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ORIGINAL PAPER

Pathways to Sexual Health Among Refugee Young Women: A Contextual Approach

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Abstract

Refugee youth face sexual health challenges, and research investigating contributing factors has primarily focused on identifying contextual barriers. However, it is also important to investigate protective factors, as well as how risk and protective factors work together across contexts. The present study explored both contextual facilitators and barriers to refugee young women's sexual health and how these factors intersect to influence behavior. Interviews were conducted with twelve female refugees ages 18-24. Participants' countries of origin included Burma, Central African Republic, the Democratic Republic of Congo, and Somalia; most participants had lived in the United States for over five years. Data were analyzed using thematic text analysis and narrative analysis. Findings revealed four primary themes: sex/relationship restrictions, judgment/disapproval, support, and youth outcomes. Themes varied by context (e.g., family, peers, religion, culture) and were related to one another in important ways, such that refugee young women who violate sociocultural sex/relationship expectations experience actual or anticipated judgment from others, which leads to fear, embarrassment, and risky sexual behavior. However, participants also shared that social and institutional support would contribute to improved sexual health outcomes. Findings highlight the importance of considering refugee young women's sociocultural contexts when addressing sexual health challenges.

Keywords Sexual health · Reproductive justice · Refugee women

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Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), a refugee is someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (UNHCR, 1951, p.14). Currently, 26 million people fit that definition as a result of current and historical conflicts spanning multiple regions. The global refugee crisis has reached record numbers and continues to grow (UNHCR, 2020).

Almost 40% of refugees worldwide are under the age of 18 (UNHCR, 2020), and a growing body of research has demonstrated that young refugees face many health concerns pre- and post-resettlement, including in sexual and reproductive health domains. Research has revealed that refugee youth are confronted with unique challenges across multiple contexts (e.g., family, peers, culture) which contribute to negative sexual health outcomes (McMichael & Gifford, 2009). However, much of the literature has focused primarily on the health barriers refugees face, while overlooking facilitators. Additionally, it is important to identify not just the contextual factors themselves, but how these factors work together to influence refugee youth's sexual health behavior. The present study used a qualitative approach to investigate refugee young women's perceptions of barriers and facilitators of sexual health across multiple intersecting sociocultural contexts.

Refugee Youth Sexual Health

Refugee youth often lack the knowledge they need to make healthy and empowered decisions regarding their sexual health. More specifically, research has documented that refugees from a variety of cultural and ethnic backgrounds may be unaware of specific sexually transmitted infections and their symptoms, methods of pregnancy prevention, and options for reproductive health services (Botfield, Zwi, Rutherford, & Newman, 2018; Lazarus et al., 2006; Metusela et al., 2017). Refugee youth may also hold misconceptions about sex, such as believing that one's first time having sexual intercourse cannot result in pregnancy (Benner et al., 2010). Additionally, refugees encounter a new set of laws and policies post-resettlement. Dhar et al. (2017) reported several misunderstandings about legal rights among Bhutanese refugee young women living in the United States (U.S.), including that male partners must consent to a woman having an abortion. Given these findings, it is unsurprising that refugees are at higher risk for negative sexual health outcomes compared to native-born youth. For example, research has documented that refugee women from multiple geographic regions including Africa, Asia, and Latin America have lower rates of contraceptive use (Aptekman et al., 2014) and in turn, higher rates of teenage and unintended pregnancy (Benner et al., 2010; McMichael, 2013; Vangen et al., 2008).

Systemic Barriers to Refugee Young Women's Sexual Health

Sexual health issues among refugee youth are influenced by more than individual-level factors. The reproductive justice framework is relevant here, as it acknowledges that multiple systems intersect to affect women's sexual health (Eaton & Stephens, 2020; Gilliam et al., 2009). Reproductive rights are positioned within a social justice lens by centering marginalized women, considering power dynamics, and targeting systemic oppression (Eaton & Stephens, 2020; SisterSong, 2016). One can imagine several social, cultural, economic, and educational barriers that may all contribute to sexual health inequities among refugee youth, and particularly refugee young women. Indeed, extant research with refugee young women offers several examples of these barriers and provides evidence for how they affect sexual health.

For example, one study conducted with refugee young women from Somalia found that they had difficulty talking to their parents about sex and romantic relationships because of their parents' strict rules, which may lead them to seek sexual health information from peers or the internet instead (Kingori et al., 2018; McMichael & Gifford, 2009). There are also educational barriers that contribute to lack of sexual health knowledge. Many refugees experience disruptions in formal schooling because of displacement, and even in the education they do receive, sexual health is often not prioritized (McMichael & Gifford, 2009). This gap in sexual education is only magnified post-resettlement, and some Bhutanese refugee young women reported being pulled out of health class to attend English as a Second Language courses (Dhar et al., 2017).

Refugee young women also experience barriers to seeking reproductive healthcare, including difficulties with transportation and language, concerns about confidentiality, and cultural taboo around seeing a healthcare provider of a different gender (McMichael & Gifford, 2009). These things make it difficult for them to get their questions about sexual health answered and obtain the reproductive health services they need. Cultural values affect sexual health too for refugees of diverse cultural and ethnic backgrounds, albeit more indirectly. The most salient example is the value placed on abstinence from sex before marriage, and women's virginity is especially valued (Dhar et al., 2017; McMichael & Gifford, 2009; 2010). The shame surrounding unmarried pregnant women can have harsh consequences, including being gossiped about in the refugee community, being kicked out of one's home, and reducing one's prospects for marriage (Dhar et al., 2017; McMichael & Gifford, 2010; McMichael, 2013). Refugee young women clearly face injustices across systems that limit their agency in making decisions about their sexual health and behavior.

Present Study

While scholars have begun to explore the influence of sociocultural contexts on young refugees' sexual health, there has been less attention to the ways in which these contexts intersect with one another. It is also important to investigate

both facilitators and barriers, as different contexts likely each hold challenges and assets. Furthermore, a focus on refugee young women is warranted because research has demonstrated that refugees have unique sexual health needs based on gender (Kaczkowski & Swartout, 2019) and that refugee women are disproportionately affected by sexual health issues and their consequences (McMichael & Gifford, 2010). Thus, the present study applied a reproductive justice framework to focus specifically on the intersections among multiple systemic factors and how these intersections influence refugee young women's behavior. The present study asked the following research questions: (1) What are the facilitators and barriers to sexual health among refugee young women across multiple contexts? and (2) How do these facilitators and barriers work together to influence refugee young women's sexual health? Qualitative methodology was selected to empower refugee young women to voice their own narratives about sexual health, thus centering their voices in answering the research questions.

Method

Author Reflexivity Statement

The authors acknowledge that their social identities, academic disciplines, and prior experiences with refugee populations intersect to influence the present study's methodology and interpretation of results. The first author is a white female doctoral candidate in clinical-community psychology whose native language is English. She has eight years of experience conducting research and volunteer work with refugee communities, with a focus on contextual factors that influence health outcomes. The second author is an Asian American female community psychologist whose native language is Cantonese. She is from a refugee family and has conducted research with refugee communities for 15 years, focusing on positive youth development. The third author is a white female nurse and public health worker whose native language is English. She specializes in sexual and reproductive health with seven years of experience working in the area of refugee resettlement, managing programmatic efforts to provide access to culturally-competent health care services for refugee clients and leading grant-funded research projects. Community collaboration in research is strongly valued by all authors and the present study's design, data collection, and analysis was done in close partnership with the refugee resettlement organization for whom the third author is employed. For example, interpreters employed by the refugee resettlement organization, many of whom are refugees themselves, provided feedback on the study design and interview guide to ensure cultural appropriateness. The suggestions they made were implemented, such as adjusting the data collection format from focus groups to individual interviews due to the cultural and religious stigma of discussing sexual health issues.

Participants

A refugee resettlement service organization located in a large, southeastern U.S city recruited participants from various youth programs run by the organization. Program staff provided information about the study and eligible participants were given the researcher's contact information to schedule interviews. Twelve individual interviews were conducted with female refugee young adults between the ages of 18-24. The countries of origin represented were Burma (n = 6), Central African Republic (n = 2), the Democratic Republic of Congo (n = 3), and Somalia (n = 1). Ten participants had lived in the U.S. for more than five years, while the other two participants had migrated to the U.S. less than two years ago. All participants had at least conversational English skills, as English language ability was required to participate in the present study. Information on socioeconomic status was not collected for this study, but most of the resettlement organization's clients live at or below 200% of federal poverty guidelines. Each participant was compensated with a $20 retail gift card.

Procedure

The Institutional Review Board of ICF, the consultation organization involved in the research study, approved all study procedures. Interviews took place in a private room at the refugee resettlement organization's office. An Asian American female employee of the organization who specialized in sexual health services conducted the interviews in English while the first author took detailed notes. The consent form was read aloud to participants who then gave their verbal informed consent prior to beginning the interview. The following general topics of inquiry were included in the interview guide: 1) perception of healthy relationships, 2) sexual health problems and unplanned pregnancy, 3) access to information about sexual health, and 4) facilitators and barriers to seeking sexual health services. The semi-structured interviews ranged from 30 to 60 minutes. All interviews were audio-recorded and transcribed.

Data Analysis

Thematic Text Analysis

Data were analyzed using thematic text analysis, a method of qualitative analysis that uses categorization to emphasize patterns across data. Analysis included four phases: 1) initial coding, 2) theme development, 3) thematic coding, and 4) theme-based analysis (Braun & Clarke, 2006; Kuckartz, 2014). NVivo software was used to manage data analysis for the last two phases. First, the first author coded each transcript line-by-line. Participants' words were prioritized to ensure codes came from the text rather than imposing existing theories onto it. Next, all codes were sorted categorically to establish broader themes. Themes and sub-themes were established

based on their relevance to the research questions. A preliminary codebook was created and included the theme name, definition, and example quote(s) for each. Two members of the research staff (the first author and an Asian American female doctoral student) then used the preliminary codebook to code three interviews (25% of the data) independently. Afterwards, the two researchers reviewed each other's coded transcripts and met to discuss discrepancies and reach consensus. There was strong agreement across themes, and together the research team made minor adjustments to the codebook, such as eliminating the "abstinence" theme because it was determined that all of these passages fit within the broader "sex/relationship restrictions" theme. The first author then used the final list of themes to code the remaining transcripts. Once all data were coded, summaries were composed for each theme and representative examples of each were highlighted. Relationships among themes were also considered.

Narrative Analysis

Because the emerging themes seemed to be related to one another in important ways, researchers determined that it was important to directly investigate these relationships before creating a final thematic paradigm. A narrative approach was selected in order to develop a better understanding of how individual participants connected the different themes in their discussion of sexual health issues. To accomplish this goal, four transcripts (33% of the data) were explored in greater depth. Two transcripts were chosen because they were representative of the themes described above and gave particularly rich detail regarding the causal relationships among them. A third transcript was selected because the interviewee was unmarried and pregnant at the time of the interview, lending a unique personal experience. Another interviewee expressed some hesitancy to discuss sexual health topics during the interview, so this was chosen as the final transcript to offer a different perspective. The first author then composed a brief narrative summary of each of the four transcripts.

Thematic Paradigm

The information obtained from the thematic text analysis and the narrative analysis were integrated to develop a final thematic paradigm. The paradigm depicts major themes and the relationships among them to establish a working conceptualization of female refugees' sexual health experiences and decisions across multiple systems.

Results

The results of the thematic text analysis and the narrative analysis are described below. Quotes are written exactly as participants said them, with the exception of the removal of filler words (e.g., like, um) to improve reading ease and flow. Because English is not the participants' first language, several grammatical errors (e.g., subject-verb agreement errors) were kept to minimize researcher modifications to the data.

There were four primary themes identified in the thematic text analysis: sex/relationship restrictions, judgment/disapproval, support, and youth outcomes. These themes and relevant sub-themes are explained with particular attention to how themes varied across different contexts (i.e., parents, peers, community, healthcare).

Theme 1: Sex/Relationship Restrictions

Participants described sociocultural restrictions regarding sex and relationships. These norms and restrictions were generally consistent across parents, religion, and culture.

Parents

Several young women noted their parents do not permit them to be in romantic relationships prior to marriage. For example, one woman stated:

> Your parents don't allow you to have a boyfriend. They just want you to concentrate. Some of them, they bring us here for education so we have to focus on our education. – *Participant 2, Central African Republic*

Even if youth can date, they are expected to obey parental rules. These rules center on youth's behavior in their relationship, such as where they can spend time together, appropriate displays of affection, and most importantly, abstinence before marriage. Avoiding premarital sex was emphasized in the sex education young women receive from their parents.

> Of course, my family going to say to not have sex when I'm dating with him… My mom told me if a guy ask you, "Can I have sex with you?" while you're dating, that means that guy is not good for your future, so just leave him. – *Participant 8, Burma*

Religion and Culture

Participants also acknowledged ways in which broader contexts such as religion and culture influence their views on dating. Such issues often came up in discussions about cultural differences between the U.S. and the participants' countries of origin. Participants particularly emphasized that dating relationships are not acceptable in their culture and/or religion, and this was the case across all countries of origin represented in the sample. For example, one woman stated:

> In United States, if you are teenager or adult so you can be in a relationship where in my country, my religion we cannot be in a relationship until you get married. – *Participant 6, Central African Republic*

The importance of abstinence from sex before marriage was repeatedly emphasized and was discussed as a cultural and religious value youth are expected to uphold. Several young women described adopting this value as their own:

> Young people, they might want to do some sex, I don't know, but [it] is good if they didn't do it. For us, for me, I'm Christian and I'm the real one…we are not allowed to sleep together or do sex before marriage. – *Participant 10, Burma*

Theme 2: Judgment and Disapproval

Participants indicated there is often harsh judgment toward youth when other people disapprove of their sexual and relationship decisions, but the ways judgment was expressed varied by context.

Parents

Participants said when refugee youth go against the family's established relationship rules and expectations (Theme 1), parents get angry and blame their children. Young women also described behavioral consequences, such as getting in trouble if their parents find out about a forbidden romantic relationship. The most severe consequences participants described were for unmarried pregnant girls:

> Some fear their parents, because you know how African parents are. They are kind of hard. Some African parents are like, "You got pregnant?? Get the hell out of my house!" – *Participant 4, Democratic Republic of Congo*

Peers

Refugee youth also experience and observe judgment and disapproval from their peers, although it is expressed differently than by parents. Participants reported that refugee youth experience verbal criticism when they make decisions regarding sex and relationships that do not fit within sociocultural expectations (Theme 1). For example, young women noted unmarried pregnant girls are gossiped about and verbally harassed:

> Oh, what young people think is "she's a bad girl," and talk bad things about her. They be like "She's a slut. I feel bad, she's just going to have a baby, her life's going to be messed up" like that stuff. – *Participant 8, Burma*

Refugee youth also encounter new norms in the U.S., and may face judgment if their behaviors regarding sex and relationships are different from those of other peers who were raised in the U.S. For example, one woman stated:

> Sometimes you might have friends who are American friends and they might ask you "Have you ever had sex?" And when you say "no," they will start laughing at you. – *Participant 12, Democratic Republic of Congo*

Taken together, these results suggest the different cultural values around sex and relationships between one's country of origin and America (Theme 1) make it difficult to subscribe to social norms from both cultures simultaneously, thereby also making it difficult to fit in with friends from either.

Community

Refugee young women also described judgment from the community in which they live. There are a variety of behaviors that may lead to verbal harassment, such as public displays of affection. One woman stated:

> I mean even though you're dating and then, and while you're dating you hold hands and kiss in public…if my people see it they will talk bad things about you to all these people. – *Participant 8, Burma*

Another participant who was unmarried and pregnant at the time of the interview relayed her personal experiences with judgment from the community:

> Some people make fun of me. Some ask me…they call me, they mock me. They say, "You're going to finish your education before you get married, but now you're pregnant. Stop doing that." And then, anyway, they make fun of me because I'm not married and I just get pregnant. – *Participant 2, Central African Republic*

Refugee youth not only face judgment and disapproval from their most immediate contexts of family and friends, but also on a larger scale from their community as a whole.

Theme 3: Support

Participants also described examples of receiving support for their sexual health concerns from parents, peers, and healthcare settings, as well as several ways that they would like to be better supported.

Parents

Refugee young women noted that their parents or other family members were the best people to go to if they had questions about sex. Several participants specified that they would seek out information from their mothers especially.

> Maybe I should ask someone. "Mom, you are the first one who is give me birth. I have to know too. Can I know from you?" It's a good thing that you learn from a parent, from mom. Especially mom. – *Participant 3, Somalia*

Although many people would like to learn from their parents, they also indicated that parents may not be willing to talk to their children about sex and relationships. Young women wanted their parents to be an approachable source for questions about these topics, conveyed in the following example:

> I mean, tell the parents, do that sex educations. Actually, it should be non-judgmental sex education. You don't judge anyone by what they do. – *Participant 4, Democratic Republic of Congo*

Peers

The support that refugee youth received from their peers often involved help accessing sexual health services. One woman said:

> She can trust that she's her friend or best friend…she can believe that person. Some of them say, "Are you sure?" They don't believe it. "Are you sure it's a good clinic?" "Yeah, I've been here before. He give me good medicine and I'm better now. I know what I have to do." She can tell about it. – *Participant 1, Burma*

Refugee youth also provided behavioral support to their friends, such as accompanying a friend to the clinic. One participant also described taking the initiative to talk to her doctor on behalf of a pregnant friend:

> I once talked to one of the doctors around when my friend got pregnant and I really wanted to get her to help. I talked to one of these doctors when I went to the hospital to get a shot, and they were so good. – *Participant 4, Democratic Republic of Congo*

Discussions of peer support suggest that young women view their peers as sources of information and sources of encouragement when it comes to accessing sexual health services. Since refugee youth may be hesitant to reach out to peers out of fear of being judged (Theme 2), peers who do offer support may be particularly important for facilitating resource access.

Healthcare

Refugee young women described several ways that clinics could increase their likelihood of using sexual health services. One strategy they suggested was clinic outreach to increase awareness, through methods such as videos on YouTube, home visits, and outreach events:

> They [clinic] should…reach out to those communities…The young people are there. You do always exciting things, you bring pizza, and they are all there. They come for that. Then you talk to them one-on-one, you know? "This is what we do" and they get to know about it. Because if you don't have information about the clinic, how do they know that they offer these things? – *Participant 4, Democratic Republic of Congo*

Refugee youth also talked about what clinics can do to make them feel comfortable once they arrive. First impressions matter and can be made more positive by having welcoming pictures on the wall and a friendly receptionist. Perhaps most emphasized was the importance of the quality of their interactions with healthcare providers. Participants shared that doctors and nurses should be friendly, encouraging, and non-judgmental, and that demonstrating these traits will help make patients feel more comfortable talking about sexual health:

> I think they [providers] should say "This is not a big deal, if you're worried about it, we can help you out with it…if you worry about getting pregnancy, we can help you with what you want." – *Participant 10, Burma*

Overall, participants offered some specific examples of support from parents, peers, and healthcare settings, but primarily described how they would like to be better supported.

Theme 4: Youth Outcomes

Refugee young women not only discussed the messages that they received from different contexts, but also how these messages influenced their behavior and emotions.

Fear and Embarrassment

Participants described several fears related to sexual health, including talking to their parents about having sex and other people in the community discovering their use of sexual health services:

> One of the reasons that I think people are scared to get tested is—especially young people—because if they get tested their life is ruined, which means they might not get married or probably everyone will start laughing at them they because they were too dumb to notice that condoms are out there or maybe they will just feel left out from the community when they have the STD. – *Participant 12, Democratic Republic of Congo*

Fear is clearly linked to the possibility of judgment from other people (Theme 2), whether from parents, peers, or the community at large. This link was again made in their descriptions of embarrassment:

> I might even feel shy to go there [clinic] if my friends see me and they will say 'Oh, she's going there.'… I'm just thinking my friends might say, "Oh! What's she doing there? She's going to have sex." – *Participant 7, Burma*

Behaviors

Participants communicated that a variety of behaviors can result from judgment (Theme 2), fear (Theme 4), or embarrassment (Theme 4). For example, refugee youth may hide dating relationships or sexual activity from their parents because they feel ashamed about breaking the rules:

> I think if they do something, what their parents don't like it, they'll feel embarrassing so they just do it behind, even though their parents don't like it. – *Participant 5, Burma*

Refugee participants also described different actions that unmarried pregnant women take. Abortion was brought up by several young women. Some mentioned that it is considered a sin within their religion. However, multiple young women also

said that pregnant youth still choose to terminate their pregnancy, in part because they are afraid of their parents' discovery:

> Because of that fear, they end up aborting. They don't want their parents to know about it. So they do the abortion. Basically, that's how they react. – *Participant 4, Democratic Republic of Congo*

For unmarried pregnant women whose pregnancy is already public, suicide was presented as a possibility. One young woman stated that being mocked by community members leads to feelings of shame, which in turn leads pregnant youth to commit suicide. She said:

> Wherever you're passing, they say, "Oh look, she's pregnant when she's not married. Oh, look." At the end of the time, you can feel ashamed. Sometimes they kill themselves because everyday, when I go to the market, "Oh look, she didn't get married, she get pregnant."…They get disappointed and they feel ashamed. At the end of time, she's pregnant but she kill herself. Because of they are pointing her every day, every time. – *Participant 3, Somalia*

The above quotes indicate that fear (Theme 4), embarrassment (Theme 4), and judgment (Theme 2) have several negative consequences for the well-being of refugee young women.

The thematic text analysis revealed multiple facilitators and barriers related to refugee youth sexual health. Furthermore, these factors work together to affect their decisions, which was explored further in a narrative analysis.

Narrative Analysis

Narrative summaries for each of four transcripts are included below. They highlight how each participant discussed the themes from the thematic text analysis and the relationships among them.

Participant 4 (Democratic Republic of Congo)

Participant 4 gave especially compelling descriptions of the themes that emerged in the thematic text analysis. She said that refugee youth defy sociocultural expectations about sex and relationships when they come to the U.S. because of new cultural norms and peer pressure to be in a dating relationship. Participant 4 stated that when refugee youth do not subscribe to sociocultural values, some parents will punish their children (Theme 2) but others will support them (Theme 3) because "it depends on their culture, their customs, their religion." However, the fear of judgment from family, peers, and community is enough to stop them from buying contraception (Theme 4): "Fear. How to go to a supermarket and ask for a condom. Actually, people don't have that freedom. Especially the African community, we always say, 'How do we do it? There is so much judgment. How will they see me do this thing?'" At multiple points, she shared that she feels that the way to encourage

youth to make healthy sexual decisions is to provide support through "non-judgmental sex education" from parents, school, and religious leaders (Theme 3).

Participant 10 (Burma)

Participant 10 also discussed causal connections among the themes. She described a direct link between refugee young women violating the religious and cultural value of abstinence before marriage (Theme 1) and judgment from others (Theme 2): "They already get pregnant and they are not married, so no one going to like them anymore." This disapproval from parents, peers, and community members leads youth to feel scared (Theme 4), which in turn pushes them toward certain behaviors, such as having an abortion or committing suicide (Theme 4). For example, she said that "If their parents are really strict and they are really scared, I feel like they might kill themselves…because if their parents find out that they have a baby, like their parent might kick out. They're not going to like it." In order for youth to use sexual health services, she said that the clinic needs to "help them feel better, talk to them, and make them feel like this is a good thing" (Theme 3).

Participant 2 (Central African Republic)

At the time of the interview, participant 2 was pregnant and unmarried, so she described her unique personal experiences. She shared that she had dated someone who did not have her parents' approval (Theme 1). Early in the interview (prior to disclosing her pregnancy) she reported that parents make refugee young women feel guilty for unplanned pregnancy, and she shared that her parents disapproved of her decisions and pregnancy (Theme 2). She also stated that people in her community would "mock" and "make fun of" her for getting pregnant before marriage (Theme 2). When responding to a question about what might stop youth from using sexual health services, participant 2 expressed that youth "don't want their parents to know because they are scared" (Theme 4), and that if they were to use these services, "they would worry about their parents yelling" and "getting kicked out of the house" (Theme 2). In order to "feel comfortable" using these services, she felt that clinics should provide outreach and ensure that their staff are friendly (Theme 3).

Participant 7 (Burma)

The interview conducted with participant 7, from Burma, was divergent from the others in that she mentioned her difficulty answering the interview questions multiple times due to her avoidance of discussions about sex: "I don't know much about the answers to these questions. I think the reason is we don't talk about this with my friends." However, this does not mean the themes from the thematic analysis were entirely absent from participant 7's interview. She mentioned that abstinence before marriage is important in her religion and culture (Theme 1) and that community members gossip about unmarried pregnant women (Theme 2). Additionally, Participant 7 made a notable causal connection, stating, "I might even feel shy to go there [clinic] if my friends see me and they will say…'Oh! What's she doing there?

She's going to have sex.'" This demonstrates that peer gossip after seeing her go to a health clinic (Theme 2) would lead her to feel embarrassed about seeking sexual health services (Theme 4).

Thematic Paradigm

The thematic text analysis and the narrative analysis together revealed that the qualitative themes participants raised are not independent of one another but are instead connected in important ways that affect refugee young women's sexual health behavior. The information from both analyses was used to develop a thematic paradigm (Figure 1). All arrows displayed in the figure are connections that participants themselves made during interviews. As presented in the paradigm, when refugee young women defy sociocultural expectations for sex and relationships, there are several possible outcomes. If their action is public knowledge, they often face judgment across multiple systems: parents, peers, and community members. Even when others are not aware of their behavior, refugee youth still describe feeling embarrassed and afraid of judgment. Both actual and anticipated judgment can contribute to refugee young women engaging in unhealthy behavior. Sometimes these actions are specific to sexual health, such as choosing to avoid getting tested for STDs, but they can also affect other domains, such as mental health. Despite these negative consequences, refugee young women suggested many forms of support that they feel would contribute to more positive sexual health outcomes, including non-judgmental sex education, peer assistance, and clinic outreach.

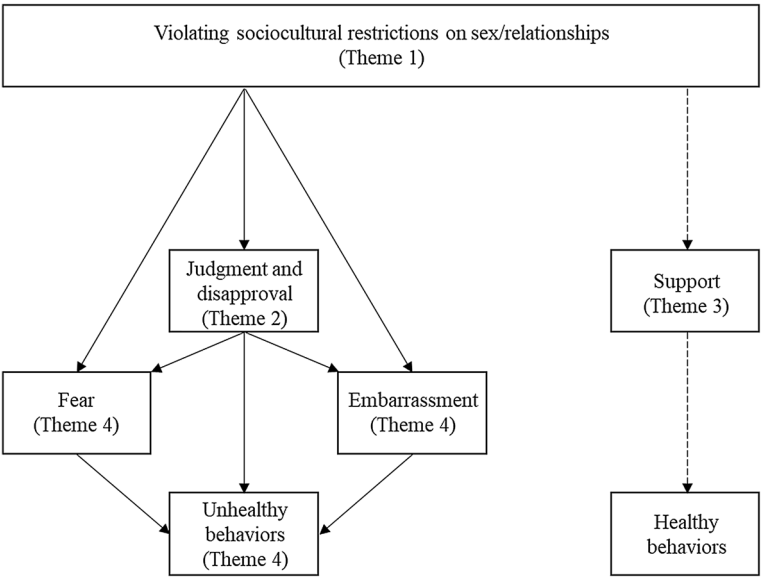

Fig. 1 Final thematic paradigm. Figure depicts multiple pathways from violating sociocultural expectations for sex/relationships to unhealthy behaviors. Dotted lines represent an alternative pathway to healthy behaviors that participants describe as being accessible through support from various contexts

Discussion

The purpose of this study was to identify barriers and facilitators to refugee young women's sexual health across multiple systems and how factors within these systems intersect to influence sexual health behavior. Results revealed that sex/relationship restrictions, judgment/disapproval, and support were each present in multiple systems (e.g., parents, peers, community, culture, and religion) with considerable emotional and behavioral consequences for refugee young women. Furthermore, through thematic text analysis and narrative analysis, notable associations among the factors were identified which demonstrate how they work together to affect young women's sexual health behavior.

First, findings indicated that refugee young women face multiple systemic barriers that impede their agency over sexual health and their ability to seek sexual health services. Participants described facing judgment for their sexual choices from parents, peers, and their community at large. They also discussed religious and cultural values about sexual ethics, primarily the strong emphasis on abstinence from sex before marriage. These cultural values are likely even more salient for refugee young women post-migration, because they are surrounded by new cultural values in America that are different from (and at times contradicting to) those of their ethnic culture.

While each of these barriers has been discussed in prior research (e.g., McMichael & Gifford, 2009; 2010), results from this study provide additional insight into the ways in which these barriers combine and interact to influence refugee young women's behavior. The links shown in the final thematic paradigm help to identify the multiple pathways to sexual health outcomes. Causal statements made by refugee young women suggest that judgment (and fear of judgment) is often rooted in the strong sociocultural expectation of abstinence from sex and romantic relationships outside of marriage. In turn, judgment, fear, and embarrassment lead them to engage in behaviors such as avoiding sexual health services, hiding things from their parents, or having unwanted abortions. There are considerable power dynamics at play at multiple levels, all the way from broad cultural values to individual family relationships, and these dynamics prevent refugee women from feeling free to make decisions about their sexual health without consequences. In other words, refugee young women's sexual agency is limited because of the way that systemic barriers intersect with one another. These intersections are an important component of the reproductive justice framework, as understanding how multiple barriers and oppressions work together for marginalized women is essential to developing holistic solutions (Eaton & Stephens, 2020).

Refugee young women in this study expressed some of their own ideas about what solutions might facilitate better health outcomes. First, they believed that social support would make a positive difference. This is not surprising given evidence of social support as a protective factor for refugee youth in other domains of well-being, such as mental health (Fazel et al., 2012). However, in addition to social support from parents and peers, refugee young women also described the importance of institutional support from health clinics. They wanted clinics to host outreach

events and create spaces that were youth-friendly and noted that these things would increase their likelihood of seeking sexual health services. The placement of support in the pathway also matters. Refugee young women described support as a replacement for judgment and disapproval, rather than as a way of helping them cope with it. In other words, this is an alternative pathway: instead of judgment, fear, and embarrassment leading to unhealthy behaviors, support from key people and systems would promote healthy decision-making.

Implications for Intervention

The results from this study demonstrate that while several systemic barriers contribute to unhealthy sexual behavior, refugee young women also believe that support from various systems has the potential to change these negative outcomes and act as a facilitator of sexual health. Increasing support from these systems is an important target for intervention. Parent-child communication is one area of intervention relevant to the current study. Evidence from communities of color in the United States reveals that increased parent-child communication about sex is associated with decreased sexual risk-taking (Coakley et al., 2017), and that parent interventions are effective in promoting parent-child communication (Santa et al., 2015). These interventions target a variety of outcomes such as communication skills, parent self-efficacy, and positive outcome expectations (Santa et al., 2015), and could be adapted for parents of refugee youth. When developing an intervention for this population, it would be especially important to consider refugee youth's perception of parent-child communication about sex. While many refugee youth in this study noted that their parents were not comfortable talking about sex, other participants shared that their parents do talk to them about sex, but that the conversations are not perceived as helpful. This demonstrates the need for alternative communication rather than simply increased communication, indicating that communication skills would be an important target in an intervention for parents of refugee youth. If refugee young women and their parents are able to discuss sex in an open, non-judgmental way, it may increase their ability to make decisions about sex that are right for them, rather than being limited by fear of consequences from their parents.

Another potentially fruitful area for intervention involves the healthcare setting. Participants provided several suggestions for how clinics could increase the likelihood of refugee young women accessing services, such as having approachable healthcare providers, a youth-friendly space, and clinic outreach. Using these suggested strategies for improved clinic support in combination would likely be most effective, as a recent review article found that providing training for healthcare providers was not enough on its own; the most effective interventions also made adolescent-friendly changes to the clinic and successfully disseminated information about services (Denno et al., 2015). Eliminating barriers to accessing services and reducing fear and embarrassment about these services would help to empower refugee young women to get the care they need.

Limitations and Future Directions

This study has limitations that should be addressed in future research. The study only included participants who could converse in English, but English was not participants' first language. Refugee young women likely would have found it easier to communicate in their first language, which may be particularly true for this study given sexual health is a sensitive, personal topic. Additionally, refugee youth who speak English fluently typically have had longer residency in the U.S.; in this sample the majority had lived in the U.S. for over five years. These refugee youth are likely more acculturated to American culture in terms of language, behavior, and identity than newly arrived refugee youth and may therefore have a different perspective on sexual health and relationships. Future research should provide language interpretation as an option because encouraging greater diversity in language would likely generate a more diverse sample in terms of length of residency and level of acculturation.

Another limitation related to the study sample is that all participants were ages 18-24, and their experiences of sexual health are likely different from younger adolescents. For example, refugee young women who are still in the early stages of puberty may be less concerned than participants in the present study about how their sexual health decisions affect future marriage prospects, but more concerned about immediate bodily changes. It is important to take into consideration how life transitions such as puberty and marriage influence sexual health opinions and decisions and investigating these influences is a key direction for future research.

The study also relied upon secondary data, which meant that the interview guide was not developed with the purpose of answering these research questions. While participants provided extensive information about the contextual factors that influence their sexual health decisions, they may have offered additional insights about facilitators and barriers to sexual health if asked about this topic more directly. Additionally, future quantitative research could increase understanding of which barriers in which contexts predict youth sexual health decisions most strongly, providing insight into what to prioritize when developing interventions.

Conclusion

The present study found several facilitators and barriers to refugee young women's sexual health present across multiple systems, including parents, peers, health clinics, community, religion, and culture. Furthermore, these factors work together to influence refugee youth's thoughts, feelings, and behaviors. Refugee young women who violate familial or cultural expectations about sex and relationships often experience judgment from others, which can lead to unhealthy behaviors, such as not using contraception or avoiding sexual health services. These are serious consequences and understanding the pathways that lead to them provides important insight into how to intervene. Interventions should include multiple contexts in the intervention process, as refugee young women described a need for greater support from parents, peers, and health clinics. Strong support

from these contexts will help to empower refugee young women to make healthy decisions about sex, and in doing so, move from settling for reproductive rights to promoting reproductive justice.

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Data Availability The interview guide used for this manuscript is available upon request. The raw data contained in this manuscript are not openly available due to privacy restrictions set forth by the institutional ethics board.

Declarations

Conflict of interest All authors have no conflicts of interest to declare that are relevant to the content of this article.

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