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ORIGINAL PAPER

Reflections from Refugee Adolescent Girls on Participation in a US-Based Teen Sexual Health Promotion Project

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Abstract

Refugee girls may be unprepared for the sexual risk challenges facing teens in the US. We sought to understand refugee girls' general experience, discussions with parents and motivations related to participation in an evidence-based sexual risk reduction program. Through semi-structured interviews with twelve girls ages 15–17 years from nine countries, we acquired insight into the girls' reactions to the program, if they had discussed their experiences, and reflections on their decision to participate. Qualitative analysis of verbatim transcriptions identified three themes: (1) my cultural norm is not to ask; (2) groups were a safe way for me to learn and share; and (3) I learned to use my voice. As the numbers of adolescent refugees grow, we cannot ignore their need for tailored sexual health research and programming. This first-of-its-kind study provides insight into acceptability, motivation for participation, and impact of a sexual health promotion program.

Keywords Adolescent health · Sexual health education · Refugees · Qualitative research

Background

Since the passage of the Refugee Act in 1980, the United States has admitted more than 3.1 million refugees; many of those are adolescents and young adults [1]. In addition to adapting to a different culture and lifestyle, these girls are faced with the challenges of adolescence. This developmental period is highly influenced by peers and typically distinguished by risk taking behaviors, experimentation, and emerging risky sexual behaviors [2]**.** Both culture and language barriers compounded with the impressionability of adolescence leaves young refugee girls increasingly at risk for negative sexual and reproductive health outcomes as they acculturate to a country where adolescent girls bear a disproportionate burden of unplanned pregnancies, STIs, and heterosexually-acquired HIV [3, 4]. Yet the sexual and reproductive health needs of refugee, migrant, and displaced girls have been neglected with a notable deficit in programming or interventions.

Studies across different refugee populations document that sexual health knowledge and skills to reduce risk are limited for many entering host countries [5]. Refugee women commonly report not having adequate knowledge of how to protect themselves from STIs and HIV [3]. Along with misconceptions surrounding the availability of sexual health resources, cultural norms also serve as a deterrent against seeking out such resources or information as this may be strongly stigmatized in many countries where these adolescent girls were raised [5]. Similarly, in focus groups conducted with refugees ages 18–24, both males and females appeared to have limited sexual health knowledge [6, 7]. Sadly, the first time many refugee girls learn about sexual and reproductive health is in response to an unplanned pregnancy or STI diagnosis [8, 9]. Studies have found that adolescent females are not comfortable discussing sexual health issues with family members or providers, rather rely on information from other sources such as the internet or peers [8, 10, 11].

The vulnerability of adolescent refugee girls, combined with lack of knowledge and skills needed to deter negative sexual health outcomes, makes this a much-needed study. As studies with adolescent refugee girls who have participated in an evidence-based sexual health promotion program are limited, we sought to understand through qualitative individual interviews the girls' general experience, discussions with

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parents and motivations related to participation. Interviews are often most appropriate where little is known about the issue and are particularly appropriate for exploring sensitive topics, where participants may not want to talk about such issues in a group environment [12]. Considering the paucity of understanding or programming addressing sexual and reproductive health outcomes in this vulnerable population, this study will help set the stage for understanding adolescent refugee girls participation in such programs.

Methods

The purpose of this study was to gain insight into factors influencing refugee adolescent girls' decision to participate in a sexual health promotion program and their general experience. We conducted individual interviews from April to June 2021 with girls who were clients of a refugee resettlement agency. This study, approved by the Ohio State University IRB, helped us to gain understanding of the girls' reactions to the program, if they had discussed their experiences, and reflections on their participation.

Participants and Data Collection

We identified a list of all attendees (N = 60) at an adolescent sexual health promotion program provided at the International Refugee Committee (IRC) Atlanta site. This organization is a major hub for entry, helping refugees whose lives have been shattered by conflict and disaster to survive, recover, and gain control of their future. Those girls had all attended a virtual program for 4 weeks conducted by two trained female facilitators with groups averaging eight per/session. From that list of attendees, a trained recruiter contacted the girls who participated to gauge interest in the interviews. The recruiter then contacted parents for full consent and followed that with assent of each interested participant.

We conducted individual interviews with girls who had participated in at least one of the four sessions of the sexual health promotion program (N = 12). Due to COVID pandemic restrictions, these interviews took place by phone with the trained interviewer, a trained interpreter, and the participant. Interviews took place in private rooms for the interviewers and interpreters and for most participants to facilitate confidentiality. Participants received a $25 gift card for their participation.

Measures and Analysis

Research team members, trained by the principal investigator, carried out consent, data collection, coding, and analysis study components. Each interview lasted approximately one-half hour following a standardized semi-structured interview guide (see Table 1) that allowed for prompts, clarifications, and expansion of discussion. Audio-tapes of the interviews were sent externally for verbatim transcription. Following line-by-line confirmation of transcription accuracy, the five team members independently identified meaningful responses on each interview transcript. We then met as a team to determine transcription response agreement for inter-rater reliability (confirmed at > 95% on all quotes). Then, all selected quotes were compiled into a single data set and common codes and themes for within-group analysis were identified.

To improve credibility, dependability, transferability, and confirmability, we addressed trustworthiness of the data by using multiple approaches. We used a detailed interview guide and team members debriefed after each interview. We analyzed data sets independently (individual team members) and then together (team), established inter-rater reliability on transcript coding, described the sample and setting for transferability reflections, and enhanced description by using direct quotes exemplifying each theme. By providing a detailed audit trail to enable readers to follow our team's logic, we sought to enhance qualitative data trustworthiness.

Table 1 Adolescent girls' interview guide

1. When you were asked to join the health classes, was there any additional information would you have liked to have learned before you decided to participate?
2. What reasons led you to participate? A reason is something that made you decide yes, I want to be part of this
3. Were there any things/concerns that made you think about NOT attending the health classes?
4. Did you talk to your parents/others about your experience?
Did they ask you any questions about what you were learning or if you liked it?
5. What should we do to make it easier for other girls to be comfortable and attend our health classes? Would you recommend our health classes to your friends?
What did you like the most about the classes? The least?

Results

The purpose of this study was to understand the perspective of the girls who participated in a sexual health promotion program, their reasons for consenting to participate and general impressions and discussions with parents. Participants were predominantly young women of color between the ages of 15–17 years (M = 16.1), from a range of nine countries (see Table 2). They had been in the US, on average, for 3 years and spoke seven different languages (majority Swahili). We identified three distinct themes from the interviews: (1) My cultural norm is not to ask; (2) Groups were a safe way for me to learn and share; and (3) I learned to use my voice.

My Cultural Norm is Not to Ask

We identified that cultural standards play a large role in the perception of need for, and appropriateness of, sexual health education for these girls. The participants explained that they were not accustomed to, nor comfortable with, openly discussing the topic of sexual health or asking questions about it. Like many noted, one girl expressed how people in her culture do not discuss these topics but that this opportunity could help address that information gap, giving her the opportunity to ask questions,

> In our culture we don't know that stuff … Even our family, they're shy about that kind [of information], to speak of [it]. I think because of that I joined.

Table 2 Study participant demographics

Demographics	Refugee girls (n = 12)	
Age	15 years old	2
	16 years old	7
	17 years old	3
Race/ethnicity	American Indian or Alaska Native	0
	Asian	4
	Black/African	6
	Native Hawaiian or Other Pacific Islander	0
	White/Middle Eastern	2
Country of origin	Democratic Republic of the Congo	1
	Eriteria	1
	Kenya	1
	Malaysia	1
	Myanmar	1
	Syria	1
	Tanzania	2
	Thailand	2
	Turkey	1
	Uganda	1

Because information about sexual health was so hard to come by in their country, many girls felt nervous to begin learning about it. Participants had to overcome beliefs that these topics were something that should not be discussed. One girl mentioned,

> In our country, they never talk about those kinds of stuff and it will be the first time somebody tell me those stuff so I was just kind of worried about it. But when I joined, I was like I was feeling, 'Oh, that's fine. It's not a big deal.'

This sexual health program provided the girls with valuable educational material that they had not been exposed to previously due to the cultural norms. A girl showed her appreciation for these groups helping to address topics not routinely discussed saying,

> (In the groups) We also learn about how to use condom and all this stuff and I think it's really good and interesting. I was really interested because I never heard about it before. And I learned about it was really helpful, I think, and good for girls who don't want to have any kind of disease or all that stuff.

Groups Were a Safe Way for Me to Learn and Share

Due to Covid restrictions, the sexual health program was provided virtually in small-group format originally planned for face-to-face. Many of the girls remarked that the groups provided a welcoming, safe environment for them to learn and grow. Many shared the belief that being in groups helped them overcome shyness and led them to be more willing to share. As one girl stated,

> I'm kind of free, comfortable, and I told you, because we all girls and (the facilitators) was really nice. And the way you talked to us, the way you explained, it wasn't in a bad way or something. It was just explain(ed) to us in perfect way and how we talk about everything. It was really nice. It wasn't make me shy or something.

The size of the group also seemed to determine the comfort level of the girls. Some participants explained that a smaller group was favorable to a larger one because it fostered more meaningful conversation, allowing more time to discuss sexual health issues. One of the girls shared her view saying, "The small groups can help [other girls] to also express themselves because it's not a lot of people. So you can get the time to talk about yourself or talk about something else".

Overall, most of the girls noted that the use of small groups (as compared to large classroom or individual meetings) facilitated their comfort levels. The combination of a welcoming environment and small group sizes

enabled the girls to overcome the nervousness they may associate with sharing and express themselves. Despite their families being connected to refugee services at IRC, many of the girls did not know each other, yet successfully established rapport through this virtual context. One girl spoke to how the girls were able to overcome any uneasiness,

> The one thing that made me feel comfortable is how everybody will get a time to talk. So that would make it a little bit less nervous for those who are normally nervous, because they could get their turn to talk and express themselves. That made me feel a little bit comfortable in class. Also that everybody was engaged too in the groups, I also like that.

I Learned to Use My Voice

Overall, the girls agreed that the classes led them to share their thoughts and opinions. The girls expressed that the sexual health classes helped them to develop the ability to stand up for themselves and improved their ability to communicate. One girl attested to this stating,

> For example, I learned how to respond to someone who wants me to make a decision that I don't want to, or how to deal with people who peer pressure and stuff. And also how to protect myself against some diseases.

Echoing the same sentiment, another girl told us that the classes helped her to be able to say 'no' to people and take a stand. She also shared that the classes led her to invite her friends to join her as well. She commented on skill building that took place across the program sessions telling us that,

> They [my friends] actually joined the class when I told them the class was good, it was helpful, and they joined it. They helped me because I learned how to say no to people, I think, cause sometime[s] someone would be forcing me to do stuff and I felt I just have to do. [The class] helped me so much.

The girls not only expressed interest in sharing with their friends, but also seemed motivated to share with their family what they had learned. Some girls noted that they had shared information learned with sisters or friends. One girl made it a routine to share with her mother stating,

> I told [my mom] what we were talking about in the class. Sometimes she joined me when I was in the meeting too. She was like, "Oh, that kind of stuff?" When we joined, when we watched the videos, she was sitting next to me and she said, "That's fine. It's okay when we learn about those stuff," because she told me I can join.

Discussion

There is a dearth of research conducted with adolescent refugees, and even less regarding any aspect of sexual health or education directed to girls. This study sought to understand reasons why twelve refugee girls ages 15–17 decided to participate in a sexual health promotion program and their overall reaction to what they had learned. Girls were consistent in describing their interest particularly because this topic is often not discussed in their cultures and, as a result, most girls did not feel comfortable bringing up questions or concerns. Using a small group format, provided virtually, served as a productive environment for girls to meet each other and to listen, learn, and share. Whether it was this virtual environment (with no actual direct contact) or if the gathering together of young women of similar ages in small groups lead to this comfort in participation is unknown, but certainly the approach used was impactful and acceptable to the girls. We do know from other studies that small-group format in same gender groups has been identified as valuable and preferred approach to providing sexual risk reduction interventions [13–15].

Being in small groups provided a safe, private venue to learn about a topic often not discussed within their own cultures was clearly acceptable and desired by the girls who provided interview data. Many noted that they would not have spontaneously brought up this topic to others and, even if they had questions, they felt most comfortable avoiding the questions and simply did not ask. These health promotion groups encouraged just the opposite reaction and many participants asked questions or for clarifications during groups and reported enjoying and learning from the program. Many remarked specifically about the communication skill-building component of the program noting that they ultimately used "their voice" and these much-needed skills outside the program in their everyday lives.

Certainly, the girls comfort levels with the trained facilitators who communicated their investment in the girls' success and participation is always a key to effective interventions. Having facilitators of the same gender who worked at IRC (a known and trusted organization for these families) was seen as critical for promoting comfort with potential participants and was highlighted during enrollment in the sexual health program. Certainly, enrollment numbers and program satisfaction may not have been as successful had the groups and facilitators not been engaged with this community-based organization. Participants considered these facilitators a trusted source, thus this relationship limits the generalizability of these findings for other organizations and populations. Other limitations relate to the small sample size; those who were not interviewed may have different reflections of the program.

Contribution and Conclusion

As the numbers of refugee adolescents entering the US continues to grow, we cannot ignore the need for both research studies and programming that is tailored, both culturally and developmentally, across health topics, particularly, sexual health. This is the first identified study that interviewed refugee adolescent girls regarding their participation in, and impact of, a sexual health promotion program. Future research should address the effectiveness and acceptability of various formats or modalities for providing sexual health programs to refugees (e.g., small-group, virtual, online self-directed). Findings will help address whether it was the small group format or virtual programming that most impacted acceptability and satisfaction in this study. As refugee girls acculturate into US. society, they will face the same complex sexual risk challenges facing teens across the country. They should not be forgotten when it comes to HIV, STI and pregnancy prevention interventions. This study provides preliminary insight into the acceptability of, and reflections on, such a program.

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Data Availability Data collection and preliminary analysis were sponsored by The Ohio State University College of Nursing.

Declarations

Conflict of interest There is no conflict of interest noted. Dr. Morrison-Beedy is owner of HIP4Change, LLC that provides training for HIPTeens intervention delivery. It is hoped that the findings from this study will provide important information to the readers on this topic. It is not intended to be comprehensive nor does it involve sales of a product.

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