HIV/STI RISK OF YOUNG SOUTH ASIAN SEXUAL MINORITY WOMEN

PRAGYA MISHRA

A COMMUNITY-ENGAGED STUDY TO UNDERSTAND THE HIV/STI RISK OF YOUNG SOUTH ASIAN SEXUAL MINORITY WOMEN IN THE GREATER TORONTO AREA

By

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ABSTRACT

The human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic has surpassed forty years with many medical advancements in prevention and treatment. Often believed to be at negligible or low risk by society at large, sexual minority women have remained understudied regarding their risk of HIV and other sexually transmitted infections (STIs), leaving their sexual health inadequately understood and supported in healthcare and social services. The sexual health of young South Asian sexual minority women, who are multiply minoritized due to their intersecting identities, has been entirely overlooked. This qualitative study aimed to understand the knowledge, attitudes, and practices of young South Asian sexual minority women as it pertains to their HIV/STI risk. Barriers and facilitators to accessing community-based sexual health supports and services were also investigated.

A community-engaged approach was taken to develop this study in partnership with the Alliance for South Asian AIDS Prevention to investigate the HIV/STI risk context and sexual health needs of this group residing in the Greater Toronto Area. A maximum variation sampling strategy was used to recruit six young South Asian sexual minority women and semi-structured in-depth interviews were conducted to collect narrative data. Narrative analysis of the data found socio-cultural and structural influences which guide the HIV/STI risk context for this group. The participants illuminated an inadequate understanding of sexual health when engaging in sex with women, an overall low HIV/STI risk perception, barriers to adequate sexual healthcare and health promotion resources, and multiple minority stressors which impacted their access to safe sex. These findings have major implications for school-based sexual health education, medical training for healthcare practitioners, and sexual health support and services provided by community-based sexual health organizations in the Greater Toronto Area.

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DEDICATION

I would like to dedicate this work to all diasporic South Asian women who have carried generations across and forward; without whom we may have never laid new foundations and created new homes.

To all the queer South Asian women, and especially those who exist within the boundaries of a ‘closet,’ I hope you construct, and de-construct, and re-construct your queerness as you desire. May loves you find never be limited by boxes and categories that were constructed for you. Your existence is an act of resilience; may you never fail to see the beauty within yourself. In solitude, may you find warmth, love, and joy.

PREFACE

The experiences of any individual or group must be understood contextually; geopolitically, culturally, and whatever else we have constructed. We have always drawn lines and created categories to make sense of things, but rarely have these categories included those who experience life at the margins of dominant culture.

Here, I co-construct with diasporic queer South Asian women and offer knowledge from the liminal spaces of categories. I draw new lines and create new categories to better understand the current context where these findings may be applied. May even these lines and categories be dismantled in the future if that promises a more equitable world.

In hopes that one day, HIV/AIDS will be remembered as an eradicated disease of the past. May it guide us to deconstruct, re-think, and adapt for a better world for all.

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ASAAP	Alliance for South Asian AIDS Prevention
BV	Bacterial Vaginosis
CDC	Centre for Disease Control and Prevention
CER	Community-Engaged Research
Cis	Cisgender
gbMSM	Gay, Bisexual, Men Who Have Sex with Men
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
LGBTQ+*	Lesbian, Gay, Bisexual, Transgender, and Queer
PrEP	Pre-Exposure Prophylaxis
STI	Sexually Transmitted Infection
Trans	Transgender
WLW	Women-Loving-Women/Women Who Love Women
WSW	Women Who Have Sex with Women

*At times, variations of the acronym (e.g., LGBQ/LGB/LBQ) are used in contexts where certain sexual identities or transgender individuals were not represented within a particular study as to ensure nuance.

A note about language:

The literature review conducted for this study uses the terms WSW, LGBQ+, and queer interchangeably to refer to cisgender sexual minority women. Cisgender women here refers to individuals who were assigned female at birth and who identify as women. For the large part, this review does not include the experiences of transgender women who may identify as WSW or

LGBQ+ as transgender individuals’ experiences are vastly different from those who are cisgender, and the failure to understand these differences runs the risk of glossing over experiences unique to transgender women which impact health. As such, the review focuses on data from cisgender South Asian women, specifically, as these identities more closely align to those of young South Asian cisgender sexual minority women.

Declaration of Academic Achievement

I, Pragya Mishra, declare this thesis work to be my own as the sole author. My supervisor, Dr. Saara Greene, and community partner, the Alliance for South Asian AIDS Prevention (ASAAP), guided the creation of the study design. I collected data, conducted the analysis with feedback from ASAAP, and wrote this thesis document thereafter. Dr. Greene provided detailed feedback throughout my writing process and my committee members, Dr. Emma Apatu and Dr. Dale Guenter, provided feedback on the contents of this document.

CHAPTER 1: INTRODUCTION

1.1 Overview

The year 2020 marks 40 years since the beginning of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic; an illness which continues to impact many lives globally. At the end of 2016, there were 63,110 Canadians living with HIV, and 14% of cases were estimated to be undiagnosed. Canada has seen an increase of 25% new HIV infections between 2014 and 2018 (from 2,040 in 2014 to 2,561 in 2018), wherein Ontario accounts for the largest proportion of all new cases (Haddad et al., 2019). While the gay, bisexual, and other men who have sex with men (gbMSM) exposure category remains the highest proportion of all cases, this proportion has decreased over time. This is likely due to HIV care and support dedicated to this population since the beginning of the epidemic. Notably, women[1] have experienced a larger increase in new infections and diagnosis rate according to Canada's 2018 HIV Surveillance Report (Haddad et al., 2019). This is significant considering an approximate $686.8 million was spent on HIV prevention and treatment in 2015 (Dieleman et al., 2018). Despite this investment, new infections in women have continued to rise, shedding light on the need for targeted prevention strategies if the eradication of HIV/AIDS epidemic as a public health threat is the ultimate goal.

Although there is no known cure for HIV infection, significant medical advancements have made this disease more manageable, less likely to be transmitted (with appropriate treatment), and importantly for public health, preventable (Cohen et al., 2016; Nicol et al., 2013; Rodger et al., 2016, 2019). At present time, when people who are infected with HIV are on antiretroviral therapy (ART) and have an undetectable viral load, the potential for HIV transmission is very low (undetectable = untransmissible, U=U) (Rodger et al., 2016, 2019). At the same time, certain

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[1] Women: For the 2018 HIV Surveillance Report, the Public Health Agency of Canada's (PHAC) overall rates included cases where sex was transsexual, transgender, not reported or unknown. However, PHAC excluded these cases to calculate proportion of new HIV cases by age group and sex. Numerical data in this review thus only mentions data on individuals assigned female at birth.

populations within Canada continue to face barriers to HIV care and support and access to relevant sexual health information, creating conditions for higher rates of HIV transmission to occur. Included in this group are lesbian, bisexual, and other women who have sex with women (WSW).

Research recognizes that lesbian, bisexual, and other WSW experience unique vulnerabilities to HIV infection. However, to this date, there have been no studies done with young South Asian sexual minority women to understand their risk of HIV and other sexually transmitted infections (STIs) in the Canadian context, creating a notable gap in the literature which needs to be addressed in order to better understand the HIV/STI risk and sexual health needs of this group residing in the Greater Toronto Area; home to the largest number of South Asians in Ontario (Islam et al., 2017).

1.2 Research Questions and Objectives

The present study aims to answer the following research questions:

1) What are the knowledge, attitudes, and practices of young South Asian sexual minority women living in the Greater Toronto Area (GTA) pertaining to HIV/STI risk?; and
2) What barriers or facilitators affect access to community based sexual health supports and services?

The research objectives of this study are as follows:

- To understand the HIV/STI risk of young South Asian sexual minority women living in the Greater Toronto Area (GTA);
- To inform HIV/STI prevention programming for the Alliance for South Asian AIDS Prevention (ASAAP) and other HIV/AIDS service organizations.

- To produce literature on the experiences of young South Asian sexual minority women pertaining to HIV/STI risk and their sexual health needs.

1.3 Research Scope

This thesis study aims to be contextualized to the experiences of young, diasporic, South Asian cisgender sexual minority women who live in the Greater Toronto Area, the most populous metropolitan region in Canada. I aim to learn how young South Asian cisgender sexual minority women approach sex and relationships, make meaning of their experiences, calculate risk pertaining to HIV/STIs, and practice sexual health protection. This study does not aim to measure the magnitude of HIV/STI risk experienced by participants. Rather, it aims to produce disaggregated data to conceptualize and illuminate the HIV/STI risk context for a group that repeatedly falls between the gaps of HIV/STI research, education and prevention resources. This work does not aim to prove that young South Asian cisgender sexual minority women are at higher or lower risk of HIV/STI compared to other populations. Instead, it aims to showcase contexts where HIV/STI risk is produced and emphasizes that understanding these contexts equips communities with tools for health promotion and health protection. As such, the findings of this research would be most relevant to community based sexual health services, AIDS service organizations, sexual health education and prevention programs, and sexual health policy makers.

CHAPTER 2: LITERATURE REVIEW

This literature review examines literature to form a biological, structural, and social understanding of HIV/STI risk in which young South Asian sexual minority women living in the Greater Toronto Area may be situated.

2.1 HIV/STI Transmission Among Cisgender Lesbian, Bisexual, and other WSW

HIV transmission rates that occur solely as a result of sexual activity between cisgender (cis) women who only have sex with other cis-women are very low. In the context of undetectable = untransmittable (U=U), it is unlikely that HIV transmission will occur through sexual activity between two cis-women in the event that there are no other risk factors (e.g. needle sharing during intravenous drug use, unprotected sex with cis-men, transgender women, and multiple partners whose HIV status is unknown) (Cohen et al., 2016; McNair, 2005; Rodger et al., 2016, 2019). Additionally, STI transmission between cis-WSW is possible and has been reported (Bailey, Farquhar, Owen, et al., 2004; Logie, Navia, et al., 2015), although it remains an underreported statistic in high-income countries. This may be due to sexual stigma, low HIV/STI screening, and low HIV/STI risk perception amongst cis-WSW (Rothblum, 2020). It is important to consider that Canada's HIV statistics do not include or accurately reflect HIV transmission between cis-women since these women cannot report having a female sexual partner, resulting in lack of complete and accurate data on this population (Logie & Gibson, 2013). Along with erasing the lived experiences of sexual minority women, this eliminates the possibility of HIV risk transparency for cisgender women who are not strictly heterosexual.

Assessing the sole risk of HIV transmission between two cisgender women has been difficult due to the presence of other risk factors in individuals' lives. As of 2021, there have been some reported cases of HIV transmission through sex between cisgender women in North America, where no other risk factors were present. Of those cases, two transmissions likely occurred as a result of the exchange of blood-tinged vaginal fluid (Chan et al., 2014; Kwakwa & Ghobrial, 2003). Notably, in both cases, the women rarely used protective barriers during sex, engaged in sex during menses, shared sex toys, and the HIV positive partner had a detectable, thus transmittable, viral load. Kwakwa and Ghobrial (2003) refer to this as an "uneasy coexistence" of case reports with confirmed HIV transmission between cis-women and lack of empirical evidence showcasing sole risk of such transmission. This has been due to larger studies, such as one conducted by Petersen et al. (1992), attributing HIV positivity in cis-WSW to other risk factors which were simultaneously present since hierarchized exposure categories are used when collecting data (ie. unprotected sex with men, injection drug use, etc.).

A number of studies done with cis-WSW show a high prevalence of STIs in the population due to low perceived risk of infection, low testing, and lack of access to relevant sexual health education and prevention resources (Fethers et al., 2000; Marrazzo, 2004; Mullinax et al., 2016). We currently know that transmission of STIs such as bacterial vaginosis, genital herpes, trichomoniasis, human papilloma virus, and hepatitis C between cis-women is possible (Bailey, Farquhar, Owen, et al., 2004; Bauer & Welles, 2001; Fethers et al., 2000; Marrazzo, 2004). This is supported by studies finding that STIs remain prevalent amongst cis-WSW who have never had sex with men (Bailey, Farquhar, Owen, et al., 2004; Lindley et al., 2007). In some cases, cis-WSW had a higher risk of STIs compared to heterosexual women. A Toronto-based study showed that amongst cis-WSW, STI history was correlated with sexual stigma, forced sex, and the belief that their healthcare provider was uncomfortable with their sexuality (Logie, Navia, et al., 2015). Evidently, this points to structural and social factors which impact HIV/STI risk for cis-WSW.

It will likely remain difficult to assess sole risk of HIV transmission between two cis-women, given that the population of cis-women who only have sex with women and have no other risk factors for HIV is small. As a result, it may be concluded that HIV transmission between two cisgender women who are unaware of their HIV status or where one has a detectable viral load is rare, but possible. Additionally, STI transmission between cis-WSW is prevalent. The dearth of research aiming to understand and report the risk of HIV/STI transmission for cis-WSW perpetuates the misconception that these women cannot be at risk of STIs and do not need relevant sexual health education to promote their health and prevent HIV/STI transmission. Consequently, the public health focus is that women should be informed of STI risks relevant to their lives, be aware of their own HIV status, and have access to relevant and necessary information and education to make decisions about their sexual health and prevention needs.

2.2 Structural Context of HIV/STI Risk: Education and Prevention

Structural interventions are integral to global HIV prevention strategies as they prevent spread at the population level. These interventions aim to change the context in which risk is produced and promote contexts conducive to resiliency against exposure to HIV/STIs (CATIE, n.d.). Structural factors which impact health are defined as the economic, policy, organizational, justice, educational, and healthcare systems in which risk for a particular health event is produced (Sumartojo, 2000). Lack of access to relevant sexual health education and resources, barriers to relevant healthcare, construction and use of risk categories, and lack of access to HIV prevention medication increases vulnerability to HIV/STIs for cis-WSW. These form the structural context in which young South Asian cisgender sexual minority women may be situated.

2.2.1 Sexual Health Education and Resources

Access to relevant sexual health education can help prevent new HIV infections and lower rates of STIs amongst youth. However, school-based sexual health education has been shown to be insufficient and irrelevant to the lives of lesbian, gay, bisexual, and queer (LGBQ+) youth (Elia & Eliason, 2010a). School-based sexual health education has mainly focused on abstinence, condom use to prevent pregnancy, and heterosexual sex, failing to acknowledge gender and sexual diversity and the specific needs of these youth, such as other forms of sex, prevention of STIs, and forming and maintaining healthy relationships (Gegenfurtner & Gebhardt, 2017; Poon & Ho, 2008). This leaves youth vulnerable to STIs or misinformation, hindering them from having the resources to promote and protect their sexual health. Not only do these curriculums perpetuate heteronormativity, but they also overlook HIV/STI risk factors such as events in which sex occurs due to uneven power dynamics, violence, or stigma.

School-based sexual health education can be an important prevention entry point for sexual minority youth, especially for those who experience sexual stigma. However, not all immigrants enter Canada at school age, and this impacts exposure to sexual health education as well. Salehi and Flicker (2010) found that youth not born in Canada were significantly less likely to report exposure to sexual health education compared to those born in Canada. Notably, 18.8% of newcomer youth who were born elsewhere and had been in Canada for 3 years or less had never received any sexual health education. Community based organizations can fulfill this gap by implementing health promotion and prevention programming and providing resources. However, as it relates to ethnic sexual minority youth, resources from mainstream LGBTQ+ organizations have been considered culturally irrelevant and thus not always applicable to the lives of these youth (Griffiths et al., 2008; Poon & Ho, 2008).

Interventions are best received when they are contextualized to the community (Bhattacharya, 2004). When educational and organizational spaces do not support this need, uptake can be thwarted. As a result, it is imperative that culturally relevant sexual health education be available and accessible to ethnic sexual minority youth, such as young South Asian cisgender sexual minority women. A gap in relevant sexual health education and resources remains a significant structural barrier to HIV/STI prevention – an investment into which can equip youth with relevant resources at the population and community level.

2.2.2 Barriers to Relevant Healthcare

Sexual stigma experienced in healthcare settings can deter cis-WSW from seeking health-related services (Johnson et al., 2008). One study found that lesbian and bisexual women were more likely than heterosexual women to have poor health behaviours and worse access to healthcare, concluding that sexual orientation has an independent effect on health behaviours and access to care (Diamant et al., 2000). In the Canadian health system, where majority of healthcare is federally funded, access to competent care for cis-WSW remains an unmet need. Mathieson et al. (2002) found that their participants experienced stigma and homophobia in healthcare settings which contributed to delayed health care seeking. Additionally, over half of their sample perceived HIV/STIs and safer sex information as important, meanwhile significant lack of knowledge regarding risks of STI transmission between women and low perception of HIV risk were prevalent in the sample.

Bailey and colleagues (2003) found that physicians often failed to gain complete sexual history from lesbian and bisexual women when they assumed that having a lesbian identity meant sexual activity with men is entirely eliminated. On the other hand, research which acquires self-reported data may contain cases where STIs were undiagnosed and asymptomatic, leading to underreporting and underestimation of risk (Bauer & Welles, 2001). If women are unable to comfortably disclose their experiences and physicians cannot obtain a realistic and holistic picture of women's sexual lives, relevant healthcare access is hindered even when it is available.

Experiences of homophobia and lack of competent LGBTQ+ care create an obvious gap in healthcare for these women, producing a barrier to relevant and competent health services. Young South Asian cisgender sexual minority women, in particular, may experience additional deterrents to healthcare access due to community norms such as denial of HIV and same sex intimacy within the South Asian community (Bhattacharya, 2004; Hawa et al., 2017). This is explained further in social contexts contributing to HIV/STI risk. The use of risk categories compounds vulnerabilities to HIV risk through the social construction of low risk and erasure of cis-WSW in dominant HIV discourse.

2.2.3 Risk Categories and the Social Construction of Low Risk

Since the beginning of the epidemic, hierarchized risk categories have been constructed to communicate HIV risk within different populations. As a result, groups considered 'high risk,' such as gbMSM, transgender women, and cisgender heterosexual women have been prioritized in HIV prevention strategies. This has contributed to the increased stigmatization of certain groups due to association with HIV and on the other hand, erasure in HIV discourse and research, and thus lack of access to HIV prevention, care and support for others. Lesbian, bisexual, and other cis-WSW have long been constructed as "immune" to HIV, which has been reinforced by underrepresentation of lesbian, bisexual, and other cis-WSW in HIV research (Logie et al., 2012; Logie & Gibson, 2013; Mathieson et al., 2010; Richardson, 2010). This institutionalized exclusion of cis-WSW from research and thus prevention fuels a gap still existing in research and sexual health services today; where lack of research on HIV/STI risk for cis-WSW drives lack of funding for HIV/STI prevention programs for cis-WSW, such as young South Asian sexual minority women.

The construction of low or no risk of HIV amongst cis-WSW was founded on the fact that HIV transmission between cis-women is inefficient. While that is true, it is important to consider the coexistence of the female sex's increased biological susceptibility to HIV infection and other vulnerabilities which impact risk of HIV exposure, such as homophobic or misogynistic violence, injection drug use, and ever having an STI (Public Health Agency of Canada, 2012). Perception of low risk often leads to low testing for this group, increasing the chances of HIV/STIs remaining undiagnosed (Somayaji et al., 2017). It is important that women know how HIV is transmitted and how STIs present in cis-women so that women are equipped with prevention resources and are able to access relevant healthcare as early as possible. Evidence thus urges us to focus on combination risks of HIV infection which reflect the lived realities of people in their respective contexts (Pinto et al., 2005). The social construction of low risk does not consider these complexities. With this knowledge, it is imperative that sexual health screening for cis-WSW not differ from heterosexual women, cis-WSW be encouraged to test for HIV/STIs, and have access to relevant sexual health information and resources to make informed choices about their health.

2.2.4 Pre-Exposure Prophylaxis: Prevention and Access

The development of pre-exposure prophylaxis (PrEP) in 2012 was a significant advancement in HIV prevention for people at risk of exposure through sex or injection drug use. PrEP is highly effective at preventing HIV infection when taken consistently (99% effective for sex and 74% for injection drug use), making adherence essential to maintaining drug efficacy (CATIE, 2016; CDC, 2020). However, while PrEP is available in Canada, it is not accessible to everyone who may be at risk of HIV. Further, the lack of clinical trial data for cisgender women, varying levels of awareness and willingness to initiate PrEP among communities, and healthcare provider knowledge, attitudes, and practices on the subject of PrEP all impact accessibility to HIV prevention knowledge and resources for cis-WSW.

Currently, PrEP is prescribed under the names Truvada and Descovy, of which the former was approved by Health Canada in 2016. These drugs have been found to be effective in preventing HIV infection in cisgender men and transgender women; wherein transgender women require regular monitoring due to inconclusive data on drug interactions between PrEP and feminizing hormones (Anderson et al., 2016; Deutsch et al., 2015; Grant et al., 2016; Hiransuthikul et al., 2019). This quality of data on PrEP safety and efficacy for people who have receptive vaginal sex however is lacking, leaving cis-WSW entirely out of HIV prevention research and efforts. Safety and efficacy data are especially important when the limited research which has included cisgender women show low drug levels in vaginal tissue compared to the rectum (Hendrix et al., 2013; Louissaint et al., 2013; Patterson et al., 2011). This suggests that cisgender women may be protected from HIV with strict PrEP adherence and possibly higher dosage compared to cisgender men and transgender women. This knowledge and present data make access to PrEP an important stride in HIV prevention for all.

In 2019, the Food and Drug Administration approved Descovy as a new HIV prevention drug, but not for anyone who has receptive vaginal sex. This is solely because the clinical trial only included cisgender gay men and transgender women, of which the latter were only 1% of the sample (Rosenberg, 2019). When sizable groups, such as people who have receptive vaginal sex, are excluded from large randomized control trials, which are considered the gold standard for clinical research, such exclusions contribute to a narrative that women are at low risk of HIV infection and do not benefit from drugs such as PrEP. A cycle of risk is produced when multiple risk factors are not well understood, thus (mis)informing empirical studies which exclude groups from prevention research and consequently resources.

Healthcare providers' knowledge, attitudes, and practices pertaining to prescribing PrEP also impact accessibility to information and resources for people. Krakower et al., (2017) found that primary healthcare providers who were specialized in LGBT care were better able to understand HIV risk for LGBT patients and thus prescribe PrEP, whereas generalist primary healthcare providers felt less equipped to make decisions regarding prescribing PrEP to patients. Despite the efficacy of this drug, its use amongst clinicians remains limited (Krakower & Mayer, 2012). Primary healthcare providers may be able to prescribe PrEP to those who can benefit from it but lack of competent LGBTQ+ care impedes access.

Calabrese and colleagues (2016) suggest that inclusive PrEP messaging may support the funding of PrEP policies and programs whereas targeted messaging (ie. PrEP for MSM) was found to be associated with greater prejudice and lower support for funding PrEP initiatives. Evidently, PrEP awareness, acceptability, and utility vary across communities, highlighting the need for inclusive and community-contextualized prevention programs and messaging. As community LGBTQ+ and sexual health organizations secure the most stable funding from HIV prevention services (Lenke & Piehl, 2009; Ward, 2008), it is important that empirical research support risk transparency for all populations, and PrEP messaging be inclusive so as to garner greater support for funding PrEP initiatives and to not further stigmatise groups. These approaches would ensure that prevention resources and information are available and accessible to everyone who may be at risk.

In light of the susceptibility to HIV when one has an STI history, instances of when women are unable to negotiate condom use, situations where sex is non-consensual, and the biological premise that PrEP administers lower efficacy in vaginal tissue, it is evident that structural factors contribute to a cycle of risk for women, wherein WSW are entirely overlooked. Understanding the social contexts of young South Asian cisgender sexual minority women helps to further situate HIV/STI risk for this population. The interaction of race, gender, sexuality, and culture as it relates to HIV/STI risk has not yet been studied for this specific group. The importance of understanding the convergence of these factors on HIV/STI risk may be realized in community-based combination prevention strategies and culturally competent sexual health education.

2.3 Social Context of HIV/STI Risk for Young South Asian Cisgender Sexual Minority Women

Social factors which influence health refer to the conditions and circumstances into which people are born, grow, socialize, work, and form relationships (WHO, 2008). For young South Asian cisgender sexual minority women, intertwined racial, ethnic, gender, and sexual identities embed themselves in the diasporic South Asian community's social context. Social norms which exist at the intersection of these identities determine resilience or vulnerability to HIV/STIs for individuals. These contexts shape how individuals understand and calculate personal risk of contracting HIV/STIs, and how they navigate sexual experiences and power. Thus, these contexts also explain the discrepancy which exists between community beliefs and individual behaviours. At present time, literature on the intersection of sexual minority identity and South Asian identity for cisgender sexual minority women living in Canada is limited to one study, however extant literature on the knowledge, attitudes, and practices of South Asian cisgender heterosexual women pertaining to HIV/STIs offers insight and showcases a need for access to sexually inclusive and culturally specific resources and interventions.

The sexual health of cis-WSW is not well understood because it is rarely examined at the intersections of other identities; intersections which more accurately reflect the lived realities of these women. A woman's ability to decide how and with whom to have sex, and if and when protection is used is entrenched within the social and cultural lives of women. Lenke and Piehl (2009) provide a nuanced understanding of the ways in which cis-WSW may be at risk of HIV/STIs due to social factors. Namely, the overrepresentation of cis-WSW among drug users, their susceptibility to homophobic and misogynistic violence, and negative mental health outcomes indicate a high vulnerability to HIV/STI. Even then, how cis-WSW are constructed by society at large seldom aligns with lived experiences, and coexisting factors which may mediate or exacerbate these risks are not well understood (Lenke & Piehl, 2009). Specifically, 'institutionalized WSW' must be understood differently from 'marginalized WSW.' Institutionalized WSW are relatively culturally and historically accepted (in a specific context) and refer to individuals whose practices are recognized (or generally accepted) because they were established by dominant cultures (e.g., White queerness) whereas 'marginalized' WSW lack the cultural heritage (e.g. due to factors such as colonization, etc.) needed in order to gain cultural and social acceptance (in that same context), describes Wieringa (2008). Modern day 'marginalized' WSW consist of middle-class women who may live their lives relatively openly, and other WSW who live in isolation and silence, resulting in limited access to information and community because they do not or cannot subscribe to the queer culture dictated by institutionalized queer individuals. Such may be the case for young South Asian sexual minority women living in Canada.

The following description of social factors affecting HIV/STI risk for young South Asian cisgender sexual minority women follows the guidance of Dworkin (2006) and attempts to break up the WSW category and examine the diverse aspects of sexuality and factors which impact it specifically in South Asian women's lives. The lack of discussion surrounding sex, prevalence of homophobia, experiences of racism and acculturation status, and hegemonic masculinity impact HIV/STI risk for young South Asian cisgender sexual minority women.

2.3.1 Lack of Community Knowledge Surrounding Sex and Homophobia

Cultural patterns of South Asian communities show that protecting public honour, or "*izzat*," is an important community norm which impacts individuals' choices and behaviour (Weston, 2003). The onus of protecting *izzat* falls on each individual member of the family and thus individual actions are deemed reflective of familial values. Individual behaviours are rationalized in the context of community norms, so as to maintain *izzat* in the community (Bhattacharya, 2004). This impacts knowledge sharing as taboos around the discussion of sexual matters are a major driver of lack of HIV/STI knowledge and denial of HIV and same sex intimacy in South Asian communities.

Conversations about safe sex and STIs between parents and children are uncommon and considered "off limits" (Hawa et al., 2018; Vlassoff & Ali, 2011; Zhou et al., 2016). Oftentimes, parents deny that their children are having pre-marital sex or having same sex relationships, inevitably concluding that HIV is not a concern for them, their children, or the community. For example, a common myth about HIV transmission is that one cannot get HIV after marriage (Vlassoff & Ali, 2011). A Canadian population-based cohort study examining the sociodemographic factors for *Chlamydia trachomatis* infection found that persons of South Asian descent had a protective association (ie., South Asian identity was associated with low rates of infection) with chlamydial infection. However, South Asians were also less likely to get tested for *Chlamydia trachomatis*, potentially contributing to the low number of cases (Somayaji et al., 2017). Myths about HIV/STI transmission, incomplete knowledge, and misinformation have been found to be common amongst South Asian women (Hawa et al., 2017; Vlassoff & Ali, 2011; Weston, 2003). While attitudes towards HIV have shifted over the years, it is the incomplete knowledge which is produced by accepting broad generalizations about HIV and drawing inaccurate conclusions which has resulted in increased stigma amongst South Asians (Vlassoff & Ali, 2011). HIV/STI risk is thus embedded in the social context of South Asians and dependent on how, when, and where individuals are able to attain accurate and relevant sexual health information.

Moreover, engaging in same-sex intimacy is deeply taboo in the South Asian community. The intensity of this prohibition may be understood by how many South Asians who engage in same-sex intimacy lead 'marriages of convenience' in order to fulfill cultural expectations and familial obligations (Choudhury et al., 2009). Although diasporic youth are better equipped with sexual health information than their parents due to generational differences in exposure to education, same sex intimacy is still widely rejected within the community, and accurate and relevant sexual health information for young South Asian cisgender sexual minority women is therefore limited (Vlassoff & Ali, 2011; Zhou et al., 2016). As a result, many LGBQ+ youth find themselves either going against cultural norms and being rejected from the community or living in silence and not finding information and services relevant to their lives. An overview of the sexual and reproductive health of South Asians living in the United Kingdom shows that contraceptive use is poor and anal sex is prevalent among South Asian youth, likely as means of contraception (Griffiths et al., 2008), showcasing potential behaviours that other diasporic South Asian youth may be engaging in.

Evidently, stigma surrounding sex, same-sex intimacy, and HIV/STIs create a cycle of disruption to knowledge, contributing to HIV/STI risk for young South Asian cisgender sexual minority women. Wong and colleagues (2019) note that the lack of access to HIV prevention resources and sexual health information may perpetuate misconceptions and maintain denial of HIV in the community. Denial that HIV and same sex intimacy exist within the community contributes to a narrative that South Asian youth do not need access to HIV/STI knowledge, further preserving this gap in awareness.

2.3.2 Racism, Dual Identity, and Acculturation

The diasporic experience holds many instances of acculturation stress and racism. When compounded, these factors change the risk context of HIV/STI infection by impacting the overall wellbeing of South Asian immigrants. The immigrant identity is important to consider when working with diasporic populations as many factors mediate or exacerbate risk. The sexual minority South Asian community is itself very diverse, and the ability of sexual minority youth to fare well in the North American context is mediated by education level, generations in Canada, identification with own culture and ethnicity, interaction with the larger lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, social class, and experiences of racism and exclusion (Ibrahim et al., 1997). These factors affect how youth find community, form support systems, and navigate decisions about their health. Although the experiences of young South Asian cisgender sexual minority women are not well documented, experiences of other racialized sexual minority youth may provide insight.

Participants in a study investigating the contemporary race relations within Toronto's LGBTQ+ community shared that there is a false sense of community cohesiveness within the community. Racism impacts how racialized sexual minority youth are able to form community but is often not prioritized as a topic of discussion when HIV/AIDS still remains a stigmatized topic within the community (Giwa & Greensmith, 2012). Racially charged microaggressions, such as the expectation to 'come out' to be accepted as queer, continue to invisiblize South Asian sexual minority women in Toronto's larger LGBTQ+ community (Patel, 2019). However, coming out can have severe consequences for young South Asian women and may not always be a culturally conducive way to express queerness as a South Asian sexual minority woman. Sandil et al (2015) found that a higher level of outness, or the extent to which one is open about their sexuality, exacerbated psychological distress, where racist events were linked to high psychological distress for South Asian LGBQ individuals. On the other hand, Patel (2019) highlights the nuances of shadism which privilege lighter skinned South Asian women compared to those with darker skin, concluding that even within queer South Asian women, marginalization and privilege are not uniform. Ultimately, dual exclusion is faced by young South Asian sexual minority women when they are not accepted by the South Asian community and feel that they do not completely belong in the White dominated LGBTQ+ community in Canada. South Asian sexual minority women are thus poorly conceptualized and often maintain their location at the margins of Toronto's broader LGBTQ+ community.

Many South Asian sexual minority youth are unable or choose to not disclose their sexual identity for safety reasons and fear of rejection from their family or community. As a result, compared to their White counterparts, racialized sexual minorities are less likely to frequent social settings that reinforce LGBTQ+ identities (Patel, 2019; Rosario et al., 2004), further preventing access to relevant sexual health information and a knowledge-sharing community. Additionally, many lesbian and bisexual women engage in sexual activity with men as an effort to deny same sex desire to oneself or to family members (Rosario et al., 1996). Considering the rejection of same sex intimacy within South Asian communities, this may be plausible behaviour for young South Asian cisgender sexual minority women.

Furthermore, sexual minority newcomers may immigrate to Canada to escape religious persecution and homophobic violence in their home countries. However, emigration does not always guarantee safety and community for these youth. Munro and colleagues' (2013) participants chose Canada due to its multiculturalism, but youth reported facing racism by social service providers, immigration authorities, and even members of the larger LGBTQ+ community in the GTA. Additionally, many youth struggled to "prove" that they were gay, especially to service providers and immigration authorities, as these youth did not conform to authorities' stereotypical perception of how gays and lesbians dress or behave (Munro et al., 2013).

Acculturative stress is the product of trying to adapt to a new culture by incorporating unfamiliar cultural traits of the host society into one's own native culture (Samuel, 2009). Acculturation stress, such as intergenerational conflict, has been found to contribute to poor mental health for South Asian women. Fuks and colleagues (2018) detail the before immigration, during the decision to immigrate to Canada, and post-immigration experiences of LGBTQ+ immigrants. They found that HIV risk perception was often shaped by the nature of the epidemic in the host country, and that LGBTQ+ immigrants were found to be less likely to view HIV as a personal risk to them in the host country if HIV rates and education were not prominent in the host country. Acculturation stress was also found to result in the use of alcohol and drugs as a coping mechanism (Shedlin et al. 2006). Acculturation status, or the extent to which one adopts the host country's culture or modifies one's own in order to successfully integrate into society, is a key factor in health outcomes among LGBTQ+ immigrants. For instance, a low acculturation status has been found to predict higher levels of risky sexual behaviours, such as consuming drugs or alcohol before engaging in sex (Bianchi et al., 2007) and greater mental health help seeking for LGBTQ+ immigrants (Dasgupta, 2007). Even then, acculturation should not be assumed as a tool to alleviate psychological distress and somehow save youth from racism.

Peel region is a suburb of Toronto, consisting of Mississauga, Brampton, and Caledon and is home to over 50% of Ontario's South Asian population. A study aiming to understand the mental health challenges and service access barriers experienced by South Asian youth in Peel region found that acculturation stress and intergenerational conflict were major mental health stressors for youth, often adding stress to their relationship with their parents (Islam et al., 2017). Participants described relationship stress as a major contributor to their mental health. Young women in particular experienced the pressure to marry early but were also told to avoid dating and interacting with the opposite gender. Youth reported resorting to alcohol, tobacco, and marijuana use as a coping mechanism to stressors. Adding to this, youth did not feel well informed about mental health resources and only about a third of participants were able to identify mental health resources available in their local community (Islam et al., 2017).

The protection of one's health is dependent on if youth are able to access relevant sexual health information, form community with individuals they identify with, and develop a reliable support network in their lives. How youth perceive their HIV/STI risk and how, and if, they choose to protect themselves also impacts how sexual health may be safeguarded. Social contexts, such as experience of racism, acculturation stress, and navigating dual identities, help us view and understand populations holistically. Further, understanding hegemonic masculinity and its relation to social and sexual power for women aids in further situating the HIV/STI risk context for South Asian women.

2.3.3 Hegemonic Masculinity and Sexual and Social Power

Women's social and sexual power is sited within the patriarchal structure within South Asian communities. Patriarchy may be assumed and accepted as an immutable 'cultural' trait when considering HIV/STI vulnerability but must be understood relationally, explain (Hawa et al., 2018). This means that because the relationship between patriarchy and 'culture,' or community norms, is constantly evolving, hegemonic male dominance should not to be rationalized or accepted by evoking notions of 'culture.' Hawa and colleagues (2018) emphasize utilizing an anti-racist lens when working with the South Asian population. They highlight that it is important to not essentialize culture; that is to ascribe cultural traits to people and then assume that things can never change. This leads to a false assumption that collective norms are reflective of individual behaviours and perspectives, where we know that is not the case for many South Asian women and may not be for young South Asian sexual minority women as well.

Sexual power discerns to what extent one is able to maintain control over sexual activities they are engaging in. Gagnon and colleagues (2010) found that more men than women felt they had high decision-making power regarding sexual activities the couple engaged in. Hawa and colleagues (2018) uncovered patriarchy embedded within the South Asian social context and its impact on HIV vulnerability for women. Namely, the prevalence of hegemonic masculinity restricted women's social, relational, and economic power, resulting in increased vulnerability to HIV. Restrained sexuality, lack of discussion surrounding sex, protection of family honour, upkeeping religious practices, and strong attachment to community were found to be common norms which contributed to HIV vulnerability for South Asian women (Hawa et al., 2018; Weston, 2003). These norms resulted in experiences where women contracted HIV due to their husband's infidelity, were unable to negotiate condom use, or did not have HIV/STI knowledge to maintain their sexual health. It is important to note that hegemonic masculinity and patriarchal values were also sustained by women themselves, and a desire to pass the same values to their daughters was prevalent (Hawa et al., 2018). These patriarchal norms drive and maintain the discrepancy between collective community values and individual behaviours, wherein the individual must conceal actions which would be considered socially unacceptable, such as same sex intimacy.

A Montreal-based study, conducted with South Asian women found that nearly a third of the participants said they had never heard of HIV and 13% of participants felt they were personally at risk of infection (Gagnon et al., 2010). Women who scored as having "high" decision-making power were more likely to have heard of STIs and felt they could negotiate condom use during sex with their partner. Interestingly, women with "low" power had higher "STI symptom knowledge" as well. However, this was attributed to the reticence of South Asian women regarding the topic of sex. Focus group data of the study showed that some women may have said "yes" to knowing something when they might not have actually had the information so as to not discuss the topic further. Such findings of resistance to discussions about sex and STIs are consistent across many studies, and this results in incomplete knowledge and thus restricted sexual power for women.

Stigma surrounding topics of sex, sexuality, and HIV/STIs is prevalent in South Asian communities and hinders conversations about safe sex practices which may be had in the community, especially for young women. Ultimately, lack of knowledge, experiences of racism and acculturation, immigration, and presence of hegemonic masculinity shape how South Asian women understand and perform sexuality and sexual power, and this forms their risk of HIV/STIs.

Conclusion

Combatting HIV/AIDS requires a multi-dimensional and long-term response rather than an emergency framework, which often overlooks populations not believed to be at risk. Affecting the social and structural contexts which maintain HIV vulnerability amongst cis-WSW and South Asian women is important in long-term prevention of HIV and other STIs. Access to relevant sexual health education and resources, sexual stigma in healthcare settings, use of hierarchized risk categories, and access to HIV prevention medication form the structural context of HIV/STI vulnerability. The social context in which young South Asian cisgender sexual minority women are situated showcases the lack of discussion surrounding sex, prevalence of homophobia, experiences of racism and acculturation, and hegemonic masculinity which elevate HIV/STI risk for South Asian women.

As such, the approaches to combatting HIV/STI vulnerability and risk require combined prevention strategies which are contextually developed to target different populations, such as young South Asian sexual minority women. In order for the HIV pandemic to end, no one population that is vulnerable can be overlooked or neglected. Notably, neglect of one population can be a driver of HIV vulnerability for all, and in turn act as a barrier to eradicating HIV/AIDS globally.

CHAPTER 3: METHODOLOGY AND METHODS

This study aims to explore the knowledge, attitudes, and practices that impact the HIV/STI risk context and sexual health of young South Asian cisgender sexual minority women living in the Greater Toronto Area (GTA). The absence of research on the interface between culture, sexual identity, ethnicity, and race, and the impact these have on the sexual health of young South Asian cisgender sexual minority women, highlights the need to conduct qualitative research in order to investigate sexual health needs and relevant experiences. Further, in response to the dearth of research in this area, this study seeks to understand what barriers or facilitators impact access to community based sexual health supports and services for these youth.

Increasing our understanding of these experiences requires placing the voices of people with lived experiences at the centre of research. Centering lived experiences allows the researcher to gain insight from the subject who has navigated the intersections of their identities and given meaning to their experiences (Reid et al., 2005). It situates the participants as experts of their own experiences, which drives an analysis grounded in the participants' sociocultural and geopolitical context (Fossey et al., 2002; Reid et al., 2005). Importantly, this methodological approach recognizes that community-based public health interventions are context-dependent and requires the analysis of narrative data to discern risks to health, sexual health needs, and gaps in existing service.

In concert with the aims of objectives of this research, the present study employs queer theory and the minority stress model as theoretical frameworks to situate the experiences of young South Asian cisgender sexual minority women. Community-engaged research is also described as the approach taken to conduct this research in partnership with the Alliance for South Asian AIDS Prevention (ASAAP) located in Toronto.

3.1 Theoretical Framework

3.1.1 Queer Theory: Contextualizing to South Asian Sexual Minority Diaspora

This study draws on queer theory as a framework to situate the experiences of those who do not subscribe to normative identity categories. Queer theory is a critical theory with its roots in gay and lesbian studies and feminist theory (Jagose, 1996). The term "queer," which by definition refers to that which is different or deviant in relation to the 'norm', is commonly used to refer to individuals belonging to the larger lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) community, among many other identities. Although the term has a history of being used as a homophobic and transphobic slur, over time 'queer' has become a reclaimed term within the community (Jagose, 1996). It is also important to consider that queer does not refer to any one identity in particular, implying an intentionally vague identity that deviates from the 'normal,' or what is considered normal in a particular context. For this chapter solely, the terms queer and sexual minority will be used interchangeably when discussing queer theory. The term sexual minority or LGBQ+ will be used predominantly thereafter in relation to the community of interest in this study.

Hartman (2017) discusses queer inquiry as a process of disrupting normative ideologies to showcase the experiences, and the queer knowledge, which exists in liminal spaces of normative categories and cultures. The process of queering exposes the complexity in human experiences whereas categorization and adherence to normativity hides those complex interactions, withholding knowledge that queering reveals. Queer inquiry facilitates context-dependent knowledge as it pertains to marginalized communities. This is important in contrast to large-scale studies which attempt to produce context-independent knowledge that is to be used for 'most' people (Hartman, 2017). As such, I contend that queer inquiry can provide public health practitioners access to hidden knowledge as it relates to sexual health in order to develop culturally responsive programs and interventions for overlooked and marginalized groups within larger communities, such as young South Asian cisgender sexual minority women.

Defining a term such as queer, which contests being restricted by definition or stabilizing identities, requires one to deconstruct the difference between what a subject does or the role they take in society, and who a subject is at their core (Dilley, 1999). This distinction describes the former as constructionism and the latter as essentialism. In simpler terms, people's identities are constructed through social relations, desires, and meaning, and thus subject to change over time. Identities are not an inherent quality which are immutable and thus do not always predict behaviour (Dilley, 1999). This distinction has resulted in a particularly important reframing in current sexual health interventions as well, where the focus has shifted from sexual identity to sexual behaviour, especially pertaining to HIV/AIDS. The shift in language from "gay men" to "men who have sex with men" is one such example.

On the premise that the concept of 'normal' is contextual and ever-changing, and that social norms are created and thus subject to change, queer theory helps us understand the experiences of those who fall outside of socially constructed normative identities or practices. Heteronormativity is a major subject of queer discourse as it showcases the power dynamics underlying societal structures, which privilege individuals who identify with normative identity categories, such as being cisgender and heterosexual, and marginalize those who do not, such as those who are anything but that (Namaste, 1994). As a result, queer theory proposes that in order to understand 'queered' identities, we must also observe who is most privileged in a particular context and question what is considered the norm, and how those who do not identify with the norm may be oppressed (Namaste, 1994). Importantly, gender plays a critical role in how the heteronormative society understands sexuality. Queer theory asks the inquirer to deconstruct gender in the (hetero)normative society to understand sexuality and social behaviour.

Judith Butler, one of the early contributors to the development of queer theory and sexuality, described gender as a performance. Butler argues that gender is not an underlying essence of nature nor is it an inherent function of biological sex. Rather, gender is performed through repeated action and speech (Butler, 2011). For some individuals, their gender expression aligns with socially constructed characteristics associated with being male or female. For others, this may not always be the case. This points to the performative nature of gender and the shifting nature of social norms. 'Queer' identifies those individuals who do not always closely align with socially constructed gender expression norms or who fall outside of the margins of binary categorization, and gives identity to individuals irrespective of gender performance (Butler, 2011).

Michael Foucault highlighted the fluid nature of sexuality and described it as a "constructed category of knowledge," affected by culture and meaning assigned to practices (Spargo, 2001). This work is supported by Butler and Jagose who describe that queer incorporates "mismatches between sex, gender, and desire" (Butler, 2011; Jagose, 1996). A particular focus of Foucault's work was to understand how sexuality functions in society due to institutions and social values in place (Spargo, 2001). This work revealed the privileging of normative sexual identity, such as being heterosexual, through institutions such as marriage; and the marginalization of individuals who are not strictly attracted to the opposite gender or do not view gender as any basis for attraction.

Queerness has a rich history in pre-colonial South Asia. The Hijra, Khawaja Sira, and Aruvani community amongst others bear testament to South Asian culture's pre-colonial understanding of nonconforming genders and sexuality. Although Nepal, Pakistan, Bangladesh, and India all now recognize a 'third gender' by law, same-sex intimacy is still largely shamed and discriminated. In particular, Section 377, which criminalized same-sex intimacy, had a significant impact on the treatment of non-heterosexual individuals and the 'queer' community at large residing in now India, Pakistan, and Bangladesh (then British India) under British rule (Chaudhary, 2019). Section 377 was introduced to British India as a way to police desire which was considered unacceptable according to Victorian Christian values upheld and imposed by the British, namely heteronormativity (Chaudhary, 2019). India abolished this section of the penal code in 2018 as means to release its colonial legacy. However, Section 377 is still maintained in both Pakistan and Bangladesh. Heteronormativity and shadism, which refers to prejudice on the basis of skin pigmentation, have actively persisted thereafter and continue to impact sexual minority South Asians in the Western diaspora. The erasure of South Asian queerness and the impact of racism has contributed to the silencing of queer South Asian women's needs in the diaspora (Patel, 2019).

A notable critique of queer theory is the term's conception in Western discourse largely written by White upper middle-class theorists, thus deploying a White and class-based subjectivity to the description and experience of queerness. Queer theory discourse has been institutional in large part, allowing a small group of academic 'elites' to write, publish, interpret, and interrogate for other members of this narrow academic community who can reciprocate the technical jargon (Malinowitz, 1993). The theory facilitates an inquiry which acknowledges the existence of a myriad of sexual practices which can impact sexual health. However, the experiences of queer racialized individuals have typically been neglected in understanding the interaction between sexuality and race. In such a framework, how may the experiences of multi-oppressed identities be understood? An intersectional lens allows us to understand the coexistence of multiple identities and how they interact to impact individuals. Acknowledging the multiple oppressions which can intersect with sexual identity allows for a deeper understanding of minority experiences. Through this lens, oppressive norms such as classism, racism, and misogyny can be analyzed simultaneously, allowing for a more holistic and intensive analysis that discards the single-issue framework (Hartman, 2017). A single-identity framework homogenizes a particular narrative to communities and oversimplifies the complexities associated with existing societal structures and politics at play.

As it relates to public health practice, queer theory emphasizes the need for sexual categories to be understood as open and fluid when developing sexual health education and interventions. Through acknowledging liminal experiences that exist between socially constructed categories, queer theory offers a tool to produce more nuanced sexual health knowledge that can be culturally tailored. I argue that queer theory can be utilized as a public health intervention in the ongoing HIV epidemic as it relates to combination prevention strategies tailored for different communities. Queer theory falls in line with a core public health tenet which posits that the health of all requires meeting the health needs of the most marginalized communities to promote both social justice and health equity (Galea & Vaughan, 2019). Furthermore, queer theory as an analytic tool increases risk transparency by rejecting socially constructed binary categories and focusing on the lived contexts of people (Argüello, 2016).

3.1.2 Minority Stress Model

Minority individuals are exposed to chronically high levels of stress, due to their minority identities, which accrues overtime and can negatively impact the overall health and wellbeing of minority individuals, such as gender and sexual minorities. The Minority Stress Model developed by Meyer (2003) refutes earlier classification of lesbian, gay, and bisexual (LGB) identity as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM), wherein researchers’ attempted to showcase higher prevalence of disorders amongst LGB individuals. While ‘Is homosexuality a mental disorder?’ was being explored, the operationalized research question was actually ‘Do homosexual individuals have a higher prevalence of mental disorders?’ Marmor (1980) pointed to this discrepancy and stated,

> *“In a society like ours where homosexuals are uniformly treated with disparagement or contempt – to say nothing about outright hostility – it would be surprising indeed if substantial numbers of them did not suffer from an impaired self-image and some degree of unhappiness with their stigmatized status.” (p. 400)*

Meyer’s (2003) minority stress model illuminates this gap in understanding by conceptualizing distal and proximal stress processes experienced by sexual minority individuals. Stress refers to any condition which has the potential to arouse the adaptive machinery of the individual, wherein events or conditions which exceed the individual’s capacity to endure carry the potential to induce mental or somatic illness (Dohrenwend, 2000; Pearlin, 1999). As it relates to minority status, discriminatory social and structural environments serve as a stressor to sexual minorities when their life experiences are incongruent with dominant values and structures. The institution of marriage is one such social structure which has historically erased lesbian, gay, and bisexual experiences and denied access to intimacy and family life for these individuals. As such, researchers conclude that minority stress is unique, chronic, and socially based (Meyer, 2003). Minority stress is unique in that it is additive to general stressors experienced by all people. It is chronic since it is embedded in the social and cultural structures in which the individual navigates life. Lastly, it is socially based as it originates from and is reproduced by social institutions, processes, and structures.

The minority stress model comprises three primary tenets upon which minority experience is theorized; (i) minority status leads to increased exposure to distal stressors, (ii) minority status leads to increased exposure to proximal stressors due to the presence of distal stressors, and (iii) minority individuals bear poor health outcomes due to long-term exposure to both distal and proximal stressors (Meyer, 2003). Distal stressors are external to the individual and refer to experiences of stigma, prejudice, and discrimination due to the individual's position in society. Distal stressors are often understood as objective stressors since they do not rely on the individual's perceptions or appraisals, and thus may impact individuals despite the individual's self-identity as lesbian, gay, bisexual, or queer. This can be seen as homophobic violence or employment discrimination. Proximal stressors are often the by-product of distal stressors and rely on how distal stressors have manifested in thoughts, feelings, and action for the individual (Lazarus & Folkman, 1984). These are understood to be subjective as they depend on the individual's appraisals and perceptions of the distal stressor. Concealment of one's sexual identity, internalized homophobia, and rejection sensitivity comprise stress processes internal to the individual. Correspondingly, a multiple minority stressor framework indicates that this effect is exacerbated when an individual possesses multiple marginalized identities (Meyer, 2003). This model thus also calls for an intersectional approach to understanding the interactions of these stressors and how they drive behaviour, thus contributing to unique health outcomes for racialized sexual minority individuals.

Drawing on the minority stress model is critical to understand how young South Asian sexual minority women's life context presents stress and drives behaviour and choices concerning sexual health. The lives and daily experiences of these young women are situated within their sociocultural and geopolitical context, both of which play a salient role in the way young women navigate sex, intimacy, and relationships. Although these have not been previously investigated for this population as it relates to sexual health, literature shows that stress and community resilience processes differ between racialized sexual minorities and their White counterpart (McConnell et al., 2018). This contrast urges inquirers to explore what community may look like for racialized sexual minority groups and how access to relevant services can be better supported in a culturally responsive manner. Understanding how stressors interact helps to theorize participants' experiences and make sense of resulting choices and behaviours which shape HIV/STI risk context for these women, which can also inform recommendations for practice.

I conclude theorizing minority stressors with cogitating on the variance in individual capacity to withstand stigma, prejudice, and discrimination. Rather than viewing minority individuals as victims and passive recipients of harm and prejudice, stress ameliorating factors must be considered as these tools increase resiliency to negative health outcomes. Ultimately, it is important to staunchly reflect on the relationship between impact of oppressive structures and individual resilience so as to not transfer the responsibility of oppressive social institutions in maintaining health disparity to individual capacity to cope.

Resilience and Stress Ameliorating Factors

In responding to stressors, minority individuals also garner important skills and resources to cope and protect their physical and mental wellbeing. For some people, coming out (ie. not hiding their sexual identity) can be a stress-ameliorating factor as it supports self-acceptance and provides skills to overcome internalized homophobia, amongst other stressors (Morris et al., 2001). Family support and in-group solidarity and cohesiveness were found to be other stress-ameliorating factors for LGBQ+ individuals (Hershberger & D'Augelli, 1995; Postmes & Branscombe, 2002).

Branscombe and Ellemers (1998) ask us however to differentiate between resources which function at the individual level and those which operate at the group level. While factors at the individual level can alleviate stress (ie. variance in personality, coping, etc.), the lack thereof at the group level can maintain health disparities for minority groups at large. Group level factors ensure that stressors are being addressed at the population level and resources are available to all members of minority groups. When members of minority groups are able to find community cohesiveness with others whom they identify with, the in-group identity allows a reappraisal of the stressor, cultivating protection against psychological distress. Reappraisal and in-group cohesiveness serve to validate the experiences and feelings of minority individuals (Thoits, 1985). Some individuals may possess innate tools to access these spaces, however if these spaces are not structurally present, validated, and made safe, minority individuals are susceptible to being overlooked and underserved in the broader community.

While at first glance, young South Asian cisgender sexual minority women seem to be a homogenous group, it is important to consider the diversity in religious practices, cultural norms, and the within-group interactions of South Asian individuals towards other South Asians. Within-group prejudice and discrimination on the basis of skin pigmentation, caste, religion, amongst other social structures remains present in the diaspora. Notably, shadism and casteism function to privilege some South Asians while disempowering others (Patel, 2019). Again, intersectionality guides us to recognize these mediators and acknowledges that some young South Asian women are able to access resources and supports more readily than others, facilitating an analysis of data that does not treat young South Asian sexual minority women as a monolithic group.

Lastly, while resilience and coping allow minority individuals to withstand various stressors, they take a toll on the individual. For instance, concealing identity for safety, coming out to overcome internalized negative attitudes and gain self-acceptance, and group solidarity can all serve as stress-ameliorating factors. Nonetheless, while resilience and coping showcase the human capacity to endure and persist, withstanding chronic stress and long-term coping can have lasting effects on minority individuals' overall wellbeing (Miller & Major, 2000; Smart & Wegner, 2000).

Conclusion

Drawing on queer theory and the minority stress model provides an appropriate lens from which to understand the sexual health and HIV/STI related needs of young South Asian sexual minority women. Queer theory offers a foundational understanding of queerness and sexuality and provides a tool for the deconstruction of normative ideas surrounding sex and sexuality along with an understanding of non-normative identities in society. The minority stress model discusses distal and proximal stressors which accrue overtime and contribute to poor mental and physical health for minority individuals**.** These stressors are compounded for individuals with intersecting marginalized identities, as is the case for young South Asian cisgender sexual minority women who encounter experiences such as racism, sexism, and queerphobia. The minority stress model thus allows an exploration into how oppressive social systems impact these individuals' health and asks us to remain vigilant to acute and chronic stressors faced by this group. It requires that we understand the relationship between stress and resilience to better understand health behaviours and eventually predict outcomes. Collectively, queer theory and minority stress model theories generate a methodological framework which is drawn upon to approach and analyze the data. This allows us to inform culturally and sexually relevant support services alongside relevant sexual health education. Public health ultimately benefits when all youth, including sexual minority youth, receive relevant sexual health information and access to services.

3.2 Methodology

Qualitative research design is the preferred method of research to explore and understand the experiences of an understudied population. The absence of scholarship on the interface between culture, sexual identity, and race, and the impact this has on the sexual health of young South Asian sexual minority women, highlights the need for a qualitative approach to research inquiry. Qualitative research approaches to collecting and analyzing data provides researchers with methods necessary to deepen their understanding of the social and cultural contexts in which participants experience life and give meaning to their experiences. A community-engaged approach to research ensures that participants' lived experiences remain at the center of the research and that findings can be used to make actionable change.

Research Approach: Community-Engaged Research

Community engaged research (CER) is defined as a collaborative process between the researcher and groups of people affiliated by geographic proximity, special interest, or similar situations, with the aim of addressing issues which affect the wellbeing of people within the community (Balls-Berry & Acosta-Pérez, 2017). Often, CER involves partnerships that aid in mobilizing resources, disseminating knowledge, and influencing changes in policies, programs, and practices. For the present study, this approach was selected on the premise that community-based organizations possess credible, legitimate, and intimate understandings of local assets and community needs and concerns (Harvard Catalyst, n.d.). CER principles involve a bi-directional relationship that involves mutual trust, understanding, and sharing of strengths in order to address a community issue (Michener et al., 2012). Furthermore, community engagement practices acknowledge that communities' lived experiences provide them with the expertise and knowledge to influence policies and make decisions which improve the health of individuals and the community as a whole.

The present study aims to conceptualize the HIV/STI risk context through exploring knowledge, attitudes, and practices of young South Asian cisgender sexual minority women living in the Greater Toronto Area along with investigating the barriers and facilitators to accessing community-based sexual health support and services. As such, the Alliance for South Asian AIDS Prevention (ASAAP) was selected as the community partner. With over 30 years of experience serving the South Asian community in the Greater Toronto Area, ASAAP's community experience and intimate knowledge of the intersection of South Asian and sexual minority identities were considered invaluable in conducting this research. Community engagement practices exist on a continuum and vary depending on time and resources available. This continuum is described in theory and embedded within the methods (See Section 3.3) in relation to the partnership between ASAAP and McMaster University for this study.

A CER approach incorporates varying levels of collaboration from research question development to knowledge dissemination. One of the principles of CER outlines learning the history and culture of the community along with political and power structures, norms, trends, economic and social conditions of the community and organization as integral in building the relationship and trust between partners (Michener et al., 2012). As such, I was able to attain a summer student position at ASAAP under the supervision of the Women's Sexual Health Coordinator at the time. This two-month term allowed me to learn the organization's history, culture, norms, current programs, and women’s programming needs. A member of the ASAAP support staff was later identified as the organization’s representative to provide insight and feedback during the development of the research question and study design. Involving community members early in developing the research focus allows academic partners to understand community needs, concerns, and gaps, and discuss study designs which fit the organization’s culture and research objectives (Michener et al., 2012). Community-engaged practices employed in this study are discussed in the methods section of this chapter.

3.3 Methods

Qualitative research approaches to collecting and analyzing data provides researchers with methods necessary to deepen their understanding of the social and cultural contexts in which participants experience life and give meaning to their experiences (Fossey et al., 2002). The study employed community-engaged methods during the recruitment and sampling, data analysis, and knowledge dissemination phases of this research.

(i) Recruitment and Sampling

Participants were recruited via online social media platforms such as Instagram, Twitter, and Facebook. Recruitment strategies were limited to online platforms due to the Covid-19 pandemic. South Asian individuals with a large network were engaged to reach young women who may not frequent mainstream LGBTQ+ spaces or are not visibly ‘out’ about their sexual identity. The study advertisement was also shared on ASAAP’s social media platforms and online spaces dedicated to South Asian LGBTQ+ individuals.

The inclusion criteria for this study population was any individual who identifies as South Asian (ie. originating from Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, or Sri Lanka); are a cisgender woman (ie. assigned female at birth and identify as a woman or have proximity to womanhood); identifies as a sexual minority (ie. any non-heterosexual sexual identity); and are between the ages of 18 and 29, as this age group is classified as 'youth' in HIV/AIDS literature. Finally, the participant was required to be residing within the Greater Toronto Area and had to be able to provide consent prior to being interviewed for this study. The exclusion criteria were as follows: any non-South Asian identity, transgender men or women or cisgender men, heterosexual-identifying individuals, or individuals outside of the 18 to 29 age range. Respondents who possessed all other inclusion criteria but did not live within the Greater Toronto Area were excluded from the sampling pool.

The study advertisement was posted and distributed in early May 2020 and received 57 responses within 6 weeks from young South Asian sexual minority women in the Greater Toronto Area. Respondents who did not provide their inclusion criteria data in their initial email were contacted once as a reminder and later excluded if they did not follow up. Despite the high number of responses, the realistic sampling pool was further reduced due to availability and safety of the participant. The Covid-19 pandemic restricted people to their homes during these months. For many potential participants (especially younger ones) this meant living with family or people where they would not be able to engage in conversation about sex, sexuality, and HIV/STIs due to fear of having their sexual identity exposed and taboo surrounding the topic of sex. Physical distancing protocol due to Covid-19 and fear of creating suspicion at home constituted primary safety concerns for respondents. In consideration of factors listed above and respondents which were lost to follow-up, the final sampling pool was reduced to 17.

A maximum variation sampling strategy was employed when approaching this sampling pool. This entailed pre-determining criteria that differentiates the sampling pool and then selecting respondents which are quite different on the respective criterion. For example, while being South Asian was an inclusion criteria, the sampling pool was ethnically and religiously diverse, making it important to ensure that no one identity is over-represented. Creswell & Poth, (2018) share that when variations amongst participants are maximized at the beginning of the study, it increases the likelihood of the findings reflecting those differences or different perspectives, which is considered an ideal in qualitative research. As such, respondents' answers to the inclusion criteria were documented to screen and document the diversity of respondents based on age, sexual identity, gender identity, ethnic identity, and city of residence within the Greater Toronto Area. These factors were considered so as to acknowledge the differences in experiences of the sample and how these impact knowledge, attitudes, and practices pertaining to HIV/STI risk and access to community-based services. Some identities presented in majority, while others were represented by one or two respondents. For example, the majority of the sampling pool identified as Indian, as a cisgender woman (as opposed to gender fluid), and between the age of 18-25. As such, participants from the majority categories were selected randomly and remaining participants (who were under-represented) were included in the final sample.

A final sample of 6 diverse young South Asian women were interviewed. This sample size was considered appropriate due to the exploratory nature of the study, and limited time and resources. All participants were recruited online, were able to electronically sign the Information and Consent Form for this study and participate in the study for the full length of the interview while ensuring safety and confidentiality. The participants received a $30 honourarium for their time along with a list of community-based services and support provided by ASAAP.

(ii) Data Collection

In-depth interviews give insight into people's perceptions, understandings, and experiences, allowing the interviewer and participant to co-construct knowledge which will be beneficial in understanding the community's sexual health needs. Further, narrative research has become an important tool in understanding the cultural context of health in public health promotion and interventions (Greenhalgh, 2016). A key strength of conducting interviews is its ability to elicit narrative data which allows the researcher to investigate attitudes and behaviour in greater depth (Alshenqeeti, 2014). A one-on-one interview also allows privacy and openness to the interviewee which is not available through questionnaires or focus groups. This data collection method was considered most appropriate by ASAAP and the present study's research committee as the HIV/STI risk context has not been investigated within this population and these findings will be the first to conceptualize the HIV/STI risk context of young South Asian cisgender sexual minority women.

A short demographic form was administered to participants prior to the interview. This form collected information such as age, sexual identity, education level, immigration status, employment status, and level of outness (see Appendix A). The semi-structured interview guide was adapted from Ingham and Stone's extensive work in developing interview guides pertaining to sexual behaviours among young people (Ingham & Stone, 2005). Some sample questions in the interview guide included "How knowledgeable do you feel about sex and sexual health matters?"; "Do you feel personally at-risk of contracting HIV or other STIs?"; and "Which forms of protection against pregnancy and STIs do you generally use?" (See Appendix B).

In-depth interviews were conducted with 6 young women to collect narrative data on the knowledge, attitudes, and practices pertaining to HIV/STI risk, followed by factors which facilitate or bar access to community-based sexual health services for these young women. Four interviews were conducted over the online Zoom platform, one was conducted over the phone, and one interview was conducted in-person in accordance with the provincial Covid-19 guidelines on physical distancing at the time. The length of the interviews ranged from 78 minutes to 237 minutes. Some participants required additional time to take breaks as needed in order to preserve their safety at home and emotional wellbeing throughout the interview.

The interview began with a temporally ordered narrative form wherein participants described their experiences of sexual identity formation from their earliest memory until present time. This was followed by in-depth questions from the interview guide pertaining to the research questions of the present study. For example, questions investigating knowledge explored knowledge construction pertaining to sex, HIV/STI risk, and sources of sexual health knowledge; questions aimed at understanding attitudes investigated perception of HIV/STI risk, feelings towards barrier protection, and factors which influence attitudes towards HIV/STIs; and lastly, questions relating to practices queried STI testing practices, sexual activities, and experiences of sexual abuse, to name a few. The interview concluded by addressing barriers and facilitators to accessing community-based services which may be relevant for sexual health promotion and protection.

Collaborative interviewing strategies were used to address the power asymmetry inherent in interviewing processes (Creswell & Poth, 2018). This allowed the interviewee and me to approach equality in questioning and making meaning of the narratives shared during the interview, as suggested by Brinkmann and Kvale (2015). For example, follow-up questions such as "How did that experience affect your decisions?" and "How did you make sense of this experience?" were embedded throughout the interview in order to maintain the truth and authenticity of the participants' experiences and ensure participants led their own meaning-making processes. Finally, ASAAP did not partake in the data collection process so as to allow participants to speak without reservations.

(iii) Data Analysis

The analysis draws on Riessman's (2008) extensive work in narrative analysis methods, which focuses on 'what' is said in the data, rather than 'how' it is said and allows researchers to theorize across a number of cases. Data analysis was discussed to be carried out by myself and guided by consultation with the community advisory board. This held me accountable to the community, ensuring that my interpretation of the data was accurately represented through the findings.

A thematic analysis, which is a type of narrative analysis, was conducted and codes were developed using the *NVivo Qualitative Coding Software*. Four initial codes titled Knowledge, Attitudes, Practices, and Community-Based Service Access were developed to organize the data from interview transcripts as it pertained to the research question. This was followed by an inductive coding strategy to develop expanded codes (via in vivo coding) and identify emerging ideas within each set of data (ie. knowledge, attitudes, etc.). In total, 31 expanded codes emerged across the four initial codes. Similar codes were reduced, resulting in 20 final expanded codes. All expanded codes were then categorized to form subthemes (e.g. concealment stress and internalized homophobia impact HIV/STI risk, etc.) which materialised across interview data. Finally, the sub-themes were re-organized to produce overarching themes (e.g., heteropatriarchal and heteronormative systems subjugate the sexual health needs of young South Asian sexual minority women) which emerged from the data as they pertain to knowledge, attitudes, practices, and community-based service access, respectively. A codebook was utilized during the data analysis process for criteria guiding. This allowed me to monitor how codes differentiated from each other and record how data was rationalized before being assigned a final code during analysis (see Appendix C).

Through finding common thematic elements in events and experiences reported by participants, a general understanding of the participants' experiences was formed. Participants' experiences of internalized homophobia, identity concealment stress, and rejection sensitivity were embedded within the participants' meaning-making processes, and these were analyzed as factors contributing to identity-related stress which impact sexual health and help-seeking behaviour. Correspondingly, experiences of prejudice, stigma, and discrimination were identified as distal stressors and analyzed similarly.

(iv) Researcher Reflexivity

I approach this work as a diasporic South Asian woman currently living in the Greater Toronto Area. My interest in the field of minority health stems from a personal space of self-inquiry and a strong desire to elevate the voices and lived experiences of diasporic South Asian youth. Having moved multiple times across North America during my adolescent years exposed me to many social and institutional interactions, calling me to reflect on my positionality in my new 'home' again, and again. In each new place, I have been reminded of various identities I hold, some that I did not know I held, and some that were handed to me growing up. These experiences exposed spaces where the consequences of my skin colour were evident, and other spaces where I was able to access privilege due to factors such as the caste I was born into. The ongoing dance between stress and resilience, and disempowerment and privilege, has often invited me to reflect on what constitutes safety, community, and capacity for me; and then, for others like me.

My introduction to qualitative research began as a student research assistant during my undergraduate studies. I contributed to a global health study during its data collection phase by conducting structured interviews with participants in a refugee camp setting. This is where I garnered a unique sensitivity to the experiences of people who have been displaced and forced to create a new sense of safety and home. Following this, I transcribed interviews for a different qualitative study with refugees living in Canada. The importance of context and centering the lived experiences of people became increasingly clear. What became clearer was the need for a research process where those affected by the research are engaged early in the development of the research question and research design; an approach to research I had not yet been exposed to.

I was first introduced to Community-Based Research principles as a first year Master of Public Health student at McMaster University. Developing a critical analysis of collaboration and community-based research ethics along with analyzing and evaluating strategies for community-based participation and leadership were some objectives which piqued my interest. In particular, the notion of insider/outsider status as a researcher was a deep point of reflexivity when I concurrently decided I would like to engage in South Asian health research as a part of my Master's thesis. Indeed, my insider status as South Asian gave me privileged entrance into the group that I wanted to study. On the other hand, it was clear that community collaboration was critical for gaps where my lived experiences and insights fell short.

I was fortunate to attain a two-month summer student position reporting to the Women's Sexual Health Coordinator at the time at the Alliance for South Asian AIDS Prevention located in Toronto. Having served the South Asian community in the Greater Toronto Area for over 30 years, this organization's intimate knowledge of the intersection of South Asian and sexual minority identities was considered instrumental to studying the HIV/STI risk of young South Asian sexual minority women; something that the organization had not previously explored in an academic capacity as it relates to this specific population. Conversations with community members and staff highlighted a need for space and programming dedicated to young South Asian sexual minority women. A community-academic partnership was proposed at the end of the summer and the development of the research question ensued. Through this partnership, I was able to actively engage community leaders doing HIV/AIDS prevention work and knowledge sharing for the South Asian community. This allowed me to ensure that the study met community objectives throughout the research process while simultaneously being transparent about my capacity as a student.

Approaching the narrative data required me to reflect on my positionality as a South Asian woman as to not accentuate personal experiences I have had by seeking similarities within the sample. While I was able to understand and relate to cultural experiences, there were many experiences the participants shared which were dissimilar to mine. I navigated insider and outsider status with the help of a member of ASAAP's support staff overseeing this study, who was able to fill gaps in my knowledge and experience and provide explanations of their understanding where needed. As a student with access to a position to conduct this type of work, I found myself in a privileged locus to provide institutional support for this work. This collaboration continuously challenged my reflexivity, balancing where I was able to contribute to the co-construction of knowledge with participants and filling in the gaps where my lived experiences fell short. Power and positionality were thus addressed through the community-engaged research approach to this study.

(v) Ethics and Confidentiality

Ethical considerations for this study mainly revolved around its in-depth interview design. Prior to the interview, details of the purpose of the research, the types of questions that will be asked as part of the interview, and potential risks, such as strong emotional responses or triggers, were explained to the participants. In-depth interviews pose risk of emotional distress to the participant. Undeniably, in-depth interviews that include asking intimate and personal questions can result in triggering emotional responses from participants. Safeguarding the interview through a continuous process of requesting consent to proceed allowed me to minimize levels of distress for the participants during the interview. Breaks were taken when necessary and participants were reminded that they do not have to answer if something is too difficult to engage with. Finally, ensuring that ASAAP would be able provide support and resources should participants need it was necessary. As a result, all participants were provided with a list of community-based supports and services should they need it so as to minimize distress and ensure relevant support was available and accessible. This study was approved by the Hamilton Integrated Research Ethics Board (HiREB) under project #8107 (see Appendix D).

To protect the privacy of the participants, all data was cleaned to remove identifiable information before data analysis. Participants' names were removed from their transcripts and each participant was assigned a pseudonym. Additionally, demographic information collected such as age, educational level, employment status, and other such personal identifying information was also removed from transcripts and subsequently destroyed so as to ensure participants are not traceable through these identifiers. Finally, the file containing pseudonym assignments was destroyed after the analysis phase of the study, and thus the data was stored and analyzed in an anonymized manner. All data was stored in password protected and encrypted files on one computer throughout the data collection and analysis processes.

(vi) Knowledge Transfer and Mobilization

A community-academic relationship ensures that findings do not fall in the "valley of death," and communities are able to immediately access findings and implement them into practice or accessing funding (Alshenqeeti, 2014). Knowledge dissemination and mobilization will allow other community-based organizations to utilize findings in their own practice. Disseminating and mobilizing knowledge will be an ongoing task on the ends of both partners post-research and publication. ASAAP will be using this research study to learn how their current programs can be improved to create and maintain space for young South Asian sexual minority women. The findings of this research will also be disseminated to their community partners who may be serving this population as to continue mobilizing knowledge.

As it relates to this study and its community engaged approach, this project incorporated community engaged principles in the research objective, study design, recruitment of participants, analysis, and knowledge mobilization phases of the study.

CHAPTER 4: FINDINGS

Description of Participants

These findings showcase the experiences of six (n = 6) young self-identified South Asian lesbian, gay, bisexual, and queer (LGBQ) women living within the Greater Toronto Area as it relates to their knowledge, attitudes, and practices pertaining to HIV/STI risk. Additionally, experiences of access to community-based organizations for sexual health support and services were explored. The average age of the sample was 24 years and the highest level of education ranged from Undergraduate studies (in-progress) to Juris Doctor studies (in-progress). The participants in this sample navigated varying levels of identity disclosure (i.e., being 'out') where they assessed disclosure depending on environmental context in order to ensure safety. Younger participants (between 18 and 24) were contextually 'out'= (i.e., to select friends, etc.) while older participants (25-29) were publicly 'out' about their sexual identity. Four participants were born in Canada and two immigrated. Two participants self-identified as lesbian, one as gay, one as bisexual, and two as queer. Five participants identified as cisgender women and one participant identified as gender fluid. The sample descended from Bengali, Gujarati, Punjabi, and Tamil cultural ethnic groups.

4.1 Impact of Heteropatriarchal and Heteronormative Structures and the Subjugation of the Sexual Health Needs of Young South Asian Sexual Minority Women

The analysis of participants' narratives revealed the impact of heteropatriarchy and heteronormativity within the South Asian and the broader community which form the foundation on which the subjugation of the sexual health of South Asian sexual minority women is produced. This sociocultural foundation is compounded with the structural inadequacy within school-based sexual health education and medical settings which construct and then perpetuate an overall low

HIV/STI risk narrative. These early experiences manifested as concealment stress and internalized homophobia which shaped participants' early sexual experiences.

4.1.1 Addressing Shame and Stigma: Construction of South Asian Women as Non- Sexual Beings

Pre-marital sex is taboo as a woman. An important theme emerging from the participants' interviews was a shared experience of the silence surrounding sex within diasporic South Asian communities. Discussing sex or sex-related matters was considered shameful and this largely shaped early experiences of understanding sex for participants. Correspondingly, this propagated the notion to participants that sex was only something to concern oneself with later in life, and only in regard to engaging in sex with men and in connection to marriage, as described by participants:

> *"I never had a sex talk with my parents. They never, like the assumption was just that I'm never going to have sex until I get married… Brown people hate talking about sex and it's really not something we talk about outside of marriage, like even heterosexual sex."- Meghna*
>
> *"I think a lot of that is tied to my South Asian identity – being told that sex is meant only for marriage, sex is meant for a man's pleasure, it's not enjoyable for women, it's not a pleasant thing. Those are the things I kind of heard from women in my life growing up." – Shanaya*

The absence of discussion about sex, sex education, and sexual health thus constructed young South Asian women as non-sexual beings. Pre-marital sex was discussed as remaining deeply taboo within families, rendering participants to adopt the perception that engaging in sex as a young woman decreases self-worth and invites shame which can negatively impact public honour within the community. Chayanna's narrative showcased the burden of double standards pertaining to sex that young South Asian women carry as they consider their early sexual lives:

> *"That idea that women shouldn't have as much sex as men like I could see it [with my friend] and how damaging that is, like she's had two boyfriends and in her head she's like "[I've] already had sex twice, with two different people" ... She has you know friends who kind of like say "oh that's horrible, if someone found that out it's so bad," ... I've seen that's how she approaches sex, that's how she approaches relationships. She has to be perfect because she can't keep adding on these numbers, like she can't make a mistake so I can see how that's really damaging."*

As a result, participants did not consider parents as a source of knowledge pertaining to sex or sexual health. In instances where participants' sexual lives were disclosed to their parents, they were met with a deep sense of shame. This was poignantly reflected in Meghna's description of how she came to learn that engaging in pre-marital sex was viewed as shameful within her family and culture:

> *"At that time, I was protected too, it wasn't even about protection, it was just that my body had been used and like that no one would want me anymore and that I should never tell anyone that I've had sex with people… She was like you need to tell every person that you're ever going to have a relationship with that you're a virgin and you're never going to have sex with them."*

These kinds of experiences resulted in barriers to seeking out information and support regarding sex and sex related matters from parents or other family members. This also prevented participants from seeking out education and support from their family doctor due to fear of this information being disclosed to parents. This was especially a concern for younger participants who were still sharing their primary physician with their family.

Protecting public honour: "What will people think?" The shame surrounding sex is driven by a *"What will people think?"* ideology, as highlighted by participants, which underlies individuals' choices and what they are or are not able to present to the public eye as means to protect public honour. This added a burden on young South Asian women as it relates to sex, and further as it relates to same sex intimacy. Queerphobia was discussed to be rampant within the community which often created unsafe spaces for participants, forcing them to conceal their identity for long periods of time. As one participant shared:

> *"People don't have the confidence or open spaces to even have those conversations because it would just be talked in such a negative way instead of a way to like help. It's judgement, it's like shame, it's all that stuff. I think that's a big, big factor of like what will other people think, or say. Just hush hush like keep it to yourself." – Chayanna*

While some participants were able to garner some family support, ranging from tolerance to acceptance, through 'coming out' to parents, it is this ideology that continued to prevent access to information and support for participants, as described by Shanaya:

> *"For my parents, it was this idea of, "What will people think?" They'll think that we failed as parents and that's such a prevalent way of thinking in my family, and families like mine. That for them it was more about the image than about you know, is my child happy? Is my child safe? ... When I had initially come out, they said to me "You know, you've told us now that's fine like you don't need to date anyone, you don't need to have children, like you don't need to do any of those things, like we know, nobody else needs to know.""*

As such, while some participants shared feelings of acceptance upon 'coming out' to their parents, this was often followed by a request to continue concealing their sexual identity. As a result, participants did not often feel supported in discussing or understanding their sexual identity and were further hindered from seeking information and having space to discuss and understand their sexual identity. The younger participants described being contextually 'out' to friends and peers in spaces where they felt comfortable, whereas older participants described themselves as being publicly 'out,' pointing to a long period of time that young South Asian sexual minority women may spend having to conceal their identity while attempting to garner relevant information and support through their young adulthood. Hence, South Asian families often operate on a collective value system wherein one's individual public honour is representative of their familial honour. As such, an individual's actions and choices also carry the potential to risk the family's public honour. Sex is therefore maintained as existing in heterosexual marriage for young South Asian women. As a result of these cultural forces which maintain a deep sense of shame pertaining to sex and where queerphobia is pervasive, sex-related matters and thus sexual health for a young sexual minority woman are left entirely unaddressed within the familial and cultural context.

4.1.2 Understanding Sexual Health: Construction and Maintenance of a Low HIV/STI Risk Perception

Heteronormativity and homophobia in school-based sexual health education. As participants acquired post-secondary education, they drew on their middle and high school experiences as constructing a heterosexual perception of what constitutes sex and therefore, what impacts sexual health as a woman. All participants in this study received some form of school-based sexual health education during their adolescent and teenage years. This education exposed participants to knowledge of sexual health risks, such as contracting STIs and unplanned pregnancies. Abstinence was highly endorsed through a fear-based instruction of sexual health where participants were shown images of STI presentation in women and videos of the birthing process.

> *"In high school it was a lot of like about sex, and it was just about contraceptives, and I feel like they showed a video about something like a birth… I just remember it being a very short, like I didn't learn much. I just learned that that's where babies come from and that was pretty much it… Throughout the years like I know the first thing that I think about wearing a condom is more so like "Don't get pregnant" than STIs, which is kind of scary." – Chayanna*

> *"In high school it was more about like STIs, STDs, HIV, here's an image of AIDS, don't get that. Gonorrhea? Nasty." – Aqsa*

As evidenced by participants' narratives, sexual health was constructed as relevant to heterosexual sex. Additionally, immigration to Canada at an older age also played a role in exposure to sexual health education and access to knowledge. For Naira, who immigrated to

Canada in her late 20s, knowledge pertaining to sex and HIV/STIs was hindered entirely due to social stigma surrounding sex and STIs in India, illuminating a distinct experience compared to participants who were raised in a Western context.

As participants navigated concealing their sexual identity for safety during their adolescent and teenage years, they emphasized having minimal support and resources for understanding sex and sexual health. As such, participants described learning about relevant sexual health and sex practices from significant others, online resources, or pornography, all of which contributed to low confidence in participants' understanding of safe sex and sexual health in same sex relationships. Overall, the absence of a lesbian, gay, bisexual, transgender, and queer (LGBTQ+) inclusive sexual health curriculum was emphasized by participants.

> *"Obviously in school I've only learned about heterosexual sex, I never learned anything else. And I don't really have like too many queer like I have one queer friend who possibly would be a good resource for me to reach out to but I wouldn't feel comfortable enough to like ask her so I don't really have like resources who I can ask about for these type of questions." – Chayanna*

Furthermore, participants' narratives exemplified the reproduction of homophobic spaces due to the absence of LGBTQ+ inclusive sexual health education in schools. Specifically, the exclusion of LGBTQ+ inclusive sexual health education had dire consequences for participants because it invisibilized those who were not 'out' and relegated those who were perceived as 'out.' Aqsa drew on a critical experience where she was asked in front of the class if she would prefer a separate lesson on sexual health:

> *"I was really uncomfortable with that experience only because like I was never out to her. Even if it was visibly apparent, like I was never out to her. And like everyone in the class was lined up next to me, know what I mean? So everyone was in that classroom listening to our conversation, and like then I was just like "No, I'm okay, like I'll pass…" Don't ostracize me from the group, I've never been ostracized before. It felt really weird."*

Aqsa's experience of being 'outed' prevented her from accessing any relevant sexual health education thereafter. She points to the lack of formal and culturally competent LGBTQ+ inclusive sexual health education and how this further hinders access to knowledge for young South Asian sexual minority women. Aqsa's narrative illuminates a unique issue faced by participants where spaces expect a level of outness that these individuals may not consider culturally safe or where 'outing' oneself is too psychologically distressing. Aqsa concludes on this experience by sharing,

> *"Just talk to the class as a whole, it would've been fine. Who knows, maybe someone else could benefit from it."*

Consequently, heteronormative structures, such as school-based sexual health education, reproduce homophobia, subjecting sexual minority youth to experiences of ostracization and compulsory 'outness.' Precisely, such structures overlook a critical element of the South Asian sexual minority experience: contextual sexual identity disclosure which aids in ameliorating stress and ensures some level of safety for young sexual minority individuals. The opportunity for early knowledge construction and access to relevant education, which can facilitate prevention as a sexual health intervention for HIV/STI transmission amongst youth is resultantly entirely disregarded, and LGBTQ+ youth fall in the gaps of early sexual health education from which their heterosexual peers benefit.

Assigned-sex based and gendered approach to calculating HIV/STI risk. School-based sexual health education constructed a notion for participants that sexual health is not a concern for women who (may) engage in sex with other women. As such, participants adopted an assigned-sex based and gendered approach to perceiving and calculating HIV/STI risk, wherein sex with individuals assigned male at birth was considered highest risk:

> *"I would say mostly people with penises, I would say are more likely to contract or pass it along in unprotected sex with any partner." – Meghna*

Correspondingly, HIV/STI risk when engaging in sex with women was inadequately conceptualized, as revealed by participants' narratives:

> *"It's one of those things where it's like I know it's [transmitting STIs between women] possible but when I'm putting myself in the situation, what are really the risks for me?" – Tanisi*
>
> *"I feel like there might be a higher STI risk if I was having sex with a [cis] man versus a [cis] woman, and that is just no educational base, that's just me trying to think in my stupid common sense that it might be, mostly because I don't really know how queer sex and STIs really interact like how it works." – Chayanna*

For the participants in this study, the absence of LGBTQ+ competent sexual health education thus led to an inability to calculate risk when engaging in sex with women. Aqsa draws on narratives she witnessed growing up which contributed to her perception of HIV/STI risk when engaging in sex with other women:

> *"I don't think of them [STIs] as much as I should, I guess because whenever you hear about STIs, it's always like between a man and a woman. It's like STIs from like guys sleeping around, "he's giving STIs to someone," but it's never like she could be giving STIs to somebody. That's always the direction of the conversation like "He's sleeping around and he's spreading it." It's never like "oh she's spreading it." That's why I've never really thought about it that much."*

Over time, this shaped a false narrative that STIs are only a concern when men are involved, or sperm is present. As it relates to sex with women, an overall low HIV/STI risk perception was produced for participants, who often carried this perception into their safe sex practices. Participants did not perceive barrier protection as necessary when engaging in sex with women due to associating condoms with preventing pregnancy and not additionally preventing STI transmission. As such, utilizing a gendered approach to calculating risk facilitated an HIV/STI risk perception which did not necessitate barrier protection when engaging in sex with women. Tanisi illuminates the association between risk perception and its impact on safe sex practices:

> *"A major difference I've noticed for me is that… Any time that I'm with a woman, protection is not really something that we think about… Protection was only a thing I thought about when I was like "don't get me pregnant," so it was very gendered for me. If I'm with a dude, or someone that can get me preggo… The other thing too actually is the HIV risk, because I'm so fed the like, I don't know it was like, just being fed that whole narrative of like "STIs are a heterosexual, or like passed through heterosexual sex or between gay men" kind of thing. It's like I think because of that I just associated it with like "Oh well it comes from sperm."*

As a result, most participants felt protected against STIs when engaging in sexual activity with men due to the knowledge of and option of using a condom. The same did not hold true with women as barrier protection was not often used, dental dams were not readily accessible, or the participants felt they had minimal knowledge of what constitutes protection with women and level of risk associated with various sexual activities.

Ultimately, participants acknowledged a two-fold consequence of early heteronormative sexual health education: (1) that it contributes to the erasure of the experiences of LGBTQ+ youth, thereby (re)producing homophobia, and (2) that it constructs a gendered and heterosexual understanding of sexual health and HIV/STIs risks. Concurrently, safe sex when engaging in sex with other women is inadequately conceptualized.

Healthcare practitioners legitimize low HIV/STI risk perception. Interactions with healthcare practitioners in medical settings further legitimized a low-risk narrative for participants and resulted in low STI testing when engaging in sex with women. Healthcare practitioners often made heterosexist assumptions about the lives of participants. Consequently, participants did not always disclose their sexual identity and only felt able to access care when they were having sex with men. Meghna explained her hesitancy to access sexual health services after being told that she did not need to get tested if she was having sex with women:

> *"It took me a while to go back until I had sex with a guy and then I was like okay now I can go."*

The lack of LGBTQ+ competency amongst healthcare staff thus significantly hindered access to information and support for participants. Additionally, participants described interactions with healthcare practitioners as anxiety-producing as lack of information provided by healthcare practitioners upon sexual identity disclosure was perceived as homophobia. Such instances subsequently impeded future support-seeking behaviour while concurrently preserving a heterosexual awareness of HIV/STI risk. Naira's rationale showcases the impact of such interactions:

> *"One would be in my mind that okay maybe he's just homophobic, and two that he doesn't have knowledge, and actually there was a third thought that came in my mind that maybe there is nothing to worry about in a two-female relationship."*

Other participants echoed these sentiments, underscoring how heteronormativity continues to seep into sexual health care delivery and information provided by medical professionals. Healthcare services can be a prominent source of health promotion resources and information. However, when healthcare professionals lack LGBTQ+ health competency, attitudes towards protective behaviour can significantly shift for individuals receiving care. In instances where participants had some knowledge regarding protection, the lack of information provided by doctors continued to perpetuate a low-risk narrative pertaining to sex with women, as explained by Tanisi:

> *"I figured there's no risk because she didn't say anything. If she had something to say, she would've said it because she immediately started going off about condoms for men… I knew about condoms and dental dams and she didn't say anything… At that point I started questioning like "What if these just exist for the sake of existing? They're not actually like necessary?" She really conveyed a narrative to me that had me questioning what I learned."*

As evidenced by participants' narratives, participants carried an underlying assigned-sex based and gendered approach to perceiving and calculating HIV/STI risk when engaging in sex as a consequence to early sexual health education. This often translated into a lack of barrier protection used with women partners and an overall inadequate conceptualization of HIV/STI risk when engaging in sex with women. A low HIV/STI risk perception was further emphasized after interactions with healthcare practitioners upon disclosing sexual identity. Conversely, some participants missed opportunities for information in cases where they did not feel comfortable enough to disclose sexual identity.

"If you don't know there's a reason to go get access to information, why would you?" (Tanisi). As mentioned earlier, younger participants often did not disclose their sexual orientation to their family doctor as these individuals were likely to share their doctor with family. As such, the reality of being 'closeted' and living with one's parents further contributed to low accessibility to relevant supports and services, especially for younger participants who lived in the suburbs of the Greater Toronto Area due to the presence of multiple stressors which impeded support-seeking, Meghna elaborated:

> *"A lot of people don't have a car, you have to take the bus, and like your parents may know your location, and it's just like a very different experience, I think some people have versus not having ethnic parents. I don't know how to explain that other than that."*

While participants acknowledged some community-based organizations that could provide support to sexual minority youth, proximity to Toronto was found to be a significant factor in mediating access to these services, wherein services were least accessible to participants living outside of downtown Toronto. As such, services which may be relevant to participants were largely concentrated in Toronto and were inaccessible due to distance. Younger participants thus experienced additional barriers to accessing relevant supports and services, especially if they lived outside of Toronto. Participants largely attributed this to living with parents, or extended family, to whom they are accountable and highlighted that due to these stressors, many young South Asian sexual minority women may not access supports and services they needed until their late twenties.

In consideration of early sociocultural factors (e.g., shame, stigma, and queerphobia) compounded with structural inadequacy in school-based sexual health education and then within medical settings, participants found it difficult to discern what information they should be seeking and how this information may be sought. Simultaneously, feelings of helplessness and isolation arose amongst participants when discussing lack of services in the suburbs, creating a cycle of not knowing how to realistically protect their sexual health compounded by not having relevant resources locally available. Tanisi described this conundrum of sexual health faced by young South Asian sexual minority women:

> *"Being so entrenched in like South Asian families where it's like very difficult to get access to this information [sexual health] unless you willingly go get access. But if you don't know that there's a reason to go get access to such information, why would you?"*

Tanisi's narrative illuminates the impact of early construction of what constitutes sex and sexual health in young women's lives. She describes the difficulty in getting access to information and education surrounding sex within family and cultural contexts, compounded by what is learned at school and then perpetuated within medical settings. Ultimately, these experiences translate to not knowing if there is specific sexual health information to seek from support services as it relates to queer sex and being a sexual minority individual.

4.1.3 Early Sexual Interactions: Impact of Internalized Homophobia and Concealment Stress

Existing outside of the margins of the heteronormative binary and under the pressure of heteropatriarchal culture was found to be a critical point of long-term distress for participants. All participants identified concealment stress (i.e., stress associated with having to actively hide sexual identity or chronic fear of non-consensual sexual identity disclosure) and internalized homophobia as chronic stressors which impacted participants in several ways, including how they navigated early relationships and understood sex and sexual health. The prolonged fear of being 'outed' resulted in participants feeling like they had limited time to explore their sexual identity. Concealment stress and internalized homophobia that resulted in denying oneself of entering into same sex relationships, resulted in some participants feeling the need to 'catch up' on *"lost knowledge"* through various covert relationships with women. Meghna drew on her early sexual life to illuminate the experience of navigating sexual identity wherein early knowledge construction did not support non-heterosexual sexual identity formation:

> *"I feel like a lot of queer and South Asian people may feel like they need to make up for that in some way, make up for their lack of knowledge and I think that results in a lot of hypersexual behaviour… I really saw that in myself… It's like you need to do it until you can't do it because you have no idea when you're going to be outed or like going to be a martyr for like whatever, you have no idea right?"*

Serial dating under this stress exposed participants to relationships where safe sex was not regularly practiced or dynamics where participants were unable to access safe sex due to factors such as being feminized and racism resulting in invalidation of queer identity, to name a few (See Section 4.2.1 and 4.2.2). Participants felt unable to access support during these times due to the covert nature of these interactions.

While concealment stress forced participants into covert relationships with women as they explored their sexual identity, internalized homophobia led to unenthusiastic (ie. forcing oneself to enjoy) dating behaviour and sexual encounters with men. Naira described her early dating behaviour as means for coping with internalized homophobia:

> *"I had to keep doing it for my identity. I felt that if I am with men longer then I'll be attracted to them and I won't be attracted to females anymore."*

Hence, dating and engaging in sexual encounters with men was often described as means to alleviate psychological distress and maintain proximity to heterosexuality. Further, engaging in heterosexual sex as means of coping with internalized homophobia exposed individuals to situations where condom use was not easily negotiated, as revealed through Shanaya's narrative:

> *"He was using a condom and then he wasn't, and then I got Plan B the next morning."*

Coping with internalized homophobia can thus uniquely increase the risk context for young South Asian sexual minority women by exposing individuals to instances where condom use is not adhered to. Such instances further increase risk when HIV/STI status of either partner is unknown.

4.2 Interactions with the Broader LGBTQ+ Community: Experiences of Invisibilization, Racism, and Women-Loving-Women (WLW) Dating Dynamics

Interactions with the broader LGBTQ+ community subjected participants to experiences of invisibilization and racism, both of which compounded to deny access to relevant support and safe sex for participants. Participants illuminated the nuances of women loving women (WLW) relationships which they consider important to understand HIV/STI risk at the individual level.

4.2.1 "No one was taking me seriously": Experiences of Invisibilization and Racism

Participants' interactions with the broader LGBTQ+ community in Toronto and within spaces on their school campuses highlighted concerns of invisibilization through invalidation of queer identity and racism, both of which were reproduced within dating dynamics and denied access to safe sex for participants. Invisibilization often translated in support and service provision as lack of cultural competency which deterred participants from seeking support from mainstream LGBTQ+ organizations and spaces and maintained participants at the margins of service access.

Not 'queer enough,' not White enough. A major theme emerging from participants' narratives as they began interacting with the broader LGBTQ+ community and spaces in Toronto was being met with invalidation of their queer identity. Feelings of invalidation stemmed from not being perceived as 'queer enough' in LGBTQ+ spaces as they did not conform to Western conceptualizations of what a queer individual looks like. Meghna described her feelings of invalidation stemming from how LGBTQ+ spaces promote a narrow representation of LGBTQ+ individuals which consequently invisibilizes South Asian queerness:

> *"They would always assume that [my White friend] was the gay one even though I was the gay one so I would really feel invalidated so there was this idea of invalidation because of my femme presenting, that I'm Brown, no one was taking me seriously in my identity, I just felt really invalidated and invisible."*

As a result, participants often felt invalidated when accessing LGBTQ+ spaces, concluding that services which existed would not cater to their needs. Lack of South Asian representation in these spaces further thwarted trust for participants, who highlighted the need for increased visibility of queer South Asian individuals. Aqsa articulated,

> *"It's just like all White people that are friends with each other. There's no one who looks like you."*

As a response to these experiences, the younger participants in particular expressed a lack of desire to further interact with the broader LGBTQ+ community in Toronto and described this dissuasion as stemming from anticipating rejection or racism. Chayanna supported the aforementioned sentiment and highlighted the reality of their racialized status:

> *"I do think it's like a racial thing, I just get afraid that I will be singled out."*

Rejection sensitivity, which refers to the chronic anxiety-producing expectation of rejection based on a minoritized identity (Meyer, 2003), was expressed amongst participants in this sample particularly when sharing a lack of community cohesion or a sense of belongingness within the broader LGBTQ+ community. As a result, participants perceived mainstream LGBTQ+ organizations and spaces to be White dominated and felt deterred from accessing these supports. The lack of representation and fear of racism resulted in stressors that rendered participants' sexual health a low priority. For example, Tanisi's interview exposed the consequences of compounding stressors and how these impact help-seeking behaviours:

> *"Sexual health I find is so low on that list of priorities of how we get access to things: A) because that information isn't out there, it's not explicit, so if you're not in the mainstream you're probably not going to be exposed to sexuality because I find that the LGBTQ+ community is so big on like sexuality and sexual liberation but if you're not in that main core, if you're out of the circle, it's kind of just, that's not your immediate priority. Your immediate priority is how do I secure my safety… Before we can finally get to meeting our sexual health needs and learning and getting access to those services. Until then, it's just – it's not that we don't want to, it's just that we have so many other identity related stressors as a result of being so neglected and overlooked that it's almost a privilege to be able to access information and resources for sexual health as a queer South Asian woman and I stand by that."*

Multiple minoritized identities thus served as chronic stressors for participants. Anticipating invalidation of their queer identity and racism were found to be dual stressors described by participants when engaging with the broader LGBTQ+ community. Consequently, feelings of neglect and invisibilization ensued upon these interactions. Evidently, while these spaces exist and claim to be inclusive of all LGBTQ+ individuals, within-group hostility often maintained participants at the margins of existing queer spaces.

Invisibilization in existing spaces can perpetuate racism within the LGBTQ+ community and further within interracial relationships. Tanisi recalled the experience of proposing safer sex supplies to a partner as having her queer status revoked. Her partner believed that protection was not necessary when having sex with women and that using protection meant one "was not fully gay." At the same time, Tanisi describes invalidation stemming from racist assumptions, such as implying that South Asian sexual minority women do not truly exist as they eventually partake in heterosexual arranged marriage. Tanisi shares this intersection of dual stressors (i.e., invisibilization and racism) and how it results in decreased access to safe sex as a young South Asian sexual minority individual steering their sexual life in a diasporic context:

> *"I don't think safe sex is the fucking norm in the lesbian community… Nobody in the lesbian community trusts that you're fully gay if you want to use safe sex supplies… As a South Asian, when you're already constantly invalidated and fighting for a sense of "No, I am gay," you're forced to engage in [unprotected sex]."*

As demonstrated by Tanisi's narrative, invisibilization, compounded with racism, has dire consequences as it disaffirms the experiences of entire communities, such as South Asian sexual minorities, contributing to a false notion that racialized sexual minorities do not have stressors which uniquely impact access to safe sex and thus overall sexual health. Participants' narratives showcase how young South Asian sexual minority women are susceptible to such forms of invalidation and racism while navigating their sexual identity formation and positionality within the broader LGBTQ+ community in the Greater Toronto Area.

Invisibilization produces lack of cultural competency in existing services. When accessing support or services, participants highlighted a lack of cultural competency within existing LGBTQ+ organizations which deterred them from seeking further support. For example, participants noted how counselors or service providers emphasized 'coming out' as an important step in alleviating psychological and social distress but did not understand why 'coming out' is rarely a culturally safe option for LGBQ+ South Asian women; and conversely, that choosing to 'come out' as an LGBQ+ South Asian woman requires ensuring safety mechanisms are in place during the process. Participants highlighted this need as crucial to service access:

> *"I would want to be like understood that okay like either like kind of like the cultural background of it all would be understood, and kind of like the position that I'm in. I think a lot of the times when I try telling people about my experiences, [they're] like well "why don't you just do this?" Well, the position that I'm in doesn't really give me the privilege to do that. Otherwise, if I did have that freedom, I*

> *would be able to. That's what I mean by understanding." - Chayanna*
>
> *"I didn't see that my experiences were mirrored by others. There wasn't conversation about how it is to be like a South Asian person, to be in that partially-closeted state, for like a long term, for like a long period of your life, that you could be in this state like I've already been." – Meghna*

Participants thus did not often consider 'coming out' a feasible choice, and neither did 'coming out' permanently safeguard participants from violence or psychological distress. Participants described 'coming out' as unsafe and preferred to calculate sexual identity disclosure based on self-assessment of risk within a particular context. As such, participants described cultural competency as strategies which protect service users' identities and do not require a high level of outness when accessing services, emphasizing that the lack thereof can significantly deter young South Asian sexual minority women from accessing relevant support and services.

> *"I can't do a phone call if you're going to give me results about something because I'm going to be at home. That's cultural fucking competency. I find that a lot of this big bullshit cultural competency which already barely exists, exists on a privileged tier of cultural competency for people that have access and have privilege. It doesn't assume the worst-case scenario type of thing. It sucks but a lot of queer South Asian women, a lot of us, we are the worst-case scenario." – Tanisi*

Invisibilization, resulting in lack of cultural competency within services was thus emphasized as a major barrier to accessing mainstream community-based services and support. Further, participants elucidated relationship frameworks and WLW dating dynamics as situating HIV/STI risk for young South Asian sexual minority women.

4.2.2 Women Loving Women (WLW): Relationship Frameworks, Dating Dynamics and Shame

Dating practices and relationship frameworks situate HIV/STI risk context for youth. It is within dating dynamics that vulnerability to HIV/STIs is produced, or conversely, where sexual health may be safeguarded with relevant support and health promotion resources, such as skills for negotiating safe sex and maintaining sexual boundaries. Participants shared experiences of having multiple sexual partners or engaging in polyamorous or open relationship frameworks along with dating dynamics (e.g., masc/femme, top/bottom) which can guide sexual practices and therefore risk for women who have sex with women.

Gender expression and identities in WLW relationships. Participants discussed how their identities within WLW dyadic relationships may dictate their sexual activities and what facilitated or prevented them in expressing their sexual power (i.e., having control over which sexual activities occur). For instance, participants discussed how "femme" (referring to feminine) or "masc" (referring to masculine) identities sometimes had a positive impact on who 'led' a sexual event and who 'followed.' Aqsa, who described themselves as masculine-presenting, explained this dynamic and stated,

> *"Women I date are more feminine-presenting… So there's like kind of the expectation that I am kind of leading the entire experience… So I feel like I'm in control of what's happening to me and them."*

While gender presentation and identity may not always dictate who has access to sexual power, participants shared nuances within WLW relationships which they considered important in understanding risk at the individual level. Notably, participants who described themselves as femme or were feminized by partners shared narratives of lowered sexual power and thus felt they had lesser control over which sexual activities would take place during sex with their partners. Decreased sexual power was also coupled with invisibility experienced by feminine lesbians compared to those who described themselves as "stereotypical lesbians." A number of factors may contribute to this invisibilization, such as how "stereotypical lesbian" implies a conformity to Western conceptualization of queer or lesbian, which in turn draws visibility for some individuals in the Western context. However, not all South Asian sexual minority women perform or express their queerness in such ways. As illuminated by participants' narratives, the reproduction of heteronormativity or heteropatriarchy within WLW relationships can decrease sexual power for some individuals and impact young sexual minority women's ability to request safe sex; similar to how racial dynamics can introduce an additional system of power within WLW dyads and further complicate this as described by participants (see Section 4.2.1). Meghna, who described themselves as presenting femme shared instances of feeling pressured to perform and thus engaging in sexual events where consent was not willingly given:

> *"I felt like I had withdrawn consent, like if I could withdraw consent I would have. It's still something that I kind of struggle with today."*

Violence and abuse within lesbian and WLW dyadic relationships exists uniquely compared to heterosexual relationships (Ristock, 2002). Almost all participants shared instances of sexual trauma, homophobic violence, or abuse which impacted their ability to request safe sex, illuminating an issue which needs further exploration within the context of sexual minority women's lives.

Participants also described a "top/bottom" dynamic, referring to a binary sometimes constructed within WLW relationships, wherein the "top" and "bottom" are expected to perform their respective sexual roles. Tanisi described being "bottom" as someone who prefers to receive and does not engage in activities which depict 'giving' in a sexual act, and conversely "top" as someone who 'gives' more often than they 'receive'. They describe the intersection of being feminized whilst being a "bottom" and how it shaped their risk context:

> *"Especially with me, my body is constantly feminized, and I don't have that ability to [request safe sex]… So like just anybody else that is just engaging in this stuff, engaging in queer relationships, I can't even imagine… you're forced to engage in at-risk activities… If you don't want to reciprocate, you don't want to eat out, and you don't want to finger somebody, you shouldn't have to, but it's so*

> *normalized in lesbian communities to be like "Oh you're just a lazy bottom, you're a pillow princess," and using those as like not respecting consent… and forcing someone to do something they don't want to do."*

Unmistakably, prevalent dating and sexual dynamics can influence access to decision making during sex and thus influence risk context for young South Asian sexual minority women. It becomes important then for women to understand how they may navigate safe sex in a WLW dyad while ensuring that their sexual boundaries are not surpassed, and preferences are maintained.

Low STI risk perception and shame. As participants discussed their experiences with dating women, they acknowledged the prevalence of a *'women are clean'* attitude which exists within the lesbian, bisexual, and other WSW community. They attributed this to the early construction of a low HIV/STI risk perception which is perpetuated through school-based education and interactions with healthcare practitioners as it relates to WSW (See Section 4.1.2). As a consequence of this attitude, participants described shame and silence surrounding contracting STIs or other sexually facilitated infections, such as bacterial vaginosis (BV), from a woman partner. Aqsa described community perceptions pertaining to sexually facilitated infections amongst WSW:

> *"There's no reason for you to catch something from a female… [and] if you do catch something… [that's] just such a bad rep to get."*

Shame thus persists within the community upon a *'women don't pass anything'* narrative which draws excessive shame towards women who may be(come) infected with STIs or sexually facilitated infections in a WLW dyad. Tanisi shared their experience of discovering they contracted BV from a partner during a routine pap smear, highlighting how lack of discussion surrounding BV particularly inhibits lesbian, bisexual, and other WSW from protecting their sexual health when engaging in sex with other women:

> *"I have never ever seen like discourse about like lesbians and safe sex… After I caught BV, I was like how the hell did I get this, then my doctor said it's very transmittable between queer women… I feel like within the lesbian community there's some sort of like "We don't pass anything" … There's some sort of shame associated with it… This general sense of not talking about it in our community."*

While it is fundamentally untrue that women can only facilitate BV when engaging in sex, Tanisi's lived experience draws attention to the higher burden of BV experienced by lesbian, bisexual, and other WSW as compared to their heterosexual counterparts (Forcey et al., 2015). As such, lack of discussion surrounding sexually facilitated infections amongst WSW perpetuates shame within the WSW community and develops sexual health as a cryptic topic for lesbian individuals. Further, an overall lack of WSW specific sexual health resources was identified which maintained lack of awareness at the service provision level:

> *"I think for women, there aren't very many [resources] because we won't be taken seriously when we go and say like, "I'm in a WLW [women loving women/women who love women] relationship, what are my resources?" I've tried that before… I asked them, I remember, and I was like, "Where can I find resources for South Asian queer women?" and they were like, "We're mostly for men" … Every time you ask about HIV resources, there's nothing." – Tanisi*

Evidently, the lack of these resources, which may educate young sexual minority women about sexual health risks and alleviate shame pertaining to sexually facilitated infections, leaves this group of women unequipped and hinders their ability to protect their sexual health through barrier protection use and appropriate testing.

Conclusion

Participants' narratives bring insight into the knowledge, attitudes, and practices pertaining to HIV/STI risk of young South Asian sexual minority women as they navigate overlapping cultural, social, and structural contexts wherein HIV/STI risk is situated. Stigma and early lack of access to sexual health information, resources, and knowledge impacts later attitudes towards self-perception of risk and safe sex practices. Simultaneously, pervasive attitudes within structural contexts, such as school and medical settings, contribute to a low-risk perception of HIV/STI risk between women. Further, young South Asian sexual minority women experience multiple minority stressors which impact sexual interactions in which HIV/STI risk is produced and how support and services are accessed. Figure 1 showcases how HIV/STI risk may be understood for this group in consideration of these factors and how these factors interact to produce risk therein.

Figure 1: Conceptual diagram of the interaction of factors contributing to HIV/STI risk for young South Asian sexual minority women living in the Greater Toronto Area in Ontario, Canada.

CHAPTER 5: DISCUSSION

The findings of this study fill a gap in the literature as it pertains to understanding the HIV/STI risk context and sexual health needs of young South Asian sexual minority women. Participants' narratives presented a cultural, social, and structural understanding of what shapes the HIV/STI risk context for young South Asian sexual minority women living in the Greater Toronto Area, providing new insight into how present society may need to understand HIV/STI risk as opposed to hierarchized risk categories often used when discussing HIV/STI risk.

The sociocultural context of participants' lives highlighted the impact of growing up in a heteropatriarchal and heteronormative context where access to support and information is minimal, resulting in prolonged periods of distress for this group as it relates to their sexual lives, sexual identity, and manifests into understanding sexual health relevant to their lives. The structural context is characterized by the absence of LGBTQ+ competent sexual health education, compounded with interactions with healthcare practitioners, which produce and perpetuate a low HIV/STI risk narrative. This structural context manifests within WLW relationships as low use of barrier protection and uncertainty surrounding how to navigate safe sex when engaging in sex with women. Behaviour driven by stress and the mechanisms to cope with internalized homophobia are exposed through participants' narratives, showcasing how HIV/STI risk context is uniquely shaped for young South Asian sexual minority women as these individuals begin to understand their identities and manage stressors while becoming sexual beings. Further, interactions with the broader LGBTQ+ community illuminated experiences where participants were met with invisibilization and racism which additionally impacted their access to support services and safe sex along with dating dynamics unique to women loving women (WLW) relationships as experienced by participants.

These experiences showcase how the sexual health of young South Asian sexual minority women may be understood and how these individuals' sexual health is routinely subjugated. As such, a combination risk and multiple minority stress framework situate HIV/STI risk for groups such as this one and should be considered in program development and health promotion strategies. These findings have major implications for school-based sexual health education, medical training for healthcare practitioners, and sexual health support and services provided by community-based sexual health organizations in the Greater Toronto Area.

Implications

Three major implications emerge from examining extant literature and how the present study's findings are situated therein. The implications discussed below follow participants' temporally ordered narratives to observe existing research, gaps filled by the present study, and conclude with implications for education, practice and service.

1. LGBTQ+ Inclusivity in School-Based Sexual Health Education

The participants in the present study discussed the lack of LGBTQ+ inclusive sexual health education at school and the impact this has on knowledge construction pertaining to sexuality and sexual health. The participants pointed to the absence of inclusive education as erasing the lived experiences of LGBTQ+ youth, specifically South Asian sexual minority youth, and subjecting these individuals to enforced outness in order to access any relevant information and support. Simultaneously, through exclusion of LGBTQ+ experiences from sex education, a heterosexual awareness of sexual health is constructed, rendering sexual health an inadequately understood topic when engaging in sex with women.

Extant literature finds that the absence of LGBTQ+ inclusive sexual health education contributes to the further stigmatization, and results in worse overall health, for gender and sexual minority individuals within the school climate due to experiences of peer victimization and exclusion which eventually translates to low support seeking behaviours and isolation (Bay-Cheng, 2003; Gowen & Winges-Yanez, 2014; Hatzenbuehler et al., 2014; Proulx et al., 2019). At the same time, the lack of inclusive sex education curricula significantly impacts self-efficacy in sexual health and safe sex practices for LGBTQ+ youth compared to heterosexual youth (Charest et al., 2016; Coulter & Miller, 2018). These impacts are largely due to sexual minority youth having to rely on partners, online resources, or pornography for information, rendering low confidence in safe sex practices (Charest et al., 2016), as found within the present study's sample as well. Notably, while online searches have become an increasingly common tool for sexual health resources for LGBTQ+ youth, young WSW are unlikely to be motivated to search for HIV/STI risks and safe sex resources due to an underlying low perceived risk of STIs and distrust in online resources versus offline resources, such as doctors (Magee et al., 2012). As such, while cisgender and heterosexual youth benefit from this early priming of sexual health, those outside of the gender and sexual binary, particularly young WSW, fall through the gaps of education, and are forced to acquire relevant information outside of structured education. This leaves young WSW susceptible to misinformation, such as prevalent "low risk" attitudes, and not acquiring important skills such as negotiation of safe sex within relationship frameworks relevant to their lives (Elia & Eliason, 2010b; Formby, 2011; Mitchell et al., 2014).

In schools where LGBTQ+ inclusivity within the sexual health curriculum may be present, the curriculum often discusses these topics within the context of HIV/AIDS, employing a 'pathologizing narrative' which further stigmatizes people within the LGBTQ+ community

(Gowen & Winges-Yanez, 2014). Safe sex information pertaining to WSW is often entirely ignored or inadequately addressed here as the focus is often on gay or bisexual men, or HIV transmission within heterosexual sex, thus enforcing the notion that unprotected sex outside of heterosexual sex has negligible or low risk for a woman and constructs lesbian women as virtually immune to HIV/STIs (Kubicek et al., 2010; Logie, Lacombe-Duncan, et al., 2015; Marrazzo et al., 2005; Marrazzo & Gorgos, 2012; Power et al., 2009; Richardson, 2010). When structured education attributes HIV/STI risk to identity, it reduces individuals to labels which do not inherently dictate risk. Instead, if youth are given tools to understand and assess their own risk, it empowers individuals to protect their own sexual health. Relatedly, when WSW are not acknowledged in sexual health education, it creates sexual health as a riddle for WSW when engaging in sex with women.

Integrating the experiences of LGBTQ+ youth in sexual health education has demonstrated an improvement in supportive school climate and equitable education for LGBTQ+ youth (Gowen & Winges-Yanez, 2014; Snapp et al., 2015). However, the voices of racialized and ethnic LGBTQ+ youth in the Western context remain particularly scarce within the data (Roberts et al., 2020; Toomey et al., 2017). Findings emerging from a recent study which sought the perspectives and experiences of LGBTQ+ students of colour regarding sexual health education found that these students felt unrepresented, unsupported, and stigmatized within their school climate (Roberts et al., 2020). The students in Roberts et a.l's (2020) study proposed that changes within LGBTQ+ inclusive sexual health education curricula include factors such as culture, religion, race, and ethnicity in order to accurately represent diversity within the LGBTQ+ community.

The findings of the present study are consistent with Roberts et a.l's (2020) data and fill this gap in understanding by illuminating the needs of young South Asian sexual minority women who require culturally sensitive and women-centred sexual health promotion resources and education. One example was forced outness and the detrimental effects this can have on the safety of young South Asian sexual minority women. Sexual minority youth of colour navigate outness in complex ways in order to ensure safety often until they acquire post-secondary education and possibly thereafter (Garvey et al., 2019). If safety is not prioritized, these youth are at greater risk of poor mental health and adverse outcomes during middle and high school when school-based sexual health education is administered.

While integrating culturally and racially sensitive education would ensure that everyone in the classroom is represented within the sexual health education curriculum, it would also prevent enforced outness experienced by ethno-racialized LGBTQ+ youth. Given that these youth experience additional and cumulative stressors due to their racialized status, as evidenced by the narratives of the present study's participants, it becomes integral to further understand how existing LGBTQ+ inclusive sexual health education may be improved to adequately cater to the needs of these youth and circumvent the added burdens experienced by ethno-racialized LGBTQ+ youth. The implication for school-based sexual health education is that education equitably reflect the diversity of the LGBTQ+ community, especially in the Greater Toronto Area which is home to more than 50% of Ontario's South Asian population and remains one of the most diverse metropolitan areas in Canada (Islam et al., 2017).

Overall, future risk for youth is evidently created very early on when structural factors such as school-based sexual health education ignore social vulnerabilities which young sexual minority women may be susceptible to, such as homophobic violence and intimate partner violence (Gillum & DiFulvio, 2012; Heintz & Melendez, 2006; Irwin, 2008). Participants within this sample discussed instances of dating violence in same sex relationships along with racial dynamics which uniquely shape the HIV/STI risk for young South Asian sexual minority women living in the diasporic context. It becomes critical then that early sexual health education is keen to this diversity of youth's experiences and equitably represents gender and sexual minority individuals so that these young people benefit from this early education as prevention for future HIV/STI risk.

2. Healthcare Practitioner Competency in LGBTQ+ Health

The participants in this study described interactions with healthcare practitioners as anxiety producing and most participants did not disclose their sexual identity when discussing sexual health, inhibiting them from access to relevant support and care entirely. Further, participants described being discouraged from STI testing if they were not having sex with men upon disclosure of sexual identity. These findings point to the structural inadequacy in LGBTQ+ health competency and institutional heteronormativity in sexual health care provision amongst healthcare practitioners. Thus, lesbian, bisexual, and other WSW are prevented from acquiring relevant sexual health care and support.

These experiences coincide with existing literature and characterize how the sexual health of lesbian, bisexual, and other WSW is routinely disregarded in medical settings, resulting in delayed access to relevant support and care (Macapagal et al., 2016; Martos et al., 2018; Munson & Cook, 2016). As the primary point of contact for healthcare, interactions with family doctors and healthcare practitioners greatly shape access to relevant information, such as personal risk and health protection behaviours. However, for young sexual minority women, unmet healthcare needs, such as regular pap smear testing, and barriers to accessing relevant support and care have long been documented with insufficient improvement over the years (Alencar Albuquerque et al., 2016; Bjorkman & Malterud, 2009; Bonvicini, 2017; Mathieson et al., 2010).

Factors such as fear of rejection, uncertainty about relevance of sexual identity disclosure, and low self-perception of STI risk keep sexual minority women from disclosing their sexual orientation to physicians (Cattallozzi & Rudy, 2004; Martos et al., 2018; Munson & Cook, 2016). Notably, disparities to healthcare access exist greatly even within the LGBTQ+ community where cisgender White gay men have greatest access and sexual minority women of colour remain considerably overlooked (Klitzman & Greenberg, 2002). The issue is certainly double-sided as clinicians simultaneously lack the LGBTQ+ sexual health competency required to appropriately screen, counsel, or refer LGBTQ+ individuals to relevant support and services (Knight et al., 2014; Parameshwaran et al., 2017).

The lack of LGBTQ+ competency and expertise amongst healthcare practitioners is widespread and a critical concern as it has the potential of disregarding a larger group of people than we may presently realize. While fear of disclosing sexual orientation for young South Asian sexual minority women will likely persist due to social factors (e.g., stigma, cultural constraints, access to social support, experiences of racism and queerphobia, and extent of internalized homophobia, etc.), the responsibility falls to improving healthcare practitioners' skills through mandatory training, thereby targeting institutional aptitude to address sexual health needs for diverse populations. If people are not given the sexual health care and support that is relevant to their lives, new HIV/STI infections are likely to remain mismanaged and inadequately prevented.

Furthermore, there is a dire need to dispel the narrative of negligible risk of HIV/STIs for WSW considering factors such as previous incidence of STIs or sexually facilitated infections, such as bacterial vaginosis, untreated STIs, and coinfection increase risk of future STIs and HIV (Coudray & Madhivanan, 2020; Newbern et al., 2013). The present study found low STI testing for participants when having sex with women while simultaneously an incidence of bacterial vaginosis within the sample was discussed. Although no relationships can be drawn here, participants' narratives shed light on issues which have been supported in the literature within the past 20 years.

Firstly, we do not know the magnitude of HIV risk between WSW as HIV statistics do not accurately represent this data since these women cannot report having a female partner (Logie & Gibson, 2013). Additionally, while existing literature is inconclusive as to how exactly bacterial vaginosis is transmitted, transmission between women has been reported via exchange of vaginal fluid (Bailey, Farquhar, & Owen, 2004; Evans et al., 2007). In fact, WSW carry a higher burden of bacterial vaginosis compared to their heterosexual counterpart, wherein risk is positively associated with number of female partners in both, lifetime and within three months prior to diagnosis (Forcey et al., 2015). Finally, some STIs, such as human papillomavirus (HPV), can make individuals susceptible to other illnesses, such as cervical cancer. Yet, many sexual minority women do not perceive themselves to be at risk of HPV (Agénor et al., 2019; Polek & Hardie, 2010). Whereas lesbian and other WSW access STI testing, pap tests, and cervical cancer screening less frequently than heterosexual women, it becomes important to ensure that this population is not routinely overlooked in the medical setting and is appropriately screened and encouraged to test (Mathieson et al., 2010; Tracy et al., 2010). Ignoring the sexual health of sexual minority women entirely inhibits individuals' opportunity for receiving comprehensive healthcare.

Healthcare professionals occupy a privileged social position and hold power in shifting the narrative around risk. Offering services such as appropriate risk-reduction counselling and encouraging HIV/STI testing for all people, considering anyone engaging in sex can be at risk of HIV/STIs if they are not well informed, are valuable interventions which may prevent future HIV/STI risk for young sexual minority women. In line with the social justice values of healthcare practitioners and public health, the onus falls on targeting medical and pre-licensure training of medical staff, such as physicians and nurses, so that health inequities experienced by LGBTQ+ individuals and further by racialized sexual minority women, may be reduced at the population level (Keuroghlian et al., 2017; McNiel Paula L. & Elertson Kathleen M., 2018; Sekoni et al., 2017). This would ensure that physicians and nurses are trained in LGBTQ+ health needs and are vigilant to the sexual health needs of sexual minority women.

In summation, it is imperative that community-informed LGBTQ+ health competency training be included in medical and pre-licensure training for physicians and nurses so that all people are able to access sexual health support and care relevant to their personal lives. This training would have implications in sexual minority women receiving appropriate risk-reduction counselling, HIV/STI screening, pap smears, and social prescribing that would address lesbian, bisexual, and other WSW's unique sexual health needs.

3. Sexual Health Support and Service Provision in Existing Community-Based Organizations

Community-based sexual health services and support can be an important resource for individuals who experience significant barriers to healthcare or information, or who require community-specific resources which are not readily found in structural settings. For participants in the present study, while LGBTQ+ services existed within Toronto, participants were hindered by the absence of cultural competency within existing programs along with the lack of HIV/STI resources developed specifically for WSW.

The need for cultural competency within service and care settings has become increasingly recognized, outlining that effective care requires that an understanding of cultural impacts on health and access are implemented in program and care design (L. M. Anderson et al., 2003; Brach

& Fraserirector, 2000; Stone, 2004; Tombros et al., 2007). Utilization of sexual health services has been reportedly low for diasporic South Asians, especially South Asian women, due to factors such as shame and stigma associated with sex and HIV/STIs, 'modesty' required of women, and low sexual health knowledge within the broader community (Chaudhry et al., 2003; Gray et al., 2021; Jahangir & Meyer, 2020; Vahabi & Lofters, 2016; Weston, 2003). This makes it important that cultural competency be embedded within sexual health programs and health promotion services so that large populations, such as South Asians, can equally benefit from existing services.

The access needs of South Asian sexual minority individuals are likely to differ and be nuanced by variances in social support, sexual identity, gender expression, and level of outness, to name a few. The participants in the present study expressed concerns surrounding confidentiality and distance to relevant services from suburban areas outside of the downtown Toronto core. Such access issues can make utilizing existing services an anxiety-producing endeavour which may ultimately deter young South Asian sexual minority women. It is imperative then that organizations serving South Asians actively include this group in designing programs. While participants in this study expressed strategies such as online services, over the phone counselling, and greater outreach to suburban areas, further research should explore strategies to ensure the safety of young South Asian sexual minority women and target sociocultural influences such as queerphobia and shame surrounding sex within the community. Employing these strategies dually (i.e., socially and structurally) is likely to alleviate the multiple stressors experienced by young South Asian sexual minority women, such as gender-related expectations, concealment of sexual orientation, and internalized homophobia.

Additionally, participants identified WLW-specific relationship issues such as dating violence, dynamics, and maneuvering safe sex negotiation as concerns for which support and resources lacked. Notably, experiences such as intimate partner violence have been found to increase HIV risk amongst sexual minority groups (Heintz & Melendez, 2006). Participants thus shed light on sexual health issues unique to young South Asian sexual minority women which may be addressed by improved support and service provision by existing community-based organizations as well. Existing literature has identified nuances which exist within same-sex couples and uniquely impact experiences of sexual abuse, violence, and sexual assertiveness within these relationships (Gillum & DiFulvio, 2012; Heintz & Melendez, 2006; Ristock, 2005; Ristock, 2002). Experiences such as intimate partner violence and sexual abuse can have severe long-term impacts on individuals, such as depression, anxiety, substance use, and suicidal ideation (Girshick, 2009). This is exacerbated for young sexual minority women who are unlikely to or delay seeking help if they are actively concealing their sexual identity amongst family and peers (Gillum & DiFulvio, 2012).

While much of the previous work addresses issues in these relationships related to the pressures of concealing sexual orientation, impact of internalized homophobia, experiences of feminization, and reproduction of misogyny or heteronormativity within same-sex relationships, investigation into the additional impact of racism and racial dynamics within WLW relationships has been limited (Curtin et al., 2009; Gillum & DiFulvio, 2012; Greene et al., 2015). The present study illuminates this additional layer of oppression faced by young South Asian sexual minority women living in the Western diaspora, highlighting the need for comprehensive and community-informed strategies which can address these layered burdens experienced by this group.

Experiences and perceptions of lesbian gender labels, such as masc/femme and top/bottom, can have an impact on sexual minority individuals who are beginning to develop their sexual identity and have minimal resources for understanding their experiences. During such times, youth are susceptible to stereotypes or norms inflicted on them by the broader community or in interaction with partners. Walker et al. (2012) finds that these stereotypes do not always translate to sexual behaviour and that attraction and behaviour remain fluid within the community. However, when youth are susceptible to misinformation or internalizing community stereotypes due to lack of support or resources, as illuminated by the participants in the present study, this can impact the sexual encounters they find themselves in and how sexual assertiveness is able to be practiced. As a result, sexual health risk is influenced in these circumstances, when individuals feel forced to adopt labels and perform as such. The findings of the present study can thus be used by dating violence services, community-based sexual health organizations, and mainstream LGBTQ+ spaces to re-define and improve what they deem cultural competency within their context so that young South Asian sexual minority are not dually overlooked by existing structures and again by social services.

Strengths

A major strength of this study is the qualitative nature of data collection. The lived experiences shared by participants in the in-depth interviews draw insight into complex interactions between level of knowledge, formation of attitudes and perceptions, and how these impact sexual behaviour, decision-making, and practices. The interviews followed a semi-structured format, allowing the participants to highlight experiences which they deemed crucial to this work, along with sharing meaning-making processes which researchers may not have access to via other tools, such as surveys or questionnaires. The level of participants' education may also mean that this group was more equipped to express, discuss, and engage in dialogue regarding issues addressed in this study.

Further, considering the sample was drawn from a region which is home to approximately half of Ontario's South Asian population and the narratives draw insight to high level structural and social factors where HIV/STI risk is situated, areas of health promotion and sexual health intervention which can impact a large community within this small geographic radius are highlighted. Finally, although small, the sample had individuals from multiple ethnic groups, showcasing major similarities which exist within the South Asian diaspora, and which serve as barriers to relevant care, service, and support for this large and diverse group residing within the Greater Toronto Area.

Limitations

As the first exploratory study of its kind to investigate the sexual health risk context of young South Asian sexual minority women in Canada, this study is not without limitations which must be considered when integrating findings to practice.

Firstly, the small sample size of this study limits the vast experiences of this group. Factors such as acculturation status, within-group dynamics in the South Asian community, and effects of socioeconomic status within which one was raised and then exists in presently were unable to be adequately addressed here but must be kept in mind when considering how these factors affect learning and access for individuals.

Secondly, the lack of adequate representation of gender non-conforming individuals should be noted. Gender expression and performance can have significant impact on how individuals are able to access support and services and how sexual health is perceived and understood in addition to a sexual minority status. This study aimed to provide disaggregated data to showcase these nuances. As such this was an intentional distinction made at the beginning of the study so as to not gloss over the experiences of gender minority and transgender individuals. Program developers must be vigilant to this fact and understand that active and meaningful inclusion of gender minorities is essential to forming comprehensive sexual health services for minority individuals. Similarly, while other individuals, such as trans-masculine or transgender men, may relate to some of these findings as individuals assigned female at birth, the trajectories and life experiences of this group are significantly distinct, and these findings should not be used to dictate the experiences of other groups assigned female at birth. As a result, these findings are most relevant to individuals who were assigned female at birth, identify as a woman (or have proximity to womanhood), and are South Asian, specifically.

Further, all participants in this sample were post-secondary school enrolled or graduated individuals who had access to campus-based services where possible. The findings thus likely represent a ‘best-case’ scenario for this population which may not be the case for individuals who do not pursue post-secondary education and likely experience different and additional barriers to access and community. Further research regarding this group’s sexual health experiences should aim to recruit a larger and more representative sample so that a more holistic understanding of this group’s experiences can be formed. Finally, only one participant immigrated to Canada at an older age, highlighting significantly different experiences compared to individuals raised in the Western context. As such, it is important to acknowledge variances in immigration experiences which can uniquely impact sexual health and access needs.

Conclusion

The present study offers nuance to the understanding of HIV/STI risk and sexual health needs of diasporic South Asian sexual minority women. The above findings invite one de-construct existing modes of assessing risk in order to better understand how minoritized individuals interact within existing sociocultural contexts and make choices within dominant structures. When individuals are equitably empowered to make decisions to promote and protect their own health, then we may move forth to discuss equality.

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APPENDIX

Appendix A: Demographic Form

Demographic Form

Full name:

Age:

Gender identity:

Sexual identity:

Current relationship status:

Ethnicity:

City of residence:

Length of time in Canada:

Education level:

Current employment status:

Outness:

Compensation method:

Appendix B: Semi-Structured Interview Guide

Sexual identity formation:

1. Could you begin by describing to me how you came about realizing your sexual identity and what that experience has been like for you in your past *x* years? (ie., timeline, key experiences, etc.)

PRACTICES

1. What have dating and relationships been like for you? How do you feel this compares to your peers?

   (a) Has anyone ever influenced your choice of partner(s) (any type of relationship)?

2. Describe to me, in as much detail as you can, what your first sexual experience was like.

   (a) When did it happen?

   (b) Was protection used? Why or why not?

3. Looking back, what sexual activities have you engaged in? Have your sexual practices changed over the years? Anything you anticipate engaging in?
4. Have you ever engaged in sexual activities in which blood was drawn?
5. Have you ever had more than one sexual partner? How often is protection used?
6. Do you have multiple partners? Times when you're seeing more than one person?
7. Do your partners have other sexual partners as well as you?
8. Are your partners aware of your other sexual partners and vice versa?
9. Which forms of protection against pregnancy and STIs do you generally use?
10. To what extent do you feel like you have say in what sexual activities you engage in?
11. Have you ever felt pressured into any sort of sexual interaction? **please answer this question to the extent that you feel comfortable, you can skip it if you want**
12. Have you ever contracted STIs before? Do you know how? **remind them they do not have to disclose HIV status**
13. Have you ever had sex under the influence of alcohol/drugs? Is it rare or common?

14. Have you ever participated in injection drug use?

15. With what proportion of partners have you always/sometimes/never used protection?

ATTITUDES

1. When you're having sex with a partner (regardless of assigned sex at birth), what risks do you feel you're at, if any? Why?

2. To what extent do you think about any risks involved with sex? Do you feel protected against STIs more sometimes than others?

3. What factors influence if protection is used during sex?

4. Do you feel personally at risk of contracting HIV? What about any other STIs?

5. How often would you say you get tested for STIs? Have you ever been tested for HIV? What factors influence the decision to get tested?

6. Is there a conversation about STI testing/having been tested prior to having sex with a new partner? Why or why not?

KNOWLEDGE

1. How and where have you learned about relationships, sex and contraception? Whom or what do you rely on for information regarding sex?

2. How knowledgeable do you feel about sex and sexual health matters?

3. Did your parents (or elders) ever talk to you about sex or discuss any matters related to sex with you?

4. Did you ever receive sexual health education at school?

5. How do you think people contract HIV? What about STIs?

6. Who do you think is most at risk of HIV or STIs?

SERVICE ACCESS

1. Can you list for me all the places and people you know of which young people like yourself are able to visit and talk to, to learn about relationships, sex, contraception, STIs etc.?

2. Have you ever accessed community-based sexual health support or services? If so, what was your first experience like? What encouraged you to go?

3. Have you been more than once to that first service? If not, why not?

4. What are your general feelings about the services you have accessed?

5. How can services be improved?

Is there anything else you'd like to talk about or mention that you feel is relevant to what we talked about today?

Appendix C: Example of Codebook Entry

Theme	Sub-Themes	Definition	When to use	When not to use	Example
Subjugation of the sexual health needs of young South Asian sexual minority women	Heteropatriarchal and heteronormative structures bar early knowledge construction pertaining to HIV/STI risk with women	Any evidence pointing to lack of understanding of queer sex or sex between women, or protection methods available for sex with other women	Use when participants cannot discern 'safe sex' or identify risks when referring to sex with other women	When participant describes various safe sex methods that may be used for different people	*"If I were to have sex with women, I would know nothing in terms of protection… I wouldn't know what to do… But with a man, the only thing I would know is like the mainstream condom." - Chayanna*
	Shame and stigma hinder community knowledge-sharing	Any evidence referring to feelings of shame surrounding sex and inability to share sexual experiences or HIV/STI knowledge due to feelings of stigma	Use when participants verbalize feelings of shame and stigma pertaining to HIV/STIs and sex	When referring to openness and acceptance surrounding conversations about HIV/STIs and sex	*"Brown people hate talking about sex and it's really not something we talk about outside of marriage, like even heterosexual sex, so I feel like a lot of queer and South Asian people may feel like they need to make up for that in some way, make up for their lack of knowledge." - Meghna*

Appendix D: HiREB Final Approval Letter

HiREB
Hamilton Integrated Research Ethics Board

Feb-14-2020

Project Number: 8107

Project Title: A community-engaged study to understand HIV/STI risk in the South Asian female sexual minority youth population living in the Greater Toronto Area

Student Principal Investigator:

Local Principal Investigator: Dr. Saara Greene

We have completed our review of your study and are please to issue our final approval. You may now begin your study.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Demographic Form_Feb 9_V2	Feb-09-2020	2
Email correspondence_Feb 9_V2	Feb-09-2020	2
HiREB Protocol	Jan-03-2020	1
ICF_Feb 9_V2	Feb-09-2020	2
Semi-structured Interview Guide_Feb 9_V2	Feb-09-2020	2
Sexual Health Study Ad_Feb 9_V2	Feb-09-2020	2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
HiREB Cover Letter	Feb-09-2020	1
tcps2_core_certificate	Apr-16-2014	TCPS2(CORE)

Any changes to this study must be submitted with an Amendment Request Form before they can be implemented.

This approval is effective for 12 months from the date of this letter. Upon completion of your study please submit a **Study Completion Form**.

If you require more time to complete your study, you must request an extension in writing before this approval expires. Please submit an **Annual Review Form** with your request.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Good luck with your research,

Kristina Trim, PhD, RSW
Chair, HiREB Student Research Committee
McMaster University

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton and the Faculty of Health Sciences at McMaster University and operates in compliance with and is constituted in accordance with the requirements

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of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; for studies conducted at St. Joseph's Healthcare Hamilton, HIREB complies with the Health Ethics Guide of the Catholic Alliance of Canada