Exploring young second-generation South Asian Canadian womxn's experiences with sexual and reproductive health information and services in Ontario

Sarah Shahi

A thesis submitted in partial fulfillment of the requirements for the

Master's degree in Interdisciplinary Health Sciences

Interdisciplinary School of Health Sciences

Faculty of Health Sciences

University of Ottawa

Abstract

Second-generation Canadians are often referred to as the children of immigrants. Second-generation Canadians may find themselves in a position where the values of their parents or ethnic group are different to those of dominant Canadian culture; this dynamic has been documented within the second-generation South Asian Canadian population. The South Asian community traditionally views discussions of sexuality and intimate relations as taboo. This may have implications for how young second-generation South Asian Canadian womxn access sexual and reproductive health (SRH) information and care. This multi-method qualitative study explored the experiences of young second-generation South Asian Canadian women and other pregnancy capable people (womxn) accessing and receiving SRH information and care in Ontario through an anonymous online survey and in-depth interviews. We found that womxn's dual identity as Canadian and South Asian plays a role in their access to comprehensive SRH information and adequate SRH care. Privacy and confidentiality within the healthcare system impact use of information and services for this community. There is an evident need for improved information resources and education across all generations.

Résumé

Les Canadiens de deuxième génération sont souvent appelés les enfants d'immigrants. Les Canadiens de deuxième génération peuvent se retrouver dans une situation où les valeurs de leurs parents ou de leur groupe ethnique sont différentes de celles de la culture canadienne dominante; cela a été documenté au sein de la population sud-asiatique canadienne de deuxième génération. Traditionnellement, la communauté sud-asiatique considère les discussions sur la sexualité et les relations intimes comme taboues. Cela peut affecter la manière dont les jeunes femmes sud-

asiatiques canadiennes de deuxième génération accèdent aux informations et aux services de santé sexuelle et reproductive (SSR). Cette étude qualitative multiméthode a exploré les expériences de jeunes femmes et d'autres personnes capables de grossesse (womxn) sud-asiatiques canadiennes de deuxième génération accédant et recevant des informations et des services de SSR en Ontario, au moyen d’un sondage et des entretiens approfondis. Nous avons constaté que la double identité des femmes en tant que Canadiennes et Sud-Asiatiques influence leur accès à des informations complètes en matière de SSR et à des services de SSR adéquats. La confidentialité et la discrétion influencent l'utilisation des informations et des services pour cette communauté. Il existe un besoin évident d'amélioration des ressources d'information et de l'éducation à travers toutes les générations.

Acknowledgements

There are many people that helped me through this journey. Each of you provided motivation, guidance, and support allowing me to be successful and for that I would like to thank you.

To *Angel*, my supervisor, thank you for allowing me to create a project I am so passionate about. Your guidance and mentorship throughout this journey have made me a better researcher.

To *Dr. Karen Phillips and Dr. Raywat Deonandan,* my thesis advisory committee members, thank you for your contributions, guidance, and enthusiasm for my project.

To *Dad, Momma, Megan, and Amrit,* thank you for supporting me throughout this journey and being my biggest cheerleaders and sources of motivation.

To *Jordan,* thank you for being a light when I needed it the most.

To *RJ*, thank you for everything you do and everything you are. I could not have done this without you.

To my *friends and family*, thank you for letting me talk about this project non-stop for the past 3 years. Your interest in my work and belief in me means more than you'll ever know.

To my *peers*, thank you for your support over the last 3 years. From our group chat to weekly catchups, you made this time memorable.

And lastly, to my *participants*, thank you for sharing your stories. Your time and willingness to share made this project a success.

I would like to dedicate this thesis to my brother *Raj*. Your final encouraging words stayed with me every step of the way. I hope this work makes you proud. I'm finally on your level now!

Table of contents

List of acronyms and abbreviations

EC	Emergency contraception
IUD	Intrauterine device
OB/GYN	Obstetrician-gynaecologist
OCP	Oral contraceptive pills
PCOS	Polycystic ovarian syndrome
REB	Research Ethics Board
SRH	Sexual and reproductive health
STI	Sexually transmitted infection

Chapter 1: Introduction

Background

The South Asian region

South Asians are an ethnically, linguistically, and religiously diverse community. The South Asian region comprises Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and the Maldives, formally known as the Indian subcontinent (a map of this region is shown in Fig.1) (Allard et al., 2005; Statistics Canada, 2022d). The South Asian region is home to nearly a quarter of the world's population (Véron, 2008) and its diaspora is the largest in the world, a result of both colonialism and modern migration patterns (Chatterji & Washbrook, 2013).

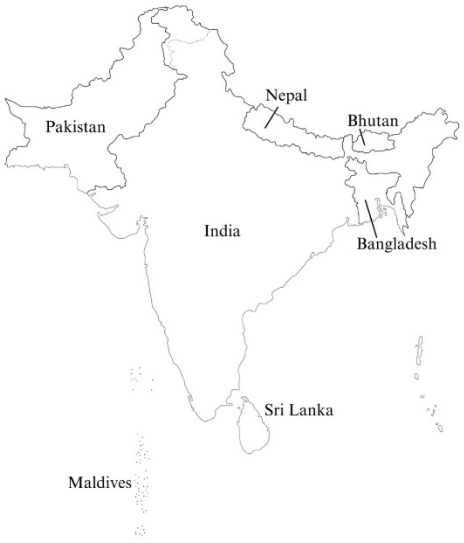

Figure 1: Map of South Asia

South Asian population in Canada

South Asians make up the largest visible minority group in Canada with a population of over 2.5 million people (Agrawal, 2013; Statistics Canada, 2023). Statistics Canada defines South Asian as one with ethnic origins in the southern part of Asia, or who self-identifies as a member of a South Asian minority group (Allard et al., 2005). This definition includes people from a variety of ethnic/national backgrounds some of which are Bangladeshi, Bengali,

Bhutanese, Gujarati, Indian, Malayali, Nepali, Pakistani, Punjabi, Sinhalese, Sri Lankan, and Tamil (Statistics Canada, 2022a). Additionally, there are over 75 different languages spoken by Canada's South Asian population (Allard et al., 2005). The most common languages spoken other than English include Punjabi, Urdu, Hindi, Tamil, and Gujarati (Statistics Canada, 2022c). In terms of religion, the four most common religions within the South Asian community in Canada are Hinduism, Sikhism, Islam, and Christianity (Statistics Canada, 2022b).

The history of the South Asian diaspora in Canada

The South Asian diaspora population in Canada is incredibly diverse and includes people with origins in South Asia, Africa (mainly Eastern and Southern regions), the South Pacific Islands, and the Latin American and Caribbean region (Buchignani et al., 1985). Canada saw its first South Asian immigrants in the early 1900s with mostly Punjabi Sikhs arriving in Western provinces (Allard et al., 2005; Buchignani et al., 1985). South Asian immigration began to increase as there was a higher demand for manual workers. However, in 1908 Canada implemented the continuous journey regulation, an exclusionary law that made immigration from South Asia, specifically India, near impossible (Agrawal, 2013; Buchignani et al., 1985). This paused the arrival of South Asian immigrants and some early settlers returned to India (Agrawal, 2013).

In the late 1950s and 1960s, South Asian immigration continued after a relaxation of laws allowed for sponsorship of relatives, immigration of skilled workers, and immigration of more women and children. As a result, the South Asian diaspora in Canada began to diversify; immigrants were no longer solely Punjabi Sikhs (Agrawal, 2013; Buchignani et al., 1985). Different religious and ethnic groups from India, Pakistan, and Sri Lanka began to arrive in the

1960s. By the start of the 1970s, the number of South Asian immigrants was 12 times higher than that of the 1960s and continued to rise during the 1980s as well (Agrawal, 2013). The Canadian government further altered the immigration criteria to include both skilled and unskilled workers, which contributed to the diversity of South Asian immigrants (Agrawal, 2013; Buchignani et al., 1985). In the 2006 Canadian census, people of South Asian origin became the largest minority group in Canada, surpassing Chinese Canadians (Agrawal, 2013; Allard et al., 2005). Today, South Asians are spread throughout the provinces and territories. However Ontario and British Columbia continue to be hubs for South Asian immigration (Allard et al., 2005; Statistics Canada, 2023; Walton-Roberts, 2013).

The current South Asian population in Canada comprises non-permanent residents, new immigrants, first- and second-generation Canadians as well as multi-generational families (Agrawal, 2013; Allard et al., 2005). Statistics Canada defines first generation Canadians as those who were born outside of Canada and have now obtained citizenship (Statistics Canada, 2021). Second generation Canadians are often defined as the children of immigrants, as they were born in Canada with at least one parent who was born elsewhere. Third generation or more are those born in Canada with two Canadian born parents (Statistics Canada, 2021).

According to the 2021 Canadian Census, there are over six million second-generation Canadians with over 650,000 identifying as South Asian (Statistics Canada, 2022d). Young second-generation Canadians are often in a position where the values of their ethnic group (and the values of their parent(s)) are different to those of “dominant” Canadian culture (Zaidi et al., 2016). This dynamic has been documented within the second-generation South Asian Canadian youth population (Sundar, 2008; Zaidi et al., 2016).

South Asian values and acculturation of young second-generation Canadians

The South Asian diaspora in Canada is a heterogenous community in terms of ethnicity, religion, and time of immigration. However, there are some overlapping values and cultural beliefs within this community. Within the South Asian region, researchers have found there to be a strong collectivistic cultural foundation (Chadda & Deb, 2013; Zaidi et al., 2016). As such, traditional cultural values tend to give family and social networks significant importance (Chadda & Deb, 2013; Zaidi et al., 2016). Thus, the values and needs of the family often come before those of any individual family member. Furthermore, individual members of a family are often not considered separate from the family unit (Zaidi et al., 2016). In accordance with these values, decision-making may involve the whole family unit and possible implications on the social network, family, and community relationships are often considered (Zaidi et al., 2016).

Additionally, adherence to these traditional cultural values may contribute to an unequal division of power between men and women within some households. Traditionally, men are seen as having more economic and social value, while women may be seen as posing a financial burden (Fikree & Pasha, 2004). The actions of women are sometimes seen as a direct reflection of the reputation and honour of the family (Zaidi et al., 2016). Some South Asian women are socialized and taught about cultural, religious, and gendered expectations in terms of South Asian values and norms. They are often taught to be "obedient" wives and behave in modest and respectful ways, as their actions reflect on their parents and family (Zaidi et al., 2016). Digression from these norms and values by women are often described as rebellious and deviant (Handa, 2003; Zaidi et al., 2016). However, some young second-generation South Asian women recognize that this is not the norm within "dominant" Canadian culture. As a result of their dual cultural experiences, young second-generation South Asian women report mixing positive

aspects of both cultures to form their identities as both Canadians and a “good” South Asian women (Sundar, 2008).

Sexual and reproductive health in the South Asian community in Canada

South Asian communities typically view sexuality and intimate relationships, particularly prior to marriage, as taboo and these issues are heavily stigmatized (Zaidi et al., 2016). Abstaining from sexual relations is the expectation, as virginity is tied to family honour and respect. Sexual “deviancy” is thought to bring shame upon the family, not just the individual (Zaidi et al., 2016). However, research shows that South Asian youth are not abstaining from intimate relations or sexual interactions (Zaidi et al., 2016). Furthermore, young people that experience uncertainty surrounding their cultural identity have been found to be more likely to partake in risky sexual behaviours (Meherali et al., 2021).

Despite the current knowledge of sexual behaviours among young South Asians, there is limited research on the sexual and reproductive health (SRH) of this community. One study found that Canadian immigrants that sought an abortion were less likely to be using hormonal contraception and more likely to be using a “counting days” method when compared to those born in Canada (Wiebe, 2013). Overall, immigrants reported having less experience with hormonal contraception and had more negative views about these methods. Additionally, the length of time since immigration contributed to the use of and attitudes towards contraception as those who spent less than five years in Canada reported more negative views and less use of contraception (Wiebe, 2013). However, this study focuses specifically on immigrants, not second-generation Canadians.

Young South Asians in Canada reported experiencing a number of barriers when accessing SRH services which may contribute to decreased service use within this population (Meherali et al., 2021). Young South Asians often report fear of being stigmatized, judged, or observed by others as major deterrents to accessing SRH services (Griffiths et al., 2008; Meherali et al., 2021). Additionally, researchers have found that issues surrounding confidentiality and privacy within clinics are common concerns within the South Asian community (Griffiths et al., 2008; Meherali et al., 2021).

Abortion use and access among South Asian Canadians has largely been discussed in the context of sex-selective abortions. As "traditional" South Asian values place primacy on men based on financial and social worth, this may create a preference for sons over daughters among some members in the South Asian community (Fikree & Pasha, 2004; Wanigaratne et al., 2018). Research has found that both first- and second-generation South Asian mothers who had at least one abortion gave birth to significantly more males than females and that this association was especially strong if the woman had already given birth to two girls (Wanigaratne et al., 2018). This may be a reflection of the continuance of more traditional cultural values and practices among South Asian immigrants and second-generation South Asian Canadians (Wanigaratne et al., 2018). However, little research has been done that explores South Asian Canadians' lived experiences.

Rationale

Despite making up a large portion of the population, there is very little research on the health of the South Asian community and even less about their SRH (Quay et al., 2017). Additionally, second-generation youth may face challenges when attempting to balance their

identity as a Canadian and their identity as a South Asian (Sundar, 2008; Zaidi et al., 2016), which may have implications for how this population accesses information and services related to SRH. This thesis aims to contribute to filling this gap.

Research questions

My exploratory research project aimed to answer the following questions:

1. What are young second-generation South Asian Canadian womxn's experiences with seeking and receiving SRH information in Ontario?
2. What are young second-generation South Asian Canadian womxn's experiences accessing SRH care in Ontario?
3. What can be done to improve SRH information and services in Ontario for the South Asian community?

For this study, we focused on abortion, contraception, and sexually transmitted infection (STI) screening, diagnosis, and care.

Throughout this thesis, I use the term 'womxn' to acknowledge the social construction of gender and exclusionary nature of traditional terms. By using this term, we hope to include all those who are pregnancy capable but recognize that most of those who seek contraception and abortion care identify as "women." While we hope to increase inclusion, we acknowledge that this term may not represent non-binary or gender non-conforming persons (Mavuso & Macleod, 2020).

By studying the experiences of second-generation South Asian Canadian womxn, we hoped to identify perceived barriers or facilitators to accessing SRH information and services. This study also aimed to highlight the complex experiences that stem from being a child of

immigrants. These findings can potentially inform the activities of health care providers and those working with the South Asian Canadian community.

Thesis structure

This thesis is presented as a "thesis by articles" and is divided into 5 chapters. Chapter One: *Introduction* provides an overview of the South Asian region and background information of the South Asian diaspora in Canada. This chapter describes some of the values and beliefs that exist within the South Asian community and discusses the implication these may have for young second-generation South Asian Canadians. Additionally, this chapter outlines what is currently known about the SRH of the South Asian community while highlighting the gaps in the current literature. Lastly, this chapter contains the research questions and rationale that guided this study.

Chapter Two: *Methods* outlines the methodological approach implemented in this research study. This includes an explanation of all data collection tools, recruitment strategies, and analytical plan for each component of this multi-method qualitative study.

Chapter Three: *Article #1.* Entitled, "'It's very much a taboo subject': Exploring young second-generation South Asian Canadian womxn's experience with sexual and reproductive health information in Ontario", this article outlines the findings related to SRH information and education from the online survey and in-depth interviews. We formatted this article according to the requirements and guidelines for the peer-reviewed journal *Culture, Health & Sexuality.*

Chapter Four: *Article #2.* Entitled, ""You're always kind of worried about judgement": Exploring second-generation South Asian Canadian womxn's experience with sexual and reproductive health care and services in Ontario", this article outlines the findings related to SRH

care and service access from the in-depth interviews with participants. We formatted the article according to the requirements and guidelines for the journal *Contraception*.

Chapter Five: *Discussion* offers a synthesis of the results. In this chapter I discuss the major themes from both articles including concordant and discordant findings. Additionally, this chapter explains the significance followed by the strengths and limitations of this study. This chapter includes a reflection on my positionality as a researcher and a statement of contribution for all those involved in the project. This chapter ends with concluding remarks and reflections on future directions for research.

Chapter 2: Methods

Component 1: Online survey

This component of the study involved an anonymous online survey that aimed to address the first research question and act as a recruitment tool for follow-up interviews. I designed the survey portion to explore participants' experiences seeking and receiving sexual and reproductive health (SRH) information and services in Ontario. In addition to having access to an Internet-enabled device, the eligibility criteria for the survey were womxn who self-identified as being:

1. Between the ages of 18-30 years old (inclusive);
2. A member of the South Asian community in Ontario;
3. A second-generation Canadian (born in Canada with at least one parent born elsewhere); and
4. Sufficiently fluent in English to answer the survey questions.

The age range for this study was based on the Statistics Canada definition of youth or young Canadians as those aged 15-30 years old (Garriguet, 2021). However, we decided to center the experiences of those who were likely to have had completed high school and thus used 18 years as the lower bound.

We defined someone as a member of the South Asian community if they self-identified as those with ethnic origins in the southern part of Asia or as with a variety of ethnic/national backgrounds including: Bangladeshi, Bengali, Bhutanese, Gujarati, Indian, Malayali, Nepali, Pakistani, Punjabi, Sinhalese, Sri Lankan, and Tamil (Allard et al., 2005; Statistics Canada, 2022a). I intentionally kept this definition broad to capture a variety of backgrounds and perspectives.

We developed the survey questions using questionnaires from previous studies conducted by graduate students in the Foster research group (Brogan, 2019; Cazeau, 2020; LaRoche et al., 2018). The survey included the following domains of inquiry: demographic information, SRH history, contraception knowledge and experiences, self-reported knowledge of SRH, experiences with seeking and receiving SRH information, experiences with seeking and obtaining SRH services, and perspectives on how information and services could be improved for the South Asian community in Ontario. Demographic information included age, education, ethnicity, religious affiliation, gender identification, sexual orientation, birthplace of parents, year of parents' immigration, and postal code of current residence. At the end of the survey, the participants had the opportunity to submit their contact information if they were interested in taking part in a follow-up interview.

We employed a multi-modal recruitment strategy that included both in-person and online methods. In-person methods included posting flyers in clinics, pharmacies, and salons, with a focus on regions with high South Asian populations (a copy of the recruitment flyer is shown in Appendix A). Online methods included posting on social media sites and fora on sites such as Reddit. We also reached out to South Asian community organizations, student associations, and religious organizations to disseminate information about the survey on their social media and within their networks. Later in our recruitment process, we utilized Instagram advertisements by creating a sponsored post and boosting this to our target audience. Additionally, snowball sampling aided in us reaching our target demographic as numerous survey participants inquired about sharing the link within their own social networks.

The online survey was administered through Survey Monkey and was live for five months. During this time, we received a total of 303 participants and after cleaning the data to

align with our eligibility criteria, we had a final sample size of 247 participants. On the last page of the survey, participants were able to enter their name into a draw for an Amazon gift card (CAD50) as a token of appreciation for their time spent completing the survey. We awarded one gift card for approximately every 50 participants; with a final sample size of 247, we selected five participants for the draw.

Component 2: In-depth interviews

In order to gain a deeper understanding of the experiences of South Asian womxn, I conducted in-depth, semi-structured interviews. The semi-structured interview structure allows the interviewer to alter the questions and topics based on participants' responses. Additionally, this format facilitates a conversational style of interview that potentially made the participants feel more comfortable when discussing sensitive topics.

I conducted each interview using an interview guide that was made specifically for this study well before the first interview took place. I then tweaked the guide over the course of the first five interviews. The sections of the interview included demographic information, SRH history, experiences accessing and receiving SRH information and services, and recommendations for improving SRH information and services for young South Asian womxn in Ontario. I modelled the structure of the guide after other studies conducted by graduate students in my supervisor's research group (Brogan, 2019; Cazeau, 2020; Hukku et al., 2022; LaRoche et al., 2018).

Interviews with interested survey participants took place over the phone or online through Zoom (audio-only). In addition to the eligibility criteria for the survey, interview participants must have accessed, or attempted to access, some type of SRH service. The services that I

included in the initial interview guide were contraception, abortion, emergency contraception, and sexually transmitted infection (STI)/HIV testing or treatment. Interviews ranged in length from 21 minutes to 75 minutes, with an average length of 52 minutes.

With a survey sample size of 247, I was able to conduct 20 interviews. We suspected that we had reached thematic saturation after 18 interviews, at which point I conducted two more to confirm. With participants' consent, I audio-recorded all interviews and transcribed them verbatim in order to analyze for content and themes. In addition, I took notes during every interview and completed a formal memo immediately following the interview (Birks et al., 2008). The memoing process helped me to identify when I have reached thematic saturation. This is defined as the point at which additional interviews do not yield additional information or themes related to the primary research question (Ando et al., 2014). Each interview participant received an Amazon gift card (CAD40) as a token of appreciation and to compensate them for the time spent on the interview process.

Data analysis

Once we had reached our target sample size for the survey, we exported all data from eligible participants from Survey Monkey and transferred them to Microsoft Excel® for analysis. I analyzed the survey data using descriptive statistics such as frequencies and cross-tabulations. I analyzed open-ended survey questions for content and themes.

I managed all interview data using ATLAS.ti version 23.2.0. For the interview, data included the audio recordings of the interviews, transcripts, field notes, and memos. For the in-depth interviews, I employed an iterative six-phased process to analyze for content and themes. I began to review data as I collected them in order to identify initial codes and themes. Content

analysis involves making inferences while analyzing individual pieces of oral or written data (LaRoche & Foster, 2015). Thematic analysis involved interpretation of content within a set of data to identify patterns (LaRoche & Foster, 2015).

Before I began analyzing my data, I created a codebook of *a priori* codes in collaboration with my supervisor. I created this codebook using the interview guide and my memos. As I became more familiar with the data, I created emergent categories and codes based on the interview data. Initially I analyzed the open-ended survey answers and in-depth interviews separately. However, in the final stages of the analysis process I integrated the findings, paying close attention to concurrent and discordant findings.

Ethical considerations

This study received ethics approval from the Social Sciences and Humanities Research Ethics Board at the University of Ottawa. This is part of a larger multi-methods project documenting the availability and accessibility of SRH services in Ontario. I have included a copy of the REB certificate can be found in Appendix B. We detached all personal information listed on the last page of the survey from the rest of the survey responses. In presenting the results we removed or masked any identifiable information and used pseudonyms throughout the thesis and articles. These pseudonyms were assigned by the research team or chosen by participants at the time of the interview.

Chapter 3: Article #1

We prepared this manuscript for submission to *Culture, Health & Sexuality.* This article conforms to all formatting, word limit, and style requirements of this peer-reviewed journal.

‘It’s very much a taboo subject’: Exploring young second-generation South Asian Canadian womxn’s experience with sexual and reproductive health information in Ontario

Sarah Shahi, MSc(c)[1]
Oviya Sritharan[1]
Angel M. Foster, DPhil, MD, AM[1,2*]

1. Faculty of Health Sciences, University of Ottawa, Ottawa, ON, Canada
2. Institute of Population Health, University of Ottawa, ON, Canada

* Corresponding author

1 Stewart Street, 312-B Ottawa, ON K1N 6N5 Canada +1-613-562-5800 ext. 2316
angel.foster@uottawa.ca

Funding details: This research project was supported by a grant from an anonymous foundation. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

Disclosure statement: The authors declare that they have no conflicts of interest, financial or otherwise.

Data availability statement: De-identified survey data are available on request.

Word counts: Abstract: 195 Manuscript: 5,540

Abstract

We aimed to explore the experiences of young second-generation South Asian Canadian women and other pregnancy capable people (womxn) accessing sexual and reproductive health (SRH) information in Ontario. We administered an online survey to reach South Asian Canadian womxn who were age 18-30 (inclusive), had at least one parent born outside Canada, and were living in Ontario. We also conducted semi-structured, in-depth interviews with a subset of survey participants that had accessed, or attempted to access, SRH services. We used descriptive statistics to analyze survey data and analyzed our interviews for content and themes using both deductive and inductive techniques. We received 247 survey responses and conducted 20 in-depth interviews. The majority of our participants used the Internet as their main source of SRH information describing it as discrete and safe; many reported that they did not go to parents or family for this information. Some participants disliked SRH information that stemmed from religious beliefs. Participants valued information in the form of personal experiences and stories. Many participants felt that there needs to be improvements in SRH education, particularly within schools. Our findings highlight the need for comprehensive and culturally-tailored SRH education at all ages.

Key words: Canada, education, information, sexual and reproductive health, south Asia

Introduction

South Asians make up the largest visible minority group in Canada with a population of over 2.5 million people (Statistics Canada 2023). The province of Ontario is home to over 1.5 million South Asians, making it the region with the largest South Asian community in the country (Statistics Canada 2023). This group includes people with ethnic or ancestral origins in Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and the Maldives (Fig. 1). The first South Asian immigrants are reported to have arrived in Canada in the early 1900s. This small group of immigrants were mostly Punjabi Sikhs seeking economic and employment opportunities. After a change in Canadian immigration laws and quotas in 1958, South Asian immigration increased rapidly, a dynamic that continued well into the 1980s. Since the 1980s, the influx of South Asian immigrants has allowed the population to diversify (Buchignani 1985; Agrawal 2013). Today the South Asian community in Canada is made up of non-permanent residents, new immigrants, first- and second-generation Canadians, as well as multi-generation families belonging to over 20 ethnic, national, or religious groups (Statistics Canada 2022a; 2022b; 2022c).

Second-generation is defined as those born in Canada with at least one parent born elsewhere (Statistics Canada 2021). Young, second-generation Canadians are often in a position where the values of their ethnic group and parental upbringing differ from those of "dominant" Canadian culture. Canadian culture follows an individualistic mindset, where the needs and desires of an individual are prioritized. In contrast, the South Asian community generally maintains a strong collectivist cultural foundation, which often gives family and social networks significant importance. The actions of family members, specifically women, are often a reflection of the parents and reputation of the family unit (Chadda and Deb 2013; Zaidi, Couture-Carron, and Maticka-Tyndale 2016). South Asian children within diasporic populations are often

socialized in accordance with cultural and religious values. As such, South Asian women are expected to prioritize modesty and protect the family's honour (Zaidi, Couture-Carron, and Maticka-Tyndale 2016). However, the limited research with young, second-generation South Asian Canadian women suggests that they are mixing positive elements of both cultures, forming their identity as a Canadian and a South Asian woman (Sundar 2008).

Sexuality and intimate relations are often regarded as taboo within the South Asian community (Zaidi, Couture-Carron, and Maticka-Tyndale 2016). Abstaining from sexual relations prior to marriage is the expectation, especially for women, as virginity is tied to family honour. In some instances, deviating from these cultural expectations is thought to bring shame upon the family and tarnish the family's standing within the community (Zaidi, Couture-Carron, and Maticka-Tyndale 2016). In accordance with these norms and values, accessing sexual and reproductive health (SRH) information is often reserved for married women and within the context of fertility or reproduction (Kiridaran, Chawla, and Bailey 2022). While abstinence is the expectation, young, second-generation South Asian Canadians are not refraining from having intimate relationships or sexual interactions (Zaidi, Couture-Carron, and Maticka-Tyndale 2016). Studies have found that youth who experience uncertainty surrounding cultural identity are more likely to partake in risky sexual behaviour (Pottie et al. 2015). However, young people having adequate access to SRH information can lead to safer sexual practices (Rotermann and McKay 2024; World Health Organization 2018). It is important to note that structural and cultural barriers may impact access to comprehensive SRH information (Meherali et al. 2022; 2021).

This study evaluates young, second-generation South Asian Canadian womxn's[1] access to

[1] We use the term "womxn" as a way of including women/girls, transgender men, and gender non-binary folks with the capacity for pregnancy and recognizing that the binary construction of gender influences cultural norms around sexual and reproductive health.

and experiences with SRH information in Ontario as well as avenues for improving SRH information for the South Asian community. We completed this qualitative study to explore the lived experiences of young, second-generation South Asian Canadian womxn and daughters of immigrants.

Materials and methods

Our multi-method qualitative study involved two components: an anonymous online survey and semi-structured, in-depth interviews with a subset of survey participants. In order to be eligible for the study, participants had to identify as a woman, transgender man, or gender non-binary individual with the capacity for pregnancy and have access to an Internet enabled device. Additionally, participants had to self-identify as a member of the South Asian community in Ontario and as a second-generation Canadian, be between the ages of 18 and 30 (inclusive), and be sufficiently fluent in English to complete the survey. In addition, interview participants must have accessed, or attempted to access, SRH services in Ontario. We used a multi-modal recruitment strategy that involved social media posts, online advertisements, and posting flyers in clinics and pharmacies. The Office of Research Ethics and Integrity at the University of Ottawa approved this study.

Online survey

Our online survey included close-ended and open-ended free text questions and took our participants an average of 15 minutes to complete. SS, an MSc student in Interdisciplinary Health Sciences, and AMF, a medical doctor and medical anthropologist, created the questions using previous questionnaires conducted by AMF's research group at the University of Ottawa (LaRoche et al. 2018). Before the launch of the survey, we pilot tested the online tool with a small group of students at the University of Ottawa. The survey contained a total of 64 questions and asked participants to share demographic information including ethnic background and the immigration history of parents, sexual and reproductive health history, and contraception knowledge and experiences. Participants were then asked to share their experiences seeking and

receiving sexual and reproductive health information and services in Ontario and offer their perspective on how information and services could be improved for the South Asian community in Ontario. We focused the survey on contraception, abortion, and sexually transmitted infections (STIs). On the final page of the survey, participants were able to enter their name into a draw for a CAD50 gift card and indicate their interest in participating in in-depth interview; we detached any identifiable information from survey data.

In-depth interviews

In the second phase of the study, we contacted interested survey participants by email to participate in a telephone/audio Zoom interview. At the start of each interview, we obtained oral consent from participants and with their permission we audio-recorded all interviews. SS conducted all interviews which lasted an average of 50 minutes. SS received training on conducting and analyzing in-depth interviews from AMF. SS and AMF collaborated on the interview guide for this study that included open-ended questions about the participant's background, reproductive health history, and experiences seeking sexual and reproductive health information and services. We investigated the sources that each participant was most likely to go to for sexual or reproductive health information and the factors that influence their choice. We concluded the interview by asking each participant how sexual and reproductive information and service delivery can be improved for South Asian womxn in Ontario. We took detailed notes during the interview and completed a formal memo afterward (Birks, Chapman, and Francis 2008). All interview participants received a CAD40 gift card to reimburse them for their time and thank them for their participation. We transcribed all interviews verbatim in order to complete the analysis process.

Data analysis

We exported our survey data to Microsoft Excel® and completed descriptive statistical analyses. We analyzed the open-text questions for content and themes using both inductive and deductive methods. OS, an undergraduate student researcher, assisted with analyzing the survey data. We began analyzing interview data during the collection phase to identify initial themes and connections. SS and created an initial codebook, using the research questions, interview guide, and early themes identified through memoing to develop and define a priori codes. As we familiarized ourselves with the data, we developed emergent codes and categories. We used ATLAS.ti to organize and manage all interview data, including field notes, memos, and transcripts. Our first phase of analysis focused on creating categories of information and deriving connections between ideas. In the last phase of our analysis, we integrated the findings from both study components, looking closely at discordant findings. This article shares the primary themes related to SRH information access. We removed/masked any personal identifying information and use pseudonyms throughout.

Results

Participants characteristics

The survey was active for five months and we received a total of 247 eligible responses. The average age of our participants was 23.9 years and majority identified as women (97%). Our participants reported a diverse set of ethnic origins with Indian (30%), Punjabi (27%), and Tamil (21%) being the most common. Many of our participants (62%) considered some kind of organized religion or spirituality to be important in their life. Table 1 provides more

demographic information about our participants. At the time of the survey, 65% of our participants had at least one sexual partner in their life. 65% used a form of contraception in their life. Table 2 provides more details about the SRH experiences of our participants.

We conducted 20 interviews with South Asian Canadian womxn who had accessed or attempted to access contraception, emergency contraception, and STI/HIV testing in Ontario. Our participants' ages ranged from 18 to 30 years old with an average age of 24.8 at the time of the interview and the majority lived in Eastern and Central Ontario. Our participants belonged to a variety of ethnic groups with Punjabi, Tamil, and Sri Lankan being the most common. A majority of our participants had completed or were in the process of completing post-secondary education (n = 19) and one participant was completing her high school education, with a plan to continue to post-secondary school.

South Asian womxn access SRH information from discrete, reliable, and safe sources

> *I think [the Internet, clinic websites, and friends] are just safe options. Those are all just options that are guaranteed without judgement and I think that's huge for something like sexual health or anything really like personal to you, in that way.* (Naomi, 27, Punjabi)

Our participants discussed a range of sources for SRH information, with many being most comfortable with online resources. Of our survey respondents that accessed contraception information, many (69%, 135 of 196 responses) reported that they either always or usually used the Internet to access this information. Similarly, a number of our interview participants shared that they often consulted online resources for information on a range of SRH topics including contraception, menstruation and menstrual concerns, and STIs. This set of participants felt that online resources were reliable and discrete methods of accessing the information they needed. As Nithya, a 26-year-old Malayali graduate student, explained:

> It's anonymous and accessible…It's like you turn on incognito mode and type in any question, and I think by now the internet's kind of organized itself where there are a lot of reliable resources online to look at…So it's just easier to get detailed information.

When asked if there are specific online sources that our interview participants visit, participants shared utilizing general Google searches, scientific journal articles, and social media pages, each for different reasons. The majority of our participants carried out Google searches to find information quickly or about general SRH concerns. Participants that used scientific or scholarly resources often did so to learn about more complex SRH issues. Participants used social media pages, specifically on Instagram, to access tailored information for South Asian women or for specific conditions. As Prabhleen, a 26-year-old Punjabi Sikh graduate student, shared, 'There [are] a couple of Instagram pages that are South Asian specific pages that I'll follow that talk about menstruation and your different cycles and things like that, that I'll follow a little bit more just because I know it's catered to South Asian women.'

While participants often accessed information from online sources, many felt less comfortable discussing SRH information and topics with parents or other family members. The overwhelming majority of our survey participants that sought out contraception information reported rarely or never going to parents (86%, 169 of 196 responses) or other family members (80%, 156 of 196 responses) for this information. Meena, a 28-year-old Hindu Punjabi healthcare professional, shared, 'you're kidding! An Indian [parent] having the birds and the bees talk, that's hilarious!' Many of our interview participants shared a similar sentiment while also describing feelings of discomfort while talking to parents about SRH topics. As Vaishnavi, a 23-year-old Tamil working professional, described:

> I think sexual and reproductive health is super stigmatized. I think that it, at least in my experience, is seen as very much related to having children…So I think the fact that I'm

> not married…I just wouldn't feel comfortable having those conversations. But I also don't know how much information I would actually get from my family about it.

In addition to feeling uncomfortable with parents or family, some participants shared that they felt their parents were not knowledgeable in this area and therefore would not provide accurate or reliable information. As Allysa, a 24-year-old Guyanese working professional shared:

> I think again it comes down to the misinformation around the topic, so I don't think I'd be getting entirely accurate information. And on top of that…as a teenager or someone in my early 20s I feel like I would have honestly gotten in trouble or reprimanded for [accessing SRH information] with my mother or some of my relatives.

Consistent with the sentiments expressed by Allysa, both survey and interview participants feared the cultural/familial consequences of seeking SRH information. Among the survey participants who experienced barriers to obtaining SRH information, 59% (60 of 102 responses) reported a personal fear of their parents or other family discovering their use of such information. As such, many participants sought out information from sources that minimized the risk of family finding out and safe from possible consequences. As Rani, a 30-year-old Bengali PhD student, explained, '[Searching the Internet is] discreet, and it avoids any sorts of repercussions on a cultural basis. I feel like being sexually active in South Asian communities isn't something that's encouraged…there is a bit of stigma in the community.'

South Asian womxn are less likely to access information that has a religious influence

Not looking to seek out information oriented around religious beliefs (Survey participant)

Of the survey participants that reported accessing SRH information, 56% (105 of 189 responses) shared that religious beliefs influence who they <u>avoid</u> going to for SRH information.

A number of our interview participants shared similar feelings as they preferred SRH information not rooted in religion. These interview participants felt that any information they received from parents or family was often influenced by religious beliefs. As Nithya explained:

> My mom did talk to me about periods and you know, this is the male anatomy and the female anatomy…But nothing about contraception or details around STIs or anything like that…it was very, obviously [religiously influenced] because it was very 'you can't have sex until you get married, it's a sin.'

Some interview participants felt that combining SRH information with religion increased the stigma associated with this topic. As Simran, a 27-year-old Punjabi working professional, explained, 'The thing is that like why is sexual health something that is stigmatized like it came from somewhere right? And what it usually comes from is religion because most major religions in the world do say that you shouldn't you don't have sexual relations until you're married.'

Additionally, participants felt that when providing SRH information based on religion women do not receive true and complete information, specifically related to contraception and abortion. Nithya shared:

> South Asian culture is very conservative when it comes to reproductive health [and] things like that. But then also, I did go to a Catholic school. So, when it came to [sexual education], it was almost like a double whammy in terms of like the misinformation, and the lack of information, and the stigmatization around women's reproductive health and things like abortions and contraceptives.

South Asian womxn value information in the form of personal experiences and stories

> *I think that was really helpful…just talking to other women, especially women of colour, it was very validating.* (Hanna, 27, Pakistani)

Many of our interview participants discussed fondness for receiving SRH information in the form of personal experiences. Participants received information through stories and personal experiences from colleagues, friends (both South Asian and non-South Asian), trusted siblings,

and social media accounts. Participants felt that acquiring knowledge from peers was valuable as they were able to learn about SRH topics and treatments that they had not previously explored. As Sinthuja, a 24-year-old Tamil graduate student, explained, '[Friends] tell you [about] their experience regarding a variety of different things, contraception, different sexual events, and stuff like that. So, I feel like you can compare and contrast and kind of get a gist of whatever you need from that.'

Among survey participants that accessed SRH information, 96% (187 of 195 responses) reported comfort level influencing who they go to for SRH information. Many interview participants found speaking with peers and learning from stories to be a comfortable and non-judgemental way of receiving information. Prabhleen spoke of her experience receiving information from her friends, 'They potentially dealt with certain situations or similar situations. So, I can just vent to them and they'll hear me out they will offer advice. We can have a casual conversation and it's not uncomfortable.' In some cases, the information and advice that participants received from personal stories informed their SRH actions. As Tareen shared, 'I do have a friend she was on [Depo] Provera. So I was asking her questions about that and then I eventually did also go on Provera.'

Additionally, a number of participants shared that they not only enjoy learning from personal experiences, but also enjoy sharing their own experiences with South Asian women around them. Indeed, one of our interviewees had created an Instagram page to share her experiences with polycystic ovarian syndrome and nutrition. Participants felt that sharing information within the community helps foster more acceptance and openness of SRH topics. Manpreet, a 25-year-old Indian Sikh working professional, shared her perspective on information through personal experiences:

> I do like participating in conversations about this subject and naturally learning what others are up to. I love when I'm asked about my experiences and I'm able to share and be useful… it just makes me feel even more like South Asian people having sex is normal and okay.

South Asian womxn expressed a need for more and improved SRH education

> *We start off as South Asian girls going to public schools and Catholic schools…We need a better education system and I know there's been a recent education reform…I hope that it's serving our youth better than it served us when we were in school.* (Meena, 28, Hindu Punjabi)

Our interview participants highlighted numerous avenues to improve SRH information for South Asian womxn, for many this included an overall increase and improvement in SRH education. Many participants felt that the sexual education they received in elementary and secondary school was insufficient. As Tareen, an 18-year-old Bengali high school student, shared, 'I honestly [have never] had a good [sexual education] class or a good anatomy class. And then they don't even talk about the things like contraceptives which are extremely important.' Sinthuja, 24 and Tamil, echoed this sentiment, 'I honestly think like we just need more access to this information when we are younger. And I don't think health class is enough and I don't think health class is teaching us what we need to be taught.' Based on their experiences, some participants felt improving sexual education within the formal education system is vital. Sinthuja provided her perspective on what types of changes may be beneficial:

> I wish [sexual education in schools] got less technical and scientific, and more social and cultural…I feel like we need a more comforting experience when it comes to talking about these things, especially BIPOC [Black, Indigenous, and other people of colour] women. Because we don't talk about these things at all; it's very much a taboo subject.

Hanna, a 23-year-old Pakistani working professional, highlighted that while improving education in schools is vital, parents not consenting to their child receiving SRH education continues to be a barrier. Hanna shared, 'My parents, for example, they got more strict…my

brother was just taken out of all like [sexual education] classes for his grade school experience…I guess you can't really control when parents pull their kids out of stuff like that.'

In addition to improving SRH education in schools, many participants felt that it is important to create culturally-tailored SRH information for South Asian womxn. Some participants recommended online anonymous resources that are dedicated to South Asian womxn and the SRH health concerns of the community. As Simran shared, 'Having some sort of website kind of discrete where you could tell people, especially South Asian woman, where [SRH] clinics are that would be really helpful.'

For many, culturally-tailored information included representation in informational resources. Participants felt that having people who look like them on informational sources may make them feel more validated. As Manpreet explained, 'If we could just see more content, see more people that we respect, that look like us, having these conversations or normalizing [SRH topics], I think that could make the interactions way better.'

Discussion

Young second-generation South Asian Canadian womxn have specific needs and concerns when accessing adequate SRH information. It is important to understand the cultural and structural factors that impact access to and use of SRH information for this community. Many second-generation South Asian womxn attempt to balance two different sets of cultural values and expectations while also prioritizing their personal health. Our findings reiterate the idea that demographic factors such as cultural background, religious affiliation, and generation status impact one's access to adequate and quality SRH information and education (Meherali et al. 2021; 2022; Griffiths, Prost, and Hart 2008).

In today's digital world, health information is at our fingertips through Google searches, social media, texting with trusted friends, or telehealth platforms. Many of our participants used technology in some capacity to access SRH information, a route that is becoming more common for young people in Canada (Black, Rouhani, and Cook 2018; Meherali et al. 2022; Rotermann and McKay 2024). This trend may be attributed to the judgement-free and discrete nature of accessing information online. It is also important to note that the accuracy of online resources varies, which may impact the quality of information that young people are receiving. This highlights a need to prioritize the delivery of accurate and comprehensive SRH information online to young Canadians, including the second-generation South Asian womxn community. With Internet usage becoming more common for youth, using these spaces as tools for delivering SRH information is vital as is ensuring that the resources are culturally tailored and reflective of the racial and ethnic diversity in Canada.

Within South Asian cultures storytelling is a key method of passing on information, including health information, within and between generations. Story-based education may allow listeners to make sense of their own lives and experiences through affective engagement (Greenhalgh, Collard, and Begum 2005; Palacios et al. 2015; Wong et al. 2019). Our interview participants shared a liking for receiving SRH information in the form of personal experiences and stories. Sharing of stories and personal experiences does not have to be limited to conversations but could also include Internet or social media platforms. This highlights an opportunity to combine high Internet usage with story-based education to provide a culturally relevant platform for South Asian womxn to share accurate recounts of their experiences with SRH for fellow South Asian womxn and young Canadians to learn from and reflect on.

Many of our participants felt that there needed to be improvements in SRH education,

particularly within the school setting. The lack of adequate SRH education in schools was reported by other South Asian Canadians and South Asians in other diaspora communities (Meherali et al. 2021; Griffiths, Prost, and Hart 2008). In recent years, the Ontario sexual health curriculum was a topic of contention for many people, including parents of school aged children. In 2015, the Ontario government introduced a new health and physical education curriculum, the first significant update to the curriculum since 1998. This change was met with protest from parents and religious groups. The current curriculum, created by the Ontario government in 2019, is a near identical curriculum with an option for parents to remove their children from classes relating to sexual health (Saarreharju, Uusiautti, and Määttä 2019). While many of our older participants did not experience this new curriculum, the majority of our participants that spoke of SRH education in schools felt that the education they did receive was inadequate. Young Ontarians, including the second-generation South Asian womxn population, may benefit from a more comprehensive sexual education curriculum that goes beyond scientific facts and is culturally relevant.

The overwhelming majority of our participants did not use their parents as a source of SRH information. Our findings reinforce the claim that parents and parents' cultural or religious values and expectations can act as a barrier to adequate SRH information (Meherali et al. 2021; 2022). Similar to our participants, the 2019 Canadian Health Survey on Children and Youth found that more South Asian Canadian youth reported not having an adult to go to for SRH information compared to white Canadians (Rotermann and McKay 2024). This trend may be a result of the cultural stigma surrounding SRH that exists within many South Asian cultures and religions (Kiridaran, Chawla, and Bailey 2022; Meherali et al. 2021; 2022). This highlights an opportunity to educate parents on the importance of SRH information and education within the

school setting. Additionally, it is important to center conversations with and resources for young second-generation South Asian Canadian womxn on cultural acceptance and understanding instead of reinforcing the cultural stigma.

In our study, we defined second-generation using the definition employed by Statistics Canada. In doing so, we did not capture the experiences of South Asian Canadians that immigrated to Canada at a young age and grew up with both sets of cultural values. Future studies may benefit from expanding the inclusion criteria to capture the experiences of this group. Although we are confident that our findings are transferrable, we caution against using the findings to depict larger trends.

As the South Asian community continues to grow, it is important to understand the health needs and concerns of this population as well as the cultural nuances that exist. Our findings highlight the impact of culture, age, and generation status on one's access to quality and adequate health information as well as the intricacies that stem from being a daughter of immigrants.

References

Agrawal, Sandeep K. 2013. “Economic Disparities among South Asian Immigrants in Canada.” *South Asian Diaspora* 5 (1): 7–34. https://doi.org/10.1080/19438192.2013.720514.

Birks, Melanie, Ysanne Chapman, and Karen Francis. 2008. “Memoing in Qualitative Research: Probing Data and Processes.” *Journal of Research in Nursing* 13 (1): 68–75. https://doi.org/10.1177/1744987107081254.

Black, Amanda, Setareh Rouhani, and Jocelynn Cook. 2018. “Ten-Year Trends in Sources of Sexual Health Information in Canada: Has the Internet Replaced Health Care Providers?” *Journal of Obstetrics and Gynaecology Canada* 40 (6): 828. https://doi.org/10.1016/j.jogc.2018.03.031.

Buchignani, Norman. 1985. *Continuous Journey : A Social History of South Asians in Canada*. A History of Canada’s Peoples. Toronto: Published by McClelland and Stewart in association with the Multiculturalism Directorate, Dept. of the Secretary of State, and the Canadian Government Publishing Centre, Supply and Services Canada.

Chadda, Rakesh K., and Koushik Sinha Deb. 2013. “Indian Family Systems, Collectivistic Society and Psychotherapy.” *Indian Journal of Psychiatry* 55 (Suppl 2): S299-309. https://doi.org/10.4103/0019-5545.105555.

Greenhalgh, T, A Collard, and N Begum. 2005. “Narrative Based Medicine.” *Practical Diabetes International* 22 (4): 125–29. https://doi.org/10.1002/pdi.781.

Griffiths, Catherine, Audrey Prost, and Graham Hart. 2008. “Sexual and Reproductive Health of South Asians in the UK: An Overview.” *Journal of Family Planning and Reproductive Health Care* 34 (4): 251–60. https://doi.org/10.1783/147118908786000352.

Kiridaran, Vaishali, Mehar Chawla, and Julia V. Bailey. 2022. “Views, Attitudes and Experiences of South Asian Women Concerning Sexual Health Services in the UK: A Qualitative Study.” *The European Journal of Contraception & Reproductive Health Care* 27 (5): 418–23. https://doi.org/10.1080/13625187.2022.2096216.

LaRoche, Kathryn J., Eva Gross, Grace Sheehy, and Angel M. Foster. 2018. “Put a Ring in It: Exploring Women’s Experiences with the Contraceptive Vaginal Ring in Ontario.” *Women’s Health Issues* 28 (5): 415–20. https://doi.org/10.1016/j.whi.2018.04.009.

Meherali, Salima, Samantha Louie-Poon, Sobia Idrees, Samar Kauser, Shannon Scott, Bukola Salami, Helen Valliantos, et al. 2022. “Understanding the Sexual and Reproductive Health Needs of Immigrant Adolescents in Canada: A Qualitative Study.” *Frontiers in Reproductive Health* 4 (July): 940979. https://doi.org/10.3389/frph.2022.940979.

Meherali, Salima, Bukola Salami, Philomina Okeke-Ihejirika, Helen Vallianatos, and Gillian Stevens. 2021. “Barriers to and Facilitators of South Asian Immigrant Adolescents’ Access to Sexual and Reproductive Health Services in Canada: A Qualitative Study.” *The Canadian Journal of Human Sexuality* 30 (3): 329–38. https://doi.org/10.3138/cjhs.2020-0056.

Palacios, Janelle F., Benissa Salem, Felicia Schanche Hodge, Cyndi R. Albarrán, Ann Anaebere, and Teodocia Maria Hayes-Bautista. 2015. “Storytelling: A Qualitative Tool to Promote Health Among Vulnerable Populations.” *Journal of Transcultural Nursing* 26 (4): 346–53. https://doi.org/10.1177/1043659614524253.

Pottie, Kevin, Govinda Dahal, Louise Hanvey, and Meghan Marcotte. 2015. “Health Profile on Immigrant and Refugee Children and Youth in Canada.” The Health of Canada’s Children and Youth: A CICH Profile. https://cichprofile.ca/wp-

content/uploads/2017/10/Complete_Immigrant_and_Refugee_Health_Profile_Module_Eng.pdf.

Rotermann, Michelle, and Alexander McKay. 2024. “Where Do 15- to -17-Year-Olds in Canada Get Their Sexual Health Information?” *Health Reports* 35 (82).

Saarreharju, Maiju, Satu Uusiautti, and Kaarina Määttä. 2019. “‘It Goes beyond the Fundamentals of Sex and Education.’ Analysis on the Online Commenting on the Curriculum Reform in Ontario.” *International Journal of Adolescence and Youth* 25 (1): 609–23. https://doi.org/10.1080/02673843.2019.1699839.

Statistics Canada. 2021. “Classification of Generation Status.” https://www23.statcan.gc.ca/imdb/p3VD.pl?Function=getVD&TVD=117200&CVD=117200&CLV=0&MLV=1&D=1.

———. 2022a. “Ethnic or Cultural Origin by Gender and Age: Canada, Provinces and Territories.” [object Object]. https://doi.org/10.25318/9810035501-ENG.

———. 2022b. “Religion by Visible Minority and Generation Status: Canada, Provinces and Territories, Census Metropolitan Areas and Census Agglomerations with Parts.” [object Object]. https://doi.org/10.25318/9810034201-ENG.

———. 2022c. “Visible Minority and Population Group by Generation Status: Canada, Provinces and Territories, Census Metropolitan Areas and Census Agglomerations with Parts.” [object Object]. https://doi.org/10.25318/9810032401-ENG.

———. 2023. “Visible Minority by Gender and Age: Canada, Provinces and Territories.” [object Object]. https://doi.org/10.25318/9810035101-ENG.

Sundar, Purnima. 2008. “To ‘Brown It Up’ or to ‘Bring Down the Brown’: Identity and Strategy in Second-Generation, South Asian-Canadian Youth.” *Journal of Ethnic And Cultural Diversity in Social Work* 17 (3): 251–78. https://doi.org/10.1080/15313200802258166.

Wong, Josephine Pui-Hing, Roula Kteily-Hawa, Lori A Chambers, Shriya Hari, Chikermane Vijaya, Ragulan Suruthi, Shazia Islam, and Mandana Vahabi. 2019. “Exploring the Use of Fact-Based and Story-Based Learning Materials for HIV/STI Prevention and Sexual Health Promotion with South Asian Women in Toronto, Canada.” *Health Education Research* 34 (1): 27–37. https://doi.org/10.1093/her/cyy042.

World Health Organization. 2018. *WHO Recommendations on Adolescent Sexual and Reproductive Health and Rights*. Geneva: World Health Organization. https://iris.who.int/handle/10665/275374.

Zaidi, Arshia U., Amanda Couture-Carron, and Eleanor Maticka-Tyndale. 2016. “‘Should I or Should I Not’?: An Exploration of South Asian Youth’s *Resistance* to Cultural Deviancy.” *International Journal of Adolescence and Youth* 21 (2): 232–51. https://doi.org/10.1080/02673843.2013.836978.

Characteristic	***Online survey participants n (%)***
Age (years)	
18-22	89 (36.0)
23-26	102 (41.3)
27-30	56 (22.7)
Gender identity	
Woman	239 (96.8)
Gender non-binary/gender expansive	6 (2.4)
Prefer not to disclose	2 (0.8)
Education	
Some high school/high school diploma	39 (15.8)
Some college/university	27 (10.9)
Bachelor's degree/college diploma	109 (44.1)
Some graduate school/professional program	18 (7.3)
Graduate/professional degree	49 (19.8)
No response	5 (2.0)
Religious/spiritual beliefs*	
Agnostic	35 (14.2)
Atheist	12 (4.9)
Buddhism	12 (4.9)
Christianity	26 (10.5)
Hinduism	71 (28.7)
Islam	61 (24.7)
Sikhi	51 (20.6)
None	13 (5.3)
Other	3 (3.6)
No response	9 (1.2)
Living arrangements	
Living alone	25 (10.1)
Living with a romantic partner	25 (10.1)
Living with other family	3 (1.2)
Living with parents/in-laws	154 (62.3)
Living with roommates	32 (13.0)
Other	3 (1.2)
No response	5 (2.0)

Table 1: Demographic characteristics of second-generation South Asian Canadian online survey participants (*N*=247)
*Participants were able to select multiple options

Experience	*Online survey participants n (%)*
Relationship status	
Single	93 (37.7)
Casually dating one person	14 (5.7)
Casually dating more than one person	7 (2.8)
In a committed monogamous relationship	118 (47.8)
In more than one committed relationship	1 (0.4)
Other	3 (1.6)
No response	10 (4.0)
Sexual partners in lifetime	
0 – never had a sexual partner	70 (28.3)
1	67 (27.1)
2	25 (10.1)
3	15 (6.1)
4	14 (5.7)
5	9 (3.6)
6	10 (4.1)
7	4 (1.6)
8	2 (0.8)
More than 10	15 (6.1)
No response	16 (6.5)
Use of a contraception method	
Yes	161 (65.2)
No	63 (25.5)
Unsure	3 (1.2)
No response	20 (8.1)
Number of pregnancies	
0	222 (89.9)
1	9 (3.6)
2	3 (1.2)
3	3 (1.2)
No response	10 (4.0)

Table 2: Sexual and reproductive health experiences of second-generation South Asian Canadian online survey participants (*N*=247)

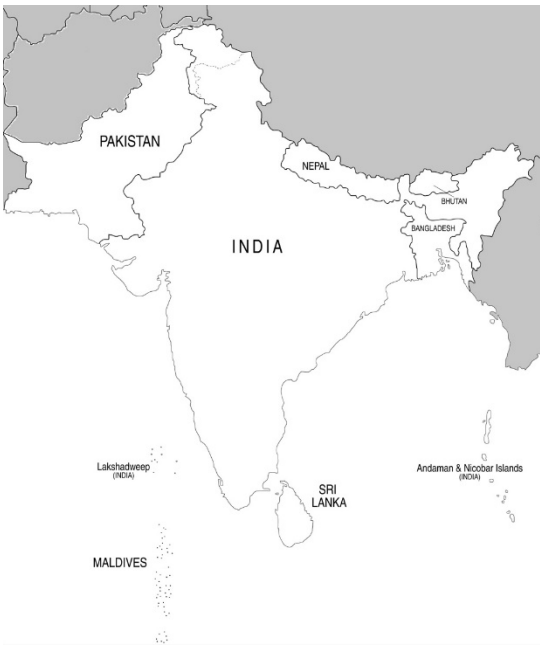

Figure 1: Map of South Asia

Chapter 4: Article #2

We prepared this manuscript for submission to *Contraception*. This article conforms to all formatting, word limit, and style requirements of this peer-reviewed journal.

"You're always kind of worried about judgement": A qualitative study of second-generation South Asian Canadian womxn's experiences with sexual and reproductive health services in Ontario

Sarah Shahi, MSc(c)[1]

Oviya Sritharan[1]

Ayesha Qadri[1]

Angel M. Foster, DPhil, MD, AM[1*]

3. Faculty of Health Sciences, University of Ottawa, Ottawa, ON, Canada

* Corresponding author

1 Stewart Street, 312-B Ottawa, ON K1N 6N5 Canada +1-613-562-5800 ext. 2316

angel.foster@uottawa.ca

Word counts: Abstract: 231; Manuscript (abstract, figures, references): 3720

Introduction (472), methods (571), results (1991), discussion (686)

"You're always kind of worried about judgement": A qualitative study of second-generation South Asian Canadian womxn's experiences with sexual and reproductive health services in Ontario

Abstract

Objectives: We aimed to explore the sexual and reproductive health care experiences of second-generation South Asian Canadian women and other pregnancy capable people (womxn) living in Ontario and investigate avenues for improving these services for the South Asian community.

Study design: We conducted semi-structured, in-depth interviews with South Asian Canadian womxn who were age 18-30 (inclusive), had at least one parent born outside Canada, were living in Ontario, and had accessed, or attempted to access, sexual and reproductive health services. We audio-recorded and transcribed the telephone/Zoom interviews and managed data with ATLAS.ti. We analyzed the interviews for content and themes using both inductive and deductive techniques.

Results: Many of our 20 participants reported that their South Asian identity impacted their sexual and reproductive health seeking behaviours and experiences with care. Although most participants were able to access the care they wanted and needed, several noted that stigma surrounding sexual and reproductive health in their communities shaped their experiences. Participants prioritized privacy and anonymity in their interactions with the health system and few of our participants were able to advocate for themselves. Our participants expressed the need for culturally informed information and services for Canada's South Asian community.

Conclusion: Our participants navigated structural and cultural barriers to access the sexual and reproductive health care they needed. Our findings highlight the importance of understanding the cultural nuances that impact one's ability to access health services.

Implications: All Canadians, regardless of age, ethnicity, or generation status need equal and adequate access to sexual and reproductive health information and services. As the South Asian Canadian community continues to grow, exploring and addressing health inequities that may exist is vital.

Keywords: Canada, Contraception, Ontario, Second-generation, Sexual and Reproductive Health, South Asian

1. Introduction

The South Asian diaspora is the largest in the world, an outcome of colonialism and modern migration patterns [1]. This diaspora population includes people with ethnic or ancestral origins in Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and the Maldives (Fig. 1) [2]. Canada saw its first South Asian immigrants in the early 1900s, with immigration increasing rapidly after the 1950s [3,4]. Today, there are over 2.5 million South Asian people living in Canada making them the largest visible minority group in the country. Within Canada, the largest South Asian community resides in Ontario, with a population of over 1.5 million and is an ethnically, linguistically, and religiously diverse group [5–8]. The current South Asian Canadian population includes non-permanent residents, new immigrants, first- and second-generation Canadians, as well as multigenerational families [6].

Second-generation Canadians are often referred to as the children of immigrants [9]. The official definition of second-generation is someone born in Canada with at least one parent born elsewhere [9]. Young, second-generation Canadians may find themselves balancing the values of their ethnic group or family unit with the values of "dominant" Canadian culture. Traditionally, South Asian communities view sexual and reproductive health (SRH), including sexuality, as taboo and these issues are often heavily stigmatized. South Asian daughters are often raised with abstinence being an expectation, as one's virginity reflects their upbringing and family [10]. This viewpoint stems from both longstanding cultural values and religious influences. In accordance with these norms, accessing SRH care and services is deemed suitable only for married women [11]. However, current research has found that South Asian Canadian youth are not abstaining from sexual activities or intimate relations [10]. Young, second-generation South Asian women

often find themselves navigating between the values of their ethnic group and Canadian cultural norms, which may have implications for how this group accesses SRH information and services.

South Asian Canadians encounter a number of barriers when accessing SRH services, including structural and sociocultural barriers. Some South Asian Canadians are unaware of where to access SRH services or the cost to access care and services is high [12]. Additionally, fears surrounding confidentiality and privacy within the clinic setting are common for South Asians [11–13]. The cultural stigma around SRH that exists within the South Asian community acts as a major barrier to access [11–13]. However, it remains unknown if being born in Canada and being accultured with both sets of values has an impact on access to or use of SRH services.

To date, no studies have documented the lived experiences of young, second-generation South Asian Canadian womxn[2] accessing SRH care and services. We completed this qualitative study to explore the complex dynamics that exist between generations and unique experiences that stem from being a child of immigrants, while investigating how SRH service delivery may be improved for the South Asian community.

[2] We recognize the social construction of gender and the exclusionary nature of traditional language. We use the term womxn to include all those that are pregnancy capable.

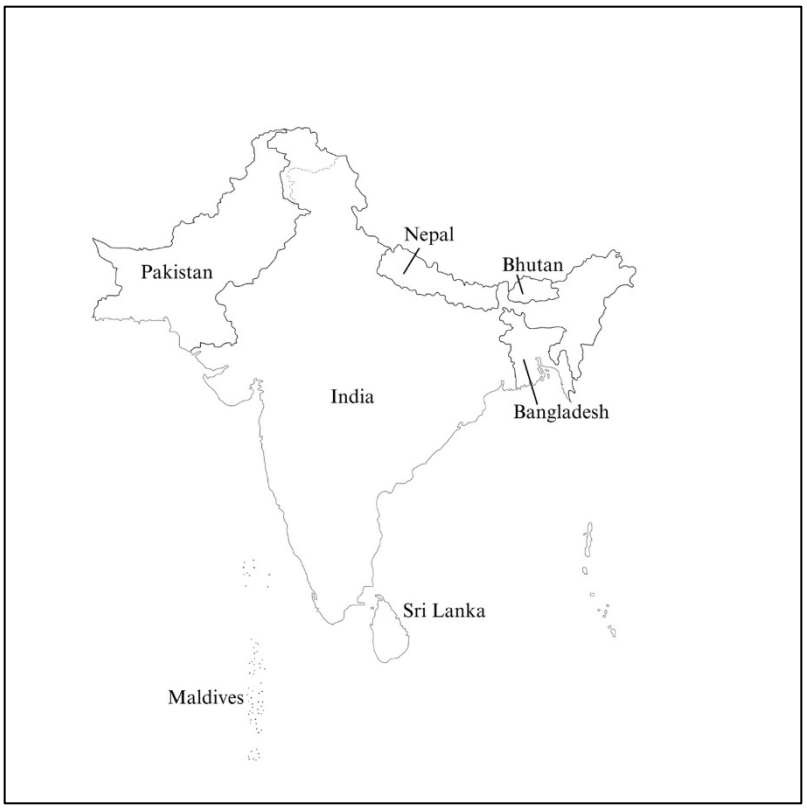

Fig 1: Map of South Asia

2. Methods

Between March and July 2023, we conducted semi-structured, in-depth interviews with 20 South Asian Canadian womxn who accessed, or attempted to access, SRH services in Ontario. In order to be eligible for the study, participants had to identify as a woman, transgender man, or gender non-binary individual with the capacity for pregnancy. Additionally, participants had to self-identify as a member of the South Asian community in Ontario, be born in Canada with at least one parent born elsewhere (second-generation), be between the ages of 18-30 inclusively, have accessed or attempted to access SRH services in Ontario, be sufficiently fluent in English to answer interview questions, and have access to a telephone and/or Zoom. We provided all participants a CAD40 gift card to thank and compensate them for their time. This study is part of a multi-method qualitative study that also included an anonymous online survey.

2.1 Recruitment

We used a multi-modal recruitment strategy for this study. This included social media posts, online advertisements on Instagram, and posting flyers in clinics and pharmacies. We contacted any survey respondents that shared interest in participating in an interview through email. The study coordinator (SS) responded to questions, ensured eligibility, shared informed consent documents, and scheduled an interview at a mutually convenient time.

2.2 Data collection

SS, an MSc student in interdisciplinary health sciences at the University of Ottawa, conducted all the interviews as a part of her thesis project. All the interviews took place over the telephone or audio-Zoom and averaged 50 minutes. SS took extensive notes throughout the interviews and completed a formal memo shortly after, a practice that allowed for reflections and early identification of key themes [14]. AMF, a medical doctor, and medical anthropologist provided guidance and feedback throughout the data collection process.

We conducted each interview following a semi-structured interview guide. We began by asking open-ended questions about participants' demographics, background, family immigration history, and general SRH histories. This included contraception, emergency contraception, and STI/HIV histories. We then asked questions focused on participants' experiences accessing SRH information and services. This included details about the process of obtaining care, interactions with health care providers, feelings receiving care from a provider of the same or different ethnic background, and overall reflections on the process. We concluded the interview by asking

participants to share their opinions on how SRH information and services could be improved for South Asian womxn in Ontario.

2.3 Data analysis

SS and several undergraduate research assistants (including OS and AQ) transcribed the interviews. We had team meetings during the analysis phase to debrief and discuss content, ideas, and themes. These meetings helped us to determine when we had reached thematic saturation. We believed we had reached thematic saturation after 18 interviews, at which point we conducted two more as confirmation. Drawing on interview transcripts, notes, and memos, we conducted content and thematic analyses using *a priori* (predetermined) codes and categories based on the research questions and interview guide as well as inductive analysis techniques to identify emergent ideas. SS created an initial codebook, in collaboration with AMF, and was the primary coder for this study. We used ATLAS.ti version 23.4.0 to manage our data. We resolved rare disagreements through discussion.

2.4 Ethical considerations

The Office of Research Ethics and Integrity at the University of Ottawa approved this study. In the results section we present our key themes and use narrative vignettes and illustrative quotes to support the findings. We removed/masked all identifying information and used pseudonyms that were either chosen by the participant or assigned by a member of the study team.

3. Results

3.1 Participant characteristics

Our participants ranged in age from 18 to 30 at the time of the interview, with an average age of 24.8 years. Nineteen of our participants identified as women and one participant identified as gender-fluid. When asked to self-identify within the South Asian group, participants reported a variety of ethnic, national, and religious backgrounds. A plurality of our participants identified as Punjabi (n = 7); participants also identified as Sikh (n = 4), Tamil (n = 4), and Sri Lankan (n = 3). All our participants resided in Central or Eastern Ontario at the time of the interview. The majority of our participants had completed or were in the process of completing post-secondary education (n = 19) and one participant was completing their high school education, with a plan to continue to post-secondary. Nearly half of our participants were living with parents or other family (n = 8) and none reported any confirmed pregnancies.

Participants reported accessing oral contraception pills (OCPs) (n = 16), the transdermal contraceptive patch (n = 1), the intrauterine device (IUD) (n = 3), emergency contraception (EC) (n = 5), and STI/HIV services (n = 12) in Ontario between 2012 and 2023. Our participants accessed care at a variety of health care settings including through family physicians, walk-in clinics, campus health services, and telemedicine platforms.

3.2 Womxn feel that there is a cultural stigma around accessing SRH care and services

Sanam is a 26-year-old Malayali graduate student who is also working full-time. She is currently living in Central Ontario with a roommate. She was diagnosed with endometriosis and has dealt with heavy and painful periods for many years. Sanam has experience with OCPs related to her endometriosis.

Sanam shared that she experienced heavy and painful periods for many years before her endometriosis diagnosis. Despite experiencing pain, she was not able to access care from a provider for many years as she felt discussing menstruation was not acceptable within her culture. She explained, "The thing within our culture, I think a lot of it is like 'pain is normal when it comes to menstruation. Oh it's not a big deal.' You don't talk about it…you never bring it up." Once Sanam sought out care from her South Asian family physician, she was able to get her diagnosis quickly and was referred to a white OB/GYN. While receiving care from her family physician, OCPs were brought up as a treatment option, but not discussed further as Sanam's father was in the room during the appointment. Later, Sanam's OB/GYN offered OCPs as the optimal treatment option for her condition. Sanam explained that her use of OCPs was very difficult with her family as OCPs are stigmatized within the culture. She shared, "The perception is 'oh if you're taking [OCPs] that means you're sexually active.' Which they don't necessarily see it as medication, which is what it is for me…I can actually live my life now that I'm on [OCPs]."

As Sanam's parents did not approve of her use of OCPs, they occasionally consulted with providers within the South Asian community and a homeopathic provider to find alternatives for their daughter. Sanam discussed one interaction where she felt forced to speak with a homeopathic provider in India and follow their suggested treatment. Sanam felt that these interactions often included misinformation and the treatments did not help her symptoms.

Having received care from both a South Asian and non-South Asian provider in Canada, Sanam was able to share her perspectives and feelings with both. With a South Asian provider, she felt that her care was culturally appropriate, but fear of cultural judgement was "always in the back of [my] mind." In contrast, she felt that non-South Asian providers may not understand all the cultural nuances that impact communication. Sanam elaborated:

> Especially if it's something that [healthcare providers] have to read between the lines because I might not feel comfortable saying it because of I'm worried about judgement. You have to sit down and explain the whole thing from the beginning [to non-South Asian providers]. Versus somebody who is South Asian will just get it…It's a privilege to not have to explain yourself, right? When I'm working with a non-South Asian medical practitioner, I kind of lose that privilege that I might have with a South Asian practitioner

Fig 2: Sanam's story

Consistent with Sanam's experience (Fig. 2), many participants in our study felt that there is a stigma around accessing SRH care and services in the South Asian community. For some, the

perceived stigma was a barrier to accessing services. As Meena, a 28-year-old Hindu Punjabi healthcare professional, shared, “We don’t really talk about sex. And we don't really talk about reproductive health or sexual health. And so sometimes we don't know what our options are…[We] don't know who to go and talk to because [we] feel like [we] can't talk about this, [we] don't feel like [we’re] safe to talk about this.” Many participants shared a similar sentiment; before beginning their process of accessing care, they already felt it would be more difficult because of the cultural stigma. As Laila, an 18-year-old Bengali high school student, who accessed care related to polycystic ovarian syndrome (PCOS) said, “[non-South Asian providers] don’t completely understand how difficult even just like coming out and talking about these issues is especially as a teenager…it was really hard to even get these issues outside of my house [and] to a doctor.”

Participants felt that the cultural perception of SRH impacts their communication with providers. Jaspreet explained her discomfort asking her South Asian provider for OCPs, “Just first [asking for OCPs] was uncomfortable because in our, I guess, culture you could say, it’s not something we’re told is right. It’s mostly ‘no, don’t do this [sex] until after you’re married’…that’s how we’ve been raised.” In addition to the discomfort, some participants shared a fear of judgement they felt with when accessing services as a South Asian. As Sanam explained, “You’re always kind of worried about judgement. Which I feel like is kind of ingrained into us within the culture because it’s a very shame-based culture.”

For many, the impacts of perceived cultural stigma were felt even after the initial process of obtaining SRH care. Some of our participants shared that their parents, who were aware of their SRH service use, disapproved as their view of SRH is based on cultural norms. Deena, a 20-year-old Sri Lankan Tamil student, explained, “[My mother] was like ‘oh I don’t want my

daughter to go on this [OCPs]' because like, what if she thinks like, maybe she thought I would lose my morals or something, I don't know just, like become like a rebel or something."

Despite the stigma that many participants felt, the majority of our participants were able to access the care and services they believed were right for their health and circumstances. However, the battle between cultural perceptions and SRH needs impacted many participants' experiences. As Kiran, a 27-year-old Punjabi working professional, summarized:

> [The] experience of second-generation South Asians is quite unique. It's like we're always grappling with two identities. Like we have this like Indian or Pakistani or wherever you're from in South Asia, you have got [that] identity. And then you have some values that come with that as well, like there's a stronger sense of family community, kind of like responsibility as well. And so, you carry that with you but then when you grow up in a western country you also have this idea of like wanting to be an individual and having your own autonomy. And those ideas clash very often…especially when it comes to things like sexual health.

3.3 Womxn value privacy and anonymity when accessing care and services

Nimrit is a 25-year-old Indian Sikh working professional living in Central Ontario with her parents. She has completed a bachelor's and master's degree and is in a long-term relationship. Nimrit has accessed OCPs, EC, and STI/HIV testing.

When Nimrit made the decision to access OCPs to prevent pregnancy, she contacted her university's health clinic. Her choice of contraception method was based on what methods she felt that she could conceal from parents and family and what possible complications she could handle on her own. At the university health clinic, Nimrit met with a female South Asian provider. During the interaction, the provider urged Nimrit to tell her parents about starting OCPs. This made her uncomfortable and unsure of her decision, but she ultimately began using them. Nimrit recounts that while on OCPs, concealing the packaging was the biggest stressor. She also mentioned having to obtain refills from her campus pharmacy while living at home despite having a family physician nearby. She explains her decision to use the university clinic instead:

> I would've never gone to get [OCPs] at my family doctor's office because I wouldn't want [the physician] or the nurses in that office to know that I am going on [them]. And I would never want my family to find out somehow. [The physician's office] send[s] prescriptions right to the pharmacy [nearby], and [the pharmacists] hand my prescriptions to my dad without any problem…I didn't really have a designated known safe place to go at home for these things

Nimrit accessed EC twice, in 2019 and 2022. In 2019, she went to a pharmacy in a different city than the one she lived in and was thankful that the store was empty. When asking the pharmacist for the EC, she did not want to say it out loud, so instead typed it into her phone and showed the pharmacist. She requested that the pharmacist remove any packaging and give the medication in a very discrete manner. The pharmacist complied and overall, Nimrit found the interaction to be quite positive.

In 2022, she went to a pharmacy in her city, but carefully selected one where she felt she would not be recognized. During this encounter, there were many South Asian customers in the store and all of the pharmacy staff was also South Asian. Similar to her first experience, Nimrit did not feel comfortable asking for the medication out loud, but this time asked the provider for a paper to write down her request. Nimrit felt that this drew the attention of other customers and made the male provider uncomfortable. Ultimately, a female provider assisted Nimrit with her request. Nimrit felt that this process was not discrete or private.

Fig 3: Nimrit's story

A number of our participants shared that when accessing SRH care and services, it was important for them to have privacy and maintain a level of anonymity, as highlighted in Nimrit's experience (Fig. 3). Of the participants that accessed care related to their sexual health, many

disclosed that they were doing so in ways to avoid their parents or other family members finding out. When discussing her experience accessing sexual health care, Abinaya, a 23-year-old Sri Lankan Tamil medical student said, “I didn’t tell most of my family about [the doctor’s appointment] um, because I didn’t want them to know I was having sex…Like usually if there’s something health [related] going on I guess I lean on my family more. And so, it was weird that I wasn’t able to share something in my life with them.”

Many of our participants who used emergency contraception reported taking extra steps to ensure that their family would not know about their use. Kiran, a 27-year-old Punjabi working professional, described “So I basically [I] took [EC] in the washroom and then I like ripped up the box to shreds essentially and just made sure there is no like physical evidence and then put like toilet paper on top of the ripped box and yeah like that's essentially what I did so [my brother] wouldn't know about it.”

While those that accessed services to address a medical concern felt more comfortable sharing with their family, once care was related to sexual relations the need for privacy was restored. When describing her experience accessing care Aditi, a 20-year-old Punjabi student, highlighted “being able to access [OCPs] was easy, because it was like a legitimate medical treatment for me. But like, if I had wanted it as like a contraceptive, it would have had to have been like without [my parents] knowing.”

Our participants valued anonymity during their interactions with the health care system as well. Some participants felt afraid of being seen while accessing SRH services which at times stopped them from obtaining care. Sabila, a 30-year-old Bengali PhD student explained, “I haven’t gone for [STI/HIV] testing in the last couple years because of [the] stress of going

downtown, in an area where people might see me. And I feel kind of uncomfortable with someone possibly identifying me."

However, for some, the lack of privacy did not stop them from accessing care but made the process more difficult. When asked to describe her process obtaining EC, Sukhneet, a 30-year-old Punjabi working professional, explained:

> I think that it's not easy, especially for people, who are, like who have this fear still or are embarrassed, or like I said, there's no privacy, everyone is around you. It's not easy to access, you have to go and ask for it specifically, like it's behind the counters… I feel like there should be a better way to access these things.

3.4 Womxn reported advocating for their own SRH health and needs

Naomi is a 27-year-old Punjabi graduate student and working professional living in Central Ontario with her partner of over two years. Naomi has accessed OCPs and STI/HIV testing and attempted to undergo a tubal ligation. Naomi was able to access OCPs and STI/HIV testing from her city's public health department for free. She reflected positively on her experiences and felt that care was non-judgemental.

However, Naomi shared that she has spent a long time advocating for her own health. Naomi shared that she did not want to have children biologically and expressed interest in a tubal ligation. She sought out care from her female South Asian family physician. This provider had previously been very supportive of Naomi's SRH and general health concerns. Naomi also felt that the provider being South Asian would positively impact the interaction. She explained, "She was also a South Asian woman and that's why I chose her thinking that 'oh, maybe she'll get it' but she unfortunately had some biases that prevented me from having the care that I felt I deserved." Naomi felt that the provider was trying to convince her that she may change her mind about wanting biological children when she was older and married. The provider also shared her opinion that passing on the South Asian culture to future children is important and used this as justification for her not accepting Naomi's request for a tubal ligation. Naomi shared her thoughts of the interaction:

> I think like patient-medical practitioner relationships are really heavy in power dynamics and it's hard to advocate in those rooms to begin with and then when someone brings in their own personal perspective and then their racial identity is similar to yours, it can like really add to that.

Naomi has not been able to find a provider that will provide her with the care she desires.

Fig 4: Naomi's story

Consistent with Naomi's experience (Fig. 4) some of our participants felt that their SRH needs and concerns were disregarded by healthcare providers. When inquiring with her female provider about a follow-up appointment after her IUD insertion, Jessica, a 24-year-old Guyanese working professional, said, "[The physician] kind of dismissed it just being like, 'you're young, the chances of your IUD like becoming dislodged are very low for you so like I don't really check it.' I don't care was basically her attitude." Participants attributed the feeling of dismissal to their identity as a young South Asian. Hanna, a 23-year-old Pakistani working professional, shared an interaction at a hospital emergency department after experiencing significant blood loss from her period and almost losing consciousness. Hanna recounted:

> [A male provider] came over and he was like, "you know, sometimes like, yeah, you know, it does suck being on your period. But that's not like a reason to come into the ER"…That would not have happened if I was like a 40-year-old white woman like I know it like there's no way he was going to say that to, you know like a middle-aged white woman.

These experiences required that our participants advocate for their needs and to ensure that their health was taken seriously. Laila shared her experience receiving care for PCOS, "[The physician] was really really passive like she wouldn't really listen…And then I think after like getting really upset at her one day, she like finally sent me to a gynecologist…it took three years, it's kind of crazy actually." Hanna detailed a similar experience of self-advocacy during which her provider suggested contraception quickly, without addressing many of her concerns. Hanna shared:

> The gynecologist was essentially like, well, you're too young to have anything like that, so like, don't worry about it…you just need birth control, it'll fix it, it'll fix your heavy bleeding. And I kept being like, that's not really a solution because like, I want to know what's causing all this, and I kind of want, I want treatment for it. And I kept insisting that if I could get like further testing.

Several participants recounted that despite advocating for their health, their concerns continued to be disregarded. Nimrit had concerns while taking OCPs but felt dismissed by her provider. She explained, "This does feel like [providers] kind of put you on [OCPs] and you take the pill and it's just supposed to work. But when you notice things here or there, there's no answer for you."

3.5 Participants expressed a need for culturally relevant care and services

Our participants highlighted a number of ways that services could be improved in Ontario for the South Asian community; however, many expressed that incorporating cultural sensitivity into service delivery is essential. Our participants' identity impacted the way they view SRH topics (Fig. 2), how they felt when accessing services (Fig. 3), and their interactions with

providers (Fig. 4). They felt that their identity influenced their experiences with the healthcare system, with many expressing a desire for a more personalized approach to their care. Mathusha shared:

> Healthcare isn't like a one size fits all approach. And if you apply it like that, it's, that's a very like, bad thing in my opinion, like it's a very much a multi- multidimensional approach and different individuals need different things. Like South Asian women specifically too like, these individuals need like, they need more tailored information and tailored approaches.

A number of participants felt that providers recognizing the lived experiences and cultural values of South Asian women would create a more "comforting experience." For many, this included providing non-judgemental care and ensuring confidentiality. When asked how service delivery could be improved, Sanam described:

> Being open and acknowledging that some of this stuff, the questions, the concerns might be something that's not talked about or stigmatized in the culture. So, I think acknowledging [the stigma], goes a really long way in breaking down barriers…Just being like, "We're not here to judge; this is your health. It's not something that's going to be broadcasted for the entire community to know."

In addition, participants proposed that South Asian providers may have a significant role in improving service delivery for the community. Participants expressed that having providers who understand the stigma reassuring them that seeking these services is acceptable, would increase their comfort. Kiran suggested, "I feel like if there was some sort of community of like South Asian [providers] that specifically… kind of reduce the stigma of getting tested [for STIs/HIV] or seeking sexual health services that would be very helpful."

4. Discussion

With the South Asian population growing in Canada, it is important to highlight the health needs and concerns of this community, particularly regarding health inequities. In order to

provide adequate care to young, second-generation South Asian Canadian womxn it is important for healthcare providers to understand the cultural nuances that are at play. Second-generation South Asian womxn accessing SRH care and services involves a complex balance of cultural or religious expectations with one's personal health needs and desires. Our findings suggest that for South Asian womxn, their South Asian identity impacts their experiences and behaviours surrounding SRH care.

Our participants felt that there is a cultural stigma around accessing SRH care and services, aligning with a number of studies focused on SRH and South Asian women [11–13,15]. This stigma exists partly due to the priority placed on modesty and the value that is attached to a woman's virginity prior to marriage. The pressure to conform to these expectations can create feelings of shame, guilt, or fear of judgement [11–13]. Our participants described many of these feelings, even when accessing services for non-contraceptive purposes. Although these negative feelings made navigating service use more difficult, many were able to access the care they felt that they need. These feelings and fears are not unique to the second-generation population within the South Asian Canadian community [12]. However, our findings suggest there may be a continuance of cultural views amongst those that are accultured in Western countries. While dismantling long-standing cultural values may not be immediately possible, integrating cultural sensitivity within SRH care delivery may foster a more accepting and compassionate environment [16,17]. Additionally, providing culturally relevant information to all generations may help to lessen the stigma surrounding SRH that exists within the South Asian community.

In addition to these topics being heavily stigmatized, the reputation damage and social implications that may arise from being seen accessing SRH services appears to act as a barrier to care. As such, our participants valued privacy and anonymity during their interactions with the

healthcare system. Some of our participants expressed an increased need for privacy and anonymity/confidentiality, particularly within the pharmacy setting. Similar to our participants, common concerns during pharmacy interactions included consultations occurring in close proximity to other patients and fear of being seen accessing services; these concerns were particularly pronounced among our participants who accessed EC [18,19]. In 2008, progestin-only EC was reclassified as a Schedule III drug and accordingly it can be stocked in and sold from the self-selection area of the pharmacy (i.e., over-the-counter) [20,21]. Customers can request a consultation with a pharmacist as needed. This move was made in part to reduce access barriers. However, in many pharmacies in Ontario and beyond it remains behind-the-counter [21], requiring an interaction with a pharmacist; this not only acts as a barrier to access, but also exacerbates existing privacy concerns [20,22]. Our findings indicate that aligning EC regulation with practice, while also creating private and secluded areas for any necessary consultations could alleviate barriers to access.

Per our study design, we only interviewed those that fit the Statistics Canada definition of second-generation. Consequently, we did not capture the experiences of those who immigrated to Canada at a young age and who might still be acculturating using both Western and South Asian values. Future studies may benefit from broadening the inclusion criteria to explore the experiences of this group. Although we employed a multi-modal recruitment strategy to reach womxn of a variety of ethnic, national, and religious groups within the South Asian community, we recognize that not all groups are reflected in our sample. While we are confident that the themes and experiences are transferable, we caution against using the findings to depict larger trends. Finally, although qualitative research allows us to explore participants' experiences,

behaviours, and feelings, this research is not intended to produce generalizable or representative results.

South Asian womxn access a range of SRH services, with many navigating cultural and systemic barriers to do so. Our findings highlight the importance of acknowledging and respecting cultural differences as well as the implications that age, ethnicity, and generation status have on one's experiences.

Funders

This research project was supported by a grant from an anonymous foundation. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

Conflicts of interest

The authors declare that they have no conflicts of interest, financial or otherwise.

References

[1] Chatterji J, Washbrook DA, editors. Routledge handbook of the South Asian diaspora. London ; New York: Routledge; 2013.

[2] Statistics Canada. Visible minority by place of birth and generation status: Canada, provinces and territories, census metropolitan areas and census agglomerations with parts 2022. https://doi.org/10.25318/9810032601-ENG.

[3] Agrawal SK. Economic disparities among South Asian immigrants in Canada. South Asian Diaspora 2013;5:7–34. https://doi.org/10.1080/19438192.2013.720514.

[4] Buchignani N. Continuous journey : a social history of South Asians in Canada. Toronto: Published by McClelland and Stewart in association with the Multiculturalism Directorate, Dept. of the Secretary of State, and the Canadian Government Publishing Centre, Supply and Services Canada; 1985.

[5] Statistics Canada. Visible minority by gender and age: Canada, provinces and territories 2023. https://doi.org/10.25318/9810035101-ENG.

[6] Statistics Canada. Visible minority and population group by generation status: Canada, provinces and territories, census metropolitan areas and census agglomerations with parts 2022. https://doi.org/10.25318/9810032401-ENG.

[7] Statistics Canada. Religion by visible minority and generation status: Canada, provinces and territories, census metropolitan areas and census agglomerations with parts 2022. https://doi.org/10.25318/9810034201-ENG.

[8] Statistics Canada. Visible minority by mother tongue and generation status: Canada, provinces and territories and census metropolitan areas with parts 2022. https://doi.org/10.25318/9810032501-ENG.

[9] Statistics Canada. Classification of Generation Status. 2021.

[10] Zaidi AU, Couture-Carron A, Maticka-Tyndale E. 'Should I or Should I Not'?: an exploration of South Asian youth's *resistance* to cultural deviancy. Int J Adolesc Youth 2016;21:232–51. https://doi.org/10.1080/02673843.2013.836978.

[11] Kiridaran V, Chawla M, Bailey JV. Views, attitudes and experiences of South Asian women concerning sexual health services in the UK: a qualitative study. Eur J Contracept Reprod Health Care 2022;27:418–23. https://doi.org/10.1080/13625187.2022.2096216.

[12] Meherali S, Salami B, Okeke-Ihejirika P, Vallianatos H, Stevens G. Barriers to and facilitators of South Asian immigrant adolescents' access to sexual and reproductive health services in Canada: A qualitative study. Can J Hum Sex 2021;30:329–38. https://doi.org/10.3138/cjhs.2020-0056.

[13] Griffiths C, Prost A, Hart G. Sexual and reproductive health of South Asians in the UK: an overview. J Fam Plann Reprod Health Care 2008;34:251–60. https://doi.org/10.1783/147118908786000352.

[14] Birks M, Chapman Y, Francis K. Memoing in qualitative research: Probing data and processes. J Res Nurs 2008;13:68–75. https://doi.org/10.1177/1744987107081254.

[15] Vlassoff C, Ali F. HIV-related stigma among South Asians in Toronto. Ethn Health 2011;16:25–42. https://doi.org/10.1080/13557858.2010.523456.

[16] Singh P, King-Shier K, Sinclair S. South Asian patients' perceptions and experiences of compassion in healthcare. Ethn Health 2020;25:606–24. https://doi.org/10.1080/13557858.2020.1722068.

[17] Qureshi S. Cultural sensitivity experiences of South Asian patients in primary care. master's thesis on the Internet. University of New Brunswick, 2020.

[18] Corley AG, Sprockett A, Montagu D, Chakraborty NM. Exploring and Monitoring Privacy, Confidentiality, and Provider Bias in Sexual and Reproductive Health Service Provision to Young People: A Narrative Review. Int J Environ Res Public Health 2022;19:6576. https://doi.org/10.3390/ijerph19116576.

[19] Turnbull G, Scott RH, Mann S, Wellings K. Accessing emergency contraception pills from pharmacies: the experience of young women in London. BMJ Sex Amp Reprod Health 2021;47:27. https://doi.org/10.1136/bmjsrh-2019-200339.

[20] Eggertson L. Plan B comes out from behind the counter. CMAJ Can Med Assoc J J Assoc Medicale Can 2008;178:1645–6. https://doi.org/10.1503/cmaj.080809.

[21] Chaumont A, Foster AM. The not so over-the-counter status of emergency contraception in Ontario: A mixed methods study with pharmacists. FACETS 2017;2:429–39. https://doi.org/10.1139/facets-2017-0024.

[22] Erdman JN. Canada: Competing Frames of Access and Authority. In: Foster AM, Wynn LL, editors. Emerg. Contracept., New York: Palgrave Macmillan US; 2012, p. 57–78. https://doi.org/10.1057/9781137016485_4.

Chapter 5: Discussion

Synthesis of results

Through this study, we aimed to conduct an in-depth analysis of the experiences of young second-generation South Asian Canadian womxn with sexual and reproductive health (SRH) information and services in Ontario. During our analysis, it became clear that for many of our participants their South Asian identity impacted their access to and experiences with SRH information and services. The results of our multi-method study highlighted three major findings: 1) Cultural values play a role in access to SRH information and care; 2) Improvements in SRH education at all ages throughout all generations are required; 3) Womxn value privacy, anonymity, and discreteness when accessing SRH information and care.

Cultural values and SRH

Our findings highlight the impact of cultural values on the SRH experiences of young second-generation South Asian Canadian womxn. Many of our participants discussed the cultural stigma surrounding SRH that exists within the South Asian community. Our participants from both the survey and the interviews are a diverse group with respect to ethnicity, religion, or time of immigration. Yet, many spoke of this stigma. This signifies that although the South Asian community is incredibly diverse, deep-rooted cultural values and beliefs are common between groups.

Many of our participants experienced negative feelings due to the stigma during conversations with parents, family members, or healthcare professionals. For many participants, these feelings arose when the other person imposed their cultural views or beliefs onto them. For some, this made them feel judged or dismissed by parents or healthcare professionals.

Intergenerational conflict, similar to that described by our participants, may be a result of differing values and world views between generations (Samuel, 2009; Somerville, 2019). Parents' views and opinions of SRH acted as a barrier to care. For many, their parents' views are based on cultural or religious values. Participants shared feelings of shame, guilt, or embarrassment when accessing care, knowing that their parents' views do not align. However, other populations within the South Asian community, both in Canada and the U.K., also report similar feelings when accessing care (Griffiths et al., 2008; Kiridaran et al., 2022; Meherali et al., 2021). Additionally, parents' views impacted access to accurate and comprehensive SRH information. Some participants felt that their parents were a source of misinformation, while others reported that their parents' views stopped them from receiving any information.

Additionally, a number of our participants shared experiences accessing care related to their menstrual cycle and other reproductive health issues as well as how cultural values and stigma impacted their access to care. Participants explained that discussions of SRH topics, including menstruation were difficult between family or healthcare professionals. For some, this made accessing timely SRH care challenging. Destigmatizing SRH within the South Asian community for all generations can help womxn promptly access vital health care and services.

SRH information and education

Our findings indicate that there is a need for SRH education at all ages throughout all generations. Participants felt that the SRH education they received in school was inadequate. Some shared desire for SRH education that goes beyond scientific facts and includes sociocultural aspects. Furthermore, our conversations with participants highlighted a need for SRH education for parents and first-generation South Asian Canadians. Parents often shared

inaccurate beliefs or harmful stereotypes related to SRH. Education for this group, particularly parents, should focus on the importance of SRH. It is important to have conversations with this group rooted in cultural acceptance and addressing the stigma.

Young second-generation South Asian Canadian womxn expressed enthusiasm for this project and were very willing to share their stories with me. This highlights that being acculturated with both sets of cultural values may make this new-generation more open to these conversations. As such, second-generation South Asian Canadian womxn may be a key demographic to target while attempting to break down the cultural stigma surrounding SRH topics (Vlassoff & Ali, 2011).

In addition to sharing their experiences, participants shared a number of recommendations for improving SRH information and service delivery for the South Asian community. The need for culturally sensitive and relevant information and care is clear. Participants felt that existing information was not culturally relevant for them. As such, many sought out information that was tailored to South Asian people. Participants also mentioned a need for culture sensitivity training for healthcare professionals. It is important for healthcare professionals to be aware of the cultural nuances that exist and understand how they may impact their interactions with patients. This may create a more comforting environment for womxn and foster open conversation. Overall, cultural sensitivity training may help to address some of the barriers that the South Asian community face when accessing SRH care (Qureshi, 2020).

Additionally, participants were enthusiastic about the idea of having fellow South Asian womxn share their experiences in addition to South Asian providers speaking about the importance of SRH education and care at all ages. Participants felt that these conversations can help to lessen the deep-rooted stigma that exists.

Privacy throughout the process

Both the interviews and survey highlighted the importance that young second-generation South Asian Canadian womxn place on privacy and discreteness when accessing SRH information and services. Our participants shared a need for privacy throughout their process with SRH, starting with accessing information. Many of our participants accessed information online, stating that it is discrete and anonymous. While the sources of information online varied, the concept of discreteness was important throughout. This presents a need for accurate, culturally relevant, online resources for young South Asian Canadians.

This need for privacy continued when accessing care and services as well, particularly when intended use was contraception. Participants felt that accessing care further from their homes was more private or decreased the risk of being seen by family or community members. Some participants shared experiences of confidentiality breaches by healthcare providers. Within the healthcare system, it is important to ensure privacy and confidentiality at every stage. It is also important to remind patients that the information they share with their healthcare provider is confidential and judgement free.

Significance

To date, there is limited peer-reviewed research on the SRH experiences, needs, and concerns of South Asian womxn. This study is the first, that we are aware of, that focuses on the experiences of young second-generation South Asian Canadian womxn accessing SRH information and services. In completing a rigorous multi-method study, we captured a snapshot of young second-generation South Asian Canadian womxn on their experiences obtaining SRH

information and services, through the online survey, while also exploring the lived experiences of womxn accessing SRH care, through the in-depth interviews. We believe that this research has contributed to filling a gap in literature focused on the SRH experiences of South Asian Canadians. We hope that healthcare providers and advocates can use our findings to improve information access and service delivery.

Disseminating our findings is essential in order to reach healthcare providers, advocates, and those that frequently work with the South Asian community. Our dissemination plan includes a few different strategies, each intended to reach a different audience. First, we plan to publish the two manuscripts included in this thesis. These articles are intended for fellow researchers with the hopes of increasing knowledge of the experiences of South Asian womxn and promoting future research focused on this population. Second, we will produce a short report to share with healthcare providers and community organizations, especially those in areas with significant South Asian populations. This report will outline the major findings of the study as it relates to information and service delivery. We will create another short report intended for interested survey and interview participants. Lastly, we intend to share the findings of this study at academic conferences in Canada.

Strengths and limitations

By completing a project focused on South Asian womxn, we studied a population that is underrepresented in health research. This qualitative study allowed for the voices and experiences of South Asian womxn as well as their ideas for improving SRH for the community to be heard. We believe that the findings from this study highlight the complexities that stem from being a daughter/child of immigrants as it relates to SRH.

There were a few limitations to this study. When conceptualizing this study, we decided to recruit only those that fit the Statistics Canada definition of second-generation. As such, our study does not include the voices and experiences of those that immigrated to Canada at a young age and feel that they acculturated with both Canadian and South Asian values.

Given the tremendous diversity within the South Asian community, we were very intentional with recruitment to include the voices and perspectives from a wide range of backgrounds within the community. However, there are a number of ethnic groups that we were not able to reach. While our participants do not cover all South Asian ethnic, linguistic, religious, or national backgrounds that are present in Canada, our sample does generally align with the 2021 Canadian Census data.

I conducted all in-depth interviews, which can be seen as both as a strength and a limitation. By being the only interviewer, I was able to keep conversations and questions consistent. However, it is possible that my positionality as a researcher and a fellow South Asian woman impacted my interactions with participants.

Positionality and reflexivity

Positionality refers both to a person's world view and position in society as well as the position they take on during the research process (Darwin Holmes, 2020). Reflexivity refers to a researcher's ability to acknowledge their role in the research and understand the possible influence they have on the project. Understanding one's positionality and reflecting on its implications is a practice that should be carried through the entirety of the project (Darwin Holmes, 2020).

I believe that my world view and experiences as a young second-generation South Asian woman allowed me to understand the cultural beliefs and values of my participants and the cultural nuances at play. As a result, I felt that this positionality allowed for many participants to be more comfortable in and discussing their experiences with SRH information and care with me as well as general cultural practices. During many of the interviews I felt that my interest in the community was mirrored by participants, facilitating open and insightful conversations. However, given the significant diversity within the South Asian community, I, as a Punjabi Sikh, acknowledge that I may not have experienced SRH in the same ways as other South Asians. Throughout the research process, I actively worked to separate my own experiences from those of the participants in this study.

Prior to my masters, I worked as a volunteer within Dr. Foster's research team for two years, which provided me with the opportunity to build my qualitative research skills. I was given training in interview transcription and transcribed numerous interviews during that time. To prepare for this study, I participated in a two-day workshop with Dr. Foster that focused on conducting semi-structured interviews, memoing, coding and thematic analysis, and using ATLAS.ti. I also took part in a directed study with Dr. Foster during the Winter 2022 semester. This directed study allowed me to further develop and enhance my qualitative research skills. Furthermore, my participation in weekly group meetings provided me with additional knowledge and research skills that I used throughout my research process.

Statement of contribution

I completed this study in partial fulfillment of the requirements for the Master of Science in Interdisciplinary Health Sciences program at the University of Ottawa. As the project lead, I

conceptualized the study, designed all recruitment and study instruments, collected, and analyzed all data, and led the writing of two manuscripts for publication.

My supervisor, Dr. Angel M. Foster, supported and guided me throughout this project beginning with designing the study. This included help to narrow down my study population, help in writing my thesis proposal, and feedback on recruitment tools and study instruments. She oversaw data collection, providing feedback and guidance when necessary. After discussing thematic saturation, she approved my codebook and discussed findings from both the interviews and survey.

Two undergraduate student researchers, Ayesha Qadri and Oviya Sritharan, assisted during data collection by contacting organizations to share recruitment materials. They also helped to transcribe a number of interviews as part of their honours thesis projects. Oviya also helped to organize and analyze survey data.

Conclusion

Despite making up a large portion of Canada's visible minority population, South Asians are underrepresented in health research, particularly within SRH research. The findings from this study highlight the SRH experiences of the children of South Asian immigrants living in Ontario. Our participants navigated cultural and systemic barriers in order to access the health information or care that they desire. These findings shed light on the health inequities that may exist within our healthcare system.

Future health research, including SRH research, would benefit from focusing on or including South Asian Canadians. It is important to understand the cultural nuances at play for

this growing population. The enthusiasm to participate in this study showcases the willingness of South Asian womxn to share their stories and contribute to scientific research.

References

Agrawal, S. K. (2013). Economic disparities among South Asian immigrants in Canada. *South Asian Diaspora*, *5*(1), 7–34. https://doi.org/10.1080/19438192.2013.720514

Allard, P., Kaddatz, J., & Tran, K. (2005). *South Asians in Canada: Unity through diversity* (11-008-X20050028455; Canadian Social Trends). Statistics Canada. https://www150.statcan.gc.ca/n1/en/catalogue/11-008-X20050028455

Ando, H., Cousins, R., & Young, C. (2014). Achieving Saturation in Thematic Analysis: Development and Refinement of a Codebook. *Comprehensive Psychology*, *3*, 03.CP.3.4. https://doi.org/10.2466/03.CP.3.4

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, *13*(1), 68–75. https://doi.org/10.1177/1744987107081254

Brogan, N. R. (2019). *Exploring the Contraceptive Experiences of Adolescents Living in Rural Ontario* [Master's thesis on the Internet, [object Object]]. http://ruor.uottawa.ca/handle/10393/39859

Buchignani, N., Indra, D. M., & Srivastiva, R. (1985). *Continuous journey: A social history of South Asians in Canada*. McClelland and Stewart in association with the Multiculturalism Directorate, Dept. of the Secretary of State and the Canadian Govt. Pub. Centre, Supply and Services, Canada.

Cazeau, D. (2020). *Exploring Women's Experiences with Long-Acting Reversible Contraception: A Multi-Methods Qualitative Study In Ontario* [Université d'Ottawa / University of Ottawa]. http://ruor.uottawa.ca/handle/10393/40443

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian Journal of Psychiatry*, *55*(Suppl 2), S299-309. https://doi.org/10.4103/0019-5545.105555

Chatterji, J., & Washbrook, D. A. (Eds.). (2013). *Routledge handbook of the South Asian diaspora*. Routledge.

Darwin Holmes, A. G. (2020). Researcher Positionality—A Consideration of Its Influence and Place in Qualitative Research—A New Researcher Guide. *Shanlax International Journal of Education*, *8*(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Fikree, F. F., & Pasha, O. (2004). Role of gender in health disparity: The South Asian context. *BMJ (Clinical Research Ed.)*, *328*(7443), 823–826. https://doi.org/10.1136/bmj.328.7443.823

Garriguet, D. (2021). *Portrait of youth in Canada: Data report. Chapter 1, Health of youth in Canada* (CS42-28-0001/2021-1E-PDF). Statistics Canada.

Griffiths, C., Prost, A., & Hart, G. (2008). Sexual and reproductive health of South Asians in the UK: An overview. *Journal of Family Planning and Reproductive Health Care*, *34*(4), 251–260. https://doi.org/10.1783/147118908786000352

Handa, A. (2003). *Of silk saris and mini-skirts: South Asian girls walk the tightrope of culture*. Women's Press.

Hukku, S., Ménard, A., Kemzang, J., Hastings, E., & Foster, A. M. (2022). "I just was really scared, because it's already such an uncertain time": Exploring women's abortion experiences during the COVID-19 pandemic in Canada. *Contraception*, *110*, 48–55. https://doi.org/10.1016/j.contraception.2022.01.014

Kiridaran, V., Chawla, M., & Bailey, J. V. (2022). Views, attitudes and experiences of South Asian women concerning sexual health services in the UK: A qualitative study. *The European Journal of Contraception & Reproductive Health Care*, *27*(5), 418–423. https://doi.org/10.1080/13625187.2022.2096216

LaRoche, K. J., & Foster, A. M. (2015). *The Availability, Accessibility, and Provision of Post-Abortion Support Services in Ontario*. https://doi.org/10.20381/RUOR-1193

LaRoche, K. J., Gross, E., Sheehy, G., & Foster, A. M. (2018). Put a Ring in It: Exploring Women's Experiences with the Contraceptive Vaginal Ring in Ontario. *Women's Health Issues*, *28*(5), 415–420. https://doi.org/10.1016/j.whi.2018.04.009

Mavuso, J. M. J., & Macleod, C. I. (2020). Contradictions in womxn's experiences of pre-abortion counselling in South Africa: Implications for client-centred practice. *Nursing Inquiry*, *27*(2). https://doi.org/10.1111/nin.12330

Meherali, S., Salami, B., Okeke-Ihejirika, P., Vallianatos, H., & Stevens, G. (2021). Barriers to and facilitators of South Asian immigrant adolescents' access to sexual and reproductive health services in Canada: A qualitative study. *The Canadian Journal of Human Sexuality*, *30*(3), 329–338. https://doi.org/10.3138/cjhs.2020-0056

Quay, T. A., Frimer, L., Janssen, P. A., & Lamers, Y. (2017). Barriers and facilitators to recruitment of South Asians to health research: A scoping review. *BMJ Open*, *7*(5), e014889. https://doi.org/10.1136/bmjopen-2016-014889

Qureshi, S. (2020). *Cultural sensitivity experiences of South Asian patients in primary care* [Master's thesis on the Internet, University of New Brunswick]. https://unbscholar.dspace.lib.unb.ca/server/api/core/bitstreams/6f36c943-6721-4440-9925-acf3351bc1dc/content

Samuel, E. (2009). Acculturative Stress: South Asian Immigrant Women's Experiences in Canada's Atlantic Provinces. *Journal of Immigrant & Refugee Studies*, *7*(1), 16–34. https://doi.org/10.1080/15562940802687207

Somerville, K. (2019). Intergenerational Relations and Gendered Social Surveillance of Second-Generation South Asians. *Canadian Ethnic Studies*, *51*(3), 95–115. https://doi.org/10.1353/ces.2019.0022

Statistics Canada. (2021). *Classification of Generation Status*. https://www23.statcan.gc.ca/imdb/p3VD.pl?Function=getVD&TVD=117200&CVD=117200&CLV=0&MLV=1&D=1

Statistics Canada. (2022a). *Ethnic or cultural origin by gender and age: Canada, provinces and territories* [dataset]. [object Object]. https://doi.org/10.25318/9810035501-ENG

Statistics Canada. (2022b). *Religion by visible minority and generation status: Canada, provinces and territories, census metropolitan areas and census agglomerations with parts* [dataset]. [object Object]. https://doi.org/10.25318/9810034201-ENG

Statistics Canada. (2022c). *Visible minority by mother tongue and generation status: Canada, provinces and territories and census metropolitan areas with parts* [dataset]. [object Object]. https://doi.org/10.25318/9810032501-ENG

Statistics Canada. (2022d). *Visible minority by place of birth and generation status: Canada, provinces and territories, census metropolitan areas and census agglomerations with parts* [dataset]. [object Object]. https://doi.org/10.25318/9810032601-ENG

Statistics Canada. (2023). *Visible minority by gender and age: Canada, provinces and territories* [dataset]. [object Object]. https://doi.org/10.25318/9810035101-ENG

Sundar, P. (2008). To “Brown It Up” or to “Bring Down the Brown”: Identity and Strategy in Second-Generation, South Asian-Canadian Youth. *Journal of Ethnic And Cultural Diversity in Social Work*, *17*(3), 251–278. https://doi.org/10.1080/15313200802258166

Véron, J. (2008). La démographie de l’Asie du Sud des années 1950 aux années 2000: Synthèse des changements et bilan statistique. *Population*, *63*(1), 9. https://doi.org/10.3917/popu.801.0009

Vlassoff, C., & Ali, F. (2011). HIV-related stigma among South Asians in Toronto. *Ethnicity & Health*, *16*(1), 25–42. https://doi.org/10.1080/13557858.2010.523456

Walton-Roberts, M. (2013). South Asian diasporas in Canada. *South Asian Diaspora*, *5*(1), 1–5. https://doi.org/10.1080/19438192.2013.726420

Wanigaratne, S., Uppal, P., Bhangoo, M., Januwalla, A., Singal, D., & Urquia, M. L. (2018). Sex ratios at birth among second-generation mothers of South Asian ethnicity in Ontario, Canada: A retrospective population-based cohort study. *Journal of Epidemiology and Community Health*, *72*(11), 1044–1051. https://doi.org/10.1136/jech-2018-210622

Wiebe, E. (2013). Contraceptive practices and attitudes among immigrant and nonimmigrant women in Canada. *Canadian Family Physician Medecin De Famille Canadien*, *59*(10), e451-455.

Zaidi, A. U., Couture-Carron, A., & Maticka-Tyndale, E. (2016). ‘Should I or Should I Not’?: An exploration of South Asian youth’s *resistance* to cultural deviancy. *International Journal of Adolescence and Youth*, *21*(2), 232–251. https://doi.org/10.1080/02673843.2013.836978

Appendix A: Recruitment flyer

SOUTH ASIAN WOMEN NEEDED FOR ONLINE SURVEY

ELIGIBILITY:

- IDENTIFY AS A WOMAN AGE **18-30**
- IDENTIFY AS A MEMBER OF THE SOUTH ASIAN COMMUNITY
- BORN IN CANADA WITH AT LEAST ONE PARENT BORN ELSEWHERE
- CURRENTLY LIVE IN ONTARIO

Survey takes around 20 minutes
Participants will have a chance to win a **CAD50 gift card to Amazon.ca**

Contact Sarah Shahi at ws-stu02@uottawa.ca with any questions!

www.surveymonkey.com/r/QKMGDZS

uOttawa

Researchers at the University of Ottawa are conducting an annonymous online survey with **second-generation South Asian women in Ontario.** The purpose of this study is to better understand **South Asian women's experiences with sexual and reproductive health information and services in Ontario.**

Appendix B: Research Ethics Board certificate

30/10/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-11-19-5235
Titre du projet / Project Title	Exploring the availability and accessibility of sexual and reproductive health services in Ontario
Type de projet / Project Type	Recherche de professeur / Professor's research project
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	25/11/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	24/11/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Angel FOSTER	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street, Room 154
Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics