“We Don’t Talk About It in My Country”

A New Zealand Qualitative Study on the Sexual Health Experiences of Migrant Asian Men Who Have Sex With Men

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Abstract

Background: Sex is often taboo and stigmatised in many Asian countries. As a result, many Asian people tend to ignore their sexual health or lack a holistic understanding of sexual health. In Aotearoa New Zealand, Asian men who have sex with men (MSM) are disproportionally affected by the human immunodeficiency virus (HIV), one significant aspect of sexual health for MSM. Asian migrants may face additional challenges to their sexual health. As members of a profession that promotes social justice and human rights, social workers are well positioned to engage in sexual health, including HIV and other sexually transmitted infections, service access and uptake. However, little is known about Asian and migrants' sexual health, particularly the migrant Asian MSM cohort, from a social work perspective in Aotearoa New Zealand.

Purpose: This study aimed to explore and better understand the sexual health experiences of migrant Asian MSM and characterise key enablers and barriers contributing to sexual health recourse access and uptake among this group of Asian people from a social work perspective.

Methodology: Nine migrant Asian MSM were recruited and participated in semistructured interviews. This study employed the interpretative phenomenological analysis approach and sexual citizenship as a theoretical framework for data analysis.

Findings: The findings are presented in the creative and powerful form of composite vignettes, which represent the shared sexual health experiences of participants. Four themes were identified: 1) Seeking sexual sanctuary, 2) Coming to terms with being different, 3) Navigating the journey towards sex positivity, and 4) Confronting challenges and shaping a better future.

Implications: The social work profession can play a significant role in supporting marginalised individuals' sexual health, including migrant Asian MSM. Social workers in Aotearoa New Zealand have the potential to use antioppressive practices to uphold sexual and social justice and provide culturally appropriate support for migrant Asian MSM to become sexual citizens fully.

Keywords*:* social work; sexual health; Asian MSM; sexual citizenship; sexual justice; IPA

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Glossary

Term	Definition
Heteronormativity	The assumption that heterosexuality is the default and superior sexual orientation.
Human Immunodeficiency Virus (HIV)	A virus that attacks the body's immune system.
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning, and more.
Men Who Have Sex With Men (MSM)	Men who engage in sexual activity with other men, regardless of sexual identity.
Sexual Citizenship	A status entailing a number of different rights claims focusing on the access to rights granted or denied to different groups of individuals based on their sexuality.
Sexual Health	A state of physical, emotional, mental and social well-being in relation to sexuality.
Sexual Learning and Exposure (SLE)	An individual's learning and exposure to human sexuality.
Sexual Stigma	A form of social stigma in relation to sexuality.
Sexual Well-being	A state of well-being in relation to sexuality.
Sexually Transmitted Infection (STI)	An infection transmitted through sexual contact.
Social Work	A practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people.

Statement of Contribution

This thesis includes a published journal article. Spar Wong, the researcher of this study, was the lead author. His research supervisor, Dr Laura Ann Chubb, was the co-author. The journal article was based on the original content written by the researcher (lead author) for the literature review chapter, contributing to the majority (over 65%) of the manuscript.

The citation of the publication is as follows:

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This publication is included in Chapter 2 (2.1 to 2.8), and the researcher included a brief chapter introduction and summary (2.9) to ensure cohesion of the chapter and the whole thesis.

Chapter 1: Introduction

1.1 Background and Rationale

> *[Sexual health is] a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (World Health Organization [WHO], 2006)*

WHO's (2006) definition of sexual health highlights that sexual health should be considered beyond medicalised and pathological perspectives and addressed through a holistic approach. Sexual health is influenced by multiple social determinants, including sex, gender identity, sexual orientation, healthcare access, social and cultural norms, educational level and health literacy (Malarcher, 2010; Rao et al., 2012; Stumbar et al., 2018). However, as in many parts of the world, sex is often taboo and stigmatised in Asian countries and cultures leading to Asians' poor sexual health and well-being.

The human immunodeficiency virus (HIV) remains a crucial sexual health issue affecting many people, including in Aotearoa New Zealand (Aotearoa). According to the AIDS Epidemiology Group (AEG, 2020), 212 people were diagnosed with HIV in Aotearoa in 2019. Out of 212 people diagnosed with HIV, 27.8% were Asian (n = 59), with 51 Asian men (24.1%) and eight Asian women (3.8%). These data showed that Asian people were the most HIV-affected ethnic-minority group in Aotearoa in 2019. According to the 2018 Census (Stats NZ, 2020), the Asian population has become the second largest (15.1% of the total population) and the fastest

growing (up 3.3% compared to the 2013 census) ethnic-minority group in Aotearoa. In addition, the Ministry of Health (MoH, 2023) reported that, between 2017 and 2021, 22% of men who have sex with men (MSM) diagnosed with HIV in Aotearoa were Asian, more than Māori (14%) and Pacific people (8%)—highlighting the need to consider how we support the sexual health and well-being of this key population. However, although they are the fastest growing and the most HIV-affected ethnic group in New Zealand, no priority was given to Asian people, particularly Asian MSM, in the *Draft National HIV Action Plan* (MoH, 2022a) and the later published version (MoH, 2023).

Compared to many Western countries and cultures, Asia is considered relatively less open to sex and sexual topics (Phillips et al., 2020; Smith, 2012). As a result, many sex-related restrictions continue to be imposed upon Asian people in different ways. For example, some restrictions are gender based (e.g., women in some Muslim countries need dress and behave in specific ways). Given that only one country in Asia has fully legalised same-sex marriage (i.e., Taiwan), restrictions are also based on sexual orientation, where homosexual behaviours and beliefs not aligned with heteronormativity continue to be criminalised. Due to conservative attitudes towards sex, sexual health is often ignored and marginalised in the realm of Asian health and well-being. The lack of a holistic understanding and awareness of sexual health means that Asian people, including Asian MSM, continue to experience poor sexual health outcomes. This includes sexually transmitted infections (STIs), HIV infection, and sexual abuse, among other concerns (Gray et al., 2021; Lewis & Wilson, 2017; Medland et al., 2018; Phillips et al., 2022). Stigmatising and restrictive beliefs about sexual health influence a person's sexual citizenship, and this may be complicated if a person chooses to migrate.

Richardson (2000) referred to sexual citizenship as "a status entailing a number of different rights claims" (p. 107), focusing on the access to rights granted or denied to different groups

of individuals based on their sexuality. Richardson outlined three types of rights claims, including conduct-based, identity-based, and relationship-based rights claims. Richardson (2017) later expanded the concept of sexual citizenship beyond the Western-constructed centrality of heteronormativity to citizenship and suggested more local understandings and cultural meanings about sexualities in the Global South.

Alibudbud (2023) argued that the use of the sexual citizenship framework has prompted positive social changes (such as marriage equality) for many LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning, and more) people across the world. However, Alibudbud argued that the LGBTQ+ rights of individuals in the Association of Southeast Asian Nations (ASEAN) region have continued to be denied, including the criminalisation of sex between consenting adult men (conduct based), limited recognition of self-determined gender identity (identity based), lack of legal protection for same-sex marriage (relationship based), and inadequate antidiscrimination policies and protection for the LGBTQ+ community. As a result of the denial of these sexual rights, migration becomes an option for this community, including Asian MSM, who cannot fully become sexual citizens, compared to their heterosexual counterparts who have automatic access to these rights. Pan et al.'s (2021) study on Asian migrants and their intersectional identities, such as ethnicity, race, sexuality and gender, suggested that sexual citizenship is a valuable framework for understanding the intersectionality between sexuality and ethnicity in cross-cultural international migration settings, including access to sexual health and support services.

Turner (2020) suggested that the social work profession, with its strengths-based practice, is well positioned to promote sexual health and well-being. As a profession with long-standing social justice principles (International Federation of Social Workers [IFSW], 2014; Social Workers Registration Board, n.d.), social workers can use antioppressive practices to uphold

sexual rights and justice (Turner et al., 2018), such as providing shame-free spaces, accurate sexual health information, and challenging structural and cultural barriers to services and resources. In addition, Kim (2021) called for social workers to attend more to the growing population of Asians in Aotearoa. Therefore, there is a need for social workers to work with Asian people, particularly migrant Asian MSM, to address their sexual health needs. To develop and improve competency in supporting migrant Asian MSM and their sexual health, it is warranted for social workers to build understanding around the lived sexual health experiences of this community in both their country of origin and Aotearoa.

1.2 Significance of Research

This research study is significant for several reasons. First, the study participants, Asian MSM, and migrant Asian MSM more specifically, are a population whose needs are not well explored in social work education or responsively addressed in practice in Aotearoa. This study gave migrant Asian MSM participants the opportunity to share their own sexual health experiences, which in many cases was the first-time participants had talked about sexual health. In sharing their lived experiences, participants made sense of and understood the reasons behind their sexual health decision making. Second, the study on the participants' sexual health experiences could encourage more people to increase their awareness of sexual health and work in this important space to ensure increasing support for this growing population in Aotearoa. Last, but not least, the study's findings will have implications for improving antidiscriminatory social work practice with migrant, ethnic- and sexual-minority communities with various sexual health needs in New Zealand. Other relevant practitioners (e.g., doctors, nurses, and public health promoters) can also get a better understanding of sexual health experiences among this group of people and improve their professional practices.

1.3 Research Question and Aims

The main research question used in this study was:

> What are the sexual health experiences of migrant Asian men who have sex with men in Aotearoa New Zealand?

The aims of this research were to:

1. gain insights into the lived experiences of migrant Asian men who have sex with men learning about sexual health,
2. characterise key enablers and barriers to access and uptake of sexual health services and resources among this group of Asian people in Aotearoa, and
3. inform knowledge contributing to social work practices in sexual health.

1.4 Researcher's Positionality

Flynn and McDermott (2016) suggested that it is essential for a researcher to consider their position in research as an insider or an outsider. An insider or an "emic" researcher refers to "a researcher who belongs to a group that is experiencing a problem or concern which the researcher decides to study" (p. 11). By contrast, an outsider, or "etic" researcher does not personally experience the problem or concern being studied. There are advantages and disadvantages of being an insider researcher. Flynn and McDermott argued that insider researchers could bring their personal knowledge and understanding of the research question, making it easier to build trust with research participants. At the same time, insider researchers could be criticised for lacking the necessary objectivity and neutrality in data analysis (Flynn & McDermott, 2016).

Flynn and McDermott (2016) stated that practitioner researchers, who are "practitioners who undertake research in or on their own practice" (p. 14), address the issues or problems they encounter day to day. Social workers recognise the significance of the contextualised and

evidence-based practice nature of their profession, so some of them may carry out research to better understand their own practice and service users and improve service effectiveness (Mitchell et al., 2010). Practitioner researchers are also considered a form of insider researchers for their tacit knowledge and rich understanding of the research questions from their everyday practice (Flynn & McDermott, 2016).

In this study, I position myself as an insider researcher and practitioner researcher. I am an insider because, like my participants, I am also a migrant, Asian, and MSM. I share similar characteristics and sexual health experiences with my migrant Asian MSM participants. I can relate to many migrant Asian MSM regarding their sexual health experiences, including the challenges and barriers they face due to their intersectional identities. For example, I was unsure what the eligibility to access these services and resources was as a former international student from Asia. My shared characteristics and experience supported me in establishing trust and alliance with my participants from the beginning. Meanwhile, I could also see myself being in similar situations. For example, I believed I needed to hide my sexual orientation from health practitioner because of the fear of judgement and discrimination. On the other hand, I also spanned the outer edges of an insider identity in relation to the world of participants because of my role as a practitioner researcher that included my professional experiences in sexual health as a registered social worker and sexual health promoter.

Through my personal experiences of being a man growing up in mainland China, a MSM who accepted his sexual orientation, and a migrant in Aotearoa, I already had knowledge of some of the sexual health experiences my participants may encounter, including what challenges they may face to access sexual health services and resources in Aotearoa. However, I was curious about how other MSM in my Asian community viewed or understood sexuality and sexual health, so I identified some areas that would be relevant to explore with them, namely:

motivation to migrate, their personal experiences of sexuality, cultural and public attitudes towards sexuality and sexual health in their countries of origin, cultural impacts on their knowledge, awareness and practices of sexual health and sexual health experiences before and after migration.

The idea to conduct research on this topic dates from my first undergraduate social work placement at Body Positive (a peer-support nongovernment organisation for people living with HIV that also provides walk-in sexual health screening services for everyone, including migrants and international students) in 2020. During my placement, I encountered many Asian MSM in the walk-in sexual health clinic. Most of these Asian men were international students. They often expressed fear and anxiety about their sexual health, particularly HIV and other STIs, after having condomless sex with other men for the first time.

During my 3-month placement, there were common issues faced by MSM, including stigma around HIV and other STIs, a lack of awareness of the importance of sexual health, limited knowledge of sexual health resources and how to access them, and a lack of opportunities to talk about sex growing up with other people. When individuals, particularly Asian men, shared their life stories with me during my placement, I could often relate to their stories from my personal experiences. I then started to consider how I could utilise my positions in both social work and Asian MSM communities. I wanted my social work colleagues to have more understanding of sexual health. Moreover, at the same time, I wanted to improve the sexual health and well-being of my Asian MSM community. I was honoured to be able to connect these two communities with my professional and cultural backgrounds. I was also aware of the advantages of sharing identities with participants, such as shared migrant status, sexual orientation and ethnicity. These identities benefitted me during different stages of research,

including recruitment, data collection, organising themes from the interview transcripts, writing composite vignettes and reporting findings.

Despite the advantages of being an insider researcher discussed above, I was aware that my personal journey as an Asian and MSM could not be precisely the same as my participants. "Asian" is a broad term that entails people from many countries and regions in Asia. For my study, one of the inclusion criteria was "an Asian born and raised in an Asia country, including the Middle East." Despite attempting to narrow down the broad definition of Asian, my participants came from different countries, and some did not share the same culture as me. It also applies to my shared sexual health experience as an MSM. I was mindful of the uniqueness of individual sexual health experiences, which are influenced by personal characteristics and cultural differences. As an insider researcher, I was mindful of the "heterogeneity' of my participants. Studies (S. Lee et al., 2012; Sadler et al., 2003) have argued that the Asian community is often considered a homogenous group, but it is instead composed of multiple ethnic and cultural subgroups with considerable social heterogeneity and differences. My participants had shared similarities in their experiences as broadly Asian MSM. However, at the same time, they also had individual experiences that might have resulted from their cultural and ethnic identities. For example, I was mindful of my perspective from my personal experiences of being a Chinese growing up in mainland China, which may differ from other Chinese growing up in Malaysia and Taiwan.

With my supervisor's support, I could mitigate overlaying my participants' experiences with my own by employing a critical lens of sexual citizenship and composite vignettes in this study. The critical lens of sexual citizenship pushed me to consider participants' sexual health experiences from a rights-based perspective. Using composite vignettes to present findings helped me to focus on identifying participants who shared different sexual health experiences

to my own. These inputs from my supervisor enabled me to analyse and report differing meanings attached to sexual health experiences.

I recognise that my dual positions in the research may have given me deeper insight into participants' sexual health experiences given we have a shared migrant experience and I have learnt how to navigate the sexual health and well-being services and supports in Aotearoa. Therefore, this dual positioning has informed the epistemological and ontological positioning of the study, as described in Chapter 3.

1.5 Structure of Thesis

In Chapter 1, I have provided an overall introduction to this research study, including a brief background of the research topic. Then, I have discussed the rationale of this research study and my positionality. Finally, I have highlighted the significance of the research study and provided an overview of the structure of this thesis.

Following the introductory chapter, a more in-depth introduction of contexts around the research topic and a review of existing literature on Asian MSM's sexual health in Aotearoa are presented in Chapter 2. The chapter includes a journal article copublished with my research supervisor, based on my original work reviewing literature for this research study.

In Chapter 3, the methodological approach undertaken in this research study—interpretative phenomenological analysis (IPA)—is defined. This chapter includes an outline of the underpinning research philosophy, ontology, epistemology, and paradigm that led to the choice of an IPA methodology. A detailed description of the research design is provided, including research questions and study aims, samplings and recruitment, data collection and analysis, and ethical considerations. The chapter concludes with my reflexivity as an insider researcher and practitioner researcher.

Next, Chapter 4 provides the findings of the research. The findings from participants' semistructured interviews are presented through four thematic sections. Ideas to evidence the four themes are presented in composite vignettes, a creative and powerful approach to show the essence of shared sexual health experiences among research participants.

Chapter 5 discusses the research findings in relation to scholarly bodies of knowledge. I use *sexual citizenship* as a lens to guide the analysis, focusing on the exploration of participants' sexual health experiences before and after migration. The chapter concludes with the limitations of this research project and the scope for further research.

To draw conclusions from this study, Chapter 6 details the implications for social work practice and policy change in sexual health for ethnic- and sexual-minority communities, specifically in Aotearoa. The chapter ends with concluding thoughts on the lived experiences of migrant Asian MSM in Aotearoa and what more can be done in the areas of social work, health promotion and public health for sexual health and well-being.

Chapter 2: Literature Review

This chapter comprises an adapted version of a published article (Wong & Chubb, 2023) that I co-authored with my research supervisor. To integrate the article, I begin the chapter with an introduction to sexual health and rights to set the scene and then explores the relationship between sexual citizenship, justice, and social work. It then outlines the research contexts, such as the sexual health landscape and infrastructure, and Asian MSM and HIV in Aotearoa. Following a brief methods section for the literature search, a review of existing literature on Asian MSM and sexual health in Aotearoa is presented. In reading this chapter, the readers will develop an understanding of how learning Asian MSM's sexual health experiences can inform social work practices of sexual justice.

2.1 Introduction

Sexual health is seldom considered a significant component of a person's holistic understanding of health to the same extent as physical and mental health. The WHO (2006) defined *sexual health* as a "state of physical, emotional, mental and social well-being in relation to sexuality." When framed holistically and positively, sexual health is much more than the absence of disease and comprises respect, safety and freedom from discrimination and violence. Sexual health is expressed through diverse sexualities and critically influenced by gender norms and expectations, roles, pleasure, reproduction and power dynamics (WHO, 2006; World Association for Sexual Health [WAS], 2014). Over the last 2 decades, attitudes toward sexual health have shifted from an illness focus to a human rights perspective, positioning sexual health rights as a necessity for individual social and economic prosperity (Kismödi et al., 2017). In 1999 and 2014, WAS adopted a *Declaration of Sexual Rights* endorsed by the WHO. Bywater and Jones (2007) argued that the declaration aimed to promote healthy sexuality at all levels of society. The most recent WAS (2014) declaration stated that

sexual rights are an integral part of fundamental and universal human rights that should be defended, recognised, respected and protected. Such rights, and the responsibility one has within those rights, comprise what Richardson (2000) theorised as the concept of sexual citizenship, which can be used as a critical lens for interpreting social work responses to sexual health and promotion of sexual justice.

Our article (Wong & Chubb, 2023) is a review of literature on sexual health and HIV among Asian MSM in Aotearoa utilising a critical lens of sexual citizenship as it relates to sexual justice—the first of its kind in the country. The term "MSM" was used to include not only men who identify as gay or bisexual but also men who identify as heterosexual but engage in sexual behaviours with other men. The collated literature evidence that this community deserves greater attention concerning culturally safe health care and services that meet their needs. Insights from the literature inform social work practice with ethnic and rainbow communities regarding their sexual health and promotion of sexual justice.

2.2 Sexual Citizenship, Justice, and Social Work

Richardson (2000) argued that sexual citizenship, sometimes called "intimate citizenship" (Oleksy, 2009), is a multifaceted concept. Sexual citizenship refers to "a status entailing a number of different rights claims" (Richardson, 2000, p. 107) and focuses on the access to rights granted or denied to various social groups based on sexuality. By challenging Western-centric constructions and traditional norms of citizenship underpinned by heterosexuality and reproductivity, Richardson (2017) argued that sexual citizenship can be located beyond individualised rights and choice and the "private sphere" of intimate relations, which are constructed and regulated through public and social institutions. Authors such as Mackie (2017) also acknowledged the Eurocentric origins of the term sexual citizenship. Mackie argued the importance of considering non-Western cultures with different political, economic,

and social structures and the impacts they have on shaping ideas of sexuality and citizenship. With awareness of contextually specific ideas of sexuality and citizenship, the concept of sexual citizenship may be a useful frame for social workers to develop culturally nuanced understandings and better practices around sexual justice as an integral part of social justice, especially for minority populations who experience individual and intersecting sexual oppressions.

As members of a profession that promotes social justice and human rights, social workers are well positioned to advocate for sexual health, despite its predominant medical influences. The IFSW (2014) stated that the principles of social justice, human rights, collective responsibility and respect for diversities form the core business of social workers. Some social workers are involved in safeguarding and addressing risks related to people's sexualities by focusing on the identification, prevention and intervention of sexual coercion, exploitation, and abuse when working with their clients. However, social work scholars (Pilgrim et al., 2021; Turner, 2016; Turner & Crane, 2016) have suggested that the profession could achieve more. Turner (2016) posited "sexual justice is social justice" (p. 45), calling for the placement of sexuality and sexual health directly in the purview of the social work profession. An array of topics is included under the umbrella of sexual justice. For example, access to sexual and reproductive health (SRH) care or rights surrounding pregnancy and abortion are pivotal to achieving quality health outcomes. Additionally, reducing LGBTQ+ health disparities and continuing the fight against criminalising and punitive attitudes to sexual and gender diversity remain a challenge to sexual rights and justice for all.

It is important to recognise that challenges to sexual justice faced by LGBTQ+ individuals in non-Western countries, particularly Asian countries, can be very different from those in Western countries (Mackie, 2017). While marriage equality and other legal protections such as

the right of gay-identified people and same-sex partners to adopt children are important steps towards creating more equal societies, they may not be the most pressing issues for LGBTQ+ individuals in countries where their very survival is at stake. For example, in many places, disclosing a non-cis-heterosexual identity or seeking treatment for a sexually related condition can be dangerous or even fatal (Mackie, 2017). It is essential to address the systemic issues of discrimination and violence towards LGBTQ+ individuals in all countries to ensure equal access to healthcare services enabling people to live their lives free from fear and oppression. Additionally, laws and policies that protect LGBTQ+ individuals from discrimination can create more supportive environments for them to access healthcare services and reduce the stigma and discrimination they face. Moreover, providing comprehensive, medically accurate and shame-free sex education to reduce negative frames of sexuality and expand overall sexual literacy is imperative to realising sexual agency and equity (Turner, 2016).

HIV remains one of the most significant aspects in sexual health, particularly among sexual- and gender-minority communities, such as MSM. Since the epidemic of HIV and acquired immunodeficiency syndrome (AIDS) in the 1970s, social workers have contributed extensively to the global responses to HIV (Henrickson et al., 2017). Several international and national social work professional bodies have published policies, practice guidelines, and their stances on HIV and sexual health (see British Association of Social Workers [BASW], 2013, 2015; Canadian Association of Social Workers [CASW], n.d.; IFSW, 2006, 2012; National Association of Social Workers [NASW], 2012), but little is known about the Aotearoa social work professional stance on HIV and sexual health.

To set the stage for scoping how Asian MSM's sexual health and rights are supported, we [my supervisor and I] describe the current sexual health landscape and infrastructure, particularly relating to HIV and other STIs, in Aotearoa and highlight Asian MSM as a community at risk

of experiencing sexual health inequities. The narrative literature review that emerged out of this scoping exercise generated greater insight into the sexual health needs of migrant Asian MSM in Aotearoa and recommendations for how social workers might support those needs.

2.3 Sexual Health Landscape and Infrastructure in Aotearoa

The sexual health landscape and infrastructure include the legal environment, health policies and guidelines, services and resources in the community, which vary across countries, including Aotearoa. It is imperative for social workers to understand the sexual health landscape and infrastructure in Aotearoa in order to provide better support for service users regarding their sexual health. At present, social work education and training regarding sexual health in Aotearoa is limited to fragmented delivery of topics that fall under sexual citizenship, such as sexual violence and abuse, sexual and gender identity, women's health and intimate and family relationships.

Over the past 40 years, law reforms have provided evidence Aotearoa is shifting toward a modern and progressive society for gay rights (see Homosexual Law Reform Act 1986, Civil Union Act 2004, and Marriage [Definition of Marriage] Amendment Act 2013) and wider sexual rights (see Prostitution Reform Act 2003 and Abortion Legislation Act 2020). In addition, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993 have provided legal protection from discrimination on a wide range of grounds, including race, ethnicity and sexual orientation. These legislations are recent examples of Aotearoa's attempt to remove structural discrimination toward ethnic and sexual minorities.

In Aotearoa, SRH covers a broad range of topics and issues, including STIs and HIV, reproductive health and abortion, sexuality education, sexual violence prevention and gender-affirming care (MoH, 2022b). In response to sexual health issues, the MoH launched a two-phase process to guide the health sector using an overarching framework for action plans to

improve SRH outcomes with a resource book for Aotearoa's healthcare organisations (Miller, 2010), including specific strategies for Māori and Pacific Peoples. STIs and HIV are important components of sexual health policy because of their potential to impact anyone who is sexually active. Several strategies and action plans related to HIV were published alongside the two-phase response (Miller, 2010). Preexposure prophylaxis (PrEP) has been publicly funded since 2018 in Aotearoa for those at high risk of contracting HIV, such as MSM. PrEP is a medicine, including emtricitabine and tenofovir disoproxil fumarate, which prevents seronegative individuals from acquiring HIV. If taken as prescribed, PrEP reduces the risk of acquiring HIV during condomless sex by up to 99% (Saxton et al., 2018). As of 1 July 2022, the eligibility criteria to access PrEP relaxed and expanded to any person is seronegative and at elevated risk of HIV exposure, and the use of PrEP is clinically appropriate (Pharmac, 2022). The Associate Minister of Health, Dr Ayesha Verrall (2021), indicated the government has been developing a new sexually transmitted and bloodborne-infections strategy and a new HIV action plan, which were expected to be released in 2022. Despite the Public Health Association's (2022) call for more actions on sexual health for Asian communities, no priority was given to Asians, the most HIV-affected ethnic-minority group, as noted in the latest *Draft National HIV Action Plan 2022–2032* (MoH, 2022a).

Aside from government policies, guidelines, and laws, the sexual health infrastructure also consists of community resources. There are two primary professional bodies in Aotearoa. The New Zealand Sexual Health Society (NZSHS), a group of multidisciplinary professionals working or interested in the field of sexual health and the AEG, which have provided annual reports on epidemiological surveillance of Aotearoa's HIV infection and AIDS since the late 1980s. A review of sexual health services (Miller, 2010) found that numerous district health boards and sexual health services—either wholly or partially funded by the government—are available in Aotearoa. Service providers span 20 district health boards and four nongovernment

organisations, including Burnett Foundation Aotearoa, Body Positive, Positive Women, and Family Planning Services (Miller, 2010).

2.4 Asian MSM and HIV in the Aotearoa New Zealand Context

In Aotearoa, HIV prevalence has been relatively low but is highly concentrated among MSM since the HIV/AIDS epidemic. From 1996 (the year when information on the ethnicity of people diagnosed with HIV was first collected) to 2021, European males remain the most affected group, among people with HIV infection, followed by Asian males, as shown in Table 1.

Table 1

HIV Infection by Ethnicity

		HIV Infection															
		1996-2015		2016		2017		2018		2019		2020		2021		Total	
Sex	Ethnicity	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Male	European	1595	47.9%	113	46.3%	77	39.1%	73	41.0%	74	34.9%	72	44.4%	42	37.5%	**2046**	46.2%
	Māori	221	6.6%	17	7.0%	8	4.1%	18	10.1%	17	8.0%	12	7.4%	14	12.5%	**307**	6.9%
	Pacific Islander	81	2.4%	7	2.9%	7	3.6%	7	3.9%	6	2.8%	7	4.3%	10	8.9%	**125**	2.8%
	African	266	8.0%	3	1.2%	4	2.0%	2	1.1%	5	2.4%	2	1.2%	2	1.8%	**284**	6.4%
	Asian	331	9.9%	43	17.6%	34	17.3%	27	15.2%	51	24.1%	20	12.3%	17	15.2%	**523**	11.8%
	Other	89	2.7%	11	4.5%	15	7.6%	13	7.3%	25	11.8%	13	8.0%	3	2.7%	**169**	3.8%
	Unknown	118	3.5%	23	9.4%	26	13.2%	16	9.0%	8	3.8%	12	7.4%	5	4.5%	**208**	4.7%
Transgender	Unspecified	13	0.4%	0	0.0%	4	2.0%	3	1.7%	3	1.4%	0	0.0%	1	0.9%	**24**	0.5%
Female	European	132	4.0%	6	2.5%	3	1.5%	5	2.8%	5	2.4%	8	4.9%	6	5.4%	**165**	3.7%
	Māori	28	0.8%	1	0.4%	2	1.0%	0	0.0%	2	0.9%	3	1.9%	2	1.8%	**38**	0.9%
	Pacific Islander	34	1.0%	1	0.4%	0	0.0%	0	0.0%	3	1.4%	2	1.2%	1	0.9%	**41**	0.9%
	African	279	8.4%	3	1.2%	2	1.0%	3	1.7%	4	1.9%	5	3.1%	2	1.8%	**298**	6.7%
	Asian	113	3.4%	11	4.5%	10	5.1%	5	2.8%	8	3.8%	5	3.1%	5	4.5%	**157**	3.5%
	Other	13	0.4%	0	0.0%	0	0.0%	1	0.6%	0	0.0%	0	0.0%	0	0.0%	**14**	0.3%
	Unknown	15	0.5%	5	2.0%	5	2.5%	5	2.8%	1	0.5%	1	0.6%	2	1.8%	**34**	0.8%
Total		**3328**	**100.0%**	**244**	**100.0%**	**197**	**100.0%**	**178**	**100.0%**	**212**	**100.0%**	**162**	**100.0%**	**112**	**100.0%**	**4433**	**100.0%**

N.B.: AIDS Epidemiology Group has stated in their annual reports that the decline in 2020 and 2021 will, in part, have been affected by less transmission due to COVID-19 physical distancing measures and more limited testing access during lockdowns.

Note. Collated data from AEG surveillance reports between 1996 and 2021(AEG, n.d.).

According to statistics from the AEG (2020), of all 212 people diagnosed with HIV in 2019, 24.1% were Asian (n = 51). There was a significant increase of 89% amongst Asian men from 2018 (n = 27) (AEG, 2019), making Asians the most HIV-affected ethnic-minority group in the country. This is concerning given the 2018 Census recorded the Asian population as the second-largest ethnic-minority group, with 15.1% of the total population, and the fastest growing ethnic group in Aotearoa (Stats NZ, 2020). These statistics clearly demonstrated the need for the healthcare system to provide more culturally responsive services for the prevention of STIs, for sexual health education and encouragement to engage in safer sex practices in this community. However, current Western-style public health campaigns can potentially discourage Asians from seeking healthcare services (Jahangir & Meyer, 2020; Peiris-John et al., 2016). Further research into more Asian-Aotearoa communities and the cultures around their sexual health practices, behaviours and needs could develop insights for more culturally appropriate and acceptable sexual health promotion. Such research might provide insights that could contribute to a reduction in STIs and HIV transmission, support Asian communities' sexual health and well-being, and benefit Aotearoa's healthcare system.

2.5 Methods

A literature search was conducted that included English-language scholarly work published between 2000 and 2021. The search encompassed empirical sexual health literature focusing primarily, but not exclusively, on Asian MSM in Aotearoa. Peer-reviewed empirical literature published in Aotearoa and internationally was selected. We sourced and cross-checked literature from several databases, including Google Scholar, Taylor & Francis Online, Springer, BMJ Journals, SAGE Publications, and CSIRO Publishing. Using the concept map in Table 2, key terms were searched separately or in combination as search strings.

The research returned over 700 results, the abstracts of which were then reviewed to ensure the primary focus on the Asian MSM population. Eight pieces of literature fit all criteria for this review and are summarised in Table 3. All eight empirical studies were based in Aotearoa. Most of the literature was based on public health perspectives on sexual health, HIV and other STIs. Four qualitative studies included in this review involved interviews with members of Asian communities, including Chinese, Indian, and Filipino MSM, which explored their views and understandings of sexual health, HIV, and other STIs.

Table 2

Literature Search Concept Map

Asian	Men	Sexual health
Chinese	Gay men	HIV/AIDS
Indian	Bisexual men	Sexually transmitted infections
Southeast Asian	Gay and bisexual men (GBM)	Sexuality
Other Asian	Queer	Sexual health experiences
	Men who have sex with men (MSM)	Sexual health services
		Access to and utilisation of sexual health

Table 3

Literature Determined Relevant for Review

	Citation	Study design	Participants
1.	Adams et al. (2019)	Qualitative, individual interviews	Asian gay men (n = 18)
2.	Adams et al. (2020)	Qualitative, individual interviews	Filipino GBM (n = 19)
3.	Adams & Neville (2020)	Qualitative, individual interviews	Chinese and South Asian GBM (n = 44)
4.	Henrickson (2006)	Quantitative, survey	Asian-born men (n = 36); total LGB participants (n = 2,269)
5.	Lachowsky et al. (2020)	Quantitative, survey	Asian GBM (n = 1,003); total GBM (n = 10,525)
6.	Neville & Adams (2016)	Qualitative, individual interviews	Chinese and South Asian GBM (n = 44)

7.	Omura et al. (2006)	Qualitative, questionnaire survey for Asian students, & individual interviews with health practitioners	Asian male students (n = 66); health practitioners (n = 7)
8.	Peiris-John et al. (2016)	Qualitative, individual interviews	Stakeholders on Asian and migrant health (n = 6)

Note. GBM = Gay and bisexual men; LGB = Lesbian, gay and bisexual.

Three major themes were identified and will be further discussed in the review:

- Sexual stigma, discrimination, and prejudice
- Sexual health and layered identities
- Knowledge of safer sex practices

2.6 Findings

2.6.1 Sexual Stigma, Discrimination and Prejudice

Othering discourses play a significant role in constructing stigma toward sex and sexual health (Jensen, 2011; Silva-Brandao & Ianni, 2022). Dominant societal narratives emphasise the function of sex for reproduction and view nonheteronormative sexual practices, such as homosexual or anal sex, as deviant, unnatural, or sinful. These damaging narratives fuel sexual stigma that can compromise the health of sexual-minority populations (J. Lee et al., 2022), contributing to their reluctance to access STI testing and treatment, especially among Asians who have recently moved to a Western country (Neville & Adams, 2016; Peiris-John et al., 2016).

Few sex-related conversations were reported among gay and bisexual Asian men and their peers and family because they feared being ostracised within their social networks (Omura et al., 2006; Peiris-John et al., 2016). Such forms of sexual stigma can impact Asian people's access to and utilisation of sexual health services (Adams et al., 2019, 2020; Adams & Neville, 2020; Neville & Adams, 2016). For example, Asian MSM who access sexual health services and use PrEP to protect themselves from HIV infection can potentially be labelled promiscuous

(Adams et al., 2019). Asian participants in a study by Neville and Adams (2016) shared fears that people might perceive a person using PrEP or accessing sexual health services as "dirty" or promiscuous. In two further studies (Adams et al., 2020; Adams & Neville, 2020), this type of perceived stigma was described by many Asian MSM residing in Chinese, South Asian, and Filipino communities, which are generally small and close-knit in Aotearoa. Therefore, some Asian MSM have not disclosed their sexuality to their ethnic friends and families or family doctors, who might also come from the same community (Adams et al., 2020; Adams & Neville, 2020). Herek (2014) suggested that these negative social consequences generate psychological stress and feelings of guilt and shame, forestalling preventive approaches to HIV and other STIs. Neville and Adams (2016) noted that because of these consequences, Asian MSM are less likely to seek sexual health-related information from family, friends, or doctors or broach such topics with them. Echoing this dilemma, Peiris-John et al. (2016) noted that many Asian MSM in their study expressed concerns about privacy and confidentiality, which were discussed as an additional barrier to engagement with sexual health services and resources.

Peiris-John et al. (2016) also suggested that racism and racial discrimination significantly influence health and well-being among Asian and other ethnic-minority communities. Sexual racism refers to the sexual rejection of a racial minority, which is a form of discrimination based on race (Stember, 1978). Adams and Neville (2020) explored the complexity of sexual racism among Chinese and South Asians in Aotearoa and argued that racial discrimination exposes these groups of Asian MSM to being doubly marginalised. For example, Chinese and South Asian participants described the gay community as "hierarchical" (p. 517) and noted that discriminatory racial comments such as "No Indians" and "No Asians" (p. 517) were not uncommon on dating apps. On the other hand, an attraction based on ethnicity and race can also contribute negatively to racialised stereotypes and sexual racism, such as people who have

"yellow fever" (preference for Asian men; Adams & Neville, 2020, p. 517), which has been well documented in many international studies (Howard, 2021; Lim & Anderson, 2021; Stacey & Forbes, 2021). While some Asian MSM argued that seeking ethnic preferences is an expression of racism, others considered it as an expression of sexual freedom or becoming desensitised, particularly among those who had lived in Aotearoa longer than 5 years (Adams & Neville, 2020).

2.6.2 Sexual Health and Layered Identities

Literature from Aotearoa on migrant Asian MSM highlights how subscribing to a different culture than those existing in the country affects identity (Adams et al., 2019, 2020; Henrickson, 2006). Asian MSM in Aotearoa may hold multiple identities—as migrants and as members of ethnic and sexual minorities. These layered identities have the potential for different impacts on Asian MSM's sexual health. For example, the immigration status of Asian MSM determines their legal status and rights in a foreign country where automatic citizen rights do not exist, such as the eligibility to access public-funded health services and social welfare support. In contrast, migrants who fail to meet acceptable standards of health, including having certain sexual health conditions (e.g., HIV infection or Hepatitis B and C), could be negatively affected during their visa applications and immigration journeys.

Adams et al. (2020) suggested the migration pathway creates a tendency for migrants to prioritise more pressing issues in their lives, such as housing and employment, before their health and well-being, including accessing sexual health resources. In addition to immigration status, the length of time in Aotearoa can also influence migrant Asian MSM's sexual health. For example, Neville and Adams (2016) interviewed 44 Chinese and South Asian MSM in Auckland and explored their views of HIV/STIs and health promotion in Aotearoa. The authors noted that overall engagement in regular testing remained low among Asian MSM. However,

those living in Aotearoa for more than 5 years were more likely to engage in regular HIV/STI testing (Neville & Adams, 2016).

Several studies (Henrickson, 2006; Neville & Adams, 2016; Omura et al., 2006; Peiris-John et al., 2016) found that cultural factors can influence perceptions of sex and sexuality, further contributing to stigma and impacting sexual health experiences among Asian people. Omura et al. (2006) suggested that Asian cultures do not encourage people to discuss sexual health openly in public. The reluctance to discuss sexual health with key informants, including health practitioners and educators, has created additional and greater barriers preventing Asian men from achieving better health outcomes (Omura et al., 2006). In addition, Adams et al. (2020) suggested that religion also plays a role in influencing Filipino MSM's sexual health. Filipino MSM participants in Adams et al. described their strong Catholic faith as contributing to Filipinos' conservative attitudes toward sex and sexuality. The effects of such cultural constraints hinder Filipino MSM from achieving good sexual health.

Peiris-John et al.'s (2016) study on stakeholder views on young Asians' health and well-being also found that young Asians are reluctant to talk openly about sexuality and sexual health at home due to intergenerational and cultural issues. Peiris-John et al. suggested that Asian parents were perceived as lacking awareness about sexual health due to language barriers and unfamiliarity with health systems in Aotearoa. These challenges faced by Asian youth relating to their cultural identity during acculturation highlighted the importance of including their families in health promotion (Peiris-John et al., 2016).

The lack of culturally responsive promotion of sexual health also hinders ethnic minorities from accessing and utilising sexual health services. Neville and Adams (2016) found that some Asian MSM described previous campaigns as "highly and overtly sexualised" (p. 6), which clashed with their cultural beliefs. The respondents also stated that most models in the

campaigns were White men. Neville and Adams suggested that White-dominant campaigns can discourage Asian MSM from accessing and utilising healthcare services because they do not fit comfortably into the targeted community. Omura et al. (2006) and Peiris-John et al. (2016) also suggested that multilingual and culturally appropriate health services are needed to improve Asian people's sexual health and overall well-being.

2.6.3 Knowledge of Safer Sex Practices

With the development of medicine and a shift of the HIV landscape over the past 2 decades, a sex-positive approach has been employed in HIV prevention and safer sex practice promotion. Saxton et al. (2015) summarised five actions as part of the comprehensive HIV prevention approach in Aotearoa: condom use, PrEP, prompt testing, HIV antiretroviral treatment postdiagnosis, and vaccination against other STIs. Each action has advantages and disadvantages but can effectively prevent HIV and other STI infections (Saxton et al., 2015). Despite the general assumption that increasing knowledge improves practice, it is often not the case. Through the literature reviewed (Adams et al., 2020; Neville & Adams, 2016; Omura et al., 2006), it is evident that Asian MSM's knowledge about sexual health does not always translate into safer sex practices.

As described by Neville and Adams (2016), although Asian MSM have a "theoretical understanding of condom use as a 'desired' safe sex practice, it did not always translate into practice" (p. 4). Across multiple studies (Adams et al., 2019, 2020; Neville & Adams, 2016), inconsistent use of condoms was reported by many Asian MSM who provided various explanations, including no need to use them with their regular partners and difficulties using them with casual partners. For example, Filipino participants in Adams et al. (2020) reported that condomless anal sex was prevalent with regular sex partners or partners in stable relationships where trust was built. Hence, using a condom during anal sex was deemed

unnecessary. Neville and Adams' (2016) study on Chinese and South Asian MSM also supported this notion, with participants saying they did not have to use condoms in long-term, monogamous relationships. The perception of "unnecessary" use of condoms could pose risks to Asian MSM and their sexual health (Neville & Adams, 2016). Additionally, condomless anal sex in hook-ups or with casual partners was also reported (Neville & Adams, 2016). Among scenarios where condoms were not consistently used, Neville and Adams suggested several findings, including Asian participants' lax attitude toward condom use, the impact of condom use on sexual pleasure, and the power dynamics of negotiating condom use during sex, which highlighted the vulnerability of some Asian MSM to sexual coercion.

Compared to a relatively good understanding and awareness of condom use, the alternative approach—PrEP to prevent HIV—tells a different story. Despite the effectiveness of PrEP in HIV prevention, the knowledge of HIV among Asian MSM is scant (Adams et al., 2019, 2020). In Adams et al.'s (2019) qualitative study on immigrant Asian MSM's understanding of PrEP, they discovered several misconceptions about PrEP. Foremost, some participants confused PrEP with postexposure prophylaxis (PEP), an antiretroviral medicine taken shortly after exposure to HIV to prevent acquiring HIV infection (Adams et al., 2019). Secondly, some participants believed PrEP is a treatment for people living with HIV, a common misunderstanding of early PrEP knowledge, especially amongst some immigrant gay and bisexual Asian men (Adams et al., 2019). In addition, many participants were unaware of PrEP eligibility, and some assumed it was only funded for those at high risk, such as sex workers or people with substance use disorders (Adams et al., 2019). A few participants in Adams et al.'s study had some knowledge of PrEP. However, there was scepticism about the effectiveness and side effects of PrEP and, more importantly, its futility in preventing other STIs. Some participants said that PrEP, unlike condoms, could not provide a visible and physical barrier and a sense of safety to them (Adams et al., 2019).

Like inconsistent condom use, low levels of engagement in STI screening and testing were also evident among Asian MSM in multiple studies (Adams et al., 2020; Lachowsky et al., 2020; Neville & Adams, 2016). Neville and Adams (2016) explored the reasons behind low levels of testing among Chinese and South Asian MSM. Some participants did not get tested because they were in monogamous, long-term relationships and were "clean" from the virus and infections. The lack of awareness of needing regular sexual health screening was echoed in Adams et al.'s (2020) study on Filipino MSM. The authors found that giving priority to regular health screenings—for general and sexual health—was not a Filipino "cultural" norm or common practice. Adams et al. further explored other reasons behind the low levels of engagement with sexual health screening, including lack of education, unfamiliarity with accessibility to relevant sexual health services and the resources structure of the healthcare system and overtly sexualised HIV health promotion in Aotearoa.

2.7 Discussion

This review included eight studies published between 2000 and 2021, focusing primarily on sexual health among Asian MSM in Aotearoa. It is clear from the literature that there is an emerging concern for the sexual health and well-being of Asian men and MSM. The often-overlooked aspect presents challenges to improving individuals' sexual citizenship, which is integral to a person's holistic health and well-being. The social work profession plays a crucial role in mediating harm reduction, supporting access to social and health services, and advocating and protecting people's rights, particularly in response to HIV globally and to sexual injustices that continue to occur (Henrickson et al., 2017; Lacombe-Duncan et al., 2021; Sen et al., 2017).

One crucial issue identified in this review was the lack of social work perspectives and contributions to the response to sexual health and HIV in Aotearoa, particularly among Asian

and MSM communities. During the search, we identified previous social work and sociology studies in Aotearoa on sexual health among new Black African settlers living with HIV (Henrickson et al., 2013; Poindexter et al., 2013), Samoan youth (Veukiso-Ulugia, 2016), older sexual and gender minorities (Betts, 2020; Pack & Brown, 2017), and Chinese women (Yeung & English, 2016). As mentioned above, although social workers are well positioned to provide sexual health and HIV services, no professional stances in such field of practice are found in Aotearoa. This review can provide social workers in Aotearoa with insights into enhancing sexual citizenship through practice with service users with layered identities—in this article, Asian MSM—whose sexual citizenship is challenged by conduct, identity and relationship-based rights claims (Richardson, 2000).

The findings of this review suggest that stigma, discrimination and prejudice toward sexuality and sexual health have contributed to the lack of awareness of sexual citizenship across Asian cultures. For migrant Asian MSM in Aotearoa, their immigration status and double-minority identity have created barriers to fully exercising their identity-based sexual rights. Furthermore, the intersections of culture, race, ethnicity, sexuality and class have impacted Asian MSM sexual health and conduct and relationship-based sexual rights, including misconceptions of and challenges to negotiating safer sex practices and limited knowledge of the means to prevent HIV and other STIs, which impacts their access to and utilisation of relevant services. Systemic and cultural exposure to stigma and discrimination has partly been attributed to severe health disparities experienced by the LGBTQ+ community, together with inequalities in housing, education and employment (Kia et al., 2021). Given the considerable influence of socioecological factors such as intersectionality and social determinants of health on people's sexual health outcomes and sexual citizenship, more attention is needed at the interpersonal, societal and cultural levels, in addition to direct practice at the micro and individual level (Gray et al., 2021). It is imperative for practitioners to develop a strong understanding of how

environmental, situational and other contextual factors impact Asian MSM's healthcare access, engagement and outcomes (Natale & Moxley, 2009; Sen et al., 2017). The studies reviewed strongly call for the need for culturally responsive practice in response to Asian MSM's sexual health (Adams et al., 2019, 2020; Adams & Neville, 2020). Therefore, it is crucial to actively engage with Asian MSM to understand better what culturally responsive practice looks like from their perspective instead of making assumptions (Han, 2009).

Where Richardson (2000) outlined three substreams of sexual rights to be considered under the umbrella of sexual citizenship, we argue for an expansion of this framing to include social worker advocacy and services that support different aspects of sexual citizenship in the public space. Henrickson (2015) proposed that social workers should utilise antioppressive practice (Dominelli, 2002) in response to issues related to sexuality and challenges of power inequalities faced by sexual and gender minorities. The social work profession's emphasis on cultural sensitivity and responsiveness in different contexts and settings can contribute to positive changes in Asian MSM's awareness of sexual citizenship and sexual health outcomes, such as decision-making agency on PrEP (Lacombe-Duncan et al., 2021), service engagement (Natale & Moxley, 2009), uptake of HIV testing, and the reduction of HIV-related stigma (Sen et al., 2017).

By utilising antioppressive practices (Dominelli, 2002), social workers can take action to fight stigma and improve Asian MSM's sexual citizenship. Firstly, at the individual level, social workers should challenge heteronormativity and not make assumptions about the sexual identity or behaviour of any Asian male client they encounter (Henrickson, 2015). Furthermore, social work practice can focus on providing Asian MSM with accurate sexual health information and relevant resources to increase their knowledge and awareness. Later, at the cultural level, social workers can work alongside and with members of Asian MSM

communities to challenge the stigma, oppression and discrimination based on particular sexuality, race, and immigration identities (Natale & Moxley, 2009; Sen et al., 2017). Challenging the cultural norms of sexual citizenship can help improve Asian MSM's access to and utilisation of sexual health services. Finally, social workers can promote rights within social and public institutions. Developing social worker responses to structural oppression by deconstructing the privilege and power that underpin stigma and discrimination toward sexual health will help validate sexual citizenship among Asian MSM. In addition, encouraging Asian MSM to undergo a self-defining process concerning sexual citizenship (e.g., individual sexual identities, sexual agency, etc.) and engaging them in research that informs best practices of navigating such processes can lead to greater capacity for action and influence policy and decision making (Pack & Brown, 2017; Peiris-John et al., 2016).

2.8 Conclusion

As an integral part of an individual's health and well-being, sexual health is often overlooked and stigmatised by many, particularly among Asian MSM in Aotearoa. Sexual stigma and discrimination have contributed to the lack of awareness of sexual citizenship among Asian MSM. Additionally, their layered identities are associated with challenges in fulfilling their sexual health needs. Social workers are perfectly positioned to engage in sexual health promotion and address stigma and health disparities among Asian MSM. For example, social workers can play a significant role in breaking these barriers by promoting quality sex education and sexual health information, providing responsive practices that meet the cultural needs of Asian MSM and fighting against sex-related stigma and discrimination. However, this review found that there is a lack of scholarly social work perspectives and contributions to the response to sexual health and HIV in Aotearoa. Further social work research is needed on Asian MSM, who can share their understanding and experiences of sexual health and sexual citizenship. The findings of potentially invaluable insights could contribute to developing

increased culturally responsive support that meets Asian MSM's sexual health needs in Aotearoa.

2.9 Summary

This chapter evidenced an emerging concern for the sexual health and well-being of Asian MSM in Aotearoa. By further unpacking the concept of sexual citizenship, social workers might be prompted to consider how it can be translated to the sexual health experiences of migrant Asian MSM in Aotearoa (see Chapter 5 and 6). In the next chapter, I will discuss the methodological approach employed in this study to explore Asian MSM's sexual health experiences before and after migration to Aotearoa.

Chapter 3: Methodology

This chapter outlines the methodological approach undertaken for this study as informed by my researcher positionality described in Chapter 1. It begins by discussing my ontology and epistemology that led to the chosen paradigm and methodology for this study. A detailed research design is provided that links to the research question and study aims outlined in Chapter 1 (see Section 1.3), a description of the participants for the study and how they were sampled along with the recruitment strategy, data collection methods and the procedures for analysis, and ethical considerations.

3.1 Research Philosophy

In designing the study, I carefully considered the underpinning research philosophy. A qualitative strategy was determined optimal. Bryman (2016) argued that qualitative as compared to quantitative research, focuses on words rather than numbers in data collection and analysis. In other words, qualitative research emphasises "how individuals interpret their social world" and embodies "a view of social reality as a constantly shifting emergent property of individuals' creation" (p. 33). In line with this view, the qualitative research in my study uses an inductive approach and employs constructionism as its ontological orientation and interpretivism as its epistemological orientation (Bryman, 2016).

Ontology is concerned with reality, and the constructionism ontological orientation implies that realities are multiple. Constructionists, who hold this view, perceive social phenomena and their meanings as not fixed but instead as continually being socially constructed (Bryman, 2016). Thus, constructionism was the ontological stance I took for this study. Epistemology is concerned with "how we know the reality," and the interpretivism epistemology orientation, in contrast with positivism, emphasises that reality needs to be interpreted through individuals'

subjective meanings. Together, ontology and epistemology form the paradigm for research. I framed the research within an interpretive paradigm. Within this paradigm, the researcher focuses on the subjective and meaning-making aspects of individuals' experiences (Flynn & McDermott, 2016). Therefore, the interpretative paradigm is optimal for this qualitative study's purpose: to seek a subjective understanding of sexual health experiences among migrant Asian MSM in Aotearoa.

3.2 Methodological Approach

Related to the interpretive paradigm, this study employed IPA as the methodological approach. Three theoretical foundations influence IPA: phenomenology, hermeneutics and idiography (Smith et al., 2009). IPA focuses on the individual participants' subjective sense making of personal experience and seeks idiographic accounts of their views and perceptions within particular contexts (Finlay, 2011; Smith et al., 2009). The hermeneutic commitment of IPA requires researchers to engage in the "double hermeneutic" process, which describes the process of the researcher's sense making of the participants' sense making (Smith & Osborn, 2015). Hence, it was crucial for me to reflect on my hermeneutic "circle of understanding" during the phases of this research.

Hermeneutic phenomenology research aims to "evoke lived experience through the explicit involvement of interpretation" (Finlay, 2011, p. 110) and favours the interpretation of the contextual meanings over description (Finlay, 2011). Finlay (2011) argued that the hermeneutic phenomenological approach is characterised by the explicit use of multilayered interpretation and reflexive acknowledgement of the researcher's involvement. The multilayered interpretation of phenomena's meanings includes:

1. participants' own interpretation in the context of their life situations,
2. researchers' interpretation of data with their own understandings,

3. interpretation through a cultural and historical lens, and
4. interpretations of both participants and researchers in the research context.

Therefore, hermeneutic phenomenology researchers should actively acknowledge their own involvement and be explicitly reflective on how their own positions impact their understanding (Finlay, 2011). Gadamer (2004) described the process of coming to understand the being of something through moving iteratively between the whole and parts, and back again to the whole, as the hermeneutic circle. I will reflect on my double hermeneutic process and dual positionality in the later part of the chapter.

3.3 Participants and Sampling

Maxwell (2012) suggested using nonprobability samples to understand the social process and meaning structure of a particular setting or group. This interpretative study utilised two nonprobability sampling forms, aiming to explore the lived sexual health experiences among overseas-born Asian MSM in New Zealand—purposive sampling and snowball sampling.

Purposive sampling aims to select participants strategically so that those selected are most relevant to the research questions (Bryman, 2016). Purposive sampling was employed as the primary method to select targeted participants for the purposes of this study. For this study, inclusion criteria were employed to sample participants from the whole Asian MSM population, and they are as follows:

1. Aged 18 years old or over,
2. Able to communicate fluently in English or Chinese (Cantonese or Mandarin),
3. Asian born and raised in an Asia country, including the Middle East,
4. Migrated to Aotearoa within the last 5 years, and
5. Identifies as a man who have sex with men (MSM).

Additionally, snowball sampling was also utilised. The research participants were asked to assist me in identifying other potential participants and sharing relevant research information. Monette et al. (2014) argued that snowball sampling helps investigate sensitive topics where participants might be hesitant to approach a stranger to share their lived experiences. Similarly, Neuman (2013) suggested snowball sampling is a strategy often used to access hidden or stigmatised populations in social work and to recruit participants who are contacts of those who have already taken part in the study.

Smith et al. (2009) argued that although "there is no right answer to the question of the sample size" (p. 51), an IPA study is primarily concerned with a detailed account of individual experience and, therefore, usually employs a small sample size. Therefore, Smith et al. suggested the default size of three for a master's-level IPA study. However, Ellis (2016) suggested that a sample size of between six and 20 works better for in-depth analysis. Thus, nine participants were recruited and interviewed for this study. I believed that this sample size could provide adequate, rich, and insightful data to get a sense of the phenomenon of the sexual health experiences of overseas-born Asian MSM, especially given the current pool of knowledge on the topic in Aotearoa is so small.

3.4 Recruitment Strategy

Due to the two methods of sampling used, two strategies were used to recruit participants for this study. The primary recruitment strategy was achieved by poster advertisement through several specific sexual health community organisations, such as Body Positive. In addition, I also approached several university-based or ethnic rainbow social networks, including UniQ (University of Auckland), Out at AUT (AUT), Massey Pride (Massey University), Indian Origin Pride NZ and China Pride NZ. Moreover, posters were advertised on several rainbow Facebook groups in Auckland. These organisations and social networks were chosen due to

their close connection to the population and relevance to the research topic. Physical advertisement posters were put in the offices at Body Positive, and digital copies were placed on Facebook pages or newsletters of the organisation and social networks mentioned above. The snowballing strategy was also employed for recruitment. I asked those who took part in the study to disseminate the study information and my contact details to those in their social circles they believed might share similar experiences. Overall, six participants were recruited through poster advertisement, and the remaining three were recruited through the snowballing approach.

It was vital for me to establish trust with the participants during the recruitment and in this study because sex is a sensitive topic to discuss, and sexual health is a much more private topic to share with someone newly met. Therefore, during the recruitment process, participants were advised to approach me directly after seeing the study posters, allowing them to discuss their sexual health to tell their stories and share their lived experiences with me. After receiving expressions of interest from potential participants, I provided them with all relevant information and offered opportunities to ask questions. After the potential participants volunteered to participate in this study, they were invited to attend an individual interview.

3.5 Data Collection

IPA studies invite participants to offer a "rich, detailed, first-person account of their experiences" (Smith et al., 2009, p. 56). Hence, this IPA study used in-depth semistructured individual interviews as the optimal data collection method to access overseas-born Asian MSM's sexual health experiences (see Appendix A for interview schedule). This method allowed me to get rich data from the overseas-born Asian MSM consisting of their detailed stories, thoughts and feelings about their sexual health experiences (Smith et al., 2009). Individual interviews provided the participants with adequate time to share their stories about

their sexual health experiences, in a safe and confidential space. Smith et al. (2009) also highlighted the importance of developing a schedule for semistructured interviews consisting of various types of open questions, including descriptive, narrative, contrast and evaluative questions, and prompts and probes. This interview schedule helps facilitate a comfortable interaction between the researcher and the participants, enabling the latter to provide a detailed account of their experiences (Smith et al., 2009). At the same time, semistructured interviews allowed the participants to answer the overall interview topics and predetermined questions in their own words. Bryman (2016) discussed how semistructured interviews also provide flexibility to both the participants and the researcher. On the one hand, participants have the flexibility to share what they also see as relevant and vital while giving the researcher leeway to explore additional questions about new areas of inquiry that are raised during the interviews but not contained in the schedule. For example, some participants queried the pathway to access PrEP as a temporary visa holder in New Zealand during interviews.

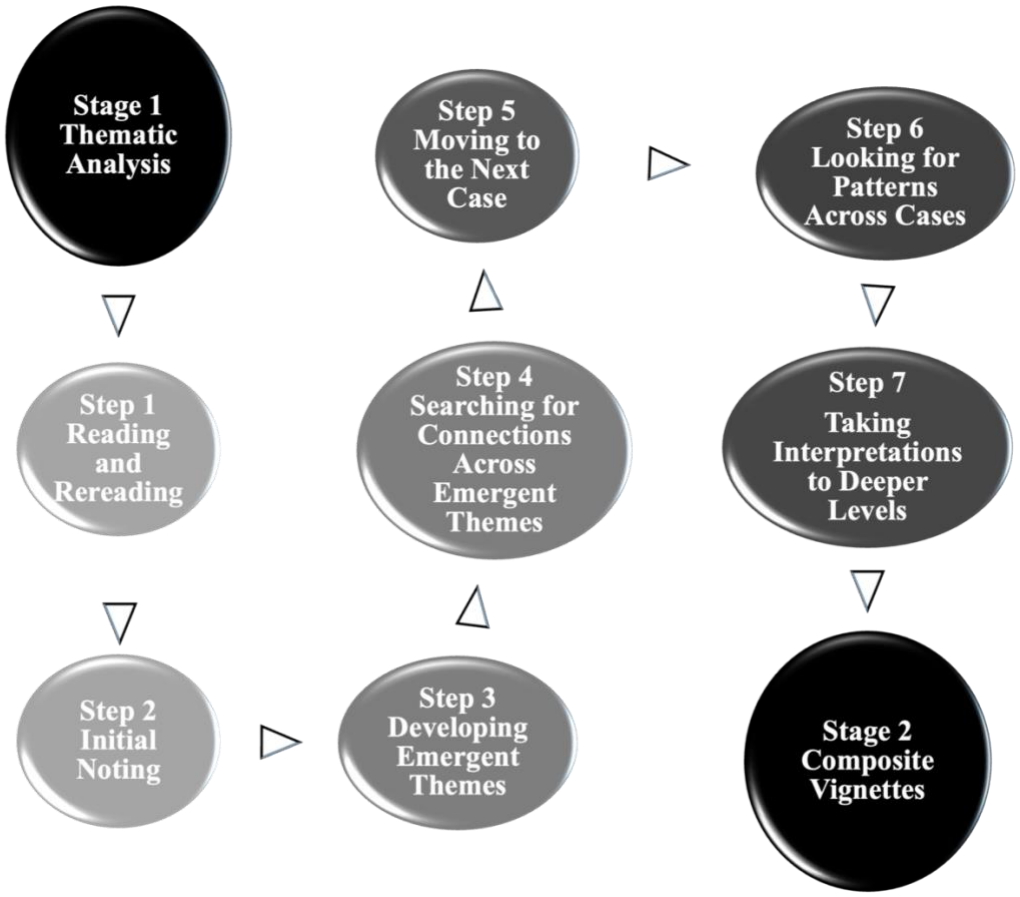
Interviews were conducted at a safe and private place of participants' choice. When some participants could not suggest a safe and private place, I suggested the meeting room at Body Positive. Body Positive is recognised as a safe and culturally appropriate space for all people to seek confidential sexual health information, especially in the rainbow community in Auckland. The interviews lasted between 60 and 90 minutes. I audio recorded the in-depth semistructured interviews and then transcribed verbatim for data analysis. All participants provided informed consent for audio recording and were offered the opportunity to edit and clarify any data in the transcripts for a period of up to 2 weeks. Two participants asked to review a copy of their transcripts, and no change was requested.

3.6 Data Analysis

I employed IPA as the primary data analysis method in this study and presented the emergent themes with composite vignettes. Smith et al. (2009) argued that there is no clear right or wrong way of conducting data analysis in IPA studies and encouraged IPA researchers to be innovative. Therefore, I analysed data in two stages (see Figure 1).

Figure 1

Data Analysis Diagram



Note. This figure shows the two stages of data analysis process, by S. Wong, 2023.

3.6.1 Data Analysis Stage 1

Stage 1 followed Finlay's (2011) seven-step approach and involved an inductive and iterative thematic analysis to identify emergent themes from interviews with participants. An overview of the steps taken for Stage 1 data analysis is outlined below (Finlay, 2011):

Step 1 Reading and Rereading. The first step involved immersing myself in the original data. After transcribing each audio recording from the interview, I waited a few days before reading the transcript print-out, which allowed me to have a fresh pair of eyes. I listened to the audio recording when I was reading the transcript properly for the first time, which helped me pick up the interviewee's tone, pauses, rhythm and the nuances within the words. During subsequent readings of the transcript, I wrote down my ideas and thoughts and kept them separately in a notebook. This was my attempt to bracket off my personal experiences linked to the participant's account.

Step 2 Initial Noting. The second step involved free association and exploration of semantic content and language use by writing notes in the print-out margin. This time-consuming initial level of analysis required me to read the transcript line-by-line and make comments against the text. Smith et al. (2009) suggested three types of comments with different purposes: 1) descriptive comments focused on the content of what the participant has said, 2) linguistic comments focused on the use of language by the participant, and 3) conceptual comments in which the researcher engages at a more interrogative and conceptual level. The conceptual comments also allowed me to reflect on how my previous experiential and professional knowledge impacted my personal interpretations of the participant's world.

Step 3 Developing Emergent Themes. The third step involved moving forward from previous line-by-line comments towards the focus on chunks of transcript and notes. Smith et al., (2009) described this as an attempt to reduce the volume of detail while maintaining

complexity. Therefore, I developed some emergent themes from the interrelationships, connections and patterns between comments and notes. From this stage onwards, I started to use NVivo 2020 software to code emergent themes.

Step 4 Searching for Connections Across Emergent Themes. In this fourth step, I searched for the connections across emergent themes by abstracting and integrating them at different levels in NVivo 2020 software.

Step 5 Moving to the Next Case. I repeated the previous four steps on the next transcript in this fifth step. I waited one day before reading a new transcript, which allowed me to read it with fresh eyes. When I read a new transcript, I tried to bracket previous identified emergent themes and keep open-minded about any new themes. I found it challenging as I could already see the links and patterns showing up, but it was also necessary for the justice and idiographic commitment to the individuality of each new case.

Step 6 Looking for Patterns Across Cases. In this sixth step, I read all transcripts and found all emergent themes from the individual cases. I used the inductive approach to find patterns of shared emergent themes across cases and then emerge and integrate them at different levels. I also noted idiosyncratic instances in each case. In NVivo, I created a number of parent codes (representing the higher order concepts from the emergent themes) and child codes (emergent themes) linked to relevant parent codes.

Step 7 Taking Interpretations to Deeper Levels. The seventh step was proposed by Smith et al. (2009) to encourage IPA researchers to deepen their analysis and take their interpretation to different levels by utilising metaphors and temporal referents used by the participants. Smith et al. also suggested that during the detailed microanalysis of the text, IPA researchers should import theoretical connections as a lens to view the analysis and emergent themes. Therefore, I conducted the data analysis with the theoretical framework, sexual

citizenship, proposed in Chapter 1. This theoretical framework guided me to identify emergent themes and organise the overarching concepts across cases.

3.6.2 Data Analysis Stage 2

Stage 2 involved creative analytic practice, a technique used by several IPA scholars, involving using my interpretation and constructing a series of composite vignettes that were illustrative of emergent themes from Stage 1 (Carless & Sparkes, 2008; Ely et al., 1997; Spalding & Phillips, 2007; Sparkes, 2002, 2005). Presenting emergent themes in the form of composite vignettes is congruent with the underlying philosophy and double hermeneutic commitment inherent in the IPA methodology. The development of composite vignettes makes it more accessible for the readers outside of the experience to understand participants' lived experiences and voices (Ely et al., 1997; Yungblut et al., 2012).

Each emergent theme is presented through one or two composite vignettes. The composite vignette was chosen as it provides "a rich reflective, descriptive, and interpretive portrayal of themes" (Leo & Goodwin, 2014, p. 151) encompassing the participants' description of their lived sexual health experiences. While each participant gave unique elements in sharing their sexual health experiences, common threads were derived from their experiences and used to shape the composite vignettes. Thus, each composite vignette is a representation of different shared realities of nine migrant Asian MSM participants involving both participants' raw extracts and my interweaving interpretations (Leo & Goodwin, 2014; Smith et al., 2009). Each composite vignette aims to provide the readers with a narrative showing a rich and interpreted illustration of migrant Asian MSM's lived sexual health experiences (Ely et al., 1997).

3.7 Methodological Limitations

There were several methodological constraints. The sampling and recruitment processes have limitations as the sample may be biased toward those who may have established a connection

with the rainbow community or sexual health services where this study was advertised. The findings cannot fully capture the voices of those who are not well connected with the established services and networks. Then, although participants came from different countries in Asia, the small number of participants from each country cannot fully represent the sexual health experiences of other migrant MSM from the same country. The selection of participants also posed some limitations for this study. Although the criteria included bisexual Asian men, no one with this identity participated in this study, meaning a lack of different insights into sexual health experiences from bisexual individuals. In addition, no participants came from the Middle East and Central Asia regions, where people may have different sexual health experiences compared to those from East, South-Eastern and South Asia.

3.8 Ethical Considerations

I applied for ethics approval through the University of Auckland Human Participants Ethics Committee (UAHPEC), which was approved on 22 July 2022 (UAHPEC 24557) with approval for a duration of 3 years (see Appendix B). Several critical ethics issues were carefully considered, including informed consent, anonymity and confidentiality, data storage and management, benefits and risks, and conflict of interest. After potential participants expressed their interest in this study, I provided them with the participation information sheet (PIS) and the consent form (CF) and offered them opportunities to ask questions. The PIS includes the project description, procedures, ethical considerations and contact details for me and my supervisor. Once the potential participants were fully informed about the study, they were required to sign the CF in person before the interviews started. The CFs were kept separately from the audio recordings and transcripts to protect participants' anonymity and confidentiality. All participants were asked to choose a pseudonym to protect their anonymity and confidentiality. Interviewees were only referred to by their chosen pseudonyms during the interview and on the transcripts. However, I also acknowledged that, despite every attempt

made to protect participants' anonymity and confidentiality, there was a slight chance that what was said may be recognisable to other people in the small rainbow and Asian MSM communities in Aotearoa.

3.9 Summary

As this interpretative study aims to explore migrant Asian MSM's sexual health perceptions and experiences, a qualitative strategy was employed to collect rich data from participants' lived experiences. Using purposive and snowball sampling approaches, nine participants were recruited through organisations and social networks linked to sexual health among the rainbow community. In the next chapter, data collected through in-depth interviews with this group of Asian MSM provide rich insight into the enablers and barriers to accessing sexual health resources and services, and the tensions experienced around negotiating sexual citizenship as an Asian MSM.

Chapter 4: Findings

This chapter outlines the findings of nine Asian MSM migrants who participated in this study and shared their sexual health experiences. It begins by presenting participants' demographical information and is followed by four major themes derived from data analysis:

1. Seeking a sexual sanctuary
2. Coming to terms with being different
3. Navigating the journey towards sex positivity
4. Confronting challenges and shaping a better future

Each emergent theme will be presented through one or two composite vignettes. While each participant gave unique elements in sharing their sexual health experiences, common threads were derived from their experiences and used to shape the composite vignettes. Thus, each composite vignette is a representation of different shared realities of nine Asian MSM migrant participants. Seven composite vignettes will be represented across four emergent themes in this chapter (see Table 5).

4.1 Participant Demographics

Table 4 shows the demographical information of nine Asian MSM migrants who moved to New Zealand within the last 5 years. Out of nine participants, three were in their 20s; five were in their 30s, and the remaining one was in his 40s. Participants had a range of Asian nationalities. Three came to New Zealand from China, and the rest came from Taiwan, Malaysia, Vietnam, Philippines, India, and Sri Lanka. Figure 2 shows these countries in Asia on a map.

Table 4

Participants' Demographics (n = 9)

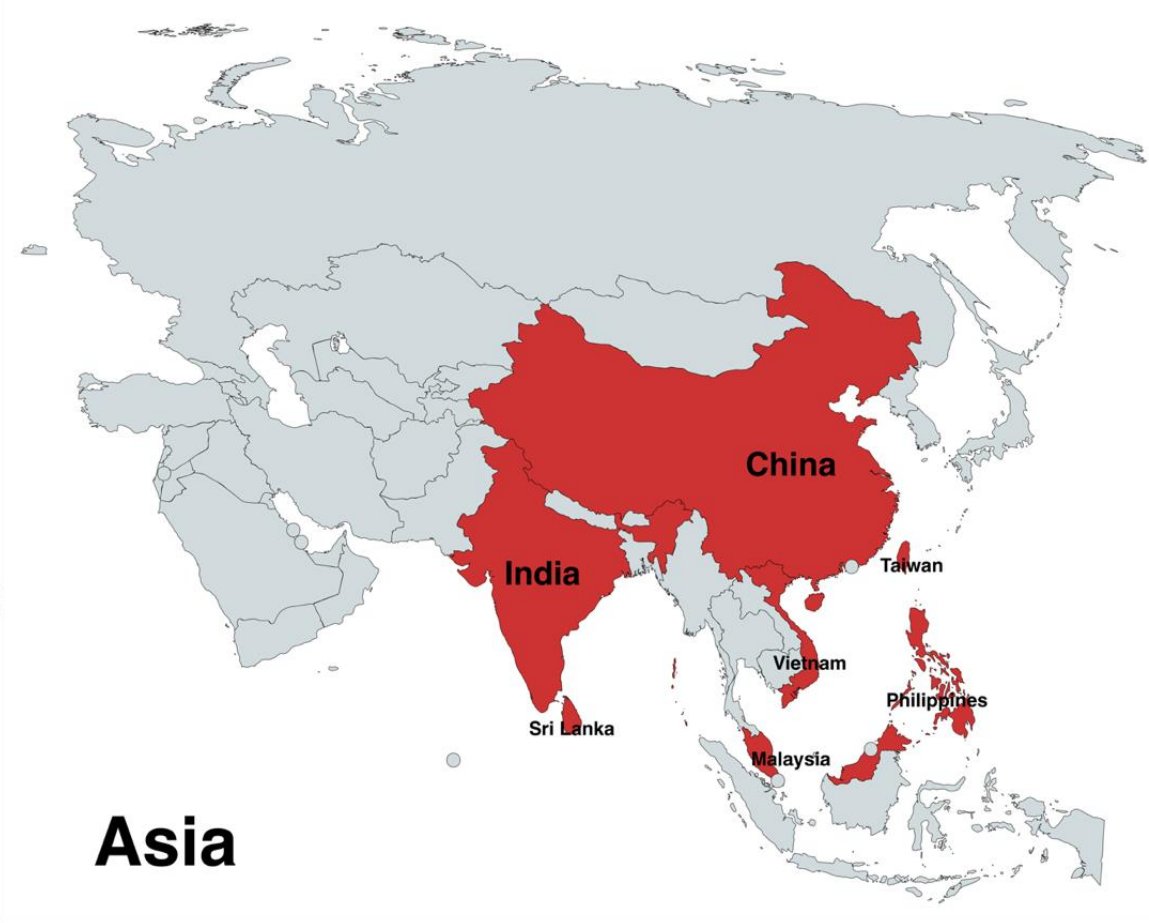
Name	Age	Nationality	Ethnicity	Visa status	Time spent in NZ
Andrew	22	Malaysian	Chinese	Student visa	4 years or more
Frank	32	Chinese	Chinese	Student visa	Less than 1 year
Gary	31	Chinese	Chinese	Work visa	Less than 1 year
Jordan	31	Sri Lankan	Sinhalese	Work visa	4 years or more
Lion	42	Philippines	Filipino	Permanent resident	4 years or more
Meimei	38	Taiwanese	Taiwanese	Permanent resident	1–3 years
Nathan	26	Vietnamese	Vietnamese	Student visa	1–3 years
Peter	36	Chinese	Chinese	Work visa	4 years or more
Ricoh	24	Indian	Indian	Student visa	Less than 1 year

Note. All participants were identified as cisgender and gay men.

These participants identified with six ethnic groups: Chinese, Vietnamese, Taiwanese, Filipino, Indian and Sinhalese. The nine participants were in various stages of their immigration journeys, with five student visa holders, three work visa holders and two permanent residents. Lastly, the length of time spent in New Zealand also varied among the nine participants. Three of them had moved to New Zealand less than 1 year prior to participation, and the remaining six had lived in New Zealand for a more extended period, ranging from 1 to 5 years.

Figure 2

Participants' Countries of Origin



Note. This figure shows participants' countries of origin in Asia. Adapted from *MapChart*, by S. Wong, 2023 (https://www.mapchart.net/asia.html). CC BY SA 4.0.

Table 5 shows the four emergent themes derived from data analysis. Each theme will be presented through one or two composite vignettes. Each composite vignette shows a newly created character telling his story, which represents different shared realities of nine Asian MSM migrant participants. Seven new characters were created based on participants'

nationalities and merging similar threads from the original participants' narratives. Each of following composite vignettes starts with brief background information about the character, followed by the main body of the vignette, and ends with a summary of key insights from each composite vignette.

Table 5

Themes and Composite Vignettes

Themes	Composite vignette	Name	Nationality
Seeking a sexual sanctuary	1	Lee	Malaysian
Coming to terms with being different	2	Han	Taiwanese
	3	Asanga	Sri Lankan
Navigating the journey towards sex positivity	4	Huy	Vietnamese
	5	Kang	Chinese
Confronting challenges and shaping a better future	6	Shahid	Indian
	7	Juan	Filipino

4.2 Seeking a Sexual Sanctuary

Migration was a decision each participant made at some point in their journey. However, factors contributing to the decision to leave their home country and move overseas varied. Some moved to New Zealand for a better education and career development, while others moved here for its relaxing lifestyle and a work–life balance. Across all participants, there was one significant contributing factor that impacted most participants' migration decisions to various degrees—their sexual orientation.

Several participants stated that New Zealand offers legal protection for gay people, particularly the recognition of same-sex marriage, which was prohibited in their home countries in Asia (except Taiwan—the first and the only country so far to legalise same-sex marriage in Asia). These participants also described the unfriendly environments for gay people in their home countries, including fear of disclosing sexual orientation to other people, parental pressure to marry, lack of protection for gay rights, stigma on homosexuality, and even fatal assaults on

gay people—making New Zealand, in contrast, seem like a sexual sanctuary. Below is a composite vignette of Lee, who shared why he chose to leave Malaysia and move to New Zealand.

4.2.1 Composite Vignette 1—Lee

Lee was an international student from Malaysia studying law at the university. He called himself a gay asylum seeker in New Zealand. He wanted to escape his home country, Malaysia, where he felt neither fitted nor safe to live a life in which he could truly express himself.

> As a gay man in high school, I already didn't fit in with the idea; let's call it "the Malaysian Dream." People would say things like, "You need to find a girl to settle down, marry her, have two children and form a family." I'm not a fan of this Malaysian Dream. It didn't really fit people like me. I am not going to get married to a lady. I don't see myself being able to settle down with a woman. I am a gay man. However, I did meet some gay Malaysian men who would follow these so-called Malaysian Dreams. They moved here on their own for university. They would have sex with other men here. When they finished their studies, they would move back home and marry a woman because that's what their parents expect them to do. That's not something I would do. That's not me. I don't want to get pressured by parents like these men to marry a woman.
>
> Growing up in a Christian family and a Muslim country, I have always felt unwelcome. My parents came from a conservative Christian background and often associated with people from church. I think they are pretty homophobic. That's why I would never discuss anything about my sexual orientation with my family. I don't think they would accept me being gay. I also think it's unsafe to be a gay man in Malaysia. You would hear a lot of stories about the police don't protect people who are queer. And so there

> is like an implicit license to assault queer people. Malaysia is very close-minded when it comes to diversity in sexuality. Well, it is also highly conservative about sex in general. We can't talk about sex openly as it is considered offensive speech, especially in some states where they practise Muslim law and have morality police. After high school, I decided to leave Malaysia and pursue my tertiary education in New Zealand because it is queer friendly and provides legal protection for gay men. New Zealand offered me that sanctuary where I could be free and safe.

Lee shared that his decision to move overseas was primarily due to matters relating to his sexual orientation. He did not want to follow the parental expectations of marrying a woman and having children in a traditional heterosexual relationship. He also felt alienated by the heteronormative social expectations that some other gay men would choose to follow (e.g., marriage to a woman). Moreover, he did not feel welcome growing up in a dual-religious environment. Lee expressed frustration with the close-mindedness of sexual diversity and the pure focus on sex for reproductive purposes in his home country. On the other hand, he also felt concerned about his safety due to his sexual identity. Feeling unsafe contributed to his decision to leave his home country, Malaysia, and move to New Zealand—a sanctuary where he felt safe to truly express himself.

4.3 Coming to Terms With Being Different

Accepting and exploring one's sexual orientation is an integral part of sexual well-being. The discovery of sexual orientation is a unique journey for each individual. While some might find it easy to explore and accept their sexual orientation, others might face multiple challenges and spend a longer time coming to terms with being "different" (e.g., being gay).

Nine participants shared their journey of discovering and exploring their sexualities. Despite the uniqueness of each participant's journey, they shared several similar experiences, such as

being exposed to sex-related subjects through porn or peers at an early age, struggles and fears to talk to friends or family about their sexual orientation, and a lack of support and resources for homosexuality in their home countries. This theme is best represented through two composite vignettes of Han and Asanga. Although they both came to terms with their sexual orientation later in life, Han and Asanga faced different difficulties in their own journeys.

4.3.1 Composite Vignette 2—Han

Han, from Taiwan, has only been in New Zealand for a few months with a working holiday visa. He shared how he was exposed to sex growing up in his home country. He also shared how he discovered that he was different—being gay and later accepting his sexual orientation after going to university.

> My first exposure to sex was definitely porn, shared by my friends in secondary school. You know, it was common that a group of boys of 15 or 16 downloaded porn illegally on their phones and shared them with others. I remembered watching some clips of men and women having sex, but I only felt attracted to those male porn actors, not women. I didn't tell my friends that back then. Probably I didn't want them to make fun of me for being different. That was when I started to realise that I'm attracted to guys, not girls. Since then, I began discovering what it means to feel attracted to guys. I was scared and afraid of letting anyone know. I didn't understand the word "gay" until later. I went online and searched for what it meant.
>
> I don't remember seeing any gay people in real life growing up. But I did remember seeing some gay characters on TV shows and movies growing up in Taiwan. They were always portrayed in the form of a joke. Those men were often cross-dressing, wearing women's clothes and acting femininely. People would call these characters gay and often laugh at them when they were on the screen. That's also how I knew about being

> gay. I mean, I have always known that I was different. Compared to other boys in school, I was thin and acted femininely. So some boys in school, particularly those sporty and masculine ones, sometimes called the quiet boys "sissy" or "gay." I experienced some of those slurs in high school, which I would now call homophobia and bullying. I don't know how they learnt about that, probably from the TV shows. That was not a pleasant time, but I survived, I guess.
>
> I didn't spend too much time exploring my sexual orientation in school as I focused on studying. After going to university, I learnt more about what gay means through a small student association for people like me. I got to meet some people and explore my sexuality, including having sex with other men for the first time. It's definitely different from what people are doing in porn. I also learnt lots of information about sexuality and sexual health when I was in that group, like how to have sex, use condoms and get treatment for STIs. I think I finally accepted that I was different and gay in my second year of university. Since then, I have been living as a proud gay man.

Han shared that his sexual learning and exposure was through porn shared by his high school friends, which was a common way for other teenagers to learn about and get exposed to sex for the first time. However, he was uninterested in the heterosexual porn shared by his friends. Out of fear of being laughed at for being different—he was not sexually attracted to the female actors—Han decided to hide his homosexual sexual attraction from his friends. Due to the lack of representation of gay-identified people in real life, except the gay characters in television shows, Han was unclear about the concept of being gay. However, these gay television characters were always portrayed in the form of a joke or as a cross-dressing male to make the audience laugh. As a result, by associating being gay with being feminine, some students used it as a slur to make fun of people who looked or acted similarly to those on television, such as

Han. Joining a queer group at the university after leaving school was a change of environment for Han. He entered a safe and open space, where he was not different for being gay. This safe and open space allowed him to actively explore his sexual being and later accept his sexual orientation without the fear and bullying experienced in school.

4.3.2 Composite Vignette 3—Asanga

Asanga, from Sri Lanka, worked in hospitality. He shared his story of encountering sex as a child before understanding what sex was. He also went through a period when he was unsure of his sexual orientation during his teenage years but later accepted that he was gay.

> It's a very funny story. I actually had sex at a very young age, maybe 6 years old. I ran into a neighbour one day when he was jerking off. He asked me to come over, put his penis in my hands, and said move your hands up and down. So it began like that. And he used to take me for a walk after dinner sometimes. We would go for a walk and do it again. He was relatively older than me, maybe around 13 or 14, and I was not aware of what was happening, whatever was happening. Then a few years later, I had sex with my cousin as well. You know, we used to sleep and lay naked together; I helped him to jerk off. He was maybe around 14 or 15 back then. It was not until one neighbour showed me porn that it became clear that what I had been doing with my neighbour and cousin was called having sex. The sexual education I got initially came from porn. And you know how porn works; it's already very mucked up. So I thought this is how it should be.
>
> I wasn't sure about my sexual orientation for a long time. I mean, I was having sex with men, but I didn't think I was gay. You know, having sex with men doesn't automatically make you gay. Just like my neighbours and my cousin, they married women. So I dated a girl when in high school for about 2 years. We never had sex; we used to just make

> out and spend time together. At the same time, I was hanging out with a guy. We went to tutorials and spent lots of time together. We kissed, cuddled, and had sex. Of course, we were using condoms because we didn't want to get HIV. You know, HIV was seen as a terrible disease, and people would die. Over that period of time, I started to develop an attraction to him more than my girlfriend. I was very confused at the time. I wasn't sure what was wrong with me; am I gay or bisexual? Later, the guy told me he couldn't hang out and have sex with a guy anymore; he was moving to another city. I realised then I was only attracted to men. So, I broke up with my girlfriend.
>
> I only came out to a few close friends, not my parents, family or anyone at work. I didn't feel safe coming out to my colleagues when I worked in my home country. You know, I might have been humiliated for that. They might have made some random jokes about me. I didn't think people would accept me, and you can't expect people to understand. I wanted a good life in terms of my sexuality. Some people are brave enough to be whoever they want to be. I'm not brave enough; I can't even wear a pink T-shirt outside. I am that closeted, to be honest.

Asanga shared his sexual experiences when he was at a very young age. While he did not understand what sex was or define it as sexual abuse when the narratives were shared, from a Eurocentric frame, his neighbour and cousin would be described as the perpetrators of child sexual abuse. It was also unclear whether Asanga's neighbour and cousin understood what their behaviours meant to Asanga, a much younger child. Having been exposed to sex without fully understanding what it was or meant, Asanga could not give informed consent. He only learnt about what sex was after being exposed to porn when he grew older. Due to his early exposure experiences, he was ambiguous about his sexual orientation. He initially thought he was not gay because he saw his neighbour and cousin marry women while they had sex with men.

Asanga went through a period of exploring his sexual orientation, including dating both a girl and a guy. After experiencing a breakup with a guy, he then came to term with being gay and attracted to men. However, he was still afraid to come out to his family and colleagues due to shame and internalised homophobia.

4.4 Navigating the Journey Towards Sex Positivity

Sexuality is an integral part of sexual health and well-being. However, negative attitudes towards sexuality were commonly reported during participants' interviews. Nine participants' accounts demonstrated that sex negativity was rooted in their home countries. They all shared that sex is still considered a taboo topic, particularly among the older generations. Limited sex education was offered in their school curricula, which only focused on the reproductive health systems, the use of condoms for contraception and the danger of STIs.

Sex positivity, on the other hand, challenges the shame and stigma surrounding sexuality and encourages open conversations and communication about sex, safer sex practices and relationships. The journey to navigate sex positivity is unique to individuals. Each participant in this study found themselves at different stages of this journey, influenced by multiple factors, including correct knowledge of STIs, access to support and resources about sex, and open and safe space for sex-related discussions and personal experiences. Two composite vignettes of Huy and Kan show how they were positioned on the journey to navigate sex positivity.

4.4.1 Composite Vignette 4—Huy

Huy, a 30-year-old Vietnamese, worked in the finance sector. He felt uncomfortable and embarrassed to talk to other people about sex-related topics. Although he accepted himself as gay, Huy was still not open to sharing his sexuality with others as he considered it a private matter.

Sex is still taboo in general in Vietnam. People won't discuss it. They would never talk about it. You know, it's like Lord Voldemort, you can't say his name in Harry Potter. Sex is a private thing. They won't talk about it, particularly in my parents and grandparents' generations. I remember my mum once said, "why do you want to have sex? Are you a dog? You are better than a dog." Just like that, I'd never raise a discussion about sex with my parents; it's just awkward and embarrassing. But things have changed a lot for the current younger generations; young people think that sex is a natural thing. They are more open to talking about it on the internet and with friends privately. Why? Maybe it's because of the generational gap, and the education we received was totally different.

When it comes to sexual health or sexual diseases, nobody wants to talk about it. And I didn't know much about it growing up. I mean, I've heard so many stories about people getting AIDS or something terrible from unsafe sex. They said online that if you get it, you will die. Back in university in Vietnam, I had unprotected sex once with my ex-boyfriend. After that, I felt terrified and stressed because I didn't know what would happen. I bought a test online to make sure I didn't get AIDS. But when I saw the negative result, I wasn't sure if it was correct. I was confused and worried for a few days before getting a professional test. At the hospital, I remember being scared to tell the doctors I had unsafe sex with a man. I needed to lie and say I had unprotected sex with a female prostitute. If you tell them that you had sex with a guy, they would simply judge you or treat you differently. So they took my blood and sent me home. I remember I waited for a few days. I was so anxious and needed to force myself to do something to distract myself. Luckily, the results came back negative, and I was clean.

> That happened in 2016, I think. Since then, I haven't had . . .I mean, I have sex, but I don't do the top or bottom, you know, anal sex anymore. I'd never do it again. That was the last time I had a test. I'm very sure I will not get AIDS, so it's not necessary to do the tests again. At the same time, I feel sad for people having AIDS. They need to take a lot of drugs. All the drugs have side effects and will affect their physical conditions. I feel sad for them because they have become a patient and unhealthy.

Huy grew up in an environment where sex is considered a taboo topic. He used a metaphor to emphasise that sex is something that people are unwilling to talk about in his country. In addition, sex was shrouded with stigma and shame in Huy's upbringing. His mother stigmatised sex as animal behaviour while ignoring that sex is natural for individuals. Huy believed this negative mindset about sex was prevalent among the older generation compared to the younger one, which is more open to sex. Huy also shared his experience of a potential exposure incident to HIV when he engaged in condomless sex with his ex-boyfriend. Huy appeared to consider HIV and AIDS the same and referred to HIV infection as AIDS in his later accounts. He also believed that HIV and AIDS were deadly. He was anxious about the potential infection because he had heard multiple terrible stories about people getting AIDS on the internet. He took two tests to confirm his serostatus, a self-testing kit with negative results and, because he was worried that the self-testing kit result was inaccurate, a complete blood test at the hospital which he took at the cost of needing to lie to the doctor that he had sex with a woman instead of a man. Huy was also anxious when he needed to wait a few days to receive his negative result from the hospital. Since the incident, Huy decided not to engage in penetrative anal sex due to fear of AIDS. As a result, he did not consider that he needed to engage in regular STI testing. While staying cautious about AIDS, Huy expressed his sympathy for those having AIDS because he considered them unhealthy.

4.4.2 Composite Vignette 5—Kang

Kang, originally from China, recently graduated from university and worked in the healthcare sector. He considered himself to be very open about his sexuality. He felt liberated when he had discussions about sex with his friends. He learnt lots of sex-related information from his friends, who have improved his sexual health and well-being.

> I remember we had biology classes in school where our teacher would teach us about sex. But it was very brief and limited information, mainly the reproductive health system and the use of condoms for contraception and prevention of STIs. We definitely didn't learn about what sex really was and how it works, not to mention anything about gays or lesbians. I knew that I was gay when I was in high school after having a crush on a boy in the same class. But I didn't do anything back then; I didn't come out to anyone, not even the boy I had a crush on. I didn't know what to do, so I kept it all to myself.
>
> I moved to Auckland for university when I was 18; that was when I started exploring every aspect of my sexuality. I have made some great friends, gay and straight. And I am pretty open to discussing sex with them, like the guys I am seeing and hanging out with and my sexual experiences. It's fun and liberating for me. I also enjoy and am open to all kinds of sex. You know, sometimes you like it hot and wild, playing in a group or orgy, or having kinky plays etc. At the same time, I also enjoy soft sex and intimacy more now. I used to do many hook-ups when I first moved here, but things have changed; I've learnt to understand sex better over time. Sex doesn't have to look like what they show you in porn. It doesn't have to involve penetration. Sex can also be just two people lying in bed together, naked, intimate, enjoying themselves and touching each other.

> I have now become very sex positive in my sexuality and sexual health. I am very open about my sexuality with my colleagues and friends here. I don't feel like I need to stay in the closet, which is liberating. And I believe that being open about our sexual orientation is very closely related to sexual health. I am lucky that I have a group of friends who are very open about sex; some of them are even straight. They helped to transform me from being shy to being open and free. They also taught me about all the safer sex practice methods, like consenting, using condoms, taking PrEP and having regular STI testing. I got chlamydia and gonorrhoea before but received treatments and recovered now. My friends told me that STIs are common, and I didn't need to feel ashamed or worried about it as long as I got the treatments early. You know, it's not something that most people talk about openly. But I feel connected to them when I can have these kinds of talks freely. It is a safe space to share my life and issues with boys and vice versa. The sense of belongingness and safety has changed me, particularly in improving my sexual health and well-being.

Kang shared that he learnt some basic knowledge about sexual health in biology classes, including the anatomy and the use of condoms for contraception and STI prevention. In the school curriculum, there was no mention of pleasure or healthy sex or homosexuality. Although Kang knew he was gay in high school, he did not explore his sexuality because he was unsure what to do or how he could do it. He only started to explore his sexuality after moving overseas and has become open and sex positive. Kang described his sexual exploration as fun and liberating. He expressed his open attitudes towards all types of sex, including wild and kinky, such as group sex and kink plays, and gentle and soft sex. Han described that he engaged in many hook-ups when he first moved here, but he then started to learn and discover what sex means to him over time. He now considered that sex is more than what porn shows; it is instead about the connection and intimacy between people. Kang attributed the changes to sex

positivity attitudes to his friends, who provided a safe space for him to be open about his sexual orientation. He also learnt correct sexual health information and safer sex practice methods from these friends. In addition, when he encountered STIs, his friends provided him with nonjudgmental and stigma-free support. He believed that the connectedness with his friends had improved his sexual health and well-being because of the sense of belongingness and safety they provided.

4.5 Confronting Challenges and Shaping a Better Future

People often face many different types of challenges during individual sexual health journeys, and some might be more difficult than others. Nine participants shared the challenges they had faced during their sexual health journeys, such as shame and stigma towards HIV and other STIs, lack of knowledge and awareness of sexual health, issues with accessing quality services and treatments, healthcare workers' judgemental attitudes and difficulties in finding relevant resources in a new country.

However, on the other hand, identifying challenges can lead to suggestions for future improvement. Nine of the participants shared what they would like to see improve from their past sexual health experiences. Some recommended increasing the student insurance coverage to sexual health-related claims, and others suggested more Asian representation in the healthcare workforce in LGBTQ+ communities and sexual health. The two composite vignettes of Shahid and Juan illustrate shared challenges they faced in their sexual health journeys and future improvements they would like to see to enhance their sexual health and well-being.

4.5.1 Composite Vignette 6—Shahid

Shahid is a doctoral student from India who has been living in New Zealand for almost 1 year. He shared the differences in STI testing experiences in India and New Zealand. He also shared some of the challenges relating to sexual health after moving here.

I have had sexual health experiences in India and New Zealand. Back in India, I used to have HIV tests done two or three times a year because I knew I needed to care about HIV as a gay man. Having HIV is still the biggest taboo, to be honest. When I went to get a test, the nurses would ask "why would you like to get tested?" They would say things like "you don't need to test for HIV; normal people don't need that." I would answer I wanted to take care of my sexual health. My answer would surprise them like it's some new idea. When I had my medical check for immigration, the clinic called me 2 weeks after and told me that I had syphilis. I lived far away from the speciality clinic, about 60 or 70 kilometres; I needed to travel multiple times to get my treatments. I couldn't talk to my family about it at all. I was not out to my family. I had syphilis, but I couldn't speak to anybody about it. It's because it's a shameful thing for me. It affected my mental health a lot. I didn't want to infect anyone else with any STI. But we wouldn't talk about this elephant in the room in India. Nobody talks about it because of the culture, society, social norms and traditions. After moving here, things have been good and bad. I'm still finding my feet. I came to know the Burnett Foundation [formerly New Zealand AIDS Foundation] because of its ads on Grindr [the gay dating app]. I wouldn't have known it if not from there, to be honest. It's so much easier to get a test here, and you can do it on your own at home. How amazing!

I still try to get tested every 3 months because I want to be sure about myself, my status. However, I'm also still figuring out how to access PrEP. Back in India, there's no access to PrEP; you don't get PrEP so commonly. I'm not sure how I can access it as an international student. Another challenge I've been facing is finding it very hard to fit in and make friends. It's difficult for me to find a good friend or a partner because some people are pretty racist. They don't want to meet a Brown person or an Asian guy. They want White guys, like tall and well-built ones. Sometimes when I send my pictures on

> the app, I might get blocked or messages like, “fuck off, you dirty Indian.” or, “sorry, I don’t do brown guys.” On the other hand, I also have trouble fitting in with other Indian people. Because they’re very much cis-heteronormative, they only care about money, family and kids. It’s just not something that I am even remotely interested in. They also seem to think the queer community is all about sex and hook-ups. I find it quite challenging mentally and emotionally. It’s difficult for me to seek friends from my community. I really hope that there’s no discrimination towards each other within our queer and ethnic communities.

Despite HIV being considered taboo in India, Shahid still tried to have regular HIV testing because he understood the significance of HIV as a MSM. However, when he went for an HIV test, he encountered obstacles from nurses. He described that they believe that normal people do not need an HIV test, implying that they are not at risk. These nurses would get surprised when he answered that he wanted to take care of his sexual health because of the lack of awareness of sexual health in India. Shahid also shared his stressful experience of discovering his syphilis infection during an immigration medical health check and the need to travel long distances multiple times to get proper treatments. However, he could not tell anyone, including his family, because he did not come out to his family and considered syphilis a shameful disease. Shahid described that he was having a stressful time, which has impacted his mental health. At the same time, he recognised that people would not discuss “the elephant in the room”—STIs—due to stigma and discrimination embedded in the culture, social norms and traditions.

After moving to New Zealand, Shahid learnt about the Burnett Foundation from its advertisement on a gay dating app. He described that self-testing is much easier to access and can be done independently at home. Shahid then shared several challenges relating to sexual

health he is facing in New Zealand. Firstly, he is trying to find out how to access PrEP in New Zealand as an international student. He wanted to start taking PrEP but could not do it in India as it was not accessible or commonly used. He also found it challenging to make friends and connections with people from both his queer and ethnic communities. He described that he faced racism and discrimination within the queer community due to his race and ethnicity. On the other hand, he found he had little in common with other Indians and was challenged by their close-minded assumptions about the LGBTQ+ community.

4.5.2 Composite Vignette 7—Juan

Juan was a banker from the Philippines. He shared his past and current attitudes towards sexual health and improvements in sexual health that he would like to see to happen from an Asian migrant perspective.

> I never really took care of my sexual health before. I came here as a foreigner and had other priorities; you know. It's more of those practical things, where to find a job, how to get along with people and how to make friends. I had to put a lot of energy into setting up a life here when I first moved. Also, I didn't know I needed to take care of my sexual health. The only thing I knew about sexual health was to use condoms to prevent STIs. In the Philippines, it was difficult to talk about sex or sexual relationships. Even in schools, sex education was neglected and ignored. Not to mention sexual health, it's the first time today [in the interview] that I learnt about the sexual health definition. We don't talk about it in my country.
>
> After reading the definition for the first time today, I remembered something. Not entirely sure if it fits under sexual health, but it affected my sex life for a while. Last year, I had a haemorrhoid that later became an anal infection. It was untreated for quite some time due to various reasons. It became quite a big problem for me. You know, it

means I couldn't have sex with my boyfriend due to the infection. As for my mental health, I felt terrible, like a sense of inferiority of being unable to get with my boyfriend because I couldn't fulfil his needs. It caused lots of stress for me, physically and mentally. Now I think about it, I guess it affected my sexual health as well. I'm starting to understand the connection between physical, mental and sexual health.

I wish I could have had someone to talk about this when I had the infection. I'm unsure about my friends, as telling them these things is weird and embarrassing. But not with my doctor, who doesn't know I'm gay; I couldn't share my feelings with him. Sometimes I hope we could have more gay doctors. They would have been more knowledgeable about gay men's health issues. Also, from an Asian and a migrant perspective, I hope we can have some Asian representations in the sexual health or health systems. I mean, if the new migrants or Asian people could see these representations, they'd feel safe because they would have more understanding about the person from the same background. If I knew a gay Filipino working in sexual health, he would understand me better as we speak the same language and come from the same country. Costs are also another significant barrier. Luckily my student insurance covered the costs of the infection. But also, when I was reading my insurance policy, I realised it wouldn't cover anything related to sexual health. That's bizarre. Lastly, I wished there had been some sexual health information or resources provided to me when I first started university, like during the orientation events? I mean, that would really help me to change the awareness of my sexual health and well-being, like, oh yes, I should probably start to care about it as it seems important.

Juan described that he did not use to consider sexual health as a priority, especially as a newcomer to a foreign country. As an immigrant, he needed to prioritise his energy to set up a

new job, find a job, and make friends. It seemed that Juan's sexual health knowledge was limited to using condoms to prevent STIs. He attributed it to the lack of open discussion about sex and relationships and proper sex education in the Philippines. As a result, he did not have much knowledge or awareness of sexual health.

After reading the WHO definition of sexual health for the first time, Juan had a new understanding of sexual health. While recalling a time when he had a physical condition, he started to consider the relationship between sexual health and physical and mental health. This physical condition impacted his mental health because he felt inferior by not being able to meet his boyfriend's sexual needs. Juan provided some suggestions he would like to see for sexual health from an Asian migrant perspective, including more queer health professionals, more Asian and migrant representations in sexual health, and reduced costs for migrants to access sexual health care. Lastly, he called for more proactive sexual health information sharing for new migrants and international students, who might have had little or no exposure to sexual health information in their home countries.

4.6 Summary

This chapter has outlined findings from participants' interviews. Four major themes were identified and crafted into composite vignettes that represented the shared sexual realities of Asian MSM who migrated to New Zealand. Each theme was represented through one or two composite vignettes. The themes woven into the composite vignettes represent aspects of how participants were exposed to, learned about and accepted sexuality; how sociocultural factors contribute to sex negativity; why sexual identity can be a catalyst to leave one's home country; and the challenges to navigating support, access and knowledge when arriving in the new country—in this case, Aotearoa.

Participants' shared realities show that a meaningful understanding of sexual health is significant to reaching a positive sense of holistic health and well-being. However, the sexual aspects of health and well-being were often marginalised and not prioritised by the Asian MSM migrants who took part in this study. In the next chapter, these findings are explored through the lens of sexual citizenship and situated in relation to previous understandings of Asian MSM migrant sexual health as well as within the broader delivery of healthcare to this population in Aotearoa.

Chapter 5: Discussion

This research study sought to explore and better understand the sexual health experiences of migrant Asian MSM. In particular, it aimed to characterise key enablers and barriers to sexual health resource access and uptake among this group of Asian people. This study employed an IPA methodology (Smith et al., 2009) with semistructured interviews with Asian MSM who migrated to New Zealand within the last 5 years, to explore their sexual health experiences.

In this chapter, the concept of sexual citizenship (Mackie, 2017; Pan et al., 2021; Richardson, 2000, 2017) (see Chapters 1 and 2) is employed to guide analysis of findings presented through composite vignettes in the previous chapter in relation to existing scholarly bodies of knowledge. The discussion is divided into four sections: 1) Sociocultural Factors Contributing to Sex Negativity, 2) Sexual Learning, Exposure and Acceptance, 3) Sexual Identity as a Catalyst for Migration, and 4) Intersectional Identities and Sexual Health. The first three sections focus more on participants' sexual health experiences before migration, although recognising that some elements discussed continue to influence all stages of their sexual health journeys. The final section focuses on the challenges and difficulties faced by these Asian MSM after arriving in a new country, such as Aotearoa. Recommendations to support this community are also reported. The chapter concludes with study limitations and recommendations for future research.

5.1 Sociocultural Factors Contributing to Sex Negativity

Sociocultural factors, such as cultural values, societal norms and religious beliefs, play a pivotal role in influencing participants' sexual learning and exposure (SLE) experiences (Fortenberry, 2014), shaping their attitudes toward sex, sexuality, and sexual health in their countries of origin in Asia (Gray et al., 2021; Jahangir et al., 2022; Okeke, 2021). These

sociocultural factors are often inextricably intertwined and contribute to negative and stigmatised attitudes towards sex and viewing it as taboo, embedded through sex-negative ideology and practices (Goffman, 1963; Ivanski & Kohut, 2017; McFarland & Williams, 2016). As a result, discussions around sexuality, such as sex, sexual orientation and sexual health, are often shrouded in shame and stigma, leading to the lack of open conversations in many Asian countries (Iyer et al., 2014; Kwok & Kwok, 2022; Phillips et al., 2020; Ziersch et al., 2021). Consistently, findings in this study showed that Asian MSM participants experienced sex negativity embedded in heteronormative cultural values, societal norms, and conservative religious beliefs in their countries of origin, which was expressed across all composite vignettes.

Societal norms of sexuality are deeply rooted and often revolve around gender roles and traditional family values, parents' expecting their sons will marry women and have children (Hart et al., 2021; Smith, 2012). These parental expectations of heterosexual marriage and procreation can create a hostile environment for Asian MSM, who may struggle to meet their expectations and societal norms, as echoed by participants in this study. The pressure to conform to these expectations and norms can be overwhelming, leading to shame and guilt (Hart et al., 2021; Phillips et al., 2020; Philpot et al., 2023). Philpot et al. (2023) argued that the shame and guilt of one's sexual orientation can negatively contribute to internalised stigma and prevent gay and bisexual migrants from Asia accessing to sexual health services and support.

Moreover, these societal norms and beliefs in Asian countries are heavily influenced by heteronormativity: the assumption that heterosexuality is the default and superior sexual orientation. Heteronormativity pervades many aspects of society in Asia, including negative media portrayals of MSM and the lack of legal protection for same-sex relationships

(Fongkaew et al., 2019; Yue, 2016). As a result of heteronormativity being favoured in participants' countries of origin, the most significant consequence of societal norms of heteronormativity is discrimination against and stigmatisation of homosexuality. This discrimination and stigmatisation can have far-reaching effects on Asian MSM's mental health and self-esteem, leading to profound shame about their sexual orientation (Hart et al., 2021). It is critical for social workers to challenge heteronormativity and not make assumptions about the sexual identity or behaviour of any Asian male client they encounter (Henrickson, 2015).

Furthermore, the societal stigma surrounding homosexuality often discourages Asian MSM from seeking information and resources related to sexual health. In many Asian countries, discussions about sex, sexual orientation, and HIV/AIDS prevention may be relegated to the shadows due to fear and shame (Iyer et al., 2014; Okeke, 2021; Phillips et al., 2020, 2022; Philpot et al., 2022, 2023). This lack of access to comprehensive sexual education and healthcare resources can leave these Asian MSM ill-equipped to make informed decisions about their sexual health and put them at risk for HIV and other STIs (Logie et al., 2016; Philbin et al., 2018). Likewise, and through the lens of sexual rights, this study revealed that the Asian MSM participants could not fully exercise their sexual citizenship at the same level as their heterosexual counterparts.

In addition, religion also plays a pivotal role in shaping cultural attitudes toward sexuality and sexual health in many Asian countries. Often, conservative religious doctrines label homosexuality as immoral or sinful, deepening the stigma associated with homosexual identities (Hart et al., 2021; Iyer et al., 2014; Phillips et al., 2020; Philpot et al., 2023). The intersections of religious and cultural conservatism reinforce each other, resulting in heightened stigmatisation of Asian MSM, such as the criminalisation of homosexuality in Muslim countries in Asia (Alibudbud, 2023; Arli et al., 2020; Human Rights Watch, 2022). In

this study, multiple religious beliefs were discussed by participants, including Christianity, Islam, Buddhism, and Hinduism. Building on previous findings, this study (e.g., Lee, Composite Vignette 1) provided evidence of how conservative religious beliefs (i.e., Muslim and Christian) in Malaysia and within Lee's family did not allow him to be open about his sexual identity or feel safe to be his authentic sexual self.

The influence of these cultural values, societal norms, and religious beliefs contributes to the embedded sex negativity in Asian MSM's SLE environments. As discussed above, sex negativity is evident in participants' accounts across multiple composite vignettes (see Composite Vignettes 3, 4 and 6). Through the lens of sexual citizenship (Richardson, 2000, 2017), these sociocultural factors, including cultural values, societal norms and religious beliefs, dictate the boundaries of acceptable behaviours (e.g., heterosexual intercourse) and relationships (e.g., marriage between a man and a woman) in participants' countries of origin in Asia, preventing them from fully participating as sexual citizens. Moreover, the intersections of cultural and religious conservatism and legal discrimination severely constrain these participants' ability to assert their sexual rights, resulting in further stigmatisation, marginalisation and discrimination. Maree (2017) argued that "the processes and modes of inclusion and belonging" (p. 2) are central to sexual citizenship, which is manifested in legal, societal and cultural practices. In line with Maree's (2017) assertion, this study showed that when Asian MSM could not find a sense of belonging in their countries of origin, they turned to pursue sexual citizenship somewhere else, in this case, Aotearoa.

5.2 Sexual Learning, Exposure and Acceptance

Self-acceptance of sexuality means "accepting one's sexuality as it is and being comfortable with this part of the self" (Camp et al., 2020, p. 2354), including the acceptance of sexual orientation, an integral part of one's sexuality (Elizur & Mintzer, 2001). Based on the findings

of this study, it appears that MSM share both similarities and differences in their journey of sexual self-acceptance upon first discovering their attraction to men. They often share the feeling of being somewhat different to their heterosexual counterparts. Yet, each MSM navigates their own journey of learning, understanding, accepting or rejecting their sexual orientation.

How well people navigate their journeys of self-acceptance is heavily impacted by their SLE experiences (Fortenberry, 2014). These SLE experiences constitute how people learn or are exposed to sex and sexuality during their upbringing, through formal and informal education such as school-based sex education, media, pornography, and friends and family, as reported by the participants in this study. Building on this, it was vital to examine migrant Asian MSM's SLE experiences growing up in their countries of origin to understand how they arrived at self-acceptance of their sexual orientation and its influence on how they navigated their sexual health journey once in Aotearoa.

School-based sex education, or sexuality education, was highlighted as one key means to receive sex-related information by many participants in this study. UNESCO (2012, 2021) reports found that sex education has been taught in school curricula in different forms across many Asian countries over the past decades. However, the quality of sex education and its delivery approach vary in different parts of Asia (Gray et al., 2021; UNESCO, 2021). Moreover, Iyer et al. (2014) argued that HIV and sexuality topics are integrated into the existing curricula in subjects such as biology, health and physical education. Some of these subjects are optional in different countries, which leads to inconsistent and sporadic delivery and content coverage (Iyer et al., 2014). Correspondingly, the findings from this study (e.g., Juan, Composite Vignette 7) highlight how some Asian MSM could only think of the usage of condoms when discussing sexual health, but really only came to learn the definition of sexual

health for the first time in the interview. Juan's story was a testament to how limited sex education in Asia can contribute to the lack of holistic understanding of sexual health, impacting migrant Asian MSM's ability to develop sexual agency and, therefore, a strong sense of sexual citizenship.

For participants in this study, sex education was not only limited, but it was also heteronormative. This echoes findings from Phillips et al.'s (2022) study as previously mentioned, where Asian MSM reported receiving sexual education in their countries of origin that was primarily taught and discussed only in the context of heterosexual sex between a man and a woman. No information about same-sex relationships or sexual health was provided through their education (Phillips et al., 2022). Complementing these insights, this study revealed that some participants (e.g., Kang, Composite Vignette 5) said they only received brief and limited information about sex concerning the reproductive health system and the usage of condoms and could not recall learning any information related to MSM. The absence of same-sex topics and the persistence of heteronormative curricula in Asia impact the development of sexual citizenship of these Asian MSM as it denies them access to accurate information about their sexual health and well-being. By utilising antioppressive practices (Dominelli, 2002), social work practice can focus on providing Asian MSM with accurate sexual health information and relevant resources to increase their knowledge and awareness.

The media plays a crucial role in shaping people's understanding of sexuality. Due to the lack of comprehensive sex education through school curricula, Asian MSM in this study tended to find alternative means to access sex-related information, such as from the media. Han's story (Composite Vignette 2) suggested a lack of a positive portrayal of MSM in the media in Taiwan. Han described that gay characters were often portrayed negatively on TV, such as in the form of a joke. This finding concurs with multiple studies (Detenber et al., 2007; Fongkaew

et al., 2019) that found when MSM are underrepresented or portrayed negatively in the media, it perpetuates feelings of isolation and invisibility, which negatively impact MSM's journey to understand and explore their sexual orientation. Han's story shows that he was bullied in school by other students who used the word *gay* as a slur after seeing the negative portrayals of gay characters on TV. The lack of positive representation of MSM in Asian media can be seen as the denial of Asian MSM's sexual rights and citizenship, which are actively exercised by their heterosexual counterparts (Richardson, 2000, 2017), hindering Asian MSM's journey towards sexual self-acceptance.

Pornography was reported as another source of information about sex by the study participants. Han (Composite Vignette 2) and Asanga (Composite Vignette 3) said that they initially learnt about sex through watching illegal pornographic videos. However, pornography often portrays exaggerated and scripted sexual encounters that may not reflect the complexities and realities of intimate relationships in real life (Byron et al., 2021). For Asian MSM who already contend with societal pressures, a dearth of comprehensive sexuality and porn literacy education (e.g., pornography is illegal in many Asian countries) can impact the development of self-acceptance and sexual agency (Healy-Cullen et al., 2023; Mustanski et al., 2011). Relying on pornography for sex education can lead to unrealistic expectations and misconceptions about sex, undermining the exercise of sexual citizenship and the significance of sexual health (Byron et al., 2021; Healy-Cullen & Morison, 2023). As described in Composite Vignette 5, Kang later realised how sex means so much more than how it is depicted in pornographic videos after his extended SLE experiences in his adult life. Therefore, providing support to help migrant Asian MSM to relearn what sex means beyond the portrayal in porn is warranted to increase awareness of sexual health, develop sexual agency and promote sexual well-being.

Friends and family were also discussed as alternative sources of information about sex. Participants shared that due to intergenerational differences, they tended to feel more comfortable discussing sex with their friends than with family members such as parents and grandparents (Phillips et al., 2022). Friends were often more open to discussing sex-related topics, including sharing pornographic videos, as shown in Composite Vignettes 2 and 4. Compared to their friends, Asian MSM's adult family members were more reluctant to talk about sex as they often view sex as an awkward or taboo topic (Hart et al., 2021; Okeke, 2021; Phillips et al., 2022). Parents or other adult figures tended to avoid such conversations by changing topics abruptly, providing minimal information or stigmatising sexual acts. For instance, when Huy (Composite Vignette 4) wanted to have a conversation about sex, his mother associated sex with animal behaviour to discourage Huy from thinking and talking about sex, a common strategy used by Asian parents (Kao & Martyn, 2014). Huy's mother's response showed that parental attitudes towards sex are still conservative and hostile (Roomruangwong & Epperson, 2012). As a result, participants often chose not to disclose their sexual orientation to their families due to the conservative and negative attitudes towards sexuality. Yet, intergenerational sexual communication between Asian parents and children (Kao et al., 2007; Kim & Aronowitz, 2021) could influence Asian young people's agency and decision making concerning their sexuality and sexual health.

The interplay between self-acceptance and sexual agency has profound implications for the sexual and overall health and well-being of Asian MSM (Phillips et al., 2020, 2022). When self-acceptance is lacking, individuals may engage in risky sexual behaviours driven by shame or a desire to conform to societal expectations, including sexual coercion and engagement in high-risk sexual practices, which elevate the risk of contracting STIs and other health issues (Gray et al., 2021). On the other hand, individuals with a strong sense of self-acceptance and sexual agency are better equipped to seek out and access appropriate healthcare services,

engage in routine sexual health check-ups, and be proactive about their sexual well-being (Vanwesenbeeck et al., 2021). In essence, sexual agency becomes a means of self-advocacy, allowing Asian MSM to assert control over their sexual lives. By taking better control of their sexual lives, Asian MSM can exercise their sexual rights and citizenship. Therefore, it is important to develop a comprehensive sexuality education programme for migrant Asian MSM, consisting of shame-free, stigma-free and correct information about sex and sexual health, in order to develop their sexual literacy and agency as sexual citizens.

Self-acceptance is the cornerstone upon which an individual's sexual agency is built. It entails an individual embracing their sexual orientation, recognising it as an integral part of who they are, and dispelling associated feelings of shame or guilt. Based on the findings of this study, it appears that the lack of comprehensive sex education from formal and informal SLE approaches contributes to Asian MSM's limited understanding and awareness of sexual health, and to them ignoring the interconnected relationship of physical, mental and sexual health. Furthermore, the path to self-acceptance for Asian MSM can be riddled with unique challenges stemming from cultural norms and societal expectations, impacting their SLE experiences in their upbringing.

5.3 Sexual Identity as a Catalyst for Migration

Migration is an uneasy and complex decision for many people to make, attributed to multiple factors with which people feel dissatisfied within their countries of origin such as education, employment, politics and so on. Sexual identity was highlighted as a catalyst for migration among Asian MSM participants in this study. The decision to leave their countries of origin in Asia was not easy. Still, the desire to live authentically as a MSM was too compelling to ignore for these participants. On the one hand, participants were resisting the heteronormative societal expectations and family pressures of marrying a woman and having a child (Smith, 2012; Yue,

2008), for example, the "Malaysian Dream" for Lee (Composite Vignette 1). On the other hand, participants' safety in their home countries could not be guaranteed and was likely to be violated by the police due to hostility and discrimination against their homosexual identity, such as Lee's accounts of police assaults against queer individuals in Malaysia (Human Rights Watch, 2022). Lee's descriptions of Aotearoa, being a "sexual sanctuary," showed that the host country offers him the prospect of acceptance, love, and the freedom to express his true self. This view was shared by multiple participants when they decided to migrate to Aotearoa, to various degrees.

Carrillo (2004) described that sexual migration means "international relocation that is motivated, directly or indirectly, by the sexuality of those who migrate" (p. 58). In this study, representing multiple participants' accounts, Lee's story was a testament to the transformative power of sexual migration (Carrillo, 2004). Lee became a sexual migrant who relocated internationally from Malaysia to Aotearoa, attributing this directly to his homosexual identity. Lee utilised his migration as a quest to exercise full sexual citizenship in a foreign country where he could openly express his true self without the fear of discrimination and repercussions. Over the past decades, multiple studies have shown a similar trend of queer Asian migrants feeling dissatisfied with their home countries and choosing to relocate to Western countries to seek greater sexual citizenship rights, including destinations like Australia (Phillips et al., 2020; Smith, 2012), New Zealand (Adams et al., 2019; Adams & Neville, 2020), North America (Kimmel & Yi, 2004; Poon et al., 2017) and European countries (Golembe et al., 2020). These Western countries are considered more progressive (Phillips et al., 2020; Smith, 2012) in protecting queer rights, such as recognition of same-sex civil unions and marriage, where queer Asians do not need to hide their sexual identity for fear of legal persecution, social ostracisation and physical violence (Alibudbud, 2023; Human Rights Watch, 2022; Manalastas et al., 2017).

The decision of Asian MSM, such as those in this study, to migrate to Western countries can be perceived as pursuing sexual rights and citizenship, human rights and equality, highlighting the stark disparities in gay rights between their countries of origin and foreign countries where safe spaces can be provided (Smith, 2012). However, migration may also create unique vulnerabilities for Asian MSM regarding their sexual health and well-being, including the transmission and acquisition of STIs and exposure to new sexual knowledge, norms and values in Western countries (Carrillo, 2004). Phillips et al. (2020) argued that gay Asian migrants were strongly influenced by their previous exposure to embedded societal and cultural beliefs on sexuality and sexual health in their countries of origin, similar to the men who participated in this study. Therefore, migration to a Western country does not automatically change those embedded societal and cultural beliefs that influence gay Asian migrants' knowledge, attitudes and practices in sexual health (Phillips et al., 2020).

5.4 Intersectional Identities and Sexual Health

Intersectionality focuses on how different aspects of a person's identity can intersect and expose them to overlapping forms of discrimination and marginalisation, contributing to poorer health outcomes and health inequity (Collins & Blige, 2016; Hankivsky & Christoffersen, 2008). Migrant Asian MSM in this study needed to navigate their intersectional identities—as migrant, ethnic and sexual minority—during their sexual health journey across nations. In addition, studies (Rao et al., 2012; Stumbar et al., 2018) have argued that sexual health is influenced by multiple social determinants, including healthcare access, social and cultural norms, and health literacy, resulting in health disparities and inequities. Pan et al. (2021) suggested that it is critical to understand how queer Asian migrants' sexual citizenship and sexual health are impacted by their intersectional identities and other social determinants.

Participants reported that their SLE experiences in their countries of origin often did not equip them with comprehensive knowledge about sexuality, a holistic understanding of sexual health or an awareness of safer sex practices. Furthermore, embedded societal and cultural beliefs continued to influence their knowledge, attitudes and practices in sexual health (Phillips et al., 2020). In addition, migration has provided additional layers of complexity to the migrant Asian MSM's sexual health journey (Baroudi et al., 2021; Blondell et al., 2015; Ross et al., 2018; Yarwood et al., 2022). As a result, these Asian men are more likely to face intersectional barriers to accessing sexual health services (Philpot et al., 2022).

Upon arrival in a new country, migration can further impact Asian MSM's sexual health in many different ways, including limited access sexual health services due to cost, lack of understanding of the healthcare system in Western countries, language and cultural barriers, as well as the lack of queer healthcare workforce (Agu et al., 2016; Gray et al., 2021; Hart et al., 2021; Henderson & Kendall, 2011; Mengesha et al., 2016; Pan et al., 2021; Philpot et al., 2022). Cost was reported as one of the barriers to accessing sexual health services faced by this study's participants. While some participants in this study were eligible for public-funded healthcare as a work visa or resident class visa holder, others were international students who were required to self-fund healthcare by opting for mandatory health insurance. Juan's story (Composite Vignette 7) showed that sexual health-related illnesses are excluded from international student health insurance coverage. Structural barriers, like cost, can discourage health-seeking behaviours from migrant Asian MSM, particularly international students, such as accessing sexual health services and care for their sexual well-being (Agu et al., 2016; Parker et al., 2020). Secondly, new Asian migrants are often unfamiliar with the Western healthcare system, including sexual health clinics, further exacerbating health-seeking behaviours. (Hart et al., 2021; Parker et al., 2020).

Furthermore, this study highlighted language and cultural barriers as a challenge for migrant Asian MSM (see Composite Vignette 7). Gray et al. (2021) argued that language barriers remain a challenge faced by many migrants in Western countries. Studies (Gray et al., 2021; Henderson & Kendall, 2011) suggested that the lack of sexual health literacy in English can prevent migrants from accessing sexual health services. On the other hand, participants in this study reported the lack of Asian representation in the sexual health sector. Multiple studies (Agu et al., 2016; Henderson & Kendall, 2011; Mengesha et al., 2016) suggested that healthcare practitioners from the same cultural backgrounds as the patients tend to have a better understanding and be able to provide more culturally responsive support. Another barrier mentioned was the lack of a queer healthcare workforce. The participants in this study suggested that queer doctors and healthcare practitioners are more likely to be LGBTQ+ culturally competent (Yu et al., 2023) and support gay men's health issues than their heterosexual counterparts.

As previously discussed, the new environment in the new country can be liberating for Asian MSM, allowing them to explore their sexuality with fewer societal constraints (Parker et al., 2020; Phillips et al., 2020). However, self-acceptance remains a deeply personal and intersectional process that may still be influenced by sociocultural factors back home (Hart et al., 2021; Parker et al., 2020; Phillips et al., 2020). The internalised stigma and shame around sexuality (Goffman, 1963; Hart et al., 2021; Hatzenbuehler et al., 2013; Philpot et al., 2023; Quinn et al., 2014) stemming from their upbringing can undermine Asian MSM's abilities to fully embrace their identities, engage in healthy sexual behaviours, and access sexual health services and information actively during every stage of their sexual health journey. Hart et al. (2021) suggested that new migrants may not want to access sexual health services due to the fear of being outed or judged by being seen at a venue known for providing sexual health and HIV services. Similar to results found in this study, past negative sexual health experiences in

participants' home countries, such as homophobia and discrimination from healthcare practitioners (see Composite Vignette 4 and 6), may also hinder Asian migrants' willingness to access sexual health services and resources (Ayhan et al., 2020; Hart et al., 2021).

Furthermore, Hart et al. (2021) suggested that these Asian MSM face double marginalisation in both ethnic and sexual communities in Western countries, contributing to social isolation and loneliness. Shahid's accounts (Composite Vignette 6) were a testament to this double marginalisation experienced by many migrant Asian MSM in Aotearoa. Some Asian MSM participants found it challenging to engage with their heterosexual counterparts from the same cultural background because they feared disclosing their sexual orientation to others from the same cultural background and lacked common interests. At the same time, they also faced challenges of sexual racism and full participation in the Western gay community, where White men dominate and have more social power (Adams & Neville, 2020; Peiris-John et al., 2016; Phillips et al., 2020;). The lack of social power could lead to problems causing these Asian MSM to compromise in sexual relationships to meet their needs for intimacy and acceptance, placing them at risk for HIV and other STIs (Hart et al., 2021; Huang & Fang, 2019).

In the context of HIV for migrant Asian MSM in this study, several challenges and difficulties related to their sexual health were highlighted (see Composite Vignettes 6 and 7). The group of migrant Asian MSM who had developed an understanding of the importance of sexual health through their early sexual journey found it challenging to access PrEP and sexual health support and resources when they first arrived in Aotearoa. For example, multiple studies (Adams et al., 2019, 2020; Phillips et al., 2022) found that migrant Asian MSM were unsure where and how to access these relevant supports and resources in terms of eligibility, costs and means to connect with the queer community outside of online dating apps, despite wanting to stay on top of their sexual health and well-being. On the other hand, due to the lack of comprehensive

sex education and sociocultural factors contributing to stigma around sexuality and HIV (Ziersch et al., 2021), migrant Asian MSM in this study lacked a clear understanding of sexual health and its significance to their holistic health and well-being. Participants called for early and proactive sexual health education and support for new gay migrants, particularly international students from Asia. Multiple studies (Blackshaw et al., 2019; Lewis & Wilson, 2017; Medland et al., 2018;) found that migrant MSM are more likely to engage in high-risk sexual activity due to social and economic upheaval and exposure to new sexual scenes upon arrival in a new country. Lewis and Wilson (2017) argued that it is critical to provide HIV prevention within the first few years after migration for this community with multiple identities. Providing information, literacy, and tools related to sexual health for migrant Asian MSM can help them to develop agency and autonomy to take control of their sexual health and well-being and promote sexual citizenship.

It is evident that migrant Asian participants' SLE experiences did not provide them with a comprehensive understanding of sexuality and sexual health, leading to struggles to come to terms with their sexual orientation. Additionally, their SLE experiences were significantly impacted by the intersection of multiple sociocultural factors, including sex-negative cultural values, heteronormative societal norms and conservative religious beliefs. As a result of being unable to be a fully participating sexual citizen in their countries of origin, this group of Asian men chose to migrate to a Western country, Aotearoa, to pursue their sexual rights. However, migrant Asian MSM continue to struggle to exercise their sexual rights and citizenship due to their intersectional identities in Aotearoa, leading to challenges to their sexual health experiences. It is critical to provide culturally appropriate support to these Asian men to pursue the very sexual rights and citizenship for which they leave their countries of origin. Social workers can work alongside and with members of Asian MSM communities to challenge the stigma, oppression and discrimination based on particular sexuality, race, and immigration

identities (Natale & Moxley, 2009; Sen et al., 2017). Challenging the cultural norms of sexual citizenship can help improve Asian MSM's access to and utilisation of sexual health services.

5.5 Study Limitations

As is the case with any research, this study has some limitations. For example, the scope of this study was limited as it was a small-scale qualitative study using semistructured interviews. The goal was not to generalise the findings but to offer participants an opportunity to share their voices on their sexual health experiences, a topic that is often overlooked. While participants provided answers about their sexual health history, including their history of STIs and HIV testing and treatment, if any, I did not emphasise behavioural epidemiology, a well-developed approach in sexual health study. Instead, I focused on understanding participants' SLE experiences from a rights-based perspective, which can provide invaluable insights into the theoretical understanding of sexual health among migrant Asian MSM in Aotearoa useful for addressing sexual health inequity among this marginalised population.

5.6 Recommendations for Future Research

While this is the first research project of its kind exploring migrant Asian MSM's sexual health experiences from a social work perspective in Aotearoa, the scope of this research is limited. Based on the findings and limitations mentioned above, I suggest that future social work research is warranted in sexual health. Future research could focus on recruiting more participants from different regions of the Asian continent, such as the Middle East. It would be beneficial to understand Middle Eastern Asian's sexual health experiences and explore the similarities and differences of Asian people from other regions of the continent. A larger scale quantitative study or a mixed-method study with more participants is also recommended for future research. In addition, future research design could also focus on recruiting participants from certain countries or regions, for example, all participants from China, India, East Asia or

Southeast Asia, which could explore how the particular culture in that country or region impacts individuals' sexual health experiences differently. Moreover, it would be beneficial to recruit participants who are bisexual in future research as they may offer different perspectives and insights compared to their homosexual counterparts. Lastly, research with social workers would be beneficial. A future study focusing on social workers' understanding of sexual health and capacity to work in sexual health would be beneficial for social work professional development to provide better support for individuals' sexual health and well-being.

5.7 Summary

The findings suggest that this group of Asian MSM are likely to experience challenges in becoming fully participating sexual citizens in both their countries of origin and Aotearoa. Therefore, while recognising that improving these men's past SLE experiences is impossible, I call for more support and resources for this group of Asian men in Aotearoa. In the next and final chapter of this thesis, key learnings are summarised, and the implications of these findings for social work practice and policy are outlined, which will also be applicable to other public health practitioners to support migrant Asian MSM's sexual health journey.

Chapter 6: Conclusions

Sexual health is more than the absence of disease. A good state of sexual health and well-being is also closely associated with sexual justice, citizenship and pleasure. It is imperative that, from a rights-based perspective, Asian MSM in Aotearoa can exercise the sexual rights they deserve and access the quality sexual health services and resources they are entitled to in this new country that they now call home. As a profession that promotes social justice and is part of allied health, social workers can make a difference in contributing to addressing public health inequity in sexual health among Asian MSM in Aotearoa.

This final chapter includes a summary of key learnings from this research study on migrant Asian MSM's sexual health experiences. Then, it discusses the implications for social work practice, professional development and policy change. It concludes with my final thoughts and calls for incorporating sexual health in Aotearoa social work practice.

6.1 Summary of Key Learnings

There are several key learnings from this research study:

- Asian MSM's SLE experiences, influenced by multiple sociocultural factors embedded in heteronormativity and sex negativity, can impact their acceptance of sexuality and the development of sexual agency.
- As a result of the heteronormative and sex-negative SLE experiences, Asian MSM tend to lack a holistic understanding of sexual health and cannot fully exercise their sexual rights as sexual citizens in their countries of origin.
- Asian MSM's decisions to migrate to Aotearoa were influenced by their sexual identity and the desire to pursue sexual rights.

- After arrival in a new country, Asian MSM with multiple-layered identities face intersectional challenges, such as the cost to access sexual health services, language and cultural barriers, lack of awareness and knowledge of sexual health, social isolation and sexual racism.
- Asian MSM's sexual citizenship is impacted in both their countries of origin and Aotearoa, and social workers can play a crucial role in supporting these Asian men, with access to sexual health services and resources, and improving their sexual health and well-being.

6.2 Implications

This research study revealed that migrant Asian MSM are facing intersectional challenges related to their sexual health. Through the lens of sexual citizenship, these marginalised and disenfranchised individuals have attempted to pursue sexual rights through cross-cultural international migration. However, this group of men has continued to experience marginalisation and discrimination in Aotearoa, a sexual sanctuary, where they thought they could fully exercise their sexual rights and become sexual citizens. It is necessary to address these intersectional challenges and protect the sexual rights of these men who travel abroad to be true to themselves.

The study's implications are relevant in multiple areas, including social work practices, public health services and health policy in Aotearoa. Firstly, this study has implications for social work practice in Aotearoa. At present, many Aotearoa social workers are working in areas that fall under sexual citizenship, such as sexual violence and abuse, sexual and gender identity, women's health, and intimate and family relationships, and other areas, such as physical and mental health, poverty, and homelessness. With the findings of this study, social workers can better understand how to provide adequate support for migrants and sexual and ethnic minorities, such as the migrant Asian MSM participants in this study. In addition, social

workers can start considering how they can utilise and extend existing strengths-based and antioppressive practices to work in the field of sexuality and sexual health and well-being.

This study also has implications for public health. Public health has worked closely with various individuals and communities, including the migrant, ethnic and rainbow communities, and focused on addressing social determinants of health that impact health outcomes and equity. As stated in previous chapters, Asian MSM are experiencing disproportionate sexual health disparities in HIV, but no priority was given to this vulnerable group in the latest *National HIV Action Plan* (MoH, 2023). The public health sector needs to work closely with migrant Asian MSM to address the intersectional challenges and poor sexual health outcomes they are bearing. From a social justice and health equity perspective, in particular, migrant Asian MSM deserve more public health input and support to improve their sexual health and well-being.

Lastly, this study has implications for health policy in Aotearoa. Several structural barriers were identified in the findings, such as the cost to access sexual health services, exclusion of sexual health-related claims by health insurance and the lack of an Asian and queer workforce in sexual health. Health policymakers, the MoH and the government should provide additional resources and support to address these structural barriers, including expanding affordable and accessible sexual health services to those who are not eligible for public-funded healthcare; providing health promotion to increase sexual health knowledge and awareness among migrant Asian MSM; and developing a workforce in sexual health that can meet the needs of migrants, ethnic minorities and the queer communities.

6.3 Final Thoughts

This study provided an opportunity for participants to talk about their sexuality and sexual health, a topic that was often ignored in their countries of origin and their everyday lives. With

multiple identities myself, as a migrant, an Asian, a MSM, and a social worker in Aotearoa, I was honoured that I was able to offer my participants the chance to express their sexual voices. After hearing these voices, more work is needed. More resources should be prioritised to increase Asian MSM's sexual health awareness, improve their sexual literacy and help them understand their sexual rights. In addition, more Asian healthcare workers in sexual health are needed to improve the health and well-being of this marginalised population.

The findings from my study align with Turner et al.'s (2023) statement on social work and sexual health:

> *Sexual well-being is social work. Sexual health is more than a medical issue and social work needs to claim its usefulness within this practice area. (p. 3253)*

Social workers have the capacity to provide support in sexual health and can play a pivotal role in improving people's sexual health and well-being. Therefore, I call for the social work professional body in Aotearoa, including the Social Workers Registration Board and the Aotearoa New Zealand Association of Social Workers, to align themselves with the broader and global social work practices of their international counterparts, such as BASW, CASW, IFSW and NASW. Moreover, the social work profession must take a clear stance on protecting the sexual rights and citizenship of the migrant, ethnic, queer and other marginalised communities in Aotearoa. A clear starting point would be to promote better education of social workers on the topics of sexual well-being and human sexuality, because ensuring the sexual wellbeing of all is part of amplifying social justice, a core mandate for all social work practitioners.

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Appendices

Appendix A: Interview Schedule

EDUCATION AND SOCIAL WORK
SCHOOL OF COUNSELLING, HUMAN SERVICES AND SOCIAL WORK

INTERVIEW SCHEDULE

TE KURA
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New Zealand

Project title: *Migrant Asian MSM and their sexual health experiences*

Principal Investigator/Supervisor: *Dr Laura Ann Chubb*

Student Researcher: *Mr Spar Wong*

Topic 1: Immigration journey

1. Can you please tell me some information about you, such as your nationality, where were you born and raised? And how long have you been living in NZ?
2. How would you describe your immigration journey?
3. What factors contribute to your decision to emigrate from your home country?

Topic 2: Sexual learning and exposure experiences

1. When you hear the word sex, what does that mean to you or what would be your description for the word?
2. Can you share a little about your sexual learning experiences - when, where and how did you learn about sex?
3. When did you first realise your sexuality/sexual orientation?
4. In your home country, how is sex discussed?
5. Have you talked about sex with others, like friends, parents, or siblings?
6. In what ways, if any, do you think norms, attitudes and beliefs around sex differ in New Zealand as compared to your home country?

Topic 3: Sexual health:

1. What does sexual health mean to you?
2. Considering the idea of your sexual health, how important would you say it is in comparison to your physical and mental health?
3. What kinds of behaviours, if any, do you practice improving your sexual health?
4. Are there specific protections you use during sex, for oral sex, receptive and insertive anal sex, or other types of sex?
5. What kinds of impacts, if any, does your home culture have on your sexual health experiences now?
6. Why do you think your home culture impacts your sexual health experiences in the way you described?
7. Were there any changes to your sexual health experiences after moving to NZ?

Topic 4: HIV/STIs:

1. Do you know some of the common types of STIs and their means of transmission?
2. What approaches are you aware of, if any, for preventing HIV/STIs?
3. What is your attitude towards HIV/STIs? Why do you feel that way?
4. Have you ever had an STI?
5. Have you ever been tested for HIV?
6. Are you aware of any sexual health resources or organisations?

Topic 5: Enables and barriers to access and uptake of sexual health services:

1. What factors could positively contribute to your sexual health?
2. What factors could negatively impact your sexual health?
3. What suggestions do you have for relevant sexual health practitioners so that they can provide better culturally responsive support to meet your sexual health needs?

Appendix B: UAHPEC Letter of Approval

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Level 3, 49 Symonds Street
Auckland, New Zealand
Telephone (09) 373 7599 Ext 83711

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

22/07/2022

Dr Laura Chubb
Counselling, Human Services and Social Work

Re: Application for Ethics Approval (Our Ref. UAHPEC24557): Approved

The Committee considered the application for ethics approval for your study entitled "**Migrant Asian men who have sex with men and their sexual health experiences**".

We are pleased to inform you that ethics approval has been granted for a period of three years.

The expiry date for this approval is **22/07/2025**

****Restrictions to contact with participants in person due to the current COVID-19 protection framework setting may make the approved study methodology impractical. The Committee would like to remind researchers that they should check guidance updates and submit an amendment request if any changes need to be made to the approved ethics application to enable you to continue with your study.

Ministry of Health guidance:

https://covid19.govt.nz/

University of Auckland guidance:

https://www.auckland.ac.nz/en/news/notices/2022/covid-19.html

https://www.staff.auckland.ac.nz/en/covid-19/uoa-covid-protection-framework-plan.html

https://www.staff.auckland.ac.nz/en/covid-19/researcher-support-and-information/covid-19-research-continuity-guidance.html

If you have any questions about research continuity not answered by the pages linked above, please contact your Faculty/Institute Research Service Team representative, your Faculty/Institute Business Continuity Lead, or email researchcontinuity@auckland.ac.nz.

Completion of the project: In order that up-to-date records are maintained, you must notify the Committee once your project is completed.

Amendments to the approved project: Should you need to make any changes to the approved project, please follow the steps below:

- Send a request to the UAHPEC Administrators to unlock the application form (using the Correspondence tab in Ethics RM).
- Make all changes to the relevant sections of the application form and attach revised documents (as appropriate).
- Change the Application Type to "Amendment request" in Section 13 ("Submissions and Sign off").
- Add a summary of the changes requested in the text box.
- Submit the amendment request (PI/Supervisors only to submit the form).

If the project changes significantly, you are required to submit a new application.

Funded projects: If you received funding for this project, please provide this approval letter to your local Faculty Research Project Coordinator (RPC) or Research Project Manager (RPM) so that the approval can be notified via a Service Request to the Research Operations Centre (ROC) for activation of the grant.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at humanethics@auckland.ac.nz in the first instance.

Additional information:

- Do not forget to fill in the 'approval wording' on the PISs, CFs and/or advertisements, using the date of this approval and the reference number, before you use the documents or send them out to your participants.

All communications with the UAHPEC regarding this application should indicate this reference number: **UAHPEC24557**.

UAHPEC Administrators

University of Auckland Human Participants Ethics Committee

c.c. Mr Spar Wong

Appendix C: Participant Information Sheet

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

EDUCATION AND SOCIAL WORK
SCHOOL OF COUNSELLING, HUMAN SERVICES AND SOCIAL WORK

PARTICIPANT INFORMATION SHEET

TE KURA
TAUWHIRO TANGATA

Epsom Campus
Gate 3, 74 Epsom Ave
Auckland, New Zealand
T +64 9 623 8899
W education.auckland.ac.nz
The University of Auckland
Private Bag 92019
Victoria Street West
Auckland 1142
New Zealand

Project title: *Migrant Asian MSM and their sexual health experiences*

Principal Investigator/Supervisor: *Dr Laura Ann Chubb*

Student Researcher: *Mr Spar Wong*

Researcher Introduction

This research will be conducted by Mr Spar Wong as part of the Master of Social Work programme in the Faulty of Education and Social Work at the University of Auckland. Spar completed his Bachelor of Social Work (Honours) degree in the same school and has been working as a community sexual health promoter since late 2020 after his social work placement at Body Positive. He is interested in addressing disparities in sexual health faced by ethnic and sexual minorities to improve their health and wellbeing.

Project Description and Invitation

Overseas-born Asian men who have sex with men (MSM) face difficulties from their multi-layered identities (i.e., Asian, immigrant, gay or bisexual) on a daily basis in New Zealand. At the same time, sex is a taboo topic in many Asian countries, and sexual health is often overlooked as a result. However, sexual health is an essential part of an individual's holistic health and wellbeing, which can impact their physical and mental health, relationships with others and the development of sexual self-awareness. Hence, there is a need to support Asian MSM who experience difficulties due to their multi-layered identities to improve their sexual health and wellbeing from a social work perspective.

This research aims to explore overseas-born Asian MSM's experiences of sexual health after their immigration journey from home countries in Asia to New Zealand. To understand these experiences, Asian MSM will be invited to share their knowledge, attitudes and practices concerning sexual health, especially HIV and other STIs. Additionally, you will be asked to describe any enablers and barriers to sexual health resource access and uptake you may have experienced in New Zealand. I kindly invite you to participate in this research as your insights will inform the development of recommendations on culturally responsive competencies for practitioners working with Asian, MSM and other ethnic and sexual minority communities in New Zealand. Your participation in this research is completely voluntary.

I am seeking to speak individually with 8 to 12 people and would like to invite you to join this research project if you are:

1. aged 18 years old or over;
2. able to communicate fluently in English or Chinese;
3. born and raised in an Asian country;
4. migrated to New Zealand within the last five years; and
5. identified as a gay or bisexual man who has sex with men.

Project Procedures

Please read the Participation Information Sheet and Consent Form thoroughly to gain an informed understanding of this study. If you agree to participate voluntarily, you are invited to attend a one-off individual face-to-face interview with Spar at a public and open venue deemed suitable for private conversations at your convenience (such as a park, a library or a café). Should you agree, a list of questions will be provided before the interview. Interviews are expected to last 60 to 90 minutes and audio-recorded by a voice recorder, then transcribed by Spar for data analysis. Should you wish to receive and review a copy of your transcript, you can indicate so on the Consent Form attached. There will be no physical risks or harm in this research. However, it is anticipated that some psychological stress or discomfort may arise when discussing your sexual health experiences, such as embarrassment and shame. Please feel confident that the space for our conversation will be safe and non-judgemental. All matters discussed will be confidential. A referral to social support and health services will be arranged if needed. A $40 voucher will be offered in recognition of your time given to the study and help offset any travel costs before the interview starts.

Anonymity and Confidentiality

No individuals will be identified in the research. You will choose a pseudonym (i.e., a fake name) before the interview starts and only be referred to as the chosen pseudonym during the interview. No identifiable information will be collected. Access to the audio recordings, transcriptions and Consent Forms will be restricted to the Principal Investigator and the Student Researcher.

Data Storage/Retention/Destruction/Future Use

The audio recordings and transcripts will be stored on a password-protected computer during data collection, with a secure backup on the University's Research Drive. After each interview has been accurately transcribed, the digital recording will be erased. All identifying materials, including the Consent Form, will be kept separately inside a locked file cabinet in the Principal Investigator's office for six years. Only the Principal Investigator and the Student Researcher will have access to them. After six years, all the paper form data will be shredded, and digital data will be deleted.

After the research, findings will be shared with you in the form of a report summary via email should you choose. The findings may also be published in academic journals or shared in seminars and conferences to enhance practitioner learning.

Participants' Right to Withdraw

Participation in this research is completely voluntary. You have the right to withdraw participation at any time without giving any reason. You may also choose not to answer any questions or leave the room without giving any reason. You may request that the voice recorder be turned off at any time without giving any reason. You may

withdraw any data provided within two weeks after receiving the transcript if you have indicated to receive one on the Consent Form.

Conflict of Interest

Spar was a social work student at Body Positive for his social work placement, arranged by the Faculty of Education and Social Work, between August and November 2020. After his placement, Spar works a community sexual health promoter on a consultant basis for Body Positive. This role involves conducting sexual health screenings and promotions at several community venues in Auckland. Spar is not a paid employee of Body Positive. Spar is not involved in any organisational operation or management at Body Positive. Body Positive has assured that anyone's participation or nonparticipation will not affect their abilities to access Body Positive's services. Body Positive will not be informed of anyone's participation or nonparticipation. All personal information will be kept confidential and not be disclosed to any third parties outside the Student Researcher and the Principal Investigator for this project.

Contact Details

If you would like to participate in this research project or have questions about involvement, please contact any of the following:

Student Researcher: Mr Spar Wong
School of Counselling, Human Services and Social Work
Faculty of Education and Social Work
University of Auckland
Email: jwan446@aucklanduni.ac.nz

Principal Investigator/Supervisor: Dr Laura Ann Chubb
School of Counselling, Human Services and Social Work
Faculty of Education and Social Work
University of Auckland
Email: l.chubb@auckland.ac.nz

Head of School: Dr Allen Bartley
School of Counselling, Human Services and Social Work
Faculty of Education and Social Work
University of Auckland
Email: a.bartley@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, Office of Research Strategy and Integrity, The University of Auckland, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 8371. Email: humanethics@auckland.ac.nz

Thank you for taking the time to read this participant information sheet.

Approved by the University of Auckland Human Participants Ethics Committee on **22/07/2022** for three years.
Reference Number **UAHPEC 24557**

Support Organisations and Recourse

- **Body Positive** A peer support organisation founded by and run for all people living with HIV in New Zealand. **0800 448 5463**
- **Burnett Foundation Aotearoa** Formerly New Zealand AIDS Foundation. Their services include prevention, testing, counselling and support for people living with HIV. **burnettfoundation.org.nz**
- **Rainbow Youth** An Auckland-based organisation that provides information, advocacy and education for queer young people, their friends and whānau. **ry.org.nz**
- **Youthline** Free, confidential and non-judgemental telephone counselling service and other resources for young people, including about your sexuality, gender identity, sexual health, relationship issues and anything else you want to talk about. **0800 376 633**
- **OUTLine** A national telephone counselling and information support service for the gay, lesbian, transgender, takatāpui and bisexual people of New Zealand. **0800 688 5463**
- **Just the Facts** This website tells you how to look after your sexual body, keep yourself safe from sexually transmitted infections (STIs) and what to do if you catch one. **Justthefacts.co.nz**
- **Healthline** Call Healthline free on **0800 611 116** for health advice and information. A trained nurse/doctor can give you advice on what to do about any sexual health issue.
- **Sexual Health Clinics** For any sexual health issues, call Auckland sexual health free on **0800 739 432**
- **Safe to Talk** For free, confidential information and support for people affected by sexual harm (sexual violence, rape, sexual assault, sexual abuse). This helpline is staffed by specialists trained in sexual harm support. **0800 044 334**

Appendix D: Consent Form

EDUCATION AND SOCIAL WORK
SCHOOL OF COUNSELLING, HUMAN SERVICES AND SOCIAL WORK

CONSENT FORM

TE KURA
TAUWHIRO TANGATA

Epsom Campus
Gate 3, 74 Epsom Ave
Auckland, New Zealand
T +64 9 623 8899
W education.auckland.ac.nz
The University of Auckland
Private Bag 92019
Victoria Street West
Auckland 1142
New Zealand

Project title: *Migrant Asian MSM and their sexual health experiences*

Principal Investigator/Supervisor: *Dr Laura Ann Chubb*

Student Researcher: *Mr Spar Wong*

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction.

- I agree to take part in this research and my participation is voluntary.
- I understand that I will be interviewed about my sexual health experiences.
- I understand that my personal information will be de-identified to ensure confidentiality and privacy.
- I understand that I am free to withdraw my participation at any time without giving reason.
- I understand that the data will be kept for six years following the interview, after which time any data will be destroyed.
- I agree to be audio-recorded.
- I wish / do not wish to receive a transcript of my interview for editing. (Please circle one)
- I understand that if I request to review my transcript, I have up to two weeks to withdraw any data.
- I wish / do not wish to receive the summary of findings. (Please circle one)

Name: _____

Signature: _____ Date: _____

Email/Postal address: (If you wish to receive a copy of the transcript and/or the summary of findings):

_____

_____

Approved by the University of Auckland Human Participants Ethics Committee on **22/07/2022** for three years.
Reference Number **UAHPEC 24557**