Navigating shame to negotiate sexual agency in British born South Asian women: A grounded theory study

By

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A thesis submitted in partial fulfilment for the requirements for the degree of Doctor of Philosophy at the University of Central Lancashire

March 2022

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School: **School of Community Health and Wellbeing**

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Contents

Contents i
List of Tables x
List of Figures x
List of Abbreviations x
Abstract xii
Acknowledgements xiv
1.0 Introduction 1
1.1 Thesis structure 3
2.0 Background 6
2.1 Introduction 6
2.2 What is sexual health? 6
2.3.1 Global trends 8
2.3.2 National trends 9
2.3.3 Social determinants 10
2.4 Religion and culture 13
2.4.1 Religion 13
2.4.2 Synopsis of religions 14
2.4.3 Culture and religion 19
2.4.4 Enculturation 21

2.4.5 Acculturation 21
2.4.6 Acculturation: the early use of a model 23
2.5 Sexual health education 25
2.6 Sexual health service provision 26
2.6.1 The implications of culture on sexual health care 29
2.7 The literature review in grounded theory 30
2.7.1 Identifying the literature 31
2.7.2 Summary of relevant studies 32
2.8 Rationale for the study 37
2.9 Conclusion 38
3.0 Theoretical positioning and methodology 40
3.1 Introduction 40
3.2 Epistemology and ontology 40
3.3 Theoretical perspectives 42
3.3.1 Positivism 42
3.3.2 Interpretivism 43
3.3.3 Feminism 44
3.4 Methodology 47
3.4.1 Grounded Theory 48
3.4.2 Glaser and Strauss (Classical) 49
3.4.3 Strauss and Corbin 51

3.4.4 Charmaz's Constructivist Grounded Theory – a social constructionist approach 52

3.5 Conclusion 54

4.0 Methods 55

4.1 Introduction 55

4.2 Feedback from South Asian women 55

4.2.1 Feedback from women 55

4.2.2 Reviewer one 56

4.2.3 Reviewer two 57

4.2.4 Implications from the reviews 57

4.3 Reflexivity 58

4.3.1 Rigour 59

4.4 Sampling 62

4.5 Sample and inclusion and exclusion criteria 63

4.6 Ethical considerations 64

4.6.1 Autonomy 65

4.6.2 Non-maleficence 66

4.6.3 Beneficence 68

4.6.4 Justice 68

4.7 Confidentiality and storage 69

4.8 Recruitment process for phases one and two 69

4.9 Data collection methods 70

4.9.1 Formulating the focus group and interview schedule 70
4.9.2 Rationale for data collection methods 71
4.9.3 Personal characteristics form 72
4.9.4 Focus groups 72
4.9.5 Semi-structured interviews 75
4.10 Data collection procedures and processes 77
4.11 Phase one 80
4.12 Phase two 81
4.13 Transcribing 82
4.14 Software for managing the data 83
4.15 Data analysis 84
4.15.1 Initial coding 84
4.15.2 Focused coding 85
4.15.3 Categories 85
4.16 Theoretical sampling 86
4.16.1 Theoretical saturation 88
4.16.2 Member checking within theoretical sampling 88
4.16.3 Theoretical sorting 89
4.17 Reasoning 91
4.18 Theoretical interpretation and construction 92
4.19 Conclusion 93
5.0 Overview of the findings 94

5.1 Introduction 94

5.2 Participants 94

5.3 Reflections on wider participant information 95

5.4 Personal reflections on data collection 96

5.5 Overview of findings 98

5.6 Conclusion 102

6.0 Findings: Being influenced by religion, culture and the community 103

6.1 Introduction 103

6.2 The influence of religion on behaviour and beliefs 103

6.3 Being part of the community 106

6.4 Knowing your boundaries 109

6.5 Identifying gender differences 111

6.6 Discussing sexual health issues and experiences with fathers 113

6.7 Falling pregnant before marriage 116

6.8 Focusing on marriage 118

6.9 Conclusion 122

7.0 Findings: Maintaining the secret relationship and acculturation 123

7.1 Introduction 123

7.2 Encountering acculturation 123

7.3 Maintaining secrets 127

7.4 Discussing sexual health issues with mothers 128

7.5 Disclosing the relationship to mothers and other females 132

7.6 Conclusion 133
8.0 Findings: Accessing sexual health services, advice and awareness 135
8.1 Introduction 135
8.2 What is sexual health? 135
8.3 Accessing services for testing, screening or advice 138
8.4 Engaging with professionals for sexual health needs 144
8.5 Feelings and beliefs towards sexual health education 148
8.6 Conclusion 154
9.0 Literature review 155
9.1 Introduction 155
9.2 What is a scoping review? 155
9.3 Scoping review framework 156
9.3.1 STAGE 1: Identifying the research question 157
9.3.2 STAGE 2: Identifying relevant studies 158
9.3.3 STAGE 3: Study selection 160
9.3.4 STAGE 4: Charting the data 161
9.3.5 STAGE 5: Collating, summarising and reporting the results 162
Identification 162
Screening 162
Eligibility 162
Included 162
9.3.6 Summary 171

9.4 Conclusion 172
10.0 Theory construction 173
10.1 Introduction 173
10.2 Theory Construction 173
10.3 What is shame? 174
10.4 Models and theories of shame 177
10.4.1 Kaufman's shame-inducing process: breaking the interpersonal bridge .. 177
10.4.2 Gilbert's model of shame 177
10.4.3 Lazare's model of shame 178
10.5 What is sexual agency? 179
10.6 Theories and models of sexual agency 180
10.6.1 Pittard and Robertson's theory of sexual agency 180
10.6.2 Cense's integrated model of sexual agency 180
10.7 Constructing theory: Navigating shame to negotiate sexual agency 182
10.7.1 The grounding context of shame 185
10.7.2 Connectedness with others 186
10.7.3 Finding their way 189
10.7.4 Continuum of theoretical interpretation 191
10.8 Conclusion 192
11.0 Discussion 193
11.1 Introduction 193
11.2 Summary of key findings 193

11.3 Navigating shame to negotiate sexual agency 195

11.3.1 Shame 196

11.3.2 Sexual Agency 200

11.4 Unique contribution to knowledge 204

11.5 Strengths and Limitations 205

11.5.1 Insider Researcher 206

11.5.2 One homogenous group 206

11.5.3 Participant numbers 207

11.5.4 Pursuing other lines of enquiry 207

11.5.5 Member checking 208

11.5.6 Moderator and note-taker in focus groups 208

11.5.7 Interpretations 208

11.6 Implications for research 209

11.7 Implications for policy and practice 210

11.8 Conclusion 212

12.0 Conclusion and personal reflections 213

12.1 Conclusion 213

12.2 Personal reflections: the start of the journey 214

12.3 Personal reflections: throughout the journey 214

12.4 Personal reflections: the end of this journey 215

Reference List 216

Appendix 244

Appendix 1: Search terms for initial literature search using MEDLINE and EBSCO 244

Appendix 2: Attendance at workshop with Charmaz 246

Appendix 3: Recruitment Flyer 247

Appendix 4: Interview and Focus Group Schedule 248

Appendix 5: Participant Information Sheet, Phase one 249

Appendix 6: Participant Information Sheet, Phase two 252

Appendix 7: Consent Form, Focus Group, Phase one 255

Appendix 8: Consent Form, Interviews, Phase one 257

Appendix 9: Consent Form, Focus group, Phase two 259

Appendix 10: Consent Form, Interviews, Phase two 261

Appendix 11: Personal Characteristics Form 263

Appendix 12: Lone working risk assessment 264

Appendix 13: Template letter to community groups 270

Appendix 14: Template letter to colleges 271

Appendix 15: Useful contacts for support 272

Appendix 16: Example of Initial Coding with Gerunds using Max QDA software 273

Appendix 17: Example of Focused Coding with Gerunds using Max QDA software 274

Appendix 18: Examples of Clustering exercises 275

Appendix 19: Coded segments – Confidentiality 276

Appendix 20: Memo writing 277

Appendix 21: Charting the data 278

Appendix 22: Interpretive theorising image.. 287

List of Tables

Table 1	Summary of studies included from initial literature search	32
Table 2	Personal characteristics table	90
Table 3	Links between the aims and objectives and the themes from the findings	93
Table 4	Free text responses of sexual health services	131
Table 5	Other sexual health responses provided	132
Table 6	PIO search terms mapped against inclusion criteria	153
Table 7	Categories and themes from the findings that influenced the stages of the model	179

List of Figures

Figure 1	Berry's model of acculturation	24
Figure 2	Example of memo writing	87
Figure 3	Overview of findings and theoretical development	96
Figure 4	Flow chart of search process and results- adapted from the PRISMA flow chart	157
Figure 5	Theoretical model – navigating shame to negotiate sexual agency	178
Figure 6	Continuum of model	186

List of Abbreviations

AYPH	Association for Young People's Health
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic

CAQDAS	Computer Assisted Qualitative Data Analysis Software
CaSH	Contraception and Sexual Health
CRD	Centre for Reviews and Dissemination
DH	Department of Health
FSRH	Faculty of Sexual and Reproductive Health
GP	General Practitioner
GUM	Genitourinary Medicine
MaxQDA	Max Weber Qualitative Data Analysis
MedFASH	Medical Foundation for AIDS and Sexual Health
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NPL	Naz Project London
NMC	Nursing and Midwifery Council
PE	Physical Education
PHE	Public Health England
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PSHE	Personal, Social, Health and Economic Education
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TSA	Trust for the Study of Adolescence
UCLan	University of Central Lancashire
UK	United Kingdom
UN	United Nations
WHO	World Health Organization

Abstract

Sexual health relates to perceptions and experiences of sexual-based relationships and needs. It is viewed as a fundamental component of overall health. Positive sexual health is dependent upon various determinants which include communication, education and access to services. However, there are a number of barriers to positive sexual health due to its taboo nature. The sexual health needs of young people is a public health priority, in particular those from ethnic minority backgrounds. In the UK, the largest ethnic minority group is South Asian.

Individuals from South Asian communities are socialised into the beliefs and norms of their culture through a process of enculturation. British born, South Asian women will also experience different levels of acculturation as they are influenced by the wider social context and cultures of the society they live in. Acculturation can influence their choices and beliefs where sexual health matters are concerned. Many South Asian religions emphasise the forbidden nature of pre-marital sexual relationships and may limit information about positive sexual health. However, within the British culture, young people generally have more permissible standards and beliefs surrounding sexual health. This may be particularly problematic for some British born, South Asian women who may be influenced by both the South Asian and British culture. Currently there is a lack of understanding into how young people navigate sexual health in these circumstances. My study aimed to explore the perceptions, awareness and experiences of sexual health among British born, South Asian women, aged 18-25 years: it was not limited to a particular South Asian group.

I undertook a constructivist grounded theory study with purposive, snowball and theoretical sampling methods used within two recruitment phases. Both phases recruited females who were residing in the North West of England. Data collection methods involved focus groups and interviews and a total of 16 participants were recruited. Techniques of initial coding, focused coding, constant comparisons and theoretical sorting were used to analyse the data. Three main categories of 'being influenced by religion, culture and the community', 'maintaining the secret relationship and acculturation' and 'accessing sexual health services, advice and awareness' were identified. An overarching theory of 'navigating shame to negotiate sexual agency' was constructed – this theoretical interpretation draws on theories of shame and sexual

agency depicted through a three stage interconnected model: ‘the grounding context of shame’, ‘connectedness with others’, and ‘finding their way’. Overall these findings highlight how women position themselves on a continuum where shame and sexual agency are concerned. This model provides a theoretical framework which identifies how some women may remain close to their encultured religious and cultural values and may be influenced heavily by shame. Whereas others adopt more Western values through acculturation in engaging in sex-based relationships. This model offers a unique theoretical interpretation which can be used by health professionals and young women to understand their position in relation to sexual health and to enhance knowledge of the issues faced. Implications for policy, practice and research are detailed.

Acknowledgements

I would firstly like to thank the women who shared their experiences as participants in my study. This study would not have been possible without you.

I would like to express my gratitude to my Director of Studies Dr Gill Thomson. You have been there throughout this journey and have always shown kindness and encouragement and I would not have reached this stage without your guidance and patience. I would also like to thank my supervisory team Dr Fiona Dykes for her continued belief and support and to Dr Debbie Wisby for her knowledge and advice on the topic of sexual health .

A special thank you needs to go to all my PhD friends who have been on their own journeys, yet have always been there to listen, support and share experiences. I would also like to acknowledge Mark and Phil from the Digital Skills team for their I.T skills support.

Thank you to my family and friends for their continued encouragement and support. Thank you to my husband Thomas for his support and his practical solutions from building a dedicated writing space to creating storage. Finally, I would like to thank my beautiful daughters. Norah, I thank you for your patience and all your drawings of encouragement. Freya, thank you for gving me the strength, as you grew comfortably inside me as I reached the end of this stage of my journey.

1.0 Introduction

This research aims to explore the perceptions, awareness and experiences of sexual health among British born South Asian females, aged 18-25; to consider whether and how these are influenced by culture, religion and wider social factors. Sexual health is an important aspect of a person's overall health. It is concerned with respect and positive sexuality and sexual relationships (World Health Organization [WHO], 2021). As sexual health is viewed as a fundamental component of health, it is important that individuals have the ability to express their sexual health needs in order to maintain positive sexual health. National strategies and literature have previously identified the need for better knowledge and awareness on sexual health issues related to individuals from ethnic minority groups (Department of Health [DH], 2013; DH, 2004; Naz Project London, 2006; Saxena, Oakenshott, & Hilton, 2002); however a sparsity of knowledge remains. I therefore aimed to address this knowledge gap. My study focuses on South Asian women. This is because it is one of the largest ethnic minority groups in North West England (Office for National Statistics [ONS], 2018) where I am based, and because I am from a South Asian background. The academic and personal reasons for undertaking this study are outlined below.

In England, the rates of sexually transmitted infections (STIs) continue to increase and remain high among young heterosexuals aged 15-24 years (Public Health England [PHE], 2019); these individuals have the highest diagnoses of chlamydia and gonorrhoea compared to other age groups (PHE, 2019a). The Department of Health (DH, 2013) published a sexual health framework which identified that young people aged 16-24 had higher rates of poorer sexual health in comparison to older age groups. PHE (2018) highlights that women are at greater risk of experiencing sexual health issues compared to men. Young women have been identified as being more likely to receive a sexually transmitted infection diagnosis over males (PHE, 2020; Family Planning Association [FPA], 2016a). A further indicator of poor sexual health is ethnicity (Department of Health & Social Care and Public Health England, 2018). Young people from ethnic minority groups, such as within South Asian communities can face difficulties in accessing sexual health services due to cultural and religious taboos; sex-based relationships are prohibited before marriage (DH, 2013). Culture and religion have been identified as having a strong influence on an individual's sexuality and sexual health behaviour (DH, 2013). The limited literature available on South Asian women and sexual health also does not consider the specific needs of

British born South Asian women. British born South Asian women may well feel tensions in being socialised into their South Asian culture and values through a process of enculturation, while at the same time, they may face competing beliefs and influences from being socialised into a British culture through acculturation, which has more permissible sexual health standards.

As a South Asian woman, my own interests also drive this study. I am a Muslim, born in England and have been influenced by my diverse social contexts. My first marriage was to a very controlling Muslim husband who came from a different society to the one I am accustomed to in England. I have also witnessed several of my South Asian friends struggle with sex-based relationships and the expectations of our culture so the topic is close to my heart. I wanted to undertake this study to highlight the challenges women face, to understand how these challenges impact their daily lives and to identify key areas where services could be improved.

This study is underpinned by a social constructionist epistemology and an interpretive theoretical perspective that rejects the notion of a universal truth but rather perceives social reality as the product of interactions between groups and individuals (Giddens & Sutton, 2013; Lynch, 1997). I chose to adopt Charmaz's Constructivist Grounded Theory as this approach aims to understand what is occuring in a given situation, particularly in social settings where little research is available (Hunter, Murphy, Grealish, Casey, & Keady, 2011a). This approach discards the notion of a neutral observer, therefore rejecting objectivity (Charmaz , 2013) and enables the researcher to acknowledge their own impact on the research (Hunter, Murphy, Grealish, Casey, & Keady, 2011b). As I come from a similar background to those being studied, the stance that the researcher is acknowledged in the interpretive process made it more appealing.

The aim of this study was to explore the perceptions, awareness and experiences of sexual health among British born South Asian females, aged 18-25; to consider whether and how these are influenced by culture, religion and wider social factors. The research objectives were:

- To elicit participants' awareness of sexual health issues and sexual health service provision.

- To explore the participants' perceived needs, expectations and concerns related to sexual health and accessing sexual health services.
- To gather in-depth insights into the participants' experiences of sexual health and sexual health service provision.
- To consider how culture, religion and wider social influences, impact on women's understanding of and access to sexual health provision.
- To develop a theoretical framework to illuminate and interpret the findings.

1.1 Thesis structure

An overview of the thesis structure is provided as follows:

Chapter 2: Background

In this chapter, I contextualise my study by presenting background information on sexual health, epidemiology, religion and culture and the implications of culture on sexual health. I present an initial literature review that I carried out at the commencement of my study. I also outline the rationale for my study.

Chapter 3: Theoretical positioning

In this chapter, I outline my epistemological, ontological and theoretical underpinnings of my study. I describe the different approaches to grounded theory and justify why a constructivist grounded theory methodology was adopted.

Chapter 4: Methods

In this chapter I present the methods chosen for this study. I discuss feedback from two reviewers who provided their thoughts on the study at the outset. I consider rigour and trustworthiness. I outline my methods of sampling, inclusion and exclusion criteria and discuss key ethical considerations. Data collection methods are presented for both phases. I also detail data analysis and theoretical sampling using Charmaz's grounded theory approach. I provide the sociodemographic details of the participants including their age, where they were born, which South Asian group they belong to and their religion. I also include a reflexivity section pertaining to the data collection process.

Chapter 5: Overview of findings

In this chapter I provide the sociodemographic details of the participants including their age, where they were born, which South Asian group they belong to and their religion. I also include a reflexivity section pertaining to the data collection process. An overview of the findings is also presented.

Chapter 6: Findings- Being influenced by religion, culture and the community

In this chapter, I present the findings related to the category 'being influenced by religion, culture and the community'. A number of themes are presented including religion and behaviour, the community, boundaries, gender differences, discussing sexual health issues and experiences with fathers, pregnancy out of wedlock and the emphasis on marriage.

Chapter 7: Findings- Maintaining the secret relationship and acculturation

In this second findings chapter, I present the findings related to the category of 'maintaining secret relationship and acculturation'. The themes include acculturation, maintaining secrets, discussing sexual health issues with mothers and sharing the secret relationship with mothers.

Chapter 8: Findings- Accessing sexual health services, advice and awareness

In this third and final findings chapter, I present the category of 'accessing sexual health services, advice and awareness'. The themes included knowledge of sexual health, accessing sexual health services for testing, screening and advice, engagement with health care professional for sexual health needs, and beliefs towards sexual health education.

Chapter 9: Literature review

Here I present the findings from a scoping review. I outline the framework and methods adopted to undertake the review. Four key themes are reported namely 'cultural factors and influences', 'beliefs and behaviour surrounding sex', 'access to services, contraception and sex and relationship education'.

Chapter 10: Theory construction

In this chapter, I present the emerging theory from the findings drawing on the concepts of shame and sexual agency. Theoretical insights are used to develop a new three step model of how women navigate shame to negotiate sexual agency across a continuum.

Chapter 11: Discussion

In this chapter, I present a summary of my findings and discuss these in the context of existing literature concerned with sexual agency and shame. The unique contributions of my study are detailed, as well as its strengths and limitations. Implications for research, policy and practice are presented with reference to my model of sexual agency and shame. The model is depicted on a continuum which highlights that women view shame differently and this can affect their sexual agency.

Chapter 12: Conclusion

Here, I present my conclusions. The theoretical framework provides a tool which could be used to address women's sexual health needs when accessing health care services. I also present some of my personal reflections on my chosen area of study, recruitment and my methodology.

2.0 Background

2.1 Introduction

In the previous chapter, I identified the aims and objectives of my study and provided an outline of the chapters to be presented in this thesis. In this chapter, I provide a definition of sexual health and the incidence of sexual health issues, in particular among 18-25 year olds. The determinants and pre-disposing factors of sexual health outcomes and sexual health care delivery are also discussed. I then consider how religion, culture and acculturation can influence an individual's sexual health as linked to the aim and objectives of my study. In the final section I outline key issues pertaining to South Asian women and sexual health and provide an overview of an initial literature review undertaken.

2.2 What is sexual health?

One of the earliest attempts to define the concept of sexual health was by the World Health Organization (WHO) in 1975. They defined sexual health as *"the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love."* (WHO, 1975, p.6). Although this definition took into consideration the emotional and social aspects of sexual health there were problems in its adoption due to a lack of global consensus over the key terms (e.g. sexual health and sexuality) (WHO, 2006; Weston & Coleman, 2004). In 1994, the United Nations (UN) held a conference which intended to consider access to reproductive and sexual health services (UN, 1994), although in reality the discussions concerned reproductive and not sexual health services. In 1995 the UN produced the Beijing Declaration and Platform for Action [1]which made reference to the 1994 conference and emphasised the sexual equality of women and men (UN, 1995). This had important implications and suggested that sexual health was not merely about reproduction. Three decades after the concept of sexual health was originally conceived, the WHO (2006) offered a working definition:

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[1] In 1995, the UN held the Fourth World Conference for Women titled Action for Equality, Development & Peace. Delegates had produced a declaration titled the 'Beijing Declaration & Platform for Action' which was agreed at the conference and which aimed to achieve greater equality for women in all spheres of life (UN, 1995).

> Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2006, p.10)

This global working definition has been described as aspirational due to linking sexual health to human sexuality that encompassed diversity and rights (Aggleton, de Wit, Myers, & Du Mont, 2014). This definition implies that sexual health was not only concerned with negative health outcomes that needed treatment, but that sexual health was important for the holistic wellbeing of individuals. Unlike the UN definition, this new definition emphasised how sexual pleasure is an important part of an individual's sexual health.

In 2001, in the UK, the Department of Health published their first national strategy for sexual health which acknowledged the negative consequences of poor sexual health and therefore focused on improving sexual health through promotion, prevention and better services (Department of Health [DH], 2001). Prior to the publication of this strategy one of the largest studies of sexual health and behaviour has commenced in the UK in 1990 (National Survey of Sexual Attitudes and Lifestyles [NATSAL], 2019). This was pertinent as the surveys informed national policies. Three separate surveys were undertaken in Britain between 1990 and 2012 (NATSAL 1 in 1990-1991 with participants aged 16-59, NATSAL 2 in 1999-2001 with participants aged 16-44 and NATSAL 3 in 2010-2012 with participants aged 16-74) the results of which have contributed to many of the national sexual policies including *The Teenage Pregnancy Strategy* (2000-2010), the *National Chlamydia Screening Programme* (2002) and sexual health campaigns e.g. *Sex: Worth Talking About* (2010) (NATSAL, 2019). Although the DH (2001) did not provide an explicit definition of sexual health, they described what sexual health involved:

> Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of

good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease (DH, 2001, p.5).

This attempt to define sexual health bore resemblance to the WHO (2006) definition where sexual health was emphasised as being an inherent part of an individual's wellbeing across the lifespan and not merely about the adverse effects of sexual health behaviour. For the purposes of this study, the definition of sexual health as outlined by the WHO (2006) has been adopted which incorporates social, emotional, mental and physical wellbeing in relation to sexuality; this includes the right to be respected, be free from coercion and strives for positive and respectful approaches within relationships. In line with the WHO definition, for the purposes of this study, sexual health includes being in a romantic relationship but not sexually active, being in a pre-marital sexually active relationship or being in a married relationship; as all are relevant in relation to sexuality. Sexual health will also be considered in relation to the influence of culture and religion which are introduced in section 2.4.

2.3 Epidemiology

Here I outline the epidemiology of sexual health with a focus on the age group and gender of the population in my study. Epidemiology is the study of the distribution and determinants of different health issues in populations (WHO, 2019; Bhopal, 2016). In the following sections, the incidence and prevalence of sexual health problems will be outlined at global and national level. I also consider the social determinants that can influence sexual health. Social determinants[2], all of which will be discussed below, include gender, age, cultural factors (such as religion) and childhood influences (Institute of Health Equity, 2019)

2.3.1 Global trends

Sexual health issues are significant public health concerns with the WHO (2016) reporting an estimated 357 million new cases of sexually transmitted infections annually. Women's sexual health is described as one of the most prevalent global health issues of the 21st century (Jesky, 2016). A major burden of sexual ill health

[2] Social determinants can also include wider issues such as housing, employment and political environment, which are out with the focus of my study.

occurs among adolescents (Morris & Rushwan, 2015). Each year, 16 million girls aged 15-19 years give birth and in comparison to older women, adolescents face a larger risk of complications (e.g. sexually transmitted infections, anaemia, post-partum haemorrage, depression) and death from pregnancy (Morris & Rushwan, 2015). While there is a slightly higher increased use of contraception among adolescents in comparison to older women, adolescents are greatly affected by discontinued use and contraceptive failure (Morris & Rushwan, 2015). In 2000, the UN came together with world leaders to adopt the United Nations' Millenium Development Goals (MDG)[3] to improve the health and wellbeing of their populations including empowering women and improving maternal health over a 15 year period (UN, 2000). Globally approximately 225 million women have unmet family planning and contraception needs. (Every Woman Every Child, 2015; Darroch, et al., 2017) which demonstrates that little progress has occurred in the uptake of contraception (Morris & Rushwan, 2015). A review of developmental assistance for sexual and reproductive health among countries who were tracking their progress towards the MDG found that despite the countries' commitment towards the goals, sexual health projects received the lowest proportion of funding (Hawkes, 2014). It is likely that this lack of funding had a direct correlation on poorer sexual health outcomes in these countries.

2.3.2 National trends

In the UK there has been a recent increase in the diagnosis of sexually transmitted infections among those aged 45 years and over, as they may be less likely to engage with sexual health services or practice safe sex (Family Planning Association [FPA], 2016a). This could be attributed to a lack of discussion and education around sexual health issues when growing up, increased risk taking behaviour and the focus on health promotion among adolescents (Terrence Higgins Trust, 2018). Although those within the age 45 years and over group are viewed as a vulnerable group, the greatest burden of sexual health issues (in particular with sexually transmitted infection diagnosis) is disproportionately experienced by the under 25 year old age group (FPA, 2016a; Garcia, Lechner, Frerich, Lust, & Eisenberg, 2014, DH, 2004). Poor sexual health has been identified to be particularly prevalent in the under 25s (Public Health England [PHE], 2018) such as through being at a greater risk of unplanned pregnancy

[3] The MDG have been succeeded by the Sustainable Development Goals (SDG) in 2015 which are much broader. The MDG clearly highlighted goals to promote gender equality and empower women, improve maternal health and reduce child mortality whereas the SDG have a much broader focus and include goals on gender equality and reducing inequality. The specific goals around empowering women and maternal health are no longer explicitly stated.

(National Institute for Health and Care Excellence (NICE, 2016). The *Framework for Sexual Health* (DH, 2013) also highlighted how young people aged 16 to 24 have higher rates of poor sexual health in comparison with older populations. The Department of Health & Social Care and Public Health England (2018) also identified that sexual health is not distributed equally, with the highest burden being borne by women, young adults and ethnic minority groups. Young females have been identified as being more likely to receive a diagnosis of some sexually transmitted infections such as chlamydia or genital herpes when compared to males of a similar age (FPA 2016a). The NHS Digital report (2017) identified that the highest number of contact with sexual health services was by the 20 to 24-year-old age range and particularly women aged 18-19 years. Chlamydia diagnoses are highest among those aged 15-24 years (PHE, 2015a; Association for Young People's Health [AYPH], 2015; FPA, 2016a) and in 2014, the under 25 age group accounted for 63% of all new chlamydia diagnoses (AYPH, 2015). Of these chlamydia detection rates, the highest rates were among 15 to 24-year-old females residing in North West England (PHE, 2018a; PHE, 2015b). Recent national statistics have also identified that rates of conception in under 18's in North West England is worse than the national average (PHE, 2018a).Deprivation of the local areas, resource poor local authorities along with the location of suitable sexual health services i.e. ones aimed specifically at young people have been identified as key factors affecting sexual health in North West England (Olsen, Cook, Forster, & Phillips-Howard, 2012).

2.3.3 Social determinants

Poor sexual health has been associated with risk factors and social determinants among young women which include alcohol misuse, being in care, living in poverty, persistent school absence and slower than expected educational progress (PHE, 2018b). Other determinants of health and sexual health behaviour include a lack of education, discrimination, stigma, the social environment, the neighbourhood, family influence and community contexts (Friedman & Dean, 2018; Upchurch, Mason, Kusunoki, & Kriechbaum, 2004; Dahlgren & Whitehead, 1991). In relation to the key social determinant of sexual health education, the level of information and communication an individual receives, including clear messages around sexual health have also been associated with safer sexual health behaviour (Williams, Pichon, Davey-Rothwell, & Latkin, 2015). Whereas individuals who receive low levels of sexual health education and are unable to have conversations and discussions around sexual

health may experience poorer sexual health (Williams, Pichon, Davey-Rothwell, & Latkin, 2015). Aggleton & Campbell (2000) found that many parents believed that discussions on the topic of sexual health may lead their children to becoming curious and engaging in sexual activity. While the authors refute this belief, and call it a myth, they recognised how this may have led to limited discussions around sexual health taking place within families and how the concept of sexual health has inextricably been linked to negative terms (i.e.sexually transmitted infections or becoming pregnant). Higgins, Mullinax, Trussell, Davidson, & Moore (2011) concur and identify that empirical studies on positive indicators of sexual health have been very limited for young people and even more limited for women.

Second to White British, South Asians are the next largest ethnic group in North West England (Office for National Statistics [ONS], 2018) There are limited insights, research and data available on sexual health issues among women from a South Asian background (Dhar, et al., 2010) which may be linked to the low rate of sexual health issues reported by this group. The need for research on sexual behaviour and the development of sexual health services for young adults from ethnic minority communities has been identified as a priority (Department of Health, [DH] 2013; DH 2004; DH, 2001; Social Exclusion Unit, 1999). It is therefore pertinent to study this group to gain a better understanding of their experiences. Cultural and religious influences can supress discussions or considerations of sexual health from this cultural group. Dating and pre-marital sex are strongly discouraged among many South Asian groups and this may be due to upholding family reputation (Diller, 2014). Research undertaken by Saxena, Oakenshott, & Hilton (2002) found that 95% of the teenage South Asian women they interviewed were sexually active. Naz Project London (NPL, 2006) also carred out a study, which found non-contraceptive use to be higher among South Asian females compared to White females, thereby indicating a risk of teenage pregnancy or sexually transmitted infection.

Further key social determinants of religion and culture have been associated with sexual health. In a study conducted by Hobern (2014), the participants who were all staff nurses reported that patients who stated they had a religion, in particular those from a South Asian background, would not be willing to inform their sexual partners when given a diagnosis of a sexually transmitted infection for fear of the community learning that they had engaged in sexual activity. Whereas, a study conducted by Coleman & Testa (2008a) found generally poorer sexual health knowledge among

students who followed a religion compared to those who had no religious affiliation. They also found evidence of risk taking behaviour (e.g. non-contraceptive use) among religious and non-religious students who had sexual intercourse (Coleman & Testa, 2008a). Stigma and discrimination have been identified as key issues within religious communities that influence whether individuals seek diagnosis and treatment, and may also influence disclosure to friends and family (DH, 2013). Weston (2003) and Bhopal (1998: p147) also argue how there is a strong emphasis within South Asian communities in relation to the public honour (also translated as *"izzat"* among South Asian communities) of the family and community and this acts as a central framework of social control which encourages hiding any shameful events.

Bourdieu (1989) states that within the social world, there are structures that are independent of consciousness and that influence human behaviours. These structures are human created and require willing participation (Berger & Luckmann, 1967). These structures encompass social determinants such as culture, religion, community contexts and family, and Giddens (1984) describes how these structures provides rules on how individuals should behave. Structures can be viewed as both enabling and constraining i.e. systems of gender can have the ability to constrain men or women to behave in particular ways but can also provide a sense of position or a sense of identity (Hays, 1994). This sense of position or identity within a structure may provide benefits to those within it e.g. through symbolic power. Bourdieu (1986) saw social capital as a property of an individual derived from one's social position and status. Social capital relates to the social connections that a person can utilise for their own benefit or advancement (Bourdieu, 1986). This group membership provides each member with a collective capital, which may be in the form of symbolic exchanges and not necessarily economic capital (Bourdieu, 1986). For example, being a male within gendered structures that emphasise patriarchy, means that men are likely to have more social capital. Alternatively, if a woman is perceived to be behaving as a model citizen, in line with her religious values, she is likely to have more access to social relationships and resources for her own personal advancement. An individual's social capital is never independent of the social networks or structures they are connected to (Bourdieu, 1986). Bourdieu (1977) uses the term habitus to refer to the collective entity into which dominant cultural and social conditions are established and shaped. The habitus refers to socially ingrained habits, skills and dispositions an individual holds due to their life experiences (Bourdieu, 1977). It also concerns the way in which individuals react to

and perceive the social world they live in and the structures that influence them (Bourdieu, 1977).

Linked to structure is the concept of agency (Hays, 1994). Advocates of agency believe that individuals hold the power to utilise their own free will and make their own choices and can choose to sustain or discard structures (Gibbs, 2017). This suggests that agency can be viewed as a concept which is separate to structure however therin lies the structure-agency debate. Agency has been described as “embracing social choices that occur within structurally defined limits among structurally provided alternatives” (Hays, 1994, p. 65). Hays (1994) believes that the choices an individual makes through their agency, may be conscious or unconscious and are always shaped through social, cultural forces. Giddens (1984) identifies that structure and agency are not to be viewed as independent, polarised concepts as one influences the other.

Religion and culture are a powerful influence on an individual’s sexual health behaviour and beliefs (International Planned Parenthood Federation & World Association for Sexual Health, 2016; FPA, 2016b; Hobern, 2014; DH, 2013). As many of the women included in the studies may have been second or third generation immigrants, their deviant behaviours (e.g. deviating from expected cultural norms) could be explained by the influence of western values through a process of acculturation which is discussed in Section 2.4.5 below. The following section will examine religion and culture with a focus on the South Asian culture, in particular a British born South Asian culture, in line with the aims of this study. The main religious groups associated with the British born South Asian culture will also be outlined.

2.4 Religion and culture

2.4.1 Religion

Religion is defined as *“…a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and surrounded by prohibitions – beliefs and practices…”* (Durkheim 1912, p.46). It is considered that religion can provide individuals with a *“sense of ultimate significance”* (Juergensmeyer, 2003, p.5) or legitimating power which can serve to maintain the socially constructued reality in which individuals exist in their daily lives (Berger, 1969). Riesebrodt (2010, p.75)

further adds that the complexity of practices within a religion are based on a belief in the *"existence of superhuman powers, whether personal or impersonal, that are generally invisible."* Irrespective of these definitions, religion has an influencial role in how people behave and act and has been described as a form of social control (Guo & Metcalfe, 2018; Ellwood, 1918). All the major religions e.g. Islam, Sikhism, Christianity and Hinduism have offered instructions in relation to sexuality and reproduction (and what is deemed good and bad) which their followers should abide by (Arousell & Carlbom, 2016). For many religions (i.e. Islam, Hinduism), sexual health is a taboo subject which influences the knowledge and behaviour of its followers (Yousefzadeh, Golmakani, & Nameni, 2017; Roudsari, Javadnoori, Hasanpour, Hazavehei, & Taghipour, 2013). However, to say that religion is solely responsible for its followers behaviours and beliefs could be viewed as naïve as there are other factors to consider. Many religions have different denominations within one religion e.g. Christianity with Catholicism or Church of England; or Islam with Sunni or Shiite denominations which further add complexity to an already complex concept. There may be a spectrum of beliefs within a single denomination of one religion which make it difficult to comprehend beliefs associated with particular religions where public health is concerned (Foege, 2019). Foege (2019) also argued that individuals may discard some religious beliefs as their religion is one part of their lives that they try to navigate around many other issues. As a health care provider, knowing someone's religion, would therefore only provide very generalised information about their beliefs. Cultures and societies are forever evolving and this will continue to influence religion (Juergensmeyer, 2003). Juergensmeyer (2003) suggested that future religion and beliefs will adapt in response to the changes occuring in the world around it. Next, I provide a synopsis of some of the main religions associated with the South Asian culture.

2.4.2 Synopsis of religions

The 2001 United Kingdom census was the first to include religion as a question (Office for National Statistics, 2001). In line with the focus of my study, this survey identified that Christianity, Islam, Hinduism and Sikhism were the four major religions of immigrants from South Asian populations. An overview of these four religions, with specific consideration to the beliefs associated with sexual health practices will now be provided.

2.4.2.1 Christianity

Christianity is an Abrahamic faith (as are Islam and Judaism) (Timmins, 2012). Christians believe that Jesus is the son of God and the world's saviour (Timmins, 2012). Jesus was conceived by the Virgin Mary through an immaculate conception (Timmins, 2012). Christians practising and residing in the UK tend to belong to the Church of England, the Roman Catholic Church or other churches which include Methodist or Pentecostal churches (Holland & Hogg, 2010) although there are other denominations. The sacred book of Christians is the Bible. Christians may turn to prayer in times of illness or crises (Holland & Hogg, 2010).

Christians have rules pertaining to contraception. The Roman Catholic Church forbids all artificial methods of contraception (i.e. the contraceptive pill or an intrauterine device such as the mirena coil), however natural methods of contraception (i.e. the rhythm method [involves tracking a woman's menstruation cycle history] or the basal body temperature method [which involves taking your temperature as ovulation causes changes in her basal body temperature]), are permitted and can be used for family planning purposes (Family Planning Association, 2016b). Those following the Roman Catholic Church believe that contraception goes against God's natural law as the primary purpose of sexual intercourse is procreation (Pinter, et al., 2016). The older denominations i.e. Roman Catholicism tend to have stricter guidance on contraception, whereas the progressive denominations (i.e. Church of England, Methodist), tend to be more flexible with their position (Pinter, et al., 2016). The Church of England does not consider contraception to be a sin, however it does state that the ideal expression of sexual love should be within a marriage (Family Planning Association, 2016b). Termination of pregnancy is also not viewed as permissible with the older denominations such as Roman Catholicism however some Christian groups such as Methodist Christians view terminations as permissible if the mother's life is at risk (Pinter, et al., 2016).

2.4.2.2 Islam

Islam is identified as one of the world's major religions and is practised by Muslims. (Holland & Hogg, 2010). Muslims form the largest religious minority group in Britain (Anwar, 2008). Islam has many different sects (similar to the different Churches in Christianity) and some are stricter in their practices than others (Holland & Hogg,

2010). Islam has been described as a way of life as there are rules pertaining to every aspect of Muslim life. Muslims believe in one God and that Muhammad ('peace be upon him') is his messenger. The sacred book is the Quran which was revealed to Muhammad (Hanson, 2008). There are five pillars (duties) of Islam which are: The Shahada – the declaration of faith; Salah – set prayers five times a day; Zakaat – the giving to charity; Saum – fasting during the month of Ramadan; Hajj – making the pilgrimage to Mecca in Saudi Arabia at least once during their lifetime (Winter, 2008).

Islam is founded on the words of the Quran and the Hadith which are the traditions and the teachings of the Prophet Muhammad (Dodge, 2018). There is a dress code prescribed for men and women (Hanson, 2008) however different scholars of Islam convey different rules. Modesty is at the heart of Islamic dress for men and women (Abdul-Wahid, 2017). Men are instructed to ensure they are covered between the navel and the knees and any lower garments must rest above the ankle as was practiced by the Prophet Muhammad (Abdul-Wahid, 2017). There appears to be less contention with the dress code of men compared to women. Some scholars rule that the Quran instructs women to dress in loose clothing that covers them from their head to feet with only their face and hands visible however other interpretations suggest that it is recommended that the face also be covered (Abdul-Wahid, 2017). Similar to Christiany, there are a number of denominations within Islam. Suuni and Shiite are the two main sects but within these two sects, there are many denominations with different beliefs and practices (Malbouisson, 2007). The difficulties lie with the interpretation of the Quran as it requires scholars who have dedicated their lives to understanding the language, however contemporary interpretations and different scholars held in esteemed positions within the same religion mean differences in beliefs (Khan, 2015). The Muslim place of worship is a mosque.

Islam does not permit sexual activity outside of marriage (Dhami & Sheikh, 2008). Sex and sexual activity within the confines of marriage is legitimate and viewed as an enjoyable activity, and not merely for procreation (Dhami & Sheikh, 2008). However, religious and cultural taboos dictate that it remains a private matter within the married couple (Dhami & Sheikh, 2008). Khan (1994) highlighted that the belief among many South Asian cultures is that marriage is compulsory and viewed as a necessary duty and for the production of children. Khan (1994) further emphasised that individual identity is not as important as family identity within the South Asian community and therefore personal issues tend to be denied or overlooked if they do not fit with the

expectations of the family and the wider community. Muslim opinion on the use of contraception is divided, with a minority stating contraception is prohibited, whereas the majority state that it is permissible but discouraged (Dhami & Sheikh, 2008). There are verses within the Quran that recommend leaving 30 months between births to allow a mother to recover (Pinter, et al., 2016) therefore contraceptive methods needs to be considered[4]. Similar to Methodist Christians, abortions are not permissible unless there is a threat to the mother's life, as the mother's life is more important than that of the embryo (FPA, 2016b). The Quran states that the ensoulment of the foetus occurs at 120 days gestation and therefore if the pregnancy is causing a threat to the mother's life then the termination should be carried out before this point (FPA, 2016b; Pinter, et al.,2016).

2.4.2.3 Hinduism

Hinduism is viewed as a way of life and not only a religion (Holland & Hogg, 2010) and may affect cultural practices (Pinter, et al., 2016). There is no major founder or prophet in this religion, and although there is no singular sacred text unlike many other religions, the most popular book is called the Bhagavad Gita (Holland & Hogg, 2010). Hindus believe that God can take many forms e.g. an animal, a person. There are three main Hindu Gods sometimes referred to as a Holy Trinity: Brahma-the Creator; Vishnu-the Preserver; Shiva-the Destroyer (Pinter, et al., 2016). These three Gods represent the turn or cycle of the universe (Holland & Hogg, 2010). Hindus also believe in reincarnation and that their internal soul does not die but is born again in another body (Holland & Hogg, 2010). Hindus believe that their new body, their soul receives is determined by their morality in his/ her previous life (Deming, 2015; Pinter, et al., 2016). Hindus are born into a caste system which is of key importance within Indian society (Deming, 2015). The caste system is particularly relevant when considering a suitable partner for marriage (Holland & Hogg, 2010).

From a sexual health perspective there are no restrictions imposed on contraception (Pinter, et al., 2016). Importance is placed on marriage and the concept of izzat (honour), therefore should an individual deviate from tradition i.e. through having sexual relations before marriage, then this can lead to difficulties for the individual

[4] Coitus interruptus is viewed as acceptable if the wife agrees, as it may affect her sexual pleasure and many Muslims use a variety of artificial methods of contraception (e.g. condoms, contraceptive pills) for family planning (Pinter, et al., 2016).

concerned (i.e. possible rejection from the family and/ or community (FPA, 2016b). Marriage is viewed as an essential component of social order and the religion requires children to be born within marriage (Pinter, et al., 2016). Emphasis is placed on birthing a son as a son is required to perform the last rites of his parents upon their death (Pinter, et al., 2016). Many women will therefore not use contraception for family planning purposes until successfully giving birth to a son (Pinter, et al., 2016). There appear to be varying views on the subject of abortion among those practicing this religion. While Hindus view all life to be sacred and therefore a natural assumption would be that they disapprove of abortion, many Hindus are tolerant of abortion and accept it as part of modern life (FPA, 2016b). The Baghavad Gita provides moral discourse on the concept of what constitutes the least harm and following that discourse, a woman may decide that continuing a pregnancy may cause greater harm to herself, her family or the community, in which case an abortion may be justified (Pinter, et al., 2016).

2.4.2.4 Sikhism

Sikhism is the fifth largest religion globally (Reimer-Kirkham, 2009) which originated in Punjab in India (Khalsa, 2017). Sikhism was founded by Guru Nanak (UK Sikh Healthcare Chaplaincy Group, 2011). Sikhs worship one God and their place of worship is known as a Gurdwara (Timmins, 2012; Khalsa, 2017). The sacred book is called the Adi Granth (Singh, 2013). Sikhs believe that the cycle of life consists of birth, life and rebirth which is similar to Hindus (UK Sikh Healthcare Chaplaincy Group, 2011). There are three pillars that Sikhs try to strive towards which are to serve others, to work hard and speak the truth (Khalsa, 2017).

In regards to sexual health, there are no restrictions on the use of contraception (similar to Hinduism) however large families are viewed as desirable (Timmins, 2012). Similar to Catholics, Muslims and Hindus, sexual activity is reserved for a married couple and there is great emphasis on an individual’s moral character (Family Planning Association, 2016b). Sikhs can use all forms of contraception within the confines of marriage (Family Planning Association, 2016b) which is similar to the Hindu faith. Similar to Muslims, the concept of family honour (izzat) is of great importance (Gill, 2002). Abortion should only be considered in exceptional circumstances where there is a threat to the mother or if the pregnancy is due to rape (Family Planning Association, 2016b; Timmins, 2012).

2.4.2.5 Comparison of religions in relation to sexual health

Here, I compare and contrast the religions presented above as a whole rather than as individual religions, as this reflects the approach I took to not divide the participant experiences in relation to their stated religion.

Similar to Roman Catholics, some denominations or sects of Islam believe contraception to be prohibited as sexual intercourse is for the purpose of procreation, however Muslims differ in that they also believe that sexual intercourse is not solely for the purpose of producing children, but also for pleasure between a married couple (Pinter, et al., 2016; FPA, 2016b; Dhami & Sheikh, 2008; Khan, 1994). Unlike some denominations of Christianity and Islam, Hinduism and Sikhism do not pose any restrictions on the use of contraception (Timmins, 2012). While terminations of pregnancy are frowned upon, some religions accept their permissibility in some situations (FPA, 2016b). Older denominations of Christianity e.g. Roman Catholicism do not view terminations of pregnancy as permissible, however Islam, Sikhism and some Christian denominations e.g. Methodist, accept terminations of pregnancy as necessary where there is a risk to the mother's life (FPA, 2016b). There are some similarities among the religions in that some Christian denominations, Islam, Hinduism and Sikhism believe that children should be the product of marriage (FPA,2016b). Islam and Sikhism also prohibit pre-marital sexual relations (FPA, 2016). The concept of honour (izzat) is predominant among Islam, Hinduism and Sikhism, whereby behaviour that falls outside what is considered the norm or that might affect the honour of an individual or their family, may lead to adverse consequences such as being disowned by parents and families (FPA, 2016; Gill, 2002).

2.4.3 Culture and religion

This next section considers definitions of culture and religion and how they are interlinked. Culture has been defined as shared understanding and practices which are defined by customs, language and geography, and are transferred between generations through socially acquired, learnt behaviour (Napier, et al. 2014; Hickerton, 2005; Harris, 1993). Culture is based on a set of belief systems, values and attitudes (Abdulla, 2018). As depicted by Napier, et al (2014) and Hickerton (2005), culture has historically been viewed as a coherent system with boundaries and shared values

pertaining to a group of people. However more contemporary definitions consider culture to be undergoing adaptation and change, be socially constructed and associate culture with terms such as ‘fluid’ or ‘fuzzy’ (Spencer-Oatey, 2012; Reimer-Kirkham, 2009; Helman, 2007). Matsumoto (1996) identified that culture is not only a social construct, but also an individual construct whereby there are varying degrees to which individuals adopt and engage in the values, beliefs and behaviours of a culture.

There are further difficulties in attempts to provide clear definitions of culture and religion due to the interrelationship between them (Abdulla, 2018; Beyers, 2017; Kleinman, 1980). There is confusion as to whether an aspect of an individual’s life is influenced by culture or religion. Bonney provides a definition in an attempt to separate these terms:

> Culture may be thought of as a causal agent that affects the evolutionary process by uniquely human means. Religion, on the other hand, is considered a process of revelation and contains the concept of the "faithful" who receive the message of revelation (Bonney, 2004, p. 25).

Bonney’s definition suggests that religion is something that is revealed (i.e. through God or other force), and culture on the other hand is man-made. Other authors such as Helman (2007) suggest that culture includes how to behave in relation to supernatural forces and Gods which would normally relate to descriptions of religion. Reimer-Kirkham (2009) acknowledges there are universal difficulties with trying to define religion, whilst Beyers (2017) considers that religion no longer resides within consciousness but instead resides within culture.

It is argued that many individuals use their religion as their cultural identity (Beyers, 2017) such as when an individual portrays their religion outwardly (i.e. through dress). Abdulla (2018) also stated that the distinction between religion and culture is not clear with cultural traditions becoming “religionized” as she terms it, and religious beliefs becoming a part of culture (p.102). Bonney (2004) suggested that cultures tend to be localised and religions are not. With religious dress in Islam for example, there are different variations across the globe varying from a head scarf to a face covering. Many believe their version of cultural dress is mandated by religion, when it is likely they are following local cultural traditions as otherwise arguably the same rules would apply

globally. Bhopal (1998) also found that women in her study found it difficult to separate religion from culture when asked why they held particular values or beliefs. From a personal experience, I have witnessed this first hand where individuals believe that they are following the tenets of their religion when in fact it is something that has been passed down generationally through culture. For example, in Islam, it is believed that religion dictates the need to consummate your marriage on your wedding night, which is not the case within the religious texts.

While the above discussion highlights the difficulties in distinguishing between religion and culture, in the following sections I extend these arguments to consider how individual beliefs and values are learnt (through a process of enculturation) and influenced by wider social processes (through a process of acculturation).

2.4.4 Enculturation

As outlined above, culture plays an important influence on several aspects of people's lives including their behaviour, beliefs, emotions and perceptions (Helman, 2007). Enculturation is the initial process of familiarisation to a specific culture which occurs by growing up within a particular culture or society, and which ultimately leads to the acquisition of the cultural lens of that society (Public Health Notes, 2019; Helman, 2007). Enculturation enables families to teach their children the accepted values and norms pertaining to their culture during childhood (Andrew, 2018; Kottak, 2012; Herkovits, 1948) and has been described as a process of socialisation (Alamilla, Kim, Walker, & Sisson, 2017). The process of enculturation is partially conscious and partially unconscious; e.g. the child will unconsciously learn some of the behaviour they view without necessarily being taught it in a formal manner (Harris, 1993). Enculturation can serve to account for some continuity of culture but cannot necessarily be used to account for the evolution of culture in any given society (Harris, 1993). I will now discuss acculturation which is relevant to my study due to the participants being part of a British, South Asian culture.

2.4.5 Acculturation

One of the earliest definitions of acculturation appears to be that by Redfield, Linton, & Herkovitz (1936) who state:

> acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups. (p.149).

One of the essential components of acculturation is the first-hand contact between individuals of the host culture and the immigrant culture and whereby cultural attributes from the larger society become incorporated (Helman, 2007;Bourhis, Moise, Perreault, & Senecal, 1997; Redfield, Linton, & Herkovitz, 1936). Earlier understandings of acculturation suggest that this process occurs at group level (i.e. among a whole cultural group) however recent conceptualisations emphasise individual changes in behaviour and identity (Alamilla, Kim, Walker, & Sisson, 2017). This aligns with what Matsumoto (1996) (see section 2.4.3: Culture & religion above) described in relation to culture being an individual as well as a group construct. Berry (1990) concurs that acculturation at an individual level is more representative of the experience of immigrants. Acculturation is also not perceived to be an equitable process as children are born to different generations of immigrants. The South Asian cultural traits may therefore already be diluted through the acculturation process of their parents, in which case the enculturation and acculturation of such individuals will be different of that of previous generations (Kim, Ahn, & Alexandra, 2009). Individuals who are first or second generation immigrants are likely to display more traits of enculturation whereby there is more emphasis on the retention of the traditional culture (i.e. South Asian) compared with those who are further removed (i.e. third or fourth generation) and who may demonstrate more acculturation (i.e. British values) (Kim, Ahn, & Alexandra, 2009). As argued by Khan (1994)[5], the differences between first, second and third generations will be very different. Conflicts may arise between the older generations who wish to preserve traditions and those that wish to adapt and change, such as in regard to issues relating to relationships, sex and marriage (Hickerton, 2005). Women trying to balance enculturation and acculturation may publicly hold religious values and beliefs that bear little resemblance to their behaviour and actions conducted privately (Nelson, 2005; Hickerton (2005). Giles (2006) highlights how behaviour is constructed through the culture (or cultures) within which individuals exist. Many individuals may be trying to find a balance between adopting different elements of their cultures in different situations, therefore individual levels of enculturation and acculturation may inform and

[5] First generation immigrants are those who were not born in their host country e.g. they were born in India and immigrated to England whereas second generation are the children of the first generation and were born in England (Algan, Dustman, Glitz, & Manning, 2010).

determine how they view their own individual sexual identity (Sandil, Robinson, Brewster, Wong, & Geiger, 2015). For many women from South Asian backgrounds who were born in the UK, it is possible that acculturation may have influenced their encultured views and beliefs towards sexual health issues (Hickerton, 2005). While earlier authors considered assimilation whereby an individual's original culture is entirely lost to the host culture they settle in to (Gordon, 1964), it is now accepted that the process of acculturation does not mean losing one culture (i.e. the one you were encultured in to) in order to adopt another (Yoon, Hacker, Hewitt, Abrams, & Cleary, 2012). An earlier model of acculturation developed by Berry in 1974 will be discussed in the next section. Conflicts and differences between different cultures may cause issues around coping and social identity (Sam & Berry, 2010) and may affect the British born South Asian woman's behaviour where sexual health is concerned. One culture (i.e. a South Asian one) may state that dating is forbidden yet it may be viewed as the norm in the other culture (i.e. a British one) thereby posing difficulties and tensions at an individual level. These tensions may also affect a woman's experiences in terms of awareness, perception and access to sexual health care, although currently there is little known about this topic.

2.4.6 Acculturation: the early use of a model

Both enculturation and acculturation are relevant when considering the adjustment of ethnic minority groups into a host society (Paterson & Hakim-Larson, 2012). As discussed above, an individual may face difficulties trying to find their own fit or identity among the many cultures they socialised into. A model of acculturation was developed by Berry (1974,1980) which was the first to propose a bi-dimensional process of acculturation. This is where both the immigrant culture and host culture could be identified as independent dimensions. This opposes a unidimensional explanation where the immigrant's own cultural identity is lost in favour of the host culture (Bourhis, Moise, Perreault, & Senecal, 1997). Berry's model was regarded as important as it recognised the importance of minority individuals and multicultural societies (Padilla & Perez, 2003). It also highlights that individuals have a choice in their unique acculturation process whereby some may choose to become more accultured than others (Padilla & Perez, 2003). Berry's model of acculturation comprises two main dimensions in whether it is of value to 1) maintain cultural identity and characteristics and 2) maintain relationships with other groups, which depending on an individual's response could result in four main classifications of acculturation (see Figure 1).

<table>
<tr><td rowspan="4">Dimension 2:
Is it considered to be
of value to maintain relationships with other groups?</td><td colspan="3">Dimension 1: Is it considered to be of value to maintain cultural identity and characteristics?</td></tr>
<tr><td></td><td>YES</td><td>NO</td></tr>
<tr><td>YES</td><td>INTEGRATION</td><td>ASSIMILATION</td></tr>
<tr><td>NO</td><td>SEPARATION</td><td>MARGINALIZATION</td></tr>
</table>

Figure 1: Berry's Model of Acculturation

The four classifications are described as follows:

Integration: Individuals hold a desire to maintain their traditional cultural identity but at the same time adopt features from the host culture.

Assimilation: Individuals lose their traditional cultural identity and adopt the values and beliefs of the host culture.

Separation: Individuals maintain their own traditional cultural identity and do not form relationships with individuals from the host culture.

Marginalisation: Individuals reject both their traditional and host cultural identity, thus lose contact with their heritage and host cultures.

The different classifications of acculturation demonstrate that an individual from a British born South Asian background may have a number of issues in terms of sexual health to contend with. For example, if they fall in to the classification of separation, then they may not engage with sexual health education as they may deem it not relevant. This in turn could have adverse consequences when they do choose to become sexually active. Someone who integrates will potentially be grappling with two sets of competing values and beliefs.

Like the criticisms of the unidimensional model as explained by Bourhis, Moise, Perreault, & Senecal (1997) above, Berry's model could also be criticised in that it does not include movement from one category to another. Ward (2008) questions Berry's model and considers that there will be times when an individual's identity is situational,

and therefore an individual may choose to be viewed as traditional (close to their encultured values) and other times as modern (portraying themself as more acculturated). Baumeister, Shapiro, & Tice (1985) describe an identity conflict where an individual is faced with situational or social influences, which means they are committed to different values and cannot align with a single identity. This suggests that there may be times where an individual may fall within more than one of the classifications of Berry's model. A British South Asian woman may find that publicly she portrays separation, however privately due to her sexual health; she adopts integration or even assimilation.

2.5 Sexual health education

Sex and relationship education was generally taught within Personal, Social, Health and Economic Education (PSHE) lessons during secondary education which was developed locally due to no set curriculum being available (Brook & Personal, Social, Health and Economic Education Association & Sex Education Forum, 2014). It was identified that the previous sex and relationship education based on the 2000 guidance was failing many students and there was a need for change (Brook & Personal, Social, Health and Economic Education Association & Sex Education Forum, 2014). The 2000 Sex and Relationship guidance (Department for Education & Employment, 2000) did not focus on current issues i.e. the influence of digital technology and social media and the role of The Equality Act (Equality Act, 2010). The 2000 guidance did not emphasise how to manage the needs of different learner groups such as those with special education needs, disabilities or those individuals from lesbian, gay, bisexual and transgender groups, which the new guidance does. It has taken 9 years following the publication of the Equality Act for new guidance to be produced. From 2020, Relationship Education became compulsory from primary school age (Long, 2019; Department of Education, 2019).

The new guidance involves the teaching of relationship education at primary school level and relationship and sex education at secondary school age from 2020 (Department of Education, 2019). Sex education is not compulsory at primary school age but relationship education is, with the focus being on family relationships, caring friendships, respect, online relationships and staying safe (Department of Education, 2019). It is up to the primary schools however, if they wish to teach aspects of sex

education as many currently do (Department of Education, 2019). The issue of the rights of parents to remove children from particular lessons is included in the new guidance. Parents retain the right to request to withdraw their children from sex education sessions (not health education or relationship education) and for faith schools to continue to teach such subjects within the remit of their religions under the new guidance (Long, 2019). The new guidance emphasises that before such a request is agreed, it would be good practice for the head teacher to have a discussion with the parents and also the child (Department of Education, 2019). The intention for the secondary school education guidance is to be relevant to the context of today's society by including topics such as consent, online rights and responsibilities, abuse, grooming, forced marriage, honour based violence and female genital mutilation (Whittaker, 2019). Reproductive health will also form part of secondary school Relationship and Sexual Education lessons with topics to include reproduction, fertility, contraception, sexually transmitted infections, sexual pressure, pregnancy, miscarriage and choices in relation to pregnancy (Whittaker, 2019). Some of the content will be delivered through subjects such as science, physical education (PE), citizenship and computing however not all relationship and sexual education content will be covered as part of the national curriculum and therefore it is up to the secondary school to decide how to deliver this content (i.e. through PSHE lessons or through another model).

2.6 Sexual health service provision

In this next section, sexual health services and sexual health care in the UK; this is followed by the implications of culture on health care.

Sexual health provision has seen many changes in almost a century when in 1921, the first UK birth control clinic was introduced (FPA, 2011). Family planning provisions were not included as part of the NHS and therefore Family Planning Association clinics were run on a voluntary and private basis for married couples (FPA, 2011). It was not until 1960 when the first evening session for unmarried women was introduced by Helen Brook at one of her family planning clinics in London and in 1964 she opened the first Brook Advisory Centre for young, unmarried women (FPA, 2011). By 1970 anyone regardless of marital status could receive advice and treatment from Family planning Association clinics and in 1974 all Family Planning Association clinics were handed over to the NHS and their goal of free contraception to all was achieved (FPA, 2015).

Health service funding cuts between 1983 and 1987 threatened sexual health services and led to a reduction of many sexual health clinics and services (FPA, 2011). The cuts continued and service reconfiguration whereby Primary Care Trusts became responsible for secondary care such as family planning services in 1998 led to some services being integrated with other services (FPA, 2011). Some contraceptive and sexual health services were integrated with genitourinary medicine clinics that provided contraceptive provision and sexually transmitted infection screening and management (Robinson, 2009) and were no longer held regularly in local areas (Shawe, Mann, & Stephenson, 2009). These changes led to many women accessing their GPs for their basic contraception needs (due to a lack of knowldege of other services and also the stigma associated with genitourinary medicine clinics), which placed further demand on GP services (Shawe, Mann, & Stephenson, 2009).

Sexual health services in the UK are provided through the NHS to individuals regardless of their background e.g. ethnicity, age, religion, marital status etc (National Health Service [NHS], 2018). Sexual health clinics are designed to be confidential and can provide information and advice on a wide range of sexual health issues (NHS, 2018). Sexual health services which are also known as sexual and reproductive health services, include contraception and sexual health clinics in the community (CaSH), integrated genitourinary medicine and sexual and reproductive health services and, young people's services e.g. Brook advisory centres[6] (NHS, 2018; NHS Digital, 2018a; Loudon, et al., 2012). Other sexual health services are provided in hospital outpatient clinics, within GP practices, private clinics, online services and within pharmacy settings by a range of health care professionals not limited to but including nurses, midwives, GPs, health visitors and pharmacists (NHS, 2018; NHS Digital, 2017). These services include a range of provisions such as sexual health advice and treatment, chlamydia screening, contraception provision, pregnancy related care and support, abortion -related support and care, and gynaecological treatment (NHS Digital, 2017a; Public Health England, 2014). Some sexual health services can also provide more specialist services e.g. cervical screening vaccinations and services for individuals who may have been sexually assaulted (NHS, 2018).

[6] Brook Advisory clinics are established throughout the country and are a service where young people who are under 25 can seek advice and information on a range of health related issues which include contraception, sexually transmitted infections and pregnancy. The clinics are named after the founder who established the service for young women in the 1960s, who were in need of support and were unable to access contraception from anywhere else (Brook, 2018).

The move to improve the delivery of sexual health services through the use of an integrated model of sexual health delivery was promoted through national policy (DH, 2013, 2010). This model aims to provide an open access service, with extended opening hours, where the sexual health and contraceptive needs of patients could be met within one site and where possible, by one health care professional (Public Health England & Department of Health & Social Care, 2018). Despite the recommendations, the availability of integrated sexual health services varies nationally. Integrated care genitourinary medicine clinics have faced challenges in recruiting staff who have been trained in both contraception as well as the diagnosis and treatment of sexually transmitted infections. The problems with an integrated model are further compounded where gynaecological services or reproductive health issues are dominated by genitourinary issues, leading to lengthy waits for appointments and creating barriers to access (Robinson, 2009). Other concerns levied towards the integrated model are that it has led to the demise of certain services such as dedicated family planning clinics. Brook, Salmon, & Knight (2017) report how sexual health specialities in the UK are in a state of flux and therefore practitioners need to develop an accessible service that meets the needs of individuals. The need for sexual health awareness, information and services that are appropriate to groups where sexual health outcomes may be poor have been highlighted (Public Health England, 2015; Department of Health, 2010; Medical Foundation for AIDS & Sexual Health [MedFASH], 2005). The stigma that is associated with genito-urinary medicine clinics may make it less accessible for women from a South Asian background and in particular those that are unmarried. It has been identified that women from a South Asian background tend to use local family planning clinics (Dhar, et al., 2010). The demise of family planning clinics for women from this background, may therefore have created barriers to knowledge and to the access of suitable services (Dhar, et al., 2010).

Further challenges were likely to be experienced as the government announced public health spending cuts of approximately 9.7% by the year 2020 which resulted in further cuts among sexual health services (Association of Directors of Public Health, 2017). Robertson (2018) highlights that primary prevention (i.e. sexual health advice and promotion) is usually the first to experience cuts as opposed to diagnosis and treatment. Sexual health promotion has been defined as "*activities which proactively and positively support the sexual and emotional health and wellbeing of individuals, groups, communities and the wider public"* (Medical Foundation for AIDS & Sexual Health [MedFASH], 2005, p27). The promotion of sexual health therefore aims to

reduce inequalities, address the needs of the local communities and to reach marginalised groups (Medical Foundation for Aids & Sexual Health, 2005). It is argued that effective commissioning of sexual health services should focus on understanding wider determinants of health i.e. culture and gender (Public Health England, 2014); it should provide information, support and should allow individuals to take control over their own sexual health (Medical Foundation for AIDS & Sexual Health, 2005) thus allowing individuals to be informed about their own health choices and needs. However, despite knowing the importance of primary prevention and health promotion, further public health cuts as highlighted above, may negate any efforts to improve sexual health and wellbeing. The next section focuses on the implications of culture on the delivery of health care.

2.6.1 The implications of culture on sexual health care

Sandfort & Ehrhardt (2004) and Sutherland (2001) emphasised the need to take cultural practices and lifestyle into account when reviewing health care services for individuals from ethnic minority groups. MedFASH (2005) recommended the need to consider culture and to work in partnership with local communities and individuals to meet their public health needs and to ensure that sexual health services address the needs of women at all stages in their sexual lives. It has been emphasised that sexual and reproductive health services should involve service users and the public at all stages from development to evaluation (Faculty of Sexual & Reproductive Healthcare [FSRH], 2016). Health care practitioners need to be aware of social determinants e.g. culture and religion and aim to have a holistic understanding of patients within their community context (Brook, Salmon, & Knight, 2017). NICE (2016) briefly acknowledged that religion and culture may influence women's choices of contraception and therefore health care practitioners should provide women with information about all methods to attempt to meet their needs. It is important for health care professionals including nurses to recognise that religion is often interwoven into individuals' daily lives and can serve as a moral code (Reimer-Kirkham, 2009). Although Curtis, Hoolaghan, & Jewitt (1995) stressed that it is important to remain culturally sensitive as an individual's beliefs may not match their actual behaviour. *"Each woman's interpretation of her culture will be unique"* (Nelson, 2005, p. 11). As stated by Hordern, (2016), it is important to be aware that an individual's beliefs may not always reflect the norms of the culture or the religion they identify with.

The Global Advisory Board for Sexual Health and Wellbeing (2018) advise that both sexual and reproductive health providers and their patients may face difficulties discussing sex and related issues due to taboos around sexuality that exist in many cultures, which may lead to poor consultations where the health care professional simply focuses on the problem and a solution rather than taking a holistic approach and using the opportunity to educate and promote sexual health. They emphasise the need for the sexual health triangle (sexual health and wellbeing, sexual pleasure and sexual rights) to be commonplace in service delivery and thus alligned with the holistic concept of sexual health as defined by the WHO (2006). Health care workers should be equipped to provide accurate, balanced sex education, including information about contraception and condoms so that young people have the means to protect themselves, provided within a context of healthy sexuality, without stigma or judgment (Morris & Rushwan, 2015). It is therefore relevant to consider sexual health services and promotion. In the next section I discuss the purpose and remit of undertaking a review in line with the methodological approach adopted for this study (constructivist grounded theory approach-see Chapter 3). I then present the findings of this initial literature review which was conducted before data collection commenced.

2.7 The literature review in grounded theory

There appear to be varying opinions surrounding when to undertake the literature review when undertaking a grounded theory study. Glaser & Strauss (1967) advocated delaying the literature review until data analysis had begun to avoid other literature generating preconceived ideas that would influence how the data from the study was interpreted. However, Strauss (as cited in Charmaz, 2014), later acknowledged that grounded theorists would always have prior pre-understanding prior to commencing their research (Charmaz, 2014). Charmaz (2006) also recognised the tensions that exist in relation to the use of a literature review with grounded theory. She acknowledged the need to delay the literature review so as to not stifle creativity or lead the researcher to ideas found in the literature rather than what emerges from the data. Charmaz (2014) considered it appropriate to undertake a literature review once the data collection had been completed so that the focus of the literature review is relevant to the study focus. She also states that you can make links between your grounded theory study and the literature and also how your study contributed to any gaps in the literature. However she did acknowledge that grounded theorists would be familiar with the literature around their field of study. She highlighted that the

requirements to register on a programme of study or for a research grant will undoubtedly have meant that the researcher has engaged with the literature in some form or other to position the study and its unique contribution. Charmaz (2006) highlights that researchers should remain critical and reflexive towards the literature, as they begin to review it.

I made a decision to carry out an initial literature search to assess whether any similar studies had been undertaken and to help inform the aims of my study and the use of Charmaz's Constructivist Grounded Theory (justification for adopting this approach is detailed in section 3.4.4). A more formal and structured scoping review was then undertaken after I had completed data collection (see Chapter 9). I will now present how I carried out this initial literature search.

2.7.1 Identifying the literature

A preliminary literature search was carried out in 2012 and then re-run between December 2013 and March 2014 to elicit any studies (quantitative, qualitative or mixed-methods) that had been undertaken that explored sexual health issues among British born South Asian women. This initial literature search was supported by the Faculty Librarian and was undertaken with his guidance. It consisted of searching multiple databases using the EBSCO platform and a separate search using MEDLINE (see Appendix 1). I only considered papers published from 2003 onwards (10 years from when I began conducting the initial literature search) as I wanted papers that were up to date and relevant. Papers that did not meet these inclusion criteria were excluded.

My initial literature search provided me with an overview of the research available, albeit limited and ensured that my research ideas were still worth pursuing.

2.7.2 Summary of relevant studies

Overall, four papers were identified (three quantitative and one qualitative). While full details of these and other literature identified is discussed in Chapter 9 (Scoping review), Table 1 below provides an overview of the four papers which were deemed relevant as part of this initial literature search. Further details and considerations are presented below this table.

Author	Year	Title	Sample population	Study Location	Aims	Key findings
Griffiths, C; Johnson, A M; Fenton K A; Erens B; Hart GJ; Wellings K; Mercer C H (Quantitative)	2011	Attitudes and first heterosexual experiences among Indians and Pakistanis in Britain: evidence from a national probability survey	Britain with a multistage probability cluster design, with over sampling in Greater London	British Indians and Pakistanis (with approximately half the respondents reporting they were born in the UK) Indians n=393, Pakistanis n =365 aged 16-44	To compare attitudes, experiences of learning about sex and first intercourse among Indians & Pakistanis in Britain	• Religion was regarded as very important for Pakistanis and Indians • Pakistanis held more conservative attitudes and were more likely to be married at first sex • Women were less likely than men to engage in pre-marital sex • Pakistani and Indian women were more likely to not use contraception at first sex • School was the main source of sex education for Pakistani and Indian women • Pakistani and Indian women reported a lack of discussion around sex with parents
Griffiths Catherine; French Rebecca S; Patel- Kanwal Hansa; Rait Greta;	2008	'Always between two cultures': young British Bangladeshis and their mothers' views	Inner-city London Borough	Young British Bangladeshis and mothers. 25 x mothers, 31 x young men aged 16-20, 5 x young	Not clearly stated	• Mothers felt their children were always between two cultures and had concerns around pre-marital sex • Mother hoped their children would avoid any sexual temptations • Beliefs and attitudes around pre-

(Qualitative)		on sex and relationships		women aged 16-18		marital sex among young men varied • Some young men reported peer pressure to have sex • Young women reported sexual pressures came from their partners • The consequences of pre-marital sex were considered grave for women rather than men • Mothers felt it was the role of schools to deliver sex education and that it should not be discussed at home • Young people described school sex education as a joke but were eager to learn and wanted a safe place to receive sex education •
Saxena Sonia; Copas Andrew; Mercer Catherine; Johnson Anne; Fenton Kevin; Erens Bob; Nanchahal Kiran; Macdowall Wendy; Wellings Kaye (Quantitative)	2006	Ethnic variations in sexual activity and contraceptive use: national cross-sectional survey	Britain - National Survey of Sexual Attitudes and Lifestyles 2000	6932 women aged 16-44 years residing in Britain	To compare data on contraceptive use in relation to reported sexual activity in women from different minority ethnic groups	• Contraceptive use was significantly lower among ethnic minority groups compared to White women • In married and co-habiting women, lower contraceptive use was reported by Indian and Pakistani women • White women were more likely to use hormonal contraception or permanent methods compared with the other ethnic minority groups • Among single women, contraception use was highest among Indian women
Fenton Kevin; Mercer Catherine; McManus Sally; Erens Bob; Wellings Kaye;	2005	Ethnic variations in sexual behaviour in Great Britain	Britain - National Survey of Sexual Attitudes	11161 men and women aged 16-44, resident in Great Britain	Investigate the frequency of high-risk sexual behaviours and adverse sexual	• Indian and Pakistani men and women reported fewer sexual partnerships • Indian and Pakistani men and women reported fewer sexual partnerships and a lower prevalence of STIs

Maddowall Wendy; Byron Christos; Copas Andrew; Nanchahal Kiran; Field Julia; Johnson Anne (Quantitative)		and risk of sexually transmitted infections: a probability survey	and Lifestyles 2000	with additional sampling of 949 Black Caribbean, Black African, Indian and Pakistani respondents between May 1999 and Feb 2001	health outcomes in five ethnic groups in Great Britain	• The findings suggest a need for targeted and culturally competent prevention interventions

Table 1: Summary of studies included from initial literature search

All four papers were undertaken in the UK. Collectively they represent the views of 18912 participants. The ages ranged from 16-44 when stated. The one qualitative paper also included the views of mothers but their ages were not detailed. The quantitative studies (n=3) used surveys to collect data. The qualitative paper (n=1) used focus groups.

In summary, religion was regarded as important and influenced beliefs, e.g. in regard to whether individuals would use certain types of contraceptives or have sex before marriage. Despite the influence of religion and the community, many people did discuss experiences of pre-marital relationships (Griffiths et al., 2011, 2008). Education into sexual health was viewed as important and school was identified as the main source of sex education (Griffiths et al. 2011, 2008). Griffiths et al (2011, 2008) found that sexual health was not something to be discussed in the home environment among South Asian groups (Griffiths et al., 2011, 2008). Young people highlighted that they wanted a safe place to learn about sex and relationships and identified challenges to receiving such education outside the school environment (Griffiths et al., 2008). Although, in the study by Griffiths et al. (2008), participants highlighted that school-based sex education was inadequate.

Young men reported feelings of peer pressure in relation to losing their virginity, however young women identified the pressure came from their partners (Griffiths et al., 2008). The study by Griffiths et al. (2008) highlighted that the consequences of pre-marital sex were considered graver for women than boys. In addition, Griffiths et al. (2008) reported how young people felt their actions were scrutinised and under the watch of the local community.

The studies also highlight differences in sexual beliefs and contraceptive use among different ethnic minority groups (Griffiths et al., 2011, 2008; Saxena et al., 2006; Fenton et al., 2005). In a quantitative study, undertaken by Fenton et al. (2005), Indian and Pakistani men and women reported fewer sexual partnerships, later first intercourse, and substantially lower prevalence of diagnosed STIs than other groups (i.e. White, Black populations). In the national survey conducted by Saxena et al. (2006) the findings showed lower contraceptive use among women from all ethnic minorities compared to White women but this was found to be dependent on marital status. Saxena et al. (2005) stated that married South Asian women reported lower contraceptive use. Their findings also showed that overall use of contraception was lowest in Pakistani women and was highest in White women. (Saxena et al., 2006). It is

important to note that this may be due to more women from South Asian backgrounds being married in the study and therefore choosing not to use contraception.

2.7.2.1 Reflections on literature review

Overall, I learnt that by considering papers that were solely focused on British or British born narrowed the hits and had the potential to miss studies where British born South Asians were also part of the study. I also realised that as there was limited research available that it would be appropriate to widen my date range when carrying out the formal scoping review in Chapter 9 to ensure I captured as many relevant papers as possible.

Two key gaps were that it was not always clear whether the participants were British born, and many studies considered ethnic minority population needs as a whole. My study aimed to address this gap by only focusing on British born South Asian women.

Another observation was that studies collected data from a wide age range of participants where their experiences may differ and their needs may be varied. Whereas my study aimed to explore the perceptions, awareness and experiences from participants with a smaller age range e.g. 18-25 years. There was also a methodological gap as the majority of the studies were quantitative. My study aimed to provide in-depth, rich qualitative knowledge to understand women's perceptions, awareness and experiences.

From undertaking this initial literature review, I identified that there was very little research available specifically on British born South Asian women and sexual health. The four studies did allude to the importance of religion and culture on sexual health, but as only one of the studies was qualitative, these insights were restricted and none of them specifically focused on wider cultural, religious and social issues associated with enculturation and acculturation. Therefore, the extant literature offered limited insights into how and why sexual health is experienced in this population group.

I therefore aimed to address these knowledge gaps, by undertaking an in-depth qualitative based study to understand women's perceptions, awareness and experiences of sexual health and sexual health care provision, and how these were impacted by cultural, religious and wider social factors. The paucity of research studies

also provided a rationale for undertaking a constructivist grounded theory study (discussed further in Chapter 3).

The literature from this initial literature search was then left to lie fallow as advised by Charmaz (2014). As data collection commenced at a later stage in my study, and I began to analyse the data, I carried out a formal scoping review in line with Charmaz's (2014) methodological approach and from discussing my study with her at a workshop in 2018[7]. The results of this scoping review are presented in Chapter 9.

2.8 Rationale for the study

The global strategy for women's, children's and adolescents' health has identified sexual health as one of its objectives within its vision (Every Woman Every Child, 2015). It aims to create an enabling environment where women can be supported across the life course with issues concerning adolescent health and development, sexual and reproductive health issues and women's health issues (Every Woman Every Child, 2015). The need to improve service access for ethnic minority groups including those from a South Asian background through an increased understanding of sexual behaviours and beliefs has been identified (Griffiths, Prost, & Hart, 2008a). Research with young adults from ethnic minority communities in relation to sexual health has been identified as a priority for many years (Department of Health, 2013, 2004, 2001; Social Exclusion Unit, 1999), yet little research has emerged. The Association for Young People's Health (2015) stated that although there is a lot of information available on sexual health, there are many challenges faced in the collection of regular and rigorous information and data. Some potential challenges experienced by British born South Asian women have been discussed within section 2.3.3 which includes lack of sexual health education, limited opportunities for discussions around sexual health, not using contraception which places individuals at risk of unwanted pregnancy and sexually transmitted infections. The continued stigma, religious and cultural beliefs may pose difficulties for women from a South Asian background to openly discuss their sexual health needs and experiences. Enculturation and acculturation may also influence a woman in relation to sexual health. This study focuses on British born South Asian females who have been encultured through a South Asian culture but through social interaction and living with and among the

[7] In July 2018, I was able to attend a two day constructivist grounded theory workshop with Kathy Charmaz at Lancaster University. As part of the workshop, we had the opportunity to review some of our own data and discuss it with Kathy Charmaz. (Appendix 2).

dominant British culture may also become acculturated to varying degrees to the British culture. Accessing sexual health services and advice may therefore be difficult for individuals from this population group as sexual activity is forbidden for unmarried couples. The limited insights available on sexual health with this cultural group as identified via the initial literature review in this chapter strengthened the need for this study.

The aim of my study was to explore the perceptions, awareness and experiences of sexual health and sexual health service provision among British born South Asian women. This study focuses on British born participants thus exploring cultural tensions and difficulties these individuals face as they balance cultural issues in relation to sexual health. The need for sexual health services to be tailored to meet the groups of individuals in local areas has been identified. The voices of women from South Asian communities are often absent from research and policy. I considered this study would provide in-depth insights into a sensitive and taboo area and help inform needs-led service provision. The objectives of this study are:

- To elicit participants' awareness of sexual health issues and sexual health service provision
- To explore the participants' perceived needs, expectations and concerns related to sexual health and accessing sexual health services,
- To gather in-depth insights into the participants' experiences of sexual health and sexual health service provision,
- To consider how culture, religion and wider social influences, impact on women's understanding of and access to sexual health provision and
- To develop a theoretical framework to illuminate and interpret the findings.

2.9 Conclusion

In this chapter I provided background information on sexual health, related epidemiology and discussed religion and culture. I also described enculturation, acculturation and presented a model of acculturation which serves to explain differences among individuals who are influenced by acculturation. I also provided some background information on the implications of culture on sexual health, sexual health services and education. My initial literature review was also presented. This was in line with a constructivist grounded theory approach (which will be discussed in detail in the next chapter) to identify any research already undertaken and to ascertain

whether my study had the potential to produce a new contribution in knowledge. In the following chapter, I consider my theoretical position and methodology taking into consideration my epistemological position.

3.0 Theoretical positioning and methodology

3.1 Introduction

In this chapter I introduce the theoretical positioning and the methodology of the study. My epistemological and ontological positions are explored, together with a discussion concerning the suitability of interpretivism as the theoretical approach. Culture is also discussed as it is a key consideration in my study in terms of how cultural beliefs and values influence individual's constructions of reality. The justification for adopting a grounded theory methodological approach is then provided. I describe the three major factions of grounded theory, and provide a rationale for the selection of Charmaz's constructivist grounded theory approach.

Researchers are required to choose a research paradigm that resonates with their own beliefs around what the nature of reality is (Mills, Bonner & Francis, 2006). A paradigm can be viewed as a set of shared beliefs or values (Hughes & Sharrock, 1997). Carter and Little (2007) provide a paradigmatic framework for qualitative research which consists of three steps; epistemology, methodology and methods. Crotty (1998) advocates a further step after the epistemology which is the theoretical perspective. This four – stage framework has been adopted in this study to structure and present the information. The first three stages of Crotty's framework namely the epistemology, theoretical perspective and the methodology are presented in this chapter. The fourth stage (the methods) are discussed in Chapter 4.

3.2 Epistemology and ontology

The term 'epistemology' is derived from the Greek 'episteme' which means knowledge and 'logos' which means theory (Grbich, 2007). Epistemology has been defined as the philosophical study of knowledge and a way of understanding and explaining how we know what we know (Crotty 1998; Epstein, 2012; Moses & Knutsen, 2012) . Epistemology relates to our beliefs about how we might discover knowledge about our world. Epistemological issues are commonly regarded as the ones that need to be addressed first to pave the way for sound methods of inquiry ahead of the empirical research itself (Hughes & Sharrock, 1997). It is therefore judged to be important that a researcher understands their epistemological position prior to data collection and

analysis. Ontology is linked to epistemology and is concerned with reality and the nature of existence (Crotty, 1998). In order to arrive at an ontological position, it was important to consider my own worldview and that of prospective participants. There are different epistemological and ontological perspectives which include objectivism and constructionism (Crotty, 1998). Objectivist perspectives hold that reality is independent of consciousness and truth and meaning exists in an external world (Gray, 2014). I considered a reality independent of people's experience was naïve. I believe that it is not always possible to have one true account of a situation and that 'truth' is socially and individually situated (Parahoo, 2014).Constructionism provides an opposing perspective in that meaning is constructed through an individual's interactions with the world and not simply discovered (Gray, 2014). I was aware that while religion provided a 'reality' for some individuals from South Asian communities, other sociocultural influences play a key role. Constructionism has been adopted for this study, in particular social constructionism. Social constructionism is an epistemology that rejects the notion of a universal or objective truth waiting to be discovered. It perceives social reality as the product of interactions between groups and individuals (Gonzalez, 1994; Lynch, 1997; Giddens & Sutton, 2013). Berger and Luckman (1967) describe how our reality is one that is shared with others in an intersubjective world. Many of the truths by which we live are created collectively by societies (Gordon & Silva, 2015). Social construction is highly relevant to my study and as highlighted in Chapter 2, religion and culture influence an individual's behaviour. It is not an objective reality but one that is co-constructed with those in their social worlds.

This study is closely aligned with social constructionism as it focuses on British born South Asian females who have been encultured through a South Asian culture and accultured into a British culture. Enculturation and acculturation, while discussed in more detail in Chapter 2, both refer to a socialisation process. It is concerned with how culture and religion influence people's (i.e. women's) lives including their behaviour, beliefs, emotions and perceptions as well as their construction of reality (Helman, 2007; Crotty 1998). Acculturation is a process of socialisation that takes places when there is a meeting of two cultures. It is argued that the cultures we are a part of, influence how we behave and interpret our life worlds (Giles, 2006). The meanings we construct are therefore relative to the cultural context in which we reside. Some individuals may undergo acculturation more than others living in the same society. Individuals also differ in how they change during the acculturation process in terms of which cultural norms they adopt or value (Sam & Berry, 2010) (also see section 2.4.5). Conflicts and

differences between the cultures may also cause issues around social identity (Sam & Berry, 2010). It is within this context, I planned to understand the realities, tensions and challenges that young women face in relation to sexual health.

3.3 Theoretical perspectives

The two key theoretical perspectives when undertaking research are positivism and interpretivism. While interpretivism stems from constructionism and therefore the most suitable perspective for this study, an overview of both paradigms have been provided as follows. I also consider feminism and discuss why it did not align well with my adopted theoretical perspectives.

3.3.1 Positivism

Positivism aligns with an objective epistemological perspective. Crotty (1998) highlights that positivism offers the assurance of accurate and unambiguous knowledge of the world. From a positivist viewpoint, objects have meaning before and independent of any consciousness of them (Crotty 1998). Features of positivism include objectivity and the fact that only measurable phenomena exist (Ross, 2012). It views the world as a system that is ordered and made up of events which can be observed, that have an objective reality and operate in a systematic way (Stainton-Rogers, 2006). The positivist conception of knowledge places emphasis on observation and empirical method (Hughes & Sharrock, 1997). Positivists subscribe to the principle of verification (Moses & Knutsen, 2012). This means that statements should be able to be tested and verified. A systematic process is followed and the researcher remains distant and does not interact with the data as this is viewed to create bias which in turn could affect the truth of the findings (Ross, 2012). Hughes & Sharrock (1997) discuss limitations of positivism in the social sciences which include the need for testing and verification which are not always possible with social research. Moses & Knutsen (2012) highlight that positivists view statements that cannot be subjected to testing as meaningless, leading to strong criticisms of this perspective. Grbich (2007) states that despite knowing that many of our best scientific advances have occurred through a positivist perspective, changes in scientific knowledge around the twentieth century created critics who queried the probability that science could indeed provide all the answers. Positivism perceives that only factual knowledge gained through measurement is

trustworthy, however, other authors argue that this perspective fails to consider meanings and cultural interpretations of particular phenomena (Ross, 2012).

3.3.2 Interpretivism

Interpretivism assumes that no objective knowledge exists that is independent of thinking (Grbich, 2007). The interpretive theoretical paradigm does not depend on a predetermined hypothesis and theory is built upon the understandings of those involved in the study (Pearson, Vaughan, & Fitzgerald, 2005). In contrast to positivism, interpretivism generally uses qualitative methods to explore and identify interpretations of the social life-world that are culturally derived and historically situated (Crotty, 1998). Interpretivists perceive reality to be societally and socially embedded (Grbich, 2007) and involve a search for meanings, rather than facts (Epstein, 2012). The premise of interpretivism is that we all interpret phenomena in different ways and therefore there are multiple realities; rather than absolute truths (Berger & Luckman 1967; Ross, 2012). From an interpretivist perspective subjectivity is accepted on both the part of the researcher and the participant. One of the major characteristics of interpretivism is to focus on exploring how people interpret and understand their experiences in the world they live in, and how the contexts of situations within social environments have impacted on the understandings that have been constructed (Grbich, 2007).

A quantitative positivist perspective would not be suited to my study. It does not aim to establish an absolute truth through objective, validated measurement but rather to understand how meaning is constructed through interactions. Gergen(1999) highlighted that when exploring other cultures, we are drawn in to considering similarities and differences and we are fascinated by what we share and what is alien. Such distinctions are drawn from our own vernacular, the convention of constructions that we use to make sense of the world. This, in turn, can lead us to considering our own existence and how we construct the world (Gergen, 1999). As I share a similar background to that of the participants in relation to enculturation and acculturation, this approach was highly relevant.

3.3.3 Feminism

I also considered a feminist theoretical perspective as my study concerns the perspectives and experiences of women. Feminism comprises different social, political and ideological perspectives that generally seek to identify the various factors that influence equality of the sexes. However, in my study, the aim was not to understand issues around equality or power, but rather how wider cultural and social factors influence women's behaviours and beliefs in relation to sexual health. I therefore felt interpretivism was more relevant. Crotty (1998) asserts that feminist insights stem from and are grounded specifically from a feminist viewpoint. Religious rules surrounding sexual activity (as discussed in section 2.4.2), concern both men and women i.e. pre-marital sex is forbidden for both men and women in many South Asian religions. Biever, De Las Fuentes, Cashion, & Franklin (1998) identify that feminists may embrace social constructionism and interpretivism and acknowledge the heterogeneity of the experiences of women to include influences such as race, religion, age and education. Feminist perspectives place emphasis on locating the source of women's oppression and the strategies advocated for change to occur (Forbes, et al., 1999; Gagnier, 1990). My focus, however, was on how religion and culture influence, rather than oppress women. It has been acknowledged that feminists are likely "to take a political stance regarding the necessity of changing sexist behaviour and environments that are viewed as contributing to the marginalization of women" (Biever et al., 1998, p. 171). Feminist perspectives criticise other perspectives for not adopting a more political stance or advocating for oppressed groups such as women and in some constructions, allowing men to be viewed as dominant and privileged (Biever et al., 1998).

The different movements within feminism are termed waves and are somewhat aligned to different time periods (however there is overlap and some feminists align themselves to particular waves over others) (Delao, 2021; Breines, 2007; Simons, 1979). First wave feminism during the late 19th century was characterised mainly through the suffrage movement and the women's right to vote (Delao, 2021). While White women eventually gained the right to vote in 1920, women of colour living in the United States of America (USA) would not gain this right until all people were guaranteed the right to vote 45 years later. There are many critiques of earlier waves of feminism (first and second waves), including their portrayal of being a White, middle-class movement (Breines, 2007; Simons, 1979). Many minority women have also highlighted that a factor that inhibits them developing a more feminist consciousness is racism (Simons,

1979). Simons (1979) highlighted that there has been criticism in that feminist theory was seen to be ethnocentric and there was a clear lack of attention given to minority women. Simons (1979) further emphasised that there was a need to recognise that patriarchy, as portrayed in early feminist theory, may distort the experiences of women from different cultures. Some early wave feminists who were also political activists and were deeply influenced by the civil rights movements have accepted that they failed to create a true interracial feminist movement (Breines, 2007). Breines (2007) highlighted how Black, female civil rights activists were less concerned with sexism compared with White women as racial issues were deemed critical (life and death situations) and paramount over issues of gender. The situations and contexts around this time were complex and interracial connections as we know them today were non-existent which compounded the issue of feminism and racism (Breines, 2007).

The next wave of feminism saw some similarities and some development. The second wave focused on issues such as pay equality, female sexuality, reproductive rights and domestic violence (Delao, 2021). Thompson (2002) identified how much of the history on second wave feminism which emerged in the 1960s, was again concerned with being White, living in the USA, and how it continued to marginalise the views of women of colour. Thompson (2002) argued that while more views of militant, ethnic minority women and the stories of White, anti-racist women were central to this wave, these are less publicised. During this wave, it was identified that although there was some effort to encompass racial justice, this was not viewed as important as gender issues (Delao, 2021). Second wave feminism raised many debatable issues including some related to sexuality and found feminists to hold opposing views (Snyder-Hall, 2010). Some feminists viewed issues such as heterosexuality and sex work as gender oppression while others saw opportunities for empowerment and pleasure (Snyder-Hall, 2010).

A more recent third wave of feminism developed from the 1990s exhibited notions of pluralism and self-determination that sought to reunite gender equality and sexual pleasure (Snyder-Hall, 2010). This third wave of feminism was viewed as a development of the work undertaken in previous waves (Page, 2006). Third wave feminism sought to redefine femininity and challenged female heteronormativity (Delao, 2021). In a study undertaken by Page and Yip (2012), they found that among the Muslim, Hindu and Sikh religions, heteronormativity was viewed as a cultural ideology and the family and cultural communities acted as agents on emphasising and legitimising heteronormativity. The third wave was viewed as very different from the

second wave as it tried to celebrate diversity across class, race and sexual orientations (Delao, 2021). Intersectionality began to form as there was recognition that individual characteristics e.g. race, gender and class, 'intersect' with each other and overlap (Delao, 2021). This wave of feminism focused on abolishing gender-role stereotypes and addressing limitations of previous waves to include women with diverse, racial and cultural identities. The third wave has gained more importance through popular culture however it has been recognised that more attention needs to be given to it, in particular with how the third wave of feminism links with key structures in society e.g. education systems, religion and politics (Page, 2006). McPhillips and Page (2021) raised concerns about the relationship between secular and religious structures on issues affecting women. Page (2006) identified that there was a lack of empirical research around third wave feminism and religion and identified that her own work on religion and feminism provided some insight, albeit limited. This is supported by Aune (2011) who also identified that the third wave of feminism began to see some questions around feminism and religion emerge, but many of the research questions being asked were viewed as problematic. For example, Bracke (2008) critiqued the neglect of religion among secular feminists and also how religion is viewed as oppressive. Aune (2011) stated that as many western feminists have rejected religion, they fail to recognise the experiences of millions of women who are religious globally. Aune (2011) undertook a study of religion and spirituality among feminist participants in the UK. She found that religion was only a minority concern for feminists due to most being atheist, and only a small percentage stating they belonged to a major world religion (e.g. Christianity, Islam, Judaism) (Aune, 2011). It appeared that secular feminism began to emerge in the second wave and continued to gain credence in more recent waves (Aune, 2011). Braidoti (2008) claimed that aside from the work of religious feminists, the majority of European feminism appeared to be secular and this was problematic as secularism does not address the complexities of religions and their place in the lives of women. Aune (2011) highlighted that one of the most significant problem in secular feminism surrounds misunderstanding Muslim women. . A study undertaken by Page and Yip (2016) found that contrary to the popular belief that Muslim women faced oppression, a high percentage of the Muslim women in their study believed their religion to be gender-equal. Mahmood (2005) argued that the agency of women in many Islamic groups can be found in places that secular feminists perceive it to be absent. Feminist secularity has led to many women who do belong to religions to refuse to use the term 'feminist' to describe themselves (Aune, 2011). This is supported by Wadud (2006) who identified that although many Muslim women

believe their work (i.e. improving conditions for women) to be feminist, they refuse to describe themselves as feminists on the grounds of their religion and ethnicity.

Delao (2021) identified that a fourth wave of feminism has been developing over recent years but as it is still developing, it is difficult to define. Delao (2021) believes the current wave to be digitally driven, characterised by action-based viral campaigns and movements like #MeToo.

In relation to my study which is concerned with culture and religion as well as women, it is apparent that religion and feminism is a contentious area (Aune, 2011; Page, 2006; Wadud, 2006). Page (2006) emphasised that very little had been done to place religion on the feminism agenda. Furthermore, authors such as Wadud (2006) emphasise how some religious women of colour do not associate with 'feminism' due to being associated with beliefs from secular origins. Many women belong to religions and observe and accept the differences between men and women, without any feeling or belief that they are being oppressed (Massoumi, 2015; Rinaldo, 2014). Despite belonging to a religion with its set of rules and doctrines on how to behave, I was interested in how women may behave outside these norms while observing other areas of their religion. My aim was not to view whether differences between men and women were viewed as oppressive but to gain insights into how women's sexual health is influenced by wider societal and cultural factors. While some waves of feminism could provide some basis for consideration as a theoretical perspective in my study, other theoretical perspectives felt more aligned to my own position. Interpretivism was therefore adopted over feminist theory.

3.4 Methodology

Methodology has been defined as *"a way of thinking about and studying social phenomena"* (Corbin & Strauss, 2015, p. 3). For a British born South Asian female, many cultures will influence the way she interprets her world namely the South Asian culture she was born in to, any religious beliefs she may affiliate with, the British culture that she grew up with and encountered through the education system, the community she lives in, media, friends and her social circles. This may raise many issues and challenges for the individual as the different cultures she belongs to may provide different ways of viewing her world. It is therefore necessary to choose a methodology that allows the exploration of these multiple realities. Different methodologies were

considered to try and identify one that was suitable for the context of the study, for me and the adopted epistemology. The aim of this study is to explore the perceptions, awareness and experiences of sexual health among British born South Asian females, aged 18-25; with a specific focus on understanding participant's realities of sexual health and whether and how these are influenced by culture, religion and wider social factors. After consideration of the various methodological approaches, I considered grounded theory to be the most appropriate. Grounded theory is aligned with a social constructionist epistemology and aims to understand what is happening in a given situation, particularly within a common social setting that perhaps are not fully understood or where there is little research available (Hunter , Murphy, Grealish, Casey, & Keady, 2011a). Tan (2010) also highlights that grounded theory can be used when a topic of interest is new or developing or when there are few empirical insights available in the existing literature. My area of study is one that is deemed sensitive and an initial scoping review of the literature revealed that little research had been undertaken in this area. My own background in terms of being a member of the same cultural group as the participants, along with my background in nursing and nurse education led to the identification and understanding that this was an area that was not discussed openly and where there were gaps in research knowledge. This may be due to the fact that many South Asian cultural groups do not believe in premarital sex or relationships (Baines, 2016; Mahmood, 2008) and discussion around the topic is still viewed as taboo among many South Asian groups (Bhalla, 2014; Ayuda, 2011; Rani, 2009). This could explain why it is an area not openly discussed and why there are gaps in knowledge.

In the following sections, I consider the three main factions of grounded theory and I justify why Charmaz's (2006) social constructionist approach to grounded theory was considered the most suitable.

3.4.1 Grounded Theory

In this section, I provide a brief description of grounded theory followed by different approaches to grounded theory. When considering grounded theory methods, there are three key schools of grounded theory that hold dominance: classical grounded theory or the Glaserian school founded by Glaser and Strauss, the Strauss and Corbin school, and the constructivist approach commonly associated with Charmaz (Bryant &

Charmaz, 2007). Before considering the differences between each of these three schools, it is important to consider what grounded theory is as a methodology.

Grounded theory has been defined as *"the discovery of theory from data"* (Glaser & Strauss, 1967: p1). Grounded theory allows the identification and description of phenomena, their attributes, the core social process and also their interaction in the trajectory of change (Morse, 2009). It provides the tools to synthesize data, develop concepts and theory (Morse, 2009). Harris (2015) identifies the basics tenets of grounded theory as the generation of theory, theory which is grounded in empirical research and a concurrent systematic collection of data and analysis. A definition of grounded theory provided by Glaser (1999) is:

> Grounded theory tells us what is going on, tells us how to account for the participants' main concerns, and reveals access variables that allow for incremental change. Grounded theory is what is, not what should, could, or ought to be. (p. 840).

Grounded theory research does not aim to produce definitive findings or descriptions but instead it produces an ongoing conceptual theory which will be recognisable to people who are familiar with the studied situation and can be modified to similar settings (Hunter et al, 2011b). The methods grounded theory adopts are systematic, yet they provide flexible guidelines for the collection and analysis of qualitative data, concepts are constructed from the data and this forms the foundation of the theory (Charmaz, 2014).

There are some differences, however, between the main factions of grounded theory and these will now be discussed.

3.4.2 Glaser and Strauss (Classical)

Through research on death and dying, Glaser and Strauss, with their diverse approaches but mutual sociological backgrounds developed grounded theory methodology (Glaser & Strauss, 1967). Glaser and Strauss's 1967 text '*The Discovery of Grounded Theory*' had an influential role in legitimising qualitative research as a

credible methodological approach in its own right as opposed to simply being used as a precursor for quantitative research (Charmaz, 2006). Classical grounded theory involves the discovery of theory from data that has been obtained in a systematic way rather than making a priori assumptions (Glaser and Strauss, 1967). Glaser and Strauss identified that qualitative inquiry could be more than just descriptive studies and could in fact be a basis to construct abstract theoretical explanations; in particular explanations of social processes (Glaser & Strauss, 1967; Charmaz, 2014). This new approach in sociological research placed emphasis on investigating social processes and interpreting meaning through rigorously exploring the data (Glaser & Strauss, 1967; Hunter et al, 2011a). They identify that although their key text was primarily aimed at sociologists, they believed their methodology can be useful to anyone interested in researching social phenomena (Glaser & Strauss, 1967). They argued that it is only when the emerging theory becomes developed, that the wider literature should be explored and viewed as additional data. This methodological approach brought together two contrasting traditions of positivism and pragmatism. Glaser came from a positivist training background and Strauss from a pragmatist and field-based research background. The systematic approach and the logic in classical grounded theory is reflective of Glaser's background in quantitative training. Glaser instilled grounded theory with *"dispassionate empiricism, rigorous codified methods, emphasis on emergent discoveries, and its somewhat ambiguous specialized language that echoes quantitative methods"* (Charmaz, 2006: p7). Whereas Strauss viewed human beings as active agents in their own lives, as opposed to passive recipients (Charmaz, 2006).

Classical grounded theory placed a lot of emphasis on the inductive or emergent nature of the theory. The data itself was everything in the classical approach meaning that variables such as sex, race or class would not be relevant unless they are referred to in the data (Glaser, 1978). The researcher's or participants' backgrounds were equally not relevant unless they emerged as important from the data (Charmaz, 2014). However, Barnes (1996) argued that if researchers believe that a person's culture is an important influence on their construction of their behaviour and health beliefs then how can researchers ignore this when analysing and constructing a grounded theory. As I believe that culture plays an important influence on the construction of meaning, classical grounded theory therefore did not resonate with my beliefs. The objective and deconstructed stance which did not consider race and class as important variables led many to move away from this approach into more recent grounded theory methods.

3.4.3 Strauss and Corbin

Strauss broke his allegiance with Glaser and through working with other colleagues developed his own grounded theory approach (Corbin & Strauss, 2015). Strauss then co-authored with Corbin to produce a new direction of grounded theory. Strauss and Corbin however did continue to preserve the emphasis originally made with Glaser on inductive, iterative inquiry (Corbin & Strauss, 2015). As data analysis was only loosely discussed in the original text by Glaser and Strauss, Strauss and Corbin published a book '*The Basics of Qualitative Research'* to address this in more depth (Strauss & Corbin, 1990). This new approach incorporates the use of what is termed 'the paradigm'; an analytic tool that assists researchers to code around a given category and incorporates a set of questions which a researcher is able to apply to a set of data to organise concepts and find links (Corbin & Strauss, 2015). They also introduce an analytic strategy termed 'the conditional/consequential matrix *"that helps analysts identify the range of possible conditions that are operating in any situation and in turn the range of consequences that result from action-interaction"* (Corbin & Strauss, 2015: p 153). They believe that *"knowledge arises through acting and interacting of self-reflective beings"* (Corbin & Strauss, 2015, p. 19). Verification of the results is important in this version and this is done throughout the course of the research to ensure validity and reliability (Strauss & Corbin, 1994; Corbin & Strauss, 2015). This continuous verification process on the scientific methods involved in the study is said to ensure rigour and validity. I did however feel that verification of the results through scientific methods is not always possible with social research which did make me consider its suitability for this study. Glaser objected to the prescribed analytical approach as he felt it forced data and the analysis into preconceived categories and opposed the original principles of grounded theory (Charmaz, 2006). Despite Glaser's objections, their book has served as a powerful statement and its popularity has led to many editions of the book being published (Strauss & Corbin, 1990; Corbin & Strauss, 2008; Corbin & Strauss, 2015).

Strauss and Corbin's view on the use of extant literature also differed from classical grounded theory. As discussed above, Glaser and Strauss advocated avoiding undertaking a literature review until the core categories were emerging and at which point literature could be incorporated in the data analysis (Glaser & Strauss, 1967). Strauss and Corbin's approach advocated a quick review of the literature but considered there was no need to review all the relevant literature in the field of study

(Yarwood-Ross & Jack, 2015). Corbin & Strauss (2015) consider that it is impossible to know which concepts will be derived and their relevance to the research before beginning the grounded theory study. Researchers should not be "*so steeped in the literature that they are constrained and even stifled by it*" (Corbin & Strauss, 2015, p. 49). They considered that engagement in wider literature should be ongoing rather than seen as something that needs to be reviewed in depth before data collection.

3.4.4 Charmaz's Constructivist Grounded Theory – a social constructionist approach

In recent years a growing number of scholars have moved grounded theory away from the positivism evident in Glaser and Strauss and Strauss and Corbin's version (Charmaz, 2006). Charmaz was a student of Glaser and Strauss and is currently the leading proponent of grounded theory (Mills, Bonner & Francis, 2006). Charmaz's approach to grounded theory differs from the objectivist versions of grounded theory that assume a reality that is discovered by a neutral observer (Charmaz, 2008). Her approach recognises that researchers are influenced by their historical and cultural context (Catling, Dahlen, & Homer, 2014) and means that researchers must examine how their own preconceptions may shape the analysis (Charmaz, 2014). Charmaz's constructivist grounded theory is epistemologically subjective and reshapes the interaction between the researcher and the participant in the research process (Charmaz, 2014; Mills, Bonner & Francis, 2006). Subjectivity is deemed to be inseparable from social existence (Charmaz, 2014).

Charmaz (2008) does state that although she has referred to her approach as constructivist grounded theory, this was only done to distinguish it from objective iterations found in earlier grounded theory approaches and therefore her approach does align with a social constructionist approach. The terms constructivist and constructionism are often used interchangeably however constructivism is about the individual and how the individual perceives the world or constructs their reality whereas constructionism views reality as being constructed through wider social interactions and forces that shape how we view the world (Andrews, 2012; Crotty, 1998). The constructionist viewpoint advocates that theories and concepts are constructed by researchers from the stories that research participants construct when they are making sense of and explaining their experiences, both to the researcher and to themselves (Corbin & Strauss, 2008). Schwandt (2003) further identifies that we do not construct

our interpretations in isolation but against a backdrop of shared understandings and practices. Constructivist grounded theory has epistemological roots that are fundamental in social constructionism (Charmaz, 2008). Charmaz (2008) states that she assumes that people make their worlds but not as they please, as they are constructed under social conditions that shape our actions, views and collective practices. As this study is concerned with a specific cultural group's perceptions and experiences and not just their individual perceptions and experiences, a social constructionist approach has been adopted using Charmaz's Grounded Theory.

This approach enables the researcher to acknowledge their own impact on the research as researchers are able to engage with the participants and acknowledge their influence over the outcomes of the theory (Hunter, Murphy, Grealish, Casey, & Keady, 2011b; Charmaz, 2008). This differs to classical grounded theory where the constant comparison of memos and codes, theoretical sampling and the development of conceptual understanding are applied in attempts to prevent inclusion of the reflexive self (Hunter et al. 2011b). Charmaz's constructionist approach is inductive and uses constant comparisons discussed more in section 4.17, however the acknowledgement of the researcher as an active participant made it particularly appealing for my study due to having a similar background to those being studied. Reflexivity is central to Charmaz's version of grounded theory (Charmaz, 2008). Charmaz, (2014) states:

> We are part of the world we study, the data we collect, and the analyses we produce. We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices (p17).

How an individual experiences and attributes meaning to certain phenomenon, is contextually-based and influenced by factors such as time and place, cultural, religious and professional backgrounds (Corbin & Strauss, 2008). Multiple realities exist and they are influenced by the context in which they took place (Mills, Bonner & Francis, 2006). If we begin with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher's position, their privileges, their perspective and also their interactions into account as an inherent part of the research reality as it, too, is a construction (Charmaz , 2014). The researcher's background cannot be put to one side where they are expecting to view the world through an

objective lens. There may be a shared reality with the researcher and participant and Charmaz's grounded theory considers both the researcher and participant's positions (Charmaz, 2013). The participant's views and experiences and the theories the researcher discovers are all constructions of reality (Charmaz, 2014). In my study it was recognised that both mine and the participant's processes of enculturation and acculturation will play a pivotal role in the construction of final theory.

3.5 Conclusion

In this chapter I have provided an overview of my theoretical position and chosen methodology. Through careful examination of the situational context of this study, an interpretive, social constructionist approach was deemed the most suitable. As limited research was available on the topic (as presented in section 2.7 in the initial literature review) a grounded theory methodology was identified as the most suitable. A further literature review is also presented later (Chapter 9) once data collection was completed in line with Charmaz's approach. Familiarising myself with the major factions of grounded theory and consideration of my beliefs on the generation of knowledge and the acknowledgement of the researcher as an integral part of the research process led to the selection of Charmaz's constructivist grounded theory methodology. In the next chapter, I outline the methods I used for data collection, provide a visual representation of my findings and introduce the study participants.

4.0 Methods

4.1 Introduction

In the previous chapter, I provided an overview of my theoretical position and methodology. Here, I discuss the methods I used for my study and how they align with Charmaz's constructivist grounded theory. First, I present feedback I received early on in the study from two South Asian health and social care professionals (Reviewers one and two) and also through discussions I had with some South Asian women who I knew personally, which influenced a number of the methodological decisions. Next sampling, recruitment and ethical principles are outlined. I then discuss the data collection methods adopted. I also consider data analysis, theoretical sampling and sorting. I discuss how reflexivity was maintained throughout from formulating the research question to focused coding and beyond.

4.2 Feedback from South Asian women

Before embarking on my study, I was aware of the issues that I had personally encountered due to being a woman from a South Asian background who had experienced acculturation. First I discussed the issues surrounding sexual health for women from this background with a number of British born South Asian women personally known to me to identify their thoughts around the topic and also their views of my prospective study. Due to the nature of my study in that it was focused on sensitive topics with ethnic minority groups, I also felt it was appropriate to obtain the opinions and thoughts of health and social care professionals who worked with British born South Asian females to ensure the study was appropriate and to help methodological decisions. I managed to speak to three different women from my personal networks and to engage with two professionals (referred to as reviewers below in sections 4.2.2 and 4.2.3) who agreed to meet and review the overview of the study together. The conversations that took place within this meeting were envisaged to assist with my decision making. The professionals were also asked to review my proposed recruitment flyers (Appendix 3), focus group and interview schedules (Appendix 4).

4.2.1 Feedback from women

I spoke to three British born South Asian women known to me informally around their thoughts surrounding my research area. I already had my own personal insights and

experiences into the issue but wanted to ascertain the importance and relevance surrounding sexual health with others. One of the women was an 18 year old university student in a long term relationship, the second woman was 28 years old, previously divorced and now single and the third woman was a 34 year old woman who had been in two previous relationships but was now single. The 28 year old woman was very aligned to her faith, had married at a young age and had not been in any pre-marital relationships, however shared how she had friends who had found themselves in situations where they needed advice and support but did not know where to turn to. The 34 year old woman identified the issues she faced personally in terms of having previous relationships out of wedlock, and her awareness of others who may not know who to turn to for help. She identified that her sex-based relationships were kept secret amongst a select few friends. The 18 year old was in a relationship with someone who was White British and therefore did not face the same religious tensions that she did. She also mentioned the hidden nature of the relationship from most South Asian individuals in her life except a very select few who she trusted. She mentioned the difficulties when accessing sexual health support and her concerns and fears of any repercussions her relationship could cause. My conversations with these three women affirmed my personal insights into some of the issues British born South Asian were facing where romantic relationships were concerned and emphasised the need for my study.

4.2.2 Reviewer one

Reviewer one was a lead within a Clinical Commissioning Group in North West England. She felt that it would be easier to recruit 18 to 21 year olds particularly if recruiting in a university setting and may find fewer participants of the 25 year age group. She felt that the use of focus groups would be better and that the interviews may pose difficulties when expecting participants to talk about their own personal experiences of sexual health and sexual health services. She considered that women who were not local and were from out of town may be more willing to participate due to confidentiality. Reviewer one also suggested that it may be beneficial to try and recruit from community groups as they may already be ‘sold’ on the idea of getting involved and making a difference. She felt that if the participants did not necessarily have to share their own personal sexual health experience, there was a chance that they would come forward to participate. She also felt that I would not get as many girls from a

Bengali background as they were very much focused on their own culture and not wanting to integrate into the society they live in. Reviewer one considered that it was an area that needed researching and felt that I would get the views of those individuals who already volunteered to participate in studies or in feedback sessions on health services.

4.2.3 Reviewer two

Reviewer two was a Senior Practice Nurse working in an area with a high South Asian population. She offers Chlamydia screening to those aged 16+within her role. Reviewer two felt differently to Reviewer one in some regards. While Reviewer one felt I would be likely to recruit participants, Reviewer two was less optimistic although she did feel that students studying health care may. She felt by age 18, British born South Asian girls would know where to access help, especially with internet accessibility. She did state that if the participants knew each other, then this may pose difficulties in focus groups as some of the participants may not want the other girls in the group to know how aware they are of sexual health issues. She felt it was appropriate to not include males in the study as they would not come forward, especially as I was a female of South Asian origin. She emphasised confidentiality as an issue. She highlighted that school sexual health education starts ‘the ball rolling’. She stated that young girls do not like the genitourinary medicine (GUM) clinic and were more likely to use a general health service which was aimed at young people for any issues as they tended not to be sexual health specific. She also highlighted it was a ‘touchy’ topic but did state that she did get young South Asian girls coming to see her for sexual health related issues so it was an important area to study.

4.2.4 Implications from the reviews

Both reviewers had their own opinions and helped me to consider the following issues:

- Confidentiality was paramount
- British born South Asian females will have some knowledge on sexual health
- Sexual health education at school was important
- Not all sexual health settings were accessible

- Recruitment may be difficult
- Focus groups may prove problematic
- The research area was vital

How these views and opinions shaped my methodological detail will be referred to at key points in this chapter.

4.3 Reflexivity

Darawsheh (2014) acknowledged that reflexivity is a vital strategy for enhancing qualitative research and identifies its importance in promoting rigour. Reflexivity is defined in many ways but for the purposes of my study it is concerned with *"the continuous process of self-reflection that researchers engage in to generate awareness about their actions, feelings and perceptions"* (Darawsheh, 2014, p. 51). Reflexivity has been essential throughout my study and is integral and inherent within Charmaz's approach. In my study reflexivity was inherent from the outset and throughout e.g. when I began my research journey and decided on my area of research, designing the study, the use of reviewers, data collection, analysis, reporting findings and the construction of theory. Charmaz (2014) identified the importance of engaging in reflexivity where the researcher's preconceptions are relevant in shaping the analysis and theory construction. Reflexivity allows researchers to be aware of how their own life may influence their research (Charmaz, 2014). She states that this does not mean that researchers need to share intimate details of their lives however by having a reflexive stance they are aware of their position and assumptions and how they could influence their inquiry. *"A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports"* (Charmaz, 2014: p.344). Reflexivity was maintained through the use of a reflexive diary, sharing transcripts with my supervisory team and ongoing discussions with my supervisors. The reflexive diary was used at various points where I felt I needed stop and reflect. It was used to collect my thoughts before and after interviews and focus groups and served as a useful tool. Sharing my transcripts with my supervisors and having regular discussions around the findings with my supervisors was very beneficial.

4.3.1 Rigour

Qualitative researchers need to ensure that their research can be deemed credible and trustworthy through a process of rigour (Elo et al., 2014; Lincoln & Guba, 1985). The concept of rigour is concerned with the quality of the research process whereby a more rigorous process leads to trustworthy findings (Given, 2008). Rigour can refer to the strength of the research design and the thoroughness of research processes (Cypress, 2017). Lincoln and Guba (1985) are considered to be seminal authors in this area, and use the term trustworthiness to depict their criteria of rigour for evaluating qualitative studies. Four criteria for trustworthiness were first proposed by Lincoln & Guba (1985) which included 'credibility', 'dependability', 'confirmability' and 'transferability'. These criteria and how they were addressed in my study will now be discussed:

4.3.1.1 Credibility

Credibility is concerned with confidence and truth, where truth relates to the context of the study, rather than a fixed immutable truth (Barusch, Gringeri, & George, 2011). Lincoln & Guba (1985) stated that credibility is concerned with the value and the belief in the findings. A method that I used to assess credibility in my study was via member checking (see section 4.16.2). Although member checking is not mandatory in grounded theory, it is recognised as a useful tool linked to assess the authenticity of the findings (Stanley & Nayar, 2014; Lincoln, 1995). Nyathi (2018) confirms that credibility is also enhanced through reflexivity. The reflexive methods I used in this study included memo writing when analysing the findings and a reflexive diary was also used at various points of data collection and analysis. Regular consultations were also held with my supervisory team to discuss the research process, data collection, transcripts and findings. This also served as a tool for reflection in particular when discussing the findings emerging from my data. I also utilised 'peer debriefing' which is defined by Lincoln and Guba (1985) as a process that allows the researcher to share aspects of their research with someone who is external to their research process in order to explore aspects that may have been overlooked or not given enough thought. I had in-depth conversations about the findings of my study with two others; one was a PhD student and the other a nursing lecturer colleague who was also on a programme of doctoral study.

4.3.1.2 Dependability

Dependability is concerned with the reliability of the study and maintaining dependability through all stages of the research process (Lincoln & Guba, 1985). Forero et al. (2018) highlight how dependability is concerned with establishing an audit trail and keeping a record of the data collection processed. Houghton, Casey, Shaw and Murphy (2012) argue how it is pertinent to outline the steps and decisions made throughout the research process so that readers can understand the processes followed. Focus group and interview schedules (Appendix 4) were adhered to for data collection. The data collected was shared with my supervisory team which also enhanced dependability as not only was I able to review the transcripts with the audio files for accuracy, so could my supervisory team. As I carried out all the interviews and focus groups, this meant there was a consistency in approach. I also used a qualitative software programme – MaxQDA. The use of Computer Assisted Qualitative Data Analysis Software (CAQDAS) is believed to enhance rigour as it can provide a trail that shows the decisions made between data collection and analysis (Houghton et al. (2012). I shared my coding at the initial coding and focused coding stages through using MaxQDA software (see section 4.14) with my Director of Studies which generated discussion around the codes that were emerging. This facilitated clear detailed analytical stages and interpretations of the data. I used a reflexive diary to improve dependability and confirm ability through providing a means by which to express the rationale behind decisions and any personal challenges experienced. As Houghton et al. (2012) postulate, the reflexive diary can enhance transparency in relation to research processes as the reader can see the researcher's thoughts through the diary.

4.3.1.3 Confirmability

Confirmability refers to the level at which the results of a study can be confirmed by other researchers (Baxter & Eyles, 1997). It is about being able to establish that the data and findings are indeed derived from participant data and are not simply figments of the researcher's imagination (Nyathi, 2018; Tobin & Begley, 2004). Houghton et al. (2012) identified that running coding queries within computer analysis software (MaxQDA in the case of my study), means passages can be located that confirm that the findings were not the perception of only one participant, but rather a number of participants. Member checking is another tool that can be used to enhance confirmability. The discussions held with my supervisors also provided a further

measure to achieve confirmability through ensuring the interpretations were grounded in the data. Forero et al. (2018) also state that the use of a reflexive journal further helps to achieve confirmability. As discussed in the previous section, I used a reflexive diary regularly with my data collection, processes, analysis and interpretations. Memo writing and diagramming as part of the theoretical sorting process (see section 4.16.3) also provide an audit trail of the processes followed in the analysis of the data which enhances confirmability and dependability.

4.3.1.4 Transferability

Transferability is concerned with some level of generalisability and whether or not findings can be transferred to similar contexts (Lincoln & Guba, 1985). Social constructionism embraces the assumption of multiple realities (Erlinsson & Brysiewicz, 2013; Andrews, 2012; Gergen, Gulerce, Lock, & Misra, 1996). However, the dissemination of research that studies multiple realities may be potentially difficult. This may also lead to concerns around the impact such studies can have. However, Polit & Beck (2010) assert that the objective of qualitative research is not to generalise but instead to produce a contextualised understanding of some aspects of people's experiences through the thorough study of specific cases. Similarly, Galbin (2014) highlights that social constructionists "maintain that the goal of research and scholarship is not to produce knowledge that is fixed and universally valid, but to open up an appreciation of what is possible" (p.83). Barusch, Gringeri, & George (2011) found that there is an argument against the transferability criteria as it focuses on generalisability which is not necessarily aligned with qualitative research. However, through writing up the research processes in my study, I was able to provide a detailed description of the study stages which include descriptions in relation to the context and individuals which may facilitate comparisons and transferability (Nyati, 2018; Houghton et al., 2012). This information can then allow the reader to make a decision about the transferability of the findings to their own contexts (Houghton et al., 2012). Forero et al. (2018) also state that purposive sampling may be useful when studying a specific group and can facilitate transferability. Purposive sampling was one of the methods I adopted in my study. The detailed insights into the participant's faith, age, level of education and wider family contexts provide details that may aid transferability.

4.4 Sampling

Purposive and snowball sampling were used for both phases of this study. Purposive sampling allows researchers to purposely select participants according to their background and knowledge (Ross, 2012; Berg, 2007). It involves setting out clearly defined eligibility criteria which allows the most suitable participants to be identified and included (Ross, 2012). The advantage to this sampling method is that it allows the researcher to focus only on the participants or events that are deemed as critical to the research (Denscombe, 2007).

Snowball sampling was also used to recruit participants. Snowballing allows the sample to emerge through a process of reference from one person to the next and is viewed as an effective technique for building up a reasonable sized sample in small scale research projects (Denscombe, 2007). Snowball sampling has been identified as a way of recruiting hard to reach groups or to recruit to topics that are viewed as sensitive (Berg, 2007). I had already acknowledged that recruitment may be difficult and this was also expressed by the reviewers in section 4.2 above. I thereby considered that snowball sampling was key to recruitment, and particularly when trying to recruit for focus groups. When participants contacted me to express their interest in the study, I used snowball sampling to ask if they knew of anyone else that may be interested or willing to participate and whether they could pass on my contact details and information about the study to them. That way the individuals were free to contact me directly if they wished to participate. Central Michigan University (CMICH, 2016) highlight that there are two types of approaches to snowball sampling. The first approach involves potential participants being given contact information to contact the researcher directly. CMICH (2016) state that this is viewed as the less problematic approach to snowball sampling as individuals are more inclined to participate and consent freely. CMICH (2016) identify a second approach. This is where the researcher asks a potential participant for contact details of others in their network and contacts the individuals directly. This approach raises some concerns around informed consent and confidentiality. It may also have the potential to leave individuals feeling vulnerable due to feeling obliged to participate and this raises ethical concerns. I used the first approach to prevent against any undue ethical issues.

Other limitations of snowball sampling include the potential for bias in that participants may recruit others who have similar viewpoints and therefore the findings may not be generalisable (Miller & Brewer, 2003). However as this study used both purposive and snowballing methods, this may alleviate some of the limitations of snowball sampling.

4.5 Sample and inclusion and exclusion criteria

The justification for recruiting British born South Asian women aged 18-25 years is more clearly detailed in Chapter 2.0: Background). This research highlights that individuals aged 18 to 25 have the highest rate of sexually transmitted (AYPH, 2015) and that young people from ethnic minority groups are at a higher risk of poor sexual health and females in particular may encounter stigma and discrimination which can affect their ability to access sexual health services. These trends, my discussions with South Asian women and with the expert reviewers influenced why I decided to focus on this population group.

My study was undertaken in two data recruitment phases (described in sections 4.11 and 4.12). For both phases, the inclusion criteria included females who were 18 to 25 years old, British born and from a South Asian background and who were residing in North West England. The study was not limited to a particular South Asian group and targeted women from South Asian groups which included Indian, Pakistani or Bengali backgrounds (Feder, et al. , 2002; Griffiths, Prost, & Hart, 2008a; Brand, et al., 2018). Other literature considers parts of Bhutan, Maldives, Myanmar, Nepal and Sri Lanka to also be part of South Asia (Gudlavalleti, 2018; Jalaal, et al., 2019). For the purposes of my study the broader geographical area of South Asia was adopted. Much of the literature, groups the views of Black and ethnic minorities together (Khan, 1994) which prevents in-depth insights in to the perceptions and needs of the different minority ethnic groups. While some literature provides information on the needs of individuals from South Asian backgrounds as a whole, the experiences of individuals born and brought up in South Asia but living in England will be distinct to the experiences of individuals from a South Asian background that were born and raised in England. These two groups tend to be viewed as a homogenous group and although they may encounter issues that are similar, their experiences and interpretations may be distinct due to their cultural upbringing and background (Wang, Bordon, Wang, & Yeung, 2018).

For the purposes of my study it was expected that the participants would have attended primary and secondary schools in the U.K and would speak English. It was not necessary that the participants had accessed sexual health services or had personal experience of romantic relationships; rather the purpose was to explore experiences and opinions towards these issues.

4.6 Ethical considerations

Ethics is concerned with the rights and wrongs of human behaviour (Thompson, Melia, & Boyd, 1988). Ethical approval was sought from the University of Central Lancashire's ethics committee. Prior to seeking approval it was relevant for me to examine the various ethical issues that needed to be considered in relation to my study. I was mindful of the question *"ought this research be undertaken?"* (Thompson, Melia, Boyd, & Horsburgh, 2006, p. 8). The lack of research available with this cultural group; the number of national reports highlighting an issue existed and through discussion with the reviewers affirmed a need for this research to be undertaken. It was therefore necessary to consider appropriate literature on research governance prior to planning my study.

I was aware of the importance of relating ethical principles to research principles which is also highlighted by the Council for International Organizations of Medical Sciences (CIOMS, 2002). Relevant ethical principles are discussed below within this section. I accessed the University of Central Lancashire (UCLan) Code of Conduct for Research which is the University's research governance policy (UCLan, 2008). Through my background in nursing, I was also aware that I would have to adhere to the Nursing & Midwifery Council (NMC, 2018) Code. These documents enabled me to relate ethical principles to research principles in my study. Having read these guidance documents, ethical principles are now discussed as follows.

Beauchamp & Childress (2013) conceived a principles based moral framework which is commonly known as the four principles approach to bioethics. Bioethics is a discipline which addresses the risk of harm to people's wellbeing and health (Spagnolo, 2017). Thompson, Melia, Boyd, & Horsburgh (2006) define a principle as *"A fundamental truth or doctrine that is the source of inspiration or direction for moral action or used as the starting point for moral reasoning"* (p. 29). As this study is concerned with health and

health care it felt appropriate to consider principles that were relevant to this focus. The four principles are autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2013). I will now describe what these principles are and how they were adhered to in my study. To contexualise the ethical considerations, it is relevant to mention that some of the methods that I planned to use in my study are interviews,focus groups and a personal characteristics form. The rationale behind this will be discussed later (see section 4.9) and and ethical considerations relating to these methods will also be considered within the next section.

4.6.1 Autonomy

Beauchamp & Childress (2013) define autonomy as having freedom of will, the right to liberty, privacy, individual choice and being one's own person. *"At a minimum, personal autonomy encompasses self- rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding"* (Beauchamp & Childress, 2013, p. 101).

The use of a participant information sheet (Appendix 5 & 6) related to the principle of autonomy in that the information presented enabled participants to make an informed choice as to whether they wanted to participate. The sheet informed participants that their involvement was voluntary and they could leave at any point. It also informed participants that the focus groups and interviews would be recorded. If participants did not consent to the focus groups being audio recorded (due to the group-based nature of the discussion), an individual interview where the researcher wrote detailed notes could be arranged. The participant information sheet also emphasised the need for choice through autonomy by informing participants that if they did take part in a focus group their comments would not be able to be withdrawn once the focus group had taken place; alternatively those who took part in an interview could withdraw their data up to one month following data collection. All the participants were happy for the focus groups and interviews to be recorded and none of the participants contacted me to withdraw from the study. Before the interviews or focus groups commenced, I re-iterated the voluntary nature of participation in that they could end the interview or leave the focus group at any point without providing a reason and that they were not obliged to answer all the questions. Their participation was entirely voluntary.

Once the participants had the opportunity to read and familiarise themselves with the participant information sheet and had any queries answered, they were then asked to provide their written consent to participate or decline from the study. Consent was sought through participants being asked to read, initial individual statements and to sign a consent form (Appendix 7-10). The consent form also asked if participants would like to receive a copy of the key themes to emerge from the study, however none of the participants requested to receive the key themes. I reflected that maybe the participants did not want to receive further information after participation to maintain confidentiality.

As identified in section 4.6, I adhered to the NMC Code (2018) due to my role of nurse educator (NMC, 2018). The NMC provides guidance on safeguarding the heath and wellbeing of the public. It also highlights a need for treating people as individuals, ensuring consent is gained and to maintain clear professional boundaries. Almost all prominent research codes and institutional rules of ethics dictate that investigators must obtain informed consent from participants prior to data collection (Beauchamp & Childress, 2013). The principle of autonomy was adhered to at all the relevant stages of the study.

4.6.2 Non-maleficence

"*The principle of nonmaleficence obligates us to abstain from causing harm to others*" (Beauchamp & Childress, 2013, p. 150). Nonmaleficence focuses on the intentional avoidance of harm and therefore tends to take the form *"Do not do X"* (Beauchamp & Childress, 2013, p. 152). Non- maleficence is also embedded within the NMC Code (NMC, 2018) in terms of respecting a person's right to privacy and confidentiality, preserving safety and recognising when an individual is in distress and to respond accordingly. I had identified the possibility that some participants in my study may experience distress or discomfort due to the nature of the topic. In anticipation, I had compiled a list of organisations offering support and advice which I took to the focus groups and interviews in case it was needed. The NMC (2018) state that it is crucial to recognise situations when individuals are distressed and to respond in a compassionate way. None of the participants became upset or distressed during the focus groups or interviews. Confidentiality was anticipated (and also identified by the reviewers) as being one of the concerns a participant may have. I had made it explicit

on the recruitment flyer that individual interviews were an option if potential participants did not feel comfortable participating in a focus group (Appendix 3). The reviewers' comments around the fact that focus groups may prove problematic, as participants may not wish to share their thoughts and experiences with other South Asian females for fear of anything being discussed outside the focus group did play on my mind. I felt that the use of snowball sampling could alleviate some of these concerns, so when a participant contacted me showing as interest in participating, I asked if they knew of anyone who would be willing to participate with them. All the focus groups used snowball sampling.

Confidentiality was imperative in this study at all stages due to the nature of the topic and is relevant to the principle of non-maleficence. Confidentiality relates to the assurances of privacy and anonymity given by researchers to their participants (Parahoo, 2014). Mealer & Jones (2014) highlight the importance of minimising the risk associated with breach of confidentiality through reasonable safeguards when research is being carried out on sensitive topics. Confidentiality was at the fore when I conducted the interviews and focus groups. I decided that I would not leave any voicemails on participant's phones concerning the study. The Participant Information Sheets (Appendix 5 & 6) also emphasise confidentiality and acknowledged that participation in this study may not be viewed upon favourably by some individuals from the South Asian community or by some family members of the participants. The Participation sheets therefore ask participants to try and provide contact details that are private and can only be accessed by them. However, I did not have to leave any telephone messages. When undertaking the telephone interviews, I did discuss confidentiality with the participants and informed them that if they felt confidentiality or privacy could be breached, such as someone walking into a room, the interview could be rearranged. No disturbances that could breach confidentiality did occur. In line with Parahoo (2014), I considered it essential that the confidentiality of the data gathered from participants was respected (Parahoo, 2014). Fortunately, there were no interruptions during the telephone interviews. All participant data (e.g. personal characteristics forms (Appendix 11), consent form (Appendix 7-10), transcripts etc was linked by a code and stored separately to maintain participant anonymity and confidentiality. All paper data was stored in locked filing cabinets within a locked office at UCLan (e.g. consent forms, personal characteristics forms); with electronic data (e.g. interview/ focus group transcripts) stored on password protected University computer files. Data storage will be considered in more detail in section 4.7 below.

I had to consider and preserve my own safety when carrying out data collection. I compiled a lone worker risk assessment (Appendix 12) which served as a check to prevent any physical harm coming to me and made me aware of any potential threats to my own safety. This included considering any dangers when considering the location to collect data, the consideration of timings when scheduling interviews and focus groups, potential risks in participants' homes and ways in which this risks could be minimised.

4.6.3 Beneficence

Beneficence requires action that involves helping such as preventing or removing harm or promoting good (Beauchamp & Childress, 2013). *"Principles of beneficence potentially demand more than the principle of nonmaleficence because agents must take positive steps to help others, not merely refrain from harmful acts"* (Beauchamp & Childress, 2013, p. 202). The aim of this study is centred around the principle of beneficence. As there was little knowledge available on the sexual health needs of British born South Asian women, it was considered that enquiry in to this topic would promote 'good' through enabling health care providers to gain a deeper insight in to any difficulties which this group may have and may facilitate the development of appropriate service provision. Beauchamp & Childress (2013) posit the presence of an implicit assumption of beneficence in all health care professions and health care environments. Allowing participants to discuss sexual health related topics in an open and non-judgemental setting may also have the impact to stimulate them to consider any issues in depth and to seek out information which may improve their sexual health.

4.6.4 Justice

Justice is the final of the four principles. The type of justice I am concerned with here is distributive justice in other words I am concerned with the distribution of health care in particular the fair and equitable distribution of resources, benefits and burdens (Beauchamp & Childress, 2013; Duncan, 2010). Inequalities in health care are present in terms of accessibility to services or the availability of appropriate services and resources and this makes the principle of justice prominent. Justice is also concerned with the duty to not discriminate people on the grounds of race, age, gender or religion (Thompson, Melia, Boyd, & Horsburgh, 2006). This principle also resonates with the duties that are outlined in the Nursing & Midwifery Council (2018) which include a need

to consider cultural sensitivities. I was aware that there would be issues faced by this group due to their cultural beliefs and I was also aware of the consequences of not accessing appropriate service provisions. One of the core areas of my study was to examine the issues that British born South Asian females aged 18-25 encounter in relation to sexual health. There may be instances where British born South Asian women need access to needs-based care and support and therefore it was relevant to identify whether this was readily available and accessible or whether there were any aspects relating to the sexual health care needs of South Asian women that were being omitted or not considered when providing care.

4.7 Confidentiality and storage

Participants were asked to indicate a YES/NO on the consent form to the following statement "I agree that UCLan may keep my anonymised data on file for use in the future for other related research projects". All the participants agreed to their anonymised data being stored. Any identifiable information (i.e. the consent form and the personal characteristics form) were kept in separate locked filing cabinets in my office at UCLan. All electronic data (i.e. interview and focus group transcripts) were stored on UCLan password protected computer files. The transcripts and recordings shared with the supervisory team were anonymised. The digital recordings were deleted once transcribed and verified by the supervisory team to further maintain confidentiality. Any identifiable data and information (e.g. personal characteristic forms, consent forms will be retained for a minimum of five years from the end of the study to comply with the University's guidelines (UCLan, 2008) and will then be destroyed.

4.8 Recruitment process for phases one and two

Recruitment was undertaken in two collection phases. Participants were recruited through flyers asking participants to contact me directly if they wished to participate (see Appendix 3). For phase one I adopted a more open approach whereby hard copies and e-copies were distributed on campus at UCLan. Electronic recruitment flyers were also sent to three local colleges. Electronic recruitment flyers were also posted on social media through Facebook and Twitter and hard copies of the flyers posted to any South Asian community groups advertised online in the North West.

Most of the participants during phase one came from the electronic flyers distributed on campus and through social media. I received several ‘Mail undeliverable’ flyers back from the letters I sent to community groups (see Appendix 13). This suggested that many of the community groups had relocated or where no longer in existence. The Principal of one of the local colleges did acknowledge my recruitment flyer and letter (see Appendix 14) but responded stating that as they were a Catholic college, they would not be interested in my topic of research. When I did receive any interest to participate from the flyer (which was always via email), I emailed them back to thank them for showing interest and provided them with the participant information sheet and consent form electronically and asked them to send me their preferred contact details if they were willing to take part. I made every effort to recruit through the methods described above. I was aware that due to the sensitive nature of the topic and the population group, I may experience challenges where recruitment was concerned but this did not deter me.

When using grounded theory, analysis begins once data is available. This data is also used to inform recruitment decisions (which forms part of theoretical sampling – see section 4.16) to ‘test’ out the initial interpretations and theories with others as appropriate. All the participants recruited during phase one had attended university or were currently studying at a university. In line with Charmaz’s theoretical sampling process, a decision was made to focus on participants who had not accessed university education for phase two to identify if similar views were shared. Charmaz (2014) states that through theoretical sampling you can discover variation within your categories and identify and address any gaps. By focusing on females who had not attended university in phase two, I hoped to identify any variations or to learn if similar views were held with participants irrespective of wider individual and context-related factors.

4.9 Data collection methods

4.9.1 Formulating the focus group and interview schedule

When formulating the focus group and interview schedule (Appendix 4) I had key areas that I wanted to explore which linked to my aims and objectives (see Chapter 1). The main research questions that I wanted to answer were about: knowledge and understanding; issues with sexual health services; recollection of sexual health education; and where the participants would turn to for any sexual health support.

These areas were then grouped together and became concepts that I used to loosely structure the interview and focus group schedule (Appendix 4). I will discuss why I used focus groups and interviews later in this chapter. The five concepts used to focus the questioning in the focus groups and interviews were: knowledge and understanding of sexual health issues; expectations of sexual health services; issues around sexual health services; education around sexual health; support and advice. It was felt that these areas were sufficiently broad and allowed a starting point for individuals to discuss and reflect on their experiences. Charmaz reported it is important to consider "*the fit between ...initial research interests and ...emerging data*" (Charmaz, 2014, p. 32). I drew on Charmaz's approach which enabled me to follow any leads that emerged in the data. This meant that further questions were asked if clarification was needed or if the participant began discussing something that I felt was central or relevant, to ensure the opportunity was not missed.

4.9.2 Rationale for data collection methods

When using a constructivist grounded theory approach, researchers aim to use methods that elicit glimpses of the participant's world, as viewing the participants' lives from the inside may provide an otherwise unobtainable view (Charmaz, 2014). One of the advantages to using constructivist grounded theory is that new pieces can be added to the research puzzle or new puzzles can be produced while data is being gathered and analysed (Charmaz, 2014). This means that as participants introduce new lines of information, or where analysis reveals key data, or incomplete information, these leads can then be followed through future data collection or member checking (see section 4.16.2). Data analysis occurs simultaneously with data collection which allows the researcher to ensure any questions arising through analysis can be addressed with future participants. Charmaz (2014) argues the need to *"choose data collection methods that help you answer your research questions with ingenuity and incisiveness – and be willing to alter your research questions when you discover that other questions have greater significance in the field"* (p. 26).

Ellis (2016a) highlighted the importance of justifying the type of interview method chosen but also identifies that some methodologies associate a particular type of interview to the methodology e.g. grounded theory being associated with the use of semi-structured interviews. Charmaz (2014) refuted that interviews are the sole data

collection method in grounded theory but instead stated that data collection methods are seen to flow from the research question; *"let your research problem shape the methods you choose"* (Charmaz, 2014, p. 27). Grounded theory coding can be applied to interviews, documents, focus groups and anything that is data or text-related (Urquhart, 2013). Some research questions point to the use of one data collection method whereas certain research questions may indicate the use of several combined data collection approaches (Charmaz , 2014). The different data collection methods used in this study are discussed as follows.

4.9.3 Personal characteristics form

The first method of data collection was a personal characteristics form (Appendix 11). The participants in both phases were asked to complete this form once they had completed the consent form. The personal characteristics form provided some information about the participant's demography but also considered their knowledge around sexual health services. The questions on the form included their age, place of birth, which South Asian group they belong to, religion and which services they felt were sexual health services. All the participants were asked to complete the form and hand it back to me before the interview or focus group commenced. The purpose of this exercise was to ascertain what they felt was a sexual health service before they discussed it as part of the focus group or interview.

4.9.4 Focus groups

One of the main data collection methods used was focus groups. Focus groups are regularly used in health care settings (Greenwood, Ellmers, & Holley, 2014; Then, Rankin, & Ali, 2014). Focus groups are a qualitative method of research used to gather knowledge about perceptions, opinions and beliefs around a particular topic (Then et al. 2014). They comprise a group of individuals who are purposely gathered to participate in a facilitated discussion (Jones, 2015). The group discussion is led by a moderator via the use of set questions or topics (Connelly, 2015; Doody, Slevin, & Taggart, 2013). In the case of my study, I was the moderator, and I used a list of key topics to focus the discussions on the topic of study (see Appendix 4).

When recruiting, even though Reviewer one had felt that I would only get those who already volunteered in studies, I was actually able to get a broader sample. Although Reviewer two expressed her reservations over the use of focus groups in situations where the participants knew each other as they may not disclose their true thoughts, in my experience I found the focus groups worked well as the participants were recruited through snowball sampling and knew each other and appeared to have close friendships. I feel this comment from Reviewer Two shaped my practice when recruiting to the focus groups. I suspect that had participants joined focus groups as individuals and not through snowball sampling and encountered individuals from their respective communities at the scheduled focus group who they were not close friends with, then the dynamics of the focus groups I encountered would have been altered and I feel Reviewer two's reservation would have been correct.

One of the main differences between a group interview and a focus group is that participants are able to interact with one another during a focus group (Greenwood et al. 2014). I decided on a focus group format as I felt it was imperative that the participants could interact and freely discuss the issues with one another so that they did not feel like they were in a formal interview. The ability to interact with other participants and build on each other's thoughts or experiences during focus groups has been viewed as an advantage (Leung & Savithiri, 2009). Collecting data from a focus group means participants are able to react to what others participants have said and may disagree or reinforce the discussions (Connelly, 2015). Another advantage of focus groups is that they provide a platform whereby participants can purvey their own meanings of issues around health which would not normally be captured through other means (Wilkinson, 1998). Wilkinson (1998) identifies the use of focus groups as beneficial when conducting health research which aims to gain deeper insights into participants understanding and health beliefs. Connelly (2015) identified that groups tended to be homogenous (i.e. similar ages and cultural backgrounds) to facilitate discussion as having a group where participants are considerably different may lead to limited interaction or discussions being dominated by a few. In my study, the participants were all from a similar background and from a similar age group which meant they were able to share their experiences and thoughts around the questions I asked. Typically focus groups are held in formal settings and with individuals who do not know each other, as there is a concern that should participants know each other, this has the potential to inhibit disclosure, particularly if discussing sensitive issues (Acocella, 2012; Krueger & Casey, 2009). However, others argue that familiarity or acquaintanceship does not necessarily have an adverse effect on data collection, in

particular where the focus group moderator has a strong skill set (Morgan, 1996; Fern, 1982). Slevin, & Taggart (2013) argue that the focus group moderator is there to encourage interaction and will know when to remain quiet to allow the discussions to develop between the participants and will know when to intervene as appropriate. This was relevant on a number of occasions where the participants began asking questions between each other to get each other's viewpoint and it was crucial that I did not interrupt them. Some of the cautions against including people in focus groups who know each other or are friends (such as within my study) include issues around anonymity, private conversations occurring during the main focus group, and the endorsement of each other's views therefore influencing responses (Templeton, 1994). However, recent literature has viewed the use of focus groups where the participants are friends to have the potential to be a viable method of qualitative study (Jones, et al., 2018). A study conducted by Jones et al (2018), found participants who were in friendship groups did share their experiences and were willing to discuss sensitive topics. As I wanted to discuss a sensitive topic, I was aware that it was highly unlikely that young women would share their experiences among other women who were strangers due to concerns over their experiences being kept confidential. I therefore felt focus groups recruited via snowball sampling had the potential to alleviate some of these concerns.

Another key issue with focus groups that I contemplated over was the use of one of my supervisory team as a note taker[8]. However I was concerned this may have created a power difference, which inhibited my ability to fully relax and engage in the discussion. Another key point of consideration was that my supervisory team are all White females. The membership role of qualitative researchers whereby the researcher is viewed as 'an insider' (due to shared characteristics or similarities) or 'an outsider' (no shared commonalities) is discussed in the literature (Dwyer & Buckle, 2009). As I am from a similar ethnic background to the participants I found being an insider to be beneficial as I could relate to the experiences they were discussing and, although infrequent, they were able to use 'terms' in the South Asian language without the need for interpretation; terms such as '*nazar*' referring to an 'evil eye' or 'envy'. Dwyer and Buckle (2009) state that there appear to be as many arguments for the use of an insider researcher as there are against it. For example, a positive is that being an insider can encourage open discussions – whereas a negative is that prejudices may mean that the topic is not fully debated. Another positive could be that there is already

[8] Having a note taker during focus groups is usual practice (Krueger, 1998).

a ‘trust’ of sorts which may otherwise have taken time to build which could mean participants are willing to disclose more however another negative of being an insider is that I may not realise further clarification was needed with a response as I may have felt I understood the context in the moment but when later listening to the recordings may find that there was scope to seek clarification or to try and get the participant/s to expand further on a topic.

4.9.5 Semi-structured interviews

Interviews can be used to discover perceptions, feelings and understanding around a research issue (Ellis, 2016b). There are different types of interviews which include unstructured, structured and semi-structured (Baumbusch, 2010). Unstructured interviews are exploratory in nature and rather than having an interview schedule or questions they tend to use just one broad question and will then use probing questions (Ellis, 2016a). This form of interview has been described as being similar to having a conversation as there is a key topic being discussed and which allows the participant’s responses to lead the direction (Baumbusch, 2010). As the topic of my study is one that may cause embarrassment, I did not feel an unstructured interview would be appropriate. I envisaged that participants would need questions to provide the information I was hoping to gather. Structured interviews have a set of questions and the researcher must not deviate from the interview guide or schedule (Baumbusch, 2010). Structured interviews are more formal whereby interviewers are unable to ask additional questions and are perceived to be similar in format to a pen and paper survey (Berg, 2007). Whereas semi-structured interviews aim to explore the participant’s in-depth experiences around the topic of research and to identify the meanings that they attribute to the experience (Adams, 2010). One of the advantages to semi-structured interviews is that they have the potential to allow researchers to explore perceptions, beliefs and to understand how individuals interpret their experiences (Low, 2019; DeJonckeere & Vaughn, 2019). Another advantage when using semi-structured interviews are that they are a useful research tool when studying topics that may be particularly sensitive or where little is known about the subject area (DeJonckeere & Vaughn, 2019; Low, 2019; Adams, 2010). DeJonckeere & Vaughn (2019) also highlight that the researcher can continually seek informed consent where difficult topics may be being discussed during the interview. I chose to use semi-structured interviews as I perceived them to possess traits which could be aligned with

Charmaz's Grounded Theory methodology (2014). Semi-structured interviews use a set of questions, however these can be reordered as necessary during the interview. There is flexibility over the wording of the questions, the level of language may be altered to suit the needs of the participant and the interviewer may feel it necessary to probe further in to some of the responses through further questioning (Berg, 2007). Charmaz's (2014) approach favours flexibility and provides the researcher the ability to add in new questions or seek clarification as data collection continues. As analysis of the data begins once data is collected, the researcher can introduce new questions if new issues were being raised through analysis.

Semi structured interviews are flexible as they allow for elaboration of information that the participant feels is relevant and which previously may not have been thought to be important by the researcher (Gill, Stewart, Treasure, & Chadwick, 2008). DeJonckeere & Vaughn (2019) identify a disadvantage in that some participants may be reluctant to share information around sensitive or personal topics and therefore interviews may not always provide the information sought. However, in my experience I found that similar issues were being raised among the focus groups and semi-structured interviews and that I was able to probe or seek further clarification as appropriate. I felt confident that semi-structured interviews would allow me to collect the data that was needed.

Interviews could take place face to face or over the telephone. As I was recruiting participants from North West England, I was aware that some of the participants may have children, be employed or have other commitments which make it difficult to find a mutually convenient time and location to meet in person. Two telephone interviews were conducted with participants who did not live locally and had time constraints. While it has been acknowledged that there is little evidence available on the use of telephone interviews as a method of data collection in qualitative interviews (Irvine, 2011; Glogowska, Young, & Lockyer, 2011), telephone interviews have been identified as a useful method for conducting interviews when there may be geographical considerations (Mealer & Jones, 2014). Other potential benefits of telephone interviews have been highlighted by Musselwhite, Cuff, McGregor & King (2007) which included efficiency (cost and time), anonymity, the ability to take notes discreetly and researcher safety. Telephone interviews can provide further reassurance where confidentiality is concerned, in particular when researching sensitive issues such as with my study (Irvine, 2011). There may also be some issues when undertaking telephone interviews. These include challenges with interpersonal communication such as not picking up

visual cues and it may hinder the formation of trust between the researcher and participant (Mealer & Jones, 2014; Block & Erskine, 2012). I therefore felt it was essential that I used verbal communication skills effectively over the telephone (see section 4.10).

4.10 Data collection procedures and processes

At the start of each scheduled focus group and interview, I reiterated the aims of the study and ensured that the participants had read over the participant information sheet (Appendix 5 & 6). I also gave the opportunity for any queries to be answered before asking each participant to complete a consent form (Appendix 7-10). All the participants were sent a copy of the consent form and participant information sheet to their personal email accounts. Consent forms and personal characteristics forms (Appendix 11) were completed either in person, or in the case of telephone interviews, were signed on their behalf once they responded to all the questions on the consent form over the telephone and confirmed that they had read and understood the participant information sheet. The telephone interview participants were then asked to sign and return an electronic copy of the form. I had also collated a useful contacts sheet for any participants who may have need further support (see Appendix 15).

I felt it important to consider how I came across to the participants and how the questions were being asked during the interviews and focus groups prior to starting data collection. My previous knowledge on questioning techniques and non-verbal communication from a counselling course and my nursing background served as a good starting point. I considered it relevant to not only reflect on verbal communication and how I worded the questions in the schedules, but also non-verbal cues in communication. I found a useful communication model originally developed by Egan three decades ago when considering non-verbal communication (Egan, 2014). Egan's communication model uses the acronym SOLER which stands for:

"Face the client *Squarely*
Adopt an *Open* posture
Remember that it is possible at times to *Lean* toward the other
Maintain good *Eye* contact
Try to be relatively *Relaxed* or natural in these behaviours."

(Egan, 2014, p. 77).

Although this model was developed to be used in counselling, it is also relevant in situations where non-verbal communication is used. Egan's model made me aware that I needed to consider how I sit when facing my participants - sitting squarely so they knew I was interested in what they were saying. I adopted an open posture by not folding my arms or looking disinterested. When I felt I needed to lean towards the participants to demonstrate my engagement in what they were saying, I felt comfortable enough to do so. Although I was making notes and referring to the focus group and interview schedules, I felt able to maintain appropriate eye contact. Being relaxed was also essential as had I not been relaxed; the participants would potentially not have felt comfortable to open up about their experiences. This was conveyed through my verbal and non-verbal communication and the use of Egan's communication model (Egan, 2014). Although, this model is aimed at face to face communication, I was able to use its principles with telephone interviews. As the participants were unable to see me, it was still relevant to adopt the principles of the model to ensure I did come across as relaxed and attentive through my verbal communication by taking into consideration my tone of voice and my pace of speech for example.

Crean (2018) highlights that recent literature on the insider-outsider researcher identifies that it is a complex notion (see section 4.9.4). For example, the way I dress could cause a complexity as it may affect whether I am fully viewed as an insider or not. I wear western clothing which may mean that participants may be willing to share their experiences in relation to sexual health and may feel more relaxed than if I was wearing cultural or religious attire. From the participants' comments in focus group 2 about my dress (see section 4.11 below), it was clear that my clothes did affect how I was viewed. Traditionally, a researcher is given either an insider or outsider status (Merriam, et al., 2001). In my study, I could be perceived as an insider due to sharing the same South Asian ethnic background; however it was recognised that this may not always be the case. In the context of ever changing societies where individual and group identities may be flexible and multiple, the distinction between insider and outsider researcher may be blurred (Crossley, Lore, & McNess, 2016; Merriam, et al., 2001). Collins (1986) introduced the term 'outsider-within' where Black women working in academic settings were viewed as outsiders-within as they would use their marginalised position in predominantly White academic settings to allow them to

examine race, class and gender with a different lens. They were an outsider with access within the academic setting to dominantly White insider perspectives (Collins, 1986). The outsider-within status emphasises a need to examine hierarchies in connection with each other (e.g. to examine social-class in connection with ethnicity) (Rogers & Hoover, 2010). According to Flores (2016) scholars from ethnic minorities do not benefit from White privilege and are therefore afforded outsider status, however, they do benefit from hidden privilege due to the prestige associated with working in an academic setting and being privy to information 'within' the setting. Although I felt that I had 'insider' researcher status when conducting my study, the participants may have viewed me as an outsider and from a position of privilege, due to the structures (i.e. class, social status) associated with working in an academic setting. "Culture is more than a monolithic entity to which one belongs" (Merriam, et al., 2001, p. 411). Internal variations exist within cultures (Merriam, et al., 2001), which questions the possibility of ever being a true insider researcher and therein lies the complexity of the insider-outsider researcher and the notion of an outsider-within. As the participants in my study were forthcoming with their responses and appeared to feel comfortable with me, I felt that I was accepted in some form as an insider researcher.

As identified by Holian and Brooks (2004), there are ethical issues to consider around being an insider researcher. One of the ethical concerns is where the researcher has multiple roles within an organisation which could lead to role conflict (Holian & Brooks, 2004). Holian and Brooks (2004) also stress the need to widely advertise the study, ensure consent is obtained; to provide the participants with a genuine choice to opt in/ out of the study at any point; and also raise ethical concerns around the confidentiality of participants should they be known to the researcher.

I am a lecturer within the university where some participants were recruited, however I ensured that none of the participants were my own personal students. Should my students have come forward then this may have raised issues around voluntary consent and whether their participation was genuinely voluntary or because of my status or what could be viewed as a position of power as their personal tutor. As my students were not recruited, this also alleviated concerns of confidentiality. I recognised that had a participant been one of my personal students then this could have placed me in a difficult position depending on what was disclosed. The insider researcher position is therefore not without complexities and ethical concerns which must be considered thoroughly.

It is usual to include a note taker during focus groups (see section 4.9.4). I chose to not use a note taker. I did not have access to funding for additional research support. I was also aware that people from South Asian backgrounds may face difficulties in sharing their views, and which could be even more prohibited if talking to two, rather than one, unknown individuals. While my supervisors would have been willing to support, the fact that they were from a White ethnic background meant it was not appropriate.

4.11 Phase one

Phase one consisted of two face to face semi-structured interviews, two telephone interviews and two focus groups. The first two respondents for phase one approached me as individuals and at that stage I was unsure as to whether I would get any further interest, so I proceeded to interview them individually. When a respondent approached me saying there were a few friends that wanted to participate and they would be willing to do so in a group format, I asked for all their contact details and sent them the participant information sheet and consent forms and then arranged a date for the focus group. I took blank, hard copies of both the participant information sheet and consent form to the interviews and focus groups for the participants to read and sign but also in case any additional came along.

The first two face to face interviews were carried out in classrooms on the university campus. The first focus group consisted of four participants while the second focus group only consisted of three. While focus groups generally comprise four individuals or more (Carlsen & Genton, 2011), this group was a smaller number due to a participant dropping out on the day. This participant then rescheduled and participated through a telephone interview. The other telephone interview was scheduled due to the participant's limited availability and preference. She scheduled it at the end of her working day and stayed in her office to undertake the interview. The first focus group was held locally on campus in a classroom. I referred to my lone working risk assessment (Appendix 12) and checked in with my Director of Studies at regular intervals when I was conducting interviews and focus groups away from the university. The second focus group was held at a different university in North West England to the first focus group and in a participant's bedroom. The participants all spread out on the bed as if that was how they would meet and relax regularly. I was given a chair in front of the bed so we were almost sat in a circle but with me maintaining some distance.

The face to face, semi-structured interviews were between 32 minutes and 46 minutes. The telephone interviews were between approximately 22 minutes and 32 minutes. The focus groups were between 56 minutes and 1 hour and 19 minutes.

I made notes to accompany the recordings to ensure I could identify the participants during the transcribing process and to match them to the personal characteristics forms. Overall, I found it easy to differentiate the participants as the group numbers were small and their voices and accents were distinct.

Reflecting on the focus groups after they took place allowed me to see the positive impact that snowball sampling had made to the data collection. In both focus groups in phase one all the participants knew each other and talked openly with the others who were clearly their friends. I realised that had these participants not known each other, this would have greatly restricted what was discussed. The familiarity and relaxed nature of the friendship led them to discuss their sexual health encounters and relationship experiences. What was interesting in the second focus group was that one of the participants commented after the focus group had ended that she had been relieved when she saw me. I asked her what she meant as I did not want to assume. She stated that my appearance and friendliness made her relax as she was originally concerned that I may be a very religious person and would make judgement about her choices and beliefs. The other participants nodded their agreement. On reflection, I realised the value of how I had dressed (in casual western clothes) and the non-judgmental way in which I spoke to them. What was interesting was that the way that I dressed was linked to how 'religious' they perceived me to be. Their body language and the way they sat and lay on the bed showed they were at ease in their usual surroundings and felt comfortable enough to open up and share their experiences. This made me reflect on Reviewer two's comment (section 4.2.3) where she felt that participants may not disclose sexual health issues if they knew others in the focus group but I felt this concern was alleviated through the use of snowball sampling as described earlier.

4.12 Phase two

Phase two consisted of two focus groups and one face to face interview. Both focus groups were scheduled with four participants but only two attended on the day. One

participant who could not attend did contact me to reschedule and participated in an individual, face to face interview a few days later; the others(n=3) did not. The first focus group was held on the university campus in a classroom, and the second was at a participant's home. The focus groups lasted beween 36 and 46 minutes. The interview lasted approximately 20 minutes. Although the interview was approximately 20 minutes, the participant did share her experiences and feelings openly. As with the first phase, I made notes to accompany the recordings and as there were only two participants in each focus group, it was much easier to differentiate their voices. It was apparent that the participants in both the focus groups were friends and were able to talk about sexual health issues freely. The participants in the first focus group were college students. Some of her views were different to her friends in the focus group and I wondered if she intentionally rescheduled so she could speak freely (Munira).

As the second focus group was in a participant's home, I was more aware of my safety and surroundings and ensured I adhered carefully to the lone worker risk assessment (Appendix 12). The second focus group was interrupted part way with a grocery delivery but we resumed the discussion soon after. One of the participants had a young toddler who was present in the room and continued to play with toys throughout the duration. While both participants led me to believe that the participant with the child was married, towards the end of the focus groups she revealed that she was not. I was concerned in case I had made that assumption, but her friend stated that they always say that she's married as they find it easier to provide this mistruth rather than state she has a child out of wedlock. This is reflected on further when describing the findings (section 6.7).

4.13 Transcribing

Transcribing is the process of transforming speech into text in order that it can be analysed (Azevedo, et al., 2017). While all participants had the option of the interview being hand recorded (if they took part in an individual interview), all were happy for the discussion to be recorded using a digital recorder. Azevedo, et al. (2017) identified that the use of recordings minimises limitations associated with recall of information and facilitates the repeated examination of the interviews. I chose to personally transcribe each recording as it meant I could be fully engaged with the recording and could listen out for any points that I may not have noted during the interviews and focus groups.

This process was valuable, and I was able to immerse myself with the data which may not otherwise have been achieved had I chosen to use another individual or service for transcribing. I am multilingual and therefore believed that I would be best suited to carry out the transcribing should the use of South Asian terms be used. The importance of trustworthiness and validity with transcription in qualitative research has been emphasised (Davidson 2009; MacLean, Meyer, & Estable, 2004), and I was very mindful of the transcribing process. I asked my supervisors to listen to each recording and to check the transcribed interviews and focus groups to check their accuracy. Choosing to transcribe the interviews and focus groups myself did prove challenging at times due to the amount of time it took, but it was during the transcribing process that a basic level of analysis began. As the analysis process was iterative, transcribing began immediately after the first focus group and continued throughout data collection.

4.14 Software for managing the data

The use of electronic data analysis is more commonly associated with quantitative methods (Zamawe, 2015). The use of computer assisted qualitative data analysis software (CAQDAS) has been developed in recent use and beginning to be used more with qualitative methods (Zamawe, 2015). Zamawe (2015) highlighted some of the disadavntages and misconceptions around qualitative researchers using computer assisted software. One of the disadvantages highlighted is the time and new skills needed to master the software. One of the misconceptions he highlighted is whereby the software removes the researcher from having control over the anlaysis. He refutes this idea and states that the key function of CAQDAS is not to analyse the data but that it is to serve as a tool to support the analysis process. He reiterates that the researcher must always remain in control and that the software aids the researcher during the analysis process.

I used MaxQDA software as a tool to for storing, organising and coding my data. This electronic software can be used to import, organise and support the analysis of qualitative, quantitative and mixed methods data (Verbi, 2017). MaxQDA software does not carry out any analysis but through content and data analysis, the researcher is able to draw their own conclusions about the data (Verbi, 2020).The software allowed me to see patterns in the codes and make connections[9]. Charmaz (2014) highlights how the

[9] See Appendix 19 for examples of coded segments using MaxQDA.

use of codes can demonstrate how data is organised and allows analysis to begin. The use of CAQDAS can provide an efficient work process through saving time and being able to handle large quantities of data effectively (Verbi, 2020). I found that I was able to easily identify similar codes between participants which would otherwise have taken a lot more time and been a more difficult process. The use of MaxQDA helped me facilitate the organisation and coding of the data.

4.15 Data analysis

Charmaz (2014) described how grounded theory begins with an inductive approach (see section 4.17 Reasoning below), it involves iterative strategies that go back and forth between data and analysis, uses comparative methods, and allows ongoing interactions with the data and analysis that emerges. The analysis process begins as soon as data collection starts and involves constructing codes and categories from the data, constant comparison, memo-writing and advancing theory development (Glaser & Strauss, 1967). The first analytical stage – coding – is made up of two phases, initial coding and focused coding (Charmaz, 2014) described as follows:

4.15.1 Initial coding

Initial coding involves studying each line of data and each sentence and categorising it with a short name (or code) that summarises and accounts for what that segment of data is concerned with - also referred to as line by line coding (Charmaz, 2014). Charmaz (2014) stated that researchers may be amazed at how much more is viewed in their data using line by line coding as opposed to coding for simple topics and themes. The initial coding allowed me to consider all the issues being raised (see Appendix 16 for an example of initial coding). Charmaz (2014) also advocated coding in gerunds (which are the noun form of word or the action or doing words e.g. feeling, thinking and negotiating); gerunds embed action into the codes which may allow for connections and processes to be seen that may otherwise remain invisible. Charmaz (2014) identified that coding should occur for processes, actions and meanings and not merely to sort and summarise data in to themes and topics and which is why gerunds can prove useful. She emphasises that even when we think our codes may form a fit with events and actions in the studied world or think that our codes capture an empirical reality, we have to remember that the codes represent the researcher's words, views and interpretations. I found that as I generated codes, I continually refined them as many codes were connected and in line with Charmaz's guidance, I paid close

attention to the participant's perspective so that the codes represented their reality. Charmaz (2014) also places emphasis on processes and actions as this is a key strategy to construct theory, and where gerunds foster "*theoretical sensitivity*" (p.161). Theoretical sensitivity is defined as "*the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena*" (Charmaz, 2014, p 161). The process of coding develops theoretical sensitivity as it enables you to fragment the data in order to analyse them, find meaning in the patterns emerging and decide which direction to take them theoretically. Theoretical sensitivity allows you to view connections between codes and allows a researcher to bring analytic precision to their work (Charmaz, 2014).

4.15.2 Focused coding

Focused coding is the next stage and involves using the most significant or most frequent initial codes to synthesise and organise the data (Charmaz, 2014). Focused coding provides a conceptual relationship between the data which can facilitate the emergence of theory (Holton, 2007). The focused coding stage allows the researcher to make decisions as to which initial codes can be used analytically to categorise the data incisively and completely (Charmaz, 2014). This process allowed me to continually refine the codes and to compare them with another to ascertain whether the focused code can account for other data (Giles & De Lacey, 2016). An example of focused coding is provided in Appendix 17. Charmaz (2014) further explains that by comparing codes with codes allows the researcher to begin to consider which codes may be revealing tentative categories (discussed in section 4.15.3). The codes and categories generated can direct further data gathering (Charmaz, 2014). My categories and emerging theory arose from a process of theoretical sampling which was the next step following initial and focused coding which will be discussed below (sections 4.16) Theoretical sampling can lead to categories (section 4.15.3) and theory being generated.

4.15.3 Categories

Following focused coding, the data are analysed for similarities and differences and data that are conceptually similar are grouped together (Corbin & Strauss, 2015). The purpose of the constant comparison is to assess whether the data support and continue to support the categories that are beginning to emerge (Holton, 2010).

Charmaz (2014) states how succinct focused codes can lead to clear categories and advises the researcher to understand how their codes fit together as this can lead them to understand the properties of their categories. Clustering is one tool that Charmaz (2014) advocates when trying to understand the data, where a researcher can really take the time to understand their codes and the connections between them. It provides a visual and flexible technique to organise data (Charmaz, 2014). She states that it usually consists of a central category or idea which is circled and then further spokes containing connecting properties are added to show connections. While Charmaz (2014) identifies how clustering can liberate creativity, I found clustering useful in the initial and focused coding stages as I could see the connections between the initial codes and the focused codes. This then allowed the refinement of the focused codes and to identify possible categories. An example of some of the clustering exercises I carried out are in Appendix 18. Charmaz (2014) highlights some of the focused codes may become elevated to category status and this was apparent within my study. For example, the initial focused codes I had created of 'Being part of the community' and 'cultural influences' were elevated to category status via a category named 'Being influenced by religion, culture and the community'. The categories are then used as a means of further analysis to develop the emerging theory. A key method in theory building concerns theoretical sampling.

4.16 Theoretical sampling

Theoretical sampling is different from the initial sampling discussed earlier in section 4.4. Charmaz (2014: p197) states that *"initial sampling in grounded theory gets you started; theoretical sampling guides where you go"*. She explains how initial sampling is used to establish criteria to sample in relation to people, settings and situations before you begin data collection e.g. females aged 18-25 from a British born South Asian demographic background. The purpose of theoretical sampling on the other hand is to obtain data to explicate one's categories which allow the researcher to define pivotal traits and qualities of the experience being studied (Charmaz, 2014). It is a process in which initial data analysis leads to ideas, categories and possible explanations of the data set and which will directly inform the next steps required in data collection (Harris, 2015). Theoretical sampling decisions are made in relation to the direction of the study and what data would be needed to develop the emerging categories and theory (Glaser & Strauss, 1967). Charmaz (2014) supports this by stating how theoretical sampling is only concerned with the development of theory and not increasing the generalisability of your findings (Charmaz, 2014).

In my study, theoretical sampling was used to direct phase two recruitment as outlined earlier. While participants did not need to have accessed sexual health services to take part in the study,[10] rather their willingness to discuss these issues, all participants in phase one had attended university and many had accessed sexual health services. The emerging categories were around agency and control, shame, respect and acculturation. It became evident that in order for the tentative categories to have greater theoretical reach, I would need to recruit participants from a varied educational background in order to check whether the emergent categories only had salience in this context. Holton (2010) stated that emerging theory will control data collection beyond the initial decisions made about data collection by the researcher. While not anticipated, during phase one, it was clear that many of the participants had accessed sexual health services and were willing to share their experiences both in the interviews and the focus groups and tentative categories were emerging which allowed me the flexibility needed at this early stage of analysis. As initial data analysis ran parallel with data collection it became necessary to consider how phase two was approached to ensure emerging categories and concepts were focused on and developed. The tentative theory that was emerging meant that I still had questions as to whether those that had not attended university had similar experiences and views. Using theoretical sampling allowed the refinement of the emerging categories and the eventual theoretical interpretations that were generated (see section 4.18 for theory construction). Although I adopted an open approach where my sampling and recruitment strategies were concerned (e.g. through the use of social media and attempting to recruit through community groups, rather than education based facilities), all the participants that volunteered were in further education or had previously attended further education but had not continued to higher education. It was important to note that the quality of my data may be affected insofar as women who had not continued through formal education following high school were not represented. However statistics highlight that only a very small percentage of 16-18 year olds in England do not attend further education for study which includes apprenticeships (Association of Colleges, 2021). 86% of 16-18 year olds attend education (34% attend further education and sixth form colleges, 25% attend all state funded schools, 12% attend higher education, 5% attend independent schools, 5% undertake apprenticeships, 5% access other education and training). The remaining 14% are in

[10] I had originally anticipated that participants in phase one might not discuss their experiences of accessing sexual health services due to the sensitive nature and because focus groups may have limited disclosure in a group and therefore I had asked females who had been recruited to phase one to indicate on the consent form if they were willing to participate in an individual interview in phase two if they had accessed a sexual health service.

employment, attend special schools or are identified as not in education, employment or training (NEET) (1% attend special schools, 7% are employed and 7% are identified as not in education, employment or training) (Association of Colleges, 2021).

4.16.1 Theoretical saturation

Determining adequate sample size in qualitative research is ultimately a matter of judgement and experience in evaluating the quality of the information collected against the uses to which it will be put, the particular research method and purposive sampling strategy employed, and the research product intended (Sandelowski, 1995). In grounded theory, saturation or theoretical saturation occurs when no new information or theoretical categories emerge during data analysis and also when sufficient data has been gathered to support the emerging theoretical categories (Charmaz, 2014). Theoretical saturation is reached once the analysis of data through coding and constant comparisons stops revealing new dimensions or information (Holton, 2010).

During the transcribing process and the initial analysis of phase one data, I found similar information and answers were being produced. In collaboration with my supervisory team, I decided that should any further participants volunteer for phase one then they could be interviewed however as no new information was emerging, it felt prudent to begin phase two.

Although I had less participants in phase 2 of the study, overall, I felt that theoretical saturation was achieved in so far as the analysis of the data led to the emerging theory and that no new information was being revealed. Charmaz (2014) emphasised that theoretical saturation is about the saturation of the emerging categories and concepts which difffers from saturating data and can only occur through constant comparison and analysis. "*Categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories*" (Charmaz, 2014, p. 213). Theoretical saturation is a consequence of theoretical sampling (Charmaz, 2014).

4.16.2 Member checking within theoretical sampling

Charmaz (2014) stated that member checking is an accepted process within theoretical sampling which may lead to recruiting new participants or returning to earlier

participants to clarify points or ask further questions. Member checking is also identified to be a notion of rigour (see section 4.3.1). In this study it was intended that I would revisit participants to discuss the emerging categories and consider whether these related to the participant's experience, with revisions then made as appropriate. Charmaz (2014) also highlights that as theoretical sampling is not without its problems, she suggests that tools such as member checking may be useful to gather further insights or elaborate categories[11]. Overall, I was only able to meet with one participant (Yasmin) from phase one who provided confirmation and also further information where there had been a gap in data in relation to why she felt her mother colluded to maintain her secret relationship. (Member checking is also discussed in the Discussion chapter, section 11.5.5).

4.16.3 Theoretical sorting

Theoretical sorting provides a means by which the analysis can be organised and facilitates the generation of theoretical links (Charmaz, 2014). Theoretical sorting facilitates analysis and theory development and Charmaz (2014) promotes the use of methods such as memo writing and diagramming to facilitate this process. What memo writing and diagramming are, and how they were used as an integrated process of theoretical sorting will now be considered.

4.16.3.1 Memo writing

Memos can be described as theoretical notes about the data which aim to capture the researcher's emerging thoughts around the codes and categories (Charmaz, 2014; Holton, 2010). *"They are the narrated records of a theorist's analytical conversations with him/ herself about the research data"* (Lempert, 2007, p. 247). Memos are written about the codes, the data and the emerging categories (Charmaz, 2014). Memos are the researcher's thoughts, observations and questions on the data and which can lead to areas that need to be understood further (Hunter, Murphy, Grealish, Casey, & Keady, 2011b). It is also considered that self awareness can be expressed through honest memo writing which is crucial in maintaining reflexivity (McGhee, Marland, & Atkinson, 2007). As Charmaz defines *"memo-writing provides a space to become*

[11] While I made attempts to contact some of the participants for member checking purposes, I experienced difficulties due to many of the participant's educational email addresses being inactive.

actively engaged in your materials, to develop your ideas, to fine-tune your subsequent data-gathering, and to engage in critical reflexivity" (p. 162). Memos can be written in informal and unofficial language as they are for personal use and Charmaz (2014) argues that what matters most is to keep writing memos and in a way that advances your thinking. Ghezeljeh and Emami (2009) also argue that memo writing creates a dialogue for the researcher which can help clarify what occurred during data collection and to identify what is explicit and implicit in the data. I used memo writing throughout the analysis process with one example included here, and a further one in Appendix 20.

Example of Memo

I asked Munira what should be taught in school around sexual health education. She had already identified that most of what she had learnt was from her mother.

> *Munira: What is safe sex and definitely the consent thing as well. Cos I know like in school I've learnt that if your husband wants sex you have to give it to him but I don't believe in that because I am an individual myself, I am not there to merely serve his purpose. I think mainly like safe sex and consent for me.*

I asked her to clarify what she meant by consent.

> *Munira: The right to say no.*

Despite Munira describing herself as more religious than her family, she did not agree with this religious teaching. She valued herself as an individual and her agency mattered to her. She mentioned consent in marriage which related to this religious teaching also. This concerned me as there may be women who may take this teaching literally without reading it in context with what the role of the husband towards his wife may be for example. I also wondered why Islamic faith based schools delivered this teaching in isolation without looking at both the role of the wife and husband. This could lead to women enduring situations of marital rape. Saleha and Fatima also brought up this teaching in phase two. This also resonated with an earlier interview with Safia in phase one, who brought up the issue of marital rape and women not realising that what they were enduring was rape as it occurred within the confines of marriage. The issue of agency was clearly an issue.

Figure 2: Memo writing

4.16.3.2 Diagramming

Diagrams provide *"concrete images"* and a *"visual representation of categories and their relationships"* (Charmaz, 2014, p. 218). There are no set rules to the types of diagrams, whether charts or figures, or at which stage of analysis you choose to use diagrams, however it has been suggested that they are an intrinsic part of grounded theory (Charmaz, 2014). I found diagramming, to be very useful when analysing the data as it provided a visual picture of the categories and helped to consider the directions and connections between them. Charmaz advocates the use of clusters as discussed earlier in section 4.15.3, which helped me to form connections between the codes. I found the use of visual methods to be very helpful and therefore continued to use diagramming more than memo writing to help refine the analysis.

The diagrams continued to be refined as data collection and analysis progressed and in line with Charmaz (2014), I found theoretical sorting to be a crucial stage in the construction of theory.

4.17 Reasoning

Reasoning has been described as "*the act of drawing inferences from evidence, and is an essential component of human intellectual functioning*" (Hayes, Stephens, Ngo, & Dunn, 2018, p. 1333). There are three common types of reasoning in the literature namely deductive, inductive and abductive. Deductive reasoning begins with a more general hypothesis which is the narrowed down to something which can be tested and confirmed (Trochim, 2006). Deductive reasoning does not provide the opportunity for new information to emerge and has been said to limit creative thinking (Cline, 2019) and was not considered within my study. Inductive reasoning "*begins with a study of a range of individual cases and extrapolates patterns from them to form a conceptual category*" (Charmaz, 2014: p343). It is through data collection and analysis that patterns may be detected, which in turn may lead to the generation of tentative hypothesis and the development of general conclusions (Trochim, 2006). Inductive reasoning can provide new ideas and enhance worldly knowledge (Cline, 2019). Constructivist grounded theory begins with inductive reasoning but moves to abductive reasoning through theoretical sampling.

Abduction is a type of reasoning that begins through inductive inquiry and is a mode of reasoning, *"researchers invoke when they cannot account for a surprising or puzzling finding"* (Charmaz, 2014: p200). Abduction is also viewed as a moments when understanding is grasped (Lipscombe, 2012). Abduction requires researchers to make an *"inferential leap"* when observing and analysing the data for any theoretical observations which in turn will lead to theoretical interpretation and construction (Charmaz, 2014: p 200). Lipscombe (2012) also explains abductive reasoning to occur when researchers develop beliefs about the meaning of the data they are analysing. Abductive reasoning then allows the researcher to return to the data or gather more data from new or earlier participants to confirm the emerging theoretical interpretation (theoretical sampling). Grounded theory is an abductive method as it involves *"reasoning"*, where the researcher makes *"inferences"* about *"empirical experiences"* (Charmaz, 2014: p201). This type of reasoning has been referred to as intuitive and instinctive in nature, and it comes into play when something new emerges or is observed and can be used to provide an explanation (Walton, 2005). Abductive reasoning can lead researchers to emergent and unanticipated theoretical directions which in turn can lead to a unique interpretation of theory (Charmaz, 2014). I will now discuss the construction of theory.

4.18 Theoretical interpretation and construction

Theoretical understanding is obtained through the theorist's interpretation of what is being studied (Charmaz, 2014). When using grounded theory, the theory development involves inductive and abductive reasoning via creating codes, the use of constant comparison in developing and forming categories, writing memos and/ or diagramming, coupled with reading and engaging with literature around the categories (Charmaz, 2014). Constructing theory is not viewed as a mechanical process and being open to the unexpected may expand the view of what is being studied and in turn the theoretical possibilities (Charmaz, 2014). While engaging with the literature around the categories, reasoning using Charmaz's approach as discussed above, and through the analysis that took place following the processes of theoretical sampling sorting and diagramming, led me to the emergence of a theoretical interpretation of my findings- presented and discussed in Chapter 10.

4.19 Conclusion

In this chapter I have outlined the methods adopted during data collection. This included the collection and consideration of reviewer feedback, the need for flexibility within data collection methods, how concepts of rigour were adhered to and how key ethical principles were followed in my study. All the stages of coding using a constructivist grounded theory approach have also been described and to illustrate how they facilitate the emergence of categories and the eventual construction of theory. In the next chapter, the sociodemographic details of the participants are presented. I also provide an overview of the findings and include a table which shows how the themes link to my aims and objectives.

5.0 Overview of the findings

5.1 Introduction

In the previous chapter I detailed the data collection methods, ethical considerations, rigour and data analysis used in my study. I also described how constructivist grounded theory approaches were adopted. In this chapter I provide an overview of the participants collected from the personal characteristics form (Appendix 11) and a visual overview of the findings. Pseudonyms have been used to protect participant identity. My reflexive notes around the focus groups and interviews are also included along with participant characteristic information for both phases of the study.

5.2 Participants

An overview of participant information is found in the personal characteristics (Table 2) below.

Name	**Age**	**Place of birth**	**Ethnic background**	**Religion**	**Education level**	**Data collection method**
Phase one data collection						
Safia	23	Blackburn	Pakistani	Islam	University	Interview
Sara	21	Preston	Pakistani	Islam	University	Interview
Rizwana[12]	24	Preston	Indian	Islam	University	Telephone interview
Anisha	19	Lancaster	Indian	Islam	University	Focus group 1
Memuna	21	Preston	Pakistani	Islam	University	Focus group 1
Khadija	20	Burnley	Bangladeshi	Islam	University	Focus group 1
Naznin	21	Blackburn	Indian	Islam	University	Focus group 1
Amelia[13]	21	Birmingham	Mixed race	NA	University	Focus group 2
Yasmin	20	London	Indian	Islam	University	Focus group 2

[12] Rizwana was married
[13] Amelia was mixed race. Her father was Mauritian and her mother was English

Shabana	20	Nuneaton	Pakistani	Islam	University	Focus group 2
Maria	21	Chester	Sri Lankan	Christian	University	Telephone interview
Phase two data collection						
Saleha	18	Preston	Indian	Islam	College	Focus group 3
Fatima	18	Preston	Indian	Islam	College	Focus group 3
Uzma	19	Blackburn	Pakistani	Islam	College	Focus group 4
Adeela	21	Blackburn	Pakistani	Islam	College	Focus group 4
Munira	18	Preston	Indian	Islam	College	Interview

Table 2: Personal characteristics table

5.3 Reflections on wider participant information

Here I reflect on some of the wider participant related information. Saleha and Fatima in focus group three were dressed in Islamic clothing so it was obvious they were both Muslim. Saleha came dressed in full black Islamic clothing including the face veil (nikab). She removed this once we were inside the classroom and the door was closed so I was able to see her facial expressions. Fatima also wore black and was covered from head to toe but she did not wear a nikab. Munira, who was originally scheduled for focus group three but rescheduled, also wore black from head to toe but did not wear a nikab. Khadija and Uzma also wore a hijab. Killian (2003) identified that the variety of styles of Islamic dress throughout the world reflect local cultures and diverse interpretations of religious requirements but highlights that many children of immigrants are donning the veil and face coverings through personal freedom and in a search for cultural identity. There appears to be a lack of consensus in terms of the face covering being a religious requirement and Ahmed & Keating (2013) found that women wore the veil or headscarf for numerous reasons which included religious reasons, to raise other women's awareness of the sexist messages portrayed by society and for self-identity.

Overall, all bar one of the participants was married (Rizwana). In focus group three, Adeela's young child was present, and both participants (Adeela and Uzma) initially told me that Adeela was married. However, part way through the focus group, it

transpired that she was single but tended to tell people that she was married due to the potential of judgement of having a child out of wedlock.

5.4 Personal reflections on data collection

When data collection commenced, I was mindful about waiting for enough participants to schedule a focus group so arranged interviews with the first two participants that enquired. I felt it was important to begin data collection as I already had concerns over whether women would contact me to participate. However, after these two had been completed, I started to feel more comfortable about raising focus groups as an option with the individual women.

I went to great efforts and attempts to recruit women to the study. As previously identified, I tried to recruit through community groups, colleges, universities and through social media. I contacted any contacts and leads I could follow. Flyers were sent out electronically and as hard copies. Some community group envelopes were returned as non-deliverable. I regularly felt waves of disappointment when I did not hear back from possible contacts or when only a small number of women responded. Before commencing this study however, I was aware that there was a risk that I would not recruit any participants or that the numbers would be too low due to the nature of the topic being deemed as sensitive among South Asian women. Whilst I was aware of this, I felt that it was important that I continued to pursue this study and try and exhaust all methods available to me to recruit participants. The number of participants recruited may influence the quality of the data however, while the numbers are low, the value of the women sharing their experiences and hearing these ‘hidden’ stories is immeasurable.

All of the focus groups were arranged through snowball sampling, whereby women who contacted me were asked if they knew of others who would want to join the study and to take part in a group discussion. In all of these occasions, it meant the participants seemed to be at ease to discuss and share their experiences. I did not feel that a group of participants who did not know each other would participate comfortably and openly in a focus group on this topic.

Focus group two took place in a participant’s bedroom in a house she shared with one other, with all participants sat on the bed, and myself on a chair facing them. Despite my reservations of where the focus group was taking place, it was clear the participants were familiar with the setting and each other. The bedroom had a lock. To try and

guard against any potential breaches in confidentiality, the focus group was scheduled at a time when her other housemate was not home. After the focus group was over, Shabana commented how relieved she had been when she first met and spoke to me; she had been concerned that the researcher may have been someone who came across as religious and this would have affected her ability to participate openly (see section 4.11). I could relate to her comments as someone overly religious would likely have prohibited disclosures of 'forbidden' practices such as sex outside marriage.

Focus group three was with college students. Munira had contacted me to indicate that she was not attending as part of the focus group but would be happy to be interviewed separately. On reflection this worked well, as she disclosed issues about a friend that she may not have felt able to do during the focus group. While not explored, her choice to not attend the focus group and to be interviewed separately may have been intentional. The numbers of participants in the focus groups were low. I can see advantages and disadvantages to this. The discussions between a focus group containing only two participants may be limited compared to a focus group with higher numbers and may therefore influence the quality of data. I felt that the focus group that had four participants and even three participants led to the participants developing the discussions in a more detailed manner in comparison to the focus groups where there were only two participants. However, I also considered the possibility that due to the nature of the topics being discussed, it was important that the participants were at ease with each other and felt they could talk freely which all the participants in the focus groups appeared to do so. I am unsure whether the participants would have been able to talk as freely had the focus groups had larger numbers.

Focus group four also only had two participants despite planning for more and took place in one of the participant's homes. The locations of the focus groups and interviews may influence the quality of data. If the location is not suitable for all participants then they may not feel comfortable sharing their insights which will then influence the quality of the data obtained. I felt that I had to be flexible with regards the location of the focus groups and interviews to enable women to participate where they felt comfortable. I found it easier to undertake the focus groups on campus as it was a familiar setting for me. I was nervous travelling to the other locations in North West England as I would not know the setup of the space where I would be undertaking the focus groups apart from knowing that the participants had confirmed they had access to a space where the focus group could take place privately. Once I arrived at the locations and had met the participants, I felt reassured and able to undertake the focus

groups with confidence. I also felt that as the focus group took place in their environment, that the quality of data collected was less likely to be compromised.

While most of the interviews were undertaken face to face, two took place over the telephone. Rizwana had requested a telephone interview due to the difficulties in finding a suitable location in the city where she lived and trying to schedule the interview around work and family commitments. Maria scheduled a telephone interview with me as she had been unable to attend focus group two. I guarded against potential breaches in confidentiality by agreeing a time to undertake the telephone interview when the participants knew they would be alone and would have privacy. Rizwana chose to schedule the telephone interview while she was in her office at work, at the end of her working day. Upon commencement of the telephone call, I also asked the participants if they were alone and whether they were able to participate in a confidential discussion. While there are issues about the quality and depth of information obtained via telephones (see section 4.9.5), e.g. missing vital interpersonal cues such as body language, the interviews proceeded well. Rizwana was also able to offer different insights as a married woman. For me personally, I preferred the face to face interviews and focus groups over the telephone interviews, however as my participant numbers were low, it was important that I did not lose the insights of women who had agreed to telephone interviews. The discussions that took place in the focus groups may have provided deeper insights than the data obtained through the telephone interviews. Although I was aware that having different modes of data collection could influence the quality of data, I was concerned with obtaining the views of all the women who had volunteered once they met the inclusion criteria. I also didn't want to exclude women by restricting the different modes of data collection available.

Due to acculturation, the findings have the potential to reflect the experiences of young women from a number of cultural groups in the UK and not solely reflect the experiences of British born South Asian women.

I encountered challenges with member checking as described in section 4.16.2 as I found that I was only able to re-contact one participant due to the participants' education-based email addresses no longer being active.

5.5 Overview of findings

A visual overview of the findings is presented in Figure 3 below. Diagramming (section 4.16.3.2) was used as a process of theoretical sorting (section 4.16.3) which facilitated

analysis and aided the generation of theoretical links. Themes were developed from the focused coding stage, which led to three main categories of findings which are presented in the next chapters. How these themes link to my aims and objectives are presented in Table 3 below:

Aims and Objectives	Themes
Aim:	
To explore the perceptions, awareness and experiences of sexual health among British born South Asian females, aged 18-25; to consider whether and how these are influenced by culture, religion and wider social factors.	• The influence of religion on behaviour and beliefs • Being part of the community • Knowing your boundaries • Identifying gender differences • Discussing sexual health issues with fathers • Falling pregnant before marriage • Focusing on marriage • Encountering acculturation • Maintaining secrets • Discussing sexual health issues with mothers • Disclosing the relationship to mothers and other females • What is sexual health? • Accessing services for testing, screening or advice • Engaging with professionals for sexual health needs • Feelings and beliefs towards sexual health education
Objectives:	
To elicit participants' awareness of sexual health issues and sexual health service provision.	• Discussing sexual health issues with mothers • What is sexual health? • Accessing services for testing, screening or advice • Engaging with professionals for sexual health needs • Feelings and beliefs towards sexual health education
To explore the participants' perceived needs, expectations and concerns related to sexual health and accessing sexual health services.	• Disclosing the relationship to mothers and other females • Accessing services for testing, screening or advice • Engaging with professionals for sexual health needs • Feelings and beliefs towards sexual health education
To gather in-depth insights into the participants' experiences of sexual health	• The influence of religion on behaviour and beliefs

and sexual health service provision.	• Being part of the community • Knowing your boundaries • Identifying gender differences • Discussing sexual health issues with fathers • Falling pregnant before marriage • Focusing on marriage • Maintaining secrets • Discussing sexual health issues with mothers • Disclosing the relationship to mothers and other females • Accessing services for testing, screening or advice • Engaging with professionals for sexual health needs
To consider how culture, religion and wider social influences, impact on women's understanding of and access to sexual health provision.	• Encountering acculturation • What is sexual health? • Accessing services for testing, screening or advice • Engaging with professionals for sexual health needs • Feelings and beliefs towards sexual health education

Table 3: Links between the aims and objectives and the themes from the findings

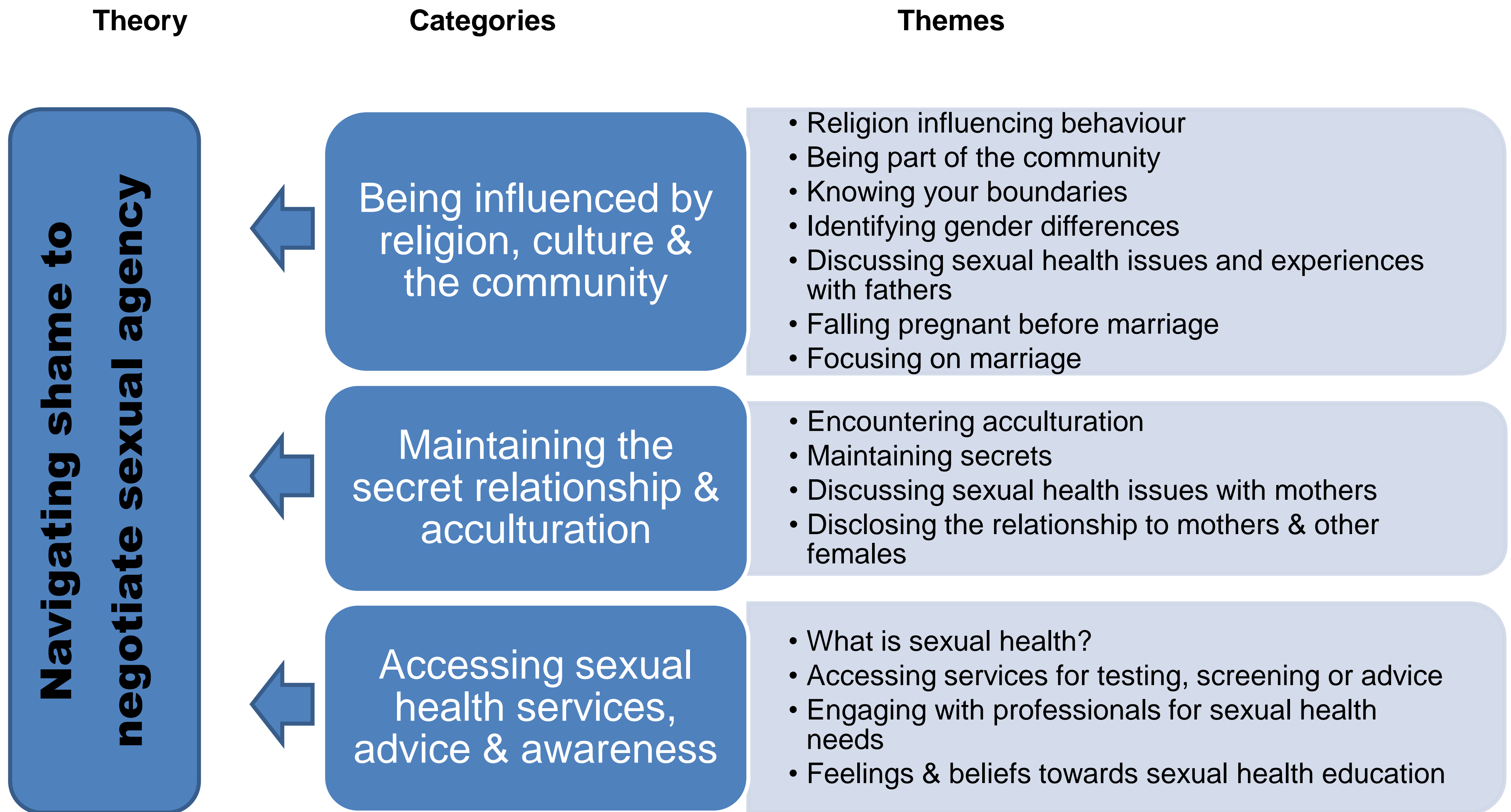

Figure 3: Overview of findings and theoretical development

5.6 Conclusion

In this chapter I have detailed participant characteristics and included some wider reflective notes on arranging and undertaking the focus groups and interviews. I have also presented a visual overview of my findings. In the next chapter, the first category of ‘being influenced by religion, culture and the community’ will be presented.

6.0 Findings: Being influenced by religion, culture and the community

6.1 Introduction

In the previous chapter I I provided participant information, an overview of the findings and some reflections of undertaking and organising the focus groups and interviews. This chapter is the first of three chapters that present the three key categories that emerged from the data set. In this chapter I present the category 'Being influenced by religion, culture and the community' which consists of seven main themes 'the influence of religion on behaviour and beliefs', 'being part of the community', 'knowing your boundaries', 'identifying gender differences', 'discussing sexual health issues and experiences with fathers', 'falling pregnant before marriage and 'focusing on marriage'.

6.2 The influence of religion on behaviour and beliefs

Prior to describing the participants' views of how religion influenced behaviour, it feels important to re-define religion (with further details provided in Chapter 2). As described in Chapter 2, what practices and beliefs constitute religion or a facet of culture is complex, with different opinions noted. This was evident in my study in that while participants identified themselves as belonging to a religion, their practice of religion varied in that some participants practiced some elements of their religion more than others, which suggests the impact of culture. This further added to the complexity of understanding the influence of religion on an individual.

Most of the participants identified that they belonged to a religion and whether this was Islam or Christianity, the religions provided norms, *'rules'* and expectations on how an individual should live their lives; *Yeah. Obviously you have to like stick to the rules.* (Uzma, Focus group 4, Phase 2). Some of the participants alluded to how religion was used as a means to control and regulate their behaviour in interacting with the opposite sex, platonic or otherwise. The key concern was that socialising with the opposite sex could eventually lead to feelings of romance and sex. Therefore while marriage was a key and ultimate goal - *Islam says you should get married* (Uzma, Focus group 4, Phase 2) – interactions with males were often moderated or prohibited to prevent relations outside of being wedded. For a few of the women this meant that they were

not able to play out when younger due to the potential for mixing with boys. Not socialising with the opposite sex was often instilled from a young age:

> *My parents were okay with it [mixing with some boys when young] but it was the mosque, cos there used to be boys there and we weren't allowed to mix with the boys.* (Khadija, Focus group 1, Phase 1)

A number of participants described how their families prevented them befriending boys on social media. These sanctions also extended out to educational establishments whereby those who contravened religious values, such as through interacting with boys via social media, had adverse implications:

> *Naznin: Yeah they were liking on each other's walls*
> *R: So just being friends on Facebook got them suspended?*
> *Naznin: Yeah.* (Focus group 1, Phase 1)

With the Islamic faith, women are viewed as temptation and thereby limiting socialising between the genders was perceived as an important strategy to limit any urges or desires (Saalih al- Munajjid, 2018). This is supported by other Islamic scholars who state that women should avoid being in seclusion with a man who is not their husband or close relative in order to maintain a barrier between any thoughts or actions (Al-Qaradawi, nd).

The participants in focus group 2 discussed how religion was also used as a means to restrict what females wore. Clothing (e.g. short skirts, low cut tops) that had the potential to attract attention from the opposite sex was forbidden:

> *Yasmin: or like stuff like this dress, I'd never be able to get away with this dress at home.*
> *Shabana: Really?*
> *Yasmin: No. I would have to wear up to here at least cos of my dad [referring to neckline]. My mum's fine with it. My mum's like wear what you want. Even my gran to an extent, especially in the summer. It's terrible. My dad will make me cover up all over but even my gran's like a bit looser with stuff like that. But my dad's always like people will be looking at you*
> *Shabana: Does it still happen even though you're like 20?*
> *Yasmin: Yeah definitely.*
> *Shabana: How do you deal with it?*

> *Yasmin: I don't. I don't live there do I?! I only go home once a month.* (Focus group 2, Phase 1)

One of the women (Amelia), although not religious, still felt there were expectations on her in terms of her dress and behaviour when in the company of family members who were. The way a woman dressed was associated with respect:

> *Amelia: Yeah I've got my dad's family who are Muslim who expect the grandchildren to go the Muslim way and my mum's side that are completely English and it's fine what you do with your life […] I'm not religious at all really but when I'm with my dad's side of the family, I feel like I've gotta. I respect Muslim ways and stuff like that but feel, like you said with your clothes and stuff, I have to cover up.*
> *Shabana: I think that's like respect.*
> *Amelia: Yeah*
> *Shabana: I wouldn't wear a short dress if I went to my nan's or to other family members cos you wouldn't do that.* (Focus group 2, Phase 1)

Saleha had attended an Islamic girls' high school and as identified in section 5.3, she wore a black nikab that covered her face and hair and wore a loose black dress that covered her whole body and therefore explicitly displayed her religion through her clothing.

Although most of the participants identified themselves as belonging to a religion which stipulated they should not engage in pre-marital sex or have romantic-based relationships outside marriage, it was apparent that many did. A few of the participants who had not been in romantic relationships, in particular those from a Muslim background that had not attended university, expressed their shock when they heard about other Muslim individuals who were involved in pre-marital relationships:

> *Well I've heard of it personally where people are. I was just so shocked!* (Saleha, Focus group 3, Phase 2)

Saleha went on to say that if an individual or their family were viewed to be less religious, and they engaged in behaviour that contravened their beliefs i.e. having a pre-marital relationship, then this was not as shocking as a Muslim who was viewed as religious and therefore would be expected to know all the rules surrounding their religion:

> *The thing is that if […] people (Muslims) […] are not as religiously inclined, who don't really know what's happening, in terms of what Islam says, then it's alright but I know people (Muslims) who are above me in terms of their religious knowledge […] and they know everything.* (Saleha, Focus group 3, Phase 2)

Her judgement therefore alluded that religious individuals should know better. In her opinion it was clear that relationships should not occur before marriage. In the same focus group, her college friend, Fatima, who was also a Muslim and had not been in a romantic relationship due to her religious beliefs, believed the actions of females who entered in to romantic relationships outside of marriage to be *wrong* with clear judgement displayed:

> *I think some girls do; they know what they are doing is wrong and that their parents' image will be put out there for people to talk about.* (Fatima, Focus group 3, Phase 2).

6.3 Being part of the community

A 'community' has been defined as *"a group of people living in the same place or having a particular characteristic in common"* and as *"the people of a district or country considered collectively, especially in the context of social values and responsibilities; society"* (Oxford (2018: para 1). For the participants in this study, 'community' referred to the wider South Asian community. There were no definitive relational or geographical boundaries; rather it included those from a South Asian background that knew each other directly or indirectly. The community could span across towns and cities and further, and with family members and unknown others from a shared ethnic background.

All the participants talked about how the community had a considerable influence on an individual's behaviour and actions. There was clear concern across the participants about the community finding out about romantic relationships, as reflected in one of the focus groups:

> *R: What would happen if someone found out?*
> *Memuna: They'd be in trouble.*
> *Khadija: Yeah*
> *R: Is that if it got back to the parents?*

Khadija: Yeah. But it doesn't, like within an Asian culture if one person finds out then someone else is gonna find out cos Asians tend to talk.
Memuna: Tell each other
Khadija: They'd be like "have you heard about this girl", blah blah blah. (Focus group 1, Phase 1)

This fear was also reflected by Uzma who shared her experience attending a sexual health clinic for advice:

Uzma: I had to make sure no one was looking.
R: What was your worry?
Uzma: People seeing me and obviously you know what Asian guys are like. They'd be like, she's gone to X [name of clinic]! She's doing this! She's doing that! Can you imagine?! People talk these days as well. (Focus group 4, Phase 2)

The community knowing about an individual's relationship was believed to have adverse ramifications. A participant in one of the focus groups reported that:

If the family background is that they are very religious and then their daughter is going off and doing things in private like that then I guess it's that, if they have got a good image out there in the community then it's like trashing that image. Cos if everybody knows them, then it's bad for them. (Fatima, Focus group 3, Phase 2)

Fatima refers to how knowledge of a woman's indiscretion could lead the community to 'trash' her reputation and social status. A further participant (Khadija) described how, *'she'd be looked down upon'*. Other participants, such as Munira below, also reflected how this had wider implications, with negative impacts for the reputation of the woman's family:

I think it's like your reputation as well. Like reputation is such a big thing in the Asian community, like a massive thing, that's why when it comes to sexual health not many Asians talk about it because if the word was let out then their reputation would be down the drain. (Munira, Interview 5, Phase 2)

In one of the focus groups the participants referred to daughters being in romantic relationships to be perceived by the 'community' as a reflection on poor parenting:

R: What does that actually mean though when you say looked down upon?
Khadija: They'd be like look how they've brought their daughter up.
Memuna: It's disrespectful.
Anisha: It's like a big thing in the Asian community it's like if it was to come out like one of their daughters had done something then they would lose like a lot of respect and that's a big thing
Memuna: And a bad name in the mosque
Naznin: And it makes other people think how did they bring their children up, their daughters?
Khadija: What sort of upbringing have they had? (Focus group 1, Phase 1)

Participants considered how such an indiscretion could culminate in the entire family being ostracised from social occasions:

But I think some people have the fear of the community and the community may do something or they might not invite us to things and stuff. (Sara, Interview 2, Phase 2)

These insights thereby reflecting that judgement and shame were not simply reserved for the individual who was perceived to be behaving disrespectfully, but rather aimed at the whole family. The '*disrespectful*' act of being in a romantic relationship could lead the whole family to be negatively perceived. This was reflected by Rizwana, via use of a hypothetical scenario. She considered that if the community had knowledge of her being in an intimate relationship, this could lead to her sister being negatively appraised even if her sister was not in a relationship:

I have a sister so there will be an assumption, everyone will just assume that these two girls they just hang around with boys and have no care for their reputation or their standing in the community. (Rizwana, Interview 3, Phase 1)

One participant also reflected on how knowledge of sexual-based relationships held ramifications that extended to the wider community:

Yeah, it's like Muslims believe you should have sex after marriage and obviously people are having sex at a younger age now. It's from people like from Pakistan or the older generation, they'd be like your daughters done like, slept with someone, that's not good. She's bringing disrespect to the community and stuff like that. (Sara, Interview 2, Phase 1)

The community was clearly made up of a variety of different cultural groups which could include cultures of religion, cultures in terms of where families originated from and then there were further subcultures within these cultures e.g. castes. Where a couple were attracted to each other and were considering marriage, being of the same religion and having that in common did not necessarily mean that parents would allow the marriage to take place:

> *Safia: It was like he was Indian and I'm Pakistani so that was an issue as well.*
> *R: So despite him being Asian that's two different cultures isn't it?*
> *Safia: So it was like ermm totally different cultures to be fair, even though we're both Asian, the way he did things and the way I did things were different.*
> (Interview 1, Phase 1)

While on this occasion, the woman was the same religion as her boyfriend, however, as they were from different countries of origin and therefore had different customs, her family would never accept any future plans for marriage. Another participant also brought up a similar issue:

> *And another thing is if I'm an Indian and you're a Pakistani, well then you shouldn't be liking a Pakistani or you shouldn't be liking a Bengali, you shouldn't be liking anyone else. Just Indian, just keep it inside so I think that's a big problem that a lot of girls have.* (Saleha, Focus group 3, Phase 2)

The different cultures albeit from the same religion, were opposed to cross-cultural relationships and marriage. This was not simply about race, or beliefs but rather indicative of maintaining a particular heritage.

6.4 Knowing your boundaries

Many participants brought up the issue of maintaining their virginity before marriage:

> *Yeah but then my mum has kind of like indicated like sort of areas of being sexually having good health and keeping yourself prim and proper and everything like that. It's a lot like keeping your virginity is seen as, it's something like respect. A woman keeps her respect if she has her virginity.*
> (Safia, Interview 1, Phase 1)

As reflected by Safia above, maintaining virginity was fundamentally associated with

respect. Although romantic based relationships were forbidden on religious grounds, some participants referred to how they were 'bending the rules' by being in a relationship but were not sexually active. Many participants highlighted how the need for *'boundaries'* and to not have sex was paramount amongst their parents. Anisha described how her mother used the term *'boundaries'* as an unspoken rule:

> Anisha: Yeah with sexual health she wouldn't say anything. She's fine with me having friends who are boys. My dad isn't, my mum's fine with it but she always like says, well she never says stay away from sexual relationships but she does say you know your boundaries and what you're not allowed to do.
> R: Boundaries meaning to maintain your virginity?
> Anisha: Yeah but she'll never say it explicitly. (Focus group, Phase 1)

Some participants suggested that women would flex boundaries to meet their relationship needs. Fatima felt that other females who were involved in premarital relationships may be finding ways to convince themselves that it was acceptable:

> *I guess it's that thing that if you know it's wrong, but you can make yourself believe it's not wrong, you can convince yourself and then all that just kind of goes away.* (Fatima, Focus group 3, Phase 2).

What I interpreted from this was that if a female knew she would eventually be marrying her boyfriend, then she was not doing anything wrong. Or if a female had a boyfriend but did not have sex with him, then this was also permissible. It felt like individuals found ways to manipulate the rules or teachings of their religion to suit their situations. An example of this behaviour was demonstrated by Safia where she discussed the extent of her sexual behaviour with her boyfriend:

> *We weren't totally sexually active. We may have kissed and stuff but that was about it. We never actually did the deed.* (Safia, Interview 1, Phase 1)

Safia identified that she belonged to the Islamic faith and stated that she entered any relationship with the *'intention to get married'*. So in this occasion, she reflects Fatima's view of how individuals *'can convince'* themselves that entering a romantic relationship is okay if your *intention* was to marry them:

Well yeah, if I'm being honest, the thing is, I always talk about marriage whenever I have a partner cos that's my intention to get married. I know that sounds silly although we never did actually. (Safia, Interview 1, Phase 1)

Further findings on the emphasis on marriage are presented in section 6.8.

6.5 Identifying gender differences

Some participants identified that culturally, beliefs towards male behaviour in terms of being in a romantic relationship were viewed very differently to female. Saleha and Fatima reported:

Saleha: It's really easy to hide what they've [males] *done.*
Fatima: I feel that if a girl does something then the whole world will know and it stays but if a guy does something it's talked about for two or three days and then it goes away. (Focus group 3, Phase 2)

These findings were similar to what was discussed in focus group 1 where participants felt that there were stark differences between the genders where romantic or sexual based relationships were concerned:

Memuna: It's more frowned upon if it was a girl.
Khadija: It's brushed under the carpet if it's a boy but if it's a girl. Like when marriage proposals and stuff come and then they find out she's had sexual experience they'll probably turn her down. But if it's a boy they won't really know either.
Anisha: They say with girls it's more shameful for girls to have sex with someone but if it's a boy it's like oh it doesn't matter like he's staying in his family
R: Right so when you say staying in his family, you mean that the girl is marrying into his family and going to live in the boy's home?
Anisha: Yeah. It's like if a girl has a bad reputation or something then no-one's going to want to marry her but if it's a boy he can marry whoever he wants […]
Naznin: Again it links to culture. How they see boys and girls
Memuna: Boys get away with everything and girls just get the stick for everything. (Focus group 1, Phase 1)

The participants felt that males were treated differently to females and there were fewer repercussions where males were found to be in relationships. Anisha felt that the

expectations placed on males and females culturally differed and that males were aware of these differences so they could be more open about their relationships:

> *They're a lot more open about having sexual relationships and for them it's alright, well not alright but everyone seems to thinks it's alright for them to do it cos they're boys but with girls it a bit more, it's different.* (Anisha, Focus group 1, Phase 1)

Khadija shared a story about a video she had seen previously which reiterated that some males felt that they were above such cultural expectations and the repercussions were only aimed at women:

> *Khadija: Yeah. I was watching this video a couple of week ago and it was about this married couple, it was like Muslim videos and the guy had found out that his wife, before she had turned proper religious she used to like have boyfriends and stuff and then he said to his friends "I'm gonna divorce her because of her past" and then she said to him "you already knew that I didn't used to be quite religious and I used to like talk to boys and stuff". One of his friends said to him what if that was you in that situation and he said well that's different.*
> *R: So it's almost like different expectations and the rules are different for boys?*
> *Khadija: Yeah.* (Focus group 1, Phase 1)

This example highlights that even the media portrayed men to consider themselves differently to women further identifying differences among the genders.

Boundaries set by parents were discussed in the previous section; however this section considers the women's own boundaries. Although the participants described that their boyfriends generally understood their need to not have sex before marriage due to being from the same religion, they also identified that their boyfriends were less concerned over maintaining their virginity before marriage:

> *R: What […] are the boundaries you set yourselves as girls [and are they] different to the boundaries that your boyfriends might expect from you?*
> *Khadija: I don't think sex is an option.*
> *R: Do you think he's ok with that and he understands that?*
> *Khadija: Yeah […]*
> *Anisha: With me you can't have sex before you get married but I know my boyfriend, he would if he could. He sort of understands so it's alright.*
> *Memuna: He knows it's not gonna happen […]*

Khadija: Boys, they socialise more differently, like if they could, they would just do it. But with girls they think about so many things. They think about their family and they think about oh what if something happens
R: So the girls are thinking about the consequences?
Khadija: Yeah, the boys they just think about the action. (Focus group 1, Phase 1)

As reflected in the discussion above, they reported how their boyfriends did not have the same consequences to consider, as they did. The consequences could include pregnancy or should they not marry their boyfriend then they would be entering marriage without being a virgin. Naznin, discussed her fears, challenges and her views on sex before marriage:

Naznin: Well I think if you're gonna get married to him then I don't think it's really a big problem because at the end of the day you're gonna get married to him but then again you just don't know. With me it's like my boyfriend he is a different caste to me. I'm Indian, he's Pakistani.

Despite religion forbidding pre-marital relationships, some women believed that if marriage was inevitable then they could have more intimate relationships with their boyfriends. In this scenario Naznin had strong desires to marry her boyfriend and felt it was acceptable for her to have sex with him. Naznin's boyfriend was waiting for her to be like him - *'ready'* to discuss marriage with their respective families. However, Naznin refrained from approaching her family due to a fear that her family may not accept her boyfriend's marriage proposal due to his cultural background whereas her boyfriend was ready to *'go and sit with [his] family and tell them about [her]'*. As identified earlier and reported by others (section 6.3), the participants were often well aware of the characteristics of a 'suitable' future husband.

6.6 Discussing sexual health issues and experiences with fathers

Being able to discuss relationships or sexual health issues was not easy for many of the South Asian women in my study. Most identified that they would be unable to turn to their fathers for sexual health information or advice. Memuna highlighted the need to *'hide'* issues that were seen as *'women's issues'* that could not be discussed with male family members. Munira stated:

R: Who would you definitely not turn to for sexual health information and advice?
Munira: My dad. Definitely not to my dad.
R: Is that cos he's male?
Munira: Just out of respect I wouldn't turn to him. (Munira, Interview 5, Phase 2)

Similar to issues surrounding virginity, the non- disclosure of sexual health issues was associated with respect. Munira, as well as others indicated that as sexual relationships (and therefore sexual health issues) were not permissible before marriage then disclosures with fathers prior to wedlock would be disrespectful. Yasmin described an incident where her father observed her in the company of a male friend:

> *Actually once I was walking to school with a friend that was a boy who lived at the top of my road and my dad drove past and was convinced I was snogging him. We were walking to school. It's ridiculous!* (Yasmin, Focus group 2, Phase 1)

Any behaviour that could be misinterpreted to have a sexual nature had to remain hidden to avoid being questioned thereby highlighting how even being in close proximity with a male could be perceived as disrespectful.

While Shabana's parents were divorced, she described how different her situation would have been had her father been around:

> *Yeah I think if my mum was still with my dad then definitely it would have been a completely different story, like right now I probably wouldn't even be here [University].* (Shabana, Focus group 2, Phase 1)

Shabana believed that she would not have been allowed to move away from home to study at university if her father still lived at home. For her father, living away from home and outside the parental gaze, meant there was freedom to make choices which may in turn cause disrespect.

Safia also disclosed how she felt unable to turn to her father for sexual health information and advice:

> *I wouldn't turn to my dad… there's a caring sort of role with a father and obviously if you're sexually active you're no longer a child and your innocence has left you. And your dad sees you like a little child. I don't know, it's like an Asian thing I think where the father figure's always there, no matter what.* (Safia, Interview 1, Phase 1)

Safia did not want to lose her status as her father's *'little child'* as she associated being sexually active with losing your childlike *'innocence'* and did not want to be perceived differently by her father. Whereas Adeela stated that while she did not grow up with her father, she now had a relationship with him whereby he supported her and her situation of becoming a mother out of wedlock:

> *R: Would you have felt comfortable turning to him? I'm guessing you lived with your mum?*
> *Adeela: Yeah ermm*
> *Uzma: Dads are more strict!*
> *Adeela: No but my dad's not though. You know what my dad's like though. He's proper lenient and stuff like that. I've got two babies though and when he found out I was pregnant with the second he was like, don't have any more (giggling) and he was like helping me. Like he used to come every day and help with her (referring to the toddler) and he was like look it doesn't matter at the end of the day they're my grandkids. Whatever you've done, you've done but he was alright with it.* (Focus group 4, Phase 2)

The relationship Adeela described was very different to the father-daughter relationships expressed by others. Adeela was able to discuss her relationship and pregnancies outside of wedlock with her father. Although it was possible that as Adeela did not grow up with her father, this had a bearing on their open relationship.

While Anisha's mother was happy for her daughter having male friends, her father was not. There were some differences between what fathers or mothers allowed their daughters to do (with issues about relationships with mothers discussed further in Chapter 7). Memuna described that while sex was forbidden, she could talk to her father if she was interested in someone for the purpose of getting married:

> *R: So you wouldn't talk about sexual health or relationships with him*
> *Memuna: Well relationships he says you know your boundaries but if you find someone you like and you think it's gonna be serious and you're gonna get married to them then that's fine he said. You can get married to them.*
> *R: So would you be allowed to date?*
> *Memuna: Well this happened with my sister and my dad was cut out of the picture. So my sister was going out with him at uni and my mum and dad didn't know about it either and they were going out for a few years and when she wanted to get married, it was time to tell my dad. She told my dad then and my dad said that's fine.*
> *R: So she was in a relationship at uni*
> *Memuna: Yeah but my dad didn't know. My dad's said to me though now, that if you find someone and you think you might wanna get married to them and*

> *they're Muslim etc etc then that's fine. He doesn't mind talking about potential relationship, just not sex.* (Focus group 1, Phase 1)

This quote highlights that although Memuna's father was amenable to discussions about a potential husband (similar to perspectives of mothers discussed later in the next chapter), being in a relationship was not permissible.

6.7 Falling pregnant before marriage

The issue of pregnancy before marriage was brought up by a few of the participants:

> *There is a lot of pressure. Like my family is really modernised but I think it's the granddad, grandma and it's because of that you feel a lot of pressure. Like I think my mum and my stepdad's quite laid back but obviously if I was pregnant I'd tell them but they'd be like What the F***, Sorry to swear.* (Shabana, Focus group 2, Phase 1)

Irrespective of a family being *modernised* or more acculturated; becoming pregnant before marriage was an issue of concern:

> *Yasmin: To an extent. I think personally when I think I'm pregnant I get a hell of a lot more panicked because if I'm pregnant and I'm not married, I'm dead.*
> *R: In what way?*
> *Yasmin: My parents would just go mental, absolutely mental and then I would then have to go further and seek advice about termination and stuff like that. It would go that far as that's how much I feel it would have an impact on my life.*
> (Focus group 2, Phase 1)

Yasmin highlighted that she would not tell her parents if she became pregnant before marriage and would seek a termination. When she was asked what the implications would be, she responded:

> *Yasmin: Oh I'd be in a lot of trouble which sounds very childish but I really would be in a lot of trouble.*
> *R: What do you think would happen?*
> *Yasmin: I think I would be disowned […] basically they would no longer know me any more especially if I decided to keep it.* (Focus group 2, Phase 1)

Yasmin felt she would have no choice but to have a termination to avoid being disowned by her family. This situation was even in the context of her mother being aware of her relationship, but kept hidden from extended family to avoid shame (as discussed above). Rizwana also expressed similar feelings, identifying that a woman who fell pregnant before marriage would have limited family support and *“be seen as a disappointment and an embarrassment and the family would be too ashamed to help her and she’d have to muddle through on her own if she had the confidence to tell them what happened”.*

Adeela had introduced herself as being married with a child. However, on further discussions about pregnancy outside marriage, she disclosed that she was not in fact married. Adeela told me she was not concerned if people knew she was an unmarried parent. I had to stop and reflect as although she was saying she was not concerned if people knew, it seemed she preferred to tell people that she was married. I was a stranger carrying out research and bound by confidentiality, but she still felt it was necessary to portray she was married in this situation:

> *Uzma: (giggling) cos she always says she is*
> *Adeela: Yeah it’s easier to say I’m married than having to explain.*
> *Uzma: Cos she always says I’m married […]*
> *Adeela: People seem to talk but personally I don’t think about what people think or say. They may know my business. Obviously some people know but I’m not bothered*. (Focus group 4, Phase 2)

Although Adeela stated that she was ‘*not bothered’*, this was a clear contradiction to her behaviour. Despite living outside the South Asian cultural norms through having an illegitimate child, she presented herself under the guise of being married. Therefore while acculturation would have offered permissibility of her situation, her encultured values meant she presented herself otherwise. Others also reflected how falling pregnant before marriage was becoming a reoccurring issue as more females entered romantic relationships:

> *Adeela: It’s just becoming so common. To a point it’s kind of normal now*
> *Uzma: I think back then if you did get pregnant and stuff they would take you to get married straight away […] Even now they would do.*
> *Adeela: Course they do.*
> *R: Do you think that would mean the parents would force the girls to get married?*

Uzma: Not forced but yeah they will say to them, yes I suggest you get married to them. You're having the baby so get married to them. (Focus group 4, Phase 2)

While women such as Yasmin considered how they would need to terminate the pregnancy immediately, others such as Adeela and Uzma reflected on how parents would persuade their daughter to marry the father of their child quickly in order to protect the family's reputation. These women discussed a girl who fell pregnant with her boyfriend and then married him for the sake of the family. However, in reality, the marriage was simply a front and that the couple were actually not together:

Adeela: She's just got pregnant, her family's
Uzma: a bit quiet
Adeela: a bit strict whereas ours is not. My mum's not. Her dad is and he was like I don't want her living in the house but she stayed there while she was pregnant
Uzma: Parents can't kick em out when they're pregnant!
Adeela: She got married.
Uzma: Oh did she?
Adeela: They had their Nikah [Muslim marriage ceremony] done and they still didn't want her to live at home […] She's got her own house.
Uzma: And where's the dad?
Adeela: He's got a girlfriend […] but she's married to him!
R: So she's married to him.
Adeela: Exactly! (Focus group 4, Phase 2)

The participants' views on this were clear through the intonation in their voices and the use of the word "*Exactly!*" This situation saddened me, as it meant that the girl they were describing was now in a sham of a marriage, for the sake of her family and their reputation in the community.

6.8 Focusing on marriage

The participants confirmed that there was a major focus on marriage within their culture. All parents expected their daughters to get married. Khadija described discussions with her mother:

A few times she's said if you like someone just get married but I've said to her I don't want to get married now as I'm still in education and I have to say to her that I don't have anyone but she's like if you do then you might as well just tell us and at least, so afterwards [afterwards meaning after university] we don't

> *have to look for anyone for you but she already knows.* (Khadija, Focus group 1, Phase 1)

For Khadija's mother, it was important to know who her daughter was interested or in a relationship with, as it meant marriage plans could potentially commence once Khadija's studies were over as marriage was a perceived reality. Khadija further described how she felt and the rationale behind not informing her parents of a boyfriend:

> *I think over the few years you both change so like if we said now I've got a boyfriend, we wanna get married I don't think it would work out right now because we're like studying and stuff like that, I think people change, cos how I am now I wouldn't be like that at the start of this course and how I'm gonna be at the end of the course, I'm not gonna be like how I am now.* (Khadija, Focus group 1, Phase 1)

Khadija demonstrated self-awareness and maturity in knowing that what she desires in life may change by the time she reaches the end of her course at university. By prematurely informing parents she was in a relationship may lead to issues arising with disapproval or being pushed towards marriage, when in a couple years' time, her heart may lie elsewhere. By waiting to mention their boyfriend or their boyfriend's details as a potential suitor for marriage, meant there was little to no risk of causing shame as their parents may not be accepting of their daughters being in a relationship before marriage. Memuna also identified '*you don't know where it's gonna end up'* suggesting a lack of certainty with some relationships.

Many mothers became aware of their daughter's relationships and then colluded to maintain the secret from others (discussed further in section 7.5). Yasmin described how there was *'pressure'* on the mothers to find a suitable husband for their daughters:

> *R: Why do you feel mothers maintain the secret about their daughter's relationship?*
> *Yasmin: Well because the end goal is marriage isn't it. So if they think we've found somebody they actually approve of or they could approve of then the pressure's off. There's no pressure there for them to find us somebody. They know the end goal that we will get there. That's what they want for us.*
> *R: […] Do you feel […] a lot of women […] are entering relationships with that end goal as well, in the hope that they've found a boyfriend who will then become their husband?*
> *Yasmin: Yeah, I think so. I definitely did otherwise I wouldn't have taken the steps that I did in my relationship if I hadn't have thought that the end goal was marriage.*

R: You mentioned that it takes some of the pressure off for the mother so do you think there is some pressure when a girl finishes university for example, then there is some pressure on the mother?
Yasmin: Yeah I think so as you have to tick all those boxes don't you
R: When you say ticking the boxes, is it almost like goal posts or milestones?
Yasmin: Like she has an education, she will get married, she will have children, she will become your perfect daughter, she will provide the grandchildren etc etc. (Focus group 2, Phase 1)

Sara reported her thoughts and the emphasis on marriage:

Yeah cos I think in the Asian community as a whole it's like you have to get married when you're 22, 23 because people are going to think there's something up with you if you get married at a later time. Even though my mum's open and stuff, she'll still talk about marriage and she'll be like "You'll have to get married" and I'm just like yeah, "we can't leave it too late". (Sara, Interview 2, Phase 1)

Although Sara's mother was very progressive in her beliefs towards relationships in comparison to other Asian families, there was still an emphasis on the need to get married earlier rather than later i.e. the early twenties. Sara stated how leaving marriage 'too late' was negatively perceived as it would limit their choice of potential suitors. Studying at university almost afforded women the freedom to remain single but with the caveat that pressure to marry would commence once their studies were over.

Yasmin described being made to consider a future marriage proposal at the age of 12:

Yasmin: But I said no to an arranged marriage and I think that's what really annoyed my parents.
Shabana: What? Really? They asked you?
Yasmin: Yeah. I got set up at the age of 12. When you're 12 all you wanna do is get married and have a party so I said yes at the age of 12 but at the age of 16 when they tried to ship me off, I was like no, not doing it.
Shabana: What? […] Oh my God. I'm so shocked. (Focus group 2, Phase 1)

Here, Yasmin reflects on how at the age of 12, her positive views of marriage focused on the wedding party and celebrations, rather than the ramifications of being married. Whereas at a slightly older age of 16, Yasmin had more understanding of the consequences, and it represented a situation she was clearly not ready for. Other participants mentioned arranged marriages, but these were discussed in relation to contemporary arranged marriages which more commonly occur within this culture. These involved parents presenting potential suitors to their daughters. Should their

daughters be interested, then they would arrange for them to meet and get to know the individual before making a final decision. This is in opposition to traditional arranged marriages where the female has no say. Anisha and Memuna discussed Anisha's experience of being approached by her father to consider an arranged marriage:

> *Anisha: Like my dad's not happy with me having friends who are boys but my mum's ok with it. I think that's to do with the fact that my mums brought up here.*
> *Memuna: It's the same with me as well. If they're from back home, they're not fully understanding*
> *Anisha: Even my mum says not to get married to someone from back home […] whereas my dad is like you could get married to this cousin from back home and I'm like yeah I don't think so.* (Focus group 1, Phase 1)

Anisha and Memuna felt that parents who had not been born in the UK, did not understand their perspectives. Anisha was able to say *'no'* when her father suggested marrying a cousin, due to her mother being supportive of her marrying someone who was British Asian i.e. not *'from back home'.*

Both Saleha and Fatima who were not in relationships and had no plans to be so prior to marriage, envisaged that their parents would find them suitable husbands in the future:

> *R: What concerns do you have say if they'd* [potential future husband] *been in a relationship before and you were getting married to them.*
> *Fatima: Of course I wouldn't and I don't think my parents would even look for a guy like that. Cos they know […] what's best for me. I trust my parents.*
> *R: So you're both hoping that your parents will be involved in the decision?*
> *Saleha: Yeah definitely yeah. I don't think they expect me to find somebody on my own and I don't really feel I expect myself to.* (Focus group 3, Phase 2)

It is important to highlight that both these participants were strongly aligned with their religious beliefs. They had both attended religious high schools and their values appeared aligned with traditional values, and trusted their parents to find the right husband for them. However both raised concerns over sexual expectations following marriage:

> *Fatima: It's because it's straight away. Cos you've had merely a few meetings and you get married and then it's your wedding night and you have to do it* [have sex]. *I don't know if that's what men expect but I don't think that's what I really want.*
> *Saleha: I think I'd want to get to know him first […]*
> *Fatima: Where nothing needs to be rushed.*

Saleha: Nothing needs to be rushed. But yeah, I think I would prefer to get to know him better rather than just jumping in to something. I think it would kind of make you feel a bit used as well. Cos it's like we just got married and you just want me for that.
Fatima: Some people have that mind though. That's what they actually expect.
Saleha: Yeah cos I've heard a lot of people like wedding night, wedding night.
R: So there's that expectation that sex will happen on that night?
Saleha: Yeah straight away and I'm not sure if I would feel comfortable with that.

While accepting their traditional values, both described wanting a period where they got to know their husbands before having sexual intercourse. Interestingly, the participants who discussed being in relationships but maintaining their virginity could be said to be doing the same but before they were married. For some participants this may justify the 'secret' relationship as it enabled them to resolve such concerns before marriage.

6.9 Conclusion

In this chapter I presented the findings related to the category of 'Being influenced by religion, culture and the community'. The findings show the extent of the influence of religion, culture and community on women and their decisions. They describe the importance of the community and the repercussions should women be seen to not conform to behaviours that are expected. The issues surrounding falling pregnant out of wedlock were a key concern. In the next chapter, the next category 'Maintaining the secret relationship and acculturation' is presented.

7.0 Findings: Maintaining the secret relationship and acculturation

7.1 Introduction

The previous findings chapter considered the influence that religion, culture and the community had on the women. This chapter presents the second category of findings concerned with 'Maintaining the secret relationship and acculturation'. The chapter is presented under four themes of 'encountering acculturation', 'maintaining secrets', 'discussing sexual health issues with mothers' and 'disclosing the relationship to mothers and other females'.

7.2 Encountering acculturation

All the participants came from the same cultural background i.e. a British born South Asian culture but belonged to different religions e.g. Christianity, Islam, Hinduism. It is important to reflect culture as a multifaceted concept and is dependent on influences such as the environment, education, and socio-economic factors (Helman, 2007; Holland & Hogg, 2010; Kagawa-Singer, Dressler & George, 2016). Further discussion around culture and religion was provided in Chapter 2.

Most of the participants had experienced enculturation into their South Asian and religious beliefs and values along with acculturation due to being born in and socialised in the UK. Therefore while all the participants had experienced some acculturation in to the British culture, the extent to which the attributes or values of the Western culture had been adopted, appeared to vary.

All the participants discussed the influence of acculturation. Acculturation was not limited to a specific religion and was evident among not only the participants but when discussing changing beliefs among parents:

> *R: Is it culture or is it religion?* [in relation to beliefs towards having a relationship]
> *Naznin &Anisha: I think it's both.*

Khadija: I have some Indian friends and they're Hindus and some of them, their parents are fine about it but the others they're not so I think it's kind of like a bit of both.
Memuna: For us, religion [Islam] says we can't have sex before marriage.
(Focus group 1, Phase 1)

A few of the participants discussed how more and more parents were becoming accepting of their children having friends who were boys and even being in romantic relationships due to acculturation:

I speak to my mum, she'll tell me stuff but then I don't think she'd expect me to go out and do it. She's made me aware of it. She's like you can have a boyfriend, that's fine, but make sure nobody sees you, stuff like that. So she's allowing me to do it but then she's like make sure such and such a person doesn't see you. (Sara, Interview 2, Phase 1)

In this situation Sara's mother could be viewed to have colluded with her daughter through her permission to have a secret boyfriend. Making sure *'nobody sees you'* also maintained the respect of the individual and family. Safia reported similar findings with her mother where respect was emphasised:

She's [mother] *aware that many girls and people from our own cultural background have had sexual intercourse before marriage so it's one of those things where you're living in certain communities and the culture is different and then there's a clash a bit so it's sort of becoming the norm but still my mum kind of tells me stories about stuff and she just mentions how there's a lot of respect behind having your virginity.* (Safia, Interview 1, Phase 1)

As reflected in the quote above, this participant's mother was aware that more girls were in relationships before marriage, however she emphasised the importance of her daughter maintaining her virginity. Safia also identified acculturation through living in certain communities where the cultures *clash* but then become the *norm* suggesting that the South Asian culture and the British culture do hold different values but as they clash a new norm may emerge:

We are able to have our own culture and […] we can look at the old and look at the new if that makes sense so we have like the new British culture that we are trying to develop ourselves and understand the world and everything. (Safia, Interview 1, Phase 1)

Safia suggested that many participants are trying to find their identity through acculturation whereby they hold some values from the South Asian culture and others from the British culture. Several participants were involved in romantic relationships which contravened their South Asian cultural beliefs but revealed a new culture among British born South Asian females. Fatima described Muslim teenagers at high school who were in relationships and felt '*it's so common for that to happen nowadays'.* This was similar to what Khadija discussed in focus group 1:

> *I think cos like sex has become like I dunno more like normal cos like when we were in high school a lot of our age people they used to like just go about it [have sex] and stuff.* (Khadija, Focus group 1, Phase 1)

Some participants identified that through acculturation individuals had adapted more Westernised views and beliefs, while still feeling able to follow their religious beliefs. The women in one of the focus group discussions reported:

> *Shabana: My step dad's Sikh. But my mum's always been Westernised, my Nan's always been Westernised but she's quite religious at the same time*
> *Yasmin: But you can be Westernised and religious*
> *Shabana: Yeah of course*
> *Yasmin: I've got family that can go out. Like I've never been able to wear a dress without leggings or jeans but I know people that do that and still go home and pray and it's not an issue.* (Focus group 2, Phase 1)

As discussed in section 6.2, the way an individual dressed could also be influenced by their religion however the participants discussed how individuals could dress a particular way but still felt comfortable to maintain other religious practices and beliefs. This is another example of how some of the participants identified that a new culture had emerged whereby individuals have chosen elements of both the cultures they belong to and ways to make the new culture part of their identity. This was demonstrated through feeling comfortable to wear clothes which may be deemed unsuitable or disrespectful by some e.g. displaying their legs or arms but then feeling confident to still go home and pray wearing the required garb.

It was evident that individuals' beliefs varied among the participants despite belonging to a particular religion. Not all the participants had been in a romantic relationship. One of the women who was a college student reflected that while her family were not

particularly religious, by virtue of attending an Islamic faith high school, her beliefs had been influenced:

> *I think it depends on how you've been brought up or your background […] but I've got friends who are Muslims from other schools […] but they don't have the same beliefs as me […] they're okay with relationships before marriage and they don't really care what they do in those kind of relationships but I think it's just subject to the person.* (Munira, Interview 5, Phase 2)

Munira viewed her family as less religious than herself as she was the only one in her family who wore the hijab and prayed; Munira was okay with this and felt it was down to individual agency where religion was concerned. Due to her mother's acculturation and openness, she invited her daughter to speak to her if she was interested in a boy or was in a relationship, despite Munira being convinced the situation will never arise:

> *Munira: Yeah but then like she [mum] does know, obviously […] that people go out with each other before they get married because my cousins do. Like I said my family are not very religious […] so she has said to me that if you do need anything then you come and tell me. I don't think personally that I would even be tempted.*
> *R: Because of your individual faith?*
> *Munira: Yeah.* (Interview 5, Phase 2)

Munira goes on to further discuss the need for balance between her encultured and accultured values:

> *Yes. Cos there has to be a balance doesn't there. You can't always do what religion tells you to do because it's going to turn you in to a whole completely different person. And especially with this society you can't always just live with what religion tells you to do.* (Munira, Interview 5, Phase 2)

Finding the right balance between religion, culture and the person as an individual, allowed individuals to maintain a level of autonomy, whereby they felt they had some control over their choices in their lives. This will be further discussed in Chapter 10.

7.3 Maintaining secrets

Although some women eventually confided in their mothers about their relationships (which is discussed later in section 7.5), it was apparent that relationships tended to be kept a secret initially. Yasmin described the early stages of her relationship as being a *'complete secret'.* Other participants described relationships that were kept secret from close family:

> *No it is true, I had a housemate last year and she was a Muslim and she was quite religious so she didn't drink or anything like that but she's got a boyfriend and he's Asian as well but like her parents don't know anything and it's all secretive. He used to come up here when she was at uni.* (Shabana, Focus group 2, Phase 1)

Here Shabana describes that her housemate was living away from home, it was easier to maintain the secrecy of her relationship from her family and people she knew in her hometown. Shabana described her own feelings now that she had moved away to university too:

> *I think I've definitely felt a lot better since I got to university. I've always had the freedom but I think here no one's gonna judge you cos you don't have any of your family members here and if you're walking around you know that no one's gonna go and tell my mum.* (Shabana, Focus group 2, Phase 1)

Some participants felt able to disclose their relationships to close friends:

> *Khadija: No you have to keep it secret?*
> *R: Who knew just you and him?*
> *Khadija: Yeah and my friends.*
> *R? Were his friends aware?*
> *Khadija: Yeah.* (Focus group 1, Phase 1)

Disclosing relationships to friends was common. The participants trusted their friends to maintain their secret and therefore had someone to confide in. Some participants also described the lengths they or their friends would go to in order to maintain their secret relationships:

> *Oh you lie about everything don't you…I've always felt like I was leading a double life.* (Yasmin, Focus group 2, Phase 1)

Yasmin's use of the term *'double life'* portrayed the extent of the lies that she had to make. She was one identity for her parents and family, and a different identity with her boyfriend and friends.

Khadija described the types of lies she would have to make to her family to be able to see her boyfriend secretly:

> *Khadija: You have to say that you're going to see your friends and stuff and the library. The other day I had to say to my mum that I'm going to Manchester to see a mate but I went and saw him […]*
> *R: Right so you tell your parents you are meeting people that your parents approve of?*
> *P6: Yeah.* (Khadija, Focus group 1, Phase 1)

Other participants who did not have boyfriends also discussed the lies women had to make to meet their boyfriends:

> *Saleha: There's a LOT of lying.*
> *R: Who are they lying to?*
> *Fatima: Obviously their parents.*
> *R: What might they lie about?*
> *Saleha: Where they go.*
> *Fatima: Where they're going.*
> *Saleha: Who they're going with. They can say they're going to a friend's house but they can end up in Manchester before their parents come to pick them up and they're back at the same spot where their parents dropped them off again.*
> *Fatima: They'll just be like I've got some after college thing or I'll stay in the library or something like that to their parents.* (Focus group 3, Phase 2)

Lying about their location raised concerns as to the safety of the women. It appeared that women were willing to take such risks to be able to be in a relationship but at the same time try and protect the family name by keeping the relationship a secret.

7.4 Discussing sexual health issues with mothers

The situations of sexual health related discussion with mothers was very different to

those described with male family members. Many participants felt close to their female family members and felt able to ask them about sexual health related issues. However, this could, on occasion, only be when other avenues of information had been pursued. A few participants mentioned the use of *'Google first'* before turning to other females for advice. Munira explained:

> *Munira: Yeah maybe the internet because I do use the internet a lot for my own research so I probably would use the internet before my mum… and then if there was anything I was confused on then I'd go and ask my mum.* (Munira, Interview 5, Phase 2)

Munira, similar to other participants (and further discussed in Chapter 8), would seek answers for her questions elsewhere prior to approaching her mother. She described how she was able to have open discussions about relationships and sex-based issues.

There appeared to be three contexts in which mothers were more likely to discuss sexual health issues with their daughters:

- they were born here or immigrated here as a very young child and therefore had been acculturated into a western society;
- they had experienced a relationship before marriage themselves
- they had experienced or endured an unhappy marriage.

In Munira's situation, it is likely that her mother spoke freely from a religious as well as western societal stance due to being 'from here' (born in England). This perspective was similar to other participants whereby they felt able to discuss sexual health related issues with their mothers, due to them being accultured in to a western society:

> *Like, she's told us everything pretty much about safe sex and all of it and she's always said to us that if you do like a boy, then come and tell me straight away. Like she's quite open like that. She's from here and she knows what it's like with the western society, especially now as she knows that not every Asian girl is private, cos they just go behind their parent's back and do it anyway. So if there was anything, then I can ask my mum about it. At school we didn't get taught about protection or contraception or things like that. It was always like religion says no to it, so it's why you don't use it kind of thing. But then my mum was like I used it for family planning purposes so you can use it.* (Munira, Interview 5, Phase 2)

While Munira's schooling did not provide information on and strongly steered her away

from issues around sexual health or contraception, her mother advised her to make her own decisions around contraceptive use but only once married:

Munira: She's like it's up to you.
R: After marriage?
Munira: Yes. Cos there has to be a balance doesn't there. You can't always do what religion tells you to do because it's going to turn you in to a whole completely different person. And especially with this society you can't always just live with what religion tells you to do. (Interview 5, Phase 2)

These insights indicated that as Munira's mother initiated open conversations about relationships and sexual health, it made it easier for her daughter to approach her.

Rizwana had a similar experience whereby she referred to her mother as the '*exception*' due to being willing to discuss sexual health issues. Rizwana's mother had been in a romantic relationship with her father before she married him which in turn appeared to have influenced her views on addressing sexual health issues:

> *Rizwana: No other girl from my background or who I'm friends with has openly told their family, this is my boyfriend and then gone on to have a normal relationship where they were allowed to meet and go to each other's houses. I don't know anyone.*
> *R: Why do you think your relationship was different? Why were you able to be open about it?*
> *Rizwana: Because my mum and dad went through the exact same thing. So they were two people that liked each other and they were told they couldn't see each other and then my dad had to say this is the girl I'm going to be with and I'm not going to marry anyone else and in the end they got married cos they refused. So in my situation I think they just wanted to avoid the whole drama and for me to just be able to say that this is the person I want to be with and to be involved in a relationship and then that way my parents were able to implement their rules i.e. curfews and things like that so things like don't stay over at each other's houses so while I was still living at my parent's house there were times when he had to go home or I had to be home so they were still structuring us.* (Interview 3, Phase 1)

Rizwana also highlighted how her mother felt able to ask her about her relationship with her fiancé and to offer advice. Here, she described a conversation with her mother when she returned home from university during the Christmas break:

> *I've been with my husband for about 6 years. In the third year we were together, I'd moved out to university and he lived in Manchester where I studied so I was living on my own and obviously he was visiting. So when I went home*

> *for Christmas my mum broached the subject and basically said to me "Are you sexually active and if you are, are you taking precautions? And if you are not sexually active but you are planning to be sexually active I would like you to be taking precautions. And if you need me I will come with you." To which I replied, "I am not having this conversation with you"…She said I know you're both adults and it's the sort of thing that naturally would happen but if it is, then I need you to be being safe.* (Rizwana, Interview 3, Phase 1)

In this situation, Rizwana's mother was familiar with the issues her daughter faced through her own personal experience of being in a romantic relationship before marriage. Although sexual relationships between an unmarried couple were forbidden, Rizwana's mother was able to offer her advice.

Although Sara's mother was born and grew up in Pakistan, she was supportive of her daughter being in a love-based relationship. Some of Sara's immediate family demonstrated that they had been socialised and accultured with western values e.g. Sara's uncle had married a woman of White British descent. This coupled with Sara's mother's negative experience of her own arranged marriage meant she just wanted her daughter to be happy:

> *Sara: My friends like can't talk about sex, can't ask parents about say oh I'll have a boyfriend this and that whereas my mum will encourage it. […] My uncle, he's got a White wife and my other uncle's got an Italian girlfriend so it's like a norm […] but some people like find it hard to approach their parents.*
> *R: Is there something about your parents that's different maybe? Like you've said your friends can't approach theirs?*
> *Sara: I think it's because my dad had an arranged marriage from Pakistan and they [mum and dad] don't really speak. So my mum knows what it's like to have an arranged marriage, not speak to your partner, but still have kids for the sake of holding the family together.*
> *R: So are they together?*
> *Sara: Yeah but they don't really talk so mum's like right I don't want you to go through what I've gone through so you need to do what you need to do to be happy.* (Interview 2, Phase 1)

Sara's mother had begun talking about boyfriends and relationships with her from around the age of 13 and had told her *'you can't trust men 100%, so just be careful'.* Sara's insights indicated how her mother's personal negative experience and unhappy marriage meant she did not want her daughter to endure the same which led to open discussions around sexual health.

7.5 Disclosing the relationship to mothers and other females

The previous section focused on situations where mothers discussed sexual health related issues with their daughters. This section now focuses on daughters confiding their secret relationships with their mothers. A number of participants reported that they had disclosed their relationships to their mothers. The alliance between several participants and their mothers was strong. Sara described her relationship with her mother as that of *'best friends'* where she would be able to have open discussions around sexual health. Both Adeela and Uzma identified that their mothers were aware of their boyfriends:

> *R: Whereas you could confide in your mum?*
> *Adeela: Yeah […]*
> *Uzma: She knows about him now because I've been with him for three years other than that she would not have known about it.*
> *Adeela: Yeah.*
> *Uzma: When I first got with him I would never tell my mum, obviously slowly, slowly, you see him every time and you go out and then mum's like ok then hang on a minute what's going on here? It's one of those. So my mum knows now.* (Focus group 4, Phase 2)

Adeela's mother was aware of the relationship from the early stages whereas it took Uzma a few years of being in a relationship, and being directly asked, before informing her mother. Aside from Adeela, it appeared that most of the participants only disclosed their relationships when it became more serious, and when they were not just dating.

Yasmin described an incident which occurred when she was 16, before her mother was certain that she had a boyfriend:

> *My mum suspected I was sleeping around. I wasn't, I had a boyfriend and I was really anaemic so I'd fainted at school and my mum took me to A & E cos she thought I'd had a concussion, and she was being really pushy and making them do a pregnancy test on me and apparently when parents are like that it gets red flagged and they had a (sexual health) nurse come in to the school to like meet with me... she was like I need you to tell me what's going on and I was, I am sleeping with someone but I'm being safe, I've got the pill and I've got stuff like that. I just couldn't believe that it got red flagged at the hospital cos my mum was being dead pushy.* (Yasmin, Focus group 2, Phase 1)

While Yasmin was able to be honest with the school nurse at the age of 16, her mother only had instincts and was not fully aware of her relationship.

Some participants described sharing relationship issues with their sisters rather than their mothers. For example, Safia reported:

> *Like female orientated stories with the girls so it would be with my sisters. I have previously had a boyfriend and my sisters all knew […] It was like he was Indian and I'm Pakistani so that was an issue as well.* (Safia, Interview 1, Phase 1)

While Safia was able to confide in her sisters, she was unable to inform her mother of her relationship due the different cultural backgrounds.

Some participants also stated that while their mothers were aware of their relationships, they had not had any conversations about sexual health:

> *R: Have any of your mums said anything or spoken to you about sexual health?*
> *Yasmin: I don't think my mum's ever felt she needed to because every time she brings it up I'm like "I've dealt with it".*
> *Shabana: Yeah.*
> *Yasmin: I don't wanna have that conversation with her because at the end of the day it's not like she's ever tried to teach me anything so it's not really her place to get involved at this stage. I've dealt with it. I know what I'm doing myself.*
> *R: Ok. What about yourself?*
> *Shabana: The same cos like I know if there's something wrong with me I'll go and sort it out myself. I don't have to be dependent on anybody else.* (Focus group 2, Phase 1)

In these occasions, it appeared that while participants were happy that their mothers were aware of their relationships, they did not want to have conversations of a more intimate nature.

7.6 Conclusion

In this chapter I have presented the findings on the category 'Maintaining the secret relationship and acculturation'. The findings varied in relation to the acculturation experienced by the participants and whether they engaged in pre-marital relationships. It transpired that mothers were more open to instigating sexual health related discussions with their daughters if they had experienced acculturation, been in a romantic relationship or had endured an unhappy marriage themselves. Many of the participants who were in secret relationships did eventually disclose their relationship to

their mother who then maintained their daughter's secret. The findings category 'Accessing sexual health services, advice and awareness' is presented in the next chapter.

8.0 Findings: Accessing sexual health services, advice and awareness

8.1 Introduction

In the previous chapter I considered the findings on 'Maintaining the secret relationship and acculturation'. This chapter focuses on the findings on 'Accessing sexual health services, advice and awareness. The chapter is presented under four themes which are 'what is sexual health?', 'accessing services for testing, screening or advice', 'engaging with professionals for sexual health needs' and 'feelings and beliefs towards sexual health education'.

8.2 What is sexual health?

When participants were asked what they understood by the term sexual health the responses varied. Many participants associated this term with contraception and protection from infections:

> *Anisha: STIs and getting protection and stuff like that*
> *Naznin: I think taking care of yourself while being sexually active*
> *Memuna: Protecting yourself from like getting pregnant and sexual health.*
> (Focus group 1, Phase 1)

Some participants stated that the internet and *'Google'* in particular were used as a resource for questions around sexual health. Others highlighted television programmes as a source of learning:

> *I've seen on the television about how there are clinics for STIs and sexually transmitted diseases and everything like that. It's not an issue for me but however I do have friends who are active and it makes me wary.* (Safia, Interview 1, Phase 1).

A few, however, appeared reluctant to share their understanding or did not know:

> *If I'm honest with you I actually don't know because I went to an all Islamic high school so over there it was kind of just expected that you don't need to know*

> *about it at this age and you're not gonna get involved in it so you don't need to know so I don't actually know anything about it.* (Munira, Interview 5, Phase 2)

Munira explained that as a Muslim, you were not expected to be concerned or involved in a relationship, therefore her high school did not promote or discuss sexual health.

Saleha who also attended a faith- based school like Munira, felt that sexual health issues were only of concern for married individuals but unlike Munira, she was aware of some sexual health issues related mainly to problems with fertility:

> *Personally I think it's to do with like problems when you're in a marital relationship […] I mean even in our theology course, there's a lot of things they go over in terms of like when you're married and problems you might have. I think I'm just gonna say it as it is, people who have problems where they aren't able to ejaculate as much… therefore they can't produce babies. I think inflammation is another one that I know of and I know like people who can't have babies, that will probably be because women can't produce eggs or like period problems etc.* (Saleha, Focus group 3, Phase 2)

Saleha's response was very different to the other participants. Her knowledge stemmed from an Islamic based theology course that she and Fatima had attended to learn more about their own religion.

Before the interviews and focus groups commenced, the participants were asked to complete a personal characteristics form (Appendix 11) and to record the sexual health services they were aware of. The free-text responses they provided are presented in the table below:

Sexual health services identified	**Participants**
Contraception	Safia Amelia Yasmin
Health & wellbeing	Safia
Infections & STDs (Sexually Transmitted Diseases)	Safia Yasmin
Chlamydia screening	Memuna
Sexual health testing	Yasmin
GUM clinic	Sara Anisha

Sexual health clinics/Clinics/ Clinics within a GP	Yasmin Shabana Maria
Talkwise	Sara
Connexions	Sara
Walk in centres	Rizwana
GP/ Doctors	Rizwana Amelia Yasmin Maria Munira
Practice nurse at the GP	Naznin
Pharmacy/ Chemist	Anisha Amelia
Brook	Khadija Naznin Uzma Adeela
CASH (Contraception & Sexual Health Services)	Khadija
Family Planning clinics	Amelia
Don't know	Saleha Fatima Uzma

Table 4: Free text responses of sexual health services

Some participants included sexual health topics and resources rather than sexual health services as part of their response on the personal characteristics form. These responses are presented in the table below:

Issues and answers written that were not sexual health services	**Participants**
Issues regarding pregnancy	Safia
Abortions	Safia
Safe sex	Safia
Sexual health talks at school/ Education	Anisha Amelia
Police helplines (Domestic violence)	Munira
Posters	Anisha

Table 5: Other sexual health responses provided

All the participants in phase 1, except for Rizwana, identified specific sexual health services, whereas Rizwana identified walk-in centres and the GP. Rizwana was married and there was the possibility that her sexual health service needs were different to those of an unmarried woman, and/ or being married meant she could openly access more generic health care services. Only one participant in phase 2 (Adeela) was able to identify a sexual health specific service without any hesitation. Adeela, aged 21, who was the oldest participant in phase 2, had a child. Her knowledge of sexual health services was therefore likely to have been influenced by her personal experiences. As presented in Table 5, some participants also included sexual health topics or resources rather than services as part of their response on the personal characteristics forms.

The difference between the participants in both phases was that the participants in phase one had all attended University, whereas the participants in phase two had not. The majority of the participants in phase one (with the exception of Sara and Memuna) all either lived away from home to study at university or travelled to a university outside their home town. For those living away from home in particular, there may have been more socialisation opportunities, thus undergoing further acculturation and potentially impacting on their knowledge of sexual health.

8.3 Accessing services for testing, screening or advice

Some of the participants discussed their experiences of accessing sexual health clinics. Yasmin identified the '*stigma attached*' with the sexual health clinic in her home town and her preference to be seen somewhere that was not a sexual health specific service. Sara also disclosed similar concerns and wished she could access services '*without being judged'.*

Amelia described her experience of judging while being judged when accessing a local sexual health clinic:

> *I've walked in before to my clinic at home and there's a lot of underage sex where I live. It's kind of that sort of area. But I've walked in to a clinic before being I think I was 18 or 19 so I was an adult and it's like normal, and there was a girl sitting there with her mum and from my perspective I know I was judging her and thinking there's obviously some reason why you've come with your*

> *mum and she was young, 15, 16 and then she looked at me as if she judged me for being there[…]I felt really uncomfortable sitting there and I'd only gone to get the pill.* (Amelia, Focus group 2, Phase 1)

Even though Amelia was of the age of consent and described herself as an *adult*, she still felt uncomfortable waiting to be seen at the clinic. She also described feeling judged by those older than her when waiting to be seen at a sexual health service which was held within a GP surgery:

> *They're like older people and they know that I'm going to a sexual health clinic. You just feel judged all the time.* (Amelia, Focus group 2, Phase 1)

The stigma mentioned by Yasmin earlier was also felt by others. Shabana felt that sexual health clinics had a '*label'* attached to them which instilled shame and doubts regarding access:

> *I think it's a label that's been attached to sexual health clinics and people assume it's a bad thing if you go but they're obviously there to help you but because of what people have heard or what's been said, it's been labelled that way, so you always feel I really don't wanna go there.* (Shabana, Focus group 2, Phase 1)

Rizwana, who was married, also highlighted challenges that a Muslim woman could face when needing support for sexual health issues:

> *I think it's just the stigma of being seen around such places. I think if someone was to find herself in a situation where she became pregnant or had contracted a STD, she wouldn't really know what to do or where to go, she'll feel like she's stuck. She can't go to her GP cos she might be seen. She can't go to a walk in centre cos she might be seen. She can't talk to anybody about it, cos that would mean admitting you'd had sex or performed a sexual act or something. I think emotionally they'd just become either detached or sink in to something like depression.* (Rizwana, Interview 3, Phase 1)

Rizwana emphasised how issues around accessing services reached beyond the physical need and may leave an individual in a very vulnerable and helpless state. The forbidden nature of sexual acts before marriage may create challenges for an individual in need of help. The personal conflicts of whether to disclose their sexual activity and

access help or whether to continue the secret nature of the relationship could escalate due to the stigma associated with sexual health clinics. The fear of disclosing an unplanned pregnancy for example may lead an individual not accessing the support they need. The turmoil an individual may face in terms of their emotional wellbeing and how their family or community may react may leave an individual in a physically and psychologically vulnerable state.

Other participants considered accessing services that were not sexual health specific, in order to maintain secrecy. Adeela, for example, discussed a health centre that housed several different services which meant there was some opportunity for confidentiality:

> *You can go there like if you need to weigh children too. No-one needs to know what you're going in for. (*Adeela, Focus group 4, Phase 2)

However, Rizwana highlighted that accessing support through non-sexual health specific clinics such as health centres was still problematic. Attempting to be unseen from the gaze of her community was near impossible. The tight communication network within the community meant that information would soon be relayed to the woman's parents:

> *There's always someone that sees you around. Just the fear of going in the doctors and I don't think it would enter my mind to think to just say well I only went in just for a check-up. It'll be why have you gone? And somebody would say to my parents, I saw your daughter going to the GP and my parents would be like you didn't tell me you were going to the doctors. Cos there's this sense of being involved in every little thing.* (Rizwana, Interview 3, Phase 1)

For some women, being seen in a GP surgery and being questioned about reasons for access could lead to the individual lying to family members to ensure their relationship remained a secret. Yasmin found herself in a situation where she had to lie to her mother as her mother found a box of pills in her room:

> *My mum found my pills in my room. I just told her that I had been to doctor cos I had heavy and painful periods and the doctor said being on the pill would help.* (Yasmin, Focus group 2, Phase 1)

Although not specific to just South Asian females, the issue around being tested for sexually transmitted infections was raised:

> *Cos I got a water infection and I ended up with a sexual health nurse for some reason and I told her I was in a relationship for that long and she was like but you don't know what that other person is doing. I don't need that doubt in my mind! She still wanted to test me for everything. It was really bad […]I think it tests the relationship cos if you get tested after that partner and you find out that you've got something and you know you haven't slept with anyone else. Even if you've ended on good terms it's going to mess something up in your head.* (Yasmin, Focus group 2, Phase 1)

Being tested after ending a relationship may unearth issues. For example, Yasmin felt that if you were to test positive for a STI, then this may raise issues around promiscuity and may make her question the relationship she had with her ex-partner.

Amelia also conveyed similar feelings about how faithful previous partners had been and the way she had felt when accessing sexual health services:

> *They make you feel like you've been stupid in some way going from one partner to another. It's how they say it. They don't say it in terms of because you have a new partner I would recommend you having another test just in case, but it's more like you don't know what he's done before .* (Amelia, Focus group 2, Phase 1)

The secrecy surrounding relationships raised questions about whether a woman would even consider issues around infections or whether previous relationship information was shared with new partners:

> *R: Do you think Asian girls would feel confident enough to ask their partner and to access services where they could get screened to find out if they did have any infections or diseases?*
> *Safia: I don't know, it depends. I know some guys would just say 'As if I have!' and just laugh about it […] I've not thought about it. It's like I've never been put in that situation before.* (Safia, Interview 1, Phase 1)

Responses such as *'As if I have!'* from male partners could make women feel awkward to pursue the matter to avoid causing conflict with their partners.

A few participants also disclosed that they would not consider being tested before they started a new relationship:

> *Yasmin: No because I wouldn't feel the need if I'm honest. If I trusted that person, personally I wouldn't feel the need. It probably is really bad and I probably should.*
> *Amelia: Yeah I'm the same, you trust that person to tell you before anything happens. To use a condom if they've got any, do you know what I mean. Trust on both parts.* (Focus group 2, Phase 1)

In these occasions, the issue of '*trust'* was raised and how the participants felt they should trust their new partners. Rather than initiating a discussion around sexually transmitted infections with her new partner before they engaged in sexual activity, Shabana revealed she would get herself tested after being sexually active with him, to avoid the need to ask him to get tested:

> *Shabana: If I sleep with someone who I haven't slept with before but it's an ongoing thing I'd just personally get checked out cos I don't know about any of the symptoms and some of them you can't see so it's for my own personal cos I just panic at everything*
> *R: So it's reassurance for you?*
> *Shabana: Like I know that I trust that person. It's got nothing to do with me not trusting that person, it's just for my own self, I need to be I'm safe, that's fine.*
> (Focus group 2, Phase 1)

Although Shabana stated that getting herself tested was not due to not trusting her new partner, there did appear to be some contradiction with her actions. Getting herself tested after sleeping with a partner indicated a lack of trust as well as having a need to keep herself safe and protected. The responses here raised an issue around the lack of confidence to discuss the issue of sexually transmitted infections and the importance of getting tested between partners. The participants displayed a level of naivety or risk taking which was a concern for me as a health professional. Broaching the issue with partners was difficult, however Safia felt that her sisters would want to know and would make efforts to find out:

> *To be honest going back to my own family, my sisters would want to find out, they'd want to know whether he's got a criminal record or whether he's got any diseases, whether he's been sexually active.* (Safia, Interview 1, Phase 1)

Some women may be more confident and want to know all they can about a future partner. Safia was talking about her sisters and their future prospective husbands. Perhaps as there was no secrecy when considering a partner for marriage, this made it easier to ask personal questions about their partners. Although whether Safia's sisters would feel confident to ask their future husbands direct about any previous relationships was not discussed.

Saleha had begun to consider the issue of maintaining her virginity before marriage and her own expectations of her future husband:

> *Cos like I'm not one of the people that is looking for that attention. I don't want it, not right now. But since my friends have been telling that they have, all of a sudden it's sparked this thing in me that what if I get married and my husband had been going around with girls, I would absolutely detest it cos if I've stayed the way I have for that many years, just to get married to him, then I expect the same from him. Like in terms of staying away from all that kind of stuff* (Saleha, Focus group 3, Phase 2).

Saleha held strong importance on being a virgin when she married and expected the same from her future husband. She identified that she hoped to marry a man who had not been in any form of relationship before. Despite being aware of individuals being in secret, romantic relationships before marriage and not necessarily marrying who they were in relationships with, it was apparent not all the participants had given thought to the prospect that their future partners or husbands may have contracted an infection or considered asking partners to get tested. The secret nature of the relationships and due to the fact that relationships before marriage were forbidden, appeared to make discussing past relationships and the need to be tested somewhat difficult.

Another reason women may need to access help was if they became pregnant. Rizwana highlighted an important issue around the needs of females who may become pregnant before marriage and the role that the health services could play to ensure their safety:

> *Offer them all the support that there is but maybe in addition offer them some guidance on how they can tackle the situation like if they needed their family to know how to go about that. Make sure they're protected. In the worst case*

scenario they are outcast or something. I know it sounds prehistoric but it could happen. (Rizwana, Interview 3, Phase 1)

The issues highlighted by Rizwana also related to those mentioned by Yasmin (in section 6.7) about cultural expectations and the consequences of falling pregnant before marriage. This signifies the importance for services to be aware of the wider issues that females from this cultural background can face if pregnant outside of wedlock. Implications for practice will be explored further in Chapter 11.

Another pregnancy-related concern was highlighted by Sara. She identified that due to many women from her cultural background getting married young they experienced teenage pregnancies:

Sara: Cos a lot of younger women have got kids and they're quite young themselves so they must have had their children at 16 for their child to be 5 now.
R: Are these British Pakistani girls you're thinking about?
Sara: Yes and now they're trying to get their lives sorted and they've got children and it's quite difficult for them so if they were more aware of the issues they may have been aware of contraception and becoming pregnant. (Interview 2, Phase 1)

Getting married at ages 16, 17and 18, meant these women often have limited knowledge of sexual health issues affecting their choices around contraception and family planning. There may also be a lack of knowledge around which services they can access for advice and support. Issues around sexual health for women from a British born South Asian background are complicated and further compounded by the secrecy and the inability to talk freely about these matters. The lack of awareness around sexual health issues and the beliefs surrounding sexual health education (see section 8.5) may leave a young bride in a vulnerable position.

8.4 Engaging with professionals for sexual health needs

The participants discussed their thoughts and experiences on accessing their own GP for sexual health related issues. Some of the participants raised issues around being treated by a doctor from the opposite sex, and that while unproblematic for general health advice, a female was preferred when discussing sexual health concerns:

For normal situations I always go to either or, but if it was sexual health I would prefer to go to the lady. (Safia, Interview 1, Phase 1)

Memuna also referred to how she would not discuss any women's issues with any member of the opposite sex, particularly one that was also from the same cultural background:

You don't talk about it in front of men basically. Periods, sex, women's stuff. They're the kinds of things that you hide so if you don't even talk to your brother or your dad about these kind of things, why would you go and talk to another Asian man?! (Memuna, Focus group 1, Phase 1)

Memuna highlighted her need to '*hide'* things from any males whether these be relations or professionals.

Although some participants knew that confidentiality would be maintained during health professional encounters, they were uncomfortable with their family doctor knowing about their sexual health issues. However, a few discussed personal experiences where the family GP brought up a health issue from a previous GP visit in the presence of their mother:

Khadija: I don't think I'd go to my doctor… It's just that thing! He's your doctor, your family doctor!
Memuna: But it's confidential
Khadija: I know I know, but still though.
Memuna: Is he Asian (South Asian) your doctor?
Khadija: No he's Chinese
R: So the issue isn't that he's the same culture as you?
Khadija: No it's the family doctor
R: Is it that fear he might tell someone in the family?
Khadija: No he won't tell anyone but it's just that thing that, I've had some problems with my periods and the lady doctor when I used to go in with my mum would be like how's your periods and it's just like okay.
R: Right so you don't want them to bring anything up if you're in with your mum?
Khadija: Yeah.
Anisha: I remember going in with my mum once and they were asking is she sexually active and my mum's like no she's not. [all girls laugh].
(Focus group 1, Phase 1)

In the discussions, both Khadija and Anisha recalled situations where they saw their family GP but found it difficult to discuss issues as their mothers were present or their mothers answered sexual health responses on their behalf.

Having the same GP as the rest of your family (irrespective of ethnicity) appeared to be problematic for several participants especially in terms of keeping their personal issues private. Several participants also identified further issues when the family GP was also from the same cultural or religious background. Sara reported:

> *Sara: Like I know when I went with my friend cos we have the same doctor and stuff she was like this is a Muslim doctor and she was like no I don't want to go there.* (Sara, Interview 2, Phase 1)

A key consideration before even considering accessing health care was the doctor's religion. A GP of the same religious background invoked concerns of feeling judged irrespective of whether GP confidentiality was maintained. In this situation, the taboo nature of sexual activity before marriage prevented these women from accessing help:

> *R: You (Memuna) brought up the question to your friend (Khadija) that 'is the GP Asian'? Why did you bring that up?*
> *Memuna: Cos Asian people judge a bit more than what other people would do.*
> *R: So an Asian GP might*
> *Anisha: Even though they're not supposed to say anything.*
> *Khadija: Doctors aren't supposed to speak to people.*
> *Memuna: No you'd feel shameful in front of an Asian guy, someone who was from the same background.*
> *R: So if you were accessing an Asian GP, there'd be an element of shame?*
> *Anisha & Memuna: Yeah.*
> *R: Is it almost like you're admitting*
> *Memuna: You've done something wrong yeah.*
> *Khadija: It's like a taboo subject.*
> (Focus group 1, Phase 1)

Other participants discussed how some South Asian GPs were viewed as part of their wider community. The likelihood of encountering GPs outside the surgery could lead to feelings of embarrassment:

One of my cousins she's started with problems and she's got an Asian doctor as well from X [area] *and obviously he knows everything that's wrong with her but every time, he's at the same wedding or the same party and stuff so it's a bit awkward when you see them outside.* (Anisha, Focus group 1, Phase 1)

Another participant also raised concerns about having a GP from the same religion, however her experiences were not about feelings of embarrassment or lack of confidentiality, but rather how her GP imparted his religious beliefs:

Sara: I've come here to the doctor to get the pill and cos I have an Asian doctor as well. Sometimes I think Oh my God what if he tells my mum? He'll be like 'Oh religion says this and religion says that' but it's like You're my doctor!
R: Do GPs say that?
Sara: Yeah and you're like I'm here to get something and not here to preach about religion
R: So have you actually spoken about those sorts of things to your GP to know he's talking about religion?
Sara: Cos I was like can I have the pill and he was like what do you need it for? And I was like obviously I just need it, I don't want to go in to detail with you. I've got a boyfriend, I'm thinking about sleeping with him and stuff and I was like I'd rather have the pill and he was like 'No you can't do that' […] and I was like excuse me you're my doctor, you need to give it me! (Interview 2, Phase 1)

Sara also shared another experience with the same GP whereby her mother had been unsupported when wanting to discuss her options to have an abortion:

Yeah, it's like once there was a case where my mum, she wasn't sure whether she wanted to keep my little sister or not, so she went to the doctors to ask what are my options. 'Well you don't have any options because it's forbidden to get an abortion and this and that' and my mum's like right ok. And she just kept it. (Sara, Interview 2, Phase 1)

Many religions forbid having an abortion, which is the case in Islam. Although Sara's mother was a married woman and due to her GP and herself sharing the same religion, she felt unable to continue the conversation due to how the GP responded. The GP reminded Sara's mother of her religion rather than solely focusing on her health care needs and options. This insight thereby indicating that some of the shame-inducing issues faced by the young women in my study were also being experienced by married older women.

Shabana also faced similar biases from a different health care provider. In the following example, she described how awkward she was made to feel when purchasing a pregnancy test from a pharmacy for a friend:

> *Yeah I know it was for my friend actually, I've always been on the pill so it's been fine but she liked missed a pill but then she was like I don't know whether I'm pregnant or not and I was like Oh God. So I had to go and typical, I had an Asian health worker and he just judged me. I asked if I can have some pregnancy test stuff and he was asking me a lot of questions and I was like it's not for me and just the looks I was getting, I was like Jesus Christ!* (Shabana, Focus group 2, Phase 1)

Discussing a sexual health issue with a GP or other health care provider from a South Asian background therefore seemed to compound an already difficult situation. It appeared the participants faced challenges at each step of accessing help. There were difficulties when deciding where to access help, the fear of being seen by someone they knew and once with the GP, should that GP be from a South Asian background then they faced feelings of shame on top of the sexual health issue they were presenting with.

It is important to reflect, however that not all participants had the same experience with their family GPs and health care professionals and some felt supported with some GPs from a South Asian background. For instance Sara described:

> *No this is an Asian man but he's more supportive and he doesn't bring religion in to the conversation. It's like you're the patient, this is your choice. I'm going to give you advice and different options.* (Sara, Interview 2, Phase 1)

8.5 Feelings and beliefs towards sexual health education

The memories the participants recalled around receiving sexual health education varied. Some had clear memories whereas other recalled receiving little to no information. Most of the recollections were about the education they received in high school which varied from *'pregnancy videos'* to practical sessions where participants practiced e.g. putting *'a condom on a banana'*. Participants that attended faith-based schools e.g. Roman Catholic or Islamic schools reported receiving little education:

> *In school it was more about the reproductive system with it being a Catholic school we never got taught about sexual health as they'd condone that sort of thing at the age you are in high school.* (Maria, Interview, Phase 1)

Similarly, the participants that attended an Islamic high school described receiving some education around the reproductive system and forms of contraception such as *'coitus interruptus'* that were deemed more natural and therefore more accepted within their religion:

> *Yeah more the natural methods but we are also told to try to stay away from contraceptives because you're kind of preventing life coming in to this world. If God's destined it to happen then you're kind of preventing that. But then on the other side, the argument is that well if God's decided for you to have a child, whether you have used contraceptives or not, if it's gonna happen then it's gonna happen cos of our beliefs. So there's that side to it as well. (*Saleha, Focus group 3, Phase 2)

Although some forms of contraception were deemed as permissible within Saleha's religion, the messages about contraception were conveyed in a manner to suggest that an individual has little control over whether they will become pregnant – if God wills it then it will happen irrespective of contraceptive use.

Interestingly, Memuna made a statement that conflicted with her beliefs:

> *They know everyone's gonna do it anyway so you might as well know how to protect yourself.* (Memuna, Focus group 1, Phase 1)

From listening to Memuna, I felt she was alluding to the fact that at some point, albeit when married, there was a need to know about contraception so it was important to receive suitable education.

Other participants reported feeling *'embarassed'* when receiving sexual health education and to such an extent that it was difficult to *'pay attention'* in class:

> *You're embarrassed in front of everyone at school so you're not really taking it in. Personally I didn't take it in.* (Adeela, Focus group 4, Phase 2)

While teenagers feeling embarrassed about being taught sexual health education would be the same irrespective of their ethnic and cultural backgrounds, what was different for many of the participants in this study is the influence of religion on their beliefs and practices. The forbidden nature of sex before marriage appeared to strongly influence their beliefs towards the education they received:

> *Some people choose to ignore it as they think it's forbidden or frowned upon until you get married but what are you going to do when you get married and you don't know?* (Sara, Interview 2, Phase 1)

The forbidden nature of sexual health before marriage thereby affected an individual's learning and recollection of what they were taught. However Sara also pointed out that if you choose to ignore it then your knowledge remained limited even at a stage when it was no longer forbidden, i.e. when married. Subsequently this could cause issues when faced with sexual health situations they knew little about.

Some of the participants recalled their schools sending letters to obtain parental permission for their daughters to attend sexual health instruction. On some occasions, parents did not provide consent and on other occasions the letters were not passed to parents for fear of how they would react:

> *Khadija: But then again in primary school you get a letter to say you're gonna have sexual health education, I remember the letter but I didn't show it to my mum and dad.*
> *R: Why?*
> *Khadija: Because I didn't know how they'd react.*
> *Anisha: I remember when we had that there were a few parents that didn't let them go.* (Focus group 1, Phase 1)

Khadija's reticence suggested that from an early age she was aware how her parents would react. The forbidden nature of sex was instilled from a young age.

Munira discussed one of the teachings that she had been taught at her faith-based school:

Munira: Cos I know like in school I've learnt that if your husband wants sex, you have to give it to him but I don't believe in that because I am an individual myself, I am not there to merely serve his purpose.
R: So consent in terms of although you're married you still have that right to say no.
Munira: The right to say no. (Munira, Interview 5, Phase 2)

Although Munira identified herself as religious, and had attended an Islamic high school, she described herself as an *'individual'* who valued her ability to make autonomous choices around sex with her potential future husband and this was not something she could *'believe in'*. As Munira recounted – the teaching in Islam is *'if her husband wanted sex, you have to give it to him'* regardless of your own wishes. Al-Munajid (2018) also highlights that within the Islamic faith the woman is committing a sin if she denies her husband sex. Saleha also brought up the same teaching that Munira mentioned above and referred to it as a *'saying'*:

Saleha: I think in Islam, there's a lot of focus on how women should attend to the man in terms of when he needs you in terms of marital relationships. If he wants what he wants then she has to give it to him. It's that saying isn't it that even if you're in the kitchen and he calls you for his needs then you have to attend to his needs.
R: When you're saying his needs are we talking about sexual needs?
Saleha: Yeah.(Focus group 3, Phase 2)

Saleha stated there is a lot of focus *'on how women should attend to the man'* but she did not mention how men should treat a woman. I felt concerned as many females who were taught this may abide by it wholly without considering the teaching from a wider perspective or to do their own research around the teaching in case this was just one element of the teaching.

Safia brought up something very similar where she complained about the lack of women's rights within marriage:

Do you know how they say in marriage you can have issues of rape and stuff like that and people might not be aware of that already whether they are being raped or not. So there's issues about that as well. (Safia, Interview 1, Phase 1).

Safia highlights key issues about the potential of sexual abuse of Muslim females due to adhering to religious doctrines. It was clear that Munira and Safia had thought about this as it made them consider their own agency and consent in marriage. This was similar to what I had also heard previously, in my first marriage when I was married to a Muslim man, but rather than just accepting it, I felt it was important for me to read around the teachings further. I learnt that what I had been told was very one sided as the woman's needs and feelings mattered also within Islamic values. If the relationship between a married couple was grounded in Islamic principles where love and kindness was present, and where all desires were settled through mutual agreement and understanding then the issue of a husband getting angry or being insistent should not arise (Naik, 2009). This made me very aware of how important my own agency was to me within the confines of my religion. This was also reflected by Munira above who made it clear that she did not *'believe'* the teaching as it had been taught to her but still raised concerns for other women who may not question it.

Many participants described their preferences over who sexual health education was delivered by. Yasmin described how it helped that their teacher was female but the fact she was from a South Asian background was *'weird'*:

> *Yasmin: Yeah female so it wasn't too bad. She was obviously very Westernised but she was still Asian so it was very weird. It's like watching one of your aunts do it and you just think, don't wanna be here. Really weird.* (Yasmin, Focus group 2, Phase 1)

Being from the same ethnic background appeared to breed familiarity which seemed to make things uncomfortable.

Many participants felt that school was the best place for them to learn about sexual health but would prefer *'health professionals'* to deliver the sessions over their own teachers. They also felt that external speakers were more suitable over professionals they would have to see regularly:

> *Uzma: I don't think teachers should do it. I know they're good at their job and what not but someone else.*

> *Adeela: It is a bit awkward cos you have to see them around but if someone was come in, they go away, you don't have to see them again, that would be better.* (Focus group 4, Phase 2)

The emphasis here was on not seeing that individual again. Perhaps suggesting that the use of external speakers may allow individuals to feel less embarrassed and at ease.

Uzma wanted a speaker who had experience around the issues and was not just delivering it as part of the curriculum:

> *They should tell you properly, not just like formal… They should teach it informal and make it fun for us not just like this is your vagina, this is this, this is that. Forget that! … you wanna know it properly with someone with experience and someone that knows they've been there.* (Uzma, Focus group 4, Phase 2)

Similarly Safia also felt it should be delivered by someone with experiential knowledge of sexual health:

> *I think it should be everyone from different backgrounds. It should involve everyone whether they're male or female, whatever age really, so there's no certain person to tell you. So it could be young people who are sexually active as well, British born Asians, Pakistanis, Muslims, White, African Caribbean…I think they should have sort of training in how to speak to people, communication skills and how to actually let people know what they want to say to make it a bit more interesting instead of a boring topic or a topic that no one really wants to listen to… But then it should come from someone who has experience and is aware of it and can reflect upon their own experience.* (Safia, Interview 1, Phase 1)

Safia, had no preference over the ethnic background of the speaker. She wanted the information to be real and relatable and demonstrated awareness that sexual health issues affected everyone regardless of their background. She desired knowledge from all perspectives which included learning and hearing from individuals who had experienced sexual activity before marriage including those where sexual activity was forbidden before marriage.

8.6 Conclusion

In this chapter I have presented the final findings category on 'Accessing sexual health services, advice and awareness'. Participants in phase one appeared to have a better knowledge base around sexual health services from their responses on the personal characteristics form. Participants identified challenges faced by women from South Asian backgrounds when trying to access services such as confidentiality. Issues faced when engaging with health care professionals also raised concerns and highlighted areas that women need to navigate, before they are able to receive the support and help they need. Finally, I also considered feelings and beliefs towards sexual health education and its delivery. In the next chapter, I present a second review of the literature. I provide details of the scoping review framework adopted, the stages involved, and present the findings.

9.0 Literature review

9.1 Introduction

In this chapter I present the findings from the scoping review which was undertaken following my data analysis in line with Charmaz's (2014) approach. I begin by providing an overview of what a scoping review is and provide details of the Arksey and O'Malley (2005) scoping review framework adopted. The details of how the relevant studies were identified and selected are described, followed by an overview of the findings (data charting). I then present four key themes to emerge from the literature. Finally, I consider how the insights from the wider literature helped to strengthen my empirical findings and to inform the construction of theory in line with Charmaz's grounded theory approach.

9.2 What is a scoping review?

A scoping review is commonly used for a number of reasons which include: to examine the nature, extent and range of research areas; to provide a summary of research findings and to identify existing gaps in the literature (Arksey & O'Malley, 2005). They are described as a tool to map the existing literature on a topic in order to identify key concepts, gaps in knowledge, types of evidence which in turn may inform future research, policy and practice (Munn, et al., 2018; Daudt, van Mossell, & Scott, 2013). A scoping review provides more flexibility than a traditional review as it can account for a more diverse range of literature using a variety of methodologies (i.e. both qualitative and quantitative research, narrative reviews and grey literature) (Peterson, Pearce, Ferguson, Langford, 2017; Arksey & O'Malley, 2005). There is no universal definition of a scoping review and there is also no universally accepted method or set of procedures used to carry out a scoping review (Peterson, Pearce, Ferguson, & Langford, 2017). Perceived strengths of a scoping review include their systematic nature, transparency and replicability (Grant & Booth, 2009). The intent of the scoping review is to chart or map what is known about the topic of study which may identify gaps in knowledge (Peterson, Pearce, Ferguson & Langford, 2017) however scoping reviews do not necessarily include the findings of the studies or consider the quality of the evidence as a priority (Considine, Shaban, Fry, & Curtis, 2017). Arksey and O'Malley (2005) also confirm that the aim of a scoping review is not to synthesise or assess the quality of evidence. A scoping review does not require an assessment of the quality of evidence

which may make some averse to this type of review (Peterson, Pearce, Ferguson & Langford, 2017). Daudt, van Mossell and Scott (2013) suggested that some may question the usefulness in relation to policy making if the quality of evidence is not assessed, in particular when the scoping review is a stand-alone project rather than as part of a bigger process. I used the Arksey and O'Malley (2005) scoping review, which is detailed below. This approach was selected as it provides clear steps, is utilised well in health care, in particular in nursing (Peterson, Pearce, Ferguson, & Langford, 2017) and provides very detailed stages to follow. The scoping process is an iterative one which allows engagement with the literature at key stages and allows the searching of a wide range of evidence (Arksey & O'Malley, 2005). As advocated by Charmaz (2014) this review of the literature was not commenced until data collection and analysis had commenced, theoretical categories had been saturated and no new themes were emerging. I was also aware from my initial literature searching exercise upon commencement of my studies, that there was limited research into this topic (see Chapter 2). Therefore, I was aware that I would need a literature searching and review method that would allow me to search broadly which is a reason why I chose this approach. I took into consideration the limitations of the scoping review method and felt that as this approach was only one method of recognising the existing issues concerning my topic (i.e. I was conducting interviews and focus groups which would provide their own data and findings); it would be suitable for the purposes of my review.

9.3 Scoping review framework

In the same way that "there is no universally accepted definition of a scoping review, neither is there an exacting set of procedures" (Peterson, Pearce, Ferguson, & Langford, 2017, p. 13). In 2005, Arksey and O'Malley published the first scoping review framework which provided information on the purpose of a scoping review and detailed stages for researchers (Arksey & O'Malley, 2005). The detailed stages in their framework provide a clear, rigorous and transparent method for researchers to adopt, and the findings of the scoping review can be utilised with the findings from a larger project (as is the case with my study), to potentially inform research, policy and practice. They emphasise that each stage should be documented in a way that it could be replicated and to maintain an explicit approach. In this way the reliability of the findings can increase and methodological rigour can be enhanced (Arksey & O'Malley, 2005). In a systematic review of scoping methods, Arkey and O'Malley's method was found to be the most commonly used (Pham, et al., 2014).

Arksey and O'Malley (2005) describe the stages of their framework as follows:

Stage 1: Identifying the research question
Stage 2: Identifying relevant studies
Stage 3: Study selection
Stage 4: Charting the data
Stage 5: Collating, summarising and reporting the results

A sixth, optional stage consists of a consultation exercise which includes eliciting the views of key stakeholders who could contribute to the review (Arksey & O'Malley, 2005). As this is an independent study, there are no stakeholders involved in my study and as my research forms part of a programme of study, I have chosen not to utilise this optional stage.

9.3.1 STAGE 1: Identifying the research question

Forming a research question can be challenging and therefore the use of a framework is advocated (Considine, Shaban, Fry, & Curtis, 2017). The use of a framework helps to construct a research question and to develop a literature search strategy (Considine, Shaban, Fry & Curtis, 2017; Doody, 2016; Bettany-Saltikov & McSherry, 2016). PICO is a commonly used framework (Considine, Shaban, Fry, & Curtis, 2017). The four components are:

P - Population or problem
I - Intervention or Issue
C - Comparison/ Control (if relevant)
O - Outcome.

Schardt, Adams, Owens, Keitz, and Fontelo (2007) found that searches performed using methods such as PICO, PIO or PEO (Population, Exposure and Outcome) returned a higher rate of relevant citations compared with searches performed using a standard search within a database. For qualitative research, a PIO framework is used, as a comparison or control group is not appropriate and therefore a PIO approach was adopted for my study.

My review question was: *What is known about the perceptions, knowledge, and awareness* **(outcomes)** *of sexual health* **(issue)** *among British born, South Asian women, aged 18-25* **(population)** *from the literature?*

9.3.2 STAGE 2: Identifying relevant studies

Before commencing database searches, a search strategy needs to be formulated. Bell (2005) emphasises the importance of setting the search parameters before commencing literature searching. She highlights that this will allow the refining and focus of keywords. I used the PIO to chart initial terms and keywords with alternative terms considered as appropriate e.g. women and females (see Table 6 below). I chose not to limit the ages of participants or look for studies that were only concerned with females as these risked not capturing studies where females and young people were included. I also consulted with the faculty librarians at my University to review my search terms prior to the searches being undertaken.

CRITERIA	**INCLUSION CRITERIA**	**EXCLUSION CRITERIA**	**SEARCH TERMS**
POPULATION (P)	Studies that include British born young females, aged 25 and under from South Asian groups living in the U.K.	Studies that do not include British born young females, aged 25 and under from South Asian groups living in the U.K.	South Asian or Indian or Pakistani or Bengali or Sri Lankan or British or British born or Females or Women
ISSUE/INTERVENTION (I)	Sexual health issues	Non sexual health related issues	Sexual health or Sexual health services or Sexual health access or Sexual health education
OUTCOME (O)	Views and experiences of sexual health issues	Non- sexual health related views and issues	Perception or Awareness or Experience or Knowledge or Expectation or Feelings or Attitudes or Views
ADDITIONAL SCREENING CRITERIA			
DATE	2000 to present		
LANGUAGE	English	Non-English	

		language	
LOCATION	Studies conducted in the U.K.	Studies not conducted in the U.K.	

Table 6: PIO search terms mapped against inclusion criteria

Arksey and O'Malley (2005) state that practical decisions about the literature search need to be made from the outset in terms of coverage, time span and language. Due to the limited number of relevant studies found in my initial literature search prior to programme approval (discussed in Chapter 2 Background),I deemed it necessary to widen the population of my search to try and capture relevant studies which may assist in answering the research question. I widened the search to incorporate studies from South Asian populations that resided in the UK but were not necessarily born here. I also set a date limit of 20 years to not limit my search too much due to knowing there were limited studies of relevance, while trying to capture contemporary insights. Non-English studies were excluded due to the time and cost implications and also because my study was focused on British born women.

Arksey and O'Malley (2005) identified that adopting limits for practical reasons may lead to researchers missing potentially relevant papers and that additional search methods should be adopted. These included checking the reference lists of relevant studies and hand-searching of key journals (Arksey & O'Malley, 2005). A broad strategy to identify literature resonates with Bates (1989) berrypicking model, which advocates that there are many methods which can lead to the location of relevant studies which include footnote chasing, citation searching, journal runs, database searches and author searches. I used reference list searches and author searches alongside database searches.

9.3.2.1 Databases used for the scoping review

The literature on systematic reviews outlines the use of Medline, EMBASE, Web of Science and Cochrane Central as a minimum (Harvard Countway Library, 2020; Levett, 2020; Centre for Reviews and Dissemination [CRD], 2009). The guidance also suggests that searching within PsycINFO and CINAHL may also be equally appropriate for health related disciplines (CRD, 2009). Although my literature review was a scoping review, I felt it would be appropriate to search a number of databases. Micah, et al.

(2015) also state that the approach in choosing which databases to search in a systematic scoping review should follow the same approach as a systematic review. The following databases were therefore searched:

Medline
EMBASE
Cochrane
CINAHL
PsycINFO
Web of Science

The databases were searched using the databases' subject headings where appropriate as well as free text terms using the PIO terms in Table 6 above. Searches conducted using both subject headers and free text can lead to a better return, precision, and efficiency (Baumann, 2016; Jenuwine & Floyd, 2004).The use of subject headings can also remove the need to try and search using every synonym, different combinations of word endings or plural and singular forms (Chapman, 2009). The subject heading and/ or free text terms were then grouped together using the Boolean Operators OR and AND. The above database searches were undertaken between October and December 2020.

9.3.3 STAGE 3: Study selection

I adapted the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009) to guide the process of study selection (See Figure 4 below), and I used Microsoft Excel to record the results. The database searches returned 72 citations and 19 studies were also identified via the other search methods discussed in stage 2 above. Duplicates were removed, and the titles and abstracts of each article were read to determine their relevance. I then read the full texts while referring to the predetermined inclusion and exclusion criteria (see Table 6 above), and all those that seemed relevant were discussed with my supervisory team to agree whether suitable for inclusion. A total of 13 papers were included in the scoping review. As per Table 6 which highlights my exclusion criteria, the exclusion criteria were linked to the aim of my study. I chose to exclude studies where there was no mention that British born young women aged 25 and under and from a South Asian background, who were living in the UK formed part

of the study. This was because their experiences may differ to women of a different age or who were not born here or not residing in the UK. I also excluded studies that were not concerned with sexual health related issues. Studies that were not conducted in the UK or were not written in English were also excluded to maintain focus on my aims and objectives.

When the participant demographics were not clear from the title and abstract, I looked for this information within the main body of the publication. I noted that some of the publications did not mention whether the participants were *British born* South Asians. However, I made the decision to include articles that had some participants who were British South Asians, even if they were not the sole focus of the study, as they may have similar issues that could be of relevance.

9.3.4 STAGE 4: Charting the data

Stage 4 of the Arksey and O'Malley (2005) framework focuses on charting the data, which involves noting relevant information from the primary research being reviewed. As used by Arksey and O'Malley (2005), I used Microsoft Excel to chart or enter the data onto a data charting form which I then chose to copy over into Word format for ease when reading (see Appendix 21: Charting the Data). The authors argue that data charting should include general and more specific information about the study (Arksey & O'Malley, 2005). They also identify that it may not always be possible to adopt a uniform approach, as the reports may fail to provide all the relevant information required. However, I felt it useful to produce a template for extraction, while recognising that some of the data fields may not be populated (due to missing or a lack of information).

Information recorded from the studies included (see Appendix 21):

Author
Year
Title
Study location
Study population
Aim/s of the study
Methodology/ Study design

Key findings

9.3.5 STAGE 5: Collating, summarising and reporting the results

Stage 5 focuses on summarising and reporting (Arksey & O'Malley, 2005). The PRISMA diagram below details the search strategy. Overall, from a total of 91 records, 13 studies were included.

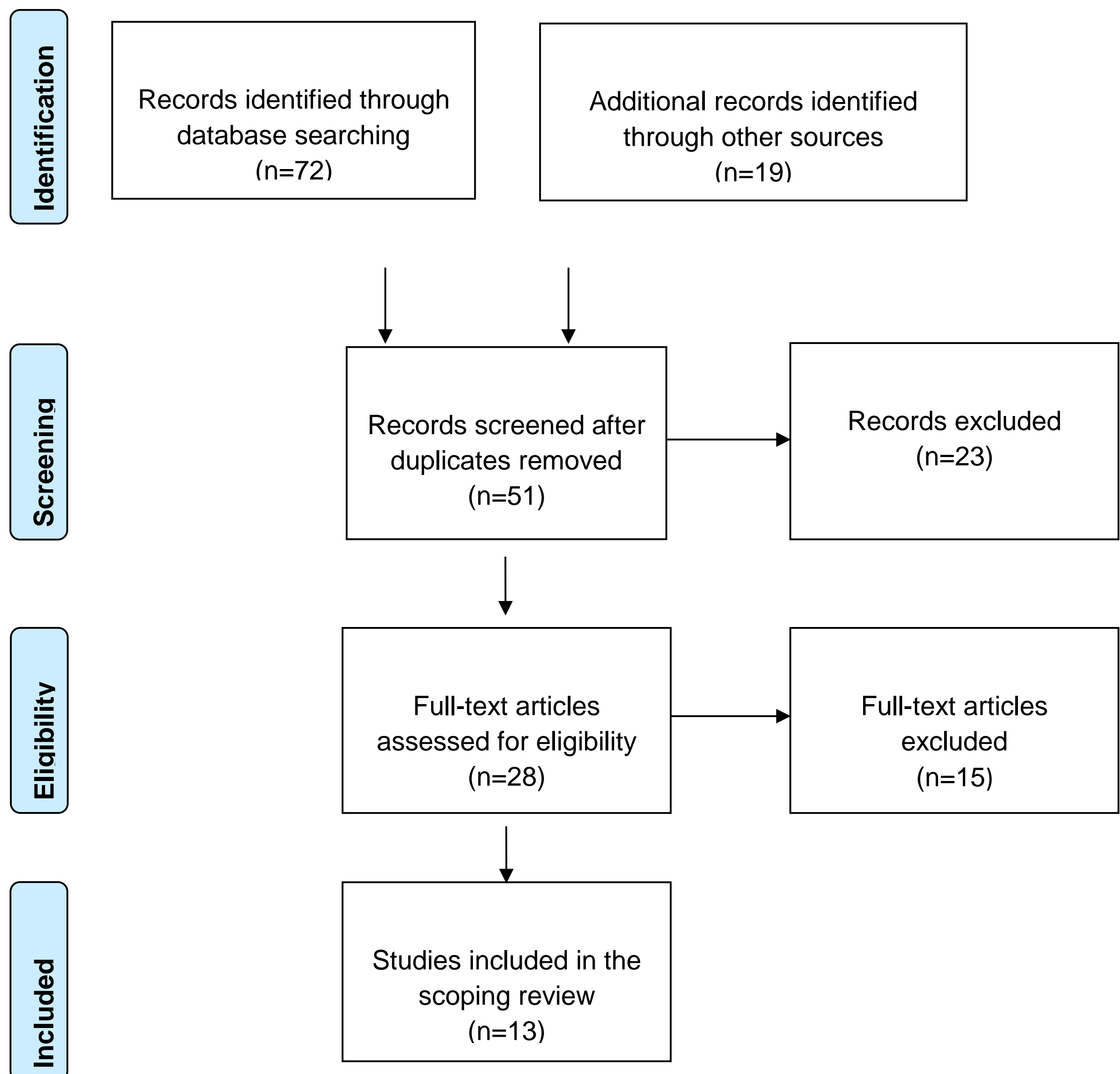

Figure 4: Flow chart of search process and results - adapted from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses: PRISMA flow chart

In line with the scoping review methodology and as per Arksey and O'Malley's (2005) framework, thematic construction was used to generate a narrative account of the literature. A "scoping review does not seek to 'synthesize' evidence or to aggregate findings from different studies." (Arksey & O'Malley, 2005, p. 27). Arksey and O' Malley (2005) state that although thematic construction is used to provide a narrative account of the literature, there is no need to consider the weight of the evidence in the review. They identify that this is due to the fact that a "scoping study does not seek to assess quality of evidence and consequently cannot determine whether particular studies provide robust or generalizable findings" (Arksey & O'Malley, 2005, p. 27) In line with the scoping review methodology and as per Arksey and O'Malley's (2005) framework,, thematic construction was used to generate a narrative account of the literature. Having 'charted' the data (see section 9.3.4 above), I was able to organise the literature into analytic themes that were congruent with the aims and objectives of my study as advocated by Arksey and O'Malley (2005). This involved reading and re-reading the data included within the findings and discussion sections of the included literature. This data was mapped into key meaning units using excel and then combined into qualitative themes (Levac, Coquhoun, & O'Brien, 2010; Arksey & O'Malley, 2005). Overall, I identified four themes that represent all the key findings from the included studies. Overall, I identified four themes that represent all the key findings from the included studies. The themes are:

- Cultural factors and influences
- Beliefs and behaviour surrounding sex
- Access to services and contraception
- Sex and relationship education

Below an overview of the study characteristics of the included literature is reported, followed by a description of each of the four themes.

9.3.5.1 Literature overview

All 13 papers included in the review were undertaken in the UK. Collectively they represent the views of 45,249 participants. The participants' ages ranged from 13 to 74 with 11 of the papers focusing on ages ranging between 16 and 44. The studies included participants from a number of South Asian ethnic groups which included Pakistani, Indian and Bangladeshi and other ethnic groups which included Black Caribbean, Black African and White ethnicities. Seven studies were quantitative using

surveys/questionnaires. The qualitative studies (n=4) used either semi-structured interviews, focus groups or both. Two studies collected both qualitative and quantitative data of which one used a survey and semi-structures interviews, and the other used a questionnaire with focus groups, a web-based discussion forum and semi-structured interviews. Further information on each study is in Appendix 21. In line with the focus of my study, and the purpose of reviewing the literature to help inform, I only report on insights relating to young women's' experiences, perceptions and views. Therefore, while some of the literature reports older participants and male views of sexual health (Dhar et al., 2010; Griffiths, French, Patel-Kanwal, & Rait, 2008; Sinha, Curtis, Jayakody, Viner, & Roberts, 2007; Testa, Coleman, Trust for the Study of Adolescence, Naz Project London, 2006; French et al., 2005; Beck, Majumdar, Estcourt, & Petrak, 2005), this has not been reported.

9.3.5.2 Cultural factors and influences

The theme was prevalent in all included literature and concerns cultural issues that may influence beliefs and behaviour regarding relationships and sex. In a number of studies, a higher percentage of Indians, Bengalis and Pakistanis in the UK emphasised the importance of religion upon all aspects of their lives compared to other ethnicities (Kott, 2011; Griffiths, et al., 2011; Sinha et al., 2007; French, et al., 2005).

In their study on young British Bangladeshis and their mothers' views on sex and relationships, Griffiths, French, Patel-Kanwal and Rait (2008) assert that understanding the cultural context within which young people live is crucial and found that the South Asian participants emphasised the importance of protecting honour (izzat) and the family reputation, among families and communities. In their study undertaken in East London with the Bangladeshi community, Beck et al. (2005) found that sex outside the confines of marriage was deemed as forbidden in religious teachings and could bring shame and stigma should it become known within the community. This was also reflected in the studies conducted by French, et al. (2005) in London, Manchester and Birmingham with participants from Bangladeshi, Indian and Jamaican groups; Dhar et al. (2010) with South Asian participants from seven genitourinary medicine clinics in England and by Griffiths et al. (2008) in London with young British Bangladeshis and their mothers. A study by Sinha et al. (2005) examining protective factors against risky sexual behaviour, found similar insights in that some 15-18 year old participants

reported how expectations and disapproval of their parents would prevent them having pre-marital sex.

Beck et al. (2005) found that some participants held beliefs that it was religiously forbidden to receive or try and learn about sexual health education, and that when the time comes, i.e. when they are married, they will learn naturally through experience. This view was also reflected in a study undertaken in seven Genitourinary Medicine (GUM) clinics across England by Dhar, et al. (2010); some participants felt that dialogues around sexual health were deemed unnecessary and irrelevant, as cultural and community values prohibited pre-marital sex.

9.3.5.3 Beliefs and behaviour surrounding sex

This theme was concerned with participants' beliefs, views and perceptions towards relationships and sex. Overall, all 13 studies, either explicitly or implicitly, reported that values, beliefs and views towards sex were influenced by beliefs and values held by young people, their families and their communities. Studies conducted by Sinha et al. (2007) and Testa et al. (2006) reported how South Asian 15-18 year olds (in particular South Asian females), were less likely to report engaging in sexual intercourse compared with other ethnicities. Women from South Asian backgrounds reported their sexual behaviour to be influenced by their cultural values more than males with females from Bangladeshi and Pakistani background reporting low rates of sexual activity and discussions around their beliefs towards rather than personal experiences of sexual health issues (Sinha et al., 2007; Testa et al., 2006). In a study by Kott (2011) on the sexual attitudes and behaviours among Pakistani and Indians in Britain, the national survey findings noted differences in beliefs between South Asian groups, as individuals from a Pakistani background (72% of males and 78% of females) were more likely to disapprove of pre-marital sex compared with those from an Indian background (47% of males and 46% of females). However, participants in a study by Griffiths et al. (2008) felt pre-marital sex came down to personal choice and did not reflect a lack of belief or faith when discussed in focus groups. While some young women stated pre-marital sex was forbidden in their religion, Sinha et al. (2007), found through their focus groups and interviews, that this did not prevent teenagers from ethnic minority backgrounds in East London, being involved in intimate ways with their boyfriends (although did not include penetrative sex). In a study by Griffths et al. (2008), young British Bangladeshis described the conflicting emotions they felt

between not abiding by their parents' wishes but also wanting what felt right for them (Griffiths et al., 2008).

Other research revealed how beliefs are not always consonant with behaviours as, for example in a study by Griffiths et al. (2011), some participants reported being in a relationship outside of the confines of marriage. Griffiths et al., (2008) found that despite concerns of honour and reputation, young people highlighted being discreet in regard to sex-based relationships, rather than abstinence, in order to maintain the family's reputation. In a study by Beck et al. (2005), younger participants and those from professional backgrounds acknowledged that sex did occur outside of marriage despite the older women participants in this study, holding the belief that *"girls don't do anything bad, they don't have boyfriends"* (p. 160). Through their analysis of a national probability survey, Saxena, et al. (2006) found that some single women from Indian and Pakistani backgrounds (albeit less than those from White backgrounds), reported being sexually active. Peer pressure was reported to have different influences in Griffiths et al's (2008) study. The young men wanted sex to fit in with their peers, whereas the young women felt pressurised by their partners rather than from peers (Griffiths et al., 2008). Similarly Sinha, et al. (2005) found 11% of young women and 7% of young men felt pressured within their relationship to the timing of first sex.

The repercussions of pre-marital sex in South Asian communities were identified as being graver for women when compared to men but there was some recognition that in current times, some parents may show some understanding (Griffiths et al., 2008; French, et al., 2005). Some studies identified that cohabitation was less common among Pakistani and Indians respondents (Griffiths, et al., 2011; Kott, 2011; Saxena, et al., 2006; Fenton, et al., 2005). Although beliefs towards pre-marital sexual relations were varied among Indian and Bangladeshi young people, negative attitudes towards becoming pregnant outside wedlock and abortions remained strong among the South Asian community (French, et al., 2005). This was similar to the views expressed in a study by Griffiths, et al. (2011) which compared beliefs and views on sex and heterosexual sex and relationship experiences among Indians and Pakistanis in Britain. There was a fear among the young Bangladeshis in the study carried out by French, et al. (2005), that a pregnancy outside of wedlock could lead to a forced marriage or being sent to Bangladesh to be married. This study also reported that despite strong religious influences indicating that abortion is forbidden, it was felt that women would

seek out abortions to avoid feelings of rejection by their families or communities (French, et al., 2005).

9.3.5.4 Access to services and contraception

This theme was concerned with experiences, issues and concerns of accessing sexual health services and contraception. Less than half of the studies in the review provided information on this topic; with the paucity of research concerning the use of sexual health services by South Asian groups in England also confirmed in the study by Dhar et al (2010). French et al. (2005) highlighted that it was evident that some young people from ethnic minority groups had poor sexual health knowledge, experienced difficulties accessing services and therefore were placing themselves in situations where there was a risk of sexually transmitted infections and unplanned pregnancies. Testa et al. (2006) further reported that a quarter of all the South Asian females in their study, who had engaged in sexual intercourse, reported non-use of contraception indicating the possibility of inadvertent infections or pregnancies. Moses and Oloto (2010) undertook a study using a needs assessment questionnaire on females accessing a specialist contraception, reproductive and sexual health service in Leicester. They found that South Asian women in the UK had specific needs relating to sexual health and contraception as they reported poor sexual health knowledge and further research into their specific needs was suggested.

Studies by Moses and Oloto (2010) and Beck et al. (2005) consider it vital to address cultural factors when negotiating and planning sexual health services. Some of the studies reported how cultural factors can influence a woman's choice of contraception (Griffiths et al. 2011; Moses and Oloto, 2010). Griffiths et al. (2008) found that whilst there were low numbers of young British Bangladeshis reporting being sexually active outside marriage, those who were engaging in sexual activity were reporting poor contraception use. Moses and Oloto (2010) found a greater proportion of South Asian women attending a Contraception, Sexual and Reproductive Health Service for non-contraceptive reasons compared to other ethnicities and cited one of the main reasons for accessing the service as not wanting to see their family GP. This service offered a number of services including smear tests, pregnancy tests and infection testing and also had the option of appointments or could be used as a walk-in clinic (Moses & Oloto, 2010).

Griffiths et al. (2011) found that half of the Pakistani respondents in their study reported non-use of contraception at first sex but also noted that this may have been due to them being in married relationships. In a study by Wayal et al. (2017) women reporting sex without using condoms, with more than one partner, was lowest among Indian and Pakistani women compared to White British women and Indian and Pakistani women were less likely to need emergency contraception compared to White British women. However in a study conducted by Saxena, et al. (2006), which compared survey data on contraceptive use among women from different minority groups, single women from an Indian background reported the highest use of contraception (100%) than other ethnicities, whereas among married women, Pakistani and Indian women were least likely to report contraceptive use compared to other ethnicities. However the authors do acknowledge that they did not ascertain pregnancy intentions so their results could be influenced by that factor (Saxena, et al., 2006).

French, et al. (2005) found many young people from Indian, Bangladeshi and Jamaican backgrounds (in particular Bangladeshi women), highlighted that it was very difficult, if not impossible to access sexual health services locally. Other studies raised concerns over confidentiality when disclosing sexual health needs with health care professionals and particularly when their GP knew their parents (Beck et al., 2005; Sinha et al., 2005; French et al., 2005) and same sex clinicians were viewed as important (Moses & Oloto, 2010; Beck, et al.; 2005; French, et al., 2005). Some young people felt there was a lack of representation of ethnic minority staff which could pose a reluctance to access services; however this was not deemed as important as the gender of the staff (French, et al., 2005).

Stigma was highlighted as a key area of concern when accessing GUM clinics and other sexual health services (Dhar et al., 2010; Beck et al., 2005). Furthermore, being seen to be accessing these services was perceived to have important implications for an individual's future and could affect a person's standing in the community (Dhar et al., 2010; Beck et al., 2005). One such implication was described in relation to future marriage prospects e.g. whereby families would not consider discussing arranged marriage prospects with a daughter or son of a family who had been seen to be accessing sexual health services (Beck et al., 2005). Beck et al (2005) also noted that there was a lack of awareness in sexual health records being kept separately from other health and medical records and that health professionals were bound by rules surrounding confidentiality.

Beck et al (2005) asserted a concern when conducting research in this area, as to whose voice was heard, as the voice of older generations, community leaders and professionals working with community groups might not be representative of the voices of the younger generation, women or those in same sex relationships whose values, beliefs and behaviours may be seen as deviant. Similar views were also expressed by Dhar et al. (2010).

9.3.5.5 Sex and relationship education

The theme concerned experiences, perceptions and beliefs towards sex and relationship education including where such education should take place and who should deliver it. Over half of the studies provided evidence for this theme. In a study undertaken by Sinha, et al. (2005), teenagers among all ethnic minority groups reported difficulties discussing sexual issues with their parents, with youths from Pakistani, Bangladeshi and Indian backgrounds found to be the least likely to discuss sexual health issues with their parents. This has similarities with a study by Kott (2011) which found less than 5% of Pakistani and Indian participants reported receiving any sex education from their parents. Griffiths, et al. (2008) found that young people from South Asian backgrounds felt that discussing sexual health issues with their parents would be viewed as disrespectful. Griffiths, et al. (2011) identified that Indian and Pakistani respondents were less likely to discuss sexual health issues with their parents during adolescence. Interestingly, some young British Bangladeshis felt that it was their parents' responsibility to impart knowledge around sexual health while recognising that many parents would not have the knowledge due to their own lack of teaching (Griffiths et al., 2008).

A study by French, et al. (2005) found that young people and their parents felt that schools did not address cultural or religious issues when teaching sexual health and relationship education, which could impact on an individual's behaviour and beliefs towards sex. Griffiths et al (2008) found that some of the younger British Bangladeshis (16-18 years old) also felt they had unanswered questions around sexual health in relation to their religious beliefs and therefore wanted faith-based sexual education however the older participants aged 19-20 year olds were not as concerned over faith based sex and relationship education.

A number of studies highlighted a lack of sex and relationship education in schools (Griffiths et al. 2008; French et al 2005; Beck et al 2005). Many young British Bangladeshis in the study by Griffith et al (2008) described the sex and relationship education they received as *"more of a joke"* as they only received one or two lessons, felt the teachers were embarrassed and identified that many students avoided these lessons and skipped class (p.717). This was similar to findings in the study by Sinha, et al. (2005) with ethnic minority youth who described the education they received to be ineffective, poorly delivered or embarrassing. Some of the participants in the study by Beck et al. (2005) believed that teaching sex education was forbidden, and therefore parents could remove their children from such sessions at school. Beck et al. (2005) found that three-quarters of all respondents wished they had more information around sex especially around the time they first experienced sexual intercourse. The study by Beck et al. (2005) also highlighted that many Bangladeshis in the UK who needed advice, would only receive it years after becoming sexually active and the advice did not include sexually transmitted infections.

In relation to the preferred setting to receive education on sexual health related issues, the study by Griffiths et al. (2008) found that young British Bangladeshi participants felt that while youth clubs could be a good setting, school was also an important venue due to not all young people accessing wider settings (e.g. youth clubs). Similarly, Griffiths, et al. (2011) stated this had implications when planning sex and relationship education, as for many Pakistani and Indian women, school was identified as the only source of education and information. In the study by Testa et al (2006), South Asian males and females showed a greater preference for school based sexual health information and a low preference for receiving sexual health education through their family. In the study by Griffiths et al. (2008), a perceived barrier to education being delivered outside school was community or parental disapproval. Previous attempts at sexual health promotion in youth clubs could lead to some girls being forbidden to return e.g. when parents became aware their daughters have received sex related leaflets and condoms (Griffiths et al., 2008). Beck et al., (2005) articulated the importance of finding a culturally appropriate balance between community values and public health issues when providing information and delivering education.

In the study by Griffiths et al. (2008) young people tended to prefer a person of a different ethnicity and in their early 20s to deliver sexual health and relationship education, however, ethnicity was less of an issue than the person being a stranger

and from a different locality to avoid it being someone who knew them or their families. Whereas young women and men from all ethnicities in the study by Testa et al. (2006), reported the most desirable person to deliver sex and relationship education was a health professional with a sexual health background. However some Pakistani males, Pakistani and Bangladeshi females stated their preference for someone to be of the same religion (Testa et al. 2006). Some of the participants in the study by Griffiths et al. (2008) suggested that activity-based sessions, which were interactive and fun, were preferred over didactic, traditional lessons. On the other hand, some of the young women were less concerned with interactive sessions and felt that informal sessions would be sufficient (Griffiths et al. 2008). What was deemed most important was that sessions were delivered in a safe environment, where what was discussed and delivered was trusted and where confidentiality would be maintained (Griffiths et al., 2008).

9.3.6 Summary

Overall, a number of key themes emerged from the literature. While the findings from the scoping review resonated with my findings, there were also some differences. For example, the literature suggested a reluctance to discuss sexual health related issues with parents, however in my study, a number of situations arose whereby discussions around sexual health would occur.

Key insights to emerge from the literature, and which resonated with my findings related to:

- Cultural and religious teachings and family and community values played a key role in influencing individual's beliefs towards sexual health and sexual relationships;
- While sexual-based relationships were generally known to be prohibited and associated with shame and threats to family based honour, this did not necessarily prevent women from engaging in romantic based relationships;
- Concerns regarding sexual health services were apparent which included confidentiality and stigma, with low use of contraception among many South Asian women suggesting a need for culturally sensitive service delivery;

- Sex and relationship education was viewed as important, although there were concerns over its delivery. The influence of culture was apparent; therefore it was vital for schools to continue to make efforts to deliver suitable sex and relationship education to inform individuals.

9.4 Conclusion

In this chapter, I have outlined the process followed to undertake a scoping review utilising Arksey and O' Malley's (2005) framework. This included identifying a research question, search strategy, identifying relevant studies, charting the main components of each included study and summarising the results. Four themes emerged namely: cultural factors and influences, beliefs and behaviour surrounding sex, access to services and contraception, and sex and relationship education. These are then followed with a summary of the findings from the themes. I argue how the findings from the scoping review strengthened the empirical findings (as presented in Chapters 6-8) and helped to direct my theorising and to develop theoretical interpretations of the data set in line with Charmaz's (2014) approach. The literature included in the scoping review highlighted similar findings to what was reported by the participants in my study, namely that structures such as culture and religion could instil shame and secrecy that impacted women's sexual health beliefs and behaviours, and that some women engaged in romantic relationships despite the concerns over shame and honour, thereby demonstrating agency and choice.

In line with the final objective of my study, in the next chapter I present my emergent theory. This was developed from my empirical findings and those from the scoping review utilising Charmaz's (2014) constructivist grounded theory approach. It draws on the work of Lazare (1984) and Cense (2019a) to create a constructed theory of 'navigating shame to negotiate sexual agency'.

10.0 Theory construction

10.1 Introduction

In the previous chapter, I presented the results of the scoping review that I undertook once data collection and analysis had commenced. Four key themes emerged from the scoping review which included cultural factors and influences, beliefs and behaviour surrounding sex, access to services and contraception, and sex and relationship education. I argue how the findings from the scoping review helped to strengthen my empirical findings and to inform the theorising process in line with Charmaz's approach (described in Chapter 4, section 4.18). In this chapter, I outline the core theory that emerged as part of my grounded theory process. I define and describe shame and sexual agency before presenting my model based on the constructed theory: Navigating shame to negotiate sexual agency. I also draw on wider literature to contextualise my theoretical interpretations.

10.2 Theory Construction

As discussed in Chapter 4, the process of theoretical sampling is vital as it allows the researcher to advance their analysis and begin theorising (Charmaz, 2014). A key purpose of the methodological approach I adopted (Charmaz's Grounded Theory), was to construct theory. Charmaz (2014) states that theorising is an emergent process, much in the same way that theoretical sampling is emergent. Theoretical sorting through the use of tools such as diagramming and memos allowed me to ascertain that the categories were saturated and new data offered no new theoretical insights (Charmaz, 2014). Charmaz (2014) and Glaser (2001) identify that saturation in grounded theory is not necessarily about the participants saying the same things repeatedly, but is about following similar explanations and insights within the data. This ensures that the different concepts within the theoretical framing are well developed (Charmaz, 2014; Glaser, 2001). Therefore while phase two actively sought individuals from a non-university background, similar issues in relation to the influence of culture and religion, acculturation, secret relationships and shame emerged.

Theoretical sorting provided me with an approach in which to organise my analysis and a method with which to create and refine theoretical links as per Charmaz's (2014) methodological approach. Charmaz (2014) also states that theoretical sorting can

facilitate the researcher to make comparisons and see the connections between the categories. She asserts that theoretical sorting serves ones emerging theoretical links as *"through sorting, you work on the theoretical integration of your categories"* (Charmaz, 2014: p216). I found the use of diagramming as part of my theoretical sorting process (as discussed in section 4.16.3.2) beneficial as it enabled me to see any links, patterns and tentative theories emerging. Charmaz (2014) highlighted how grounded theorists often use visual images through diagramming as an intrinsic part of their grounded theory methods. Thornberg and Charmaz (2021) highlight how a theory demonstrates the relationships between concepts. Charmaz (2014) identifies that from an interpretive approach, theoretical understanding is obtained through the researcher's interpretation of meaning and action.

When analysing the findings, women repeatedly used the word shame in relation to their sexual health and sex-based relationships. However, insights also described the ways in which women seemed to use personal agency in order to maintain their sexual relationships. The scoping review of the available literature also helped to strengthen these findings in that while romantic based relationships and discussions of sexual health were taboo subjects and forbidden due to the potential to instil judgement and shame in the community, this was not necessarily a deterrent (Griffiths, et al., 2011; Kott, 2011; Moses & Oloto, 2010; Griffiths, et al., 2008).

The two core concepts of shame and sexual agency were then explored further in the literature. This led me to the work of Kaufman (1974), Gilbert (2009) and Lazare (1987) on shame and the work of Pittard and Robertson (2008) and Cense (2019a, 2019b) on sexual agency. The theoretical tools (sorting and diagramming)[14], and wider reading eventually led to an overarching theoretical interpretation of my findings being developed – navigating shame to negotiate sexual agency. In this chapter, I first discuss what shame is, followed by models and theories of shame. I then introduce sexual agency and describe underpinning theories and models of sexual agency. In the final section, I present my grounded theory interpretation through an adaptation of two models 'navigating shame to negotiate sexual agency'.

10.3 What is shame?

[14] I used diagramming to further facilitate my theorising (see Appendix 22)

Gilbert and Irons (2009) state that the evolutionary basis of shame is concerned with both self-evaluation and how we are perceived by others within social contexts. Through her study on how women experience and resolve concerns around shame, Brown (2006) defined shame as an intense experience or feeling that makes an individual believe they are flawed or unworthy. Shame has been described as an inner torment within an individual, or a *"sickness of the soul"* (Tomkins, 1963, p.185). Goffman (1959) argues that there is a risk of shame in all human interactions. Shame is concerned with the whole self and can create questions about a person's whole identity and identity formation i.e. that one indiscretion may cause a person to be viewed or to view themselves as a bad person (Munford & Sanders, 2020; Lazare, 1987; Kaufman, 1974). Shame is a fundamental social emotion (Gilbert, 2009; Brown, 2006; Weber, 2004; Scheff, 2002; Mascolo, 1994). Brown's (2006) in-depth grounded theory study of shame identified how this emotion is intrinsically related to the social and cultural values of an individual's life world, and thus is inherently aligned with a social constructionist perspective, and with epistemological and ontological basis of this study. This is also emphasised in the work of Leeming and Boyle (2003) who argue that it is impossible to dispute that shame is socially and culturally embedded and arises through interaction with others. Mascolo (1994) highlights how shame can emerge as a product of social interactions with others and not simply through processes that occur within an individual. As discussed earlier (see section 2.3.3) structure in an individual's social world e.g. religion and community have the potential to hold power over an individual's agency and to cause shame (Leeming & Boyle, 2003). Leeming and Boyle highlight how the literature has tended to focus on shame being constructed and studied as an individual property rather than from a social constructionist approach through consideration of the social contexts through which it arises. Shame is commonly considered to incorporate three core elements of affect (e.g. fear and humiliation), cognition (e.g. feelings of inadequacy or rejection) and action or behaviour (e.g. withdrawal or retaliation) (Thomson, Ebisch-Burton, & Flacking, 2015; Lazare, 1987; Tomkins, 1963). Within this study, and in line with its social constructionist approach, I have explicitly considered how shame is influenced by the participant's cultural and social worlds.

In relation to the core element of affect, Thomson et al. (2015) in their study on women's experiences of infant feeding found that women experience shame through feelings of inadequacy, fear, humiliation and a sense of inferiority. A study conducted by Mayer & Viviers (2017) reported that shame was used to regulate behaviour and social relationships within ethnic minority families and communities in order to meet

social expectations. This supports the assertion made by Pillaye (1994) that shame, in particular public shame among South Asian cultures, controls behaviour. Mayer & Viviers (2017) found that shame was strongly tied to family and community culture, upbringing, and values for the ethnic minority participants whereby, violations from the norms and values of religious books can lead to shame. All these empirical findings link with the theoretical insights of Kaufman (1974, p. 569) who describes shame as individuals feeling *“an intense fear of exposure”* due to having their *“badness seen by others”*. This is also referred to as external shame and concerned with external relations, whereby an individual imagines how they are negatively perceived by others (Munford & Sanders, 2020; Gilbert & Procter, 2006).

Cognitive aspects of shame relate to an individual having feelings of worthlessness or feelings of inferiority (Gilbert & Procter, 2006). Tomkins (1963) identified how shame is the affect of transgression leading to feelings of inadequacy and a fear of rejection. Although the above suggest that shame concerns the individual, it is essentially a social phenomenon that is associated with interactions and relationships with others in social and cultural contexts (Gilbert & Irons, 2009). Social and cultural contexts determine whether the actions of an individual are deemed acceptable or not and which then can lead to the potential for shame (Gilbert and Irons, 2009). One of the Indian participants from the study by Mayers and Viviers (2017) felt that shame and race were connected and behaving outside cultural norms could lead to exclusion and rejection for the individual and their extended family. These findings are also in line with the work of Lynd (1958) who considered that shame is based upon disapproval from others and arouses a *“peculiarly painful feeling of being in a situation that incurs the scorn or contempt of others”* (p.24).

The final core element of shame comprises behavioural and action responses. Lazare (1987) highlighted how individuals would hide or avoid the objects of shame, and Gilbert (2009) refers to how these responses have an adaptive function to protect the individual from further shame. A further response to shame concerns how some individuals may retaliate against the feelings and affects of shame (Gilbert & Irons, 2009). In the study by Munford and Sanders (2020) with vulnerable young people and their transition into adulthood, individuals adopted strategies to mitigate the feelings and affects of shame such as not discussing the realities of the situations and circumstances in their lives with anyone. Brown (2006) in her shame resilience theory describes how women’s behaviours are often moderated by a need to protect themselves from shame. She highlights how women used strategies such as creating

empathetic connections with others or developing a sense of power or freedom to distance them from social and cultural expectations that instilled shame.

10.4 Models and theories of shame

I identified a number of models and theories of shame and considered these in light of my findings. These included Kauffman's (1974) shame inducing process, Gilbert's (2009) model of shame and Lazare's (1987) model of shame. Kauffman was a psychologist, Gilbert was a psychologist and Lazare was a Doctor of Medicine specialising in Psychiatry and a Professor of Psychiatry.

10.4.1 Kaufman's shame-inducing process: breaking the interpersonal bridge

Kaufman (1974) proffered that experiences of shame tend to commence with sudden feelings of self-consciousness, which lead to strong self scrutiny and become deep personal feelings of torment. He stated that such experiences tended to remain private and non-communicable. He highlighted that at its most extreme, shame can interfere with identity formation whereby the individual sees his or her identity as shameful. Kaufman (1974) considered that shame can break the interpersonal bond or *"interpersonal bridge"* between individuals (p.568). He suggested that one of the reasons behind feelings of shame in later life tended to emanate from early childhood through interactions and relationships with parents.

Although some aspects of Kaufman's theory appeared relevant to my work, his focus was on interpersonal bonds rather than what was more prevalent in my study with regard to the wider social context. The feelings of torment and confusion were relevant and although there were some elements of the shame inducing events remaining private and non-communicable, many of the participants in my findings discussed who they were able to share their actions and experiences with. I continued searching for other theories and models of shame which were more aligned with my findings.

10.4.2 Gilbert's model of shame

Gilbert (2009) believed shame can occur automatically, and an individual may not even realise the processes involved. He produced a model of shame that depicts external shame at the centre, and from which external and internal defence processes emanate. These defence processes include internalised shame (i.e. self-devaluation, feelings of depression/anxiety); humiliation (i.e. a sense of being treated in an unjust manner

which could lead to feelings of revenge and anger); reflected stigma (i.e. from their family and others associated with them or rejection by the community); and social and cultural contexts (which could include group conflicts, political issues, economic issues and cultural rules for honour, pride and shame). What influenced these defence processes were innate motives for belonging to social groups and an inherent need to stimulate positive affects into those they associate with (Gilbert, 2009).

Whilst I could relate some of my findings to Gilbert's model of shame, it included several aspects which were not entirely relevant such as economic and political issues. Feelings of revenge or anger described in this model were also not pertinent. The dimension around internalised shame was also not entirely relevant to my findings, as although there was a vulnerability to shame, this did not always lead (or was not reported) to feelings of turmoil and self-devaluation.

10.4.3 Lazare's model of shame

Lazare (1987) proposes that shame can be understood from the interaction of three factors which consist of the shame inducing event, the vulnerability of the subject and the social context (which includes the roles of the people involved). Lazare also emphasises any one of the above could be so powerful that it could dominate the experience.

The shame inducing events are concerned with any occasion, where physical or psychological shortcomings or inadequacies are highlighted and which in turn, could make a person feel stigmatised.

In regard to vulnerability to shame, Lazare states that there have been attempts to categorise situations or issues which may make a person vulnerable to shame. These include the need to be loved, and to be in control of their feelings and actions. Lazare (1987) identified that there are numerous issues concerning self-esteem which are subsumed under this particular category of shame. He also acknowledged that it is difficult to predict how individuals will react in that some may be consumed by shame, whereby it affects their self-esteem, yet on the other hand for other individuals, there may be no impact to them or to their self-esteem.

The social context of shame is another factor necessary to experience shame. Lazare identified that *"the more the person matters to the subject and the more public the exposure, the more intense the shaming experience"* (Lazare, 1987, p. 1654). The

nature of the communication in which shame occurs is also relevant, be it a facial expression or an explicit criticism (Lazare, 1987).

Even though Lazare's (1987) model was based on clinical encounters, there were transferrable elements from all three categories which were relevant to my findings. First, the shame inducing event was being in a romantic relationship whether of a sexual nature or not. The importance of culture and religion upon the females in my study created a vulnerability to shame. The tenets of religion dictate how to be a good person, therefore by behaving in a way that was deemed to not be good e.g. by having a boyfriend or engaging in premarital sexual activity instilled shame. The social context of shame was also highly prevalent in my study whereby the women's extended families and communities being aware of their pre-marital romantic relationships was a key facet of shame. Some of the participants also described social situations that induced shame in relation to sexual health such as through interactions with health care professionals.

In this next section, I will discuss the other aspect of central importance to the grounded theory interpretation of my findings: sexual agency.

10.5 What is sexual agency?

Sexual agency describes *"women's ability to realise and to act on behalf of their own wishes, needs, and interests in terms of sexual decision-making and sexual behaviour"* (Wood, Mansfield, & Koch, 2007, p. 196). Quach (2008) and Jackson (1987) stipulate that sexual agency reflects how a woman controls and defines her own sexual health within competing regimes of practice, tensions and demands. Sexual agency is believed to be important in achieving positive sexual health for women (Quach, 2008). Averett, Benson, & Vaillancourt (2008) in their study on women's views of sexual agency, with a particular focus on the messages communicated from parents about female sexuality, found that sexual agency was experienced on a continuum. Most of the women in their study found that their sexual health was an ongoing struggle of balancing the experiences, messages and tensions that potentially served to suppress the positive experiences of their sexual health.

Sexual agency is commonly considered to consist of two components: sexual self-efficacy and sexual assertiveness (Ward, Seabrook, Grower, Giaccardi, & Lippman, 2018; Curtin, Ward, Merriwether, & Caruthers, 2011). In their study on feminine ideology, sexual agency and embodiment among women, Curtin, Ward, Merriwether and Caruthers (2011) state that sexual self-efficacy is concerned with women engaging

in steps to protect themselves from sexually-transmitted infections and unwanted pregnancies through the use of contraception either used by themselves or requiring their partners to do so. Sexual assertiveness involves the ability to discuss sexual desires and to refuse unwanted sex from partners (Curtin, Ward, Merriwether, & Caruthers, 2011). Ward, Seabrook, Grower, Giaccardi, & Lippman (2018), in their study on sexual agency among undergraduate women, consider sexual affect as a further component of sexual agency. This third dimension concerns the emotions associated with an individual's sexual experiences-emotions such as shame, embarrassment, guilt or even comfort and pride (Ward, Seabrook, Grower, Giaccardi, & Lippman, 2018).

In the next section, I identify and consider models and theories of sexual agency and consider them in light of my findings.

10.6 Theories and models of sexual agency

Here I consider the only two models of sexual agency that were located in the wider literature - Pittard and Robertson's (2008) theory and Cense's (2019a) model of sexual agency.

10.6.1 Pittard and Robertson's theory of sexual agency

Pittard & Robertson's (2008) theory of sexual agency revolves around *"connection, interaction, and activity"* (p.13). This theory was located in an unpublished qualitative study report. They found that women who are active when engaging in sexual relations and feel connected to their encounter leads to positive feelings of sexual agency. This theory is concerned with sexual agency at a personal level. The stages of 'connection', 'interaction' and 'activity' relate to the interactions and connections with sexual partners and how the sexual activity made them feel (Pittard & Robertson, 2008). However my findings and the chosen demographic meant that considering the issues at an individual level were not sufficient. Family, community and culture were key influential factors. I felt that this theory did not fit the women in my study nor my findings.

10.6.2 Cense's integrated model of sexual agency

Cense's multicomponent model of sexual agency considers sexual agency to go beyond the individual and connects the choices an individual makes to moral and social contexts which young people navigate (Cense, 2019a). Cense's model was

based on her findings from four qualitative studies which aimed to explore young peoples' sexual agency (Cense, 2019a). The studies were conducted in the Netherlands with individuals from different cultural backgrounds. They were concerned with sexual boundaries, sexual discourses of ethnic minorities in the Netherlands, navigating sexual identities and teenage pregnancy (Cense, 2019a). Through this work she found that sexual agency was forged within a social context and was expressed through responsiveness to others (Cense, 2019a).

Cense's model consists of four different interrelated components which are embodied agency, bonded agency, narrative agency and moral agency (described below). The model is intrinsically linked to wider social influences - Cense believed the social context to be crucial in order to understand an individual's strategic negotiations which are employed to determine their sense of sexual agency (Cense, 2019a).

Cense (2109a, p. 253) describes the first component of embodied agency as "negotiating subjectivity in a normative landscape". Embodied agency is the process of young people engaging in sexual practices and developing sexual subjectiveness in order to position their own concepts of sexual identity, desire and practice (Cense, 2019a, 2019b). Embodied agency involves young people reflecting on their own needs and desires in relation to the contexts that influence their lives (i.e. cultural and social contexts).

Bonded agency is about using strategies, actions and negotiations to maintain relationships while navigating broader social expectations (Cense, 2019a, 2019b). For an individual, this may involve navigating choices that will ensure they receive social support (Cense, 2019a). Cense (2019a) described how Dutch participants (both White and non-White) described a desire to meet the expectations of their parents and to not lose their support. She also suggested that being aware of different sexual cultural norms (e.g. hegemonic and minority cultural norms) may enable young people access to diverse perspectives to draw upon and consider.

The third component of sexual agency relates to narrative agency - "negotiating a story of one's own" (Cense, 2019a, p. 256). Cense describes this aspect as being able to weave a story about their life that they connect with and that makes sense to them as an individual (Cense, 2019a). She states that narrative agency consists of young people's accounts of their own or other's choices and their lives. She describes how young people have to negotiate their own stories, however when it concerns those from an ethic minority background for example, a narrative power may be required to legitimate and explain the stories (Cense, 2019a). Sharing their stories or hearing

other's stories may provide the premise for a narrative agency. Narrative agency can empower women, especially when they are faced with a situation (e.g. becoming pregnant outside the confines of marriage), and can draw on other's narratives to negotiate their own meaning of the situation they are faced with.

The final component, moral agency, is concerned with negotiating the right choice and using moral frameworks to position oneself (Cense, 2019a). Moral agency is concerned with the responsibilities and obligations someone feels towards moral influences (i.e. culture and religion). Cense (2019a) described how one of her participants discussed how cultural and family issues induced issues of shame and honour. For many individuals, moral agency will be a dominating factor in their daily lives and on their behaviour and choices. Some participants may question it and may choose to find ways to negotiate their choices.

Overall this model was highly relevant to my study as all aspects of embodied, bonded, narrative and moral agency were reflected in the women's experiences. Women were influenced by and aware of their social and cultural contexts when considering their sexual agency.

In the following section I describe how I adapted Cense's model of sexual agency and Lazare's model of shame to present the theoretical interpretations of my findings.

10.7 Constructing theory: Navigating shame to negotiate sexual agency

In this section I present and describe how I have adapted existing theories of shame and sexual agency to provide a theoretical interpretation of my findings (see Figure 5). Charmaz (2014) identified that the theory resulting from a constructivist grounded theory research approach is dependent on the researcher's interpretation and constructions. The theory emerges from aiming to understand how individuals, construct meanings and actions within a particular context (Charmaz, 2014) – in this study the emergent theory relates to the ways in which individuals navigate shame to negotiate sexual agency. The model has been influenced directly by the findings of my study and this is discussed below. Charmaz (2014) argues that while the theory does not necessarily provide an explanation, it should offer some abstract understanding gained through the theorist's (researcher's) interpretations.

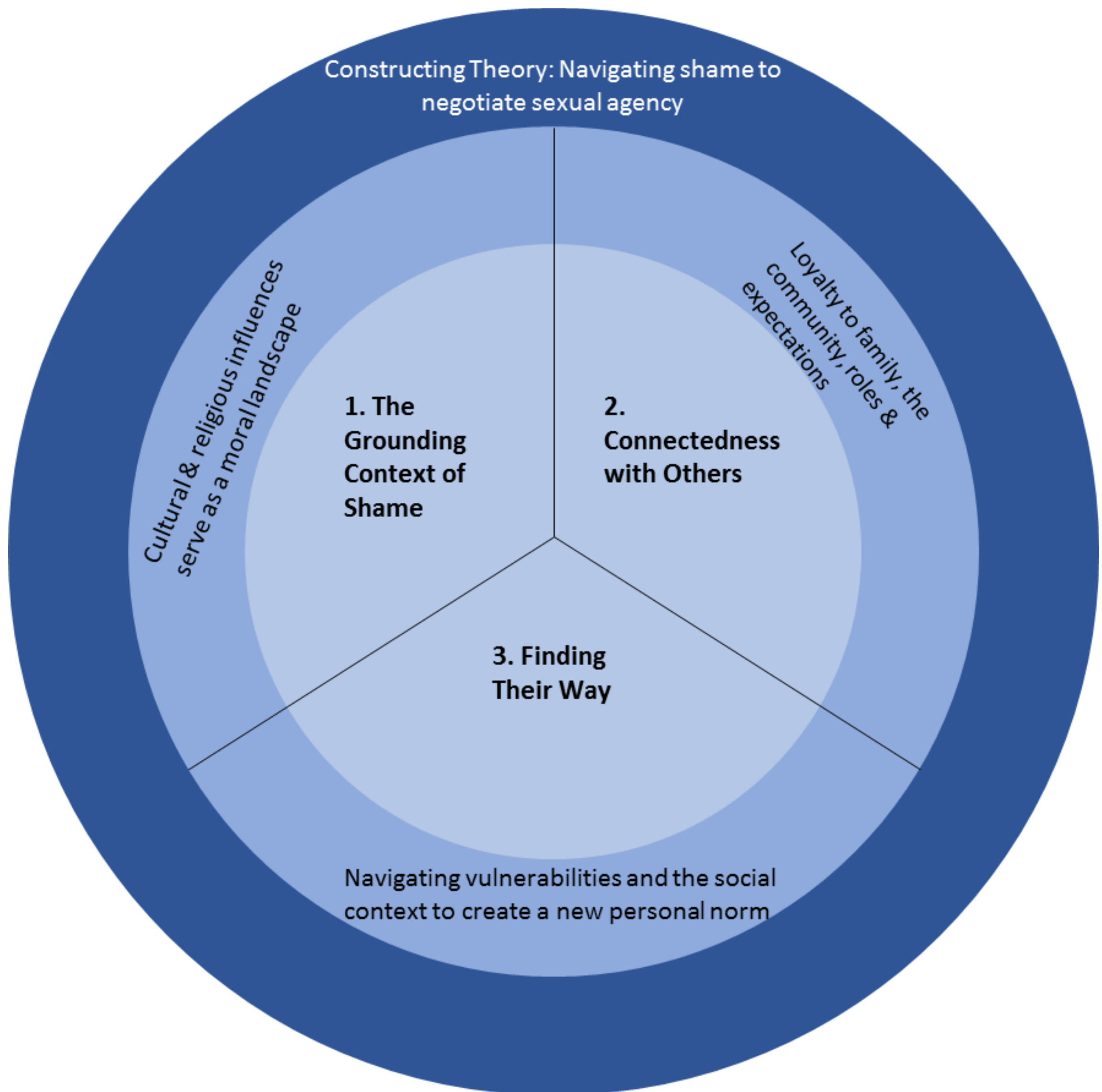

Figure 5: Theoretical model – navigating shame to negotiate sexual agency

The model above comprises three main themes – 'The grounding context of shame' positions women against a moral landscape and is influenced by religion and culture. 'Connectedness with others' relates to how the individuals' connections with others in their social networks influence their beliefs and behaviour. 'Finding their way' relates to how women navigate the influences in their lives to create their own sense of self. How the categories and themes from the findings informed the different stages of the model are presented in Table 7. The model depicts that whilst women had influences which make them vulnerable to shame; they still navigated and negotiated these to obtain

what they desired, i.e. positive sexual health. In the following sections I draw on empirical insights and the theories of Cense (2019a) and Lazare (1987) to describe my theoretical model. Links to the wider literature on shame and sexual agency are discussed in Chapter 11. As will be described below, it is important to see the model as being on a continuum whereby the extent to which wider contextual factors influenced women's behaviour and agency. The table below identifies which categories and themes from the findings, the different stages of the model were influenced by.

Stage of model	Influenced by the following categories in the findings:	Influenced by the following themes in the findings:
The grounding context of shame	• Being influenced by religion, culture and the community	• The influence of religion on behaviour and beliefs • Being part of the community • Knowing your boundaries
Connectedness with others	• Maintaining the secret relationship and acculturation • Accessing sexual health services, advice and awareness	• Being part of the community • Knowing your boundaries • Discussing sexual health issues with mothers • Disclosing the relationship to mothers and other females • Maintaining secrets • Accessing services for testing, screening or advice • Engaging with health professionals for sexual health needs • Feelings and beliefs towards sexual health education
Finding their way	• Being influenced by religion, culture and the community • Maintaining the	• Knowing your boundaries • Focusing on marriage

	secret relationship and acculturation • Accessing sexual health services, advice and awareness	• Encountering acculturation • Maintaining secrets • Disclosing the relationship to mothers and other females • Accessing services for testing, screening or advice • Engaging with health professionals for sexual health needs

Table 7: Categories and themes from the findings that influenced the stages of the model

10.7.1 The grounding context of shame

The first stage of my model is adapted from Cense's 'moral agency' (Cense, 2019a) and Lazare's 'vulnerability to shame' (Lazare, 1987). Cense (2019a) identified that moral agency involves an individual reflecting and positioning themselves within their own personal and cultural moral frameworks. Lazare's vulnerability to shame also considers a grounding or moral framework in that it relates to an individual behaving in a way that is deemed good and not bad. In relation to my findings, these moral frameworks could stem from cultural and religious beliefs and also from enculturation. My findings highlighted that social determinants e.g. culture, religion and social contexts such as the community, had an influence over the women in my study and this links to the first stage of the model. The findings that influenced this stage of model development are discussed further below. While cultural and religious norms provide a grounding context for shame, should an individual deviate from such influences then this may affect a person's self-esteem and may make them feel defective and not whole (Lazare, 1987). Whereas Cense (2019a) argued this moral positioning was important to avoid feeling responsible for bringing shame to themselves and others (e.g. their parents, family or the community in which they live).

Most of the participants in my study described themselves as belonging to a religion which imposed expectations on them in terms of their behaviour and conduct. Religion played a key influence on the participants' and their families' lives. Many women (e.g.

Khadija, Memuma, Anisha, Naznin) discussed the concern of being *"looked down upon"* should they engage in any behaviour that could lead to shame for them or their families. Some of the women (Anisha, Khadija, Naznin) described how as children they were not encouraged to have friends who were boys. Naznin identified that this even stretched to social media where some female pupils at her faith based high school, were disciplined for commenting on male friend's pages. This grounding context meant that even their friendships could be controlled. Other women described the need to be dressed in particular ways where certain parts of the body were covered. Such values around shame and morality were instilled from a very young age.

The women had been encultured into a background of religious and cultural values that considered: an individual and their family's reputation should always be held in high regard and with respect; a woman being in a romantic relationship could tarnish the reputation and bring shame and; getting married was important and engrained from a young age. Uzma and Adeela shared situations of women being made to get married to their boyfriends quickly to hide any potential shame, in particular where a woman had fallen pregnant. They described situations where some families would rather their daughters be made to marry the father of the child, even if this meant that it was not a happy marriage. As described by Cense (2019a) women may hold a moral position of responsibility in not bringing shame to others as part of their moral agency which may be why they accept such marriages. Similar to Cense's work this background context meant that women in my study were always aware of the shame their behaviour and actions could cause (Cense, 2019a). Lazare (1987) highlights how these personal feelings of shame lead to a vulnerability, which may make an individual question their worth but these feelings, cannot predict how an individual will act – as reflected in my study, some women may conform to the grounding context to shame and some may not.

This now leads me on to describe the second stage of my model: 'connectedness with others'.

10.7.2 Connectedness with others

This second stage of my model is adapted from what Cense (2019a) terms 'bonded agency' and what Lazare (1987) terms the 'social context of shame'. This second stage is concerned with how individuals are connected with others and social expectations and how this connectedness influences their beliefs and behaviours. This is informed

by the categories and themes detailed in Table 7 and aligns with my epistemological position of social constructionism. Cense (2019a) states that sexual agency cannot be viewed in isolation as it is inherently connected to relationships with others within a wider social and cultural context. Similarly, Lazare (1987) identifies the social context as an important factor in the experience of shame. As depicted in the first stage of the model, the grounding context of shame, women are already aware of the conditions of shame and what constitutes a good moral position. This in turn, could lead to a heightened awareness of how their behaviour within a social context can impact on their connections with others. The women in my study spoke of a bond or connectedness to family, friends and the community. They all discussed how the wider 'community' had an influence on their behaviour and how information spread quickly within communities. The social expectations and bonds (which were influenced by cultural and religious values) meant that there were implications surrounding the way women behaved. An example of this inherent connection or bond with others was demonstrated when Khadija described how she withheld school letters from her parents. She chose not to show her parents a letter that requested permission for her to attend sexual health sessions in school for fear of how they would react. Khadija demonstrated this awareness from a young age that sexual health related issues should not be being discussed. She was aware of the need to limit anything that may instigate shame and which may affect her bond or connection with her family.

Some of the women also discussed how their connectedness to the community included health care professionals. Accessing the family GP or other health care professionals for sexual health related issues created the possibility for the social context of shame to be experienced. Lazare (1987) describes the social context of shame when seeking professional help and how travel to services, meeting any acquaintances, the sharing of information with health care professionals and the possibility of an intimate examination will invoke feelings of shame. In my study all these aspects were present and were particularly compounded if the GP was from the same religious or cultural background. Anisha described her connectedness with her GP by him being present at social gatherings (e.g. weddings) which could create a level of awkwardness if they had interactions that concerned her sexual health. Sara also described how her family GP took it upon himself to advise Sara that considering to sleep with her boyfriend was not permissible. This suggested that perhaps it was not only the women who experienced this connectedness to their GPs, but that in certain circumstances the GPs also felt this connectedness that extended beyond their scope of health care practice.

Cense (2019a) identifies that bonded agency provides a means of support for an individual. In my study, regardless of whether they were personally in a romantic relationship or not, the women reported a common understanding that if one was in a sexual-based relationship, then this had to be kept hidden to reduce any social implications and the impact of shame. Cense (2019a) also states that bonded agency concerns the strategies and actions taken in maintaining relationships while directing wider social expectations. These may include subtle strategies such as keeping relationships hidden in order to demonstrate loyalty to those connections yet at the same time having some agency to explore their own sexuality (Cense, 2019a). This was evident in my study when women kept their relationships secret.

Rizwana highlighted the challenges this sense of connectedness could cause as it may limit who a woman can turn to for support regarding her sexual health issues. Many of the women in my study described their connectedness with their mothers and how there was a stronger connection with their mothers than with their male relations. Some women alluded to Cense's subtle strategies in terms of how their mothers were aware that they were having friendships with boys and even romantic relationships. According to Cense (2019a), acculturation means that young people will be required to navigate their connectedness to both their own cultural influences and also the broader social context. This was also evident in my study where mothers were aware of relationships, and they reminded their daughters to know their boundaries, alluding to avoiding any shame to themselves and their families. My findings also showed that some mothers were complicit in keeping their daughter's relationships a secret to prevent any potential shame arising but also in the hope that their daughters may have found their future husbands. The connections that the women had with their mothers in particular became relevant when women started to negotiate outside of the religious and cultural boundaries of shame (see the next stage of the model).

Even when some of the women in my study verbally alluded to not being concerned with the social context of shame (as was the case with Adeela who had a child out of wedlock), their behaviour suggested otherwise. The actions of Uzma and Adeela in relation to maintaining this lie that Adeela was indeed married, showed that the social context of shame was important for individuals and their families. Others discussed modifying their behaviours to navigate shame but also to negotiate some agency over their own choices. Some of the women knew that they would be disowned by their parents and faced the risk of being left alone and isolated without any support if they became pregnant before marriage. However, rather than this prohibit all sexual activity, women described how they took control over their sexual health. Yasmin described

how this situation regularly played on her mind and how although she had taken precautionary measures through the use of contraception to avoid this situation, she knew that if faced with this situation, then seeking a termination of pregnancy would be her only option to avoid the shame it would bring to her family and in the community. Even though a termination was viewed as sinful in her religion, this was deemed the better option over risking bringing shame to her family due to her connectedness to them. Lazare (1987) identified that through socialisation people learn that certain things are viewed as shameful. Socialisation also consists of exposure to more than one culture which could influence an individual's moral agency. The women in my study are living in a Western, industrialised country where they are observing their peers from different cultural backgrounds, freely being able to have sexual agency. Cense (2019a) identified how being bonded or connected to different cultures could mean individuals attempt to navigate between the different cultures to try and ascertain their own connections to them. As witnessed in my study, acculturation can provide diverse perspectives of sexual agency that an individual can navigate (Cense, 2019a). This leads to the final and third stage of my model.

10.7.3 Finding their way

This final stage of my model, 'finding their way' adapts what Cense (2019a) considers 'embodied agency' and how individuals navigate activities which have the potential to evade or induce shame, and which Lazare (1987) refers to as the 'shame inducing event'. This final stage is concerned with the embodiment of a romantic or sexual self whereby women are making decisions about their own sexual lives and relationships. Being in a romantic relationship or engaging in pre-marital sexual activity is the ultimate "shame inducing event" (Lazare, 1987, p. 1654). Therefore, this final stage of my model sees the women begin to embody their own sexual desires, and their sexual identity by navigating influences of shame. Cense (2019a) describes embodied agency as how women position themselves between all the cultural influences in their lives to engage in relationships. This final stage of my model has clear links to how women navigate shame and how they use acculturation to find the right balance for themselves to negotiate their sexual agency. This is informed by all the three findings categories presented in chapters 6-8 (and detailed in Table 7). Some women in my study (Safia, Shabana, Khadija, Yasmin) described the emergence of a new culture whereby through acculturation, women took pieces from their influencing cultures (dominant family cultures and Western values) and forged their new embodied culture or identity.

Munira described the need for individuals to find a balance between their cultures to remain true to themselves.

The women spoke of trying to find ways to navigate the various influences and potentials of shame to obtain a level of sexual agency they felt comfortable with. The emphasis on marriage, allowed some of the women to negotiate shame by perhaps convincing themselves that as long as they intended to marry their partners, then it was acceptable to be in a romantic relationship. Some women (Safia, Rizwana) described bending the rules or manipulating the religious rules to create their own rules and boundaries which allowed them to feel safe and to manage any shame. For example while they could feel comfortable with kissing; touching and being close they would not go as far as penetrative sex which Safia described as *"the deed".*

Some women discussed the need for *"balance"*, alluding to a balance between the influences in their lives. Cense (2019a) describes how embodied agency can allow young people to embrace or distance themselves from social values and norms. Even Munira, who viewed herself as more religious than her family, discussed the need for *"balance".* They were 'finding their way' through creating a balance between all the influences on their life. A further issue that demonstrated these theoretical concepts was that whilst some of the women highlighted how withholding sex from their husbands was perceived as sinful, they would not abide by these religious rulings, and that agency and consent in agreeing to sexual acts was paramount. "*Cos there has to be a balance doesn't there. You can't always do what religion tells you to do because it's going to turn you in to a whole completely different person"*. Munira's statement highlighted that many women have their own agency and they will choose to determine their sexual agency between the different influences in their lives (e.g. acculturation) and the influences which may cause a vulnerability to shame (e.g. religion). She went on to say that if you followed every rule of religion then it would *"turn you into a whole completely different person"* suggesting that her individual agency was also important. The level at which participants practiced or held beliefs about their religion varied.

All the women described the lies and secrets needed to maintain secret relationships. Although the women reflected on lying being wrong – and in line with Lazare's (1987) notion of 'a shame inducing event', lying to avoid the risk of shame through relationships being exposed was deemed more acceptable.

Some also considered that their mothers remained complicit with their secrets because if their daughters were to marry their boyfriends then it took the pressure off the mother

to find a suitable husband. On the other hand, as reflected by Sara, mothers may have wanted their daughters to experience a happier marriage than their own.

Another method to facilitate 'finding their way' and the notion of embodied agency was of access to sexual health services. While many women faced 'shame inducing events' when trying to access support, they often still went onto access the support they needed. This involved circumnavigating challenges by avoiding particular GPs and finding and accessing health care services that did not leave them feeling vulnerable to shame.

10.7.4 Continuum of theoretical interpretation

Overall, what was apparent from my findings was that there was a continuum (see Figure 6) on which sexual agency was enacted. It was clear that the stages of the continuum did not apply to all equally and not every woman would move along the continuum. On the one end there were a couple of women who were very vulnerable to shame and heavily influenced by religion, culture, family and community expectations which meant that they would never place themselves in a position where they entered a romantic relationship (i.e. Saleha and Fatima). On the other hand, there were more women in my study who were trying to navigate shame to negotiate some form of sexual agency and find the balance that was right for them despite the influence of religion (i.e. Yasmin).

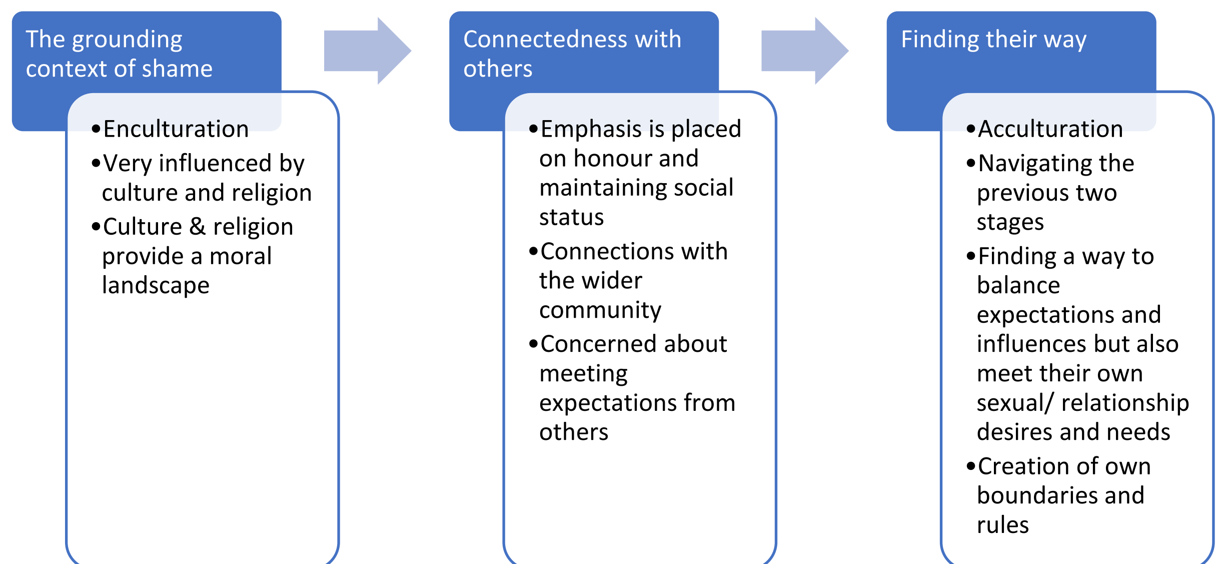

Figure 6: Continuum of model

10.8 Conclusion

In this chapter I have presented the theoretical interpretation of my findings. Shame and sexual agency were explored and existing theoretical models presented. By drawing on the work of Lazare (1984) and Cense (2019a), I developed a theoretical model: navigating shame to negotiate sexual agency. This is in line with the final objective of my study as outlined in Chapter 1. My model identifies three stages:' the grounding context of shame', 'connectedness with others' and 'finding their way'. In the next chapter, the discussion chapter, I focus on shame and sexual agency in relation to relevant existing literature. I also outline the unique contributions of my study, strengths and limitations and implications for future research, policy and practice.

11.0 Discussion

11.1 Introduction

In the previous chapter, I presented the constructed theory that emerged from my findings. I discussed theories of shame and sexual agency and draw on the work of Lazare (1984) and Cense (2019a) to develop a model that illustrates how women could be positioned in relation to shame and sexual agency concerning sexual health. In this chapter, I summarise the overall findings of my study. The core issues of shame and sexual agency are then considered in the context of the wider literature. My unique contribution to knowledge is outlined, followed by the strengths and limitations of my work. The chapter closes through exploring the implications of my study for research, policy and practice.

11.2 Summary of key findings

Overall, I found that religious beliefs and values, transmitted via family as well as community members played a key role in managing and controlling an individual's behaviour. This relates to the theory and literature (presented in section 2.3.3) on social determinants and structures (Dahlgren & Whitehead, 1991; Bourdieu,1989; Giddens, 1984). These beliefs dictated that pre-marital sex and relationships were forbidden, falling pregnant before marriage was a serious concern and something to be avoided, and that women (rather than men) should behave within acceptable boundaries. Public honour and having good standing or regard within the family and community was perceived as fundamentally important. As highlighted by Bourdieu (1989) social capital has the ability to provide an individual with symbolic power which they can use for their own benefit or advancement. Bourdieu (1989) links agency with structure via social capital. In the case of the women in my study, maintaining their public honour (e.g. social capital) enabled them to retain a symbolic power and a level of agency over their lives.

Despite this context, a number of participants were currently in or had had sexual based relationships and were navigating their own identity due to being influenced by both a South Asian and British culture. They tried to find a balance that allowed them to feel comfortable in their lives and in their relationships with their boyfriends. This

involved maintaining secrets within friendship groups, sisters and on occasions with their mother's complicit knowledge, to prevent familial shame. Participants emphasised the importance of marriage in their families and communities, and many entered relationships in the hope that their boyfriends were the one they would marry. The occasions when participants felt able to disclose their relationships with their mothers was therefore often after a lengthy (and often hidden) courtship, and when their relationship was deemed to be serious. Through secrets and lies, women used their agency to protect and retain their social capital and symbolic power as described by Bourdieu (1989). This enabled them to preserve the benefits of being part of the influential structures in their world (see section 2.3.3). Most of the women waited to share they had boyfriends with their mothers, until they were certain the relationship would lead to marriage. In this way, as described in section 2.3.3, women maintained a perception in which they were behaving as expected by the religious norms of their family and community which afforded them a sense of symbolic power and social capital. Bourdieu (1986) highlighted that an individual's social capital is never independent of their social networks or structures.

Participants' recollections of sexual health education varied. While most recalled some form of education in high school, this was not always the case for those attending faith-based schools. Sex education, as for most teenagers, induced embarrassment and a few considered their lack of engagement with the topic was likely associated with its taboo nature. Those who attended Islamic education schools also felt they were taught to consent to sex whenever their husband required, with such beliefs at odds with their own sense of agency. Participants would seek information and answers relating to sexual health via online information or their mothers (where possible).

Overall participants' understanding of sexual health provision was mixed; those who had attended university were more able to identify a specific sexual health service likely attributed to acculturation. While some of the young women had accessed services for their sexual health related needs, most described actual or perceived judgement and shame from providers and others in attendance at the clinics. Female health care professionals were preferred but not always available. There were also concerns about accessing family doctors who were of the same religion or cultural background, knew their families and most critically due to shared knowledge of pre-marital sex being forbidden. Women would often try and circumnavigate these difficulties by avoiding

being seen by particular health care professionals or access services that offered a number of services and not just sexual health related services.

11.3 Navigating shame to negotiate sexual agency

The emerging theory from my findings identified the role of shame in the women's lives and how being exposed to acculturation brought tensions and desires. Many of the women described how they would navigate shame instilled through enculturation, their families and cultural expectations in order to fulfil their own desires and sex-based needs. Bourdieu (1989) links agency to structure (through social capital). This navigation of shame allowed women to retain their symbolic power and social capital (as described by Bourdieu, 1989) while exercising levels of agency. These findings demonstrate that many women sought to strike a balance between structure and agency and view themselves as active agents of their own reality while acknowledging the many enabling and constraining social and cultural structures that influence their lives.

My model (section 10.7) depicts three stages that women may experience in relation to their sexual agency. These include the 'grounding context of shame'; 'connectedness with others'; and 'finding their way'. The 'grounding context of shame' is concerned with an individual positioning herself within her cultural, religious and personal moral frameworks. The second stage 'connectedness with others' is concerned with the connections with others, such as family, friends, community and even health care providers. The third stage is 'finding their way'. This stage is concerned with how individuals navigate issues which could potentially cause shame. This is where women define their sexual desires and mould their sexual identities. It is concerned with how the women navigated and balanced the key influences on their lives to engage or maintain a romantic relationship. Women negotiated their encultured and accultured influences to create a new embodied identity and a level of sexual agency they felt comfortable with.

In the following sections I consider the theoretical interpretations of shame and sexual agency based on the wider literature. Although shame and sexual agency are presented under two separate sections below, they are inextricably linked and

therefore where relevant, issues of sexual agency will be discussed in relation to shame and vice versa.

11.3.1 Shame

Shame is concerned with exposure: exposure to others and in all circumstances, exposure to oneself (Lynd, 1958). It is described as one of the most important social emotions, in that it greatly impacts on our experiences, on ourselves and on our relationships with others (Gilbert, 2017). As humans we are concerned with how we are viewed by others and care about creating a good impression of ourself (Gilbert, 2017). Shame requires something to be perceived as unattractive in a person (Gilbert, 2017). For example, in the case of my study, being seen to not be conforming to religious and cultural norms by being in a relationship or engaging in pre-marital sex. A situation that would make a person undesirable or unattractive and which would bring about shame and have implications for not only themselves but for their family i.e. their reputation, standing in the community. The South Asian culture is viewed as a collectivist culture, whereby the good of the community is prioritised over the individual (Couture-Carron, 2020; Cowburn, Gill, & Harrison, 2015). In the study by Cowburn et al. (2015) on sexual abuse with British, South Asian women and how cultural dynamics impact discussions, they identified that individuals in South Asian communities aim to avoid shame. They identify *"sharam"* (shame) to be a fundamental cultural inhibitor (p. 8). They highlighted that maintaining *"izzat"* (honour) and avoiding "sharam" (shame) were deemed more important than the happiness of children (p. 8). This was found in my study when Adeela and Uzma discussed women being made to marry the father of their unborn child even if they were no longer together as a couple. This was also reflected in the findings of a study undertaken by Couture-Carron (2020) on shame, honour and dating abuse among young, South Asian Muslims living in Canada found that family honour was paramount over one's own desires and needs (Couture-Carron, 2020). Individuals from a South Asian background who cause shame and endanger the honour of their family, risk being outcast by not only their immediate family but also the wider community (Cowburn et al., 2015). The role of parents reinforcing cultural norms around shame was evident in my findings. Memuna and Anisha referred to how their parents emphasised how they should know their *'boundaries'* (i.e. relating to intimacy and maintaining virginity) in order to avoid any shame being brought to the family. In their study on migrant and refugee women in Canada and Australia, Ussher, et al. (2017: p.1907) found shame to be the *"dominant discursive construction"* of

women's sexual health. They identified shame to have implications on a woman's knowledge or behaviour which had the potential to cause distress and limit agency. However, what was unique to my study, and not explicitly reported in wider literature in women from South Asian communities was how women used different methods to navigate these boundaries to have romantic based relationships and while avoiding shame. Key strategies to uphold family honour involved keeping relationships secret, setting intimacy boundaries to maintain virginity and avoiding family doctors.

Brown (2006) undertook a grounded theory study to explore women's experiences of shame. In her work she highlights why and how women experience shame, how shame impacts women and the processes women employ to manage the impact of shame. She *"proposed that shame is a psycho-social-cultural construct"* (p. 45). This definition was clearly evident from within my findings in terms of how participants experienced personal tensions associated with their desires (psychological), how their perceptions of shame were related to perceived or actual influences of others, such as their family and community (social) and how shame was ultimately associated with their (often imposed) cultural and religious values (cultural). Thomson, Ebish-Burton and Flacking (2015) used the concept of shame to consider women's infant feeding experiences and how irrespective of how a woman feeds her baby, it may make them feel negated or marginalised. These authors state that while shame comprises negative emotions, shame in an infant feeding context was fundamentally concerned with the interaction between an individual's perception of self and perception by others. This was similar to my findings, in relation to how influential the perceptions of others (even the collective and potentially faceles 'community') was in controlling and managing their behaviours. The concept of bringing shame to oneself, one's family or community serves as a means of control (Scheff, 2003; Awwad, 2001). A number of the women in Thomson et al's (2015) study would hide their infant feeding preferences from others to prevent admonishment and blame. This resonates with my findings in terms of how women used secrecy and often lies to uphold a desirable perception by others. However, while a number of women in Thomson et al's work altered or changed their behaviours to prevent against shame, in my study women demonstrated agency by using strategies to balance meeting their needs against the shame-inducing others.

Scheff (2013) identified that in Western societies the focus is on individuals over relationships with others (i.e. family members), self-reliance rather than conformity. Scheff (2013) states that the premise of modernity is built on individualism, where the

people are encouraged to *"go it alone, no matter what may be the cost to relationships"* (p.114). Individualism is viewed to have freed individuals from their relational world and emotions receive less emphasis. He stresses that shame and relationships do not merely disappear in Western societies but that they adapt and assume hidden forms. This disposition can lead people to hide their emotions, in particular shame, which he suggests is *"elaborately hidden and disguised"* (Scheff, 2013, p. 115). This notion was very relatable to my findings as the females who participated and did share experiences of sexual relationships did emphasise the need for it to be kept secret, to be hidden. These women did not simply want to conform but rather to exercise some degree of sexual agency albeit through maintaing secret relationships. Very few people are part of this secret to protect the individual and family from shame; almost like an allegiance is formed to protect the secret relationship. Forming this secret also means that the shame is hidden. Brown (2007) considers how shame can be a tool to protect individuals. This is an interesting ascertion as in my study without shame, the relationships would not be kept hidden or secret and in essence, this negotiation of shame forces individuals to find ways in which to strike a personal balance around their own sexual agency. Brown (2007) highlighted that often the relation between personal struggles and wider cultural issues was not seen due to the silence of shame. Similar to Scheff (2014, 2013) who described shame as something which is hidden, Brown (2007) stated that shame is not talked about. She identified that other emotions e.g. fear and anger have gained recognition and openness but the emotion of shame still remains taboo. This resonates with my findings in that women were continually navigating shame to keep it hidden but there were implications surrounding the hidden nature of shame in the tensions it caused and the barriers and vulnerabilities (i.e. accessing support) it had the potential to create.

In general, dating is viewed as shameful and rejected within many South Asian communities, however it is recognised that many individuals from this cultural background are involved in sexual-based relationships (Couture-Carron, 2020). One key problem is how shame can impact on an individual seeking support or help in relation to sexual health issues (Couture-Carron, 2020). This did raise some concerns in my study, in relation to accessing sexual health support. As relationships were a secret, there was a concern that any sexual health issues may not be addressed. There were also wider issues of women receiving judgement when accessing help from health care professionals. This was similar to the findings of Fallon (2012) who found that accessing emergency contraception invoked feelings of shame in young females

and this compelled many of the women to avoid accessing the support they needed. While this study did not focus on British South Asian women, shame was a fundamental theme that emerged.

In a study on shame and dating abuse among South Asian Canadians, the data showed that South Asian communities reacted more adversely to women's sexual activity over men and recognised that a woman's sexual purity was prioritised over a man's (Couture-Carron, 2020). This was also similar to the findings by Cowburn et al. (2015). Couture-Carron (2020) also identified that if a woman lost her virginity to a man, she would try and stay attached to him, even if it was an abusive relationship, as in her mind, she should be marrying him. Many South Asian women within their study identified that they enter relationships with the hope of just having one intimate relationship in their lives (Couture-Carron, 2020). My findings differed in that although the participants in my study considered marriage the end goal, some participants did allude to having been in more than one relationship or did not consider their current boyfriend to be one they would spend the rest of their lives with. Safia was aware that as her boyfriend was from a different South Asian background, it was highly unlikely she would marry him. Khadija, went so far as to state that there was no point in telling her mother about her boyfriend as he may not be the man she wishes to marry. This demonstrated a maturity and also some agency over their relationships.

Cowburn et al. (2015) highlight how the lack of discussions with parents in South Asian communities, and the limited sex education learnt from school could leave women vulnerable, as some women may not recognise they are in vulnerable positions or being abused. They identified marital rape as being perceived as legitimate in South Asian communities and in many circumstances, it is not even acknowledged (Cowburn et al., 2015). Even talking about marital rape could be seen as bringing shame to themselves, their husbands and their families (Cowburn et al., 2015).This resonated with some of the discussions the participants entered into in my study. Safia was aware that marital rape existed and raised the fact that some women were not even aware of issues surrounding consent to sex as it was within the confines of marriage. Saleha also described a teaching in her faith that concerned attending to the husband's sexual needs, even if she did not want to.

11.3.2 Sexual Agency

As discussed in Chapter 10, the women in my study were on a continuum whereby participants navigated from one stage to the next. Some participants appeared to be at the 'grounding context of shame' stage whereby they had no sexual agency or had made the choice to abstain from all romantic pre-marital relationships (e.g. Saleha). Some participants were at the 'connectedness to others' stage where relationships and choices where influenced by those they were connected to (e.g. Safia) however some of these participants, in particular in phase one reported that they would be intimate with their partners but would not have sexual intercourse with them. This was their way of finding a balance between their sexual desires and their religious and cultural influences. This could be viewed as their way of achieving some level of sexual agency yet feeling that they are maintaining some respect and avoiding a graver shame which could arise should their relationship become known to their wider families or the communities in which they live in. In relation to my model, these women could be said to be navigating between the 'connectedness to others' stage and the 'finding their way' stage. Other participants did appear to have positioned themselves firmly at the final stage 'finding their way' and appeared to have a greater sense of navigating any shame in their lives and negotiating their sexual agency (e.g. Yasmin and Rizwana).

The notion of a continuum of sexual agency (discussed in Chapter 10) was also found in a study conducted by Averett et al. (2008), on sexual agency, experiences and parental messages with young, heterosexual women in the United States of America (USA). They found that young women tended to experience sexual agency as a continuum in that there was an ongoing struggle in balancing messages, experiences and tensions (e.g. parents, culture) that suppressed their sexual voices, their desires and pleasures and also the confidence and feelings in understanding the personal power that can unfold through sexuality. In their study with undergraduate young women in the USA on the connections between femininity and sexual agency, Curtin et al. (2011: p56) stated that *"sexual health requires young women to navigate complex and multifaceted roles…advocating for their protection and their pleasure, and maintaining a positive sense of one's body during sex…with an intimate partner*". Positive sexual health is intertwined with sexual agency (Curtin et al., 2011). Similar to some of the women in my study, many of their participants had struggled for or were still striving for sexual agency. Averett et al. (2008) identified that sexual agency can take many forms which included taking initiative, being aware of one's desires and

individual freedom and confidence to express sexuality through behaviours. This also includes the freedom and confidence to not engage in sexual behaviours, however to simply say no to sexual behaviour and activity can be said without any true reflection, insight or intention and is therefore not necessarily a part of sexual agency. Some of the participants in phase two of my study (Saleha and Fatima) showed some judgement towards women from the same religion who were involved in relationships and confirmed that they themselves did not believe in being involved in any romantic relationships before marriage. They stated that they would maintain their virginity until they were married as directed by their religious beliefs. Averett et al. (2008) state that abstinence could be viewed as a form of sexual agency, however this is determined by the thinking and motives behind what leads to abstinence and whether the individual had agency and the decision to practice abstinence. Whether Saleha and Fatima who firmly believed they would not enter a relationship before marriage, could be said to have sexual agency is questionable.

Due to the secret nature of the relationships, I felt that none of the women could be described as having complete sexual agency. In her four studies exploring sexual agency and how different groups of young people negotiated their desires and sexual identities in the Netherlands, Cense (2019a) stated that sexual agency consists of the strategic negotiations an individual takes to situate themselves and their relationship choices, within their social context. The women in my study identified that there remained a key emphasis on marriage. The women in my study had a number of freedoms i.e. the freedom to attend college and university or to pursue a career but when it came to having the freedom to be in a relationship, this was deemed unacceptable due to the shame it could bring. These findings are similar to the ones in a study by Averett et al. (2008) who found parental mixed messages which included not having sex until they were married, yet on the other hand an emphasis on the need to assertive, strong and to continuously strive to achieve your desires. The fears associated with sexual experiences had *"the power to deny women agency in their sexuality"* (Averett et al., 2008, p. 338). These mixed freedoms appeared to impact the women in my study in relation to their choices about their own lives and bodies.

One of the duties outlined by many of the main South Asian religions is that children have a duty to respect their parent's views and choices. Avoiding discussions which may relate to topics which could instil shame could be viewed as a sign of respect. As found in my study, either sexual health was simply not discussed with parents or was

discussed with mothers in relation to maintaining their virginity, apart from a few mothers who were open to such discussions. Averett et al. (2008) also found that sexual agency was undermined by the messages around sexual health that the women in their study received from parents. Many of their participants identified that the focus of sexual health talks whilst growing up were always focused on the consequences and repercussions of sexual activity and behaviour. The parental focus on abstaining from any sexual behaviour or experience denies opportunities for insightful communications with their daughters about their own sexual health. Some of the women in phase two of my study mentioned a passivity in terms of sexual desires or that their sexual desires came second to those of their husbands. Munira however, who was also familiar with the religious teaching which states that women should meet the sexual needs of their husbands, explained that she did not believe in this teaching and that her wishes mattered too. This demonstrated a level of agency on Munira's part over her own desires and body. Women were repeatedly told about not embarrassing the family or losing social respect, thus reminding them about the risks of shame. However, if shame is continued to be used (through messages around social respect and family honour) as a means to control women, then this may affect whether sexual agency can truly be reached. This is also supported by Averett et al. (2008) who argue that women cannot have sexual agency if sex continues to be framed around fear of losing respect as opposed to sex been framed as desirable and pleasurable in itself.

Gender differences regarding women acting more passively where sex and sexual encounters were concerned have been reported (Klein, Becker, & Stulhofer, 2018; Burkett & Hamilton, 2012; Quach, 2008). Curtin et al (2011) found that women who held what was viewed as traditional gender role beliefs and were therefore less likely to engage in pre-marital relationships, reported less sexual health knowledge, less sexual assertiveness and less condom self-efficacy or competence. Burkett and Hamilton (2012), in their study with university students in Western Australia, on how women negotiated sexual consent, found a woman's sexual agency could be influenced by traditional discourses whereby women simply wanted to please their man and that men have heightened sex drives. Similarly, gender differences were also revealed in a study among young South African women (Kruger, Shefer, & Oakes, 2015). This study found that the young women were receiving mixed messages where on the one hand they were being educated to take responsibility for their sexual health and should have agency, but on the other hand, through implicit educational messages they were informed that taking responsibility for their own sexual health needs should only occur

within existing gendered norms whereby men are viewed to take the lead in sexual matters. What the women felt or desired was not viewed as important and these messages were convenyed not only through education, but through broader experiences at school and in their community. Social determinants such as gender and education can influence an individual's health and affect the choices they make (see section 2.3.3). This bore some resemblance to my findings when some discussed consent around sexual issues and that according to some religious teachings, it was the woman's role to meet the needs of her husband whenever he required. It also revealed issues with the way education around sexual health is provided. It was apparent from the studies in my scoping review (Kott, 2011; Griffiths, et al., 2011; Griffiths et al., 2008; Testa et al., 2006) and through my findings that school was considered the best place to provide sexual health and relationship education. Dahlgren and Whitehead (1991) highlight education as a social determinant that has an influence on health (see section 2.3.3). Methods to tackle the delivery and to limit the embarassment identified may facilitate improved engagement with school based education. As there appear to be shifts in some mother's beliefs towards discussing sexual health related issues, as found in my study, there may be scope to support mothers to feel more confident to discuss sexual health issues with their daughters. What is fundamental from not only my findings but from the wider literature concerns sexual consent within the confines of marriage.

A few participants (Munira, Rizwana and Sara), identified that their mothers were open to discussions around sexual health issues, however this did not necessarily mean the daughters wished to have such discussions with them, but knew the support was there if they needed advice. This was different to the results presented in the scoping review (Griffiths, et al., 2011; Griffiths, et al., 2008) which described limited to no discussions with parents around sexual health issues. It is these cultural discussions and teachings (or lack of) which can hinder a woman's journey to achieving a form of sexual agency they feel at ease with as these discussions do not consider their sexual desires and pleasures. An interesting point was that my findings suggested that mothers who tended to be more open to discussions around sexual health issues were those who had been born or grew up in the UK from a young age and therefore were accultured to the British culture. These mothers had also either been in a pre-marital relationship or were unhappy in their marriages and did not want the same for their daughters. This suggests that as more British born South Asian women have their own children, discussions around sexual health issues may become more commonplace due to

acculturation and their own pre-marital relationship experiences. Klein et al. (2018), in their longitudinal study which aimed to explore the impact of parental support, knowledge and communication and sex and sexual health issues on the sexual agency of young women in Croatia, found that parental communication around sexuality and sexual health positively impacted on women's sexual agency. Specific parenting traits which included communicating, providing emotional support and supporting autonomy were found to contribute to more positive sexual behaviour among the young women (Klein et al., 2018). This was similar to the findings of Averett et al. (2008) who also found that when parents were generally supportive and where discussions took place with parents, this supported the establishment of some level of sexual agency which in turn led to positive experiences with their partners.

11.4 Unique contribution to knowledge

As identified through my scoping review there have been very limited studies considering the perceptions, knowledge and experiences of sexual health and sexual health services among British born South Asian young women. Previous research is also primarily quantitative which only provides a partial and limited understanding of the issues and challenges that these women face. My study offers qualitative insights and allows hidden voices to be heard into a sensitive and emotive topic. It was also not always clear from the previous literature as to whether the issues reported impacted just the British born South Asian participants as South Asian groups were often viewed collectively regardless of whether they were British born. My study focuses on British born females, recognising the impact acculturation may have served on their perceptions, needs and experiences.

Similar to wider research my study found that culture and religion were identified as important factors in the women's lives, however, many women did find ways to be in illicit relationships. What was unique to my study was how women found ways to negotiate shame in order to maintain such relationships and to attain some control over their sexual desires and choices. This was through secrecy, collusion and interpreting the cultural and religious rules to suit them e.g. refraining from penetrative sexual intercourse or by only being intimate once they were certain that their partner was the one they would marry.

A further new finding related to the issues with health care professionals, especially those from a South Asian background. Challenges that involved shame and judgement were experienced when accessing sexual health care and thus health care professionals were part of the problem to the women receiving the care and support needed. This raises important issues in terms of training and health care delivery.

Another unique finding emerged in relation to women being encultured into religious doctrines. Women felt conflicted by religious teachings which stated that a woman should meet her husband's sexual needs whenever he desired. However they questioned how the messages did not appear to consider the woman's needs nor the role of the husband towards her. This highlighted the potential value of acculturation in terms of how women were concerned about being passive recipients of this information rather demonstrating varying levels of agency over their own bodies and sexual health needs.

This research led to the emergence of a new theoretical model (see Figure 5, section 10.7), to help understand a woman's views and experiences of sexual health. This work extends those of others to consider how British born South Asian women navigate aspects of shame in order to negotiate their own sexual agency. By understanding these needs on a continuum (see Figure 6, section 10.7.4) can help to understand the different levels of support these women may need.

A new finding also emerged which related to the role that mothers may take in colluding with their daughters to allow them to maintain secret relationships. This seemed to occur under three circumstances where the mothers were accultured to a British society as they were born or grew up in the UK from a very young age, they had experienced a pre-marital relationship themselves or if they had endured an unhappy marriage. This notion of mothers becoming complicit and supporting their daughters offers new directions for research as discussed in section 11.6 below. The work from this study has provided a number of important implications for research, policy and practice which are discussed in section 11.6 and 11.7 below.

11.5 Strengths and Limitations

11.5.1 Insider Researcher

It was important for me to recognise my position as a researcher coming from a similar background to the participants I was researching. An insider position affords the researcher insights that an outsider researcher may not see (Pelias, 2011). Researchers benefit from insider knowledge when they are viewed to have prior membership of the studied group (Burns, Fenwick, Schmied, & Sheehan, 2012). These benefits relate to being in a position to negotiate access to participants, an understanding of the participants' cultural background, and a familiarity with a language or languages spoken that may also allow a better flow of interactions in data collection (Burns et al., 2012). In this sense, my ethnic and cultural background being similar to that of the participants can be viewed as a strength. On the other hand, insider knowledge may keep researchers from seeing things objectively or they may overlook or offer their own interpretation rather than seeking clarification from the participants (Pelias, 2011). Challenges could include an over familiarity which leads to a loss of analytical perspective (Adler & Adler, 1987). However, I felt that by ensuring all my data collection processes and transcripts were reviewed by my Director of Studies, helped to minimise this potential limitation. My Director of Studies and I had regular discussions about my findings to ensure that I had not overlooked something that as an insider would be viewed as the norm. Reflexivity is identified as important to allow the insider researcher to address some of these potential challenges (Adler & Adler, 1987). It is important to try and balance insider and outsider perspectives in order *"to achieve the desired level of familiarity with, and distance from, participants"* (Burns et al., 2012, p. 59). I strove, as argued by Burns et al. (2012), to try and find a middle ground in which to position myself to ensure authenticity, ethical integrity and relationality were maintained (Burns et al., 2012). I felt that being an insider researcher was key to me being able to access hard to reach voices, in particular with regard to a sensitive subject area like sexual health.

11.5.2 One homogenous group

Many previous studies collectively research ethnic minority populations rather than considering the views of one ethnic group. A particular strength of my study is that by focusing on British born South Asian women as one group allowed focus on issues specific to them. Homogeneity with gender, age and ethnicity is recommended with focus groups where the focus may be regarding social or cultural factors (Greenwood,

Ellmers, & Holley, 2014). The findings from the scoping review identified that there were differences in beliefs and behaviour among different ethnic minority groups. Although my study included participants from different South Asian backgrounds, there were no observations or stark differences noted. The participants all related to the issues being raised with each other in the focus groups, felt comfortable discussing the issues with each other and could all relate to the points being discussed.

11.5.3 Participant numbers

The participant numbers in my study were limited. This was something that I had anticipated from the start of my study, due to the taboo nature of the topic area, and despite numerous and repeated attempts to recruit more. I offered the choice of focus groups or one to one interviews to try and alleviate any potential concerns related to confidentiality. Even though the numbers of participants were low in my focus groups, the participants communicated freely with each other and thereby the groups were still reflective of a focus group format. The fact that snowball sampling was used for focus group recruitment meant that the participants were familiar with each other. I believe this approach helped recruitment, prevented participant inhibition and enabled more open and free discussions. Therefore, despite the low numbers, I felt I was able to obtain rich data and findings to meet the aims of my study. Indeed, Charmaz (2014) states that a small sample size still has the ability to produce an in-depth study of significance.

11.5.4 Pursuing other lines of enquiry

Theoretical sampling determined the direction I took for phase two data collection. As all the participants in phase one had attended university, theoretical sampling led me to recruit participants that had not attended university in phase two. *"Theoretical sampling means seeking pertinent data to develop your emerging theor*y" (Charmaz, 2014, p. 193). Although this proved beneficial, it meant that other lines of enquiry such as considering the views of mothers were not pursued. This could be perceived as a limitation and I feel there is scope for research with mothers of British born participants in the future (discussed in more depth below in section 11.6).

11.5.5 Member checking

Member checking can be used to take ideas back to participants for their confirmation or to elaborate on a topic further (Charmaz, 2014). It has been defined as a technique to ascertain the credibility of results (Birt, Scott, Cavers, Campbell, & Walter, 2016). My intention was to member check with a number of participants, but I was only able to gain access to one (Yasmin). As the majority of participants had provided me with their educational institute emails, by the time I tried to contact them again, their email addresses were no longer active.

11.5.6 Moderator and note-taker in focus groups

I took on the role of moderator in the focus group. As I am familiar with a number of South Asian languages, I was able to anticipate that where participants used specific South Asian terms, I may not need to interrupt them to seek clarification. As discussed in section 4.10, focus groups often have an assistant moderator or a note-taker (Krueger, 1998). However, as I was mindful of the insider, outsider role (section 4.10) and the sensitive nature of my study, I decided that I would not utilise my supervisory team as note-takers due to them all being from a White ethnic background. I was concerned that participants may not open up with someone who could be perceived as an outsider. Future research should consider involving a second moderator or note-taker, from the same ethnic background.

11.5.7 Interpretations

I was aware that my findings could have been interpreted differently by a different researcher. Corbin and Strauss (2008) identify how in qualitative research, different researchers will interpret data differently and identify different meanings. They further state that different analysts could also arrive at different conclusions from the same data. I used the theory to contextualise the empirical accounts to give what I hope to be authentic interpretations of my findings.

11.6 Implications for research

My study identifies the need to understand the challenges faced by British born South Asian women. It is apparent that women fall into different stages in relation to how they navigate aspects of shame to negotiate their sexual agency. It would therefore be appropriate to study the core issues and needs around shame and sexual agency in relation to this specific group. Future research could also focus on whether British born South Asian women, in particular social and cultural contexts navigate shame in different ways. Although there were no apparent stark differences among the ethnic groups in my study, it may be useful to consider the different South Asian ethnicities to see if any differences or similarities were apparent. Similarly what influences a British born South Asian woman to feel greater sexual agency in comparison to others. It would also be useful to begin to understand how education such as attending a faith-based school impacts a woman's ability to negotiate a level of sexual agency they feel comfortable with.

There is scope for further research within community structures in South Asian communities to consider issues of religion and culture in regard to sexual health. However this would have to be approached to reflect the challenges already identified in this thesis. It would be difficult to target the wider South Asian community due to the taboo nature of sexual health and the potential that someone held in high regard within the community deems such research irrelevant. The values of British born South Asians and the need to protect honour and reputation may mean such research would not be welcomed. Therefore, a targeted approach with smaller groups would be required. As mothers were found to be complicit in their daughter's secrets, this may provide a possible avenue to pursue research. Further research to explore the mothers' perspectives and experiences would be appropriate and to understand how they navigate shame for their daughters. My findings revealed that mothers were more complicit with maintaining the secret relationship or were more open to discussions around sexual health. It may also be appropriate to investigate the support they would provide their daughters should their daughters find themselves in a situation which could leave them vulnerable and in need of help.

There appeared to be a common narrative about the paucity of school-based sex and relationship education in high school. Further research into how sex and relationship education is best delivered to young girls from British born South Asian backgrounds is

essential. This should explore appropriate content, who would be best to deliver the education and through what means or mode of delivery. In an age where women turn to the internet to find answers, it may be that technology based education could help alleviate some of the concerns over embarrassment.

A further area to research would be to explore health care professional's views on providing the right level of communication, advice, and support to young women from South Asian backgrounds in relation to sexual health. Such research could explore if health care professionals felt equipped or had the knowledge to understand and manage the challenges women approaching their services may face, and for associated training to be developed and evaluated.

11.7 Implications for policy and practice

The model depicting the emerging theory in the previous chapter could be developed further with practice providers; to create a practice-based tool to help health care practitioners understand how women from British born South Asian backgrounds position themselves in relation to their sexual agency. The tool could be completed by women accessing sexual health services so their personal needs may be understood better, taking into consideration their cultural needs. This may assist health care providers to understand their patients' needs better and to gain more confidence in providing the right level of care. The model may also be mandated within policy to underpin training for those working in sexual health. This will enable these professionals to gain a greater understanding of cultural diversity, to raise awareness of the issues service users may present with and to inform discussions or used within case based scenario or problem based learning. In relation to service providers, the study findings could provide knowledge around the barriers and challenges faced by women from British born South Asian backgrounds. This could form a part of the practice-based tool mentioned above. There appears to also be a need to assist health care practitioners to recognise how they can be viewed as barriers to service-users. This would particularly be beneficial for GPs and health care practitioners from a similar cultural background, to highlight that it is inappropriate to allow their own cultural values and morals to influence and impact the advice and treatment being given to service users. A self-assessment tool for healthcare providers could be devised which could be used in collaboration with a cultural assessment tool or training. Mandatory cultural

safety training could be developed to incorporate service-user voices to raise health care professionals' awareness of experiential insights.

The location of sexual health services and clinics needs to be considered. There is a need to maintain confidentiality and locating clinics within general health care settings, as opposed to sexual health specific settings e.g. GUM clinics, would improve confidentiality and alleviate some concerns. Health care providers could provide further online resources covering sexual health as well as non-taboo health issues that provides detailed and accurate information about sexual health. This could include links to relevant online and in person resources. It could also be used to signpost individuals to relevant support and advice available (online resources or in-person services) e.g. contraception advice, how to access counselling or where to access further support should they find themselves in a vulnerable position.

Sexual health policy needs to be addressed in order that students receive sexual health education that is fit for purpose and can assist in the promotion of a young person's positive sexual health. Education providers may need to devise new policies that set out how delivery should take place. The recent Relationships Education, Relationships and Sex Education (RSE) and Health Education guidance was published by the Department for Education in 2019. The guidance states that all schools must develop their own written policy for Relationships Education and RSE and that it should reflect the communities they serve (Department of Education, 2019). It would be appropriate to incorporate cultural needs into the local policies to ensure the teachings meet the needs of the students from culturally diverse backgrounds. The findings of my study may provide some relevant insights into such policy development.

Concerns around consent within the confines of marriage were a recurring issue. There is clearly a need to raise awareness of consent and that women can say no to their husbands. While domestic violence is discussed with women during their maternity appointments, it may be possible to also discuss the issue of informed consent during sex-based relationships. GPs and Practice Nurses could also incorporate discussions around consent with women who come to discuss sexual health related issues. When a woman undergoes her 8-week check with her GP after delivering her baby, this could be an area for discussion that could be included into this health check. This is also an

area that could be incorporated into policy that schools devise in relation to the delivery of RSE in secondary schools.

11.8 Conclusion

In this chapter I have explored shame and sexual agency through consideration of the wider literature. I have identified my study's unique contribution to knowledge as well as its strengths and limitations. Finally, I outlined implications for research, policy and practice. The following chapters will provide concluding remarks and final points of reflection.

12.0 Conclusion and personal reflections

12.1 Conclusion

In this study, I explored the perceptions, awareness and experiences of sexual health among British born South Asian females aged 18-25. I developed a theoretical framework of ‘navigating shame to negotiate sexual agency’. This framework explains that while culture and religion influenced women’s views and beliefs, it did not necessarily affect their behaviours; pre-marital relationships were common, and were kept secret. Women went to great lengths to keep their secrets hidden from family and the community to avoid any ramifications (e.g. bringing shame to themselves and their family). My study also highlights the barriers that women can face when accessing support due to shame as well as judgemental attitudes of health care providers.

The theoretical framework provides a tool to understand women’s experiences and how they viewed their own position in relation to shame and sexual agency. The model depicts a continuum whereby some women were more influenced by wider cultural, social and contextual factors which led to more shame and less sexual agency being encountered. Other women were less influenced by wider cultural, social and contextual factors but more accultured, so shame was viewed differently and they demonstrated more sexual agency. This new theoretical model provides a unique contribution to knowledge.

This model and associated training could be used as tools for health care professionals to understand women’s position and needs and to support them in a way that is meaningful. As my study highlights the need to enable women to access services without feelings of shame, the model could be used to design a self-assessment tool for women to self-identify their needs. My study also highlights issues with sexual health education and the need for further work in this area. The issue around consent to sex within marriage is a cause for concern to ensure women are not left in positions of vulnerability. Practice providers could raise awareness of this issue, as could schools when delivering sex and relationship education. While further research and tests on the theoretical model are needed, further key areas for research include exploring the role mothers may play in relation to forming alliances with their daughters and this may be an implication for future research.

12.2 Personal reflections: the start of the journey

When I originally decided to embark on a PhD study, I was not sure what path lay ahead. I knew the topic I wanted to study was an important one which affected women like me. However I was also aware that due to its taboo nature, I was worried about participants not wanting to volunteer. Despite this, I felt it was important to try as there was a clear gap in knowledge that needed to be addressed.

Upon commencement of my studies, I had an interview with my Director of Studies to enable me to reflect on my own preconceptions and values in relation to my study area. My reflective interview raised my concerns over women feeling marginalised in some situations related to sexual health. It was clear that due to my background as a woman from a South Asian background, born and raised in England, I had some insight into the type of issues women may be experiencing. I had to ensure that I chose a methodology that also aligned with my position as an insider with preconceptions and views. Charmaz’s (2014) grounded theory was relevant to my stance.

12.3 Personal reflections: throughout the journey

The PhD process was a steep learning curve for me which I feel privileged to have been able to undertake. Recruitment to the study, as anticipated, was arduous at times. Initially I was surprised that women did make contact wanting to participate. This was a really positive sign. I learnt that snowball sampling was the right choice when it came to the focus groups as the women were relaxed and all knew each other. I do not feel they would have opened up in a focus group with women who they were not close to. Issues around confidentiality and the need to avoid shame were evident. I would have liked to recruit more participants and I am aware that I have only been given a glimpse into my participants’ experiences around sexual health, but I am forever grateful for the insights I have gleaned.

It took me a while to feel comfortable with my chosen methodology. I soon realised that Charmaz’s (2014) grounded theory was the right fit for my study. I was fortunate to also meet her and to discuss my study with her at a workshop aimed at PhD students. Having that one to one time with her discussing my study, was a truly amazing experience. Her methodology could be shaped and used in different ways to meet the needs of my study. I felt her guide to analysis really helped me as a novice researcher

especially where there were moments where I questioned what to do next. Analysis of my data through the coding stages, theoretical sampling and theoretical sorting really facilitated the theory construction. I learnt that diagramming and visuals through Charmaz's (2014) approach really helped me to see connections I may otherwise not have seen. Although my chosen methodology involved theory construction, I had not anticipated or believed that I would be able to develop a theoretical framework to illuminate my findings which could have implications for further research and practice.

One of the unexpected findings in my study was that of the collusion of some mothers. I was aware of many issues and challenges, women from British born, South Asian backgrounds experienced, but had not considered the role that mothers played. This is an area I would wish to explore further and if I could have done anything differently, I would have liked to invite mothers to participate in the study to obtain their viewpoint.

12.4 Personal reflections: the end of this journey

I am grateful to the opportunities presented throughout this journey. I feel priviledged to have been supported by my supervisory team and other PhD students. I am also grateful to the participants who volunteered to share their insights and experiences. Cense's (2019a) model of sexual agency has a stage called narrative agency and I feel that this could be relevant to some of the participants in my study. Their participation could be viewed as a part of narrative agency in relation to their sexual health. Perhaps the process of sharing their insights and experiences with others is linked to their agency and knowing that others may be facing similar issues may be comforting or reassuring. Looking back, it may have been appropriate for me to ask why participants did volunteer to participate in a study around the topic of sexual health when collecting data. I am left wondering if participating did help them or empower them in any way.

My journey to submission of the thesis has been a patient one with managing the demands of full time work, part time study, ill-health, motherhood and family life but it has been an enriching process. I am very grateful to all the opportunities that this course of study has presented me with.

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Appendix

Appendix 1: Search terms for initial literature search using MEDLINE and EBSCO

MEDLINE

I used a mixture of free text terms and subject headers. The subject headers are the terms in “speech marks” in the table below that were specific to the database used. Each column was then combined using the Boolean operator AND. The use of the * meant all terms with the start of the word (truncations) were searched e.g. the use of access* meant the search would also include accessed, accessible, accessing etc.

OR	AND	OR	AND	OR		OR
British		“Sri Lanka”		Experience*		“Women’s health”
British born		“Pakistan”		View*		“Reproductive health”
		“India +”		Perception*		“Family health”
		“Bangladesh”		Access*		“Minority health”
				Knowledge		“Public health”
				Expectation*		“Sexual health”
				Attitude*		“Safe sex”
						“Sexual health”
						“Sexual behaviour
						“Sexuality”
						“Contraception behaviour
						“Sexual health services”

From the above search 33 publications were returned of which only one qualitative paper and two quantitative papers were deemed relevant.

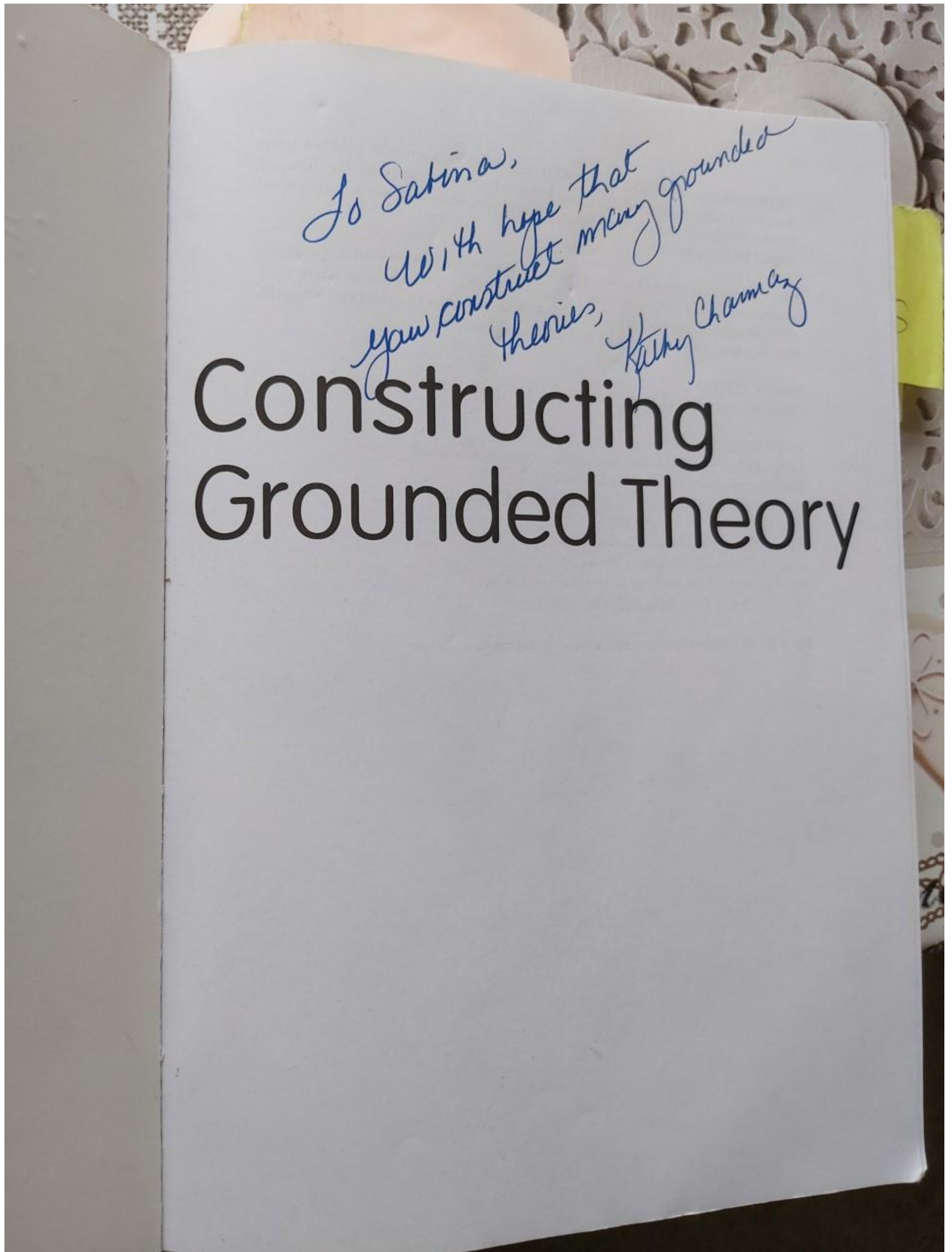
EBSCO

I then carried out a second literature search using EBSCO with the function that allows multiple database searching which for my study included: Academic Search Complete, AMED, CINAHL, CINAHL Plus, E-Journals, ERIC, MEDLINE, PsycARTICLES, PsycINFO, Race Relations Abstracts, SocINDEX. As EBSCO was searching a number of databases and each database had it's own subject headers, I was restricted to free text terms only (see table below).

OR	AND	OR	AND	OR	AND	OR	AND	OR
South Asian		Women		British born		Experience*		Sexual health
Indian		Woman		British		Feeling*		Sexual health service*
Pakistani		Female*				Perception*		Sexual health access
Sri Lankan		Girl*				Knowledge		Sexual health education
Bengali						Attitude*		
Bangladeshi						Expectation*		
						View*		

This search through EBSCO returned 10 publications. I then decided to re-run the search, removing "British born" and "British", it increased the publications to 140 however only one quantitative paper was of relevance.

Appendix 2: Attendance at workshop with Charmaz



Appendix 3: Recruitment Flyer

British Born, South Asian Female Participants Needed for PhD Research

- Are you a British Born, South Asian (Indian, Pakistani, Bengali, Sri Lankan etc) Female?
- Are you aged 18-25 years?
- Would you be interested in taking part in a focus group to discuss your perceptions and awareness of sexual health services as a British born South Asian female? If so we would like to hear from you.
- You do not need to have accessed any sexual health services and individual interviews can be arranged upon request.
- Please contact Sabina on 01772 895145 or sgerrard1@uclan.ac.uk for more details or an informal chat.
- This research has been approved by the School of Health Research Ethics Committee.

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Appendix 4: Interview and Focus Group Schedule

Knowledge & Understanding of Sexual Health Services

What do you understand by sexual health?

What services do you think are sexual health services?

Expectations of Sexual Health Services

What are your expectations from sexual health services?

Do you feel that your needs will differ to other ethnic groups? If so, in which way?

Issues around Sexual Health Services

What issues (if any) do you have in relation to sexual health?

Do you think South Asian woman have different issues to other groups? (Explore)

What issues do you feel other South Asian women may have?

Education around Sexual Health

Where have you learnt about sexual health and sexual health services e.g. school, friends, family?

Where do you think women from South Asian groups receive sexual health education?

What else do you think could be included in sexual health education?

Where do you think you should learn about sexual health?

Do you think you get enough education about sexual health? (Explore)

Who do you feel should provide the education? (Prompt – why do you feel that?)

Support & Advice

Who would you turn to for sexual health information and/ or advice? (Explore)

Who would you not turn to for sexual health information and/or advice? (Explore)

Appendix 5: Participant Information Sheet, Phase one

PARTICIPANT INFORMATION SHEET – PHASE ONE
(Version 3, dated 16.12.13)

Sexual Health Service Provision among British Born South Asian Females

You are invited to take part in a study which will provide information on the perceptions, awareness and experience of sexual health services among British born South Asian females, aged 18-25. It is important that you understand why the research is being carried out and what it will involve. Please read this information sheet carefully and discuss it with others if you wish, before deciding if you wish to participate in the research. If anything is unclear, please ask me for more information. Contact details are provided at the end of this information sheet.

Why is this study taking place?

This study is taking place as part of a Post-graduate Research Degree. The aim is to explore the perceptions, awareness and experiences of sexual health service provision among British born South Asian females currently residing in the North West of England.

The research consists of two phases. The first phase will involve focus group discussions with the objective of gaining awareness of services that are perceived as sexual health services, to explore participants perceived needs, expectations and concerns related to accessing sexual health services. The second phase will only involve participants that have accessed a sexual health service and the objective is to gather in-depth insights in to participant's experiences of sexual health service provision.

This information sheet relates to phase one only. As part of this study we want to talk to British born South Asian females. South Asian females in this study will include those from Indian, Pakistani, Sri Lankan or Bangladeshi backgrounds. The researcher is also from a South Asian background. The results of the study will be reported through the researcher's final report, presented at conferences and published through journal articles. It is hoped that this study will lead to valuable insights and that the findings may also help to inform future service delivery.

Why would I be involved in the study?
You would be involved in the study as you fall in to the category of a British born, South Asian female, aged 18-25. The research will involve approximately 12-18 participants in total. If more participants come forward than are needed then I will write to you to keep you informed. You will receive a letter to thank you for wanting to take part but will be informed if we already have enough participants.

What do I have to do?
If you are interested in taking part, this will mean taking part in a focus group (with approximately 3-5 other participants). A date and time to suit you and the other participants of the focus group will be agreed upon. The venue of the focus group will be determined by your geographical location e.g. local community centre, college, university campus etc. If you are

interested in taking part, please let me know and further communications will be made as to when and where the focus groups will be organised.

At the start of the focus group I will answer any questions you have and ask you to sign a consent form. The focus group session will usually last between 45-60 minutes. Refreshments will be provided.

At the start of the session you will be asked to complete a personal characteristics form which will include basic information in terms of your age, South Asian grouping, place of birth, religion and which services you feel constitute sexual health services. You will also be asked to sign a consent form that indicates your agreement to take part.

Discussion in the focus group will be around the services that are viewed as sexual health services, expectations of services, exploration of the needs of individuals from your community, identification of any concerns with sexual health services, discussion of sexual health and sexual health service education and where advice and information can be found.

If you feel you are uncomfortable discussing the above in a small group or where travel may pose difficulty, then the option of an individual interview with the researcher may be arranged separately.

Phase two of this study involves undertaking interviews with South Asian women who have actually accessed a sexual health service. If you have accessed any of these services, and would be willing to take part in the second part of this study to discuss your experiences in more depth, please could you indicate your agreement on the separate page of the consent form. Please note that further consent will be sought for phase two, and you can decide whether or not you still wish to take part at that stage.

With your permission we would like to digitally record the focus group. If you do not wish to be recorded, unfortunately you will not be able to take part in the focus group part due to the nature of the focus group discussion. You can however still take part through an individual interview where the researcher will take notes throughout.

Please note that a note taker may also be present at the focus group who is a member of the research team (details below).

Do I have to take part?

No- you do not have to take part if you do not wish to. Participation is entirely voluntary.

During the focus group, you do not need to answer any questions and can leave the focus group at any point. If you take part in the focus group, we will unfortunately not be able to withdraw your comments following the session due to the group based nature of the discussion.

Who has approved the study?

The study has been approved by the Built Environment, Sport and Health (BUSH) School of Health Ethics Committee at the University of Central Lancashire to ensure the research is carried out in a professional manner.

What will happen to the information/ data?

All personal data collected will be kept in a lockable filing cabinet and on password protected/encrypted files at the University of Central Lancashire. All the digital recordings and transcribed data will be retained for a minimum of five years from the end of the study to comply with the University's guidelines, and will then be destroyed.

Will the data be kept confidential?
The data will be kept confidential. We will ask that you do not disclose your name or the names of others during the focus group discussion. We will also ask that you maintain the privacy of others by not repeating or sharing the issues discussed during the focus group. All direct quotes will be anonymised and will not be attributable to any individual in any reports or publications. Where situations that cause distress are disclosed, you will be provided with a list of useful contacts/ services that can be accessed for support.

Benefits to taking part
There are no direct benefits to taking part in the study but you may benefit from the opportunity to reflect on and discuss issues. Taking part may also raise awareness of issues you may not have considered previously.

Adverse effects to taking part
No particular risks have been identified however, the researchers are aware that the discussions may lead to sensitive issues being raised. The researcher will be able to discuss accessing support through relevant services if you require further support.
The researchers are also aware that participation in this research may cause displeasure to other family members and therefore the importance of confidentiality will be emphasised during the focus groups and also when researchers contact participants. Where possible only provide contact details which are private and can only be accessed by you.

What do I do if I want to take part?
If you are able to take part in this research, please contact the researcher on the details below with your name, contact telephone number and email address if applicable. I would be grateful if you could respond within 2 weeks. I will then be in touch to organise taking part in the focus group.

Who do I contact if I have any concerns or issues about this study?
If you have any concerns or issues about this study, please contact the Director of Studies, Professor Fiona Dykes on 01772 893828, fcdykes@uclan.ac.uk or the Dean of the School of Health, Dr Nigel Harrison on 01772 893700, nharrison@uclan.ac.uk

Thank you for taking the time to read this information sheet and for considering taking part.

Sabina Sattar, 01772 895145, ssattar@uclan.ac.uk Researcher
Professor Fiona Dykes, 01772 893828, fcdykes@uclan.ac.uk Director of Studies
Dr Gill Thomson, 01772 894578, gthomson@uclan.ac.uk Research Supervisor
Debbie Wisby, 01772 893887, dawisby@uclan.ac.uk Research Supervisor

Appendix 6: Participant Information Sheet, Phase two

PARTICIPANT INFORMATION SHEET –PHASE TWO
(Version 3, dated 16.12.13)

Sexual Health Service Provision among British Born South Asian Females

You are invited to take part in a study which will provide information on the perceptions, awareness and experience of sexual health services among British born South Asian females, aged 18-25. It is important that you understand why the research is being carried out and what it will involve. Please read this information sheet carefully and discuss it with others if you wish, before deciding if you wish to participate in the research. If anything is unclear, please ask me for more information. Contact details are provided at the end of this information sheet.

Why is this study taking place?

This study is taking place as part of a Post-graduate Research Degree. The aim is to explore the perceptions, awareness and experiences of sexual health service provision among British born South Asian females currently residing in the North West of England.

The research consists of two phases. The first phase involved focus group discussions with the objective of gaining awareness of services that are perceived as sexual health services, to explore participant's perceived needs, expectations and concerns related to accessing sexual health services. Phase one is now complete. This second phase will involve interviews with participants who have accessed a sexual health service in order to gather in-depth insights in to the participant's experiences of sexual health service provision.

This information sheet relates to phase two only. As part of this study we want to talk to British born South Asian females. South Asian females in this study will include those from Indian, Pakistani, Sri Lankan or Bangladeshi backgrounds. The researcher is also from a South Asian background. The results of the study will be reported through the researcher's final report, presented at conferences and published through journal articles. It is hoped that this study will lead to valuable insights and that the findings may also help to inform future service delivery.

Why would I be involved in the study?

You would be involved in the study as you fall in to the category of a British born, South Asian female, aged 18-25 and have accessed a sexual health service. The research will involve approximately 12-16 participants in total. If more participants come forward than are needed then I will write to you to keep you informed. You will receive a letter to thank you for wanting to take part but will be informed if we already have enough participants.

What do I have to do?

If you are interested in taking part, this will mean taking part in an individual interview with the researcher. A date and time to suit you will be agreed upon. If you are comfortable with a face to face interview, the researcher can travel to a location that is mutually convenient. If you

prefer to carry out the interview over the telephone this can also be arranged at a mutually agreed time.

At the start of the interview I will answer any questions you have and ask you to sign a consent form. If you have chosen a telephone interview I will ask for verbal consent. The interview will last between 45-60 minutes.

You will be asked to complete a personal characteristics form which will include basic information in terms of your age, South Asian grouping, place of birth, religion, geographical location, which services you feel constitute sexual health services and which sexual health service you have accessed. The interview questions will be around the service/s that you accessed, why you accessed the service, what you were expecting from the service, did the service meet your expectations, did the service meet your needs, why you chose to access that particular service, exploration of you needs as an individual from a South Asian group, identification of any concerns with sexual health services, discussion of sexual health and sexual health service education and where advice and information can be found.

With your permission we would like to digitally record the interview. If you do not wish the interview to be recorded, then the researcher will take notes throughout the interview.

Do I have to take part?

No- you do not have to take part if you do not wish to. Participation is entirely voluntary.

During the interview, you do not need to answer any questions and can ask for the interview to end. If following the interview you wish your data to be withdrawn this is possible up to one month following the interview.

Who has approved the study?

The study has been approved by the Built Environment, Sport and Health (BUSH) School of Health Ethics Committee at the University of Central Lancashire to ensure the research is carried out in a professional manner.

What will happen to the information/ data?

All personal data collected will be kept in a lockable filing cabinet and on password protected/encrypted files at the University of Central Lancashire. All the digital recordings and transcribed data will be retained for a minimum of five years from the end of the study to comply with the University's guidelines, and will then be destroyed.

Will the data be kept confidential?

The data will be kept confidential. All direct quotes will be anonymised and will not be attributable to any individual in any reports or publications.
Where situations that cause distress are disclosed, you will be provided with a list of useful contacts/ services that can be accessed for support.

Benefits to taking part

There are no direct benefits to taking part in the study but you may enjoy the opportunity to reflect on and discuss issues. Taking part may also raise awareness of issues you may not have considered previously.

Adverse effects to taking part

No particular risks have been identified however, the researchers are aware that the interview may lead to sensitive issues being raised. The researcher will be able to discuss accessing support through relevant services if you require further support.
The researchers are also aware that participation in this research may cause displeasure to other family members and therefore the importance of confidentiality will be emphasised during the focus groups and also when researchers contact participants. Where possible only provide contact details which are private and can only be accessed by you.

What do I do if I want to take part?

If you are able to take part in this research, please contact the researcher on the details below with your name, contact telephone number and email address if applicable. I would be grateful if you could respond within 2 weeks. I will then be in touch to organise taking part in the interview.

Who do I contact if I have any concerns or issues about this study?

If you have any concerns or issues about this study, please contact the Director of Studies, Professor Fiona Dykes on 01772 893828, fcdykes@uclan.ac.uk or the Dean of the School of Health, Dr Nigel Harrison on 01772 893700, nharrison@uclan.ac.uk

Thank you for taking the time to read this information sheet and for considering taking part.

Sabina Sattar, 01772 895145, ssattar@uclan.ac.uk Researcher
Professor Fiona Dykes, 01772 893828, fcdykes@uclan.ac.uk Director of Studies
Dr Gill Thomson, 01772 894578, gthomson@uclan.ac.uk Research Supervisor
Debbie Wisby, 01772 893887, dawisby@uclan.ac.uk Research Supervisor

Appendix 7: Consent Form, Focus Group, Phase one

CONSENT FORM: FOCUS GROUP PHASE 1

Sexual Health Service Provision among British Born South Asian Females

Please initial the boxes to indicate 'YES' to the following statements:

		Please initial each statement
1	I confirm that I have read the participation information sheet Version 3, dated 16.12.13 for the above research. I have had the opportunity to consider the information on the information sheet, ask questions and where applicable these have been answered to my satisfaction	
2	I understand I am a voluntary participant and I am free to not answer any questions and can leave the focus group at any point.	
3	I understand that given the nature of focus groups it will not be possible to isolate my data from the group and maintain the integrity of the discussion.	
4	I agree to the focus groups being digitally recorded.	
5	I understand that my participation will remain anonymous and any personal details that could identify me will not be included in the researcher's work or related publications & presentations.	
6	I agree to protect the privacy of others in the focus group and will not repeat any issues raised during the group discussion outside the focus group.	
7	I agree to the use of anonymous direct quotes in the researcher's work which could include reports, presentations and reports that are produced from the research.	
8	I agree to take part in the above research.	
9	I agree that UCLan may keep my anonymised data on file for use in the future for other related research projects. YES/ NO (Delete as appropriate)	

Name of Participant	
Signature & Date	
Name of Researcher Obtaining Consent	
Signature & Date	

If you have accessed any sexual health services and would you be willing to take part in a further discussion. If yes, please provide your contact details. NB, further consent will be sought if you do participate in the next phase.	Yes / No Contact Details:
If you would like a copy of the key themes to emerge from this study please indicate how you would prefer to receive a copy of this document, i.e. through email or by post (home or work address) and give your contact details.	I would like to receive a copy of the key themes Yes/No I would like to receive them by Email/Post Contact details:

Appendix 8: Consent Form, Interviews, Phase one

CONSENT FORM: INTERVIEWS PHASE ONE (FOCUS GROUP ALTERNATIVE)

Sexual Health Service Provision among British Born South Asian Females

Please initial the boxes to indicate 'YES' to the following statements:

		Please initial each statement
1	I confirm that I have read the participation sheet Version 3, dated 16.12.13 for the above research. I have had the opportunity to consider the information on the information sheet, ask questions and where applicable these have been answered to my satisfaction	
2	I understand I am a voluntary participant and I am free to not answer any questions and can leave the interview at any point.	
3	I understand that I will not be able to withdraw my data from the study 1 month after the interview date.	
4	I agree to the interview being digitally recorded.	
5	I understand that my participation will remain anonymous and any personal details that could identify me will not be included in the researcher's work or related publications & presentations..	
6	I agree to the use of anonymous direct quotes in the researcher's work which could include reports, presentations and reports that are produced from the research.	
7	I agree to take part in the above research.	
8	I agree that UCLan may keep my anonymised data on file for use in the future for other related research projects. YES/ NO (Delete as appropriate)	

Name of Participant	
Signature & Date	
Name of Researcher Obtaining Consent	
Signature & Date	

If you have accessed any sexual health services and would you be willing to take part in a further discussion. If yes, please provide your contact details. NB, further consent will be sought if you do participate in the next phase.	Yes / No Contact Details:
If you would like a copy of the key themes to emerge from this study please indicate how you would prefer to receive a copy of this document, i.e. through email or by post (home or work address) and give your contact details.	I would like to receive a copy of the key themes Yes/No I would like to receive them by Email/Post Contact details:

Appendix 9: Consent Form, Focus group, Phase two

CONSENT FORM: FOCUS GROUP PHASE 2

Sexual Health Service Provision among British Born South Asian Females

Please initial the boxes to indicate 'YES' to the following statements:

		Please initial each statement
1	I confirm that I have read the participation information sheet Version 3, dated 16.12.13 for the above research. I have had the opportunity to consider the information on the information sheet, ask questions and where applicable these have been answered to my satisfaction	
2	I understand I am a voluntary participant and I am free to not answer any questions and can leave the focus group at any point.	
3	I understand that given the nature of focus groups it will not be possible to isolate my data from the group and maintain the integrity of the discussion.	
4	I agree to the focus groups being digitally recorded.	
5	I understand that my participation will remain anonymous and any personal details that could identify me will not be included in the researcher's work or related publications & presentations.	
6	I agree to protect the privacy of others in the focus group and will not repeat any issues raised during the group discussion outside the focus group.	
7	I agree to the use of anonymous direct quotes in the researcher's work which could include reports, presentations and reports that are produced from the research.	
8	I agree to take part in the above research.	
9	I agree that UCLan may keep my anonymised data on file for use in the future for other related research projects. YES/ NO (Delete as appropriate)	

Name of Participant	
Signature & Date	
Name of Researcher Obtaining Consent	
Signature & Date	

If you would like a copy of the key themes to emerge from this study please indicate how you would prefer to receive a copy of this document, i.e. through email or by post (home or work address) and give your contact details.	I would like to receive a copy of the key themes Yes/No I would like to receive them by Email/Post Contact details:

Appendix 10: Consent Form, Interviews, Phase two

CONSENT FORM: INTERVIEWS PHASE 2

Sexual Health Service Provision among British Born South Asian Females

Please initial the boxes to indicate 'YES' to the following statements:

		Please initial each statement
1	I confirm that I have read the participation sheet Version 3, dated 16.12.13 for the above research. I have had the opportunity to consider the information on the information sheet, ask questions and where applicable these have been answered to my satisfaction	
2	I understand I am a voluntary participant and I am free to not answer any questions and can leave the interview at any point.	
3	I understand that I will not be able to withdraw my data from the study 1 month after the interview date.	
4	I agree to the interview being digitally recorded.	
5	I understand that my participation will remain anonymous and any personal details that could identify me will not be included in the researcher's work or related publications & presentations..	
6	I agree to the use of anonymous direct quotes in the researcher's work which could include reports, presentations and reports that are produced from the research.	
7	I agree to take part in the above research.	
8	I agree that UCLan may keep my anonymised data on file for use in the future for other related research projects. YES/ NO (Delete as appropriate)	

Name of Participant	
Signature & Date	
Name of Researcher Obtaining Consent	
Signature & Date	

If you would like a copy of the key themes to emerge from this study please indicate how you would prefer to receive a copy of this document, i.e. through email or by post (home or work address) and give your contact details.	I would like to receive a copy of the key themes Yes/No I would like to receive them by Email/Post Contact details:

Appendix 11: Personal Characteristics Form

Please answer the following questions:

Personal Characteristic Question	Please print clearly
What is your age?	
Where were you born? E.g. town/city	
Which South Asian Group do you belong to? e.g. Indian, Pakistani, Bangladeshi, other. If other e.g. mixed race please provide details	
Religion	
Which services do you feel constitute sexual health services?	

Appendix 12: Lone working risk assessment

Risk Assessment For
Service / School: Health. (MPhil/PhD Research Field Work Interviews).
Location of Activity: Participants homes Public meeting places such as colleges and community centres in Lancashire.
Activity: Participant interviews. Date of activity: Focus Groups: January 2014- August 2014 Interviews: July 2015 – December 2015 **REF:**

Assessment Undertaken By
Name: Sabina Sattar (Research Student)
Date: 14.7.13
Signed by Dean of School, Head of Service or nominee:
Date

Assessment Reviewed
Name:
Date:

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
Danger from carrying out the focus groups in an unsuitable public place.	Research Student and/ or other group participants	Where possible arrange focus groups to take place on the university campus, college campus or community centres. Ensure others are in the building, but that privacy can be maintained through the use of a specific room.		Low
Danger from meeting in unsuitable public places when conducting interviews.		If participant wants to meet in a public place as opposed to their home, suggest somewhere suitable where other people will be in close proximity but where privacy can be arranged e.g. the University Campus or a community centre. If the participant wants to meet in a specific place I will familiarise myself with the venue/ location prior to the interview and to also ensure it is suitable. If the venue suggested causes any concerns, rearrange the interview to a different venue.		Low
Danger from carrying out the focus group at unsuitable times.	Research students and/or other group participants	Try and arrange focus groups to be undertaken during office hours to ensure that other people are in the building. If a focus group needs to be conducted in the evening, I will ensure I have the contact details of security on my mobile phone and I should also Inform other members of staff/ security what times I		Low

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
		will be on the premises for.		
A risk of verbal/physical aggression/anger when conducting interviews in a participant's home.	Student and or other people and children in the home.	Prior to the day of interviews, email a schedule of interviews to supervisors. On the day ensure supervisors know my plans for the day including where and when interviews are scheduled to take place. Ensure mobile phone is fully charged and with me at all times. Check in with supervisors using my mobile phone before and after each interview. When checking in, ensure supervisor aware of what time I will be checking back in. If the interview is overrunning and there is no reason for concern at present, then text the supervisor with a new checking back in time. Where possible though, stick to timings. Ensure supervisors are aware of what needs to be done if I have not checked in within the agreed time frame (i.e. call police). Arrive at each address in good time and establish if		Low

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
		the mobile reception is adequate. If not, find nearest area where reception is adequate or a public phone box. Ensure I have correct change for phone calls and important telephone numbers (e.g. supervisor's telephone numbers and university security) written on a piece of paper in case I cannot access the telephone numbers in the mobile phone contacts list. Make sure supervisor knows if reception is poor. Carry a personal alarm. As per previous work when nursing in the community perform a rapid risk assessment before entering the property. If anything causes concern, then make an excuse and leave. Be observant when entering the participant's home. Observe any cultural practices such as removal of shoes upon entry to not cause offence or upset. Be aware of all the possible exit strategies and how doors open and close as I enter the home. Ensure where possible that I sit close to the door where possible with my back to the exit. Inform the participant approximately how long the		

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
		interview will take and where possible ensure I stick to this. Avoid any language and /or actions which could be interpreted as judgemental, aggressive or an invasion of privacy and /or personal space. Be mindful of communication. Keep my tone of voice low and calm.		
Danger of injury from an unsafe home environment.	Research student and others within the home.	Perform a rapid risk assessment on the door step before entering the property. Reduce any identified risks as soon as possible, for example ask for a dog to be moved to another room before entering the property. If there are other members of household present remind participant that this is an individual interview and to ask others to give us some privacy. If privacy/ confidentiality cannot be established, inform the participant that the interview cannot be conducted in the current environment. Continue to risk assess and remain alert throughout. If feel threatened or concerned, make an excuse and leave.		Low.

List significant hazards here:	**List groups of people who are at risk:**	**List existing controls, or refer to safety procedures etc.**	**For risks, which are not adequately controlled, list the action needed.**	**Remaining level of risk: high, med or low**
Danger of meeting someone who is not the actual participant.	Student.	Once have contact details of participant, call the phone number to check the correct person answers. If have a land line number, check the number corresponds to correct address by using the phone book or online search.		Low.
Risk that the risk assessment carried out is not adequate.	Student.	Ensure the risk assessment is reviewed with supervisors after the first interviews, and update/amend as appropriate.		Low.

Appendix 13: Template letter to community groups

Date

Dear *Insert Name of Community Group*

I am a Senior Lecturer in Nursing and I am currently undertaking my MPhil/PhD in the School of Health at the University of Central Lancashire. As part of my studies I am undertaking a research study titled: the *perceptions, awareness and experiences of sexual health services among British Born South Asian females aged 16-25.*

I am writing to request permission to recruit South Asian women from your community group to participate in my research study. Through this study I aim to explore South Asian women's knowledge, understanding, expectations, access and education concerning sexual health services/provision. The research involves two phases. It is envisaged that the first phase will be undertaken between September 2013 and July 2014 (this includes recruitment time) and will involve women taking part in focus groups. The second phase will be undertaken between July 2015 and January 2016 (also includes recruitment time) and will involve interviews which can be undertaken either face to face or over the telephone to suit their preference, to explore these issues more in-depth. I wish to recruit approximately 12 women for each phase.

If you are in agreement, I would like to recruit South Asian women through posters displayed at the community centre and via email and social media (if appropriate). Any data collected will remain confidential/ anonymised. Participants will also be asked not to name any individuals in the focus groups to maintain confidentiality.

If enough South Asian women (group users, staff, volunteers) aged 16-25 from your community group are recruited, I would also like to request permission to conduct the focus group(s) on your premises for ease of access. The focus group(s) should take no longer than one hour to complete.

If you have any queries or would like further information about my study, please do not hesitate to contact me or my Director of Studies Professor Fiona Dykes on the contact details provided.

I look forward to hearing from you.

Yours sincerely

Sabina Sattar
Researcher
ssattar@uclan.ac.uk
01772 895145

Research Contact Team:
Professor Fiona Dykes, (fcdykes@uclan.ac.uk or 01772 893828) - Director of Studies
Dr Gill Thomson, (gthomson@uclan.ac.uk or 01772 894578)
Deborah Wisby, (dawisby@uclan.ac.uk or 01772 893887).

Appendix 14: Template letter to colleges

Date

Dear *Insert Principal Name*

I am a Senior Lecturer in Nursing and I am currently undertaking my MPhil/PhD in the School of Health at the University of Central Lancashire. As part of my studies I am undertaking a research study titled: *the perceptions, awareness and experiences of sexual health services among British Born South Asian females aged 18-25.*

I am writing to request permission to recruit South Asian women from your college to participate in my research study. Through this study I aim to explore South Asian women's knowledge, understanding, expectations, access and education concerning sexual health services/provision. The research involves two phases. It is envisaged that the first phase will be undertaken between November 2013 and July 2014 (this includes recruitment time) and will involve women taking part in focus groups. The second phase will be undertaken between July 2015 and January 2016 (also includes recruitment time) and will involve interviews which can be undertaken either face to face or over the telephone to suit their preference, to explore these issues more in-depth. I wish to recruit approximately 12 women for each phase with a maximum number of 18 participants per phase.

If you are in agreement, I would like to recruit South Asian women through posters displayed at the college and via electronic flyers and social media (if appropriate). Any data collected will remain confidential/ anonymised and I will ensure the research is conducted around student classes. Participants will also be asked not to name any individuals in the focus groups to maintain confidentiality.

If enough students or staff members aged 18-25 are recruited on campus I would also like to request permission to conduct the focus group(s) on the college campus for ease of access. The focus group(s) should take no longer than one hour to complete. Where participants are not comfortable with a focus group then an individual interview can be offered.

If you have any queries or would like further information about my study, please do not hesitate to contact me or my Director of Studies Professor Fiona Dykes on the contact details provided.

I look forward to hearing from you.

Yours sincerely

Sabina Sattar
Researcher
ssattar@uclan.ac.uk
01772 895145
Research Contact Team:
Professor Fiona Dykes, (fcdykes@uclan.ac.uk or 01772 893828) - Director of Studies
Dr Gill Thomson, (gthomson@uclan.ac.uk or 01772 894578)
Deborah Wisby, (dawisby@uclan.ac.uk or 01772 893887).

Appendix 15: Useful contacts for support

Samaritans	0845 90 90 90
Support Line	0208 554 9004
Terrence Higgins Trust http://www.tht.org.uk/sexual-health	0845 122 1200
Relate Helpline http://www.relate.org.uk/home/index.html	0845 130 4010
Talkwise/Urban Exchange Preston for Under 25s	01772255303
Brook confidential helpline	0808 802 1234
Sexwise	0800 282930
Umeed Preston Domestic Violence Services http://www.pdvs.org.uk/page17.html	01772 201 601
Freedom (Forced marriages charity) http://www.freedomcharity.org.uk/	0845 607 0133
SAFE Centre, Preston	01772 523949

http://www.lancsteachinghospitals.nhs.uk/safe-centre-what-you-can-do

Sexual Health Advice NHS

http://www.nhs.uk/Livewell/Sexualhealthtopics/Pages/Sexual-health-hub.aspx?WT.mc_id=110903

http://www.nhs.uk/worthtalkingabout/Pages/sex-worth-talking-about.aspx

Lancashire CASH Young People
(Contraception & Sexual Health
Services)
http://www.lancashirecare.nhs.uk/Services/Children-Families/CaSH/Young-People.php

Drugline http://www.druglinelancs.co.uk/	01772 253840

Appendix 16: Example of Initial Coding with Gerunds using Max QDA software

C:\Users\sabina\Documents\Phase 1 Analysis\Phase 1 Transcripts initial coding stage 1 - gerunds.mx5 - MAXQDA 11 (Release 11.0.1)

Project Edit Documents Codes Summaries Memos Variables Analysis Mixed methods Visual tools Windows MAXDictio Toolbars ?

emoticode

Document System

Documents	**601**
Participant 16, phase 2	47
Participants 14-15 Phase 2	62
Part 12-13 - Phase 2	81
P11-Ph1	13
P8-9-10-Ph1	60
P4-5-6-7-Ph1	88
P3-Ph1	50
P2-Ph1	74
P1-Ph1	126
Sets	**0**

Code System

Code System	**601**
Maintaining secrecy & the secret relationship	31
Facing Asian staff	5
Encountering healthcare workers that aren't Asian	1
Feelings towards GPs	20
choosing healthcare as a career choice for ethnic minorities	1
describing the nursing status	1
Wanting gender appropriate staff	2
Viewing sexual activity as normal after marriage	7
Identifying that marriage is the goal	8
having discussions around marriage	19
Encountering fertility issues after marriage	2
Describing experiences with friends	6
Describing experiences with siblings	2
Encountering cultural expectations	9
highlighting that ppl talk & spread news within the community	6
Being a part of the 'community'	12
encountering nazar, jealousy, evil eye	2
Wanting equal treatment - not treated differently because Asian	3
Feeling confident to ask & gain knowledge	1
Becoming pregnant before marriage	9
Stating there are different rules for boys	6

Document Browser: P4-5-6-7-Ph1

Following a / highlighting the / highlighting the / Viewing sexual / Following a / Viewing sexual

(4:14) from being sexually active R: Are you all from a particular religion as well? P7 Muslim. R: Are you all Muslim P4,5,6,7: Yes. P:7 So if I was like going to like Brook I'd be like I wonder whose there, I wonder if anyone knows me P4: I wonder if anyone would see me walking in. P5: I don't think I agree with that though cos everyone's in the same boat. Everyone does it, everyone's human so if you're gonna see someone then you're gonna see someone. P7: But again I think it's just a cultural thing. R: What would happen if someone did see you there? (4:46). P4 i think it depends who saw you. P6: It'd be awkward when you came face to face with them in another situation then they'll be thinking like why was she there and you'll be there thinking well why was she P5: (laughing) but you're both in the same boat! If you came to a sexual health clinic then what are you there for? P6: But like there's that thing where what if she drops me in it and what if something slips out from my mouth. (5:12). P5: Well you shouldn't do it then. (All participants laughing). R: Do you think they'd tell anyone or would it just remain between the two of you? P6: Between the two of you. P7: Again it depends who it is as it could be like your mum's friend who's married (5:28) and has got kids as n it would be something normal for them but they'd be like 'Oh that's my friends daughter, she's not married' and they assume things like I wonder what she's been up to? P4: Like if i was to go somewhere and I saw one of the boys I know, they'd obviously go and tell their friends. Especially for them it's a bit more normal to go to that kind of thing and then somehow it would just get back to you cos they probably know all your brothers or cousins and stuff(6:01). R: Right, I'm going to come back to that if that's ok in a second. I just want to go back to what you said earlier. So is it different in terms of when you're married? P7: I think so yeah because it's more normal to have a sexual relationship rather than when you're not married. R: When you say normal, do you mean it's allowed? P7: Yeah (6:20). R: Is it because of religion? Yeah (from all participants). R: Is it culture or is it religion? P7 & P4: I think it's both. P6: I have some Indian friends and they're Hindus and some of them their parents are fine about it but the others they're not so I think it's kind of like a bit of both. P5: For us religion says we can't have sex before marriage

Retrieved Segments

0 0 0 0 Simple query (OR combination) 1 / 1

09:15 15/02/2021

Appendix 17: Example of Focused Coding with Gerunds using Max QDA software

C:\Users\sabina\Documents\Phase 2 Analysis - incl final maxqda\FOCUSED CODING WITH GERUNDS\Phase 1 Transcripts focused coding - gerunds.mx5 - MAXQDA 11 (Release 11.0.1)

Project Edit Documents Codes Summaries Memos Variables Analysis Mixed methods Visual tools Windows MAXDictio Toolbars ?

Document System

Documents	**319**
P11-Ph1	12
P8-9-10-Ph1	54
P4-5-6-7-Ph1	74
P3-Ph1	39
P2-Ph1	59
P1-Ph1	81
Sets	**0**

Code System

Code System	**319**
DISCUSSING FATHERS & OTHER MALE FAMILY	10
EXPERIENCING CONFUSION & CONFLICT AROUND PERSONAL I...	6
ENCOUNTERING HEALTHCARE STAFF	20
DISCUSSING MOTHERS & OTHER FEMALES	37
DISCUSSING MARRIAGE & MARITAL ISSUES	22
BEING PART OF THE COMMUNITY	11
FEELING SHAME, JUDGEMENT & DISRESPECT	28
EXPERIENCING FAM VALUES,RELIG'N,CULT'L INFLUEN'S & EXPE...	32
MAINTAINING SECRECY & THE SECRET RELATIONSHIP	40
ACCESSING SEXUAL HEALTH SERVICES, ADVICE & S.H. AWARE...	113
Sets	**0**

Document Browser: P8-9-10-Ph1

MAINTAINING
FEELING
FEELING

just feel that guilt like Oh my God I feel awful.

4 R: Do you feel your needs will differ to other ethnic groups in terms of sexual health services? P9: To an extent. I think personally when I think I'm pregnant I get a hell of a lot more panicked because if I'm pregnant and I'm not married, I'm dead. R: In what way? (06:50) P9: My parents would just go mental, absolutely mental and then I would then have to go further and seek advice about termination and stuff like that. It would go that far as that's how much I feel it would have an impact on my life. R: Would you even tell your parents? P9: No, it wouldn't be something I could do. Even years down the line if I had to go for a termination, I would never tell them. R: What would happen if you told them from your perception? (07:21). P9: Oh I'd be in a lot of trouble which sounds very childish but I really would be in a lot of trouble. R: What do you think would happen? P9: I think I would be disowned. R: When you say disowned do you mean you would be outcast and not spoken to? P9: Yeah basically they would no longer know me any more especially if I decided to keep it P10: There is a lot of pressure. Like my family is really modernised but I think its the granddad, grandma and it's because of that you feel a lot of pressure. Like I think my mum and my stepdads quite laid back but obviously if I was pregnant I'd tell them but they'd be like What the F*** , Sorry to swear. No literally but I think it's different being a white person to being an Asian, ethnic minority because people talk and Asian families care about what other people think about you and your family and the surname. P9: Yeah that's it (08:25) P10: You don't wanna disgrace the surname, disgrace the family and they've built all this for you blah blah blah so it is a lot of pressure. P8: I think we're stigmatised more so than an average White person if you know what I mean. R: In what way? P8: You're supposed to have no sex before marriage, have marriage, have a child and you're supposed to be born to raise a family whereas in the Western world they haven't got these set rules to follow if that makes sense. P10: Yeah. P8: Like it doesn't matter if you've got a child before you get married, they're not pressured in to doing so its a normal way of life.

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Appendix 18: Examples of Clustering exercises

Appendix 19: Coded segments – Confidentiality

Document: **Participant 16, phase 2**
Weight: **0**
Position: **2 - 2**
Code: **ACCESSING SEXUAL HEALTH SERVICES, ADVICE & SEXUAL HEALTH AWAREN\highlighting the importance of confidentiality**
R: Do you think if she ended up in a situation where she had to access sexual health services, especially being mindful that it's a secret relationship, what do you think her expectations might be? Do you think she'd be able to her GP, or any other services? Might there be any concerns? P16: I don't think she'd be able to go to her GP. (06:39) R: No? P16: Only because it's her family GP and I don't know if she can have that confidentiality barrier with the GP. Especially with them being Asian aswell. R: So if it's an Asian GP confidentiality is a big concern? P16: Yeah. R: Even if there is that confidentiality with the family GP and it's an Asian GP how would the feeling be towards the GP or how do you think the GPs would be feeling towards them? P16: The GP would probably judge her like knowing who she is and knowing where she comes from for her to go to him and talk about her sexual health, I don't think. I don't really know to be honest. R: So there might be judgement? P16: Yeah definitely judgement. R: Even though there will be confidentiality, there might be judgement? P16 Yeah.

Document: **Participants 14-15 Phase 2**
Weight: **0**
Position: **2 - 2**
Code: **ACCESSING SEXUAL HEALTH SERVICES, ADVICE & SEXUAL HEALTH AWAREN\highlighting the importance of confidentiality**
P14: I'm not sure. P15: Would you go to Brook? P14? No I wouldn't go to Brooks. Never. P15: Would you not? P14? No I wouldn't. I've been once but I was well embarrassed cos of the main road. I had to make sure no one was looking. R: what was your worry? P14: People seeing me and obviously you know what Asian guys are like. They'd be like, she's gone to Brooks! She's doing this! She's doing that! Can you imagine?! People talk these days as well. So no I wouldn't go. I wouldn't feel confident to go there. As if!

Document: **Part 12-13 - Phase 2**
Weight: **0**
Position: **2 - 2**
Code: **ACCESSING SEXUAL HEALTH SERVICES, ADVICE & SEXUAL HEALTH AWAREN\highlighting the importance of confidentiality**
P12: I think that because it is a bit of a taboo, people don't feel comfortable erm P13: going to their GP P12: Yeah going to their GP. That would definitely be something which is a no no. I think they probably like just search on the internet or something.

Document: **P8-9-10-Ph1**
Weight: **0**
Position: **3 - 3**
Code: **ACCESSING SEXUAL HEALTH SERVICES, ADVICE & SEXUAL HEALTH AWAREN\highlighting the importance of confidentiality**
P9: It's really bad like I always feel like I can't go to my family doctor cos he's Asian and he sees my parents and you just think that even though they're not meant to say anything you're just a bit like hmmmmm don't really trust them. R: Are you worried about confidentiality there then with your family GPs? P9/10: Yes. P9: Definitely. [Girls laugh as both said a strong Yes in unison].

Appendix 20: Memo writing

Memo: Navigating shame
Participant: Adeela, Focus Group 4, Phase two

Adeela avoided telling the truth about her marital status. She had introduced herself as being married with a young child. Her friend Uzma, had also introduced her as being married in a previous conversation with me when I was arranging the focus group through her.

Adeela: Yeah it's easier to say I'm married than having to explain.

By avoiding the truth, Adeela could avoid any potential difficult discussions or questions. She may avoid feeling judged. Perhap's this was Adeela's way to navigate or avoid shame in relation to not only being in a pre-marital relationship, but also in having a child out of wedlock.
I was reminded of other participants who had discussed the possibility of falling pregnant before marriage. Yasmin, from Phase one had confirmed how much trouble she would be in if anyone found out and therefore she would have to consider a termination of pregnancy rather than risk anyone finding out she feel pregnant. She maintained how she would never disclose the termination to anyone even in the future when she was married.

Although I was from a South Asian background, and only in touch with Adeela from a research capacity, Adeela still initially maintained the guise of being married.

Adeela: People seem to talk but personally I don't think about what people think or say. They may know my business. Obviously some people know but I'm not bothered.

Adeela's behaviour clearly contradicted her words and I felt she was *"bothered".* I felt she had found her strategy to avoid or limit shame by lying and stating she was married. Perhaps this made things easier for her and her family in the community. I felt she was using this guise as a way to navigate shame.

Appendix 21: Charting the data

Authors	Date	Title	Study location	Study population/sampl e	Aim/s of the study	Methodology/ Study design	Key findings
Griffiths Catherine; French Rebecca S; Patel-Kanwal Hansa; Rait Greta;	2008	Always between two cultures': young British Bangladeshis and their mothers' views on sex and relationships	Inner-city London Borough	Young British Bangladeshis and mothers. 25 x mothers, 31 x young men 16-20, 5 x young women aged 16-18	Not clearly stated	Focus groups on sexual health knowledge & behaviour and discussions around designing the delivery and content of sex and relationships education programme	Mothers felt their children were influenced by two cultures. Many mothers felt sexual matters could not be discussed at home as it was the role of the school to educate. Some men felt it was against their religion to have pre-marital sex however beliefs varied. Some men felt they should have the knowledge to stay safe and discussed peer pressure surrounding sex. Young men also described the need to keep relationships hidden from the community. Young women felt that sexual pressures came from their partners. Women identified graver consequences of pre-marital sex for women. Young people preferred learning about sexual health from schools or youth groups, however women felt school education was vital as few women attended youth clubs or had freedom outside school.
Griffiths, C; Johnson, A M; Fenton K A; Erens B; Hart GJ; Wellings K; Mercer C H	2011	Attitudes and first heterosexual experiences among Indians and Pakistanis in Britain:	Britain with a multistage probability cluster design, with oversampling in Greater	British Indians and Pakistanis (with approximately half the respondents reporting they were born in the UK) Indians	To compare attitudes, experiences of learning about sex and first intercourse	National probability survey	Religion was regarded as very important for Pakistanis (64.6%) and Indians (28.1%) in comparison to only 6.2% from other ethnicities. Pakistanis had more conservative beliefs e.g. premarital sex. Pakistanis were more likely to be married at fist sex. Men 69.4% were more likely to

		evidence from a national probability survey	London	n=393, Pakistanis n =365 aged 16-44	among Indians & Pakistanis in Britain		be in non-marital relationships than women 25.2%. Pakistani men, women and Indian women more likely to report not using contraception at first sex. Pakistani and Indian women reported school as the place of their main source of sex education and also reported not discussing sex with their parents during adolescence.
Kott, A	2011	South Asians living in Britain diverge over views on first sex	Britain - general population	Men and women aged 16-44 which included 365 Pakistani respondents and 393 Indian median age 30.	To understand the sexual attitudes and behaviours among Pakistanis and Indians living in Britain.	National probability survey	Pakistanis and Indians share South Asian origins however significantly differ from each other and other ethnic groups in their beliefs towards first sex. Indians less likely to view pre-marital sex as wrong however Pakistanis were more likely to engage in pre-marital sex. A larger proportion of Pakistani males than females were not married at first sex. Religion considered more important among the Pakistanis than Indians. Disapproval of pre-marital sex was higher among the Pakistanis than the Indians. Not using a reliable method of contraception at first sex was higher for Pakistani males and females and Indian females. School was the main source of sex education for a larger proportion of Pakistani females in comparison to Indian females.
Beck, A; Majumdar, A; Estcourt C; Petrack J	2005	"We don't really have cause to discuss these things, they don't affect us": a collaborative model for developing culturally	East London	Bangladeshi community, 58 participants of which 12 x individual interviews (Male = 7 ages 21-42; and female = 5 ages 20-52), Focus	Identify barriers to accessing sexual health care	Qualitative interviews and focus groups.	Four themes were identified as impacting access to services which included concerns over confidentiality, relevance of services, problems discussing sexual issues, problems with previous experiences of health promotion. Existing sexual health services were viewed as culturally insensitive by patients and community groups.

		appropriate sexual health services with the Bangladeshi community of Tower Hamlets		group 1 had 7 female participants aged 23-39; FG2 has 12 female participants aged 13 to 17; FG3 had 5 female participants aged 21-29; FG4 had 3 participants of which 2 were male and 1 was female aged 23-26; FG5 had 14 female participants aged 32-60; FG6 had 5 male participants aged 25-45.			
Dhar Jyoti; Griffiths Catherine; Cassell Jackie; Sutcliffe Lorna; Brook Gary; Mercer Catherine	2010	How and why do South Asians attend GUM clinics? Evidence from contasting GUM clinics across England	Seven GUM clinics across England	4600 new GUM clinic attendees of which 5%, n=226 were of South Asian origin	To describe reasons for GUM clinic attendance among South Asian individuals in comparison to patients of other ethnicities	Quantitative study. Questionnaire completion between Oct 2004 and March 2005	South Asians, in particular women, may be reluctant to seek help from GUM clinics. The researchers concluded that South Asians attend GUM clinics for different reasons than other ethnicities. A larger proportion of South Asian men compared to other ethnicities attended GUM clinics for HIV testing. South Asian women were more likely to be referred to the GUM clinic from other services such as family planning clinics but the concern was that the women stopped seeking support once symptoms resolved or if there were long waiting times.
Moses Sharon; Oloto Emeka	2010	Asian women's use of specialist Contraception, Sexual and Reproductive	Leicester, UK	Females accessing a specialist contraceptive, sexual and	To determine who was using the service, why there were	A needs assessment questionnaire was offered to all service users	Mean age of South Asian women using the service was 27.9 with an age range of 13-52 which was similar to the mean age of non-Asians. 585 questionnaires were collected from female service users of

		Health Services in Leicester, UK		reproductive health service in Leicester	using the service and customer preferences. They also wanted to ascertain any differences between Asian and non-Asian groups to identify any specific needs which may guide service development	attending all clinics over a 6 week period between Oct and December 2007.	which 143 were from Asian women and 442 from non-Asian women. A significantly greater proportion of Asian women were attending for non-contraceptive reasons which included pregnancy tests, smears, infection tests and unplanned pregnancies. There were no significant differences between Asians and non-Asians as regards non-contraceptive reasons for attending clinic. A significantly larger proportion of Asian women described confidentiality, female staff and not wanting to see their GPs as reasons for accessing the service.
Testa Adrienne, Coleman Lester, Trust for the Study of Adolescence (TSA) and Naz Project London (NPL)	2006	Sexual health knowledge, attitudes and behaviours among Black and Minority Ethnic youth in London	London	Survey: 3007 students participated - All students in Years 11-13 (aged 15-18) from 16 secondary schools (Schools were purposively selected where ethnic minority groups comprised at least two-thirds of the student population). Interviews: 50 (n=26 females and n=24 males) ethnic minority youth, aged 16-23 from community youth	To identify ethnic variations in sexual health knowledge, attitudes and behaviour; To identify specific preferences for Sex and Relationship Information (SRI);	Quantitative- a cross-sectional, self-administered survey with students attending secondary schools in Greater London undertaken under 'exam' conditions and qualitative semi-structured interviews	Females reported higher sexual health knowledge over males. Young people were more knowledgeable about pregnancy compared to STIs. When comparing Asian ethnicities females had better sexual health knowledge over males except with Pakistani participants were males had slightly better knowledge than females. Among all the Black and Asian ethnicities, males had more liberal attitudes towards sexual health and were more likely to have experienced sexual intercourse over females. Males reported a higher percentage sex under 16 years old. A higher percentage of males reported negative reasons for first experience of sex i.e. drunk, peers. Asian females reported a higher percentage of not having equal willingness with first experiences of sex. Findings suggest 80% of the sample were not sexually

				groups, youth sexual health clinics and volunteers from the self-administered questionnaire			competent in terms of their overall sexual health e.g. reasons for having sex, willingness etc. A higher percentage of all females reported not using contraception compared to males. Ethnic minority groups generally showed more preference towards SRI (sex and relationship information).
Sinha Shamser; Curtis Katherine; Jayakody Amanda; Vinar Russell; Roberts Helen; and Research with East London Adolescents Community Health Survey (RELACHS)	2005	Starting sex in East London: protective and risk factors for starting to have sex amongst Black and Minority Ethnic young people in East London	East London	Quantitative: 13-16 yr olds(collected data from 2790 young people of which data from 2369 participants was used in the analysis); Qualitative 15-18 year olds (146 young people).	To gather information on protective factors that protect against risky sexual behaviours in ethnic minority young people in East London To provide data to inform potential policy to reduce teenage pregnancy rates in ethnic minority young people.	Quantitative - longitudinal survey - questionnaire completed in school (Wave 1 collected data from 2,790 young people aged 12-14 years, Wave 2 surveyed the same young people and new members two years later when aged 13-16 years old. Qualitative: collected data from 146 young people aged 15-18 using focus groups, an experimental web-based discussion forum and semi-structured interviews.	Compared to national data for under 16 years old, a small proportion of the East London sample reported having sex. Despite differences, knowing someone's ethnicity was not a shortcut to knowing their beliefs towards sexual relationships. Young people from Bangladeshi and Pakistani backgrounds reported drawing on extended families as sources of advice and support. There were significant ethnic differences in reported sexual behaviour amongst teenagers aged 13-15 years in East London. Bangladeshi, Pakistani and Indian young people of both sexes were least likely to report ever having had sex.
Sinha	2007	People make	East London	15-18 yr olds of	To explore	Focus groups	Religion influenced some young women's

Shamser; Curtis Katherine; Jayakody Amanda; Viner Rusesell; Roberts Helen		assumptions about our communities': sexual health amongst teenagers from Black and Minority Ethnic backgrounds in East London		whom 123 participated through focus groups and 3 through one to one interviews from a wide range of ethnic groups (50 men, 76 women)	sexual behaviour and relationships amongst ethnic minority teenagers in East London. To examine how these relationships are shaped by culture, gender, peer norms. To describe the implications for sexual health policy.	and interviews	sexual behaviour. Young women particularly wanted to avoid parental surveillance. Mobile phones provided a means to get to know partners. Gendered norms about expressions of readiness towards sex were shared across the ethnicities amongst young men. Peer pressure and peer norms influenced sexual behaviour.
French R S; Joyce L; Fenton K; Kingori P; Griffiths C; Stone V; Patel-Kanwal H; Power R; Stephenson J	2005	Exploring the attitudes and behaviours of Bangladeshi, Indian and Jamaican young people in relation to reproductive and sexual health - A report for the Teenage Pregnancy Unit	London, Manchester and Birmingham	Bangladeshi, Indian and Jamaican young people aged 13-21 years (n=75). And 13 focus groups with young people, parents of teenagers, health care workers and community organisation representatives (19 Bangladeshi participants; 18 Indian participants; 30 Jamaican participants	The aim of the interviews: to provide a better understanding of the attitudes and behaviours of Bangladeshi, Indian and Jamaican young people (aged 13-21 years) relating to sexual behaviour, contraception, pregnancy and young	Qualitative: Interviews and Gender specific focus groups. Interviews took place between Feb and April 2003.	There are marked variations in relation to reproductive and sexual health attitudes and outcomes among the three ethnic groups; cultural factors are strong influences on young people within the three ethnic groups and these factors impact on how teenage pregnancy is viewed; gender differences in attitudes and behaviours were strong; there is evidence of a gradual harmonisation of attitudes towards sexual and reproductive health due to factors unique to living in Britain and was seen to be moderated by adherence to cultural norms and religious beliefs; parents from these communities were aware of the changing context and sometimes felt powerless to fight against these trends and maintaining strong religious beliefs was a strategy to meet

					parenthood. The Aims of the focus groups: to explore the results of the interviews and investigate the implications on the provision and delivery of services for each of the target groups.		the challenges; Current knowledge and use of existing sexual and reproductive health services varied across the ethnic groups and there was some disagreement around the need for culturally specific services however the role of ethnicity specific role models and culturally identified resources were identified as being important to the young people.
Wayal Sonia; Hughes Gwenda; Sonnenberg Pam; Mohammed Hamish; Copas Andrew; Gerressu Makeda; Tanton Clare; Furegato Martina; Mercer Catherine	2017	Ethnic variations in sexual behaviours and sexual health markers: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3)	Britain - National Survey of Sexual Attitudes and Lifestyles	14563 of the 15162 participants surveyed in NATSAL-3 were included. Participants who identified as White British, Black Caribbean, Black African, Indian, Pakistani, White other, and mixed ethnicity in 2011. Ages 16-74	Examine a national probability survey to identify ethnic variations in sexual behaviours and sexual health markers	National probability survey	Recreational drug use was highest among White other and mixed ethnicity groups in men. Black African and Black Caribbean men reported a greater number of partners in the past 5 years compared to White British men. Compared with White British women, the proportions of Black African and mixed ethnicity women reporting being sexually competent were lower. Mixed ethnicity women reported larger number of partners in the past 5 years. Reporting STI diagnoses was higher in Black Caribbean men and mixed ethnicity women than in White British participants. Use of emergency contraception was most commonly reported among Black African women. The proportion of women having had a same sex experience was significantly

							higher in White other women. Pakistani and Indian women had low reports of condomless sex with more than one partner compared with White British women.
Fenton Kevin; Mercer Catherine; McManus Sally; Erens Bob; Wellings Kaye; Maddowall Wendy; Byron Christos; Copas Andrew; Nanchahal Kiran; Field Julia; Johnson Anne	2005	Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey	Britain - National Survey of Sexual Attitudes and Lifestyles 2000	11161 men and women aged 16-44, resident in Great Britain with additional sampling of 949 Black Caribbean, Black African, Indian and Pakistani respondents between May 1999 and Feb 2001	Investigate the frequency of high-risk sexual behaviours and adverse sexual health outcomes in five ethnic groups in Great Britain	National probability survey	Striking variations in number of sexual partnerships by ethnic group and between men and women were noted. Reported numbers of sexual partnerships in a lifetime were highest among Black Caribbean and Black African men, and in White and Black Caribbean women. Indian and Pakistani men and women reported fewer sexual partnerships, later first intercourse, and substantially lower prevalence of diagnosed STIs than other groups. Findings suggest a need for targeted and culturally competent prevention interventions.
Saxena Sonia; Copas Andrew; Mercer Catherine; Johnson Anne; Fenton Kevin; Erens	2006	Ethnic variations in sexual activity and contraceptive use: national cross-sectional survey	Britain - National Survey of Sexual Attitudes and Lifestyles 2000	6932 women aged 16-44 years residing in Britain	To compare data on contraceptive use in relation to reported sexual activity in women from different minority ethnic groups	Analysis of a national probability survey	Among sexually active women, contraceptive use was significantly lower in all ethnic minority groups than in White women, but the pattern differed according to marital status. In married and cohabiting women, lower contraceptive use was reported by Indian and Pakistani women. Women from all ethnic minority groups were less likely than White women to report using hormonal contraception

Bob; Nanchahal Kiran; Macdowall Wendy; Wellings Kaye							and permanent methods and instead were more likely to use barrier methods. A higher percentage of Indian and Pakistani women participating were married compared to White women. Overall use of contraception was lowest in Pakistani women and was highest in White women. Among single women, the proportion reporting contraceptive use in the past year was highest among Indian women and lower in Caribbean and Black African women.

Appendix 22: Interpretive theorising image

Interpretive Theorising

What?	How?	Why?
Navigating shame Negotiating cultural ideologies	Maintaining secrets Collusion Acculturation	Prevent shame Sexual agency