Culture and Sexual Health: Exploring the Experiences of Young South Asian Women in Nova Scotia

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For My Parents

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ABSTRACT

This qualitative exploratory study examined the experiences of a sample of young South Asian women living in Nova Scotia in relation to their sexuality and sexual health, while examining the influence of a bi-cultural upbringing. The existing literature concerning the sexuality and sexual health of South Asian women is limited and is mainly quantitative in nature. However, quantitative research often lacks the ability to explain or understand the context within which sexual development and decision-making occur. The findings of this study suggest that the influence of family and the cultural concepts of honour and shame are central to the participants' perceptions and experiences of sexuality. The lack of communication about sexuality between parent and child was salient, which resulted in the silencing of meaningful discussion about sex and sexual health. Participants tended to polarize South Asian and Canadian notions of appropriate sexuality and described their perceptions of Canadian sexuality norms as more open and gender equal than South Asian, although this is not necessarily the case. Participants reported a compartmentalized mode of living in relation to their sexual expression and experience; these young women occupy multiple selves calling upon appropriate cultural personas for given situations. This presents a dichotomy between private sexual behaviours and one's public persona. This dichotomy must be considered by sexual health educators in an effort to effectively extend sexual and reproductive health strategies and services to better meet the needs of culturally diverse communities of young people in Nova Scotia.

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Chapter One: Introduction

Canada's population is comprised of heterogeneous ethnocultural communities. According to the 2001 Census, South Asians are the fastest growing ethnic minority group in Canada, with a 36.8% increase between the years 1996 and 2001 (Statistics Canada, 2001). In Canada, the largest numbers of immigrants eventually settle in Quebec, Ontario or British Columbia, however, the Atlantic Provinces receive a steady flow of immigrants, the majority of which settle in Halifax, Nova Scotia (Statistics Canada, 2001). There were 2895 South Asians living in Nova Scotia in 2001, 2345 of who live in Halifax (Statistics Canada, 2001).

The demographic diversity of Canada poses a challenge for the field of health promotion in the development of theory, principles, and effective methods of intervention for multiracial, multiethnic, multicultural communities (Hyman & Guruge, 2002). Research indicates health information and educational interventions must be culturally sensitive and developed specifically for and in partnership with ethnic minority communities to address their unique health needs (Pasick, 2002; Sadavoy, Meier & Ong, 2004; Bhagat, Johnson, Grewal, Pandher, Quong & Triolet, 2002). In order to develop culturally appropriate health interventions there needs to be a development of a deeper understanding of the relationship between cultural factors and health behaviours. Such an understanding will require the identification of cultural concepts with potential relevance to health practices and beliefs through in-depth qualitative study (Pasick et al., 1996; Gans et al., 2003).

Research examining the health of immigrant populations in North America and Western Europe suggest that diverse ethnic groups have specific and unique health needs

(Cappon, Adrien, Godin, Singer, Maticka-Tyndale, Willms, et al., 1996; Gordon-Larsen, Adair & Popkin, 2003a; Pasick, 2002; Weston, 2003; Yeh, Arora, Inose, Okubo, Li & Greene, 2003). Ethnic minorities report higher rates of morbidity and mortality in comparison to their Euro-Canadian counterparts and only a small portion of this variation is explained by differences in socioeconomic status (Hyman & Guruge, 2002). As a result, there has been a shift in focus to identifying broader social, cultural, and environmental factors that may affect the individual health behaviours of ethnic and visible minorities (Pasick, D'Onofrio & Otero-Sabogal, 1996).

Cultural groups have different sexual customs, attitudes and beliefs which, in turn, influence sexual behaviour and expectations. "Culture" refers to a shared identity based on factors such as common language, values and attitudes, and acts as a template, shaping behaviours and consciousness within a society (Health Canada, 2000). "Culture" can be used to describe the beliefs, values, norms and customs of an interacting group, which are transmitted, through socialization, from generation to generation (Dyck, 1989; Triandis, 1994). Such cultural components have been described as forming a "complex pattern of living" that acts as a filter through which individuals interpret daily events (Dyck, 1989; Triandis, 1994). Thus, health beliefs and practices must be understood within the sociocultural contexts in which they have meaning (Holroyd, Twinn & Adab, 2004).

It may seem, since second-generation immigrants (or the Canadian born children of immigrants) are socialized in the mainstream Canadian culture, they would face fewer psychosocial challenges than their parents. Interestingly, current research suggests that second-generation immigrants living in western cultures have unique psychosocial problems and concerns which can negatively influence their health (Abouguendia &

Noels, 2001; Daley, 2005; Goodenow & Espin, 1993; Hendrickx, Lodewijckx, Van Royen & Denekens, 2002; Vollenbergh, Have, Dekovic, Oosterwegel, Pels, DeWinter, et al., 2004). This may stem, in part, from young people struggling with decisions about how to deal with the impact of multiple social and cultural influences on their lives (Abouguendia & Noels, 2001; Chen, Unger, Cruz & Johnson, 1999; Schuster, Bell, Nakajima & Kanouse, 1998). These youth often have two frames of reference, which influence their behaviours for social interaction (Abouguendia & Noels, 2001; Ghuman, 2000; Talbani & Hasanali, 2000), neither of which may feel "right". Recent studies with young South Asian Canadian women reported that these two cultural environments (South Asian and Canadian) ascribe to different norms and expectations around marriage, sexuality and dating (Ghuman, 2000; Talbani & Hasanali, 2000).

Young people's understanding of what it is to be a sexual being is a complex process; most young people engage in struggles concerning many questions about their sexual development (Shoveller, Johnson, Langille & Marshall, 2003). The development process is strongly influenced by cultural and gender norms concerning what is socially acceptable behaviour (Coleman & Roker, 1999; Rathus, Nevid & Fichner-Rathus, 2000; Soskolne & Shtarkshall, 2002; Wakil, Siddique & Wakil, 1981; Weston, 2003). Within the context of sexuality, understanding the influence of cultural and social systems on an individual's behaviour will allow for more culturally sensitive, and appropriate sexual health interventions and education programs.

Second-generation South Asian women who contradict the traditional customs and beliefs of their parents around sexuality and dating experience a degree of dissention and these issues become a clear point of contention (Talbani & Hasanali, 2000; Wakil et

al., 1981). These women are raised in the South Asian culture of Canada, not the South Asian culture in which their parents were raised, and they can therefore be viewed as part of a "new" diasporic culture which is significantly different from either South Asian society or Canadian society (Aujla, 1997; Wakil et al., 1981). In the case of sexual health services, those based predominantly on Western models of sexuality, sexual expectations and norms may be inappropriate and ineffective among young South Asian women (Okazaki, 2002; Weston, 2003). For this reason, it is important to explore the experiences of second-generation South Asian women regarding their sexual and reproductive health.

Many South Asian immigrants have made their homes in Canada, but relatively little research has focused on South Asian women's beliefs, values and experiences related to their health. Fewer still have focused on their sexuality, or sexual and reproductive health. The existing literature has focused predominantly on first-generation immigrants with a much smaller body of work addressing the health and well-being of second-generation immigrants (Abouguendia & Noels, 2001; Chen et al., 1999; Gordon-Larsen, Harris, Ward & Popkin, 2003b; Yeh et al., 2003). Some research has addressed the role of cultural factors in shaping sexuality; however, the majority is quantitative in nature and South Asians are often categorized under "Asian" or "Other" (Bradby & Williams, 1999; Meston, Trapnell & Gorzalka, 1996). While Asians do share similarities in certain cultural beliefs and behaviours regarding sexuality, this broad type of grouping tends to minimize differences both between different groups and within groups (Bhopal, 1997; Bhugra, 1997).

Research into health inequalities has increased in Canada since the 1970s, with some national surveys examining variations in morbidity by ethnic group (Statistics Canada, 2001). This work has been largely dominated by an epidemiological approach to the understanding of health which focuses on quantifying the extent of health problems and on examining correlations between determinants and disease. These types of studies often lack the ability to explain relationships between variables and to understand the context within which health decisions and behaviours take place. As a result, individual behaviours are the focus of health interventions, and this approach fails to recognize the influence of social, economic and cultural contexts and environments within which decisions are made (Marmot, 2003; Pasick et al., 1996; Raphael, 2004).

In response to this, there has been more of a focus on examining how social determinants of health affect health status among individuals and populations (Dunn & Dyck, 2000; Marmot, 2003; Pasick et al., 1996; Raphael, 2004). A determinants of health perspective recognizes that the most important antecedents of human health status are social and economic characteristics of individuals and populations (Dunn & Dyck, 2000; Kotchick, Shaffer, Miller & Forehand, 2001; Marmot, 2003; Public Health Agency of Canada, 2002a; Public Health Agency of Canada, 2002b; Raphael, 2004). To address this, researchers have proposed more comprehensive ecological research models and theories that are inclusive of the many social and environmental factors affecting health behaviours (Green, Richard & Potvin, 1996; Sallis & Owen, 2002). Ecological theories of health behaviour posit that health and behaviour are influenced at multiple levels including interpersonal, sociocultural, policy, and physical environmental factors, and

that these influences interact with one another (Green et al., 1996; Pasick et al., 1996; Sallis & Owen, 2002).

For this study, a socio-ecological perspective is used to guide the rationale for the research, which is adapted from Bronfenbrenner's ecological model of health behaviour. A socio-ecological perspective involves examining the behaviours of individuals within the context of their social and physical environment. Socio-ecological factors influencing sexuality, sexual health and sexual risk include (but are not limited to) gender norms, cultural factors, the influence of family and peer influences (Coleman & Roker, 1999; DiClemente, Salazar, Crosby & Rosenthal, 2005; DiClemente, Wingood, Crosby, Cobb, Harrington & Davies, 2001).

Purpose Statement

There are significant gaps in the social science and health promotion literature concerning the sexuality and sexual behaviour of young South Asian men and women. The existing data converge on notable differences between South Asian Canadians and the majority culture on major aspects such as sexual timetables, behaviours and attitudes surrounding sexuality, reproductive health and sexual abuse. However, the majority of this research is quantitative in nature and lacks the ability to explore the socio-cultural environment within which sexual decisions, perceptions and behaviours take place.

This study is intended to explore the context of the experiences of young South Asian women in Canada aged 18 to 23 concerning their sexual health and sexuality; and if their experiences are influenced by their bi-cultural upbringing. In addition, it examines how South Asian cultural beliefs surrounding sexuality intersect with dominant Canadian cultural beliefs for the women who participated in this study.

Specifically, the study asks:

1. What are the experiences of South Asian women living in Nova Scotia regarding their sexuality and how is this influenced by their bi-cultural upbringing?

The specific objectives of the research are listed below.

1. To explore how a bi-cultural upbringing and socialization in Western and non-Western cultures has influenced the sexuality and sexual health among a sample of South Asian women;
2. To explore bi-cultural tensions or conflicts that might arise from being socialized in these two cultures; and
3. To explore what types of sexual and reproductive health information and services a sample of young South Asian women living in Nova Scotia access.

Scope and Limitations

The researcher is presenting women's descriptions and perceptions of the ways in which their dual cultural socialization has affected their development and understanding of sexuality. The intent of this study is to explore how these young women's sexuality and sexual health is shaped by their experiences being raised in a bi-cultural environment. In contrast to research approaches focused on individual behaviours, the socio-ecological approach used in this study recognizes that behaviours are tied to the socio-cultural environment within which they occur (Green et al., 1996; Pasick, 2002; Sallis & Owen, 2002). This approach is more useful in understanding cultural influence and factors that may play a role in shaping sexuality (Pasick, 2002).

The scope of this work is limited by time and resources available to the researcher. The researcher recognizes that this small sample does not reflect the full

variation in young South Asian women's experiences. There is great intercultural variation within immigrant and ethnic groups due to factors such as the acculturation and immigration experience, socio-economic status, gender and age. South Asian women represent a diverse group with diverse attitudes, beliefs and experiences and therefore, it is inappropriate to generalize the findings of this study beyond those who participated. This research is exploratory in nature and gives expression to the authentic voices of South Asian women and should therefore be viewed as a step toward understanding the issues of sexuality, and the related psychological processes, within this particular group of women.

Significance

Health practitioners and researchers alike have understood the need to consider the effects of cultural beliefs on various individual health behaviours and conditions, and the need to provide services to ethnic minorities while respecting their specific social and cultural realities (Fisher, Bowman & Thomas, 2002; Hyman & Guruge, 2002; Leduc & Proulx, 2004; Pasick, 2002; Weston, 2003). Access to appropriate health services for ethnic minorities is sometimes complicated by cultural beliefs that differ from Western concepts, most notably with regard to perceptions of illness, health, health-seeking behaviour, and response to treatment (Hyman & Guruge, 2002; MacKinnon, 2000). It is important that health services be provided in a manner that is respectful of cultural customs and differences; this can improve health outcomes for ethnic minorities and result in a health system that can better respond to cultural values and expectations (Fisher et al., 2002; Leduc & Proulx, 2004; MacKinnon, 2000; Pasick et al., 1996). The findings of this study contribute to the current lack of qualitative research addressing the

role of culture in the sexual health beliefs and behaviours of South Asian women living in Canada, a group of women who are otherwise underrepresented in the current health promotion literature (Adrien, Godin, Cappon, Singer, Maticka-Tyndale & Willms, 1996; Fisher et al., 2002). This shifts the emphasis away from a biomedical focus to an appreciation for the role of social and cultural contexts in explaining health outcomes and the use of health services. The findings will also contribute to the existing pool of knowledge on youth sexuality and sexual health in Canada. The findings may also be used to help inform future research initiatives on the sexual and reproductive health of women from diverse ethnocultural groups.

Summary

This chapter provided an introduction to the purpose and significance of this research project. Chapter two will provide a review of literature related to this research. Chapter three will provide information on the methodology used for this study and the rationale for using this methodology. Chapter three will also provide details on the research process including the challenges and limitations associated with the method used. Chapter four will present a description of the findings of the study. Chapter five will discuss the meaning of the findings in comparison to the present literature, the implications of the findings and suggestions for future research directions.

Chapter Two: Review of Literature

This chapter offers a review of relevant literature and provides a framework for situating the present study. The chapter begins with a discussion of adolescent sexuality and gender as a determinant of health. This is followed by a discussion on the influence of culture on sexuality and a review of South Asian migration to Canada, the acculturation process and conflicts that arise around sexuality for immigrants. Included is a discussion on the role of social support, social exclusion and the part they may play in shaping the sexuality and sexual health of young South Asian women.

Definition of Key Terms

Terms such as *ethnocultural groups* and *South Asian* are central to this thesis. These terms and concepts often have diverse definitions and interpretations and it is important to clarify the researcher's understanding and use of these terms.

Sexuality: An individual's sexual attitudes, knowledge and skills are key determinants of healthy choices around sex and sexual health and have been used in quantitative health research to assess sexual understanding and risk. However, this fails to recognize that sexuality is also shaped, both negatively and positively, by prevailing social and cultural attitudes and contexts (DiClemente et al., 2005; Raphael, 2004). Sexuality is connected to one's social environment and includes a sense of gender identity and related concepts about the self and others as women or men in the context of one's society (Fisher et al., 2002; Rathus et al., 2000). The personal capacities of an individual such as coping strategies, self-esteem, sense of control and self-concept are also strongly linked with overall health and are key contributors to sexual and reproductive health (Airhihenbuwa, 1995; Raphael, 2004; Wingood & DiClemente,

2002). It is important to recognize that sexuality is a normal part of human experience and includes physical characteristics of and capacities for specific sexual behaviours, together with psychosocial values, norms, attitudes, and expectations around sexual activity, sexual experience, behaviours and relationships (Coleman & Roker, 1999; DeSantis, Thomas & Sinnett, 1999; Rathus et al., 2000).

Ethnocultural groups: Health Canada (2004) defines ethnocultural groups as those which share characteristics unique to that group. These include cultural traditions, ancestry, language, national identity and country of origin. Religion can also be linked to a group's cultural identity and can be recognized as a defining characteristic. Ethnoracial or racialized groups are sometimes encompassed by the term ethnocultural. It should be noted that the terms ethnoracial and racialized are used instead of ethnocultural to make it clear that groups are distinguishable by a visible characteristic (skin colour or other shared physical traits) and are more vulnerable to discrimination and disadvantage (Bradby & Williams, 1999; Papadopoulos & Lees, 2001). This recognizes that the concept of race is not a biological reality; rather it is a social process of ascribing meaning, usually inferiority and superiority, to physical differences (Papadopoulous & Lees, 2002).

South Asian: The term South Asian refers to people who trace their origins to the Indian subcontinent, including people from India, Pakistan, Sri Lanka and Bangladesh (Wolpert, 1993). South Asians are a diverse group of people with different customs, languages, religious beliefs and practices. Despite these differences, South Asians share many cultural characteristics such as the primacy of the family, collectivity versus individuality, emphasis on propriety and social codes, the appropriation of sex only

within the context of marriage, and respect for age and authority (Okazaki, 2002). This is not surprising considering India, Bangladesh and Pakistan were one nation (India) prior to Independence from the British Empire, which occurred in 1947 (Wolpert, 1993). India was divided into two nations in 1947, Pakistan and India, and the nation of Bangladesh, formally East Pakistan, was established in 1971 (Wolpert, 1993). For the purpose of this study the researcher will refer to people from India, Pakistan and Bangladesh interchangeably as South Asians and Indians. These terms were also interchangeably used by the sample of women who took part in this study and are not intended to minimize the distinctiveness of Pakistani, Indian and Bangladeshi people. The term Asian is used in this thesis when relevant literature and research has studied *all* people from Asia including South Asians.

Traditional Culture: South Asian women's lives are often conceptualized in terms of a duality of cultures, a "modern" or Canadian culture, and a "traditional" or South Asian culture (Talbani & Hasanali, 2000). "Traditional culture" is frequently described with a negative connotation that suggests these cultures are "backwards" or "oppressive" in comparison to Canadian or more modern cultures which are used as a measuring stick and viewed as egalitarian and progressive (Aujla, 1997; Triandis, 1994). The researcher does not wish to perpetuate negative assumptions or ideas and uses this terminology simply to refer to the culture of origin of the women in this study. The use of the word "traditional" in reference to South Asian beliefs and customs should not be construed as negative, or representing the women in this study as trying to reach some sort of a Canadian or "modern" ideal, as this is not the case.

Dominant Culture: South Asians in Canada represent a visible minority or racialized group, with Caucasians comprising the majority or dominant group. As seen in South Africa, the majority are not necessarily, by definition, the dominant culture (Airhihenbuwa, 1995); in Canada, however, the European majority do comprise the dominant culture. Generally, power and privilege in this society are held by Caucasians of European backgrounds to a greater extent than they are held by people of colour, although class does factor into this (Airhihenbuwa, 1995; Aujla, 1997). The dominant majority group shapes and controls other groups through social, economic, cultural, political and religious power (Airhihenbuwa, 1995; Aujla, 1997). This does not imply that the dominant culture is a homogenous group of people that can be lumped into one category or are lacking their own ethnicity, as this is not the case, particularly in a multicultural nation like Canada. Also, it can not be assumed that all people who are Caucasian are part of the dominant culture, as religion, accents and sexual orientation, for example, can marginalize people from the dominant society and place them at risk of discrimination. However, there are still mainstream, dominant beliefs and practices which are an influence of the British culture that are perceived as different or even running counter to the beliefs of other ethnocultural groups in Canada, such as South Asians (Abouguendia & Noels, 2001; Wakil et al., 1981).

Determinants of Sexuality and Sexual Health

There is little Canadian-based research on how social and cultural environments influence sexuality and sexual behaviour, particularly among young people. The data that have been reported come from national studies that contain few in-depth questions

on sex and sexuality, or information on the sociocultural environments in which sexual decisions are made (CMEC, 2003).

The Canadian Study on the Determinants of Ethnoculturally specific behaviours related to HIV/AIDS (Adrien et al., 1996) examined the factors related to HIV transmission in several ethnocultural communities, including South Asians. The study found that cultural norms in areas such as sex role differences, power inequalities in relationships, and attitudes toward sex education and sexual behaviour needed to be addressed in HIV program interventions (Maticka-Tyndale, Godin, LeMay, Adrien, Singer, Willms, et al., 1996; Singer, Willms, Adrien, Baxter, Brabazon, Leaune, et al., 1996). Differing expectations of parents and children were found to be a source of great frustration in families from ethnocultural communities since children tended to adopt the norms of the dominant culture, while parents retain those of their traditional culture (Maticka-Tyndale et al., 1996; Singer et al., 1996). The study provided valuable information related to HIV/AIDS in ethnocultural communities and provided useful information for developing policy and program interventions around these issues.

In 2002 the Canadian Youth, Sexual Health and HIV/AIDS study (CYSHHAS) was undertaken to help increase our understanding of the factors that contribute to the sexual health of Canadian youth (CMEC, 2003). The study provides valuable information on sexual behaviours, activities and beliefs of young Canadians. Unfortunately, it provides limited information on the context in which young people perceive their own sexuality and their sexual health. While studying knowledge and attitudes provides useful information, there also needs to be a focus on exploring the sociocultural contexts within which young people engage in sexual activities and the

belief systems that inform both positive and negative actions (CMEC, 2003). Sexuality is based on and influenced by many different factors and is experienced differently depending on gender, social, cultural and economic factors and relationships (Bradby & Williams, 1999; Coleman & Roker, 1999). Approaching sexuality and sexual health from a social determinants of health perspective recognizes that there are multiple systems of influence on an individual's behaviour that need to be examined. A social determinants of health perspective allows for an analysis of the cultural, social, biological, psychological and economic influences on women's sexuality and health (DiClemente et al., 2005; Marmot, 2003).

Gender and Sexuality

The word "sex" refers to biological features that distinguish men and women, while the term "gender" refers to the behaviours that are considered socially appropriate for men and women. Gender is socially and culturally constructed; people start with something real (sex) and project their own attitudes, beliefs, norms and values to create gender (Murphy, 2003; Triandis, 1994). Therefore, gender norms refer to the societal expectations for male and female behaviour, attitudes, traits, and socially determined roles. They reflect the relative value of males and females within a culture or society (Triandis, 1994). They prescribe the division of labour and responsibilities between males and females and accord them different rights (Murphy, 2003; Triandis, 1994). Many health issues are a function of gender-based social status or roles (Murphy, 2003; Wingood & DiClemente, 2002). Gender norms create inequality between the sexes, for example, in social power and status, autonomy, and well-being, typically to the disadvantage of females (Murphy, 2003; Wingood & DiClemente, 2002). Wingood and

DiClemente (2002) observed from a public health and psychological perspective, that these gender-related inequities and disparities in expectations generate exposures, or acquired risks that adversely influence women's health.

Children are socialized into gender-defined behaviours and attitudes early in life, predominately by parents and other caretakers treating boys and girls differently (Murphy, 2003). Continued gender inequalities are reflected in sexual relationships as children reach adolescence and adulthood (Murphy, 2003; Talbani & Hasanali, 2000). Since gender norms are linked to cultural norms it is not surprising that there is a distinct difference in gender norms regarding dating, socialization and premarital sex in South Asian and Canadian society (Anwar, 1998; Hunjan, 1997; Talbani & Hasanali, 2000; Wakil et al., 1981). Gender-based socialization plays a significant role as a technique of habituation and cultural control (Talbani & Hasanali, 2000). Constructs of masculinity and femininity have dramatic impacts on sexuality and sexual development which determine, to a certain extent, health outcomes (Shoveller et al., 2003).

The literature on South Asian women's sexuality suggests that conservative gender and cultural norms can increase women's sexual risk (Okazaki, 2002; Weston, 2003). Cultural expectations dictate sexual roles, positions of power in relationships and how women regard their own sexuality. The Theory of Gender and Power has been developed to help explain how female sexuality is socially constructed and shaped by systems of gender, race and economic relations, as well as social institutions (Wingood & DiClemente, 2002). This theory affords insight into the diverse psychosocial factors that contribute to and maintain health behaviours, providing a foundation for intervention and research (Wingood & DiClemente, 2002). The theory consists of three overlapping but

distinct structures that characterize the gendered relationships between men and women: the sexual division of labour; the sexual division of power; and cathexis (also referred to as the structure of affective attachment and social norms). Gender-based inequalities and disparities in expectations that arise from these three structures generate different exposures and risk factors that influence women's sexual risk for disease (Wingood & DiClemente, 2002). Consequently, health interventions that target these exposures and risk factors can reduce women's health risks (Wingood & DiClemente, 2002). The Theory of Gender and Power can be used to help understand and assess women's risk as a result of these central structures.

Sexuality is socially constructed, shaped and regulated by systems of gender, racial and economic relations as well as social institutions (DiClemente et al., 2001; Raphael, 2004). Gender norms are embedded in cultural norms (Smith, Roofe, Ehiri, Campbell-Forrester, Jolly & Jolly, 2002; Triandis, 1994; Weston, 2003), therefore, South Asian cultural norms play an important role in influencing women's sexual behaviours, beliefs, norms and expectations. South Asians in Canada continue to hold on to their ancestral cultural beliefs which can run counter to dominant beliefs and in turn place young South Asians at risk for negative psychological and physical health outcomes. South Asian cultural beliefs and gender norms concerning sexuality will be discussed in more detail below. This will start with a discussion on the history of South Asian migration to Canada and the processes that play a role in diasporic South Asians' realities, such as acculturation, bi-cultural socialization and related conflicts.

South Asian Culture and Sexuality

Culture will influence sexuality in different ways depending on the particular gender, racial, and economic relationships of a given society (Bochner, 1994; Triandis, 1994; Triandis, Bontempo, Villareal, Asai & Lucca, 1988). Culture has been described as a system of interrelated values active enough to influence and condition perception, judgment, communication and behaviour in a given society (Airhihenbuwa, 1995; Dyck, 1989). It encompasses the way people have learned to look at their environment and themselves, and their unspoken assumptions about the way the world is and the way people should act (Airhihenbuwa, 1995; Triandis, 1994). This is taught to children from an early age and reinforced throughout their lives (Triandis, 1994).

Triandis (1994) distinguishes between objective aspects of culture (such as tools and roads) and subjective aspects (such as norms, roles and values); by doing so one can examine how subjective culture influences behaviour. Subjective culture refers to the ideas, the theories and standards (political, religious, scientific, economic, and social) for judging events in the environment and these are human-made and shape the way we view our environments (Triandis, 1994). In terms of sexuality, subjective culture dictates what is considered to be the accepted ideas regarding sexual behaviour (i.e. cultural norms), beliefs, timetables, expectations, desires and their manifestation.

In ancient Indian culture sexuality was not a taboo subject, granted that it was discussed within the context of marriage (Okazaki, 2002). Sexuality was openly discussed in religious and spiritual texts, such as the Kama Sutra (an ancient Indian text on the art of love and meditation), and depicted in painting, scriptures and erotic poetry of the 7th and 8th centuries (Okazaki, 2002; Wolpert, 1993). However, discussion of sex

and sexuality in contemporary Indian culture is a taboo subject and is not openly discussed (Fisher et al., 2002; Weston, 2003). There is very little written on when or why this change occurred. It has been suggested that the control of sexual gratification was instigated by ancient philosophers as a means of ensuring the survival of cultural and family systems (Meston et al., 1996). Another account suggest sensuality gradually become shadowed in the 10th century when the Muslim invaders started coming to Indian cities and forced Islamic propriety and law on an already developed civilization (Wolpert, 1993).

South Asians place emphasis on propriety and the observance of strict moral and social conduct, thus modesty and restrained sexuality are valued, particularly among women (Bhopal, 1997; Ghuman, 2000; Okazaki, 2002). Asian cultures have varying degrees of openness surrounding sexual discourse (Okazaki, 2002). Sometimes there are stark differences between what Canadian norms suggest and what South Asian norms dictate (Talbani & Hasanali, 2000; Wakil et al., 1981). South Asian communities have many taboos around the discussion of "shameful" matters such as sexual behaviour and sexual health (Bradby & Williams, 1999; Fisher et al., 2002; Weston, 2003) and issues surrounding sexuality and sexual health are often not discussed at home (Okazaki, 2002). This is particularly true with young people and those who are not married. As Fisher et al (2002) reports, South Asians believe it is important to discuss sexuality and sexual health only "when the time comes", meaning after marriage.

Collectivist and Individualist Cultures

It is important to briefly discuss the cultural concepts of collectivism and individualism as this construct is often referred to in literature regarding immigrant health

research. In 1980 Hofstede proposed a construct, in the form of a continuum, to describe the relationships that exist between individuals and groups at the cultural level. On one end, individualistic societies are defined by loose ties between individuals and are characterized by individualism, autonomy, and emotional interdependence (Bochner, 1994; Kapoor, Comadena & Blue, 1996; Triandis, 1994). At the other end of the continuum, collectivist societies encourage integration into cohesive in-groups which offer security in exchange for loyalty, and in which the distinction between the group and the individual becomes blurred (Bochner, 1994; Kapoor et al., 1996a; Triandis, 1994). These groups emphasize the importance of a collective identity, emotional dependence, duties and obligations (Bochner, 1994; Triandis, 1994). In collectivist cultures individuals are treated as an extension of the various social systems to which they belong (Bochner, 1994; Tirandis, 1994).

In his study, Hofstede found that Australia, Britain and the Netherlands scored highest on individualism. Japan and India scored in the lower middle range on this construct, and Africa, Latin America and Asia were the most collectivistic (Bochner, 1994). These scores were correlated with the economic prosperity of the country, with more wealthy countries scoring higher on individualism (Bochner, 1994; Triandis, 1994). Canada has a relatively high individualism score, suggesting that, on average, Canadians tend to experience their culture as placing more emphasis on individual initiative than on family solidarity (Bochner, 1994). However, Hofstede's findings should be interpreted with caution since it is not reasonable to assume that all Australians are individualistic and all Africans are collectivist (Bochner, 1994).

Triandis (1994) has argued that people from traditional backgrounds are more likely to be collective in their orientation, in that they are more conscious of the social norms, more tuned to the value judgments of significant others and generally are more socially driven. Phinney (1990) also suggests "an orientation towards group affiliation and interdependence versus an individual orientation emphasizing independence and competition" as one of the dimensions which may be used to differentiate cultural groups. South Asians value the importance of family, respect for community, structured family roles and obedience (Agarwal, 1991; Jensen, 1988; Ghuman, 2000). Although many of these values are shared with the dominant culture, the definition and understanding are significantly different. For example, the importance of family for South Asians means that it takes precedence over the individual (Agarwal, 1991; Jensen, 1988; Ghuman, 2000; Wakil et al., 1981). Family is valued in the dominant culture as well, however the individual is valued more, along with individual decision-making (Agarwal, 1991; Wakil et al., 1981). The schools in the West encourage the development of personal autonomy, critical thinking and a generally questioning attitude to things, whereas South Asian homes try to harmonise the family's interest with that of its individual members (Ghuman, 2000; Wakil et al., 1981).

Examining the degree of collectivism or individualism among the women who participated in this study was not a focus of this research project; however, it is important to consider the stress that may be experienced by diasporic South Asians living in a country which on a whole scores rather high on individualism (Agarwal, 1991; Wakil et al., 1981). Particularly since there may be conflict between first and second-generation immigrants regarding how traditional values and beliefs will be maintained.

Migration and Acculturation

South Asian migration to Canada started towards the end of the 19th century when a small group of Punjabi Sikh men arrived in Vancouver seeking jobs in the lumber industry (Johnston, 1979). This was followed by a steady, but small stream of Indian immigrants until 1907 when the anti-Oriental riots in Vancouver and the Asiatic Exclusion League urged an immediate and total ban on all "Oriental" immigration (Johnston, 1979; Wolpert, 1993). The Asiatic Exclusion League's mandate was simple: to stop non-white immigration to Canada (Johnston, 1979). The British-controlled Government of India also placed severe restrictions on Indian immigration; between 1909 to1947 only 28 persons a year were allowed to enter Canada from India (Jensen, 1988; Johnston, 1979). In 1947 when the British departed India and created the two independent countries of India and Pakistan the immigration policy was slightly relaxed and a quota of 150 new arrivals per year was granted which was raised to 300 in 1957 (Jensen, 1988; Wolpert, 1993). However, it was not until the 1960s and early 1970s when further changes were made to the Canadian Immigrant Act that an increasing number of South Asians moved to Canada (Citizenship and Immigration Canada, 1969; Citizenship and Immigration Canada, 1972; Jensen, 1988; Wolpert, 1993). According to the Canadian census, there were over 900 000 South Asians living in Canada in 2001(Statistics Canada, 2001).

Following migration, immigrant groups undergo fundamental social and economic changes in a new social and cultural environment and most people engage themselves in a struggle to construct a new identity. This process is referred to as acculturation (Berry, 2002; Talbani & Hasanali, 2000; Wolf, 1997). Migration can cause

tensions between the traditions that a group would like to retain and the traditions in the new host culture, which may be very different (Abouguendia & Noels, 2001; Berry, 2002). This results in individuals and families redefining and renegotiating their roles and identities within and outside their traditional community (Abouguendia & Noels, 2001; Berry, 2002; Talbani & Hasanali, 2000).

As a result of the acculturation process, immigrants have two frames of reference and make comparisons between "here" and "there". Through acculturation, they learn new behaviours that are socially appropriate to the new cultural context (Berry, 2002; Talbani & Hasanali, 2000; Triandis, 1988). In the process, some "cultural shedding" may also occur that can sometimes be accompanied by "cultural conflicts" (Berry, 2002). In cases where there is cultural conflict, individuals may experience "acculturative stress" (Berry, 2002; Bhabha, 1996; Yeh et al., 2003). South Asians do report experiencing cultural conflicts and acculturative stress after migrating to Canada (Agarwal, 1991; Jensen, 1988; Talbani & Hasanali, 2000; Wakil et al., 1981). One very important area where cultural conflicts often occur for South Asians living in Canada is around dating, sexuality, and choice of life partner. This is particularly the case between first and second-generation immigrants (DeSantis et al., 1999; Talbani & Hasanali, 2000; Wakil et al., 1981).

The processes of acculturation and assimilation are often presented in the literature as a process of two cultures that involves cultural shedding and gaining cultural behaviours among first-generation immigrants. However, second-generation immigrants also experience acculturation. Researchers in the area of transnational studies have demonstrated that the process is usually much more complex than simply moving

between two cultures (Aujla, 1997; Wolf, 1997). South Asian second-generation immigrants are dealing with multiple and heterogeneous understandings and meanings of what it is to be "Indian", "Canadian", or a mix of these two identities (Talbani & Hasanali, 2000). The two-culture model fails to account for the complexity of these immigrant experiences (Bhabha, 1996; Wolf, 1997). A transnational approach to acculturation studies acknowledges that multiple locations of home may exist geographically, but also ideologically and emotionally (Wolf, 1997), for example, the South Asian household, the extended family made up of the immigrant community and the national spaces of both South Asia and Canada. The two culture dichotomy ignores the permeability of and interaction between the diasporic South Asian society in Canada and the dominant Canadian society; the two culture model of acculturation also fails to recognize the process of hybridity. (Bhabha, 1996; Wolf, 1997). Hybridity emphasizes the interaction of two or more different cultural forms in an ongoing process whereby new meaning or cultural forms are produced; the process of hybridization results in the creation of transcultural forms (Bhabha, 1996; Wolf, 1997). Hybridity moves us away from this dualism to a third space from which new cultural consciousness and cultural production may emerge (Bhabha, 1996). This approach avoids the assumption of linearity in acculturation and assimilation processes and in immigrants' thinking and practices (Wolf, 1997).

Conflicting Expectations

Minority cultural groups may feel conflicting desires and expectations for their children and often have different gender-based norms and expectations for them (Talbani & Hasanali, 2000; Wakil et al., 1981; Wolf, 1997). On the one hand, parents may fear

that their children will acquire undesirable aspects of the new culture and, on the other, they may want them to obtain characteristics of the dominant culture that will equip them for success (Anwar, 1998; Wakil et al., 1981). South Asian immigrant parents view many aspects of the new culture as necessary for their children's success and valued aspects of South Asian culture and these aspects are actively encouraged by parents. This includes mastering English, excelling at school and having professional career goals (Tirone, 1997; Wakil et al., 1981). These types of transitions, or more "Canadian" outlooks, from the traditional culture are not viewed as conflicting the value system or beliefs of the immigrant family and South Asian culture (Wakil et al., 1981).

The real pressures of "westernization" are seen in the more sensitive areas such as associating with the opposite sex and attitudes towards premarital sex, dating and marriage practices (Anwar, 1998; Talbani & Hasanali, 2000; Wakil et al., 1981). These are areas where parents see a sharp contrast between their cultural values and those of the western culture (Wakil et al., 1981). This is also the area where there are distinct gender differences and role expectations (Talbani & Hasanali, 2000; Wakil et al., 1981). Past research with South Asian immigrants has revealed that most parents are very reluctant to allow their female children to socialize with the opposite sex without supervision (Anwar, 1998; Hunjan, 1997; Talbani & Hasanali, 2000; Wakil et al., 1981). These experiences have resulted in a great deal of frustration and cause for dissent among South Asian women (Anwar, 1998; Hunjan, 1997; Talbani & Hasanali, 2000; Wakil et al., 1981).

A study by Anwar (1998) found that South Asian parents in Great Britain were protective about their British-born daughters and the majority agreed that they would not

let their teenaged daughters go to places where "Caucasian" girls go. The study's authors used the term "Caucasian" to describe those Britons who were white without making any distinction between different cultural groups. The fact that Caucasian girls "lacked morals" and because parents feared their children would learn "bad behaviours" were two reasons stated for not allowing daughters to socialize with Caucasian girls (Anwar, 1998). Parents also felt that their children, daughters in particular, must be protected from forming any undesirable relationship, such as having boyfriends. These views on socialization and dating are also associated with conservative views on sexuality among South Asians (Talbani & Hasanali, 2000; Weston, 2003).

Intergenerational Conflict around Sexuality

The potential for intergenerational conflicts exist when concepts of sexuality held by immigrant parents differ from those of their children and of the society into which they are acculturating (DeSantis et al., 1999; Wakil et al., 1981). Acculturation literature suggests that the potential for such conflict is greatest between first and second-generation immigrants, that is, the original immigrant pair and their children (Desantis et al., 1999; Talbani & Hasanali, 2000; Wakil et al., 1981). Intergenerational conflict related to sex roles is especially problematic; concepts of acceptable sexuality and behaviour with the opposite sex are deeply rooted in cultural beliefs and values learned in childhood and are continually reinforced during adolescence (DeSantis et al., 1999). When these values and beliefs are no longer reinforced by the new society, they are called into question, particularly by second-generation immigrants (DeSantis et al., 1999). Often this dissent or questioning of beliefs by young people is viewed by parents as a sense of cultural disrespect (DeSantis et al., 1999; Wakil et al., 1981). Parents tend

to attribute this dissent to the influences of the western culture, in particular its "evil" of youthful rebellion, premarital sex, common-law marriages, weak family ties and a lack of respect for elders, which are leading their children in the "wrong direction" (Agarwal, 1991; Anwar, 1998; Wakil et al., 1981).

In a 1993 study in British Columbia with college students, Meston et al (1996) looked at levels of acculturation and sexuality among second-generation Asian university students; Asian-Canadians were found to hold more conservative sexual attitudes and demonstrated less sexual knowledge than non-Asian Canadians (Meston et al., 1996). This study found that the more acculturated Asian-Canadians were to the Canadian culture, the more permissive their sexual attitudes were (Meston et al., 1996). This suggests that with more exposure to Canadian culture, there is a shift away from traditional, more conservative Indian attitudes towards more "liberal" Western attitudes surrounding sex and sexuality. This is consistent with other studies, which report that Asian-Americans sexually conservative attitudes may erode with higher degrees of exposure to the American culture, which sets up the potential for intergenerational conflict (Bradby & Williams, 1999; Meston et al., 1996; Tang, Solomon, Yeh & Worden, 1999).

Family Honour and the Cultural Concept of Shame

Culturally held notions of honour and shame play an important role in the control of women's sexuality in South Asian culture. Honour, or "izzat", is the value of a person in his or her own eyes, but also in the eyes of his or her society (Goddard, 1987). It is a quality of groups, not only of individuals (Goddard, 1987; Weston, 2003). As long as

stigmatized behaviours are concealed from the public gaze they will not incur shame and can be tolerated (Weston, 2003).

The honourable behaviour of men and women differs. A man must defend *his* own and *his* family's honour, which implies control over other members of the family (Goddard, 1987). Women on the other hand, must preserve their purity (Goddard, 1987). Men's relationship to honour is therefore seen as an active role, whereas the role of women is a passive one (Goddard, 1987). This passivity is viewed as a burden for men (Goddard, 1987; Weston, 2003). Women's honour becomes an element, a resource, which is controlled and manipulated by men (Goddard, 1987; Weston, 2003). Therefore, women's behaviour, more importantly, any behaviour that may incur shame such as premarital sex, is tightly controlled.

In order to maintain or enhance the family's izzat, women must remain chaste and marry into families with equal or higher status (Wakil et al., 1981; Weston, 2003). It has been said that the main goal of marriage within South Asian culture is to establish a family, have children, and further the family's economic and social position (Wakil et al., 1981; Weston, 2003). Practices such as arranged marriages (contracts between families) are encouraged, while dating, and love marriages are discouraged (Talbani & Hasanali, 2000; Wakil et al., 1981). Romantic love is regarded as disruptive to the extended family structure, in that it involves the direction of intense emotions towards one person instead of the group (Hunjan, 1997; Wakil et al., 1981). Therefore, romantic love is carefully guarded against through social disapproval in order to maintain family and kinship networks (Hunjun, 1997). These practices are also reinforced by South Asians' strong beliefs about destiny or "Karma", including the idea that their mate as well as their fate is

preordained, necessitating their concession to the forces of the universe (Hunjun, 1997; Wolpert, 1993).

Sexual and Reproductive Health among South Asian Women

The role of cultural norms has also been studied within the context of Asian women's sexual and reproductive health. These have mostly been conducted with women regarding their breast and cervical cancer screening practices and have found that Asian women have much lower rates of screening compared to non-Asians (Bottoroff, Johnson, Bhagat, Grewal, Balneaves & Clarke, 1998; Okazaki, 2002). Second-generation Asian-American immigrant women were found to have more cultural barriers to screening; including, for example, communication barriers with their mothers (in the case of young women) or doctors surrounding sexual and gynaecological issues, less openness surrounding sexuality and more modesty, less prevention orientation in health care and less utilization of Western medicine than their "Caucasian" counterparts (Okazaki, 2002). Even after controlling for differences between Asians and Caucasians (such as mother's education, year in college, family history of breast cancer, etc) Asian-Americans were still less likely than "Caucasian-Americans" to have had a Pap test and perform BSE (Tang et al., 1999). However, they did find that Asian-American women who were more acculturated were more likely to participate in these screening behaviours (Tang et al., 1999).

Due to the low use of screening practices, including breast self examination, Asian-Americans tend to be diagnosed with more advanced stages of cervical cancer and breast cancer than Caucasian-American women, thereby increasing the disease burden at diagnosis (Okazaki, 2002). This suggests that there are high health costs associated with

Asian-American women's reluctance to become knowledgeable about and engage in, preventive sexual and reproductive health practices.

Social Support Networks

Social support has been documented to have beneficial effects on many health related outcomes, such as buffering stress and promoting healthy behaviour (Nunes, Raymond, Nicholas, D'Meza Leuner & Webster, 1995). Cobb (1976) defined social support as the individual's belief that he or she is cared for by friends, family and communities, and is a member of a network of mutual obligations. Social support networks play an important role in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances (Cobb, 1976). Research has shown that young people who feel supported within their social context have better self-esteem and youth with higher self-esteem are reported to be more "in control" of their sexual relationship and behaviours than those with low self-esteem (Shoveller et al., 2003; Spencer, Zimet, Aalsma & Orr, 2002).

In South Asian culture, as is the case with many collectivist cultures, the family is the cornerstone of the culture (Talbani & Hasanali, 2000; Wakil et al., 1981). Family offers an important and vital source of social support, and relationships with extended family are often quite strong in comparison to individualistic cultures (Talbani & Hasanali, 2000; Tirone, 1997; Wakil et al., 1981). South Asian families are characterized as emotionally interdependent, loving, supportive, and one where all members are sensitive to others' needs within the family structure (Jensen, 1988; Triandis, 1994; Wakil et al., 1981). Conversely, the conception of self in North America is more individualized, and involves the realization of an individual's potential and capabilities

through various personal life choices (Bochner, 1994; Triandis, 1994). In collectivist cultures, the most important relationships are vertical (i.e. parent-child) whereas in individualistic cultures the most important relationships are horizontal (i.e. spouse-spouse) (Triandis, 1994).

The strong emphasis that is placed on the importance of protecting the public honour of one's family and extended kinship network acts as a central framework of social control. This encourages the masking of shameful behaviour with a public veneer of conformity (Wakil et al., 1981; Weston, 2003). The emphasis on family honour among South Asians has been attributed to the greater emphasis on family in South Asian society, compared to the individualism of Western society (Bhugra, 1997, Kapoor et al., 1996; Weston, 2003).

Social Exclusion

There is evidence in Canada of growing social exclusion in society, particularly for Aboriginal people, "racialized" groups and immigrant from countries other than Europe (Galabuzi, 2004; Marmot, 2003; Raphael, 2004). Social exclusion describes the structures and dynamic processes in inequality among groups in society (Galabuzi, 2004; Marmot, 2003; Raphael, 2004). In Canada, social exclusion refers to the inability of certain groups or individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources (Galabuzi, 2004; Marmot, 2003; Raphael, 2004). These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation and religion (Marmot, 2003; Raphael, 2004).

South Asians can experience social exclusion in many forms, including the feeling of being "other" within the dominant culture and racism (Abouguendia & Noels, 2001; Aujla, 1997). As young people go through the process of developing an independent self-identity, their peer groups will encourage individuals to express certain normative attitudes and behaviours (Shoveller et al., 2003). Individuals who express these peer-accepted attitudes and behaviours are often rewarded by being accepted by their peers and peer groups (Lay & Verkuyten, 1999). These rewards can contribute to improving individual's self-esteem and self worth (Lay & Verkuyten., 1999). In contrast, individuals who express attitudes and behaviours that are not accepted by their peers in the dominant culture may face alienation from the group and possible discrimination (Lay & Verkuyten., 1999). The consequences of this alienation or discrimination may be lowered self-esteem, lowered feelings of self-worth or identity uncertainty. Studies have found that second-generation immigrants have lower self-esteem and self-concept than first-generation immigrants (Abouguendia & Noels, 2001). This can negatively affect young people's sexuality given that research points to several important determinants of sexual health and sexuality such as self-esteem, interactions within peer groups and the sense of belonging to a peer group (CMEC, 2003).

Racism can manifest itself in the lives of young South Asians as representations, expectations or stereotypes of what it is "to be" South Asian, which are imposed by the dominant culture (Aujla, 1997). It can also manifest itself systematically in organizations, structures, institutions and programs (Aujla, 1997). Young people may feel that their cultural customs around, for example, dating and marriage are viewed as "backwards" or "oppressive" by those in the dominant culture. Internalized racism also arises in some

academic and non-academic literature on and by second-generation Canadian immigrants. Internalized racism refers to a phenomenon whereby the recipients of racism come to believe and ascribe to the stereotypes and racist constructions of their culture and their 'race' which the dominant culture imposes onto them (Aujla, 1997). This has been manifested as wanting to be white, a shunning or embarrassment of their cultural heritage, and a belief in the inferiority of their culture as compared to the dominant culture (Aujla, 1997; Jensen, 1988).

Racism can negatively influence self-esteem and self-identity among young people. Research into the prevention and control of sexually transmitted diseases has found that lower levels of self-esteem, psychological distress and depression place many adolescents at risk for engaging in high risk sexual activity (DiClemente et al., 2001; Spencer et al., 2002). Having higher levels of self-esteem has been found to have sexual health protective benefits, such as higher rates of condom use and lower pregnancy rates. Conversely, low self-esteem and high levels of distress have been associated with inconsistent use of contraceptives among women, and greater sexual activity.

Ethnicity and Research with South Asians

Ethnicity, although identified as one determinant of certain health risk behaviours including sexual risk behaviours (Bradby & Williams, 1999; Okazaki, 2002), remains a difficult concept to study. Collecting data on ethnicity provides useful information that can contribute to the creation and evaluation of targeted health promotion, prevention and treatment programs, assessment of certain at-risk groups for certain chronic diseases, as well as contribute to the development of health policy.

Generally speaking there is a dearth of ethnic-specific national data, however, Health Canada routinely collects some ethnicity data with certain surveillance studies, such as HIV/AIDS reports (Health Canada, 2004). This research is predominately quantitative in nature and more strongly influenced by biomedical perspectives rather than social health perspectives (Bhopal, 1997; Kesby, 2003). However, given that ethnicity reporting is done by physicians and other health care providers, if they choose to do it, misclassifications of ethnic status may occur (Health Canada, 2004). There is also the issue of self-identity of mixed race identities and the fear of racial profiling (Health Canada, 2004). For this reason, some people may not wish to identify themselves as belonging to an ethnic minority group. Ethnicity reporting is also constrained by the list of categories from which to choose from, which may not be an adequate representation of the racial and ethnic diversity in Canada.

The Canadian Study on the Determinants of Ethnoculturally specific behaviours related to HIV/AIDS was undertaken as a response to the lack of ethnic-specific based research in Canada. The authors established an important benchmark to provide a picture of these communities and to also act as a baseline for later research. The involvement of community leaders in the various ethnocultural communities was key to the success of this research and the authors stressed the importance of engaging the community to champion health issues.

Concern has been expressed about the potential consequences of focusing on ethnic differences in the distribution of disease (Bhopal, 1997; Bhugra, 1997; Kesby, 2003). It has been argued that a "culture blaming" analysis of health inequalities may result, which would conceal the significant influence of social, economic and political

factors in health outcomes (Bhugra, 1997). Ethnicity can then substitute as a *cause* of observable health variations rather than a common denominator requiring further exploration (Bhopal, 1997; Kesby, 2003). Combined with the challenges discussed above, the analysis of ethnic-based health information presents a challenge (Health Canada, 2004).

South Asians, as is the case with many groups of people (ethnocultural minorities, sexual minorities, women), tend to be studied as a group, which often fails to recognize the heterogeneity within South Asians and differences tend to be "flattened" (Murphy, 2003). Differences and complexities of, for example, gender relations and familial relations, are glossed over and marginalized voices, such as those of women, are often unheard (Bhugra, 1997; Murphy, 2003). Despite the many differences among South Asians, similar experiences can be identified. Since South Asians originate from the same geographic region, they share many cultural practices, customs, beliefs and norms (Anwar, 1998; Cappon et al., 1996; Okazaki, 2002). South Asians living in Canada also share the experience of living in a diasporic culture, feeling of being "other" and not belonging (Aujla, 1997). These similarities describe commonalities resulting from their shared experience situated in structures of power in the dominant culture (Aujla, 1997; Wakil et al., 1981; Wolf, 1997). Therefore, valuable information can be gained from studying South Asians as a group, particularly in a qualitative manner which begins to ensure that dissident voices are heard and reported.

Summary

This chapter provided a review of relevent literature to the study of women's sexuality among South Asians living in Canada. This included a review of how gender

places women at heightened sexual risk and how certain cultural factors and experiences influence women's sexuality in South Asian culture. This chapter also provided an overview on the process of migration, acculturation and the influence of bi-cultural socialization on self-esteem in the lives of young South Asian second-generation immigrants. The next chapter will provide a discussion of the research methodology used in this study.

Chapter Three: Methodology

Chapter three provides an overview of the research design and methods used for this study. This chapter will discuss the research approach, theoretical framework, methodology, method of data collection and analysis process. This chapter also outlines how the researcher ensured the quality of the research findings and the limitations of the research design and the study findings.

Paradigmatic Approach

According to Creswell (2003), three questions are central to the design of research: (1) what knowledge claims are being made by the researcher; (2) what strategies of inquiry will inform the procedures; and (3) what methods of data collection and analysis will be used. Stating a knowledge claim means that the researcher starts a project with certain theoretical and ideological assumptions about how and what they will learn during their inquiry. These claims might be called paradigms, philisophical assumptions, epistemologies or ontologies, and can be viewed as a set of basic beliefs or worldview (Creswell, 2003; Guba & Lincoln, 1994).

An interpretive paradigm, also referred to as the naturalistic paradigm by Guba and Lincoln (1994), was used to frame this study and guided the research design (Creswell, 2003; Henderson, 1991). Social phenomena are understood from the participant's own perspective and human behaviour is a product of how people perceive their world (Creswell, 2003; Henderson, 1991). The researcher's intent is to make sense of (interpret) the meanings others have about the world. Rather than starting with a theory, researchers generate or inductively develop a theory or pattern of meaning (Creswell, 2003; Henderson, 1991). Although the reasoning is largely inductive, the

process is also iterative, with a cycling back and forth from data collection and analysis to problem reformulation and back (Creswell, 2003; Henderson, 1991).

In terms of the ontology, which relates to the nature of reality, an interpretive approach recognizes that reality is constructed by the individuals who are involved in the research, and that multiple realities exist in any given situation (Creswell, 2003; Guba & Lincoln, 1994). Epistemology in an interpretive approach implies that researchers interact with the participants, either through collaboration or by living with or observing participants (Creswell, 2003; Guba & Lincoln, 1994). An interpretive approach acknowledges that it is virtually impossible to remain unbiased in doing research because so much interaction occurs between the researcher and those individuals being studied (Creswell, 2003; Henderson, 1991). As a South Asian woman who has been born and raised in Canada, the researcher can be viewed as the first participant in this study. The researcher shares a similar upbringing to that of the participants and has had many personal experiences that are similar to those of the participants in this study. The researcher acknowledges that her own background, perceptions and values shape her interpretation of the participant's experiences and makes no attempt to be an objective participant in this study.

Qualitative Methodology

A qualitative research methodology is used for this study, specifically one-on-one personal interviews which are often used in research where personal narratives, experiences and histories are important sources of data (Creswell, 2003). Interviews are also useful when exploring sensitive topics such as sexuality and offer more confidentiality than focus groups (Rubin & Rubin, 1995). Qualitative methods are

especially useful when one wants to understand personal experiences, feelings, perceptions and values that underline and influence behaviour (Creswell, 2003; Marshall & Rossman, 1995). For this study, qualitative methods will allow the researcher to explore participants own words and contexts to reveal their realities (Guba & Lincoln, 1994), and probe responses to reach beyond initial responses to questions (Creswell, 2003; Rubin & Rubin, 1995). Little past research has been done in this area and given the sensitive nature of the topic, qualitative research methods provide the flexibility required for this type of exploratory study.

Theoretical Framework

Theory is integral to health research; there needs to be fit between the theory guiding research and the methods used (Glanz, Rimer & Lewis, 2002). Theory is a general set of statements or propositions related to a phenomenon (Henderson, 1991) that present a systematic view of events or situations by specifying relations among variables in order to explain and predict the events or situations (Glanz et al., 2002). Theory provides a platform for understanding why people engage in certain health behaviours and why they adopt health-promoting behaviours (Wingood & DiClemente, 2002). Different research projects make use of theory in different ways depending on which research paradigm and approach is used. Theory can be tested as is done in positivist research, or can be used as a framework or perspective to guide the research design (Creswell, 2003; Glanz et al., 2002).

In this study, a socio-ecological framework is used to justify the design of the research. Socio-ecological theory has been adopted from Bronfenbrenner's ecological theory which focuses on understanding the multiple levels of influence on behaviour

(DiClemente et al., 2005; Green et al., 1996; Sallis & Owen, 2002). In contrast to individual-focused behaviour change models, ecological approaches recognize that behaviours are tied to the social environment. Ecological approaches are therefore more useful in understanding societal, cultural, family and peer influences that may play a role in shaping sexuality and sexual experience (Pasick, 2002; Sallis & Owen, 2002). A socio-ecological approach also recognizes that multi-level interventions may be the most effective for sustained, positive health outcomes (DiClemente et al., 2005; Green et al., 1996; Sallis & Owen, 2002).

Feminist research strategies are also inherently linked to the research approach in this study. Feminist methods stress the importance of egalitarian relationships in research with women (Kirby & McKenna, 1989). To achieve this relationship, the researcher treats all participants with respect and provides encouraging feedback to participants throughout the research process. Given that I have familiarity with the cultural context of the participants and have had similar personal experiences, the distance between the participant and me is narrowed. This encourages a more equal context for interviewing which allows more sensitive and accurate information to be collected (Papadopoulos & Lees, 2001).

Sampling Strategy

Qualitative samples do not always attempt to be statistically representative or generalized to the whole population. This does not mean that sampling in qualitative research proceeds without any direction (Creswell, 2003; Henderson, 1991). For the purpose of this study, a non-probability, purposive sampling strategy will be used. Purposive sampling aims to select information-rich cases for in-depth study to examine

meanings, interpretations, processes and theory (Creswell, 2003; Henderson, 1991). A diverse sample of women will allow the researcher to explore the varying attitudes, beliefs and experiences of women. With a non-probability sampling technique the aim is not to generalize about the distribution of experiences or processes, but to generalize about the nature and interpretative processes involved in the experiences (Singleton, Straits & Straits, 1993). The sample is not intended to be representative of all young South Asian second-generation immigrant women living in Canada.

Sample

The study sample consisted of young South Asian women who are second-generation immigrants to Canada aged 18 to 23. To have a more representative sample of South Asian women in Halifax, attempts were made to recruit participants from both the local University campus and from the community. The 18 to 23 age group was selected because participants are young enough to reflect on their adolescent experiences and are at an age (and in the case of university students, in an environment) where many young people have concerns and conflicts around sexuality, dating and sexual health (Boyer, Shafer, Wibbelsman, Seeberg, Teitle & Lovell, 2000; DiClemente et al., 2001; Kotchick *et al.*, 2001; Schuster et al., 1998). And unlike younger participants, older youth are more mature and have the buffer of time to facilitate their critical reflections on their experiences as teens and the factors effecting their experiences.

Inclusion Criteria

Study participants are women of South Asian origin; which includes people from India, Pakistan and Bangladesh, between the ages of 18 and 23. Participants are all second-generation Canadian immigrants, as defined by those who were born in Canada of

immigrant parents. Women who may have been born in South Asia, but who have completed their primary and secondary education in Canada were also eligible to participate in the study. When contacted by potential participants, the researcher asked questions about the participant's age, when their parents immigrated to Canada and where they immigrated from to determine whether participants fit the inclusion criteria.

Sample Size

Unlike quantitative research, in qualitative analysis it is difficult to accurately predict the sample size. The sample is said to be large enough when it can support the desired analyses (Lincoln & Guba, 1985). Lincoln and Guba (1985) suggest that sampling be terminated when no new information is forthcoming from the interviews. Theoretical saturation occurs when no new themes or categories are offered by the interviews, however, additional data can always be collected if the researcher allows the topic of the research to expand unchecked (Guba & Lincoln, 1994). The researcher must decide how much detail is required in the research, balance this with the resources of time and money available, and make a judgement about when additional sampling would be redundant (Creswell, 2003). Since data collection, coding and preliminary analysis will occur in an iterative manner, the researcher is able to make a decision on whether the data collected are rich enough and cover enough of the dimensions of interest based on the research objectives.

The number of interviews that took place were influenced by time and resource constraints. The sample size was ultimately determined by how many people responded to the recruitment flyers, how many of the participants were eligible for the study and how many could be scheduled within an appropriate time frame. Ten participants

between the ages of 18 and 23 were recruited for the study and eight of these women ultimately agreed to participate in the study. One of the women who did not participate was from Sri Lanka and decided to withdraw from the study after a natural disaster had affected her family in Sri Lanka. The other woman was scheduled for an interview, but had a personal family emergency on the same day as the scheduled interview. After three weeks, the researcher attempted to re-schedule, but was unsuccessful as the summer vacation had started and the participant was out of town.

Recruitment Process

Recruitment on campus was accomplished using flyers (Appendix A) which were displayed in visible, "high traffic" areas such as the Student Union Building, campus bars, food courts and libraries. The flyers were posted from December 2004 to April 2005, when the recruitment process was completed. Flyers were also displayed at community organizations that were approved by the Dalhousie Ethics Board, such as the Metropolitan Immigration Settlement Association, the Halifax public library, the YMCA and other local places of business. In addition, recruitment was facilitated by a community liaison who posted flyers at the Indo-Canadian community centre. Information about this study was also circulated via email to a local South Asian student group, that has members both currently in school and within the community.

Data Collection

As discussed above, one-on-one, open-ended, semi-structured interviews were used in this research because they are an effective way to collect rich, contextual, detailed data and to explore a topic in-depth. In-depth interviews provide the researcher with the opportunity to gain an understanding about the complexities of particular social realities

(Henderson, 1991). The researcher is the research instrument who guides the conversation to elicit rich, detailed accounts from the participants (Henderson, 1991). For these reasons, using interviews was a logical choice for this study.

The interview guide (Appendix B) was developed based on the objectives of the research and a review of the literature. The interview guide was used to facilitate the flow of the interviews which took a conversational format. The interview guide consisted of open-ended questions and probes that allowed for additional inquiry into participants' responses. The guide outlined specific areas and topics to be explored during the interviews and using the guide provided a degree of consistency between all interviews.

Following each interview the researcher took notes to record an overall summary of the main points of the interview. This included descriptions of body language and other contextual features of the interview. The researcher reflected on her first impressions of the interview itself and the main concepts and issues discussed. This summary, which was no more than one page in length, was written after every interview, on the same day as the interview took place. This summary was used to inform future interviews. For example, whether the flow of questions could be changed to improve the interview format, or if probes needed to be fine-tuned to ensure the topics of interest were covered. This summary also served as a form of preliminary analysis and included reflections on issues and concepts that emerged from the individual interviews.

Challenges of Interviewing

There are several advantages and disadvantages to using personal interviews for data collection. Interviews are a good method of data collection when questions are long, complex, or require subtle distinctions, or when the content area is not well defined.

Another advantage of one-on-one interviews is that the interviewer can clarify and follow up on answers or questions, and the interviewer can look for descriptive clues during the interview. Disadvantages include cost in terms of money and time, difficulty pre-testing the interview guide, and difficulty standardizing the interviews and replicating the findings (Creswell, 2003; Rubin & Rubin, 1995). Moreover, interviews provide indirect information filtered through the view of interviewees and the researcher's presence may bias responses (Creswell, 2003; Henderson, 1991; Rubin & Rubin, 1995).

In addition, respondents may anticipate what the interviewer expects of them and may act accordingly (role selection); therefore, a discrepancy may exist between what the participant says and what they actually do (Creswell, 2003). There is also the possibility that the interviewer can become more proficient at interviewing, so that later interviews will be different from earlier ones (Creswell, 2003). The researcher may give non-verbal, unconscious clues and affirmations to participants, which can lead to biased data or reporting data that the participant feels is 'right' or desired (Creswell, 2003).

Building Rapport

Interviewees do not always tell the interviewer what she or he wants to know until a considerable amount of trust has developed. The researcher must provide a way for people to respond comfortably, accurately and honestly (Henderson, 1991). The initial establishment of rapport is crucial if the interview is to be successful (Creswell, 2003; Henderson, 1991). To build rapport with the women in this study the researcher either met with each participant before the interview in person or on the telephone to determine eligibility and to schedule an interview time. At the beginning of each interview the researcher spent five to ten minutes chatting with each participant to help the individual

feel more comfortable with the researcher. In addition, the researcher gave participants encouraging feedback throughout the interviews and used non-judgemental language to create a trusting, egalitarian environment.

The researcher's status as a South Asian woman had the potential to create challenges and benefits in terms of rapport with participants. Participants may have been less forthcoming with information if they knew the researcher personally or if the researcher was part of the Halifax South Asian community, as confidentiality may have been more of a concern. In fact, the researcher felt that being South Asian worked in her favour. Participants appeared to assume a certain degree of comfort and an appreciation for the fact that they were talking to someone who they assumed had had similar experiences as themselves. This was reflected in comments made by participants such as "you know what I mean" and "you know how that goes" when talking about their experiences. The researcher also felt that the women were more forthcoming about their experiences with the researcher as they may have been less concerned with being judged regarding their cultural customs and practices.

Study Participation and Location

The interviews started during the second week of January 2005 and were completed by mid-April 2005. The interviews took place in a private meeting room on Dalhousie campus and lasted between 60 to 90 minutes. All interviews were audio tape-recorded and later transcribed verbatim by the researcher. Before data collection began, participants were reminded that they could refrain from answering any questions during the interview and that participation was voluntary. They were also told they could withdraw from the study at anytime without penalty. Participants received a one-time $30

honorarium for participating in the study intended to compensate them for their time away from their usual responsibilities. No follow up interview was required for this study.

Informed Consent

Before data collection began, participants were asked to review and sign the study consent form. The consent form (Appendix C) outlined the issues of confidentiality, anonymity, recruitment, eligibility and information regarding data analysis. Potential risks and benefits associated with the study were also presented including compensation for participating in the study. The anonymity of the participants was respected and transcripts were "cleaned" of any identifying characteristics. Pseudonyms are used in this thesis and will be used in all future written accounts. The interview tapes are accessible to the researcher and her thesis advisor only and will be stored in a locked filing cabinet in the office of the researcher's thesis advisor for 5 years, at which time they will be destroyed.

Participants were encouraged to take their time reviewing the consent forms, and the researcher verbally reviewed every section of the consent form with the participant to ensure they understood the study objectives, purpose and their role. The researcher then left the interview room to get refreshments and allow the participant time to review the consent form in private. Any questions or concerns the participant had were also addressed at this time. The only concern the women in this study expressed was around confidentiality. They wanted to be assured that no one would be able to identify them as a participant in this study. The researcher reiterated that no one would have access to the tapes or transcripts, with the exception of the researcher and her advisor, and that

pseudonyms would be used in all reports.

Analysis

The aim of this study is to explore the experiences of young South Asian women living in Canada and examine how socialization in two different cultures influences their sexuality and sexual heath. Data analysis utilized an inductive approach and was guided by the specific objectives of the study. There is a wide range of literature that documents the underlying assumptions and procedures associated with analyzing qualitative data. Many of these are associated with specific approaches or traditions such as grounded theory, phenomenology and narrative analysis; however, some analytic approaches are generic and are not labelled within one of the specific traditions of qualitative research (Creswell, 2003; Thomas, 2003). The general inductive approach is evident in much qualitative data analysis, often without an explicit label being given to the analysis strategy (Thomas, 2003).

General Inductive Approach

The general inductive approach is a procedure for analysing qualitative data where the analysis is guided by specific research objectives and the data (Creswell, 2003). This is an iterative process of which the primary purpose is to allow research findings to emerge from the frequent, dominant or significant themes inherent in raw data (Thomas, 2003). Inductive approaches are intended to aid in understanding data through the development of summary themes or categories from the raw data.

Analysis involved continual reflection about the data, asking analytical questions and writing memos throughout the study (Creswell, 2003; Miles & Huberman, 1994). The data were analyzed by a combination of hand coding and a data management

computer software program called "Atlas.ti" (selected because the researcher had access to the software). Atlas.ti software provides a system for data management and was used to facilitate coding and subsequent analysis.

Preliminary analysis started during data collection and continued throughout the interview process. As mentioned above, after every interview the researcher reflected on the main concepts, issues and questions that resulted from the interview and these summaries were recorded in a journal. This summary included notes on salient or interesting points that arose from the interview and points to consider for future interviews, such as changing the flow of questions. After each interview was completed and transcribed the researcher listened to the tapes and checked the transcripts for accuracy.

Analysis began by reading the transcribed interview text in detail to become familiar with the content and to gain an understanding of the general issues and details in the text; important passages and words were highlighted by the researcher. This close reading of the text allows the researcher to gain an overall or first impression of the data (Creswell, 2003). More detailed analysis began with coding, which is the process of organizing the material into "chunks" before bringing meaning to those "chunks" (Creswell, 2003). Two levels of categories or codes were assigned to text. The more general categories are referred to as the upper level categories and were dervied from the research aims and objectives. The lower level, or specific categories are derived from multiple readings of the raw data, this is also referred to as in vivo coding. For in vivo coding, categories were created from meaning units or actual phrases used in specific text segments (Creswell, 2003).

The text was segmented into categories which were assigned descriptive labels in the form of a word or a short phrase, often from the actual language of the participant (in vivo term). Initially the raw data generated many categories, such as "behavioural expectations for women" or "gossip within the South Asian community", for example. To reduce overlap and redundancy the categories were subsequently combined or linked under larger categories when the meanings in the codes were similar (Creswell, 2003; Miles & Huberman, 1994). For example, some codes were clustered together because they represented the participant's perceptions regarding a certain topic area or represented participants personal beliefs regarding dating. The researcher continued combining categories and reviewing the data until she felt that the summary categories concisely captured the key aspects in the raw data and were assessed to be the most important given the research objectives.

Because real life is composed of different perspectives that do not always coalesce, discussion of contrary information adds to the credibility of an account for a reader. Also, the intent of the study is to allow all voices to be heard, so contradictory points of view (or information that runs counter to the summary categories) are included in the presentation of the study findings.

Reflexivity

Reflexivity in research refers to the process whereby the researcher constantly takes stock of their actions and their role in the research process, and subjects these elements to the same critical scrutiny as the rest of their data (Creswell, 2003; Cutcliffe, 2000; Marshall & Rossman, 1995). Reflexivity allows researchers to examine their

values, characteristics and motivations in order to determine how they may affect the study design, literature review, data collection, analysis and interpretations.

Throughout the research process the researcher recognizes that as a South Asian second-generation immigrant she can not attempt to remain unbiased or act as an outsider. The researcher's previous experience has indeed played a role in formulating the research study and gives her a unique perspective on the expereinces of study participants. The researcher has kept a journal of her experiences, ideas and insights throughout the research process, which are separate from the research field notes. The journal has provided a space for self-reflection and for the researcher to journal her own beliefs and biases she brings to the study and how this influences her perceptions throughout the study. The researcher started the study with the perspective that South Asian and Canadian cultural norms around sexuality differ to some degree, as this has been her personal experiences, and that this difference has an effect on young women's perceptions, understandings of sexuality and sexual experiences. By acknowledging this and clarifying the bias the researcher brings to the study an open and honest narrative can be developed (Creswell, 2003; Cutcliffe, 2000).

Quality

Interpretive research and qualitative approaches must meet the tenets of methodological rigour. According to Guba (1981), trustworthiness in qualitative research is possible by paying attention to the methodology. Trustworthiness in qualitative research is gained through dependability, credibility, transferability and confirmability (Guba, 1981; Henderson, 1991). A parallel exists between the terminology used for the quantitative and the qualitative approach to methodological rigour. In qualitative

research, credibility is described as analogous to internal validity in quantitative research. Dependability is analogous to reliability, transferability is analogous to external validity and confirmability is analogous to objectivity (Henderson, 1991). These four terms will be discussed below to demonstrate how this study ensured trustworthiness.

Credibility

Credibility refers to how truthful the study findings are and to how accurately the researcher represents the participants' reality in the findings (Guba, 1981; Henderson, 1991). Credibility was enhanced by using member checks and peer debriefing which established a link between participants' constructed reality and those presented in the study findings (Guba, 1981; Maggs-Rapport, 2001).

Member checks involve going back to the participants to give them an opportunity to comment on the accuracy of the researchers observations, interpretations and conclusions. After each transcript was checked for accuracy against the audiotapes by the researcher and some preliminary analysis was done on the transcript the participants were emailed a copy of their own transcript and a summary of the researchers preliminary analysis. Participants were asked to comment on the accuracy of this initial analysis.

Following this, a peer debriefer was recruited to review the transcripts and findings to check if evidence is present to support the researchers conclusions. A peer debriefer also asks questions about the study so that the conclusions will resonate with people other than the researcher (Creswell, 2003; Guba & Lincoln, 1994). For this study the peer debriefer was a fellow graduate student who has done work in the area of

immigrant health, and she reviewed the transcripts, analysis and interpretations of the findings.

Dependability

Dependability and confirmability are considered the fit between what the researcher records as data and what actually occurs in the setting (Creswell, 2003; Maggs-Rapport, 2001) and the fact that the data can all be traced to the original sources (Guba & Lincoln, 1994). It can be argued that in a welldesigned and well-documented qualititative study, the data will be reliable, while others argue that replicability of the study is impossible, since the world is constantly changing (Creswell, 2003; Henderson, 1991). Whether or not it is possible to achieve dependability, it is an issue that the researcher should try to address. This can be accomplished by having a research plan that is flexible and documents how changes in the research plan have occurred (Henderson, 1991; Maggs-Rapport, 2001). The researcher documented the logic and process of decisions related to any changes made in the research design, methods and analysis. This also creates an "audit trail" by detailing the research process, including information on the challenges and any changes.

Confirmability

Confirmability refers to how objective the findings are in terms of whether they are reflective of the subjects and the inquiry and not a product of the researcher's biases and prejudices. Qualitative studies lack confirmability if the research is not reported to give accessibility to others (Henderson, 1991). While no researcher can be completely objective, the data collection can be objective. Confirmability can be strengthened by establishing an audit trail in the form of a journal, and by detailing the coding techniques

to link findings to participants' actual words (Henderson, 1991; Maggs-Rapport, 2001). A detailed audit trail that describes how one came to the study conclusions should enable another person to follow that trail and obtain the same conclusions.

Transferability

Transferability refers to whether or not the participants studied are representative of members of the population (Creswell, 2003; Guba & Lincoln, 1994). It also refers to how applicable or generalizable the research findings are to another setting or group. This is particularly important in this study given that ethnic minorities are the focus, and the context within which this study is conducted may differ from the context of other research. In order to ensure transferability and the ability to make generalizations, the researcher must have knowledge of the research setting and the literature, and of the related settings (Henderson, 1991). The transferability may be a matter of degree and this degree needs to be acknowledged (Guba & Lincoln, 1994; Henderson, 1991).

Therefore, it was important for the researcher to provide a rich, thick description of the research findings, sample, and analysis, which Guba and Lincoln (1994) suggest as the best technique for addressing transferability. The notes taken during and after the interviews and demographic questions all contribute to the rich description of the participants. Using this contextual description, individuals can determine the transferabilty these findings may have to other young women and similar groups of people.

Dissemination Strategy

In addition to the thesis examining committee, the researcher attempted to create a thesis advisory committee consisting of members of the community who are working

with immigrant and refugee groups in the area of health, and individuals involved with the Nova Scotia Youth Roundtable on Sexual Health. The purpose was to provide input and feedback throughout the research project and to be an important point of non-academic dissemination of the study findings; however, the advisory committee was not a success. The researcher had difficulty contacting and connecting with people who would be interested in providing feedback during the study. Instead of an advisory committee the researcher contacted the Alliance for South Asian AIDS Prevention (ASAAP), which is a Toronto-based AIDS service organization interested in the study findings. ASAAP is developing a website called "Brown Kiss" specifically for second-generation South Asian young people regarding sexuality. "Brown Kiss" is a website developed specifically for South Asian diasporic youth and is a forum for them to interact with one another and learn about AIDS prevention and sexual and reproductive health. It also discusses relationship and dating concerns relevent to South Asian youth. ASAAP will be dissemminating the study findings through their website and in their office.

The findings will be presented at national and international health conferences, such as the International and National Metropolis Conferences. The findings will also be published in scholarly, peer-reviewed health journals and will be made available to the study participants. A summary report of the findings will be prepared for the Nova Scotia Health Research Foundation who funded this research.

Ethical Considerations

Before data collection began, full ethics approval was obtained via the Dalhousie Research Ethics Board. The researcher adhered to the guidelines put forward by the Ethics Board throughout the study to ensure that the research did not negatively affect the

women who participated in the study. This study presented two possible ethical issues during the data collection, analysis and dissemination stages. They are outlined below.

Psychological Risk

Sexuality is a personal topic and discussing or recalling particular events may present a slight psychological risk to participants in the study. To address this risk, a list of mental health resources, including counselling support and community groups, were given out to all study participants. The referral list included information on how to access help if it was needed. At the beginning of the interview, the researcher reiterated that participants could refrain from answering any questions, and that there was no pressure to participate if the participant was feeling uncomfortable or distressed.

Cultural Sensitivity

People from different cultures possess different values, beliefs and traditions. These beliefs and values shape nearly all activities of individuals and of society at large. Since participants will be reflecting on their personal cultural experiences, there is a possibility that the presentation of the findings could represent or perpetuate cultural stereotypes or misconceptions. To address this, the researcher has taken steps to ensure that the cultural values and norms discussed in the study are done so with respect. This is achieved by using language that is appropriate and respectful.

Limitations

Sampling Strategy

One of the disadvantages of using a non-probability sampling strategy is that the researcher is not able to ensure an unbiased sample (Creswell, 2003). However, given the research objectives, a random sample from the general population would obviously not

have provided an appropriate sample of South Asian women. A purposive sample limits the possibility of generalizing the findings, however, the research findings will still contribute to the existing literature.

Sample

Although the researcher attempted to recruit women from a variety of diverse backgrounds the budgetary limitations as well as the exploratory nature of this study limited the sample size to eight women. The researcher recognizes that this small sample does not reflect the full variation in young South Asian women's experiences.

The sample is made up of women who have a relatively high socio-economic status, the majority of whom are currently pursing post secondary education. The study sample is also comprised of mostly urban women, with one woman raised in rural Nova Scotia. Time and resource constraints did not allow the researcher to contact participants in rural Nova Scotia, but given that the vast majority of immigrants in Nova Scotia live in Halifax, it would have been difficult to recruit participants in rural Nova Scotia who fit the inclusion criteria. In addition, there is no information on how these two populations differ in their experiences.

The sample is also limited in that it only explored the experiences of women and not men. The researcher felt that it would be difficult for her to interview South Asian men regarding their sexuality due to the potential gender-based power imbalance that could result. Future research with men would be very valuable to compare with the findings of this study.

Summary

This chapter provided an overview of the research methodology, including the rationale for the method used. This chapter also provided details of the study population, data collection, management and analysis, and the methods used to ensure quality of the research. The next chapter will provide a presentation of the study findings.

Chapter Four: Findings

This chapter begins with a description of the women who took part in the study and a description of the interview setting. While still maintaining the anonymity of the participants, the following description is intended to give a demographic profile of the women and provide more information on their background. This will include information on the ethnic origins of participants, when their families immigrated to Canada and information on socio-economic status.

Participant Profile

In total, eight women participated in this study. Although attempts were made to recruit women from outside of the university campus, these attempts were, for the most part, unsuccessful. Posters were displayed in various locations around Halifax, both on and off the local university campus. Women who participated in the study were also given copies of the recruitment flyer to distribute to other women they knew who fit the study criteria and may be interested in participating. Participants were encouraged to give the flyers out to women who were not post-secondary students. Despite these efforts, only one of the women who participated in this study was not a university student. The other seven were all students currently enrolled at one of two local universities in Halifax.

Interviews were between 60 to 90 minutes in length and the age of the participants ranged from 18 to 23. Three of the study participants were 18 years old; two of these women were 17 when they initially contacted the researcher and had turned 18 by the time the interviews took place. Two participants were 19 years of age, one participant was 20 years old and two participants were 23 years old.

With the exception of one woman who identified as bisexual, all of the participants in this study self-identified as heterosexual. At the time of the interviews three participants stated they were currently in relationships and five were single. With the exception of one participant who had never dated, all participants reported being in a romantic relationship within the last year. The participants were from three countries in South Asia; six women traced their origins to India, two women were from Pakistan and one woman was from Bangladesh. According to Statistics Canada estimates of ethnic origin in 2001, the largest proportion of South Asians in Nova Scotia are from India (2860), followed by Pakistan (305) and then Sri Lanka (165); no statistics are reported for Bangladesh. These statistics are estimates and are presented here for informational purposes only.

Of the eight women who took part in this study, five participants were born in Canada, and the other three were born overseas, but had moved to Canada by the age of 6. The majority of participants had their primary education in Canada. The families of the participants migrated to Canada as early as 1952 and as recently as 1990. All participants reported a middle to high socio-economic status with at least one parent from each family having a university-level education and employed full-time. The name (a pseudonym), age, nationality and religion of each participant are outlined in Table 1. Participants are listed in the order they were interviewed.

Table 1: Demographic Profile of Participants

Name	Age	Nationality	Religion
Anita	19	India	Hindu
Maya	18	Bangladesh	Muslim
Kiran	23	India	Hindu
Jasminder	23	India	Hindu
Sunita	18	India	Hindu
Rani	20	India	Sikh
Shikha	18	Pakistan	Muslim
Rekha	19	Pakistan	Muslim

Anita's father is a health professional and her mother is involved in real estate. Maya's father works at a local university and her mother is an administrative assistant. Kiran's father is a health professional, and her mother is a "housewife". Jasminder's father is a health professional and her mother is a "housewife". Sunita's father is a health professional and her mother is a health professional. Rani's father works for a telecommunication company and her mother is an administrative assistant. Shikha's father is the general manager of a company and her mother is a "housewife". Rekha's father is an engineer and her mother is a "housewife".

The purpose of the present study was to explore the context of the experiences of young South Asian women living in Nova Scotia relating to their sexuality and sexual health and how their experiences may be influenced by their bi-cultural upbringing. The young women who participated in this study have been exposed to and socialized in two cultures, the traditional South Asian culture their parents grew up in, and the dominant Canadian culture that they are growing up in; this was articulated by all of the study participants. Participants identified strongly with their traditional culture, as well as felt

comfortable within the dominant culture. Their attitudes and beliefs are reportedly shaped by both cultural contexts.

Exploring bi-cultural tensions or conflicts is a focus of this study and in presenting these women's experiences it may appear that South Asian culture is overly repressive or that these women viewed their traditional culture in a negative light or with contempt, which is not the case. These women all spoke warmly about their cultural heritage and stated that it was an important part of their lives. There are many areas where South Asian beliefs and customs differ from the dominant culture, and these are recognized as being a point of cultural distinctiveness and pride. There are also certain South Asian beliefs and customs that these women described as contradictory or counter to their own beliefs, which they viewed as being more in line with the dominant society. These are the bi-cultural conflicts or tensions discussed here.

By using an inductive analytical approach the researcher was able to identity categories from the raw data which influence participants' experiences around sexuality and dating. Direct quotes from the transcripts are used throughout this chapter in an attempt to allow participants' voices to be heard. Key elements which surfaced in the interviews are summarized into the following sections: the chapter starts off with a discussion of the meaning of sexuality as described by study participants. This is followed by a section on how the family and the role of social standing and family honour influence the experiences of these women around sexuality and dating. Following this is a section on dating and the conflicts that participants described. Characteristics of the type of communication these women have around sexuality and sexual health with their parents follows, including the salient messages they receive. The

chapter concludes with a discussion on the sources of sexual health information and the health services these women use.

Meaning of Sexuality

In the researcher's discussions with participants, most talked about "Canadian" and "South Asian" norms and expectations of women regarding dating, expressions of sexuality and sexual experience. The women talked about their experiences in relation to two distinct points of reference, Canadian and South Asian practices and values. Their comments suggest that they tend to attribute their experiences and beliefs to one of these two cultural contexts. For the most part, descriptions of the women's personal experiences and beliefs placed them somewhere between these two points of reference, moving between them when necessary.

The difference between South Asian and Canadian culture was immediately evident in the participant's discussions of "normative" sexuality. To start off the interview, each participant was asked to comment on their understanding of sexuality. Following this, participants were asked to reflect on how they believed sexuality was conceptualized within South Asian culture. This required participants to situate sexuality and their experiences in the context of their bi-cultural socialization. It made the women think about how South Asian beliefs are similar or different from their personal beliefs around sexuality and those of the dominant Canadian culture. While the participants' personal understanding of sexuality suggested that sex is a normal and natural part of human development, their discussions of sexuality within the context of South Asian culture indicates otherwise. In their personal understanding of sexuality, participants stated sexuality was a concept that encompassed sexual behaviours, attitudes, beliefs, and

orientation - overall, a holistic understanding. Without exception, all of the women in this study stated that the concept of sexuality within South Asian culture was, for the most part, "non-existent" and something that is not open for discussion, as Rekha and Kiran discuss here.

> REKHA: It's hidden. My mom has never talked to me about sex or anything like that…
>
> KIRAN: I've heard that the culture is changing and people are actually accepting sexuality as a normal thing. But from what I know, from when I was brought up, it's something that you don't talk about; it's something that you don't mention. I'd be dead if I even mentioned it in front of family or my parents and stuff.

Participants describe sex within South Asian culture in terms of procreation only. Their discussions suggest that women's sexuality is something that is tightly controlled by family members, particularly parents and male relatives and sex for women is not expected to occur until after marriage. Most of the participants felt the idea of enjoying sex, or sex as a leisure activity, which in their estimation is acceptable within Canadian culture, is not the case within South Asian culture. The purpose of sex is to have children, with a distinct preference for male children.

The impact of religion on sexuality and sexual development also emerged, but only with the Muslim women in the study, who described religion as an important feature in their lives. They talked interchangeably about "South Asian" culture and "Islamic" culture and indeed, Islam is considered a religion and a culture. The Muslim women in the study reported that the influence of Islam on sexuality was a point of distinction between Islamic and non-Islamic South Asians. They felt they were faced with firmer restrictions around sexuality and dating relative to their South Asian female counterparts.

In regards to sexual orientation, participants reported that heterosexuality was considered "normative" within the South Asian culture and that alternate sexual identities were viewed as abnormal or unnatural. Most participants stated that while they felt that the Canadian society was not completely open to sexual diversity, that it had more accepting social attitudes towards sexual minorities than the South Asian culture, as evidenced by legalization of same-sex marriage in several Canadian provinces, including Nova Scotia. Since the time of the interviews, the Supreme Court of Canada has voted in favour of same-sex marriage and it has become law. Many of the women said that there was no opportunity to even discuss sexual diversity and sexual identities within the home environment, as Maya describes here:

> MAYA: Well, for example, same sex marriage is a big no-no in our house; again it's a big thing my parents are against. And if something like that were to come on television the channel would be changed, we wouldn't even talk about it. It's just not acceptable. If I was a lesbian, that would not be a good thing, they would definitely not be open about it. I know there is still a lot of homophobia in the Caucasian culture, but I think it's getting better as time goes on and I think there's a lot of (Canadian) parents who would be way more supportive as compared to people like my parents. Who would be like okay, you have 10 days to get out. I mean we can't even talk about heterosexual sex! Do you know what I mean?

This description of intolerance towards sexual minorities, which was echoed by many of the participants, is not uncommon to the attitudes present in the dominant culture (Bhugra, 1997; Mays & Cochran, 2001). Sexual minorities fear discrimination within the dominant culture as well, and this has been associated with higher risk for stress-sensitive psychiatric disorders (Mays & Cochran, 2001). The struggles and discrimination associated with being a sexual minority can be further complicated by belonging to an ethnic minority group (Bhugra, 1997; Silenzio, 2003). Being a "multiple minority" reportedly adds to the stress and conflict that arises around identity formation among

homosexuals, particularly when members of one's own ethnocultural community may view homosexuality as a "white disease" (Bhugra, 1997; Consolacion, Russell & Sue, 2004). The participants' comments suggest that South Asian culture not only excludes non-heterosexual South Asians, but that a gay or lesbian South Asian is difficult to even imagine for some of the participants' families.

The Influence of Family

The family is a very important element in the lives of South Asians, and this held true for the women in this study. When discussing sexuality, all of the participants spoke of their family's expectations of them and the resulting pressure they felt. Prominent in the discussions were comments on the role these women believed they had to play within the family unit and the acceptable behaviour of a South Asian woman in comparison to the role of women in the dominant culture.

The Role of a South Asian Woman

Throughout the interview discussions the issue of gender-based expectations was important as was the sexual double standard. The women talked about characteristics, expectations and behaviours for women that were considered to be "Canadian" and those that were considered to be "South Asian". Many of the women spoke of the role they felt they had to play within the eyes of their family and the South Asian community, and this role was often different from the one they played within the dominant society. Generally, the perception among the participants was that it was more desirable and appropriate for them to be exhibiting predominantly "South Asian characteristics" and only certain aspects of the Canadian culture were to be assimilated to. As Shikha discusses here:

> SHIKHA: I think you're allowed to talk English, obviously (laughing), and you can have a great education, you should be successful...I think, well I don't know if

> this is with everyone, but in my family, it's like keep an open mind when it comes to different cultures, but don't adapt to it. Be like, okay, they're Canadian, I understand their point of view but don't do that because you're Pakistani.

Some of the characteristics of a South Asian woman were physical, such as having long hair, whereas others included obedience and having faith in parental decisions. Participants talked about the preference of diasporic South Asian families in Canada that young people, particularly women, refrain from dating, control expressions of sexuality and choose an arranged marriage of some sort. They described the need to appear sexually "innocent" among members of the South Asian community.

This is contrary to what they observe among young people in the dominant society. They describe their Canadian peers as openly dating and experiencing more sexual freedom. According to the women in this study, the perception is that dating and sexuality are normal and acceptable parts of life experience and growing up. While the South Asian behavioural expectations, which were primarily an influence of the home environment, were accepted and not questioned when the participants were younger, many reported that as they got older and were exposed to influences outside of the home they started identifying more with Canadian values and lifestyle. This was followed by questioning certain South Asian expectations that were placed upon them.

The pressure from the family to "be" Indian, or Pakistani, or Bengali and not "too Canadian" was echoed by all of the study participants. Participants described feeling that they had to act *either* South Asian or Canadian in certain social settings and that they moved between those two identities depending on where they were or who they were with. For example, when these women were with their families in South Asian social settings they tended to behave more "conservatively" and as one woman described,

"decently". Decent behaviour meant not openly socializing with young men and not talking loudly or laughing too loudly, as these are behaviours that are frowned upon. This was contrary to the way that they behaved when they were in other social settings such as at school or at work. This compartmentalization of behaviour, that is, following mainstream behavioural and social norms in school and in after-school activities with peers and a South Asian set of norms with parents, relatives and South Asian friends at home, appears to be a strategy most of these women employed to deal with conflicting desires and pressures from the two cultures.

Commitment to Traditional Culture

In relation to these gendered notions of propriety regarding behaviour, many participants believed their parents' expectations were an attempt to maintain cultural and group cohesiveness. The perception was that partaking in unacceptable behaviours such as dating is perceived as being "out of touch with your roots" and a negative influence of the Canadian culture, as Rani discusses here:

> RANI: A lot of stuff my parents just blamed on society, society meaning Canadian society and my peer group. And what they accept and don't accept versus what Indians accept and don't accept. That was the reason for any problems as they saw it. Which is very fair because that is where most of my characteristics and character was built, in Canadian society. So, I think they were just like, oh, well in this society, look at what she's doing, look at what she's doing that's bad...So it was just something that they tended to blame the Canadian society, the Canadian influence.

For most of the women in this study it also brought into question loyalty and commitment to cultural beliefs and traditions. Questioning dominant South Asian beliefs surrounding dating and expression of sexuality was viewed as not respecting cultural roots and not respecting authority figures. This was definitely not the case with this group of women as they all felt strongly connected to their South Asian heritage and felt

it was important to maintain certain cultural traditions. The participants were frustrated that partaking in certain behaviours like dating was equated with breaking cultural loyalty and trust. Sunita talks here about the perception within the South Asian community of young South Asian women who date:

> SUNITA: I think that tends to be the barrier between cultured and uncultured in the eyes of parents. Where they think that if you're dating someone, then it would just be like, "oh, okay, I understand you now, you're all whitewashed. And you don't really care about your culture and your family and your heritage and all these things. And now you are just trying to conform to the western standard and become one of them".

Anita describes below what happens when she questions South Asian cultural norms regarding dating with her father:

> ANITA: He would be like "why are you going against our beliefs, why are you going against what we've taught you, don't you trust us? Don't you believe us? And this is your culture, this is your heritage"...And there is no consideration for the fact that we've grown up in a really different environment, I don't think they understand.

These types of messages can cause conflict for ethnic minority youth as they attempt to reconcile the two sides of their hyphenated identity and in developing their sexual identity. While they want to participate in certain aspects of the dominant culture, it can be viewed by some as being at the expense of "belonging" to their traditional culture or community.

Social Standing and Family Honour

Social standing and family honour are important concepts in South Asian culture, as they are in many collectivist cultures. As discussed in chapter two the concept of family honour or "izzat" is very important in the South Asian family and women are the "repository of izzat", not men. Therefore, in order to maintain or enhance the family's honour, women must remain chaste and marry into families with equal or higher status

(Wakil et al., 1981). For this reason, practices such as arranged marriages are encouraged, while dating and "love" marriages are discouraged (Talbani & Hasanali, 2000; Wakil et al., 1981). According to participants comments, family honour and reputation are preserved by following certain rules and by abstaining from behaviour that may be perceived as stigmatizing or shameful in the eyes of the South Asian society. Stigmatizing behaviour described by these participants included dating, socializing with the opposite sex, talking about sexuality and engaging in premarital sex. When women exhibit behaviour that is not acceptable they face pressure to correct, alter or change that behaviour so it is deemed acceptable by family standards and will not incur shame within the community.

This gender-based double standard regarding honour and reputation was echoed in the comments made by most participants regarding acceptable social behaviour for men and women within South Asian society. Participants all stated there was more pressure on women to behave honourably than on men, and acceptable behaviour differed for men and women, most notably regarding premarital sex, sexual experience and dating. As Jasminder discusses below:

> JASMINDER: And it seems like the more prized girls were the ones that haven't had very many relationships, that were good quote-unquote "wife material", that were not, like, sexually active or not physical with many guys....Whereas with guys that wasn't really an issue, it was just almost a given that they've probably slept with so many girls. I think there is more pressure to preserve a women's honour.

While most participants recognized that gender-based expectations are also present in the dominant culture, in their experience, there were deeper gender divisions and notions of propriety within South Asian culture regarding socialization, dating and sexuality than the dominant culture. The women in this study viewed the Canadian

culture as more egalitarian in this regard. First-generation South Asian immigrant women have also reported that after immigrating to Canada they faced fewer gender-based restrictions on their behaviour and roles and enjoyed a higher status as a woman than they did in their home country (Dhari, Patel, Fryer, Dhari, Bilku & Bains, 1997; Harding, 2003). This has to do, in part, because these women are moving out of extended family homes into their own home. It is therefore not surprising that participants reported parents feel their daughters *are* experiencing greater freedom in the Canadian context, certainly more so than they had in their country of origin and they may believe that it is "enough". Parents may indeed view themselves as providing their children with sufficient freedom and participation in the dominant culture.

When South Asian families move to a new country, they lose their extended family and kinship network and form new networks with other South Asians in their new country of residence (Dhari et al., 1997). Participants in this study described the South Asian community in Halifax as a type of kinship network (for example, parents' friends are referred to as "aunts" and "uncles") and discussed feeling pressure to preserve their family honour and reputation within this South Asian network. Participants often described their behaviours and actions as being monitored by members of this network, particularly older members of the community (the "aunts" and "uncles"), but also their peers. They describe their actions, good or bad, as having ramifications for their whole family, as Sunita and Rekha describe here:

> SUNITA: Having a bad reputation means that your whole family gets discredited by everyone in the Indian community. With reputation, it's so much bigger of a deal than it really would be in Canadian culture. In Canadian culture you worry about your reputation with your friends, maybe, but even then, you don't care. You NEVER worry about what the community thinks. It's not just like it is here, like, I don't care what you think; I'm doing this for myself. It's not like that

> because you're not your own person, you can't do this yourself and think for yourself. You have to take into account the whole community and what's best for the reputation of your family, really. Because it all comes down to family, I think, when you're talking about reputation.
>
> REKHA: My mom keeps saying that children are a reflection of their house, they're the spitting image. So she'll say that 'people will think bad of me if you're doing something bad because I'm not stopping you'. She said it reflects badly on our whole family and the house.

These comments highlight the connectedness study participants have to the family unit; they believe their actions do have an affect on the family welfare. This suggests that they exhibit more collectivist outlooks, despite being raised in a culture that is considered to be quite individualistic. The women in this study also express a sense of frustration about not feeling independent from the family unit. They understand their behaviours will affect the family, but do not agree that they should.

Woman as a Family Burden

In traditional South Asian culture, women are viewed as a burden from birth and unequal to men (Winkvist & Akhtar, 2000). This burden is a result of the differential social and economic roles of women in India and also due to the agricultural economy in which boys are favoured. The system of dowry also influences this, although the payment of dowry is not as prevalent within the diasporic South Asian community in comparison to the subcontinent. South Asian women are reported to always be doing things to add to their "worth" and attempt to balance out their deficiencies in relation to men. One avenue for women to increase their status is by bearing many sons (Winkvist & Akhtar, 2000). Kiran discusses the perception of women below:

> KIRAN: It's just the whole perception of how women are viewed in the society. You know, when a girl is born into a family in Indian culture in a way it's sort of a burden. You know, I've heard that, I think it was my great grandmother, actually when I was born came into the hospital ward and she was looking really

> upset because I was born a girl. Because basically they have to find a husband, that's the way they are looking at it. And I can't take care of myself of course....And my dad has actually said a few things, like, when I wanted to go away to school, this is when I was 16 and I went away to boarding school in England, and before I went he was really upset about it and he said things like "how can I send a girl there? If you were a boy it would be different, I'd tell you to just go and do what you want".

In the discussions of family honour and reputation, this notion of a woman as a family burden was alluded to directly by two of the participants, and indirectly by the other participants. Many participants discussed the high educational standards placed on them by their family, which was, in part, to improve their relative worth among South Asians. Education was reported as one way to improve one's marriage prospects within the South Asian community. Higher education increased their "worth" and honour within the community, and also the honour of their family.

Education was also used by some families as a reason why women should not be dating since they needed to concentrate on their school work. Other women said going to university provided them with greater freedom around their time and socialization and described this as a benefit of attending university.

Dating: A Cause for Conflict

Previous research suggests that dating is an important area where South Asian youth have differing expectations than their parents (Talbani & Hasanali, 2000; Wakil et al., 1981). Dating among young people is generally not approved of by South Asians, particularly for women. Parents are described as having more traditional and conservative views regarding dating, whereas the young women in this study felt their beliefs were more in line with dating practices common in the dominant culture. Participants expressed frustration because a double standard exists when it comes to

dating within South Asian culture. Boys are allowed to, whereas girls are not, and this was not perceived to be the case in the dominant culture. These gender-based expectations were perpetuated by parental and cultural messages, control over socialization and gender segregation. The women talked about how these gender norms and expectations were reinforced by their parents at an early age, starting with socialization restrictions or strict curfews, and then carried throughout their adolescence, teenage years and into their 20s in the form of dating restrictions and closely monitoring behaviour and actions.

Most participants reported that while young men and women are sometimes allowed to interact with one another, this is only permitted within certain guidelines, mainly within academic contexts, as Shikha describes here:

> SHIKHA: I can talk to them (boys), but just at school and about school. They wouldn't be allowed to call my house, I wouldn't be allowed to go out with them and chill. Nothing like that.

This is in contrast to what they felt Canadian norms were around dating and socialization, as Maya describes here:

> MAYA: I think it's kinda funny. It's almost like there's something wrong with your daughter if she can't get a boyfriend, and with us, it's like "no boyfriends". I think that's the biggest difference… People at school, they say the weirdest things…like, "my mom is freaking out because I can't get a prom date" (laughing). That's the exact opposite to us!

Young people in all cultures go through a phase of rebellion and contesting parental control over their behaviour, but the women in this study feel that they experience greater control over their socialization in comparison to their Canadian counterparts. The degree of control appears to be dependent, to some degree, on the parent's conservatism, defined by these women as the degree of adherence to traditional

South Asian cultural norms. Religiosity also reportedly influences the degree of control over socialization. Also, given the fact that arranged marriage is still prevalent in the South Asian culture and a strongly held cultural belief, the socialization and dating norms for young South Asian women are inherently different from the mainstream culture.

While the young women in this study were encouraged to socialize with their parents and other South Asian youth at South Asian social events, they expressed frustration that they were not allowed to socialize more freely with their friends outside of these social settings. Kiran talked about how her parents did not allow her to socialize with her friends when she was growing up. This was particularly frustrating for her because she went to a school where she was the only South Asian person, and therefore, felt that she was the only one missing out:

> KIRAN: When I was growing up, with my parents, I wasn't allowed to do anything; that was there way of dealing with me. And when I went to school I was the only Indian girl and my parents didn't really notice that ... I wasn't allowed to go on field trips and that sort of thing. That was when I got a bit older, until about 12 or 13 my parents didn't really put those kinds of restrictions on me because I think they figured I wasn't thinking about those things, like, boys. But maybe when I was about 16 I can remember a couple of field trips when my class went away and I wasn't allowed to go on those. INTERVIEWER: The reason being? KIRAN: That there was going to be boys there and the people that we were going with were not responsible, my teachers aren't responsible.

Dating and the Honour of a Woman

Participants' socialization with young men was strictly controlled, but this was also the case when it came to socializing with other women, however, only other South Asian women. Those women who are known within the South Asian community to be partaking in behaviour that is considered unacceptable, usually those who were suspected of dating, were considered to be "bad girls" or viewed as having a tarnished reputation. Once a woman is seen with a man and suspected of dating, she is reportedly assumed to

no longer be a virgin and therefore, her izzat has been brought into question. This would directly affect the marriage prospects of those women who want to marry within the South Asian community. Female virginity is something that is highly prized in South Asian culture and is considered to be an important aspect of a suitable bride, with religious ceremonies reflecting the importance of the virginal bride.

In an attempt to preserve the reputations of their daughters, most parents did not allow participants to socialize with other young women who were known to be dating and have a bad reputation within the South Asian community, as Anita and Maya describe here:

> ANITA: (my mom) has heard things about her and she told me, she's like, "don't hang around with her, don't be associated with her or people will start to talk about you."
>
> MAYA: I can think of a girl, and she's quite a bit older than me, she's like 22, but she's studying to be an engineer, and of course with Brown people that's a really good thing. So my parents are a big fan and they're like, yeah, go out and hang out with her as much as you want. And then my mom saw her one day with this Lebanese guy and she got talking to another mom, I guess, and this mom had also seen her around a couple of times with this guy. So my mom asked me, and I knew, and so I told her that yes, she is going out with him. And my mom was like, oh, and then she gave me a whole lecture on how it's so crushing to the mom. She's like 'her mom is going to be crushed; she should be looking for people to marry, not to go out with. And now I'm not allowed to hang out with her.

Although this is an attempt on the part of parents to protect their daughters, it was viewed by these women to be "ridiculous" and ineffective. They also did not believe that they were negatively influenced by their peers and did not describe feeling any pressure to behave like their friends who may be dating, although peer pressure was not explicitly explored in this study.

Religious ideology was considered by the Muslim women to play a role in the dating norms imposed on them by their parents and community. They recognized that

other religions have restrictions regarding premarital sex and virginity, but that this did not trickle down to dating and socialization rules in the same way that it did for them. Participants said they felt the religious restrictions placed on male-female relationships and interactions were for the sole purpose of maintaining or ensuring female virginity at the time of marriage. They also said that although the Koran states the same behavioural expectations for men and women, the interpretation of the scripture was gender-biased, placing more restrictions on women and more severe punishment for women who were suspected of inappropriately socializing with boys or engaging in other unacceptable behaviours.

Arranged Marriage

The arranged marriages that take place within the Canadian South Asian community today are not like traditional arranged marriages, where the couple meets one time before their wedding day. The evolved version of the arranged marriage involves parents introducing young people and then allowing them to decide if they would like to marry one another. The parents are the ones involved in choosing the mate, thereby assuring a match in a good, respectable family. Young people are not given very much time to date or get to know one another before deciding to marry; dating (in the western sense) usually occurs after the young couple have agreed to marry and are officially engaged. With the exception of Shikha, who said she would allow her parents to introduce her to someone if she did not find a suitable husband on her own, none of the women believed that they were going to have an arranged marriage. They did emphasize that their parent's approval of their partner was very important, since the cost of non-approval was high, including being disowned from the family. All of the women in this

study reported their parents would only approve of a partner who was from within the South Asian community. Kiran, who had been in a three-year relationship with a man from another ethnocultural group, was not sure if she would marry her current partner, although she cared for him deeply and they had discussed marriage. She stated the cost of marrying him was losing her parents, which was not an option for her.

> KIRAN: The reason I can't be with him is my parents and that really does come into play. That's the only reason I would see me not being with him at this point in time. INTERVIEWER: So that would be a reason to break up the relationship? KIRAN: Yeah, I think that has to do with the fact that I'm an only child as well, so, I mean, people say well, live your own life. But it's really not that easy. I do realize that your parents aren't going to be there forever and it is your life. But at the same time, they did everything for you, you can't just be like thank you, and I'm going to go and do my own thing now. I can't risk losing them like that.

While being disowned for marrying someone who is not approved of by one's family is not unique to South Asians, it may be more important to these women because they come from a collectivist culture and have been raised to believe in the importance of retaining family cohesiveness and honour. Based on the comments made by the participants, they believe transgressions on their part will negatively affect their entire family. For this reason, participants may be more concerned with marrying outside of their ethnocultural group than their peers in the dominant culture. Also, marrying outside of one's ethnocultural group is often viewed by diasporic communities as rejecting one's traditional culture and assimilating into the dominant culture (Hwang & Saenz, 1990; Wakil et al., 1981).

Hiding Relationships

Since dating is not permitted, it is obviously something these women do not discuss with their parents. This highlights another important element that all the women in this study talked about; hiding romantic relationships from their parents, their siblings

and even their friends. Every single woman in this study hid elements of their romantic relationships. This varied from not telling their parents completely, to not telling their parents they were sexually active. Of the eight women who participated in this study only one was open with her parents and family about her current relationship. The other seven said their family did not know about their current or past relationships. Some women hid romantic relationships from their own friends and even their own siblings for fear of word getting out within the South Asian community and then back to their parents. Romantic relationships were hidden so that people would not talk or gossip and make inferences into the sexual status of the relationship or their virginity.

In the Canadian Study on the Determinants of Ethnoculturally Specific Behaviours related to HIV/AIDS, Cappon et al. (1996) reports that since boys are expected to have some sexual experience and South Asian girls are not allowed to date, cross-cultural dating may "fill the void" where the norms in the community at large are different than in the specific ethnocultural community. For some communities this cross-cultural dating behaviour is reinforced by the penalties applied for dating within the community, which can sometimes be severe (Talbani & Hasanali, 2000). This was not the case for these women, most of whom felt that dating within one's own cultural group provided a certain degree of comfort and understanding, and less explanation was required around dating norms. This suggests that perhaps these women feared discrimination or intolerance from their peers in the dominant culture around South Asian beliefs and customs regarding dating. Anita discusses this below:

> ANITA: The guy that I'm seeing now, we have to hide it from everyone. For more than one reason. I mean he's Indian as well, so what works about this, is that we both realize that you are going to be talked about and so you do have to hide it. So, since we both know it, we both hide it.

Participants may also prefer dating within the South Asian community since they all seek parental approval of the individual they plan on marrying and by dating within the community, they are perhaps more likely to get this approval.

Communication Around Sex and Sexual Health

As discussed in chapter two, there is a belief among South Asians that talking to young people about sex and giving them sexual health information will result in earlier sexual activity. However, existing research suggests that good communication within the family about sexual matters and making information available to young people lessens the likelihood of young people engaging in early sexual activity and increases the likelihood that they will use contraception when they do (DiClemente et al., 2005). Having a supportive home environment in relation to sexuality is one factor that is key for healthy sexuality, sexual development and sexual decision-making (DiClemente et al., 2005; DiClemente et al., 2001; McGuire, Shega, Nicholls, Deese & Landefeld, 1992).

There was little to no communication between participants and their parents around sex or sexual health. Without exception, all the women said they had absolutely no communication with their fathers around sex, dating or relationships. The relationship with the father was described as more formal and not as close as the relationship with the mother. All of the women in the study who have same-sex siblings said they talked with at least one of their sisters to some extent about sex and dating, but that these discussions focused on factual aspects such as using birth control or when to use the "morning after pill", and not on emotional or relational aspects of sexual relationships.

All of the women stated their parents believed they needed to know nothing about sex when they were growing up. Even now, with some participants in their early

20s, they reported their parents still want them to know very little about sex. The reasons these women gave for why they thought sexuality was not openly discussed within the family were: (1) sex is not something that South Asians were to be engaging in before marriage, (2) sex was something that was viewed as shameful, would ruin their reputation and therefore must be concealed from public discussion, and (3) if young people were not talking about sex, they would not be having sex. This suggests that parents do not believe they are harming their children by not discussing sex; rather, they are protecting them. Rekha, Maya and Sunita discuss this below:

> REKHA: Well, in my home, sexuality, it's a taboo. My mom never talks about it; my dad would never talk about it. In our culture, they never tell us, about your first kiss, or this or that. You get married and that's it. That's when you do everything. There's no premarital anything.
>
> SUNITA: In Indian culture, even if you're married, you just wouldn't do that. It's just not talked about; it is something that you should be ashamed to say. If someone said something about sex, it would be the gossip of the community for quite a while.
>
> MAYA: They think you don't need any sex education because you're not supposed to be doing it.

The only times that the women in this study reported hearing any discussion regarding sex was during a wedding. This happened at women-only wedding parties and they were usually jokes or lighthearted ceremonial songs about the wedding night that included comments about breaking the hymen and bleeding. Marriage was also a time that mothers reportedly gave their daughters the "sex talk" and taught them, for example, how to prevent pregnancy or how to conceive a male child.

Parental Messages Regarding Sexuality and Sexual Health

Generally, participants believed their parents had very negative attitudes towards discussing sexuality. The messages these women said were continually reinforced were to

stay away from boys, refrain from having sex and to avoid pregnancy. These messages were not within the context of a discussion, rather participants describe these comments as just being "thrown out" at random moments. These comments and messages which parents reinforced were perceived as unrealistic, as Anita discusses here:

> ANITA: She will sit down and warn us about guys, but they're just so unrealistic that we just don't even listen. But some of them are so ridiculous. Like just stay away from all guys, they only want one thing. It is always too over the top and unrealistic, mostly scare tactics.

It was clear from the discussions with these women that there was a veil of silence around discussing sexuality and sex, and the silence signaled to them that certain behaviours such as sex, dating and talking about sex were unacceptable. They did not need to explicitly hear their parents say what was okay and what was not, although many did. The women often took cues regarding acceptable behaviour from their community and culture, where no one was openly dating and where arranged marriages are still relatively commonplace, as Jasminder describes here:

> JASMINDER: They never explicitly said "no dating", I think it was just understood because, um, we saw that our cousins weren't dating, we saw that our relatives in India, obviously, weren't dating. So it was just understood within the culture, they never really said it though. I mean once in a while they threw out, you know, 'no sex, no alcohol, no drugs, no boys'. So I guess the rare times they would say it, but it was just understood, that okay we're not going to date.

Puberty and Sexual Health

Participants were asked to reflect on the type of communication they had with their mothers when they were growing up regarding puberty and sexual health. The women report having varied experiences around communication with their mothers. Some women had absolutely no communication with their mothers when it came to their

sexual health, while others describe the relationship as one that provided a certain degree of comfort through puberty.

Anita and Rekha had no communication with their mothers regarding puberty or menstruation. When Anita started menstruating she describes having no idea what was happening to her, despite having attended public school and participating in school-based sexual health education programs. Her mother had told her nothing about puberty and the changes that she could expect in her body. Looking back she described this as confusing. She felt embarrassed and ashamed about what was happening and in someway responsible for menstruating.

> ANITA: ...It's not something to be embarrassed or ashamed about at all and she (mother) just thought it was so, "oh, I can't believe it". I don't know it just seemed like she didn't want me to hit puberty at all. Then I thought "oh crap, I should have waited a few years or something". But you know, I can't control it. I felt it was kinda my fault. She totally gets awkward around things like that, which has to do with your health. You know what I mean? Because of that, it's kind of obvious, like you kinda figure out how she is with discussing other things, like sex.

Rekha also described feeling ashamed and her mother instilling in her that she was not to tell anyone she had started menstruating and that it was a private thing. This was coupled with being told she was not to attend Mosque when she was menstruating because menstrual blood is perceived as "unclean". Rekha described her mother's reaction when she started menstruating in comparison to the way her teacher responded to her:

> REKHA: My mom, actually never said anything about it. She never talked to me about it. Even the day I got my period, I remember I came home and told her and she was like, "'okay, don't tell anyone you got your period. Here's a pad, you put it in your underwear" and that was it. INTERVIEWER: So it happened to you at school? REKHA: Yes. So I told my teacher and she was all like, 'congratulations' and what not. And I go home and my mom is like "don't tell anybody and this and that". And I realized then that my culture is really different from what the

> Canadian culture is....I thought it (period) was bad because my mom was like "don't say it to your uncle", this was another uncle that was living with us. So, she was like "don't tell him, don't tell anybody".

Kiran also talked about her mother instilling in her the belief that discussing sexual and reproductive health issues with others was inappropriate, particularly with men, even her own father, as she discusses here:

> I don't have a problem picking up tampons and pads in front of a man but my mom thinks you're not supposed to do that. So she wouldn't go shopping with my father and go pick up pads or something, she'd go on her own to go and do that because he's not supposed to know.

She felt that her mother's inability to openly discuss sexual and reproductive health issues with anyone, including her doctor, was going to eventually have a negative affect on her health. This is supported by research literature which has found that Asian women access and use sexual and reproductive screening services at a lower rate in comparison to non-Asians (Bottoroff et al., 1998; Okazaki, 2002). Kiran also felt that her mother, despite having lived in Canada for many years, did not have basic sexual health knowledge and for this reason did not see the importance of going to the doctor for screening tests such as mammograms and Pap tests.

Contrary to these three women's experiences, the other five women reported they did have some communication with their mothers regarding puberty and reproductive health. When Rani got her period at a young age she recalled that her mother drew her a diagram detailing the process of ovulation and explained what was happening to her body, but beyond this initial discussion, nothing else has ever been discussed.

Regardless of whether or not participants had discussions with their mothers regarding sexual health, most believed that the reason they did not talk openly about sexual health was because their mother's believed it was related to sex and therefore, in

certain ways, a taboo topic. Many of the women said when they started menstruating they sensed that their mothers were in someway anxious or worried. Many of the women talked about statements their mother's made at the time they started menstruating that they did not understand. These comments suggested they needed to be "more careful around boys", although this was not explained, as Maya and Jasminder discuss here:

> MAYA: The first thing my mom said when I got my period, like I think I was 10, she's like "you have to be careful around boys now".
>
> JASMINDER: She didn't explain it to me, all she said was, "that you do know, no sex before marriage". So I had no idea why she was bringing that up at that time, I was like, "yeah, anyway, getting back to my problem". I just didn't see any connection between my period, sex and pregnancy. Now I see what she meant.

The women in this study perceived their Canadian friends as having more open, meaningful conversations with their parents about topics such as sex, dating and sexual health. Overall, they felt that their peers were able to communicate more openly with their family members and this was described as one of the biggest differences between the South Asian and Canadian culture regarding sexuality.

> RANI: I think that they're a lot more open. I have a lot of white friends and they told their parents when they had sex...where, with Indian parents, because you know what their reaction is going to be, you have to hold back.
>
> ANITA: I just think that it's a million times more open. Like I just find that my friends can tell their parents anything. And I'm like wow, that's just unheard of in Indian culture. I guess that's the biggest difference, they're a lot more open and accepting I guess.

It is interesting to note that the participants perceived their experiences around the degree of openness discussing sexuality with their parents as unique and distinctly a result of their South Asian cultural norms and traditions. However, the experiences participants report are in some ways similar to their Canadian counterparts, although they do not perceive this to be the case. Canadian-based research suggests that many young

people have limited communication with their parents around sex and parents report difficulty discussing sexuality comfortably with their children (CMEC, 2003; Kotchick et al., 2001; Shoveller et al., 2003). Results from the Canadian Youth, Sexual Health and HIV/AIDS Study found that approximately one-third of young women surveyed were comfortable openly discussing sex with their mothers and only about 10% were comfortable talking with their fathers (CMEC, 2003).

Sexual Education and Sexual Health Promotion Information

It is important to understand the sources of young people's sex education and sexual health information, since research suggests that insufficient sexual health information influences the ability to make healthy sexual decisions. When the participants reflected on their level of sex education and understanding of sexual health issues all of the women felt they were currently well informed, although this was not necessarily the case when they were younger. School, media sources (such as television, internet, and film), friends and health clinics were all mentioned as places where women accessed or gained health information and received medical treatment or services. As previously discussed, there was little to no communication between the women in this study and their parents around sex and sexual health, so it is not surprising that none of the women in this study said their parents were sources of sexual health information or sex education.

School as a Source of Sexual Health Information

School was the source where participants stated they got the bulk of their sexual health education. School-based education programs were also identified as the source of the most useful sex education and sexual health information for these women. This

information was gained through health class, PDR (Personal Development and Relationships) class and through completing class assignments. All of the women interviewed said their parents believed they gained their sex education and information from school-based programs. However, their parents were not always supportive of them attending sexual health education classes and this was something that they needed to negotiate or be less than forthcoming about, as Maya and Rekha discuss here:

> MAYA: I remember the first year that it (sex education) was offered my mom didn't want me to go. You know, you get the consent forms and then my mom was like "what! They're talking about sex at school! No!" So then she asked me the next day if there was anyone else who wasn't a part of that class? And I said no, I was the only one. Then she called my health teacher and I don't know what they talked about, but then she was like, "I think it would be good for you to go". So I've been going ever since.
>
> REKHA: And my aunt, my mom's sister, she's a pretty open minded person I'd say. She's a doctor herself, but she didn't let her daughter take that class (sex education), in grade 8. She was like no, you're not going to take that class. INTERVIEWER: But you were allowed to take it. REKHA: We didn't need permission forms. If we did, I think I would have been like, well, my mom is naïve, I'd tell her that it's a school trip and she'd sign it. She wouldn't care. I think we get a lot of stuff past my mom because she's so naïve.

There appeared to be a perception among many of the women in the study that their Canadian counterparts had more sex education and sexual health information than they did. Most of the women commented that they perceived their Canadian friends as having had some basic sex education at home before starting school programs. This was described as a distinction between themselves and their peers from the dominant society and they considered the fact that they did not receive any sexual health education at home to be a disadvantage, as Anita describes here:

> ANITA: I just found it weird how she (mother) didn't tell me cause everyone's parents told them. In sex ed class too, everyone knew before, they were like, "oh yeah", because their parents told them...and I had no idea what was going on. The nurse was showing us diagrams and I'd be like, I don't even know what it is. And

> like, part of the female reproductive system, I'd be like, I have that? I didn't get it, I didn't clue in. I just didn't get it.

Despite the fact that school-based programs were how most women got their sexual health information, some of the participants said they could not relate to or did not try to learn about sexual health when they were younger because it was something that they believed did not apply to them. They stated that since they were not having sex or were not supposed to be having sex according to their culture, they tended to disregard most of their early sexual health education. Jasminder said that she did not consider herself a sexual being, so she was not concerned with sexual health education and information and did not believe it applied to her. Sunita also talked about the fact that she disregarded a lot of the information in her sexual health education class. At the time she did not see the value in learning about sex because it was something that she was not permitted to do and as a result, she feels she missed out on some important early sex education.

> SUNITA: Even in sex ed class I'd just be like, oh, this is ridiculous, I don't even have to be here. Because they would just talk about sex and I was like, oh, sex doesn't apply to me, because I'm not allowed to be sexual, or talk to boys or whatever. It was just such a foreign concept, I thought, this is so crazy, why are they even telling me this. And I was completely detached from it. I was like that has nothing to do with me…

In addition to sexual health education class, those participants who had youth health centres at their high schools perceived these as being very useful. These health centres were described as relaxed, safe environments to get sexual health information or meet with a health nurse when necessary. The health centres had pamphlets and other written material and videos that the women said they found easy to read, understand and access.

Media as a Source of Sexual Health Information

When discussing sexual health information, various media outlets, such as television, movies and the internet were mentioned as sources of information. The internet was the most popular tool for researching or learning about sex outside of school, whereas television and movies were viewed more as sources of entertainment, but did at times provide useful information. The internet was noted as a useful source because it provided a way to get information that these women were not getting from other sources and it was perceived as private and confidential. Despite the appeal of the internet, many women were concerned with the degree of accurate information available. They also said that it was often difficult to find useful information that was pertinent to them. Anita describes how she and her South Asian friends supplemented their sexual health education when they did not follow the material being presented in class:

> ANITA: And so we tried to find another way to figure it out, and we went to things like the media. Which is probably a stupid idea because you should never send kids out looking for sex on that (laughing). We would look on the internet; but if you're trying to find out about sex on the internet, you won't find the most decent things. So we just kinda found whatever we got. And that's pretty much how we understood it (sex).

Friends as a Source of Sexual Health Information

Besides family, friends are considered to be an important source of education and information for young people (CMEC, 2003; DiClemente et al., 2005; Kotchick et al., 2001). For these women, friends were not necessarily referred to as useful sources of accurate information. Most of the women in this sample viewed their friends as supportive and safe places to ask questions about sex and sexuality. Since many of the women felt they knew less about sex than their Canadian peers, they described feeling intimidated asking them questions about sex or sexuality for fear they would appear

"stupid". Anita describes below feeling more comfortable talking to her South Asian friends when she had questions about sex or sexual health.

> ANITA: We felt stupid asking our Canadian friends because they knew everything, they were already having sex. So we felt stupid because they knew everything and we knew nothing.

Contrary to this, when it came to sharing information with friends, two of the women in this study stated that they did not openly discuss sexual health information or sex with their South Asian peers, but they did with their peers from the dominant society. For these women, relationships and particularly sex were something that was not discussed with South Asians, even their friends, for fear of information leaking into the community and others perceiving them to be promiscuous, as Maya describes below:

> MAYA: I have my close family friends, but when it comes to boys, boys are wrong and so I just have to omit and edit my stories because they just can't know. I can't tell them that stuff.

Rani talked about how she felt she needed to behave around her South Asian friends, versus her Canadian friends. She said that if she appeared to be too knowledgeable about sex and sexual health in front of her South Asian friends, that it would be perceived as a negative thing. Her South Asian friends would think that if she knew too much about sex, that she must obviously be having sex, which is something that she wanted to conceal from her South Asian friends.

> RANI: People would be like, why does she know so much about this? It's weird here; I know that in other places, like talking to my cousins in Toronto and England, at least they state things openly around their Indian friends. But, not here, you've got to be really careful what you say to your Indian friends. Just as careful as you have to be with your parents. No one knows, not even my best friend knows I'm sexually active. It's seriously between him, me and now, you. Three people, but that's it.

Health Professionals as a Source of Sexual Health information

Health clinics, nurses and doctors were mentioned as a source of sexual health care, but not necessarily information. Health centres were described as a source for prescriptions, Pap tests or medical emergencies. Some of the women were critical of physicians' bedside manner when it came to their sexual health concerns, particularly male physicians. Many participants also felt that they were not always forthcoming with sexual health information. These women found nurses easier to communicate with and overall they appeared to be more comfortable when discussing sexual and reproductive health issues.

All of the women in this study were reluctant to visit their family doctors when it came to sexual and reproductive health issues, opting instead to use walk-in clinics or the local campus-based health clinics. There were two reasons given for this. Firstly, they were concerned that their parents would somehow learn about the nature of their visit. And secondly, some of the women's family doctors were also family friends, and they viewed these relationships as more familial, rather than professional. Two of the women changed from Indian family physicians to non-Indian family physicians, not because they were family friends, but because of confidentiality concerns and the fact that they felt uncomfortable talking to an older South Asian person about sex and sexual health information. Community-based health services, such as Planned Parenthood, were used by only one of the women in this study, Sunita. The majority of participants stated they would go see a doctor for sexual health concerns rather than use any other type of health service.

Confidentiality

All of the women who were accessing any type of sexual health service were concerned about confidentiality and feared their parents finding out that they had used such services. Although the participants knew that legally doctors were not permitted to discuss any matters related to their health with others, they were still concerned that information would be disclosed or something would be reported on their parents' health insurance records. One of the women in this study said that the reason she does not use birth control pills is because she fears telling anyone she is having sex, including a physician, and does not want this information reported anywhere on her health records. As a result she uses only condoms for birth control. In an attempt to conceal their activities and ensure confidentiality these women often frequented different local health clinics and used different physicians each time they needed sexual health information or services, as Sunita discusses here:

> SUNITA: Because it has to be completely confidential. I won't even hint of where I'm going, so I think I tend to be a lot more secretive about accessing information. They (my parents) have no idea that I've ever been there (Planned Parenthood), they have no idea about how much I've talked to health nurses or how much I even talk to my peers about that. They have no idea how much I go after things or how much I've gone after information, or health or treatment, the pill for example. It's just something that I would not discuss with them. They would be disappointed…If they found out that I actually go out and seek this information, their reaction, well, let's say that it wouldn't be a logical one. It would be "oh my god, she's a huge slut, she's a whore. Oh my god, what have we raised? What have we created?"

Improving Services

The women in this study made some recommendations on ways to improve the delivery of sexual health services to young people. One recommendation was based on the fact that physicians and nurses appear to be judgemental at times regarding sexual

health issues and they did little to put patients "at ease" when it came to discussing sexual health issues. Participants suggested that physicians need to be better aware of how to best initiate a conversation with young people on sexuality and sexual health and how to create an atmosphere of trust and comfort.

The need for cultural awareness of South Asian beliefs regarding sex (for example, what is acceptable sexual behaviour and at what age) is something that Kiran felt doctors should have. Cultural sensitivity develops an atmosphere of trust, empathy and increases communication between patient and physician (Beagan, 2003; Papadopoulos & Lees, 2001). She felt that it was important for health care professionals to understand the cultural realities of second-generation immigrants and recognize that their experiences are unique in comparison to first-generation immigrants and their peers in the dominant culture.

The women who had the services of a health clinic with a nurse in their high school spoke very highly of its value. Many of the women valued the privacy this type of clinic offered and the convenience of being able to go and see a nurse whenever it was necessary on school property. Rani suggested having some sort of campus-wide condom outreach service. She strongly believed that a peer run outreach service which distributed condoms for free would be valuable at campus parties and would be a relatively anonymous way for people to get access to condoms.

Birth Control Options

While there were no explicit questions asked about birth control and safe sex, reference to these issues surfaced during the interviews. Those women who did talk about birth control and safe sex talked about responsibility and birth control options. All

of the women who talked about birth control stated they feel they have more responsibility regarding pregnancy prevention than their male partners, although women tend to *take on* this responsibility more than they should. These comments were conveyed as a global gender-based norm, not necessarily a culturally-based phenomenon. They felt that the responsibility should be shared equally between partners, although this was not usually the case, as Jasminder describes here:

> JASMINDER: Um, I don't think we should have more of a responsibility I think that women take on more of a responsibility. But that's not fair, because, well, it takes two. So overall, we just may feel that we should be more responsible for that, even though technically we shouldn't.

The reason given for why women take on more responsibility was that women faced greater social consequences if they were to become pregnant in comparison to their male partners; pregnancy is viewed as "her" problem. For this reason they felt the onus was on them to make sure that they were using appropriate protection to prevent unintended pregnancy. This point was echoed by many of the women in the study, as Rani discusses here.

> RANI: I think that's just what they (male partners) think. Like "aren't you supposed to be on the pill?" No, like get a condom and I'll get on the pill. Like it's a two-way thing. Especially Indians, I think the guys are trained that the girls are responsible for everything. Because if they get pregnant, they're bad. It takes two, but it's the girl's problem.

These outlooks are not necessarily based in South Asian cultural beliefs or attributable to an influence of the South Asian culture. The belief that oral contraception is a sufficient form of protection can also be found among young women within the dominant culture (Gahagan &Rehman, 2004). Participants describe being more concerned with the stigma associated with pregnancy before marriage within the South Asian community and use this as a point of distinction between themselves and their

peers. However, young women from the dominant culture have also reported that they are more concerned with pregnancy prevention than STI (sexually transmitted infection) or HIV prevention (Gahagan & Rehman, 2004; McGuire et al.,1992; Shoveller et al., 2004).

Kiran, who had very little sex education at boarding school in the UK, said that the bulk of her sexual health education came from age 18 onwards when she returned from boarding school. She talked about the first time she had sex at age 18 and how she felt that her lack of formal education and her parent's unwillingness to openly discuss sex and sexual health resulted in her being ill prepared for her first sexual encounter. She recalls not understanding the significance or importance of using a condom at the time due to her lack of education and experience.

> KIRAN: Like I have met some guys where I've done stuff with and one of them, for example, I didn't use protection. And I didn't realize, I mean I was really young at the time, and it wasn't really my fault when I think back, because how was I to know? I was really inexperienced myself. It was his responsibility, he was older than me, but you can't always trust a guy. And I think if I was more educated, like if my parents had told me more about this kind of stuff, I would have been more aware of it and responsible. You don't know what it's like to be in that moment and that really a guy might say that he used one (condom) and he didn't use one. INTERVIEWER: Is that what happened? KIRAN: Yes, basically he said that he put it on, but then he didn't. Right after (I realized) and then the thing was that I didn't even realize the importance of it at that point and time, like that I should have got tested. And I did go for a test and a pap smear later that year and everything was fine. But when I think back now, I didn't even know him all that well; you don't know where a guy has been really.

Perceived Level of Sexual Risk

All of the women in this study expressed that their primary and often only concern regarding safe sex was to prevent unintended pregnancy. In this regard, they are similar to their peers in the dominant culture. Existing research suggests that adolescents who perceive that they are at risk for pregnancy or STIs tend to engage in less risky sexual behaviours that those who do not have these perceptions (DiClemente et al., 2005;

DiClemente et al., 2001). Not one of the women expressed any concern of coming into contact with a partner who may have an STI or HIV. This may be one reason why, with the exception of one woman, the majority were more keen on making sure they were on the pill than using condoms. The women gave a few different reasons why they were more concerned about pregnancy versus STI or HIV infection, the most important being that their parents would be outraged and disappointed if they were to become pregnant. They also said that since pregnancy is not something that one can "hide" from public gaze, there was concern that the family's reputation within the South Asian community could be negatively affected.

None of the participants discussed STIs or HIV as a sexual health concern until the researcher brought up the potential risk in the interviews and even then participants did not consider themselves to be at risk. Some of the women felt that STIs and HIV were not present within their social circle and not a concern with their sexual partners. While no one reported asking their partners to take an STI test, they did say that since they knew their partner well, they felt protected from the risk of STI or HIV infection. It appeared that trusting one's partner equalled safety for these women as Rekha discusses here:

> REKHA: Yeah, I think I know about diseases…but I knew him for a long time and I knew he wasn't really sexually active with anyone else. It was pretty like, okay, it's okay, because I don't think there is a risk of sexually transmitted diseases. I was okay with it, I was comfortable.

The same beliefs are found among young people in the dominant culture as well. The findings from the Canadian Youth, Sexual Health and HIV/AIDS study indicate that the majority of young people do not consider themselves vulnerable to HIV infection and believe they know how to protect themselves (CMEC, 2003). Sunita, who is bisexual,

said that although she was aware of HIV and STI infection and methods of transmission, she considered herself not at risk and that knowing her partners well provided her with a certain degree of protection. She felt STIs were less of a health concern in comparison to HIV, because STIs were something that would not necessarily need to be disclosed to her family, unlike HIV infection.

> INTERVIEWER: What about with women? What do you use for protection? SUNITA: Nothing. Which is, yeah, I've been talked to about that before, but the chances of risk are so minimal. And what they are for are such a small kind of personal infection, or whatever, but that's something that I can deal with anyway and it's not really something that would be a problem and completely change my lifestyle. So it's not really a big concern. I know the risks, and I guess they're all kind of calculated risks that I'm taking. It's not like I just get with anyone, like, not just random people. It's obviously people I know very well and that I'm comfortable with and who I know a lot about, like their history. If it's someone who gets around a lot or something, I'd be really really careful in that case, but otherwise it's okay.

Shikha said that STIs were not a concern for her and that they did not play a role in whether or not she practiced safe sex. To her, risk was assessed as pregnancy, and others finding out that she was sexually active, not a sexually transmitted infection.

> SHIKHA: I know that you can get diseases, but when I'm doing it I don't think about it. I think of not having sex because of cultural reasons before sexually transmitted disease. I've never really thought about the disease thing to be honest. INTERVIEWER: Do you consider yourself at risk? PARTICIPANT: No. I'm not at risk because I'm not going to get pregnant and it's not going to be known, unless the guy tells or I tell. But it's not going to be known in a physical way that I've done anything, so there's no risk. I've never really thought about it that way, that I might get a disease if I do this, or he might…To be honest, I know sexually transmitted diseases are there, and I know it's a cliché to say that it won't happen to me. But I haven't really thought about it happening to me."

These comments suggest that the perceived risk of the South Asian society knowing that one is sexually active is a greater concern for these women than STI or HIV infection. This could be a result of the pressure to preserve family honour and marriage

prospects within the South Asian community and also to maintain membership within the South Asian community.

Summary

In this chapter the researcher illustrated the ways in which participants described the influence of their dual cultural upbringing, family and peers on their sexuality by including examples from the interviews that show how these forces specifically affected their experiences. These findings provide valuable insights into young people's perceptions about the interactions between socio-cultural context and sexuality. The next chapter will provide a critical analysis of the findings with existing literature to help understand the meaning in the data, and will include a discussion on the implications of the findings and future research directions.

Chapter Five: Discussion

The purpose of this study was to explore how the experiences of young South Asian women around sexuality were influenced by their bi-cultural upbringing and socialization. The objectives included exploring bi-cultural tensions and examining which sexual and reproductive services these young women access. In the discussions the influence of family and the concepts of honour and shame emerged as particularly important cultural factors in the experiences of these women around sexuality and their patterns of sexual health service usage. In addition, communication with parents, or the lack thereof, was also important. These factors will be discussed in more detail below in relation to the existing literature on young women's sexuality. Following this the implications of the findings will be discussed and the chapter with conclude with suggestions for future study.

Influence of Family

The influence of the family was central to these women's discussions and played an important role in their social and sexual experiences and expectations. Airhihenbuwa (1995) writes that although minority youth are constantly exposed to western values, their interpretations of these values are often based on their interactions with, and their relationships with their families. Family relationships are often characterized by experiences that are based in traditional culture (Airhihenbuwa, 1995). This presents a potential for contradiction and conflict in the lives of ethnic minority youth (Airhihenbuwa, 1995). It appears that the normal generational conflicts found in any family are exacerbated by both cultural and generational conflicts in the case of this sample of South Asian women and their interactions with their parents.

Based on the participants' descriptions, the family is a base for reinforcing traditional beliefs and, at times, negatively reinforcing the beliefs of the dominant culture. Participants felt that the Canadian society was portrayed by their parents as being 'immoral' in comparison to the South Asian culture. The dominant culture is viewed by parents as overly permissive in regards to sexuality and one where young people participate in sexual behaviours and activities that are viewed as inappropriate and harmful. This sentiment has been written by many South Asian and non-South Asian writers in Canada and the US (Agarwal, 1991; Anwar, 1998; Jensen, 1988; Wakil et al., 1981).

Generally speaking, the home environment was not a supportive one when it came to sexuality and sexual development. South Asian parents have difficulty in relating to teenage experiences and desires such as dating and going to dances, especially since these rituals are very different from South Asian customs and beliefs for young people (Agarwal, 1991; Anwar, 1998; Wakil et al., 1981). Participants found it difficult to discuss the perceptions of sexuality in the dominant culture within the home and felt that traditional norms for sexuality were imposed on them from their family and the South Asian community as a whole. It appeared that the boundaries between accepted South Asian and Canadian norms for sexuality were distinctly defined for this sample of women. Being in the accepted Canadian boundaries for sexuality meant being outside of the accepted norms of the South Asian culture. This polarization of Canadian and South Asian norms will be discussed in more detail later in the chapter.

Interactions outside of the home, at school and work, were described as avenues where the beliefs of the dominant culture were positively reinforced, and where

differences between the two environments were often emphasized for these women. While participants report that they identify strongly as South Asian, they can be described as exhibiting a more contemporary expression of their culture in comparison to their parents' expression of South Asian culture. Their comments suggest they value certain South Asian cultural customs and beliefs they have been raised with, however, believe that their needs to be change in some culturally held beliefs around sexuality and sexual experience to more accurately reflect the lived experiences of young women raised in Canada. Participants report their parents do not understand their experiences and desires because they do not have the knowledge of what it is to be raised and socialized in Canada. Consequently, they are unfamiliar with certain customs and traditions of the dominant culture. The conception of acceptable "Indian" behaviour in relation to sexuality held by parents is that which was prevalent in South Asia during the time of their youth and therefore, participants question the applicability of these expectations to the Canadian context. Agarwal (1991) writes that most parents are not aware of the change in social customs which have occurred in South Asia and tend to place cultural expectations regarding socialization on their children that may in fact be quite different today.

While parents may believe they have found a middle ground between South Asian and Canadian dating and socialization norms, the women in this study believe that it is much closer to traditional South Asian norms. The women describe feeling uncertain about the validity of traditional practices and beliefs in the context of the dominant culture and starting to question these expectations. Existing research suggests that along with this questioning can come a move towards a degree of denial of one's South Asian

identity and identification with more 'western' values and lifestyle (Agarwal, 1991; Aujla, 1997). This move is inherently linked to inner conflict (Aujla, 1997; DeSantis et al., 1999) and spawns a compartmentalized mode of living (Agarwal, 1991). The issue of identity, which is an interactive process between the individual and society and is highly influenced by the norms and values of the family and society at large (Agarwal, 1991; Berry, 2002), was not explicitly explored in this study. However, participants do discuss negotiating their identities across various cultural and community boundaries. The discussions indicate that the women in this study experience conflict regarding the dissonance between 'normative' South Asian sexuality expectations imposed on them and this plays a role in the compartmentalized mode of living they describe. This has been described as a coping strategy that young immigrants employ as a way of participating in certain behaviours within the dominant culture and maintaining an acceptable appearance at home (Agarwal, 1991). This allows these young women to balance their participation between the two cultural contexts they inhabit.

Agarwal (1991) characterizes the lives of young South Asians as 'walking a tightrope' and describes the lengths that young women go to in order to shield their parents from the details of the life they live outside the home, going as far as keeping a live-in relationship or even a marriage a secret. This dual life may cause uncertainties about where these women stand culturally and can cause difficulties in dealing with and processing the meaning of a hyphenated identity. Both identities may very well have components of the true self, but both may be at variance with what these women actually believe (Agarwal, 1991). Whatever the results, the need to carefully compartmentalize

one's behaviour can hardly have a positive influence on one's self-image, self-esteem and ongoing identity formation.

Many of the women in this study describe hiding aspects of their sexuality and 'sneaking' around. These are behaviours that can have negative affects on the development of sexual identity and can play a role in the sense of shame that these women describe as being associated with sexuality. Although the researcher did not get the impression that the women in this study actually internalized the belief that sex was a shameful behaviour, despite the messages they received from their parents. The process of developing one's sexual identity and conflict that arises for all young people (Bhugra, 1997) can be further complicated for the women in this study because they have conflict resulting from their traditional culture and the dominant culture as well. Moreover, having open relationships with one's parents has positive affects on one's sexual identity and instil the belief that sexuality is a normal and natural part of life, which the women in this study are lacking (DiClemente et al., 2001).

Feeling of Being 'Other'

While the women in this study were encouraged by their parents to participate in certain aspects of the dominant society perceived as beneficial, such as getting a good education, they were often reminded by their family that they are not a part of the dominant culture. Therefore, certain social norms for behaviour in the dominant culture simply do not apply to them. These women were encouraged not to assimilate or exhibit behaviours considered too "Canadian"; however, this presents a challenge in reconciling and integrating the two sides of their cultural upbringing and identity. Parents reinforce the message that you are "Indian" or "Pakistani", or "Bengali", and not "Canadian". It is

not entirely surprising that parents have this outlook since most probably do not see themselves as having a hyphenated identity, and therefore do not know how to pass this concept along to their children. Moreover, they may not recognize the implications or issues that arise for their children from this hyphenated identity (Agarwal, 1991; Wakil et al., 1981). While participants do describe identifying with the values of the dominant culture, they also describe feeling "different" from their Canadian peers. They do not feel Canadian in the same way as their peers in the dominant society do, but do not feel South Asian in the same way that their parents do. In a sense, they described feeling "othered" by both cultures and are searching for a balance in between.

Polarizing Canadian and South Asian Norms

Participants tended to polarize their experiences from those of their peers in the dominant culture. The women in this study reported that they were expected to remain sexually inexperienced before marriage, refrain from dating outside of the intent to marry, and maintain virtue to ensure marriage into a 'good' family. These were described as South Asian norms and expectations for women. The participants in this study felt that these expectations were unrealistic and 'out of sync' with the customs and beliefs regarding sexuality in the dominant culture. While the difference between Canadian perspectives of sexuality and South Asian perspectives can be supported (Bibby, 2001; Bradby & Willilams, 1999; Okazaki, 2002; Talbani & Hasanali, 2000), some of the gender-based sexuality norms between these two cultures are actually quite similar for women, are also common in the Canadian culture.

The influence of honour and shame surrounding sex and the expectation of women to remain a virgin before marriage is not unique to South Asian culture. This

particular bi-cultural tension may also be a source of stress for many other Canadian women who are from collectivist cultures and those who are not. The virginity double standard is well documented for women; however, many of the women in this study felt that this was not the case, this was something unique to them. Since these women are second-generation immigrants, their parents still hold strongly to an ideal that they grew up with. Parents may "fossilize" certain aspects of South Asian culture they grew up with and attempt to pass that on to their children in a very different context. They hold on to these beliefs tightly because they were raised and socialized in South Asia and believe certain ideals are "best" for their children, regardless of where they are living. Since the women in this study are the children of immigrants, these pressures, expectations and resulting conflicts may be heightened as a result. This may be one reason why the participants perceived their experiences to be unique and not like those of their peers.

Participants' descriptions of the lack of sexual health communication with parents and the belief that talking about sex will lead to young people having sex is similar to the experiences of at least some of their Canadian counterparts (Bibby, 2001; CMEC, 2003; Shoveller et al., 2003). Perhaps the difference lies in the fact that these women *perceive* these two contexts to have very different norms and expectations regarding sexuality. Participants' descriptions of the influence of gender on their experiences are very similar to the experiences of some of their Canadian counterparts. By polarizing the contexts, they fail to recognize the similarities in gender-based sexual norms and the similarities between the two contexts. This may also be a result of the parental messages they receive suggesting that Canadian and South Asian cultural norms of sexuality are very different,

when in fact this may not be the case. For example, parents' perceptions that all of the people in the dominant culture approve of premarital sex for young people is obviously misleading. Given this polarization of sexuality norms it is not surprising that the participants described feeling detached from the sexual health education they received at school. It appears that the messages they receive in school-based programs are not representative of their lived realities. This highlights the need for culturally relevant sexual health promotion material to increase the significance of the educational message.

Influence of the Concepts of Honour and Shame

Culturally held concepts of honour and shame play a role in the control of women's sexuality in South Asian culture. Gender-based cultural norms may instil expectations in South Asian women (such as honour and shame) that constrain their options for sexual health services and information, thereby increasing their sexual risk (Weston, 2003; Wingood & DiClemente, 2002). Women are the gatekeepers of the community reputation and protection of the community reputation falls on the shoulders of girls and women in the family (Goddard, 1987; Wakil et al., 1981). The women in this study are taught early on not to bring shame to the family unit, but rather to place the reputation of the family above their personal desires.

The importance of the collective good was reflected in many of the comments made by participants and they were mindful of this when describing or rationalizing their actions and behaviours, such as hiding romantic relationships from their parents. The consequences of breaching family honour might result in being disowned by the family or sent abroad, for instance "back to India" or "back to Pakistan". Women who do not conform to community expectations and standards are often subject to shame and blame

in the eyes of the South Asian community. The pressure to preserve honour and the fear of incurring shame and guilt has been reported in the research literature as playing a role in bringing on silence among women who are from collectivist cultures (Agarwal, 1991; Tang et al., 1999). This silence has been associated with being unable to speak out against sexual abuse and violence (Okazaki, 2002; Tang et al., 1999).

Compartmentalizing Behaviour

This framework of honour and shame is intrinsically linked to the "dual persona" participants' exhibit. Since these women do not want members of their community to know they are partaking in "stigmatizing" behaviour, such as dating or having premarital sex, they compartmentalize their behaviours depending on who they are with and where they are. Participants describe behaving more traditionally when with their family or other South Asians and exhibiting traits more typical of the dominant society when they are away from their family. This appears to be a way to mask or hide 'shameful' behaviour that may be stigmatized within the South Asian community. The distinction between behaviour and identity is used by these women to protect their own honour and in turn, their family's honour. By hiding the fact that they are sexually active, these women can maintain the identity of a respectable, honourable South Asian woman.

Given that there is a potential dichotomy between a woman's public face and her private actions, this has implications for providing sexual health services to those South Asian women who are sexually active. Sexual and reproductive health service organizations and sexual health education programmers then face challenges effectively extending health strategies to these women (Adrien et al., 1996; Cappon et al., 1996). Women who are sexually active are also less likely to access these services for fear of

tarnishing family honour. This was described as one reason why some women do not use community-based sexual and reproductive health services, opting instead to visit physicians for sexual health concerns. Participants describe that being seen accessing sexual health or prevention services or appearing too knowledgeable about sex or sexual health as tantamount to a public disclosure that they engage in some kind of socially stigmatized behaviour. This is also why some of the women in this study did not disclose their sexual health knowledge to their South Asian peers.

Communication and Sexual Risk

Participants' descriptions of their experiences around sexual health education and communication around sex suggest there is a distinct atmosphere of shame and silencing of discussion around sex. Parents are reluctant to discuss sexuality and sexual information with their children, which may be grounded in the belief that a lack of knowledge regarding sexuality will prevent premarital sexual activity, which would preserve family honour. It is not surprising that parents do not discuss sexuality with their daughters given that on the Indian subcontinent, the place where participants' parents were born and raised, sexual health education is essentially non-existent in schools and universities to this day and discussions of sexuality are still considered taboo (Aggarwal, Sharma & Chhabra, 2000; Bhopal, 1997; UNAIDS, 2004a). This is in contrast to the Canadian perspective, where sexual health education is part of public school curriculum (Bibby, 2001; CMEC, 2003). Although there are those who do not support sexual health education in public schools, generally speaking, there is agreement that school-based sexual health education is important for young people (Bibby, 2001; CMEC, 2003).

Non-communication or less frequent communication between parent and child regarding sex and sexuality is associated with non-use or less use of contraceptives (Tang et al., 1999). Existing research suggests that parents can be important agents in reducing adolescent risk-taking. By mediating the effects of social and peer influences, parent-child communication can reduce the likelihood of adolescents engaging in sexual risk behaviour (DiClemente et al., 2001). More open and frequent communication has been associated with being less likely to report being sexually active, engaging in vaginal sex less frequently and more likely to report using condoms (DiClemente et al., 2005; Tang et al., 1999). Having less knowledge about sex and sexual health puts women at risk because studies show that these women are less likely to engage in safe sex and HIV prevention activities (Hou & Basen-Engquist, 1997).

The fact that some of the participants feel uncomfortable discussing sexual health issues with others suggests that they may also be less likely to seek medical attention when they would need it, or they may wait until they have more advanced symptoms to seek help. Less openness around sexuality and less communication with one's mother have also been found to be two cultural barriers to prevention screening among second-generation Asian immigrants (Okazaki, 2002; Tang et al., 1999). The reluctance to discuss sexuality could also have implications around negotiating condom use with sexual partners, which has been found to be the case with other groups of young women (DiClemente et al., 2005; Gahagan & Rehman, 2004).

In participants' discussions of communication with parents, they emphasized the importance placed on pregnancy prevention and the seemingly lack of concern for STI and HIV prevention. The discussions with this sample of women indicate that they

themselves are more concerned with preventing pregnancy than preventing a sexually transmitted infection. Like many young people, it was clear that participants did not perceive themselves to be at risk for STI or HIV infection and several of the women reported having sex without a condom. Research evidence has shown that the low perception of vulnerability to HIV and STIs is a key factor in sexual risk behaviour among young people (Boyer et al., 2000; DiClemente et al., 2005; Smith et al., 2003). If young people consider themselves to be at little or no risk, they will be unlikely to adopt precautionary behaviour (Smith et al., 2003). Therefore, these women may be at an increased risk for STI and HIV infection; however, more research needs to be done to explore this further, such as risk behaviour studies and a more detailed examination of perceptions of vulnerability to HIV and STIs.

The emphasis South Asian culture places on virginity can place South Asian women at increased risk for STI and HIV infection (Wingood & DiClemente, 2002). Studies have shown that having unprotected anal sex may be considered an effective and viable way for young Muslim women to preserve their virginity (Hendrickx et al., 2002). In this sense, adherence to these types of conservative religious and cultural values serves to increase women's HIV and STI risk (Wingood & DiClemente, 2002). Also, since women are the repository of "izzat", they face greater pressure to maintain an acceptable appearance within the South Asian community.

The Indian Subcontinent

In South Asia, where an AIDS pandemic is looming (UNAIDS, 2004b), the greatest challenge and barrier to prevention is still education and the stigma associated with HIV/AIDS. The fact that even discussing sex to this day is taboo represents a

challenge in the South Asian fight against AIDS (Bhopal, 1997; UNAIDS, 2004a). Also the caste system and emphasis on social status are problematic since it is believed that only low class people partake in shameful behaviours that would bring upon HIV infection (UNAIDS 2004b). Combined with the significant stigma and discrimination associated with the illness, a veil of silence is created around discussion of HIV/AIDS, sexual behaviour and prevention (UNAIDS, 2004a; UNAIDS, 2004b).

The rate of HIV infection among South Asians is low in relation to the demographic representation of these communities in the Canadian population (Health Canada, 2004), but may in fact be an underestimation. AIDS diagnoses can only reflect past trends in rates of HIV infection, and ethnicity data is not routinely collected for HIV infection in Canada (Adrien et al., 1996; Health Canada, 2002; Health Canada, 2004). Research with South Asians in Britain has found that low update of medical screening services by South Asians in general, and among women in particular, coupled with communal denial about HIV, has contributed to low levels of HIV testing in the South Asian community (Anwar, 1998; Bhopal, 1997; Weston, 2003). Based on this research, the available Canadian data may not represent the true level of HIV infection in the Canadian South Asian community.

Implications

Given that culture embodies the essence of meaning that people bring to the production and acquisition of knowledge (Airhihenbuwa, 1995) characteristics of South Asian attitudes and beliefs surrounding sexuality have implications for sexual health and clinical work. Health educators and those who design health promotion programs and services must examine health behaviours in particular cultures in terms of whether or not

they are rooted in the cultural values and beliefs of the people as this will influence how health programs and services are designed, implemented and evaluated (Green et al., 1996; Pasick et al., 1996).

Cultural constructions of honour and shame can be seen as influencing public health promotion in the area of women's sexual and reproductive health in many ways, including: taboos around the discussion of sexual matters, the sharp division between identity and behaviour, and the spatial implications of shame (Goddard, 1987; Weston, 2003). Sex-related stigma can only be understood in the specific context of culture and power in which it develops (Weston, 2003). The historical associations between STI and HIV infections and socially unacceptable behaviours have formed a strong foundation for the development of stigma surrounding HIV and a taboo around discussing sexuality in South Asian communities, both in the subcontinent and the diaspora (UNAIDS 2004b; Weston, 2003). Sex-related stigma can be heightened within minority ethnic communities for whom legacies of colonialism and contemporary experiences of racism and prejudice encourage the demarcation of differences from the 'other' of mainstream society (Aujla, 1997; Jensen, 1988). In this sense, not engaging in premarital sex, dating or other *perceived* sexual norms and values of the dominant culture can be viewed as providing a point of distinction for South Asian communities. The policing of boundaries may include assertions from 'community leaders' that socially stigmatized behaviours (with an increased risk of HIV and STI transmission) do not occur within minority communities (cultural immunity) (Weston, 2003; UNAIDS, 2004b).

The reluctance to openly discuss sexual matters, both in the home and for this sample of women, at school, is problematic in that open discussion about sexual health

has been shown to be an essential factor in the success of sexual and reproductive health programs. Participants are reluctant to ask questions within school-based programs and within peer groups. Within the classroom they describe being uncomfortable and unable to ask questions or ask for clarification in sexual health education class. Participants describe being too embarrassed to ask questions in front of their Canadian peers.

In response to this, health educators need to find ways to improve the way sexual health information is offered and develop strategies to engage young women in sexual health education and make it more applicable to their bi-cultural realities. Peer health education programs may be a useful tool for accomplishing this. However, the findings from this study offer two contradictory views on who participants want to receive sexual health education and services from. Some of the participants comments suggest that they may benefit from having sexual health education and information delivered to them by a person from their ethnocultural group to increase the applicability of the information and in turn, the relevance and significance of the message. However, some of the participants reported they would be uncomfortable talking to another South Asian regarding matters such as sexual health and birth control options. In the latter case, having a South Asian person involved in sexual health education programs may prevent or deter women further from asking questions in the classroom.

It has been recognized that culturally sensitive health service provision needs to move beyond linguistic facility to appreciate that targeting individuals with information may be inappropriate in situations where obstacles to safe behaviour are related to culturally embedded norms and practices, rather than just ignorance (Beagen, 2003; Papadopoulous & Lees, 2002). Therefore, health care providers need to appreciate how

factors such as gender, cultural diversity and power relationships and other determinants of health affect well-being and health-seeking behaviours (Papadopoulous & Lees, 2002; Raphael, 2004).

Sexual health educators need to be aware of the assumptions and personal beliefs around sexuality that they have and how this influences the way they present material in the classroom. Material should be evaluated for cultural relevance and recognition of the diversity, culturally and sexually, within the classroom to create more inclusive environments for sexual health education. There needs to be an appreciation for and understanding that cultural environments shape the way individuals learn about and express their sexuality. The similarities between cultures should also be emphasized so members of minority ethnocultural groups appreciate that some of their experiences are similar to their Canadian counterparts, which may also increase the relevance of material presented in school-based programs.

It would also be valuable to involve South Asian community leaders and members in sexual health promotion programs and interventions. It is important to engage the community to recognize that young South Asians may be at risk for negative sexual health outcomes and that they are not immune to HIV infection. A study in 2004 by the Planned Parenthood Metro Clinic assessed the HIV prevention needs of women from diverse ethnocultural communities (Planned Parenthood Metro Clinic, 2004). The study found that women from diverse ethnocultural communities felt it was important to include community members when spreading HIV prevention messages and stressed the importance of hearing about HIV prevention messages from members of their own ethnocultural community. In addition, research done with ethnocultural communities will

undeniably benefit from including community members in the research process. This can ensure that, for example, a research design is sensitive to particular ethnic and cultural backgrounds (Adrien et al., 1996). Cultural competence is a term that encompasses cultural awareness, sensitivity and knowledge (Beagan, 2003; Papadapoulos & Lees, 2002). Culturally competent research will increase the quality of research findings and aid in the development of culturally relevant health interventions (Papadapoulous & Lees, 2002).

It is also important that health service providers appreciate the potential dichotomy between behaviour and identity that may exist for these women in regards to their sexuality. This dichotomy presents a challenge for educators to effectively extend public health strategies into the private realm of individuals whose behaviour may place them at risk for infection or pregnancy (Weston, 2003; Wingood & DiClemente, 2002).

The importance of privacy and confidentiality for these women when locating information resources and facilities (spatial implications) must be considered by sexual health educators (Weston, 2003). Providing sexual health resources and services within multi-purpose service centres may be one way to provide information with a 'respectable' purpose for visiting the service centre. However, if there is an increased risk of encountering community members at these locations, young women may be deterred from using them.

Participants reported using the internet to access sexual health information and enjoy the privacy of this educational tool. This form of media may be an effective way to reach these young people, who may otherwise not access or use existing sexual health services and interventions (Finnegan & Viswanath, 2002). Media may be especially

useful for teaching young people about sexual and reproductive health because elements of popular culture can be used to articulate messages and tailor them to a particular audience (Finnegan & Viswanath, 2002).

Conclusion and Future Research

This study offered a contribution towards the current limited literature addressing the role of South Asian cultural beliefs and the construction of sexuality among young South Asian women living in Nova Scotia. The research approach provided the women in this study the opportunity to express their perceptions and experiences in their own words, allowing a group of women who are often not included in sexual health research to have a voice.

The findings show that participants are shaped by cultural constructions of honour and shame and gender norms that impose different standards on men and women. The findings from this study also suggest that the women in this study receive powerful messages for appropriate conduct and behaviour from family and from the dominant culture they live in. These messages can be contradictory at times and a source of frustration for participants. In response to this, participants report a compartmentalized mode of living in regards to dating and expressions of sexuality and sexual experience. In addition to the potential negative influence on self-esteem and self-identity (Agarwal, 1991), this dual persona may also place these women at increased sexual risk by making them a 'hard to reach' population in regards to sexual and reproductive health services.

The findings have pointed out several areas where there is a need for further research. Special attention needs to be given to the relationship between parents and their children and communication around sex. It appears that perhaps the pressures of

adjustment and socialization have contributed to differing values around South Asian cultural ideals. And while compromise and accommodations are made on both sides of the relationship, it is one that has not been examined in regards to sexual expectations and norms.

Future research must also examine the experiences of South Asian men around sexuality and sexual health, which would allow for a gender-based analysis of social expectations of South Asian men and women in Canada. The relationship between sexual partners was not examined but would be interesting to explore and may provide insights into communication styles and barriers around discussing sex and negotiating birth control options.

There exists an almost total absence of quantitative research addressing the sexual attitudes and behaviours of Canadian South Asians, particularly among young people, and the effectiveness of existing sexual health services for this group. The Canadian Study on the Determinants of Ethnoculturally specific behaviours related to HIV/AIDS did a survey on understanding the use of condoms among ethnocultural communities (Godin, Maticka-Tyndale, Adrien, Singer, Willms, Cappon, et al., 1996; Maticka-Tyndale et al., 1996). While South Asians were included in the survey, only first-generation immigrant men were surveyed. Women were excluded based on feedback from community representatives, who judged women too difficult to access within the budgetary and time limitations (Maticka-Tyndale et al., 1996). There is a limited body of research conducted on the Indian subcontinent that can provide some indications of the beliefs and practices of diasporic South Asians, however, this does not account for the

impact of and experiences of migration and settlement on the sexual attitudes and behaviours of South Asians living in Canada.

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DALHOUSIE *University*

NOVA SCOTIA Health Research FOUNDATION

An Invitation to South Asian women

Would you or some one you know, like to participate in a research study designed to explore how culture influences the sexuality of South Asian women?

I am a graduate student in Health Education at Dalhousie under the direction of Dr. Jacqueline Gahagan. I am studying how culture affects women's sexuality and am particularly interested in the experiences of young South Asian women who are second generation immigrants to Canada currently living in Nova Scotia.

The information from this study will findings will contribute to the existing pool of literature on sexual and reproductive health, immigrant health and women's health. The study will also add to limited literature on the experiences of second-generation immigrants in Canada and their sexuality.

If you are:

1.) 18 to 22 years old
2.) Of South Asian descent; this includes people from India, Pakistan, Sri Lanka and Bangladesh
3.) Were born in Canada to immigrant parents, or completed all your elementary and secondary education in Canada

You are invited to participate in my study.

If you are interested in participating in this study, or would like more information please contact me: Monica Palak @ (902) 422-9425 or mpalak@dal.ca. Please note: Participation or interest in the study is only possible by DIRECTLY contacting the Principal Investigator, Monica Palak.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL.
You will receive a one-time $30 honorarium for participating in the study.

DALHOUSIE University

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Consent Form

Project Title: Culture and Sexuality: Exploring the Experiences of young South Asian women in Canada

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Introduction

You are invited to participate in a research study that is part of the Principal Investigators Masters thesis work, being conducted at Dalhousie University. Taking part in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about what you will be asked to do, about the risks and benefits which you might experience by participating in the study. Participating in the study might not benefit you directly, right away, but we will learn things that will contribute to the present literature on sexual and reproductive health, immigrant health and women's health. You should discuss any questions you have about this study with Monica Palak.

Purpose of the Research

This study is intended to explore the experiences young Indo-Canadian women aged 18-22 have around their sexual health and sexuality; and how their experiences are influenced by their bi-cultural upbringing. The study aims to respond to a need for more research into how culture and social factors affect health among second-generation immigrants in Canada.

Study Design

For this study, data will be collected using one-on-one personal interviews. Interviews are an effective way to collect information when personal narratives, experiences and histories are important sources of data.

Who can Participate in the Study

You may participate in the study if you are:
(1) A young women between the ages of 18 and 22
(2) Of South Asian origin, this includes people from India, Pakistan, Bangladesh and Sri Lanka
(3) Born in Canada of immigrant parents, or, born overseas but have done all your elementary and secondary education in Canada

Participation in this study is voluntary and participants may withdraw from the study at anytime. Those who do not wish to participate in any of the activities at any given stage of the study can withdraw.

Who will be Conducting the Research

The research will be conducted by:

Monica Palak (Principal Investigator)

What you will be asked to do

In this study you will be asked to take part in a one-on-one interview which should take approximately 1 to 2 hours. The interview is designed to explore the personal experiences of young Indo-Canadian women and their sexuality. The interviews will take place in a location of the participants' choice on Dalhousie campus in a private, quiet location, such as the Pat Richards conference room.

Your interview will be audio-tape recorded. All personal information that can identify you will be deleted and then I will send the tapes to a transcriber who will type them into a hard copy. You can ask the researcher to turn the tape recorder off at any point during the interview if there is something that you do not want to be on tape. There is no follow up interview required for this study.

I will send you a copy of the preliminary findings of the study, which will include some of the important parts of the information (quotes), gathered during the interviews, for you to review and send back to me with your comments.

Possible Risks and Discomforts

There may be a potential for a slight emotional discomfort associated with talking about sexuality, sexual experiences and your sexual health. A list of referrals to mental and sexual/reproductive health professionals and community groups will be provided if you feel the need to talk to someone after the interview, or at anytime time in the future. You can refrain from answering any questions if you have any feelings of discomfort or distress.

Possible Benefits

There are no direct benefits associated with participating in the study, however, there are indirect benefits associated with participating in the study. All participants can benefit from knowing that the findings from the study will be contributing information to the existing pool of literature on sexual and reproductive health, immigrant health and women's health.

Compensation

You will be compensated $30.00 for participating in this study, even if you decide to withdraw prior to completion of the interview.

Confidentiality and Anonymity

Your name and other personal information will remain *confidential*. You will not be identified as a study participant in any reports or publications resulting from this research. Pseudonyms will be used to protect confidentiality of the participants in the final thesis and any publications that result. No information that reveals your identity will be released or published in any form. The research results will be published in the form of a report to be the Nova Scotia Health Research Foundation. The findings extracted from the report will also be published in scientific, peer-reviewed journals and be presented at health journals.

If, during the course of the interview, you disclose the sexual abuse of a child (i.e. sibling or relative) under the age of 18, I am obligated by law to report this information. The tapes, transcripts and surveys collected from the participants will be stored in a locked filing cabinet in the office of the office of Dr. Jacqueline Gahagan, my thesis advisor for 5 years after publication of my Masters thesis. Only Dr. Gahagan and I will have access to the files and tapes until they are destroyed.

Questions

In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance at (902) 494-1462, or patricia.lindley@dal.ca.

Consent

I have read the above explanation about this study. I have been given the opportunity to discuss the study and my questions have been answered to my satisfaction. I understand that my personal identity will be kept confidential.

☐ I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

☐ I hereby give permission for the interview to be audio taped. I realize that I can request that the tape recorder can be turned off at any time throughout the interview.

☐ I hereby give permission for the researcher to use any direct quotes from the interview transcript in the publication of the study.

_____
Name of participant (please print)

_____ _____
Signature of Participant Date signed

I have explained the research to the participant, including the potential harms and benefits. To the best of my knowledge the participant has understood the proposed research and has freely consented to participation.

_____ _____
Signature of Principal Investigator Date signed

Preamble – to be read to participants at the time of the interview:

The purpose of this study is to explore how young Indo Canadian women's sexuality, sexual perceptions and values are influcenced and shaped by cultural factors. I am interested in learning about your experiences being raised in both an Indian and Canadian culture and how this may have affected your sexuality. Sexuality in this interview refers to your sexual beliefs, behaviours, values and expectations. It also refers to your sexual health and how you view your own sexuality.

You have given informed consent to participate in this interview, and to have the interview audio-taped. Only my thesis advisor, Jacqueline Gahagan, and I will have access to the audio tapes and interview transcripts. You are free to refrain from answering any of the interview questions. If there is something that you would not like to be tape recorded, you can request that the tape recorder be turned off. If at anytime you decide you do not want to participate in the interview, you have the right to terminate it. You will still receive the $30 honorarium even if you do not complete the interview.

I have an interview guide that will direct our conversation, but it is flexible, and questions may be added or removed throughout the interview. This study has received ethical approval from Dalhousie's University's Research Ethics Board. The interview will last between one and two hours. I will give you my contact information when we are finished, and you can get in touch with me later if you want to.

Do you have any questions before we get started?

To begin, I would like to ask you some questions about Canadian and South Asian culture norms and expectations regarding sexuality.

1.) How do you define sexuality? What do you think of when I say sexuality?

2.) Walk me through how you define sexuality in your culture (South Asian)?

3.) What are the different expectations that the South Asian community places on women versus men when it comes to sex and sexuality? ***OR*** How do you think the sexual experience is different for men and women in your community?

Probes:

- Can you think of a particular example?
- How is this different from what 'Canadian' society thinks?
- How does this make you feel?

4.) Does your family/parent(s) maintain these cultural traditions and beliefs? How? i.e. control over behaviour, parent-child communication, freedom to socialize, etc.

5.) How does your community (meaning South Asian community) perceive girls who date or are known to be dating?

Probes:

- In what ways is this different from Canadian perceptions/beliefs of dating?
- What are your parent's perceptions of 'other girls/people' who date?

6.) What does your South Asian community think about dating?

7.) What influences these perceptions of the South Asian community?

8.) What are your own thoughts on dating expectations, freedom to socialize and social interactions, freedom to explore sexuality?

9.) How has your bi-cultural upbringing, in both Canadian and Indian society influenced the way you view sex and your own sexuality?

Probes:

- Do you feel that these cultures have different expectations of you regarding your behaviours? Can you give me an example?
- How do you think this affects your actions? Beliefs? Behaviours?
- How do you feel your bi-cultural upbringing has influenced your sexuality?

10. In regards to sex and sexuality, what distinguishes South Asian cultural norms from mainstream Canadian norms?

Probes: How do you think sex and sexuality is perceived in the Indian community versus Canadian society?

- For women?
- For men?
- Any differences?

Now I would like to talk about levels of communication around sex and sexuality. Stuff like who you talk (and talked) to regarding sex and where you get your information regarding sexuality (including sexual health)

1.) Is sexuality discussed in your (South Asian) community?

Probes: If yes, by whom?

- What aspects are discussed?

2.) Is sexuality openly discussed in your home?

Probes: If yes, by whom?

- What aspects are discussed?

3.) Do your parent(s) ever talk to you about sex?

Probe: When is it okay to talk about/discuss sex? Within marriage?

- What aspects are discussed?

We are about halfway through the interview. Are you okay? Would you like to take a break?

4.) Do you feel that you are well informed/education regarding sex and sexual health issues?

Probe: Where have you gained this knowledge?

5.) How do your parents think you learn about sex?

Probe: What do they think you need to know about sex at your age? Or when you were younger, ie. puberty?

6.) Thinking back to puberty, did you discuss things like menstruation, puberty, interest in dating, etc, with your mother? Your father? If not either, who?

Probe: How would you describe your relationship with your mother when it comes to these types of issues? Sister(s)? Cousin(s)? Other relatives?

7.) Can you talk to your mother about issues surrounding your sexual health? Such as contraception or BSE/PAP tests? Sister(s)? Cousin(s)? Other relatives?

8.) Who do you speak with regarding your sexual health concerns? (other than mother)

Probe: Friends? Family Physician?

9.) Do you access sexual health services, such as Planned Parenthood? OR If you needed to, would you access services such as Planned Parenthood?

Probe: Why or why not?

- Where do you/would you go for sexual and reproductive health services?
- What would make such services more attractive to you?

10. Do you think that your attitudes towards sexuality and the (cross-cultural environment) culture you grew up in have influenced where and how you access sexual and reproductive health services (and information)?

Probes:

- How? Can you give me an example?

I'd like to finish by asking you some general questions regarding your background

1.) How would you describe yourself, in terms of your personal identity?
2.) How old are you?
3.) Where you born in Canada? If yes, where did your parents immigrate from? If no, when did you immigrate to Canada? And from which country?
4.) What religion does your family (or you) practice?
5.) Where do you currently live? At home? On your own?
6.) What is the highest level of education you have obtained?
7.) What are your parent's occupations?
8.) How do you describe your socioeconomic status?

Those are all of the questions I had planned to ask. Is there anything at all you would like to add before we finish?