about basically male and females interacting with each other regarding sexual relationships.

What do you think are the other issues you would associate with men's sexual health?

Well the other issues are sexual disease such as gonorreah and Chlamydia

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?

Not really with family, maybe with friends. Due to respect I won't talk about this with family, but with friends, yeah, I also talk to and my wife, my partner. It has to be the right time to talk about this; I won't talk to my family.

2. Community Level

Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?

Yeah, maybe, as long as they speak to the right people to be honest with you and the right organisations are there and the right people are there to give the right advice as well. That's what I think. They might have issues regarding sexual health and they want to be steered to the right person and speak to that person openly.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?

It's due to keeping it to them, protecting them. They don't want to share that people, I don't know, there may be a shame to those kinds of things, maybe that's why.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?

Yeah there is. I think South Asian men are more to private. In other groups people want to talk about it and some people don't.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?

Yes, I think there is because some South Asian men will comfortable talking to other South Asian men rather than talking to a stranger that they have never met or spoken to before and they may feel comfortable talking to someone who is South Asian.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?

I don't really see about South Asian men's sexual health in the media. I do listen to radio regularly and there's more other groups more open and discussing sexual health rather than South Asian people. I don't really hear male South Asian sexual health problems.

I think it would be a good idea to use media, it would provide support and information.

3. Service Level

What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?

It would be a good idea to advertise the services using leaflets and billboards on South Asian men's sexual health.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?

I think the cultural barriers would be the family. Families only discuss this within and not want to discuss outside of this or speak to other people about this issue.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?
Basically, by encouraging them and advertising services that can help South Asian communities. Visit them on a one to one basis and visit their families as well.

I think so; it depends on the individual, their life and people around that person.

4. Research related
Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?
Depends on a person's character, some South Asian may be fine to take part others may decline. It depends on the approach and how they feel. It's individually based.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?
Form a group, have meetings, and taking it from there. I would get involved in research on an individual and group basis and would not mind taking part voluntarily.

Interviewee Number: xxx

1. Individual and Personal Level
Can you tell me what you think about first when I use the phrase 'men's sexual health'?
Men's sexual health meaning any sexually transmitted diseases such as HIV, unprotected sex, not using contraception.

What do you think are the other issues you would associate with men's sexual health?

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?
Never, I don't know, with the Indian community it's very rare and it's never open, there's always been a barrier. It's always been more due to respect and whether it will be bad if I asked them kind of questions or talk about it with the elders.

I have talked about it with friends in regards to one night stand and unprotected sex, but nothing else.

2. Community Level
Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?
I think yes, I think you just need one person to speak up and you will get people to follow suit. It can probably happen if you got a group together.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
Sexual health discussed openly implies this person has been sleeping around, has many one night stands and they have a mentality of why they have HIV or sexual diseases and we have not.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?
I think they are more interested in the topic and will go to learn about it, whereas South Asian men tend to sit back don't want to know about it. With other groups are much more careful and weary.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?
I think you can set a group up, maybe even change the name, so people can talk about it openly, and not mention the sexual health aspect. That might put people off. If you were getting a group together and renamed the group, you may get the attendance. I think it just takes one person to speak up and everyone will follow, such as Men's Health Forum. That would attract men and encourage them to speak about health issues.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?
Media wise I can't say, but I don't think there's much awareness and the impact certain actions can have or ways to better yourself. I don't think there's enough information out there to educate people via the media.

One way is to use Asian channels such as Zee TV and Star Plus and they have millions of subscribers. You have many adverts on there and spread the message nationally.

3. Service Level
What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?
I think holding regular forums and keeping available information online, so if people cannot attend they can still access the information. I think it's important to hold regular meetings and holding activity days and interactive days.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?
I think it's just because you don't speak about it due to respect of the elders and the way you have been brought up.
What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?
I think getting together with everyone, rather than just South Asian men, hearing views of other people can help with rapport and everyone sharing their own experiences.

I think different people can always speak to parents about sexual health, whereas in my experience South Asian people do not do that.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

Yes, I think they would. If they saw someone undertaking research from the South Asian community would encourage others to get involved and someone they can relate.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

Financial incentives, it shouldn't be always the case, but this can get anyone moving. Organise activity days and team building exercises.

I think South Asian men should speak up, go get help, and have protected sex and I think if there's an issue, to go and see someone right away.

Interviewee Number: xxx

1. Individual and Personal Level

Can you tell me what you think about first when I use the phrase 'men's sexual health'?

It's about the sexual health of men such as diseases. Obviously, sexual health is important, you would not want to catch any diseases or pass any disease to anyone.

What do you think are the other issues you would associate with men's sexual health?

I think issues such as prostate cancer, testicular cancer. If you think there's something wrong, maybe having a check-up. You need to be careful about your sexual health and contraception.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?

Yes, sometimes at work we discuss. You hear in the news about people contracting AIDS, so we always discuss this. Why do people do this, especially when people are aware they have AIDS and still sleep with other people not using protection. Sometimes we may read something in the news and when we are all on a break at work we have a quick chat about this. What goes through the mind of people?

2. Community Level

Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?

I don't think many men would openly discuss sexual health, they may be embarrassed. I think we should to know about diseases, and people have understanding and especially for people from other countries who may not know much about men's sexual health.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
It is two different things. Cancer is on a 50/50 level, you either get better or worse. Someone with cancer will talk about the treatments they are having, whereas they don't want to about it because it's curable. In a month or two why do I need to tell people if I can cure it? I think if you have infection you should talk about it so that other people know and become aware.

Some people may not know about other sexual related diseases.

HIV is more serious, you can pass it on to other people. It should be talked about, especially if the person is involved in sexual activity with another person. The other person should know if the person has sexual diseases.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?
There's a big difference because South Asian men do not talk about it. Other communities get more involved and talk about it more so at least everyone knows. Maybe in the South Asian community are shy to talk about it. I think we should know more about it, other communities know a lot more.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?
Definitely, sexual health is important. You can set up a session to talk about it or produce leaflets so people are aware. You may even get a few people coming forward to say they have had something (disease) and may be interested.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?
Yes, I see stuff in the news. It's not related to this country but you always see things about a high population of AIDS in a country. So I think there is enough in media about sexual health.

Some people may do, some people just associate sexual diseases such as AIDS to poorer countries and that this country is better and thinks this kind of thing doesn't happen over here. They watch it in the media, talk to their family and friends, but take no notice of it.

3. Service Level
What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?
I think there should go for a check-up if they are worried about themselves. A regular check-up which may help people who have contracted diseases and are embarrassed to go and get help.

Leaflets and information about what can happen if you experience a sexual disease and what can be done to cure it.

Services should have leaflets targeting South Asian men.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?
It's probably because if other people find out, it can be shameful and will everyone find out. This may mean being picked and they may be kept away from people's families or friends. This is a big problem.

In other communities people would keep it to themselves.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?
You can overcome these barriers. You need to be confident and its needs to be done. Everyone needs to know the consequences about sexual health so people are aware.

4. Research related
Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?
Yes definitely. I think if people were aware of research taking place on sexual health, many people would come forward. It's because people would see the benefit of taking part rather than just talking about it and nothing being done. They may learn a few things.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?
They may have been through something similar, such as having a sexual disease or cancer and that may encourage them. Family members may have experience problems and this would be an opportunity to make a difference.

Interviewee Number: xxx

1. Individual and Personal Level
Can you tell me what you think about first when I use the phrase 'men's sexual health'?
It's a bit of a taboo subject in Asian men because you wouldn't really talk about sexual health in general, especially with men and it's a taboo subject and people shy away from and don't really open to.

What do you think are the other issues you would associate with men's sexual health?
It's quite weird, especially being an Asian man myself, we don't really grow up with that in your home and you always shy away from it. It's more of an ethnic, more of a cultural thing to think if I'm heterosexual I don't really have much to think about, I'm fine. You don't think about it and protect yourself in your own bubble.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?

That's interesting because you don't. Being a bloke you speak about sex, but you don't speak about if you did something this is the implication and what can happen. So, being a bloke you wouldn't think how is your sexual health because that's a conversation you would not want to have with any other male, not unless you were in a formal interview or having a meeting or discussion with your doctor or something on a professional level. Generally you just don't, knock it on the bed post and you move on from it.

I don't think you would have a conversation with your friends if you had discharge or a lump and it comes down to being heterosexual. If you are heterosexual you would not speak to another heterosexual male. It kind of goes on to thinking is the person actually homosexual. You can kind of cross that border and heterosexual men move away from that because they think others are going to find them weird. You wouldn't speak about that.

2. Community Level

Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?

I personally think it is possible, because now the generations have moved on and generations have got older. The older generation will not accept it and it won't happen with them, but this generation is grown up in Britain and is more open. Talking about sex is not that bad. Before it would have been, you wouldn't even talk about it, but now it's like you have a laugh and a joke about it. So there is a way of moving it forward to get to the stage where you can actually say you have got think about your sexual health. If it comes from a professional it has more respect and understanding, but if it comes from a general conversation with your friends it wouldn't work

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?

I think because cancers such as testicular cancer is a disease which is life threatening people find it easier to talk about it, but who they talk to about what disease they have is normally not in general public knowledge. It's probably someone who is close to you and you feel you can share that information with them. If they wanted to generally say they have cancer they would say it's a male problem instead of saying I actually have prostate cancer or testicular cancer. It does happen.

I think it's because the older generation have put us in the thinking mode of not talking about things like that. I think just now talking about breast cancer, women talking to men in the homes have got a lot easier now and more open. Prostate and testicular cancers are not discussed because there's not as much focus on them.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?

In the generation we are in, I would say it's probably the same. In the Asian community we don't talk about it, but you would hear about it in the wider community because it's more open and it's more acceptable.

If you are out of marriage you would not talk about it. It's something you do behind closed doors and no one else would know, you even tell your mate about it, as they

may think “oh my God..you filthy…” So, it’s there, I think it’s probably on the same level but we just kind of hide from it and its everything behind closed doors. So everyone shy away from it and deals with their own problems instead of opening up and saying what I have done is a mistake…”hey guys”. Prevention is the main factor. We are a lot more closed and that comes down to culture and understanding.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men’s sexual health issues and services? Why?
I think now it would be better to open up a forum, as I said, generations have moved from older generations to our generation. We are actually sitting here and talking about this which is a big leap forward than the older generation where you wouldn’t exactly speak to someone older. They just would not have this conversation with you, but now if there is a forum and a group set up and there is somewhere to go and talk about this people would go. You have got talk about this because this is happening, like it or lump it, youngsters are having sex. So you have got to deal with it and for them to actually open up and understand what’s going on.

In mainstream schooling they do have sex education, even though that still is a taboo subject within the Asian community. Parents know that’s there but won’t talk about it

How do you think the media (radio, television and newspapers) influences men’s sexual health issues? How does this impact within the overall South Asian community?
Media never portrays men’s sexual health. There was a time a few years ago bombardment from the Government advertising about prostate cancer. Check yourself. That was it. That was the only thing. They have not said sexually transmitted infections are rising amongst men. It’s always in the women’s side of things, possibly the Government think if we educate the women the men will follow and solve their problems. The Government has only done the cancer campaign as they think if people don’t check themselves it will end up as a big bill on the NHS. So that’s all they did, other than that they have not done anything about sexually transmitted infections and men’s sexual health.
There’s not much out there.

I think men’s sexual health messages in South Asia media would make a difference but I can’t actually see an Asian channel doing this. It depends on how they see it and put it across because the Asian community the younger generation live with the older generation where this is still a taboo. So trying to break into this will not work. They will start losing viewers. They would want to move away from that. It would help if there were leaflets, if there was forum, if there was a bit of understanding in general conversation on the radio or a small newspaper clip, booklets and leaflets in the GP surgery. It needs to be behind closed doors and a quick conversation. Moving on you can become more open.

3. Service Level
What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?

I think services would need to step up first before the men would actually step up. I think the services would need to try and make it easier for men to feel less embarrassed to speak. When something like this happens to a bloke, it's very difficult for a bloke and embarrassing about their own sexual health. Services need to set up general health appointments for certain generations for a health check and within that health check a discussion can take place with your GP about sexual health. When you are put in that position you are likely to discuss it.

It's a lot harder for men to approach services.

NHS needs to look at men's sexual health in accordance to age groups and target vulnerable men before it gets too far.

Work needs to be undertaken in schools, separating boys and girls and having in-depth conversations about contraception and consequences at an early age.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?
I think the other cultural barrier is that most Asians have an Asian G.P. That can be embarrassing and prevent people from talking. The NHS does provide walk in centres and services, but how am I going to walk into that in case someone sees me. It's that understanding of that embarrassment. It's a really difficult situation to be an Asian man and deal with this as it's very embarrassing and due to the community being close knit this can have a ripple effect.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?
Honestly, with men's sexual health it's very hard for men to come to terms with having or potentially having a sexually transmitted infection or I should actually get checked out. For men it's really embarrassing, but not as bad in the wider community.

There's a lot that has happened for the gay community to help them understand about their sexual health and they probably use sexual health services a lot more than heterosexual men. The way to overcome it is to have a screening, a general health check for men which would include sexual health. This would help break the barrier to speak to your doctor and make men think it's actually not that bad speaking about my sexual health with my G.P, I can now go and talk to him about sexual health matters or I can walk into a sexual health clinic and get checked out. The initial first visits always the hardest, once that's done and the embarrassments over you can do it.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?
I personally probably would to help it and to understand being the newer generation on where and how we live in the wider culture and if it will make it easier for the generations in the future. As I said, I don't think the older generations would participate. You may find only a few men of the older generation taking part in

research on men's sexual health and talk openly about the issues and how would we address these issues. I think you would need to find people with an understanding that this is related to the wider community and not culturally wrong, we should be talking about this. I think its 50/50 split, people for and people oppose.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?
Timings and things like that and help to understand this is linked with the wider community. At some point introduce an incentive such as a financial gain, especially in the Asian community as this would encourage them to step forward rather than a certificate. They would say who I am going to show this to….. That's the way it is. It comes down to how South Asian men think; if there's a financial gain they would think about participating.

I think what this research is doing is the first time I have come across such research and to think about South Asian men's sexual health and how you can move it forward and create a forum and to see where it can go. It's a wider issue that concerns all men form all culture and races. I think it's really good.

Interviewee Number: xxx

1. Individual and Personal Level
Can you tell me what you think about first when I use the phrase 'men's sexual health'?
I put it down to men possibly having problems, sexual health problems. I think I see it as a negative thing straight away, on the basis of sexually transmitted diseases and that kind of stuff and people are not aware what precautions to take. That's the first thing that comes to my mind. Negative and I feel this is to try and raise awareness.
What do you think are the other issues you would associate with men's sexual health?
I would say people's ability, sexually to be able to perform because some are not confident and don't know what they can do and what they can't do and what their bodies can do. There may be certain types of medication, physically and mentally just to be able to do well and feel confident when you are delivering and having sex. Some people may feel premature ejaculation is normal if they don't know anything else, when they to engage in sexual intercourse, they would think that's just fine. There is help that they can get whether it is medication or having problems in their own relationship.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?
Yeah, I am quite open and the people around me are quite open because maybe I associate myself with very open people.

I say it's more of a case of someone has an itch, redness or soreness, some form of being uncomfortable. Where I work the lads are quite open and I am quite a sexually active person and I am not committed to someone, so I am aware of what can happen and I'm aware of what precautions to take as well.

When I am with a different group of friends they may say you need to be careful and you may get this and get that. In my place of work when we talk about sexual health you will discuss soreness and discharge. There has been a time when I have needed to go the GUM clinic but that was like an open discussion in the office which made me think maybe I have caught something.

I guess the people I associate myself around these issues are from a non-Asian background and I feel it's a lot more open, there's awareness and it's not a bad thing should you have caught something along the way. You are not scrutinised for it and it does not make you a dirty person. I feel in the Asian community and culture, if I was to discuss this issue they would be worried and concerned and imply I am dirty.

2. Community Level

Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?

I think it is possible, I think it depends on who someone is conversing with and what angle they are taking. There is going to (coming from this community which quite narrow minded and closed) be people that see this as a bad thing straight away if someone has an issue or a problem. I do think it is a problem.

I personally would, being the stage I am in my life, I could not care what people think of me. I am what I am and do what I do and it does not make me a bad person. If someone has a problem with that, then that's theirs. I feel I would get that from the Asian community.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?

I think it's because is an extreme personal matter. Upon catching or having a sexually transmitted disease such as gonorreah or Chlamydia, people will use to judge ones character. However, with regards to a cancerous disease, people will think that can just happen to anyone. That is not a result of one's conduct or what they have done or their action that they have taken. If someone has a sexually transmitted infection that's their own doing, not taken precautions, and not been with the right people. I guess in the South Asian community, depending on what religion we are talking about, it is not acceptable to have sex with someone who is not your partner and that's it. I feel this is the reason why people do not discuss sexual diseases compared to cancer.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?

I think probably not because people are just people at the end of the day. Everyone has a belief system and people will do what they want to do even if it is secretive or openly. I think that's just human nature. We have a sex drive and we are going to do what we are going to do meet our pleasurable needs.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?

No. I don't think so. People will only openly discuss their sexual health issues with people they know and are comfortable with. If there was a forum or a group where people can go, I think one with be reluctant to go because they may know someone else may be there. It may be a good thing because if someone else is somewhere

where they are not supposes to be, because they should have taken precautions. I don't think that would be a good thing.

I think if the South Asian community associate themselves in a certain area or place I think billboards and signage with phone numbers which are discreet and confidential would encourage people to come forward and call.

I think using Asian channels would make someone think maybe I have done something wrong and people would be more open as result and discuss this over the phone and take the appropriate steps.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?
I don't think there is any media on men's sexual health because its classes as obscene in the culture. I do think radio and Asian radio and television, and even partners need to know about precautions would work. I don't think a men's sexual health group or forum would work.

3. Service Level
What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?
I think it should be treated in the same way men from other communities are being treated. Awareness needs to go in television and radio to be out there. I don't think the service needs to wait for people to get medical advice or help in that area. I think there is a system in place and it works for a very large population so I think if there was awareness then I think people would come forward and take up the relevant service.
I think should there be a billboard in a highly populated South Asian community which had a free phone number, the service should be multilingual I think would work. Individuals would thereafter go to the clinic or service as and when they want to do so.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?
I don't think the South Asian culture is backwards. It's a forbidden matter in the Asian culture, goes back to whichever belief system for people. It is not acceptable for someone to conduct themselves in that way; people should not be catching anything. They shouldn't be having issues. The only other thing I can think of is if they are impotent or premature ejaculation or not able to get aroused so that's a medical issue. I think one would go and seek advice on those issues or they would sit themselves in the corner for the rest of their lives.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?
I would say it's the same. The first part of the question I think it would need to be on a private basis. For example, when a GP meets their patients, when a patient has a medical issue should give them a leaflet and tell them if you have any problems and want to discuss sexual health you can and pass a leaflet. I think this is the only

person that an individual can break down their barriers. I am quite an open person but I would be reluctant to discuss sexual health with somebody out in the community. If there was a group I would be reluctant but in my GP I know everything I discuss remains confidential. So my first point would be by my GP and ask me questions on sexual health, but they would need to do this to all men on their patient list, not just South Asian men.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

No, because I would still see this as being frowned upon from a cultural point of view. God, if I was to say I was doing a run for breast cancer and joining my sister that would be great. If I was to say I am doing a run to prevent AIDS I think the Asian community would frown upon it and say it's a man-made disease, so it's self-inflicted. They see it as people being stupid and ignorant and over sexually active, inappropriately taking part intercourse with the wrong people. I think that view will always remain.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

No, because I would think it's quite a secretive topic and situation in the community and I think to get a group of people involved would not even work, even students would not work.

I think maybe, those that do and can catch diseases know so much about it promote sexual health on Asian pornographic websites. People viewing pornography should also view messages on those sites about men's sexual health.

There was this huge awareness of testicular cancer, and all the lads discussed this, if you have a lump check yourself and everyone did that openly but that's not a man-made diseases or the result of sleeping with too many women. Awareness should be everywhere. Asian men use pornographic magazines and this is where key men's sexual health messages should be present.

Interviewee Number: xxx

1. Individual and Personal Level

Can you tell me what you think about first when I use the phrase 'men's sexual health'?

I think of just your general wellbeing and your sexual life. Have you got any problems related or linked with it, any illnesses that impact on your sexual performance? Do you check for cancer and things like that?

What do you think are the other issues you would associate with men's sexual health?

You have sexually transmitted diseases and it's not an open subject in the community. It's not to be spoken about and it's a taboo subject and if anybody being treated for that, or if somebody finds out, it's a very dark area.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?
No. I have not experienced anything sexually before. Anything I have done is always a positive thing such as I have been with X, Y and Z and that I have done this and done that, but it's never the other side of the coin such as I could not perform last night that will never happen.

2. Community Level
Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?
I don't know. Like with everything. I am going to use cancer as an example. I have a nephew who has testicular cancer. He had a lump and the cancer spread and underwent chemotherapy. It was wow. The attitude was that those things don't happen to us. I think if the was something there, availability of groups or information available, people would. I think it's a confidence thing.

There is not enough information. When this is targeted, it's targeted at certain races and groups such as cancer only being associated with White men. Testicular cancer… you must check for it….the White man will do that. You know the whole mind set of all the advertising and information is geared towards a certain race or a community, but not targeting every single male from every single community.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?
Religion plays a big part. Religion….If someone was promiscuous and slept with three different women and caught sexually transmitted disease, you know questions would be asked such as how, when, why, with who. That individual would not be able to answer that question. You are with your wife. It's the whole religion thing. It's just forbidden; you just cannot sleep outside of marriage and have sex with a female outside of marriage. Imagine if you come back and had a sexually transmitted disease and you tell the community and pray for me. They would react and say hold on a minute you have just done something totally forbidden so you just don't announce those things. It goes on and is probably there but it's a very, very embarrassing thing. That door will never be open and accepted.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?
Yes, absolutely. The culture is different. In the White community it is acceptable. You can have a boyfriend, you can have a girlfriend, you can have sex before marriage, you can do all of those things and you can start at the age of fourteen. There are youngsters who start at the age of fourteen, if not earlier and families know about it and it's quite open. Whereas the South Asian community those things just don't happen, although they go on it's not open and families will not accept it. It just does not happen. Maybe that's the problem.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?
It goes to the subject that it's geared towards the White men and not South Asian men. It's more of a case of this should be for every single man. I think you need to go back and say hold on a minute, what group or what culture we are targeting. I

think it's there and make them aware and say this is for you as well. It's not just for White men or Black men. You don't want a separate group just for South Asian men because you will create the divide even more and that can hinder progress in the field or research in the field. You got to keep them together and it's just the way it is marketed.

Services need to promote their services for all men, not just predominantly White men.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?
I think it does, a lot of people do not listen to radio or watch television or a combination of the two. Their main source of knowledge is normally the doctor. Maybe promote this with doctor through questions, raise awareness and that there is help if you have an issue. This is initially a personal approach first as oppose to saying we have a clinic and come down. A lot people won't.

I think it's a good to use South Asia media but it goes back to divide issue. Sexual health help is for everyone regardless of race, colour and culture. So if you start going down that route you will start to exclude certain groups and certain communities…you don't want that. You want everyone to come together because that would help the research in sense of identifying what's different for a white male and what's different for a male from Africa and a male from the Indian subcontinent and things like that. That would help the research

3. Service Level
What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?
They need to promote it to all men and be inclusive of South Asian men.

I think it goes back to the GP. Then of course the media and all those play a part but it needs to make everyone aware. There was a similar campaign for coughing. If you were coughing for four weeks it encouraged you to go and see your GP. Something similar would be good. That campaign did not target each community that was aimed at everyone and used the symptoms; it was open to everybody and not to a specific race.

Promote the confidence to see your GP and seek help.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?
Embarrassment. I think embarrassment, expectations, peer pressure. It's a close knit community. There is something wrong with you…those kinds of attitudes. I think those barriers can be overcome in time. You need to open the doors first.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?

Yes, we can. There was a time when South Asian men would not be seen in a pub, but you get that now. There will never be anyone from the Indian subcontinent that would admit their families use drugs or are taking part in sex outside of marriage. The way to overcome this is to engage with people, encourage people to use services. It won't happen overnight, but in five to ten years it will be much more available and accessible.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

Yes, but in what context and what manner the research is being undertaken. Initially people will be very reluctant to be involved, or give leaflets to people to find people who have sexually transmitted disease to get involved.

Awareness needs to come first then engage with them, and spread key messages such as you people are not excluded from this. It can happen to anyone. It's not to do with colour or a religion.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

I think for them to take part and take it seriously is facts. Giving people facts, nobody is exempt; nobody is going to look down at you if you have this. Genuine real case studies, what happened and how it was treated. We don't people who are going to be shy or embarrassed. It's a case of if you leave symptoms alone then you may have implications. This is what could happen.

Interviewee Number: xxx

1. Individual and Personal Level

Can you tell me what you think about first when I use the phrase 'men's sexual health'?

Sexual transmitted diseases, male confidence and it could also (if you are married) the effect it has on your marriage with your wife or your partner. I think they are big issues for a male and a subject which is not tackled due to its sensitivity.

What do you think are the other issues you would associate with men's sexual health?

I think hygiene is very, very important because at the end of the day if someone is doing an unlawful sexual act you don't know what you can catch. I think men should regularly get checked up because it does get passed on and that can be a problem for both people.

Do you discuss sexual health with your male friends, father or other male members of the family? If not, why not?

I think the subject is discussed very lightly, in a jokingly way, more banter. I don't think men discuss problems with other men. Again, it's a confidence thing. If someone has got a real problem then they should go and speak to professional about it or a therapist.

2. Community Level

Do you think South Asian men want to openly discuss sexual health issues in the South Asian community? Is this at all possible?

I think the community is very ignorant with things like this due to religious reasons but I don't think religion should come into it. It is a general discussion, at the end of the day everyone is human. Someone somewhere will have a problem with this and I think the community needs to do more on this. There should be more professionals helping the community. Barriers include language, if someone does not know how to relate it, there should be someone in the community helping. The public does not have an understanding if it has a problem. Hence, people can find out if they have something wrong with them and get treated for it. People can carry something and not know at all.

Why do you think sensitive health topics such as cancer are more acceptable to discuss in the South Asian male population rather than sexual health?

I think because the fact the other diseases and you hear women with breast cancer, they are more comfortable with cancer because it is more discussed now than it was fifteen years ago. Cancer is more common and you have many forms of cancer. I think the awareness, if you look at the NHS and hospitals concentrate on cancer; you have charities which promote the awareness and understanding of cancer. It's more common today.

How do you think sexual health for men amongst South Asian communities and sexual health for men from other communities varies?

I think it's entirely on an individual. At the end of the day it all depends on addiction and risk taking. For example if the person sleeps around with different women, that can be any race or culture. I don't think that's particular to one community. I think it's every community throughout the world.

Do you think it is a good idea to set up a discussion forum for South Asian men on the subject of men's sexual health issues and services? Why?

I think it's very good idea but I think it's a very long term idea. I think it would take a lot people to come out such as homosexuality which is in every community. There is not such that this is not happening in the South Asian community and I think if someone did set up this it would have to be a long term project. I don't it would be an instant success overnight but as more people come to it, people would get more comfortable the fact that there is a lot people who share the same problem.

How do you think the media (radio, television and newspapers) influences men's sexual health issues? How does this impact within the overall South Asian community?

I don't think so, I don't hear anything. The two common things I hear about are AIDS and homosexuality. They are the main two things you hear about in the media.

I don't think it would make a difference using South Asian media because not everybody read newspapers or read magazines. It's up to an individual to seek out the knowledge and they would only do this if they had something wrong with them. If a doctor tells them something is wrong then they would start to look this up on the internet. There's already plenty of information on this topic.

3. Service Level

What would encourage South Asian men to access and influence local sexual health services? And how do you think sexual health services should engage with South Asian men?

It's a difficult one. The big problem you have is someone willing to speak about their problem. Everything in the community comes out negative. People will assume such and such person has done this and this is why they have got this. At the end of the day if can be a result of anything. A person cannot do anything to have a problem; it can be a medical problem. It's the embarrassment. The only way is to regularly hand out leaflets in public places. The best way is random leaflets in major supermarkets; everyone attends those shops and is handed out to everybody so no one will feel embarrassed about it. It only takes one read the leaflet, understand it and react upon it.

Services need to raise their profile in all public places. Another way is to target football grounds where ninety per cent are men and give out information as they enter the stadium. It's a more comfortable approach to pass information to men.

What do you think are the cultural barriers preventing South Asian men to access local sexual health services and discuss sexual health issues in the community?

The easy one you can keep point to is religious backgrounds. Religion will be used to solve their problems by approaching a religious leader to confide and speak to them. I don't think anyone will go directly to a doctor unless it becomes really serious. If you have a partner then the partner can help you. If you are single and carrying something like this then nobody is there to help you and what to do. Most people will carry on ignoring the problem.

What do you think can support the South Asian community overcome these barriers? And are these barriers the same for other BME and seldom heard communities?

We can overcome this problem with the awareness of symptoms and side effects. If people notice early symptoms then they can address this by seeing a doctor and speak to someone. It's all about awareness, particularly what are the first few stages of their problem.

4. Research related

Do you think South Asian men would participate in community initiatives and/or community research to influence how local sexual health services are developed for them? Why?

I think they would. I think in this country you are now getting many South Asian professionals, they are the intellectual people who can participate to represent people, families and communities and they can spread the message to friends and families. The more people know the better it is.

What incentives and motivation do you think South Asian men need to support them to be involved in research on local sexual health issues?

I think incentive for any individual would be a relief and confidence knowing that they can approach and discuss sexual health with someone. I think a financial incentive is irrelevant in these sorts of things.

I think people should seek out the knowledge for things like this, no one is immune to this and it can happen to anybody. I would say if people do approach you for this then I think there should be full hundred per cent support behind this everybody should be positive.

Appendix 23
Phase Three In-depth Interview transcript

In-depth Interview Transcript
Interview: xxx

Why do you think South Asian men's sexual health is not discussed in the South Asian community?
The cause of this being not discussed or entertained on a level is because these things within our culture are very taboo. These are things that not discussed on a general basis, especially not discussed in a setting, for example like a family setting because something like that might happen in the West or in British culture or in other cultures where you can sit down and have these conversations and talk about different aspects of sexual health or sexual relationships or relationships amongst you know, with siblings, and their girlfriends and vice versa. This is acceptable in normal Western culture but in South Asian culture these are not things that would ever be. You wouldn't even dream of discussing these things with your parents or you peers or other family members. So this is why it's a bit difficult in that sense to discuss these things on that level.

Can we take this discussion/ dialogue amongst family members and friends? And do you think we should take it in a family setting about South Asian men's sexual health?
I mean discussions about sexual health within the South Asian community; I'm not saying you can't discuss them but I think you have to have the right setting. The right kind of environment for these things to be discussed. I mean if it was a setting which was private. For example in a clinic or in some doctors surgery where it was on a one to one basis you will probably more likely to get a realistic or more honest answer or discussion that can take place. A healthy discussion can take place in that environment because you have got that relationship where you are talking to your doctor as a patient or you're talking to the nurse, some kind of person in the health system where someone might need to discuss some issues regarding sexual health. I think in that kind of environment you would get more out of it than in an informal setting where you have probably other family members, even other (South) Asian men, not necessarily related but people would be reluctant to talk about their exploration. You know it's a personal thing. I don't think.....It depends on the age as well of the people you are talking to. If you are talking to much older person they might be as not open and honest about their antics or what they have been up to or what kind of sexual activity they're involved in. Whereas you talk to someone of a younger generation they may be a bit more open and honest and happy to discuss these things where you might not get that from someone from the older generation.

I mean a lot of this is because young people I think may be reluctant to use sexual health services. There are many reasons for this like cultural barriers. Not wanting to discuss these things because they are not use to discussing these things or they have not had experience in discussing personal things with someone who they don't really know and think they can confide in. One way may...a possible way around this may be if you had clinics that were located in places where young people frequented. I don't know. Youth clubs...places where young people hang around or spend time. It might make it more easier for them to access the services but if they

was to go to a clinic at the surgery it might be a bit more difficult for them to kind of turn and say “look I need to speak to someone” because they might think someone might see them or see them visiting a STI clinic. You got to understand that traditions, culture and taboo are all intertwined and sometime it’s difficult for people to overcome these barriers. So, you need these services and if they are to be accessible they need to be in places which are easier for them to go to in discretion.

Do you think South Asian men’s sexual health should be discussed alongside South Asian women’s sexual health issues?

I think a lot of it depends to which community you are speaking to. So, I think...I mean this is my personal observation. I think that sexually related topics regardless of whether you talk to men or women will always remain a taboo subject within our (South Asian) community and I think specifically more in the Indo-Pakistani community and Bangladesh community. You have to understand that we have a strong culture traditional belief relating to sex and sexuality as a whole and these would be rarely discussed in a family circle. I don’t think you can go to any household which from the South Asian background where you can find and happily discuss these things. I think that more and more people are obviously opening up but this is not something you will find and do with ease. These things are rarely discussed in the family circle. Sex outside of marriage is not acceptable within our culture and that’s going through all communities within the Indo-Pak...people from the Sub-Continent. These things are not happening. These things are not the normal things. When they marry they want virgins. That’s how it is. Even though in reality that might not be and is not the case but ideally everyone that is looking to get married in the future, the husbands always expect a virgin. You know it’s something that’s up for debate. You understand. Going back to India might not either be the case. You know what I mean. I’m not just talking about here. These are cultural things that our community holds and we hold on to them strongly. Even relationships between boys and girls are frowned upon and it’s not acceptable. Forget going to the sexual aspect. I mean just having a relationship of boyfriend and girlfriend will be bringing dishonour to the family. People are opening up and being Westernised within our society, the society we live in, these are the normal things happening...that does have an influence, but I still think the majority of people are still holding on to their cultural beliefs and I state this is more mainly in the Pakistani and Bangladeshi community because we strong beliefs. We have religion; Islam and these things are like a no go area. No way is sex before marriage is going to be accepted or tolerated within a Muslim family unit.

I think maybe for non Muslim it’s a bit more different, I don’t know.....within the South Asian community it covers a whole series of different people and different nations. I believe there is a different attitude amongst different South Asian communities. Attitudes amongst young Indian men and women seem to be that there is more freedom within their family unit. They probably go out clubbing, pubbing. They’re fully immersed in the culture of this country that we live in. So a part of growing up and part of socialising involves going to the pub, going to the clubs. You know going to parties. These things are still not acceptable within the Islamic traditions. I’m not say it doesn’t happen but it’s less likely to happen within a Muslim culture or someone from a Muslim background to someone from a non-Muslim background. I mean if you look at the Hindu religion or people from Sikh backgrounds...in their religion its totally acceptable to drink and you know socialise and go out clubbing and

pubbing. I'm not saying it doesn't happen in the Muslim community but it's more accepted (in their community). It's just the norm. Whereas, in the Islamic culture these things are totally forbidden. I find that amongst young Indian men and women there is more to socialise with members from the opposite sex because when they are going out to these events or places, like pubs and clubs they are going within a mix group. There seems to be a loosening of parental control...if you know what I mean. Parents think this is the kind of norm. People from a non-Muslim background would not see anything wrong with this kind of behaviour, whereas in the Muslim culture this would be totally unacceptable. Like I said, the same we are talking about the Indian community this cannot be said about the Muslim community. I mean Muslim is the religion and includes people from Pakistan, Bangladesh, Sri Lanka and even India. These communities they hold values and traditions, culture along with the religion. It seems to be entrenched in them. Like this is a no no...or this is acceptable and this is not acceptable. From my own observation people from the Muslim, no matter part of the South Asia they are from are very entrenched in their beliefs and values and have systems in place. They hold on firm to these things. For them to openly discuss sexual health and sexual relationships within a family setting or informal and formal setting...these things I don't think it's going to happen because it's all about traditional beliefs and honour and respect.

Do you think there's a difference of men's sexual health from South Asian communities to men from non-South Asian communities?

No...I would say they are the same. I don't think they would have any other different needs. I mean the health issues would remain the same because we are predominantly talking about sexual health. I mean if we are talking about like other illnesses which are not related to sex than and which South Asian communities are more likely to suffer, for example diabetes and other illnesses like that. You know these are sometimes genetically handed down, for example sickle cell and things like that. You know are more likely to happen in the South Asian community as the non-South Asian communities. So, in terms of sexual health I don't think there is any different need in that sense.

Do you think men's sexual health vary amongst South Asia men?

No I don't think they have different health needs. At the end of the day you are dependent on the health service and depends how active you are. If you are going to be sexually active and have unprotected sex and experience different things then there's always a chance that at some point in your life you are going to have to use the sexual health service. I don't think that within different communities there is a different need. I think the need for all the South Asian community will be same. I don't think there would be different demands from different community groups or different South Asian men.

Do you think there is a need to work with young South Asian men?

I think it's more important to work with the younger generation because they are the ones who are more likely to be open and honest with you. If you look at the older generation who may have not necessarily gone through the schooling system or the structure here and basically... a lot of their cultures or their beliefs are from back home. So they are going to be a bit more reluctant to open up to someone. The last they want to do is talk about their personal things with someone they don't really know. Someone who is born and bred here is use to kind of going through all this

kind of questioning. It might not be relevant to sexual health. It's like for example, when you are at school you have these kind of discussions if you study biology or science or you have your personal health studies then you have gone through these kinds where you may have had open and honest discussions within an environment that is similar to one where you are trying to carry out clinical research. So it's a classroom setting. You got your peers amongst you, classmates, there are boys and girls and you are use to being open and talking about these things. Whereas, the older generation might not be that forthcoming with information because they're not use to discussing these things in this kind of environment.

If you are trying to gather information and trying to carry out studies or want to know certain things about how certain individuals are within the community your best people to target are the young ones because more than likely they are the ones who are active anyway.

Do you think there is a need for (social science) research on South Asian men's sexual health?

I think there is. There is a need and there is a demand. Obviously you are doing this research because there is a gap in this community. You are saying there is something missing...within information. Whether it's qualitative or quantitative there is a lack of information within these community groups. That's why I'm assuming you are doing this research. So to fill in the blanks there is a necessity to conduct this research but it's how you conduct it and who you conduct it with. To get the real picture of what's going on you need to do this, I think, with the younger community because you got to remember as well, maybe not, I touched upon this earlier on about the Indian and Pakistanis and Bangladeshis and the Muslim and non-Muslim communities. You got to remember that when our youngsters go through schools a lot of their knowledge is what they have learnt from friends or discussed in the playground or discussed over social networking. It's not real information and they may have not had it in a classroom setting because a lot of Muslim parents withdraw their children from sex education when it's taught in schools. If it's not compulsory, they are not going to allow their children to go and take part in these discussions even though they are in an informal environment, in a school setting. It's not about encouraging sex but parents have this belief or we have this view, even I as a parent have this view that if they don't know about it then don't tell about it. We're thinking the more you tell them....it's like you are encouraging it. You understand. So when you are telling them about sex education we're saying in our culture sex is not acceptable outside of marriage. Sex is not an acceptable thing to do until you are married. I'm not saying it doesn't happen. It happens because we know it happens. We know that within our (South Asian) community girls are having abortions or girls going for contraception or boys going for contraception. It's not something we're oblivious to or turn a blind eye to. In reality these things do happen but we as parents don't want our children exposed to this. We think if you start teaching this in schools and telling them about sexual activities and sex education and sexual relations creates a thing for them to pursue these things. So, a lot of our (South Asian) children their knowledge of sex wont have been in the correct setting, coming from a scientific point of view or a biological point of view. They would have picked up a lot of things of the television or read magazines or seen things on social media. There is this lack of knowledge possibly within a certain community, especially within

the Muslim community because they are being withdrawn from these classes and settings and that there is a lack of knowledge in certain aspects.

To get a true picture you would have to do this with the younger generation because I don't think the information that you are looking for, especially the qualitative information... you're not going to get that from the older generation. They are not going to be as open. They're going to be shy and say "oh no...we don't discuss these things", whereas with the younger generation you are going to get a more true and real picture of what's happening on the ground level because their approach to life is going to be different to how it was for the older generation.

Do you think research needs to be taken alongside non-South Asian men or best to keep it separate?

No, I think you should them together because you would get a better flavour of what's happening within the two communities and you would know from your research...you asked the question.... If you did it together then you would get a better analysis or better picture of what's actually happening. You would think Yo...these guys are the same as these guys! There's no difference. So maybe that might stop.....rather than doing two separate studies you get your answers from one study that there's no difference, that there's no different need. There may be little tweaks or little things where culturally that don't happen in the South Asian community that happen in the non-South Asian community, for example, like we discussed, discussing it openly with your mum with your dad or within a family setting. You can probably do that in a non-South Asian setting but in a (South) Asian setting you would get very few family units where these discussions are actually taking place in an honest and open fashion.

Do you think faith organisations and faith leaders have any role promoting sexual health amongst South Asian men?

No, I don't think so because I think this should be left to the (health) professionals. I mean the local religious leaders have enough on their plate to deal with... in terms culture, religion, tradition kind of things and things that are happening on a day to day basis. I mean the last thing I would want them to do is to start meddling or want to discuss these kinds of things when they probably don't have the right background knowledge or right education to bring these kinds of things to the forefront. This topic in terms of sexual health should be left to the professionals because they would be the right people to give the right advice and signpost you to the right organisations if you did need help, if you needed certain questions answering or need more information. I don't think the local Imam would be the right person to sign post you to the right place.

What kind of health education or promotion do you think would support better dialogue and recognition of sexual health issues amongst South Asian men and South Asian communities?

I think a lot of this should be done through the local GP. This is the best time...when you go to see your GP you have an open and honest discussions with them if you are suffering from illness or health problems. You already have that relationship with your GP. So, I think the person to have these talks with would be through your GP surgeries because you know you have that one to one confidentiality and you know if you go to see your GP no one will know you are dropping into a STI clinic. You

could just be going there because you are suffering from a bit of a cold or flu bug or something like that. In terms of targeting the South Asian community and in terms of accessibility the GP services would be the best services to go through.

It doesn't necessarily have to be outside in the reception. You know if your GP can have a whole array of different leaflets, different information which you might want to pick up but you are not picking it up... you might want to have look at that leaflet because you might be thinking I need to read upon this, but because you got 50 people sitting in that waiting room the last thing you want to do is look at "Oh what do I do if I got Gonorreah", that's the last thing you would pick up.

Ok, what if you don't go to see your GP, how do get hold of (sexual health) information?
I mean this kind of information should be readily available and you lots of forms communication. It doesn't have to be that we necessarily have to drop in to a clinic. You got social media. You got Facebook. You got Twitter.

You can have websites. You can have loads of different ways of targeting people but you got to understand that nowadays you can do everything, learning how to cook, get hold of a recipe, to shopping...everything....is done online. You got to understand that something you can do. You can do that on the go. You don't have to necessarily visit some place or go to the city centre or out of the city. You can be doing anything and still be online and you got to remember when you do this online over the internet then this is a personal thing. You don't have to worry or be thinking someone's going to see me pick this leaflet up or someone's going to see me read this. So we have to move...we're so stuck in that zone that there has to be a leaflet for this or there has to be a book for this or there has to be a counter for this. You got a GP surgery and they have those carousels with all the leaflets. You know we need to move on. I think we're not with the modern times and with the modern way of communicating.

Homophobia...do you think it's more prevalent amongst South Asian men and South Asian communities in comparison to non-South Asian men and non-South Asian communities?
I don't know. Sometimes it depends on the individual and target group you are have working with you. You may have certain individuals that may hold strong views about these kind of things but I don't there's a lot of homophobia amongst the (South) Asian community than the White community because you see on the news, you see on the television, you see in the media. If there is, we all hold these views and certain individuals will all hold these views. I don't think you should be saying that South Asians are more homophobic than the non-South Asians.

Do you think sexual orientation should be discussed alongside South Asian men's sexual health?
It should be because a lot of these illnesses come about.....Aids and all of that.....it's high and more likely to contract some of these illnesses and sexual health issues when you are sometimes in a same sex relationship. It should definitely be a part of the discussion because that's where you going to get all the things come up and be likely to see what's happening in homosexual and heterosexual issues. Which group has more issues with sexual health? That way

you get more balanced answers and your research would be more balanced because you would be studying both groups at the same time.

How can local sexual health services be reconfigured for South Asia men if they are not meeting needs of South Asian men's sexual health?
I mean I'm not aware of any within my own community so I don't know whether they have been advertising in the right way or whether they have the right amount of profile. There is a lack of awareness of these services. What I think when you are saying South Asian is that I should be able to go to any clinic....why do I have to go to a South Asian clinic. If I have got an issue and something's not right with me I should be drop in to any clinic. You know...I don't care who is visiting it whether they are Black, Asian, White and European. Why do you have to have a specific one for South Asian men? It's not like we got different sexual health issues to what they have.

They don't need to be targeted to specific groups because then you have labelled them. They should be open for everyone. Listen everybody has sex, some people might have it different ways but it's the same action. You're not going to suffer from something different to your non-South Asian male. If you have got issues, health issues then you have got issues.

Do you think South Asian men should be part of decision making in relation to sexual health policy and sexual health services?
I think so... they should be part of the dialogue because in that way you would be able to get a better response to understand the demand for your services better.

Do you think we should talk about men's sexual health for all men and not only the sexual health of South Asian men?
Yeah, I think sexual health should be for all men. If you are looking for specific patterns then obviously you might want study a core group. If you just looking at general things then you know I don't see why there should be specifically for South Asian men.

Anything else?
All I am saying is that this sexual health thing is not something you can discuss in an open setting, within a South Asian family setting. You need to understand that. As much as you might want it to happen...it's not going to happen. You got to understand that we got a strong tradition, strong culture...I have said this throughout my interview and a lot of this stops us from coming out with information and discussions taking place in a formal setting. As much as you would like to think its OK...I would be surprised if you can find lots of people who are willing and open to have these discussions within their own families, in front of their parents, sisters and brothers. So, it would be interesting if you do find someone.