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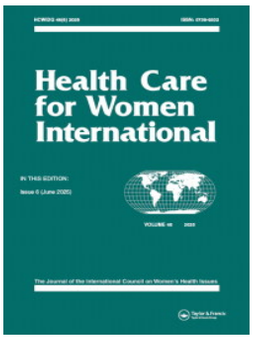

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Navigating shame to negotiate sexual agency among British-born South Asian women: A grounded theory study

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ABSTRACT

Constructivist grounded theory was used to explore perceptions and experiences of sexual health among British-born South Asian women, aged 18–25 who lived in North-West England. We aimed to explore whether and how women were influenced by religion and socio-cultural factors. Participants ($n = 16$) took part in either interviews or focus groups. A theoretical framework focusing on how women navigated shame to negotiate sexual agency was developed. Culture and religious values prohibited sex-based relationships before marriage, which meant accessing support could prove problematic. Women demonstrated different levels of agency through finding ways to maintain secret relationships and to navigate access to healthcare services.

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In this study we aimed to explore the perceptions and experiences of sexual health among British-born South Asian women aged 18–25 through a constructivist grounded theory study. This study was undertaken due to the limited existing knowledge on this topic. As part of the grounded theory methodology, a theoretical framework was developed that presents a continuum illustrating how women navigate experiences of shame—shaped by religious and broader socio-cultural influences—to negotiate their sexual health needs through processes of reasoning and personal agency. The findings will be of interest to health care professionals and researchers involved in women's sexual health, particularly those working with women from ethnic minority backgrounds. Although this study focuses on British-born women, the findings may have international relevance, particularly in contexts where women are born in countries different from their cultural origin. Additionally, the study will be relevant to those interested in acculturation and in understanding how young women navigate and balance cultural influences when born into cultures different from their parents. It is intended that this study and theoretical

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framework developed will contribute to a broader understanding of sexual health issues faced by women from ethnic minority backgrounds.

Sexual health is a fundamental aspect of health and is concerned with sexual relationships and behaviors (World Health Organization [WHO], 2022). In high-income countries, such as the USA and England, the rates of sexually transmitted infections (STIs) continue to increase and remain high among young people (Centers for Disease Control and Prevention [CDC], 2023; Department of Health [DH], 2013; Public Health England [PHE], 2019). Evidence highlights that women are at greater risk of experiencing sexual health issues compared to men (Family Planning Association [FPA], 2016; Public Health England [PHE], 2018, 2020). A further indicator of poor sexual health is ethnicity (Department of Health & Social Care and Public Health England, 2018). Young people from ethnic minority groups face difficulties in accessing sexual health services due to cultural and religious taboos (Center for Reproductive Rights, 2014; CDC, 2023).

Further social determinants of sexual health and sexual health behavior include a lack of education, discrimination, stigma, the social environment, the neighborhood, family influence and community contexts (Friedman et al., 2018). Regarding sexual health education as a social determinant, the level of information and communication an individual receives, including clear messages around sexual health have been associated with safer sexual health behavior (Williams et al., 2016). Whereas individuals who receive low levels of sexual health education and are unable to have conversations and discussions around sexual health may experience poorer sexual health (Williams et al., 2016). Cultural and religious influences can supress discussions or considerations of sexual health from South Asian communities. Dating and pre-marital sex are strongly discouraged among many South Asian groups and this may be due to upholding family reputation and honor (Couture-Carron, 2020; Diller, 2014).

Helman (2007), a prominent author on culture, health and illness recognized that women from ethnic minority groups who are socialized into cultures with more permissible "Western" standards may face further challenges due to competing beliefs and values, a process referred to as acculturation. One of the earliest definitions of acculturation highlights that acculturation refers to how individuals who are socialized into a certain culture can adapt their behaviors to meet the norms and values of the host culture (Redfield et al., 1936). Earlier understandings of acculturation suggest that this process occurs at group level (i.e., among a whole cultural group) however recent conceptualisations emphasize individual changes in behavior and identity (Alamilla et al., 2017). Matsumoto (1996) described culture being an individual as well as a group construct. Berry (1990) concurs that acculturation at an individual level is more representative of the experience of immigrants. Acculturation is also not perceived to be an

equitable process as children are born to different generations of immigrants. The South Asian cultural traits may therefore already be diluted through the acculturation process of their parents and the cultural beliefs of such individuals will be different to that of previous generations (Kim et al., 2009). British born, South Asian women will experience different levels of acculturation as they are influenced by the wider social context and cultures of the society they live in. Acculturation can influence women's choices and beliefs where sexual health matters are concerned (Helman, 2007). For example, many South Asian religions emphasize the forbidden nature of pre-marital sexual relationships and may limit information about positive sexual health (Couture-Carron, 2020; Griffiths et al., 2008; Kiridaran et al., 2022). However, within the British culture, young people generally have more permitted standards and beliefs surrounding sexual health (Griffiths et al., 2008; Kiridaran et al., 2022). This may cause tensions and challenges for British-born, South Asian women who may be influenced by both the South Asian and British culture, yet there is a paucity of research to explore the role of culture and acculturation on sexual health behaviors. The need for better knowledge and awareness of sexual health issues in minoritised ethnic groups is highlighted (Kiridaran et al., 2022).

In this paper, we present findings from a grounded theory study that aimed to explore the perceptions and experiences of sexual health among British-born South Asian females, aged 18–25; to consider whether and how they were influenced by culture, religion and wider social factors. A theoretical framework was also developed.

Methods

Design

Charmaz's Constructivist Grounded Theory approach was used as it aims to explore social processes and behaviors in areas where scarce research is available (Tie et al., 2019), as was the case for this study.

Recruitment

Purposive and snowball sampling were used. Purposive sampling allows researchers to purposely select participants according to their background and knowledge (Campbell et al., 2020). Snowballing is when participants are asked to help researchers in identifying other potential participants: an approach that is particularly valued when recruiting hard-to-reach groups (Leighton et al., 2021). In this study we focused on South Asian women as they are one of the largest ethnic minority groups in the location where this study was undertaken (North-West England). Participants were recruited through flyers distributed to colleges, universities, and South

Asian community groups across two recruitment phases. The inclusion criteria involved being a British-born South Asian female, aged 18–25 and residing in North-West England.

Data collection

Ethical approval was sought from the lead author's University (Project number: BuSH: 155). Participants who responded to the flyer were sent a participant information sheet and asked to respond within 2 weeks if interested. Participants were able to take part in either a semi-structured interview (face-to-face or telephone) or focus group as preferred. Participants were asked to sign a consent form and personal characteristics form (that collected information on their age, ethnic background and religion) before data collection. An interview/focus group schedule was developed that included questions on knowledge, understanding, expectations and experiences of sexual health issues. All the interviews/focus groups were digitally recorded and transcribed verbatim and were undertaken by the lead author who is a researcher from the same ethnic background. During the focus groups, there was no sense of dominance discourses from particular individuals. However, where participants were quiet, SG would invite them to respond through targeted communication strategies e.g., asking them questions directly and inviting them to offer their opinions on what was shared.

Reflexivity

Kennedy et al. (2024) highlight the importance of addressing researcher positionality as it can influence research processes and outcomes e.g., recruitment, data collection and analysis. Both authors are female, with backgrounds in nursing or psychology. SG is from a British-born South Asian background, a Muslim and works as a Senior Lecturer in Nursing. GT is from a White ethnic background, she is a lapsed Catholic and works as a Professor in Perinatal Health. Both believe women should have access to timely information, education, and nonjudgmental support for their sexual health needs. Kaaristo (2022) emphasizes power relations when undertaking qualitative research. We tried to address this by not involving GT in recruitment or data collection processes. SG, while sharing a similar ethnic background, dressed in casual western clothes during data collection, to not align herself with any specific faith group. Neither SG nor GT had any prior relationship with any of the participants. The membership role of qualitative researchers whereby the researcher is viewed as "an insider" (due to shared characteristics or similarities) or "an outsider" (no shared commonalities) is an important consideration in research (Dwyer & Buckle, 2009; Kaaristo, 2022). Dwyer and Buckle (2009) also state that there appear

to be as many arguments for the use of an insider researcher as there are against it. For example, a positive is that being an insider can encourage open discussions—whereas a negative is that prejudices may mean that the topic is not fully debated. In our study, SG was an "insider' in terms of shared ethnicity, this meant she could relate to the experiences discussed and, although infrequent, when participants used specific terms in a South Asian language, there was no need for interpretation. From a negative perspective, it is recognized that their shared cultural background may have inhibited participants' voices, particularly when addressing the taboo nature of sexual health. While participants appeared to be happy to share their views, including those that countered cultural norms, these views may not wholly represent their personal opinions or behaviors. GT held a pre-understanding interview with SG to help identify her pre-understandings and biases regarding the topic area at the start of the study. GT also played a key role in reviewing the interview data and analysis to ensure that their biases did not overly influence the interpretation of the findings.

Data analysis

In line with Charmaz's constructivist grounded theory approach, data collection and analysis occurred simultaneously to enable early issues to be explored with future participants and to inform theoretical sampling. As earlier participants had all accessed university, theoretical sampling was used to recruit those from different educational backgrounds to "test" the emerging theories that were being developed. Grounded theory informed analysis: data analysis involved line-by-line coding, focused coding, developing categories and theory building (Charmaz, 2014). All the interviews or focus groups were uploaded as one dataset. Neither approach was privileged. All transcripts were uploaded to MaxQDA (a qualitative software programme) to help organize and analyze the data (Verbi, 2022).

Results

Eleven women took part in a focus group (four groups in total) and five took part in an interview (three face-to-face and two *via* telephone). Most participants were Pakistani ($n=6$) or Indian ($n=6$) (see Table 1 for demographics). Participants came from the same cultural background i.e., a British-born South Asian culture but belonged to different religions including Christianity, Islam, and Hinduism.

Theoretical interpretation

Charmaz (2014) identified that from an interpretive approach, theoretical understanding is obtained through the researcher's interpretation of

Table 1. Demographic characteristics of participants.

Name	Age	Ethnic background	Religion	Education level	Focus group/Interview
Safia	23	Pakistani	Islam	University	Interview
Sara	21	Pakistani	Islam	University	Interview
Rizwana	24	Indian	Islam	University	Interview
Anisha	19	Indian	Islam	University	Focus group 1
Memuna	21	Pakistani	Islam	University	Focus group 1
Khadija	20	Bangladeshi	Islam	University	Focus group 1
Naznin	21	Indian	Islam	University	Focus group 1
Amelia	21	Mixed race	NA	University	Focus group 2
Yasmin	20	Indian	Islam	University	Focus group 2
Shabana	20	Pakistani	Islam	University	Focus group 2
Maria	21	Sri Lankan	Christian	University	Interview
Saleha	18	Indian	Islam	College	Focus group 3
Fatima	18	Indian	Islam	College	Focus group 3
Uzma	19	Pakistani	Islam	College	Focus group 4
Adeela	21	Pakistani	Islam	College	Focus group 4
Munira	18	Indian	Islam	College	Interview

meaning and action. When analyzing the findings, women repeatedly used the word *shame* in relation to their sexual health and sex-based relationships. However, the findings also described the ways women used personal *agency* to maintain sexual relationships and to access the healthcare they needed. These insights therefore reflected that while romantic based relationships and discussions of sexual health were taboo subjects and forbidden due to the potential to instill judgment and shame in the community, this was not necessarily a deterrent (Couture-Carron, 2020; Griffiths et al., 2011; Kott, 2011; Moses & Oloto, 2010). Theoretical tools (sorting and diagramming) described by Charmaz (2014), and wider reading around the theoretical concepts of shame and agency eventually led to an overarching grounded theory being developed—*navigating shame to negotiate sexual agency*.

In the following sections, we describe how existing theories of shame and sexual agency were adapted to provide the theoretical framework to interpret the findings. Charmaz (2014) argues that while the theory does not necessarily provide an explanation, it should offer some abstract understanding gained through the theorists' (researchers') interpretations. Here, we provide an overview of shame and agency and a justification for selecting the two theories (Lazare's (1987) theory around shame and Cense's (2019) theory around sexual agency) that underpin our theoretical interpretation. We then present the grounded theory using the identified theories together with empirical quotes from the data set.

What is shame?

Gilbert and Irons (2009) state that the evolutionary basis of shame is concerned with both self-evaluation and how we are perceived by others within social contexts—it is a fundamental social emotion (Brown, 2006;

Gilbert, 2009; Mascolo, 1994; Scheff, 2000; Weber, 2004). Shame is commonly considered to incorporate three core elements of affect (e.g., fear and humiliation), cognition (e.g., feelings of inadequacy or rejection) and action or behavior (e.g., withdrawal or retaliation) (Lazare, 1987; Thomson et al., 2015; Tomkins, 1963). Through her study on how women experience and resolve concerns around shame, Brown (2006) defined shame as an intense experience or feeling that makes an individual believe they are flawed or unworthy. Shame has been described as an inner torment within an individual, or a "*sickness of the soul*" (Tomkins, 1963, p.185), with the risk of shame present in all human interactions (Goffman, 1959). Shame is concerned with the whole self and can create questions about a person's whole identity and identity formation i.e., that one indiscretion may cause a person to be viewed or to view themselves as a bad person (Kaufman, 1974; Lazare, 1987; Munford & Sanders, 2020). Brown's (2006) in-depth grounded theory study of shame identified how this emotion is intrinsically related to the social and cultural values of an individual's life world, such as culture and religion (Leeming & Boyle, 2003). This is also emphasized in the work of Leeming and Boyle (2003) who argue that shame is socially and culturally embedded and arises through interaction with others.

What is sexual agency?

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

Sexual agency is commonly considered to consist of two components: sexual self-efficacy and sexual assertiveness (Curtin et al., 2011; Ward et al., 2018). In their study on feminine ideology, sexual agency and embodiment among women, Curtin et al. (2011) state that sexual self-efficacy is concerned with women engaging in steps to protect themselves from sexually-transmitted infections and unwanted pregnancies through the use of contraception either used by themselves or requiring their partners to do so. Sexual assertiveness involves the ability to discuss sexual

desires and to refuse unwanted sex from partners (Curtin et al., 2011). Ward et al. (2018), in their study on sexual agency among undergraduate women, consider sexual affect as a further component of sexual agency. This third dimension concerns the emotions associated with an individual's sexual experiences—emotions such as shame, embarrassment, guilt or even comfort and pride (Ward et al., 2018).

Theoretical framework

The participant data was the basis of our grounded theory. Based on the underlying insights that emerged within the dataset, we considered several frameworks and models of shame (Gilbert, 2009; Kaufman, 1974; Lazare, 1987) and sexual agency (Cense, 2019; Pittard & Robertson, 2008) when constructing our theoretical framework. Overall, insights from Lazare (1987) and Cense (2019) were selected as they offered the best explanatory potential to illuminate the key findings of our study. Lazare's theory was developed in a health-care setting, and therefore of direct relevance to the context of our study and Cense's work specifically focused on sexual agency with all aspects reflected in the women's experiences. The empirical insights from Cense (2019) and Lazare (1987) were integrated with our findings into a unique theoretical framework.

The theoretical framework that underpins the grounded theory is presented in Figure 1 below that comprises three main themes as identified through our findings—"The grounding context of shame" positions women against a moral landscape of influence from religion and culture. "Connectedness with others" relates to how the individuals' connections with others in their social networks lead to particular beliefs and behavior. "Finding their way" relates to how women navigate the influences in their lives to create their own sense of self. Overall, the grounded theory depicts that whilst women had influences which make them vulnerable to shame, they still navigated and negotiated these, to varying extents, to obtain what they desired, i.e., positive sexual health.

In the following sections, the themes of the framework are discussed using participant quotes and the theories of Cense (2019) and Lazare (1987).

The grounding context of shame

The first theme is concerned with wider socio-cultural influences on women's sexual health. Cense (2019) identified that moral agency involves an individual reflecting and positioning themselves within their own personal and cultural moral frameworks. Whereas Lazare's (1987) vulnerability to shame also considers how socio-cultural grounding or moral frameworks can position an individual's behavior as good bad. Most participants described themselves as belonging to a religion which imposed expectations

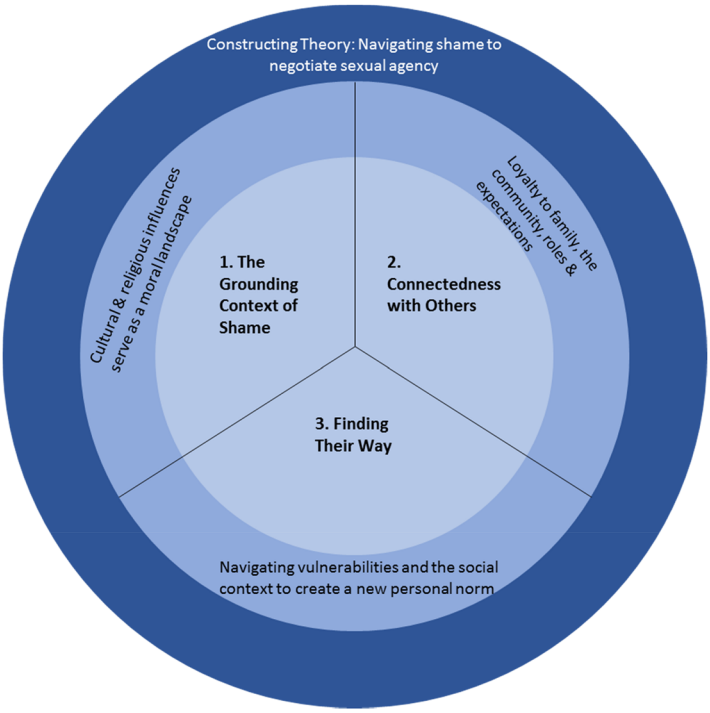

Figure 1. Navigating shame to negotiate sexual agency theoretical framework.

on their behavior and conduct and which had been instilled from a young age. Many women discussed concerns of being "*looked down upon*" (Khadija) should they engage in any behavior that could lead to shame for them or their families. One participant also highlighted that if a young woman from a religious family who had a "*good image in the community*" was found to be engaging in behaviors that contravened their religious-based expectations, then it would be "*like trashing that image*" (Saleha). Another participant reflected on how "*reputation is such a big thing in the Asian community*," with all participants stressing that these influences did not purely stem from the family but from a wider community. They all discussed how the wider "*community*" (this included the South Asian community where they reside and where they are known—locally and internationally) influenced their behaviors and how information spread quickly within communities:

> Like within an Asian culture if one person finds out then someone else is gonna find out because Asians tend to talk. They'd be like "have you heard about this girl, blah blah. I saw her in this clinic and stuff like that, and she'd be looked down upon. […] They'd be like look how they've brought their daughter up. (Khadija)

Women also highlighted how their religion provided specific "*rules*" that influenced their behaviors. These rules related to issues such as not

discussing sexual health issues, no romantic-based relationships, no sex before marriage and no mixing with the opposite sex. Some of the women described how as children they were not encouraged to have friends who were boys or "*allowed to mix with the boys*" (Khadija). One participant described that as her religion stated "*that you can't have a friend of the opposite sex without having feelings towards them*" (Maria) she avoided mixing with the opposite sex and "*any social media*" in order to avoid unwanted attention. Others referred to being disciplined for commenting and "*liking*" posts on male friends' social media pages. This grounding context of shame also meant that conversations with friends were censored such as not discussing contraception needs when not married "*cos you're not supposed to do that*" (Memuna).

Similar to Cense's work this background context meant that women in this study were always aware of the shame their behavior and actions could cause (Cense, 2019). Lazare (1987) also highlights how these personal feelings of shame lead to a vulnerability, but these feelings, cannot predict how an individual will act—as reflected in this study, some women may conform to the grounding context of shame and some may not.

This now leads on to the second theme of the framework: "connectedness with others."

Connectedness with others

The second theme is adapted from Cense's (2019) "bonded agency" and Lazare's (1987) "social context of shame." This theme is concerned with an individual's connectedness with others and how these connections affect and influence their behaviors. Cense (2019) states that sexual agency is inherently connected to relationships with others within a wider socio-cultural context. Similarly, Lazare (1987) identifies social context as an important factor in the experience of shame. In our study, women spoke of how they would act to prevent or mitigate against shame to protect their bonds or connectedness to family, friends, and the community. For example, on one occasion a woman described how she withheld school letters requesting permission for her to attend sexual health sessions in school for fear of "*how they'd react*" (Khadija).

Some women also discussed how their connectedness to the community included health care professionals. One described her thoughts when accessing her GP for sexual health reasons "*you're not supposed to have sex before marriage and he probably thinks that I'm such a bad Muslim*" (Naznin). Another woman added:

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

Lazare (1987) described the social context of shame when seeking professional help and how travel to services, meeting acquaintances, sharing information with health care professionals and the possibility of an intimate examination could invoke feelings of shame. These situations were particularly compounded if the GP was from the same cultural background. A woman described how her family GP took it upon himself to advise her that having sex with her boyfriend was not permissible.

> Cos I was like can I have the pill and he was like what do you need it for? And I was like… I've got a boyfriend, I'm thinking about sleeping with him and stuff and I was like I'd rather have the pill and he was like No you can't do that. (Sara)

This participant went onto describe how she went to the GP "*to get something and not… to preach about religion.*" This suggested that perhaps it was not only the women who experienced this connectedness with health care professionals, but in certain circumstances the professionals also felt this connectedness that extended beyond their scope of health care practice.

Cense (2019) identified that bonded agency concerns the strategies and actions taken to demonstrate agency, while trying to maintain loyalty to any connections. As some, but not all, of the women in our study were (or had been) in a romantic relationship, which contravened their religious-based "*rules*," they reported a common understanding that the relationship had to be kept "*secret*" to reduce socio-cultural implications of shame. One woman highlighted the need "*to lie about everything*" and felt like she "*was leading a double life*" to uphold her family's reputation. This was reflected by other women who discussed lying about "*where they're going*" (Saleha), and "*who they're going with*" (Maria). These behaviors enabled connections to be maintained while meeting the necessary demands of socio-cultural expectations.

A sense of connectedness could limit who a woman can turn to for support. Some women alluded to Cense's subtle strategies in terms of how their mothers were aware that they were in relationships with boys and became complicit in maintaining the secret; as one stated "*I told my mum*" (Yasmin). A few other women also confirmed that their mothers were aware of their secret relationship once they had been with their boyfriend for some time, although this was not without personal costs. One woman described that although her "*mum knows*" she still felt "*pressure*" in terms of maintaining "*respect*" for the family. Mothers reminded their daughters to know their "*boundaries*," alluding to behaving in a manner that avoided shame, namely to maintain their virginity. Some mothers were also complicit in the secret in the hope that their daughters may have found their future husbands because the "*end goal was marriage*" (Yasmin). The connections that the women had with their

mothers, became relevant when women started to negotiate outside of the religious and cultural boundaries of shame which leads us to the final theme.

Finding their way

This final theme of the framework, "finding their way" adapts what Cense (2019) considers "embodied agency" and how individuals navigate activities which have the potential to evade or induce shame, and which Lazare (1987) refers to as the "shame inducing event." This final stage is concerned with the embodiment of a romantic or sexual self whereby women are reasoning and making decisions about their own sexual lives and relationships. Being in a romantic relationship or engaging in pre-marital sexual activity is the ultimate "shame inducing event" (Lazare, 1987, p. 1654). Therefore, this final theme discusses some of the women's reasoning and actions to embody their own sexual desires and sexual identity by navigating influences of shame. Cense (2019) describes embodied agency as how women position themselves between the cultural influences in their lives to engage in sex-based relationships.

Some of the women knew that they would be "*disowned*" by their parents and faced the risk of being left alone and isolated without any support if they became pregnant before marriage. However, rather than this prohibit all sexual activity, women described how they took control over their sexual health. One referred to how she had taken precautionary measures by using contraception and would "*seek advice about termination*" should she become pregnant as it would be her "*only option.*" She also emphasized that "*if I had to go for a termination, I would never tell them*" even if it was "*years down the line*" (Yasmin). Even though a termination was viewed as sinful in her religion, this was deemed the better option than bringing shame to her family and wider community.

Another method to facilitate "finding their way" and the notion of embodied agency was of access to sexual health services. One woman highlighted how she accessed services where "*no one needs to know what you're going in for*" (Adeela) to avoid questions if she happened to be seen accessing local service. While many women faced "shame inducing events" when trying to access support, this did not deter them from seeking the support they needed. This involved circumnavigating challenges by avoiding particular GPs and finding and accessing general health care services (rather than sexual-health specific services) that did not leave them feeling vulnerable to shame.

An emphasis on marriage allowed some women to negotiate shame on an internal basis:

> If you're gonna get married to him then I don't think it's really a big problem because at the end of the day you're gonna get married to him. (Naznin)

Others referred to how they developed personal rules and boundaries to manage shame:

> You know it's wrong, but you can make yourself believe it's not wrong, you can convince yourself and then all that [shame] just kind of goes away. (Saleha)

Some referred to how they could feel comfortable with kissing; touching and being close but would refrain from penetrative sex or "*the deed*" (Safia). The belief that "a *woman keeps her respect if she has her virginity*" (Safia) appeared to allow some women some level of control over their desires.

Cense (2019) describes how embodied agency can allow young people to embrace or distance themselves from social values and norms. This was demonstrated by women highlighting that while withholding sex during marriage was perceived as sinful, they would not abide by these religious rulings, and felt agency and consent in sexual decisions was paramount:

> Cos there has to be a balance doesn't there. You can't always do what religion tells you to do because it's going to turn you in to a whole completely different person. (Munira)

Discussion

In this paper, we offer insights into British-born South Asian women's experiences of sexual health, to understand the influence of religion, culture, and the community. The theoretical framework demonstrates how women are influenced by religion and wider socio-cultural factors, but also that they demonstrate agency and reasoning to negotiate a personal level of sexual agency. Overall, what was apparent from the findings was that there was a continuum on which sexual agency was enacted. On the one end there were a few women who were closely influenced by religion, culture, family and community expectations which meant that they would never place themselves in a position where they entered a romantic relationship. On the other hand, there were more women who were trying to navigate shame to negotiate some form of sexual agency and find the balance that was right for them despite the influence of religion. While this study focused on British-born South Asian women, these findings resonate with participants from other religions, cultures (Hawkey, 2019) and ages e.g., young mothers (Fallon, 2013) from different global settings.

Our findings resonate with those of Guo and Metcalfe (2019), who found that religious beliefs and values, transmitted *via* family and community members played a key role in influencing an individual's behavior. These beliefs dictated that pre-marital sex and relationships were forbidden, falling pregnant before marriage was a serious concern and something to

be avoided, and that women should behave within acceptable boundaries. Having a good reputation within the family and community was perceived as fundamentally important (Kiridaran et al., 2022). This was also reflected in the findings of a study undertaken by Couture-Carron (2020) on shame, honor and dating abuse among young, South Asian Muslims which found that family honor was paramount over one's own desires and needs. Individuals from a South Asian background who cause shame and endanger the honor of their family, risk being outcast by not only their immediate family but also the wider community (Cowburn et al., 2015).

Notwithstanding these cultural values, most of our participants had experienced romantic relationships, often in the hope of marriage, although arguably this could be a wider influence of acculturation. Zaidi et al. (2016) found that South Asian youth living in Western society are confronted with ongoing cultural dilemmas around social and personal affairs. Similarly, Ussher et al. (2017) who explored sexual embodiment in refugee women found that many described navigating shame instilled through enculturation to fulfill their sexual health needs. Where participants felt able to disclose their relationships with their mothers, this was often after a lengthy (and often hidden) courtship, and when their relationship was deemed to be serious enough to lead to marriage. This is supported by Mehrotra (2016) who found that messages about heterosexual marriage formed part of a cultural script in South Asian women that was passed across generations and was viewed as central to the construction of womanhood. Our findings also reflect those of Kiridaran et al. (2022) who found that South Asian women kept their romantic relationships secret to prevent familial shame. However, a new finding in our study was that many mothers were complicit in these secrets.

While some of the young women had accessed services for their sexual health-related needs, several described actual or perceived judgment from providers and others in attendance at the clinics. These findings resonate with those by Waling et al. (2023) who found that shame, judgment, and embarrassment influenced participants' access to sexual health information. This situation may be addressed by female health care professionals, as highlighted in other studies (Thomson et al., 2021). There were also concerns about accessing family doctors who were of the same religion or cultural background. As women would often try and circumnavigate these difficulties by accessing general rather than sexual health-related services, this raises an important consideration of where such provision should be located and to enable women to access the help they need. Effective planning of the location of sexual health services has been identified to improve use by patients and save costs (Meskarian et al., 2017).

Practice-related implications

While a small scale study, and further research to substantiate the findings is needed, the insights generated offer practice-related implications for transcultural nursing and health care in terms of (a) mandatory cultural safety training that incorporates service-user voices and use of the theoretical interpretations to raise health care professionals' awareness of factors affecting patients' ability to access services, (b) locating sexual health services and clinics within general health care settings to improve confidentiality and alleviate concerns, (c) revisiting sexual health education to ensure it is fit for purpose to help minimize shame and to help promote positive self-agency and sexual health.

The development of theory also has implications for practice. The theoretical framework (Figure 1) considers how British born South Asian women navigate aspects of shame in order to negotiate their own sexual agency. By understanding these needs on a continuum, can help to understand the different levels of support these women may need. This may prove valuable for health care professionals to provide person-centred care. The theoretical framework could be used within training and guidance to deliver care in a culturally appropriate manner.

Strengths and limitations

A key strength of our study is that data collection was undertaken by a researcher from a similar background to the participants. An insider position affords the researcher insights that an outsider researcher may not be able to access (Pelias, 2011). While insider knowledge may keep researchers from seeing things objectively (Pelias, 2011), the second author was a researcher from a White ethnic background who helped to question pre-understandings and to prevent data collection and analysis from being overly biased. A limitation is that an in-depth literature review of the topic area was not undertaken at the start of the study, congruent with a grounded theory approach. Despite numerous recruitment efforts, participant numbers were limited, however, this is likely related to the sensitive nature of the topic area. The fact that we captured the views of sixteen participants on such a delicate topic area is a strength. Theoretical sampling determined the direction of data collection in line with grounded theory, but this meant that other lines of enquiry such as considering the views of mothers were not pursued. This is an important topic for future research.

Conclusions

In this study we explored the perceptions, awareness, and experiences of sexual health among British-born South Asian females aged 18–25 and

offers a novel theoretical interpretation drawing on the theories of shame and agency. Our findings revealed that while culture and religion influenced women's views and beliefs, pre-marital relationships were common. Women went to great lengths to keep their relationships hidden from family and the community but often colluded with their mothers, particularly when the relationship had the potential for marriage. Women could face barriers when accessing health care for their sexual health needs due to the potential for shame and judgment. This work highlights important implications for more appropriate sexual health education, venues where sexual health clinics are located, training for health care staff and further consideration of sexual health education.

Author contributions

All authors contributed to the study conception and design. Material preparation and analysis were performed by Sabina Gerrard and Gill Thomson. Data collection was undertaken by Sabina Gerrard. The first draft of the manuscript was written by Sabina Gerrard and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Consent to participate

Informed consent was obtained from all individual participants included in the study.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethical approval

This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of the University of Central Lancashire, Preston, England, United Kingdom (ref: BuSH:155).

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