

Providing for the Sexual Health Needs of Canadian Immigrants

The Experience of Immigrants from Iran

Eleanor Maticka-Tyndale, PhD

Khosro Refaie Shirpak, MD, MPH, PhD

Maryam Chinichian, MA

ABSTRACT

Background: Sexual health is increasingly understood as an integral part of health. In Canada, education for sexual health is delivered predominantly in middle and secondary school. What of adults who immigrate to Canada from countries where sex education is not delivered to youth? This paper explores the needs and experiences of one such group of Canadian immigrants: those from Iran.

Method: Ten married male and 10 married female immigrants from Iran living in a mid-sized Canadian city were recruited using snowball sampling and participated in qualitative interviews. The sample varied in age, education level, duration of marriage, and stay in Canada.

Results: Participants addressed three themes: experiences accessing information and health services, necessary content of information, and preferred ways of providing sexual health information and services. Key barriers to accessing and using sexual health services, experienced by all interviewees, regardless of the length of time they were in Canada, included language, cultural misunderstandings, embarrassment, long waits, and limited time that physicians spent with patients. Examples were provided of misunderstandings and inappropriate or even offensive questions or suggestions made by health practitioners who were unfamiliar with patients' cultural norms related to sexuality. Participants believed their needs and questions were different from their Canadian counterparts and wanted a confidential, linguistically and culturally friendly source of information such as a website in the Farsi language.

Conclusions: More attention needs to be paid to developing public health and medical services related to sexual health that take account of the cultural diversities represented in the Canadian population.

MeSH terms: Immigrants; health services; health education; sexuality

La traduction du résumé se trouve à la fin de l'article.

Social Justice and Sexual Health Research Lab, University of Windsor, Windsor, ON

Correspondence and reprint requests: Eleanor Maticka-Tyndale, Social Justice & Sexual Health Research Lab, University of Windsor, 401 Sunset Ave, Windsor, ON N9B 3P4, Tel: 519-253-3000, ext. 2200, Fax: 519-971-3621, E-mail: maticka@uwindsor.ca

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In 2000, the Pan American Health Organization's (PAHO) *Promotion of Sexual Health: Recommendation for Action*¹ broadened the conceptualization of sexual health from a mere consideration of the sexual health of individuals to discussion of the characteristics of a sexually healthy society. Among these is provision for the sexual health and education needs of *all* members of a society, across the life-span. In Canada, sex education has focused on adolescents and provision of such education through schools²⁻⁴ with all provinces and territories including some form of sex education in their school curricula.^{4,5} Thus, it is not surprising that school has been identified as the main source of information on sexuality and sexual health for Canadian high school students,³ with responsibility for sexual health education shared between parents and schools.^{3,6,7} Despite acknowledgement of the need for sex education across the lifespan,⁵ no provision is made for the sex education of adults. While it may be reasonable to expect that Canadians have acquired at least basic information about sexuality during their school years, what of those who immigrate to Canada as adults, particularly those who come from countries where sex education is not provided in childhood or adolescence?

This paper focuses on adult immigrants from Iran. Iranians grow up in a country where sexual issues are not comfortably discussed in public, sex education is not a regular part of schooling, and sexual activity is restricted to marriage.⁸⁻¹⁰ Family health practitioners are the primary source of sexual health information and services in Iran. This paper explores the experiences, concerns and needs of Iranian immigrants in obtaining sexual health and education services in Canada.

METHOD

Semi-structured qualitative interviews using an interpretive phenomenological approach were conducted with adult immigrants from Iran living in a mid-sized Canadian city. Research procedures were cleared by the Ethics Review Board of the local university.

Data collection was designed to respect Iranian norms related to discussion of sexual issues.^{11,12} Only married people were interviewed, health professionals (a male

physician and a female midwife) who were born and grew up in Iran and are fluent in Farsi conducted the interviews, and the sex of the interviewer was the same as the participant. In individual, semi-structured interviews, participants and interviewers jointly guided the conversation through sensitive issues in a way that avoided discomfort while still covering the interview topics.

Participants were recruited using snowball sampling, beginning with contacts with students and faculty at the local university and in local immigrant organizations. There was no prior relationship beyond that of casual acquaintance between the researchers and participants. Selection of participants focused on obtaining a sample that equally represented men and women, participants of diverse age, length of marriage, level of education, and time in Canada. Sampling continued to saturation, i.e., until no new information was forthcoming in the interviews. The final sample included 10 married women and 10 married men, all of whom had immigrated from Iran as adults (over 18 years of age).

Participants were asked to reflect on and share their experiences learning about sexuality in both Iran and Canada; to share the questions and concerns they had about sexuality and sexual health issues; what gave rise to these questions and concerns; where they sought answers or information; their experiences in seeking answers and their satisfaction with those answers. Finally, they were asked whether they felt they had sufficient information about the sexuality and sexual health issues that arise in their day-to-day lives as husbands, wives and parents, and what the preferred method would be for obtaining additional information in these areas.

All participants chose to be interviewed in Farsi, either at their own homes or in an interview room at the local university. Interviews lasted 1-2 hours. Interview transcripts were anonymized and all information in publications and presentations is segmented, i.e., not enough information is provided about any participant to allow identification. All interviews were transcribed and translated into English, with the accuracy of translation checked by the co-investigators. Thematic analysis was used with co-investigators checking each

other's coding for consistency and agreement. The three themes used in this paper include:

1. Experiences accessing sexual health services and information.
2. Desired content for sexual health information and services.
3. Preferred location and methods of providing sexual health information and services.

Ideas and issues raised in the earlier interviews were often reflected back to later participants to check for the consistency of experiences and views.

RESULTS

Sample profile

Participants included 10 married females and 10 married males ranging in age from 22 to 53 years for women (median 42.5) and 29 to 67 years for men (median 38.5) who have been married between 2.5 and 36 years (medians 19 for women and 10.5 for men). The majority were well educated with a median of 15 years for women (range 5-16) and 17 for men (range 5-20). All had left Iran since the revolution, with the time in Canada ranging from 8 months to 18 years with a median of 7 years for women and 4.75 years for men.

Experiences accessing sexual health services and information

Research participants spoke of the difficulty they had adjusting to a society where sexuality and eroticism were used in advertisements, television shows and movies, and where sexual messages and innuendos were visible in public interactions and dress, comparing this to Iran where there is no open, public discourse about sexuality. They were uncertain how to respond or how to position this information relative to their own beliefs about sexuality. Women who had come to Canada more recently expressed concerns about the expectations that their husbands placed on their sexual relationships; ones which they felt violated Muslim teachings.

Female 2: ... Watching such [TV] programs, men sometimes want some things that we, Muslim women, cannot accept. Two of them are oral and anal sex.

They wanted information, asking both whether these practices were 'healthy' and whether they were permitted for Muslims.

They did not know where to turn with these concerns and were generally unaware of what kinds of sexual health information and services were available in Canada. A few said they had heard about centres that provided consultation and services to female adolescents, but did not know what services were provided.

Most participants preferred to talk to physicians regarding sexual health issues. Long waits for appointments, the requirement of referrals to access specialists, the policy of many physicians to allow only 1-2 questions per visit, and the perception that Canadian physicians are too busy to talk to patients kept them, regardless of how long they had been in Canada, from approaching physicians with their concerns.

Female 1: He is a good doctor but he does not have enough time. When I ask him a question, he says, "You are here for your pap test. I will answer your question another time." You cannot ask your question because you have to go to his office for only one problem.

Modesty and embarrassment also kept both men and women from consulting a physician.

Male 5: It is difficult for us to visit a doctor to talk about our sexual problems. Shame and modesty (hojb-o-haya) about these issues are part of our culture.

Female 9: Even though my doctor now is a woman, I still feel too embarrassed to talk about my sexual problem. One of our problems is being too shy to ask about these things.

Shyness, especially across gender lines, even interfered with accessing essential sexual health services.

Female 4: I haven't had a pap test for several years because I don't have a female doctor. I feel embarrassed to have [my male physician] do the test.

Given the sensitivity of sexual matters, many, regardless of how long they had been in Canada or their schooling, felt it was essential to speak in their own language.

Male 15: No matter how good your English is, you want to raise your problem in the way that you understand it in your mother language. When you speak in English, you are not sure you are conveying the right meaning.

Besides language, cultural differences were raised by almost all participants as a hindrance to communication.

Male 15: Your doctor may consider your problem as strange and weird because it is not usual in Canada. She may suggest solutions that are unusual or inappropriate for Muslims. If I speak with someone like you [referring to the interviewer] who grew up in my culture, I am sure that you understand.

A female participant conveyed an instance of cultural misunderstanding that created problems for her marriage:

Female 2: Once I went to a health clinic to ask about birth control. I don't know why, but they thought I was complaining about my husband. They called him and warned him about his behaviour.

Another female participant complained of the difficulty she had in getting her doctor to understand that, for a Muslim woman, it was inappropriate to have a pap test before marriage since this would jeopardize her virginity.

Content of sexual health information and services

The topics about which participants wanted information ranged from sexual norms and practices within the context of their own and Canadian culture, to specific information about sexual positions and achieving orgasm. All commented on the gaps in their knowledge because they had never benefited from sex education in their youth. When considering the possibility of providing sex education to adults, most believed that because of differences in background the questions that Iranians had were different from those of Canadians, making it important to focus specifically on the needs and questions of Iranians.

Female 4: Iranians have no experience of and know little about sexuality before their marriage.... But Canadians might have [sexual] experiences from 14 or 15 years of age. So as adults, their questions are different.

The dominant concern of almost all men and women was learning how to meet the sexual needs of their marital partners. They spoke of relationship benefits and concerns about maintaining their marriage, more than about personal needs and benefits.

Female 18: Iranian women want to know how they can satisfy their husband in order to maintain their marriage.

Male 11: Couples must learn how they can maintain their relationship longer and be kind and faithful to each other.

Provision of sexual health information and services

Embarrassment and discomfort in speaking about sexual matters led participants to prefer private ways of obtaining information, counselling and services rather than classes or group sessions. Colleges and universities were preferred over health units because they were considered to be neutral, accessible and, most importantly, they provide greater confidentiality since you could be attending a number of courses and not just going for information about sexual issues.

A Farsi-language website containing information about sexuality with provision for receiving e-mailed responses to questions was suggested by several participants who felt this would provide culturally appropriate information in a private and confidential way. Culturally sensitive telephone counselling, books, magazines and face-to-face (private) counselling were other services that were mentioned; however, since most participants were either un- or underemployed and struggling to establish themselves, services not covered by medicare were a major concern.

Consistent with their cultural values and views of medical professionals, most preferred information to come from a physician specializing in sexual health who was fluent in Farsi and familiar with Iranian culture.

DISCUSSION AND CONCLUSIONS

A primary limitation of this study is that the sample came from one city and relied on word-of-mouth and referrals. Individuals not connected to the community, and those who were especially reluctant to speak of sexual matters are likely not to appear in this sample. The former may represent immigrants who have become more acculturated to Canadian society and might reflect different experiences and views related to sexual matters. The latter, on the other hand, may have even greater difficulty finding answers to

their questions and concerns. Despite the limitations of the sample, the themes and issues that were raised parallel those reported by Muslim immigrants in other North American and European cities.¹³⁻²¹ The absence of information (and considerable misinformation) about basic issues of sexual practice and health were noted in all studies and related to a lack of sex education, strict censorship of the media, and taboos against conversations relating to sexual matters in Iran. Language, cultural norms, and shyness were the prime barriers to finding answers to questions and concerns in Canada. The lack of mutual cultural literacy between Iranian patients and Canadian physicians left participants with unanswered questions and concerns or answers that were inappropriate to their needs, incomprehensible because they assumed knowledge that the participants did not have, or offensive because they assumed experiences that were taboo or reprehensible in the patients' home culture. These barriers have also been identified as interfering with immigrants' access to general health services and health information, beyond the domain of sexual health.^{12,22-25} Of particular interest is that these barriers were described by all participants even though most had at least some post-secondary education and had been in Canada for more than 7 years in the case of the women, and more than 4.75 years the men.

What this study illustrates is the dilemma faced in countries such as Canada. We encourage, welcome, and value immigrants from increasingly diverse regions of the globe. They come with experiences, cultures, and knowledge that may be profoundly different from what is common in Canada. How do we "fill the gaps," in areas such as sex education and sexual literacy that are learned during childhood and adolescence in Canada, but are absent for immigrants from cultures where these are taboo subjects, especially prior to marriage? What is the degree of cultural literacy that we expect of Canadian professionals so that they can provide appropriate care, service and education? These questions are particularly important in matters related to sexuality where cultural norms, values and sensitivities are deeply held. Clearly, if we are to meet the requirements of a sexually healthy society set out in PAHO's

Promotion of Sexual Health: Recommendations for Action,¹ more attention needs to be paid to developing public health and medical services related to sexuality and sexual health that are cognizant of the cultural diversities that make up the Canadian population.

Participants suggested that websites providing information in diverse languages and framed in ways that are sensitive to cultural differences would make an important contribution to providing sexual health information. Websites with professionally prepared sexual health information are becoming available in Canada,²⁶ and could be developed in ways that serve our ethnic communities. Toronto Public Health has arranged for translators to be available by phone to mediate in discussions between immigrants and staff. These are first steps in providing for the health care needs of Canada's growing immigrant population. This project points to the need for further research into the health education and service needs of immigrants to Canada and ways in which we can improve access to health services.

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26. See for example: <http://sexualityandu.ca> developed by the Society for Obstetricians and Gynecologists of Canada in collaboration with the Sex Information and Education Council of Canada (Accessed April 3, 2007).

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RÉSUMÉ

Contexte : On considère de plus en plus la santé sexuelle comme faisant partie intégrante de la santé. Au Canada, l'éducation à la santé sexuelle se donne principalement au premier et au deuxième cycles de l'école secondaire. Qu'en est-il des adultes qui immigreront au Canada en provenance de pays où les jeunes ne reçoivent aucune éducation sexuelle? Nous analysons ici les besoins et l'expérience d'un tel groupe d'immigrants au Canada : les Iraniens.

Méthode : À l'aide d'un sondage cumulatif, nous avons recruté 10 hommes mariés et 10 femmes mariées émigrés d'Iran vivant dans une ville canadienne de taille moyenne et nous les avons fait participer à des entretiens en profondeur. L'âge, le niveau d'instruction, la durée du mariage et la durée du séjour au Canada variaient au sein de l'échantillon.

Résultats : Les participants ont discuté de trois thèmes : leur expérience de l'accès à l'information et aux services de santé, la pertinence de l'information reçue, et leurs préférences quant au mode de prestation de l'information et des services de santé sexuelle. Les principaux obstacles à l'accès et à l'utilisation des services de santé sexuelle, vécus par toutes les personnes interrogées quelle que soit la durée de leur séjour au Canada, étaient la langue, les malentendus culturels, l'embarras, les longues attentes et le temps limité que les médecins consacrent à leurs patients. On nous a donné des exemples de malentendus et de questions ou de suggestions incongrues, ou même offensantes, formulées par des professionnels de la santé qui ignoraient les normes culturelles de ces patients en matière de sexualité. Les participants étaient convaincus d'avoir des besoins et des questions différents de ceux de leurs concitoyens et auraient voulu avoir une source d'information confidentielle adaptée à leurs besoins linguistiques et culturels, par exemple un site Web en persan.

Conclusion : Il faudrait s'efforcer d'élaborer des services médicaux et de santé publique en santé sexuelle qui tiennent compte de la diversité culturelle de la population canadienne.