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ORIGINAL PAPER

"It is Good to Know Now…Before it's Too Late": Promoting Sexual Health Literacy Amongst Resettled Young People With Refugee Backgrounds

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Abstract Little is known about access to sexual health information amongst young people with refugee backgrounds living in countries of resettlement. This paper reports on a study of sexual health amongst recently arrived young people from refugee backgrounds in Melbourne, Australia. The study employed qualitative research methods to explore and describe how resettled youth access, interpret and implement sexual health information. Between August and December 2007, data was collected through 23 focus group discussions and 14 in-depth interviews involving 142 young people with refugee backgrounds. Participants were purposively selected to reflect the ethnic composition of humanitarian entrants to Australia over the past 3 years. Their countries of origin included Iraq, Afghanistan, Burma, Sudan, Liberia, and Horn of Africa countries. The findings highlight how young people with refugee backgrounds are disadvantaged in relation to access to sexual health information. Young people had little knowledge of sexual health or STIs apart from HIV/AIDS. While they are aware of potential sources of sexual health information, few of these sources are utilized. Specific barriers to learning about sexual health include concerns about confidentiality, shame and embarrassment when discussing sexual health, and the competing demands of resettlement. The paper argues for sexual health promotion to be an explicit part of early resettlement services for refugee youth, and the implications for the development of appropriate sexual health education programs are discussed.

Keywords Sexual and reproductive health · Sexual health literacy · Refugee · Youth · Resettlement

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Introduction

Promoting the sexual and reproductive health of resettled youth with refugee backgrounds should be of high priority for settlement services and programs. Yet with few exceptions (see DHS 2008: 15), remarkably little attention has been given to the specific needs of this group of adolescents in Australia or in other resettlement countries. Sexual and reproductive health concerns of refugees are predominantly considered within developing country contexts or as complex emergency services for those living in camps and first countries of asylum (Ascoly et al. 2001; Austin et al. 2008; Jones 1999; Matthews and Ritsema 2004; McGinn 2000; Petchesky 2008). This paper focuses on sexual and reproductive health needs amongst young people with refugee backgrounds who have recently arrived in Melbourne, Australia, with a specific focus on sexual health literacy and access to information.

Australia currently provides 13,500 places annually to refugees and humanitarian entrants, of whom approximately two-thirds are aged less than 25 years at the time of arrival (DIAC 2006, 2008; DIMIA 2006: 381; Foundation House 2007). Sexual and reproductive health are issues of concern to young people with refugee backgrounds, as they are for all young people. However, young people with refugee backgrounds face specific concerns and needs due to the pre-migration experience and the resettlement context (Janssens et al. 2005). Many refugee young people have experienced violence, persecution, human rights violations, trauma, displacement from homes and communities, separation from family and friends, relocation to unfamiliar and often crowded surroundings, and disrupted schooling (Coventry et al. 2002; Gifford and Temple-Smith 2005). The instability of their living conditions in refugee camps increases the risk of unplanned pregnancies, sexually transmissible infections (STIs) and HIV/AIDS (Jones 1999; Matthews and Ritsema 2004). Refugee women and girls may have been subjected to sexual and gender-based violence including physical assault, sexual harassment, rape, torture and mutilation, and sexual slavery (Janssens et al. 2005; Population Reference Bureau 2000; VFST 2005). Many have had poor access to health care services prior to arrival (Austin et al. 2008; Krause et al. 2000). It is not uncommon for humanitarian entrants to have multiple health problems on arrival in Australia (Foundation House 2007). Of particular concern is emerging evidence that some of these youth may be vulnerable to the risks of unsafe sex and unplanned pregnancies (Gifford et al. 2009). However, recent studies also highlight the resilience of young people from refugee backgrounds and highlight how they actively build lives and identities in countries of resettlement (Beiser 2005; Kilbride and Anisef 2001; Maegusuku-Hewett et al. 2007). Sexual health is an important part of health and wellbeing in early stages of resettlement amongst young people (Dawson and Gifford 2001). There are limited data, however, reporting sexual health issues and outcomes amongst resettled youth with refugee backgrounds.

One of the challenges of promoting sexual health amongst recently arrived youth is linking resettlement policies to broader sexual health policies and initiatives in the host country. In Australia, a range of national and state-level strategies and frameworks form part of a comprehensive approach to reducing the prevalence and impact of STIs, HIV/AIDS and blood-borne viruses and improving treatment, care

and support for affected people. While there have been considerable efforts towards sexual health promotion, notification rates for STIs have increased in Victoria during the last 5 years. Since 1999, there have been annual increases in most notifiable STIs in Victoria, and particularly chlamydia, gonorrhea, syphilis and HIV (DHS 2006). Amongst young people, there are certain groups at increased risk of STIs and unintended pregnancy, particularly the socially disadvantaged and marginalized (Gifford and Temple-Smith 2005; Williams and Davidson 2004). They are often marginalized for reasons of sexuality, occupation, culture, economic disadvantage, educational opportunity, ethnicity, geographic location, age, substance use and homelessness (DHS 2006; Elam et al. 1999; Fenton 2001).

This paper reports on a study which aimed to identify how young people with refugee backgrounds access, interpret and implement information about sex and sexual health. It highlights particular challenges that these young people face in communicating about and accessing sexual health information. It also identifies implications for the development of sexual health education programs and initiatives for young people with refugee backgrounds.

Methods

This paper draws from a qualitative study conducted during April 2007–December 2008 in Melbourne, Australia (McMichael 2008). Data collection took place between August and December 2007. A total of 142 young people participated in the study: 67 males and 75 females. All participants had refugee backgrounds and were aged between 16 and 25 years. The sample reflected the ethnic composition of the humanitarian entrants to Victoria over the last 3 years, and consisted largely of young people from Iraq, Afghanistan, Burma, Sudan, Liberia, and the Horn of Africa. Participants had been living in Australia for between 1 and 5 years.

Participants were recruited through community organisations that work directly with young clients with refugee backgrounds and through schools and tertiary education settings. Youth were recruited purposively to ensure the sample included participants with a range of backgrounds and different levels of risk in terms of their sexual health, including those who were homeless, living with family, living independently, and both and not attending school.

The study included focus group discussions and in-depth interviews. Twenty-three focus group discussions were conducted with the aim of providing information around young people's attitudes and social expectations around sex and sexual health issues. Focus group discussions have the potential to identify shared constructs and points of divergence and the group setting can promote discussion and disclosure (Roberts et al. 2005). Due to the sensitive nature of the topic and gendered differences in attitudes, knowledge and experience, group discussions were conducted separately for young males and females. Ten of the focus groups included participants with a common ethnicity, and thirteen groups included participants with two or more ethnic backgrounds. In this paper, participants' ethnicities or regions of origin are provided after quotes.

Fourteen in-depth semi-structured interviews—with eight females and six males—provided detailed insight into young people's experiences. Their countries of origin included Sudan, Liberia, Ethiopia and Burma. Interviews were conducted at sites chosen by participants, and included community organisations, restaurants and participant's homes. The researchers conducted in-depth interviews both one-to-one or with pairs of friends. Fifteen in-depth interviews were also conducted with health professionals and case-workers who are involved in refugee specific programs or who engage regularly with communities from refugee backgrounds. Analysis of the interviews with health professionals and case-workers is not presented here, but will be explored in other papers.

The research tools were designed to yield a variety of data around young people's knowledge, attitudes, behaviours and experiences in relation to sexual health issues, with a particular focus on HIV/AIDS, STIs, contraception, pregnancy, initiation of sexual relationships, sources of information, and use of health services. The focus group discussions provided broad information about attitudes to relationships, sources of information, and understandings of risk and preventive behaviours; the interviews elicited more in-depth information about the social and emotional significance of relationships, and understanding and implementation of risk reduction strategies.

The focus group discussion and interview guidelines set out key issues and thematic areas, along with follow-up questions in order that interviewers could explore themes in more detail. Due to the semi-structured format of the research tools, both the group discussions and interviews did not cover precisely the same content or approach issues in the same ways. This allowed for sensitive data collection and rich understanding of participants' knowledge, attitudes and experiences. However, it inhibited comparative analysis of each theme according to sex and ethnicity. The nature of responses within groups also varied, reflecting a combination of the researchers' approach, the comfort and willingness of participants to contribute to discussion, and the base-level understanding of sexual health issues.

The interviews were conducted by three researchers who were experienced in conducting qualitative research with young people with culturally and linguistically diverse backgrounds. Researchers were gender matched with focus group participants. To establish rapport, interviewers began with discussion of young people's interests and their views about relationships before moving on to discussion about sexual health and risk prevention behaviours. The interviews and focus group discussions lasted from between 30 min to 2 h. The majority of participants had sufficient language skills to participate in group discussions and interviews in English. Interpreters were used, however, in two group discussions with newly arrived young people from Burma.

Ethical approval for this study was obtained from the La Trobe University Human Research Ethics Committee. Prior to each interview or focus group, the researcher reviewed with participants the content of an information sheet about the study and provided time for questions. Written informed consent was obtained from all case workers/health professionals who participated in interviews. Verbal informed consent was obtained from all young people with refugee backgrounds. At the start of each interview or group discussion, participants were assured of the confidentiality

of their responses and were asked to provide verbal consent to be interviewed and audio-recorded.

Interviews and focus group discussions were digitally audio-recorded and transcribed verbatim. Qualitative data in the form of focus group discussion and interview transcripts were analysed for thematic content. Qualitative content analysis comprises codes that are derived from the data and then grouped into relevant themes. An initial set of six open codes was developed from the first eight in-depth interviews and five focus group discussions. This coding scheme used a directed content analysis process that was structured according to the main thematic areas of the research tools. As additional interviews and focus groups were conducted and transcribed, axial codes were developed that provided more detailed conceptual categories and generated a refined analytic scheme. Use of the constant comparison method (Glaser and Straus 1967) allowed provisional analytical categories to be assigned and modified as new perspectives emerged, and themes emerging from initial data were used to guide subsequent data collection (Grbich 1999). The data coding process was managed using the NVivo software package.

The study was undertaken for the Victorian Department of Human Services (DHS), Australia. A research report including policy recommendations was developed and submitted to DHS (McMichael 2008). The report was widely disseminated to relevant organizations and services, government departments, and academic research centres. A policy broadsheet detailing key findings and recommendations was also developed and distributed (Refugee Health Research Centre 2008). Findings and case studies have been incorporated into policy submissions to national organizations. Key research findings have been presented at seminars and conferences.

Results

The youth in this study expressed a strong desire to increase their knowledge about sexual health. In both focus group discussions and individual interviews, they talked openly about relationships and their attitudes and understanding of sexual health issues within the wider context of being an adolescent or young adult in a new country. Indeed, we were surprised at the energy of their engagement with these often sensitive issues. Nonetheless, they displayed little knowledge about sexual and reproductive health issues, apart from HIV/AIDS, and few people thought they were at risk personally. The central barriers that stand in the way of learning about sexual and reproductive health are not young people's attitudes, but rather the contextual and structural challenges they encounter. Below we discuss these challenges in relation to sources of information prior and subsequent to arrival in Australia, and the social and cultural contexts for learning about sexual health.

Sources of Information Prior to Arrival

Many young people with refugee backgrounds arrive in Australia with limited knowledge about sexual and reproductive health. Common experiences prior to

arrival include disrupted schooling, long periods of time living in refugee camps, limited or no access to primary health care, experiences or threats of sexual violence and fragmented family life, all of which impact on sexual health literacy. The majority of participants recalled that prior to arrival there were few opportunities to learn about sexual and reproductive health:

In Afghanistan I think they are like me, and like us, they don't know about sex. They don't want to listen about sex. And after getting married, then you have to do it, and you have no idea that you have to do this… It's very different. (Female, Afghanistan)

It is a very hidden topic. Not many people talk about it. Because of the culture a lot of the people tend to just try to forget about it. There is media. People just sort of pick it up as they grow up. They don't get taught about it, they just teach themselves pretty much. That's how they learn. (Male, Ethiopia)

Very few young people had participated in sexual health education in formal settings, such as schools or education programs in refugee camps. Those who had received some form of education indicated that the focus was on medical aspects of being sexually active, including messages that sex is a cause of disease, and abstinence and condoms are a means of protecting against HIV/AIDs, STIs and unplanned pregnancy:

At the camp… I just learnt to protect myself best. To make sure and do everything right. Got to remember everything when you start to do it. (Male, Sudan)

That one year when HIV started to spread enormously in Thailand, the people got worried. Young people. And then they came in to talk about HIV. How, you know, if you have sex with someone just use the condom and stuff like that. And that's it. But most of the time people like my father try to stop that education. He said this should not be introduced to our young people. (Female, Burma)

Sources of Information After Arrival

After arrival in Australia, opportunities for acquiring information about sexual health remain limited. Young people are aware of a range of potential source of information, including: people (e.g. parents, friends); places (e.g. schools, health centres); and written materials and media (e.g. the Internet, books). However, most young people described a lack of opportunity to access these sources and to openly discuss sex, sexuality and sexual health. The section below briefly discusses young people's views about the preferences, accessibility and reliability of sources of information in each of these three areas.

People

The most accessible potential sources of information about sexual and reproductive health are through young people's social networks—the people they live and interact with in their everyday life. Family, and more specifically parents, and

friends featured highly as a potential source of information. However, participants raised a number of concerns around these important sources of information, including the approachability of parents and the reliability of friends.

Parents

As has been found in numerous other studies of adolescents and communication about sex (Manderson et al. 2002; Roberts et al. 2005; Rosenthal and Feldman 1999; Shoveller et al. 2004), participants in this study said it was difficult to talk with their parents about sex. They frequently referred to cultural and religious expectations of abstinence from sex prior to marriage, and said that parents are unable to respond to questions and concerns without being judgmental:

> *You don't even tell your family you got a girlfriend, so how you can you talk about this kind of stuff. (Male, Ethiopia)*

> *It's like this thing that's just too awkward. It's bad, but they don't talk to you about it. (Female, Africa)*[1]

Where information had been provided by parents, young people said it tended to focus on personal responsibility, reputation and warnings about the ramifications of non-marital pregnancy. Young people said they were more likely to obtain some information about sex from their mothers than their fathers. Young women were more likely to speak to their mothers, however, than young men:

> *My mum she told me something, but not too much. She told me when you have a baby, then you feed the baby, then you clean the baby, then you change the nappies, then when baby crying you can do something and make her happy (Female, Sudan)*

Fathers were not viewed as readily approachable for discussion about sex, and many young people identified their fathers as the person they are least likely to talk with.

Peers

Many young people reported that they are likely to talk about sex with friends. They tend to talk generally about relationships, however, rather than broader discussion about sexual health. While friends are the most frequently cited source of information and communication, there is concern that they provide incorrect or incomplete information:

> *I suppose it is one thing that's kind of funny, isn't it? That there are people you can talk to and then there's the people that maybe would have the best information but maybe they're hard to talk to or… It's a bit like that. I would talk to my friends but they tell you all kinds of whacky things. (Male, Ethiopia)*

[1] As discussed in the 'methods' section, some focus groups included participants from two or more countries. In this event, an individuals' specific ethnicity or country of origin can not always be specified.

Places

Health services (i.e. doctors) and schools were commonly mentioned as places through which young people can access sexual and reproductive health information. Doctors were described as professional and knowledgeable; schools were seen to be safe and credible because sexual and reproductive health education is regarded as a legitimate part of the educational curriculum.

Health Services

Doctors are perceived to be accurate and expert sources of information on sexual health due to their experience of working in the health sector:

> *I would love to hear about it from someone with a lot of experience, like a doctor. (Female, Ethiopia)*
>
> *She knows there's something wrong with her. So the doctor will know. She must go to the doctor. If nothing happen, she feels happy and she feel release. (Female, Burma)*

However, few participants said they had accessed health services to seek information or to address general health or sexual health problems. Many young people indicated that they would only seek information or assistance from a doctor if they were faced with a sexual health issue that they regard as serious, such as an STI or unplanned pregnancy. This is of concern given the asymptomatic nature of some STIs, such as chlamydia.

Some newly-arrived young people indicated that it can be hard to find out about and use health services due to language difficulties. While language barriers in health care settings are addressed through interpreter and advocacy services, these services are not readily utilised by young people for sexual health issues due to concerns around confidentiality. Young people also identified structural and administrative obstacles such as lack of transport to attend health services, and not knowing how or where to book an appointment. In particular, there is low awareness of specialist sexual health service, including free services for youth. Young people are not familiar with available health services and do not have the opportunity to seek sexual health information during consultations:

> *I don't know him, you know what I mean, whoever that is. So talking about these kinds of issues with the person, it's always a bit hard for us, yeah. It's obvious actually. (Male, Ethiopia)*

School-Based Sexuality Education

School-based sexuality education is considered to be informative and valuable. Young people who had attended sexuality education said that classes had increased their understanding of sexual health issues. As one boy said, '*it is good to know now, before you become active, and before it's too late.*' Key areas of learning mentioned included anatomy, pregnancy and birth, sexually transmitted diseases,

contraception, laws relating to sexual activity in Australia, relationships, and decision-making within relationships:

> *They taught us about all the disease you can get and how to avoid them and who we can talk to about it and where we can go for check-ups and stuff. (Male, Ethiopia)*

School-based sexuality education was often the only readily available formal source of information on sexual health and provided the first opportunity to learn about sexual and reproductive health and anatomy. Schools are strategic places for improving sexual and reproductive health literacy precisely because young people do not need to actively seek out information as sexual health education can be provided as part of the overall learning environment. However, not all young people attend secondary schools after they arrive in Australia, and others attend schools in which sex education is not offered. These young people said they have little opportunity to participate in sexual health education programs: '*when you're not going through school you miss that chance to learn about this kind of stuff*' (*Male, Ethiopia*).

Written Resources and Media

Written resources and media (e.g. radio, television, the Internet) represent the third potential source of information for these young people. However, most were ambivalent about the value of these *impersonal* resources. Several participants said that a benefit of these sources of information is that the user can remain anonymous. However, young people more frequently discussed the problem that it is not possible to interact with and ask questions of written resources and other media:

> *It's better to actually talk to someone. It's not the same as reading it, because if you don't really understand something somebody can explain it to you in a way that you understand. And a pamphlet doesn't do that. It's just 'this is how it is' and if you don't understand it you can't ask any questions. Who are you going to go and ask? (Female, Ethiopia)*

There is also the risk that parents might be suspicious if they discover their child using educational resources about sexual health. As one young male said: *It's hard to use the Internet at home and keep it a secret, what you're looking up on the Internet* (*Male, Africa*).

While written resources (e.g. books, pamphlets) are generally regarded as factual and reliable, young people are unlikely to actively seek information through these mediums. Many young people said written resources are difficult to understand if you are not fluent in English language. The Internet was occasionally identified as a source of information about sexual health, particularly amongst males. Some young people indicated that television and radio are possible sources of information about sex and sexual health. However, participants said that the information available through these sources is inconsistent, exaggerated and uninteresting:

If it is on the radio or the TV you are just going to say 'oh, that's a boring a channel' and just change the channel. You don't want to listen to someone talking about STDs or whatever it is. (Male, Ethiopia)

Ethnic media (radio, newspaper, television), written resources in community languages and Internet sites offering translated health information were not mentioned by any participant as a source of information about sexual health.

Social and Cultural Contexts for Learning About Sexual Health

The section above highlights that these resettled young people with refugee backgrounds have little opportunity to learn about sexual and reproductive health and have limited knowledge. Following arrival, while they are aware of potential sources of information, few of these sources are utilized. In particular, there is a disjuncture between sources that are considered accurate and credible (e.g. doctors) and those that are readily accessible (e.g. peers). The following section explores in more depth the social contexts of young people's everyday lives, focusing on two key contextual issues that influence and shape their ability to seek information: shame and embarrassment associated with sex and sexual health; and the competing demands of resettlement.

Shame and the Silencing of Open Discussion

Socially and culturally prescribed attitudes can limit young people's ability to learn about and respond to sex and sexual health issues (Roberts et al. 2005). The present study indicated that non-marital sex and sexual health issues are associated with shame and stigma, and the majority of participants acknowledged that this presents a major barrier to knowledge. Young people said parents and other adults place strong emphasis on protection of personal and family reputation, responsible behaviour, and the maintenance of religious and cultural values. Young women, in particular, indicated that they receive strong messages through family and communities about the shame attached to sex, STIs and non-marital pregnancy. These messages restrict young people's ability to talk and learn about sex and sexual health:

If I get married I can talk to my husband freely and shamelessly. But if I don't have any husband or am not married yet, I don't have any idea who I could talk to. (Female, Burma)

The shame associated with non-marital sex, pregnancy and STIs is a powerful barrier to communication and learning. It acts as a silencing mechanism as it inhibits the opportunity to discuss relationships, sex and sexual health:

One of my friends she got married, she didn't know about sex… Her mum told her don't shout, whatever happens, whatever happens to you, don't scream. And she was so surprised. She said: 'what's going to happen to me? Why my mum told me, don't scream or don't shout? Why? What is the reason? And the morning I wake up I know.' (Female, Afghanistan)

Young people described how they rarely discussed personal questions, concerns or sexual experiences with parents or other adults, even when they required advice or support. While a few participants said that their parents are understanding and open to communication about sex and relationships, many participants indicated they are reluctant or embarrassed to talk about sex with parents, doctors and peers. They also remain silent about relationships and expressed real concerns about relationships being discovered, particularly by parents, and the need to maintain family reputation. The consequence of non-marital relationships—particularly if there is a pregnancy—include being kicked out of home or being required to marry, although this is perceived to be more likely for young women than young men:

That's the first time I get kicked out. That's the reason. Because of him. I didn't want to lose this guy. They said 'us or the boyfriend'. I was like 'what! That's too hard. I can't choose between my boyfriend and my family'. And I was still believing that this guy was really good for me. And my family, because they heard something, they just hate him. (Female, Ethiopia)

Shame also presents a barrier to accessing health professionals for information, advice, treatment or screening. Many young people indicated they are reluctant to seek information about sex through health professionals because of the risk that confidentiality might not be maintained and family and community could find out. A few young females expressed particular concern about accessing specialist sexual health services, in case they are seen by a community member who might then assume they are pregnant or have an STI. Concerns around confidentiality are heightened if there is a need to use an interpreter. These concerns are particularly present amongst newly emerging communities where interpreters and patients and their families may be known to each other:

They're more likely to spread confidential information. You hear about it, interpreters spreading information they have learnt from interpreting for people. (Male, Africa)

Participants are also reluctant to discuss personal experiences with friends because of the risk that they might disclose that information to others. Young people frequently emphasized that gossip spreads quickly within their communities because many people are related or acquainted. As one young woman said, it would be inadvisable to even tell one's boyfriend about an unplanned pregnancy because he might spread that information and ruin the girl's reputation:

I think some people wouldn't tell their partners because if your relationship is not stable and you don't know how long it is going to last then some girls might think 'oh, he might go around telling people, oh she had an abortion, she once was pregnant from me'. So they don't really want to tell their partner about it. (Female, Africa)

Contexts of Displacement and Settlement

For many newly-arrived young people, the demands of settlement take precedence over other concerns including sexual health. There is a focus on meeting practical and social settlement needs, such as education, acquiring employment and an income, obtaining English language skills, finding adequate housing, and adjusting to a new culture and new systems. Many young people have concerns about family members who remain in countries of origin or first countries of settlement. Young people may also be expected to take on responsibilities such as caring for younger siblings, or translating for older family members. Some young people indicated that life in Australia was more difficult than they anticipated:

> *I imagined big things, but it's not true. When I was moving from there I was saying 'I'm going to go to this country, I'm going to have a nice life'. But when I came here, ooh, it's different. I thought I'm going to finish school; I'm going to be like the people you see in the movies. But it's the opposite. It's hard. (Male, Ethiopia)*

These demands of resettlement can compromise overall health, including sexual and reproductive health, because young people with refugee backgrounds are less likely to seek information or utilize preventive health services when they feel constrained by pressing settlement needs. Newly-arrived youth with refugee backgrounds who are homeless or at-risk of homelessness are particularly likely to prioritise the need for stable accommodation ahead of preventive health behaviours. Once young people are able to fulfil the most immediate practical and social needs they may experience better accessibility in seeking and using health services, including in relation to sexual health.

The resettlement context can also accentuate difficulties in communicating with parents about sexual health matters. Participants suggested that parents are often worried about the influence of the prevailing sexual imagery and liberal attitudes in Australia on their children's values and behaviours. They said that parents largely offered prohibitive messages around sex that focus on the importance of abstinence, upholding cultural values, and warnings about the stigma associated with pregnancy outside of marriage. There are particularly strong messages around the maintenance of both individual and family reputation. Parents are also concerned that their children make use of the educational opportunities provided in Australia, and they emphasize the importance of prioritizing studies over relationships:

> *They don't feel happy because in my country you can't go with your girlfriend or boyfriend in front of your friends. You keep it secret. But here, you know, everything you can do in front of everybody, your father, your brother. It's a different thing. They don't like that. They're saying, 'you have to respect us and you are still young and you have to do school and keep your study. Not about the relationship. They feel not happy. (Male, Afghanistan)*

Further, refugee experiences of displacement and resettlement often result in fragmented family networks and this can adversely affect the support and advice

available to young people from family members. A few young people said that the lack of immediate and extended family limits their ability to seek information:

> *I lost my father at a young age so I was kind of finding it hard to come back to my mum in that way. I don't know… I could never talk about that. I'm sure she would always, as a mother, want to be there anyway, anyhow. But I was having problems with it, yeah… I felt like I would have found it a lot easier discussing that with my father. (Male, Sudan)*

For many families, a key priority is to rebuild family life and for their adolescent children to acquire a good education. Thus, in addition to the difficulties that parents may have in discussing sexuality with their children, the very real priorities of building a future in Australia must be acknowledged.

Learning About Sexual Health: Information and Communication

> *For me, someone giving information about something I don't know, it's not boring. I would love to hear it. What kind of disease you can get, how you get sick, what you can do. I want to know. (Female, Ethiopia)*

There is keen interest amongst young people to learn more about sexual health. Young people said they want to be provided with clear and factual information about STIs, pregnancy and contraception before the onset of sexual relationships. It is also critical to develop young peoples' skills in managing sexual relationships, negotiating sexual pressures, and the potentially positive and emotional aspects of sex.

The most consistently identified factor for young people in the delivery of sexual health education is that sessions should be verbal and group-based. Information should not be delivered through didactic teaching methods but through interactive and activity-based learning:

> *We like to get together, socialising and friendship. So that is the most enjoyable part for us, to do something in a group and to discuss that way. That's a good way to raise issues and discuss, and probably people would bring more ideas and pass on information. (Male, Ethiopia)*

Participants stated a preference for gender specific groups with gender matched educators in order to allow open discussion of sexual health. They want to obtain information through reliable sources, including doctors, other health professionals, and school teachers. They suggested that written information could be used to support interactive models of learning.

Young people frequently articulated the view that culture and traditional values frame their knowledge, attitudes, behaviour and opportunities for communication. Nonetheless, no young person specified that sexual education facilitators should be of the same ethnicity as participants, or that groups should be ethno-specific. A few participants emphasized a preference for participating in mainstream classes, but suggested these classes should provide opportunity to reflect on personal and

cultural values and beliefs. In other words, many young believe that sexual health promotion and education should be ethno-sensitive rather than ethno-specific.

Young people also emphasized the importance of raising parental awareness about sexual health and the value of sexual health education for young people. Some who had attended school-based sexuality education indicated that their parents had concerns about the messages and morality of sexuality education curriculum, and few had discussed the content of sexuality education with their parents. They suggested that raising parental understanding of the purpose and scope of sexuality education could increase parents' willingness to openly discuss sexual health issues:

> *Another good thing is to make the parents understand. The kids, they go and do things behind their parents back, because they're scared to talk about sex with them. The only way they're going to learn is if their parents back off a bit, and understand a bit more. (Female, Sudan)*

The importance of access to sexual education before becoming sexually active was highlighted. Several young people thought that an opportunity to learn about sexual health at an earlier point could have prevented their learning *'the hard way'*. For example, one teenaged woman said:

> *The first time I had sex I got pregnant. I didn't know how it happened. It wasn't a serious relationship. I didn't know anything, I was a virgin. I was feeling sick and I told the family doctor. I didn't think I would get pregnant, but I was really sick. I didn't eat, I felt bad. The doctor said I should do a blood test and he said I was pregnant. I was scared. I felt like the world was ending. I was 16. I just thought, 'what happened to me, why has this happened to me?' (Female, Horn of Africa)*

Others described experiences in which an unplanned pregnancy or suspected infection had precipitated engagement with health care services, which belatedly led to the opportunity to obtain information about STIs and contraception.

Discussion

Over the past years, the right to sexual and reproductive health has gained increased recognition. Sexual and reproductive rights are now widely recognized by a body of international and national laws and documents, and they include the right of all persons to seek, receive and impart information in relation to sexuality (Janssens et al. 2005; United Nations—ICPD 1994). The present study indicates that newly arrived young people with refugee backgrounds have limited opportunities for learning about sex and sexual health, and there is a need to increase their awareness and understanding of sexual and reproductive health. Many of the challenges they experience around access to information are similar to those faced by all young people, particularly those from culturally and linguistically diverse communities. However, their experiences of forced migration, displacement and resettlement brings additional challenges to the process of learning about sexual and reproductive health.

Prior to arrival, young people with refugee backgrounds have often had disrupted education (Bond et al. 2007; McBrien 2005; VFST 2007) and limited opportunity to receive sexual health information in educational or institutional contexts. In the present study, participants said that information around sexual health was difficult to obtain in their countries of origin, first countries of settlement and refugee camps. Many young people were inadequately informed about key sexual and reproductive health issues, including modes of transmission, symptoms, and prevention of STIs. Most of these young people have grown up in contexts with limited or no access to health and social services and have had little experience of preventive health care, such as STI screening. Finally, some young people have experienced sexual violence prior to arrival, either personally or of a family member, and services that target these youth must be sensitive to the possibilities of traumatic pre-arrival experiences.

Following arrival in Australia, the local contexts of young people's daily lives are often unstable and this has an impact on young people's capacity to access and utilize sexual and reproductive health information and services. There is a primary focus on meeting practical and social settlement needs and young people are unlikely to seek health information or utilize preventive health services, particularly in relation to sexual health. Many young people have settled with their families in areas with poor infrastructure, including public transport and youth-oriented services which may disadvantage young people in accessing sexual health information and resources. Schooling and education often continues to be disrupted, and young people who do not attend school following their arrival in Australia have little opportunity to participate in sexual health education programs.

Family is pivotal to the lives of these youth (Gifford et al. 2009). While many have lost or been separated from family members through experiences of displacement and violence prior to arrival in Australia, remaining family members are often the primary source of security and social support in the resettlement context (Bakopanos and Gifford 2001). However, there is often an expectation placed on young people of behaving responsibly and building a good future and parents tend to provide warnings about the distraction and risks of sexual relationships. Given that newly-emerging communities are small by definition, issues of shame around STIs and non-marital pregnancy can become magnified as personal and family reputations are at stake. In addition, family conflict and ongoing changes in household composition are not uncommon (Gifford et al. 2009) which can inhibit positive communication between parents and their adolescent children.

It is important to engage families in strategies and services designed to promote the reproductive health of their adolescent children. Community participation has become an integral part of health promotion initiatives and is considered critical to the sustainability and relevance of health programs (Griffiths et al. 2008). Young people articulated the need to increase parental understanding of sexual health issues and encourage parental and community support for sexual health education. Other studies indicate that strong relationships between parents and children and good connections to community networks and structures are key determinants of healthy adolescent development and can prevent young people from engaging in unsafe or unwanted sexual behaviour (Bylund and Duck 2004; WHO 2005). In

particular, it is important that information provided through sexual education programs in schools and other sources can be reinforced at home (Turnbull et al. 2008). One limitation of this study is that parents' perspectives were not sought. Future research focusing on sexual health literacy of young people with refugee backgrounds should explore the views of parents and older community members.

Improving access to sexual health services also remains a key strategy for increasing sexual health literacy and reducing poor sexual health outcomes (Janssens et al. 2005: 82; Poljski et al. 2005). Consistent with other studies with refugees and asylum seekers (Janssens et al. 2005: 103), this study identified that young people would only seek professional help when they are already seriously ill. Further, because resettlement services rarely address adolescent sexual and reproductive health and mainstream adolescent outreach programs do not target refugee youth, recently arrived young people are at risk of falling in between health service gaps.

Barriers to accessing reproductive and sexual health service are of particular concern for those who settle in rural and regional centres. There are current policies in Australia, as in other resettlement countries, to settle humanitarian entrants in rural and regional centres (McDonald-Wilmsen et al. 2008). Sexual and reproductive health services for rural youth struggle to address their specific needs, and meetings the needs of recently arrived refugee youth is all the more challenging. Effective sexual health promotion will identify ways to engage youth with refugee backgrounds with health services, emphasize the confidentiality of health services, emphasize the value of preventative behaviours and early intervention, and increase understanding of the asymptomatic nature of some STIs.

The study also identified the need to engage with wider social contexts within which sexual attitudes, learning and behaviours operate: to address assumptions about 'safe' and 'risky' partners, empower young people to negotiate safer sex, clarify values, and address issues of shame associated with STIs and non-marital pregnancy. This is consonant with extensive evidence about the value of interventions that focus on informational and attitudinal change, participatory learning, and the development of personal competencies (Griffiths et al. 2008; Roberts et al. 2005; UNAIDS 1997). It is also aligned with efforts to move beyond individual risk factor analysis towards an approach that acknowledges the interrelationships between social structures, context and agency (Shoveller et al 2004).

Young people with refugee backgrounds are a diverse population in terms of their displacement and migration experience, gender, age, level of sexual experience, ethnicity, culture, language, socioeconomic background, religion, education, duration of residence and existing health care provision (Fenton et al. 2005; Gifford et al. 1997; Janssens et al. 2005: 95). However, this study indicates that there are common concerns around access to sexual health information and sexual health literacy. While knowledge is only one component of people's capacity to engage in protective behaviour, there is an established link between accurate knowledge and the adoption of responsible sexual protective behaviours (Oakely et al. 1995; Smith et al. 2002; Sprecher et al. 2008). The most effective and sustainable strategies for improving sexual health literacy and outcomes will be sufficiently flexible to be relevant for all social and cultural groups (Gifford et al.

1997; Roberts et al. 2005). If policies and programs are to be able to overcome health inequalities, they must also be attentive to the social conditions—especially the refugee experience and psychosocial, political and economic contexts—that shape daily experiences of resettled young people with refugee backgrounds. An evidence base that identifies how these young people seek, understand and use sexual health information, presents a foundation from which to develop effective sex education and prevention and support programs.

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