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"In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women

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Abstract
Purpose Migrant and refugee women are at risk of negative sexual and reproductive health (SRH) outcomes due to low utilisation of SRH services. SRH is shaped by socio-cultural factors which can act as barriers to knowledge and influence access to healthcare. Research is needed to examine constructions and experiences of SRH in non-English-speaking migrant and refugee women, across a range of cultural groups.
Method This qualitative study examined the constructions and experiences of SRH among recent migrant and refugee women living in Sydney, Australia, and Vancouver, Canada. A total of 169 women from Afghanistan, Iraq, Somalia, South Sudan, Sudan, India, Sri Lanka and South America participated in the study, through 84 individual interviews, and 16 focus groups comprised of 85 participants. Thematic analysis was used to analyse the data.
Results Three themes were identified: "women's assessments of inadequate knowledge of sexual and reproductive health and preventative screening practices", "barriers to sexual and reproductive health" and "negative sexual and reproductive health outcomes". Across all cultural groups, many women had inadequate knowledge of SRH, due to taboos associated with constructions and experiences of menstruation and sexuality. This has implications for migrant and refugee women's ability to access SRH education and information, including contraception, and sexual health screening, making them vulnerable to SRH difficulties, such as sexually transmissible infections and unplanned pregnancies.
Conclusion It is essential for researchers and health service providers to understand socio-cultural constraints which may impede SRH knowledge and behaviour of recent migrant and refugee women, in order to provide culturally safe SRH education and services that are accessible to all women at resettlement irrespective of ethnicity or migration category.

Keywords Migrant and refugee women · Sexual and reproductive health · Women's health · Health promotion · Menstruation attitudes · Contraception

Introduction

Sexual and reproductive health (SRH) is a key component of quality of life [1] encompassing "physical, emotional, mental and social well-being" as well as "pleasurable, safe sexual experiences that are free from coercion, discrimination or violence" [2]. This includes the right to receive education and information about sexual health, the right to equality and non-discrimination, the right to decide the number and spacing of one's children and the right to feel and express sexual desire [3, 4]. However, among a number of non-English-speaking migrant[1] and refugee populations who have resettled in the West, knowledge and uptake of preventative sexual health measures are poor, with SRH services being underutilised [5–7]. This can lead to negative SRH outcomes [8, 9].

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[1] The term migrant and refugee is used in this paper to refer to people from a non-English speaking background who have emigrated from their country of origin and resettled elsewhere. In Australia, the term Culturally and Linguistically Diverse (CALD) is used to describe such individuals.

Previous research has established that migrant and refugee women's SRH can be negatively influenced by challenges experienced through migration or displacement [5, 10–12]. Prior to resettlement, there is often limited opportunity to learn about SRH due to poor access to health services and information [9]. Among women, low prioritisation is often placed on sexual health needs due to resettlement challenges [5, 11, 13], and limited knowledge of health resources and services in the host country [6, 10, 14] can result in poor SRH knowledge [7, 9, 15]. Further, SRH knowledge is mainly sourced from peers, the media, magazines and other informal sources [9, 16, 17], allowing incorrect knowledge and myths to perpetuate among community members [15, 18, 19].

While knowledge is a major determinant of SRH behaviour, socio-cultural factors also inform and shape knowledge, beliefs and practice [12, 15, 20, 21]. Cultural and religious norms can influence acquiring sexual health literacy and behaviours, and can contribute to lack of knowledge and access to SRH services [18, 22]. Among migrant and refugee communities, talking about sex is often forbidden due to cultural and religious taboos [18, 23, 24]. Sexual health services may be seen as culturally inappropriate, thus avoided, particularly within cultures that emphasise the importance of pre-marital virginity [25–27]. Further, patriarchal values and culturally prescribed gender roles may impact on women's access to family planning services and sexual health screening [7, 28], with some married women fearful that if they demand safe sex their husbands may divorce them [29]. Cultural constructions about the aetiology and treatment of illness may also act as barriers to utilising SRH services [8, 14, 30]. For example, beliefs around conception and the causation of cervical cancer led some women in African communities to resist using contraception [15] and in Latina communities to avoid cervical screening [31].

Inadequate SRH knowledge combined with low use of sexual health services can have serious negative health consequences for migrant and refugee women [7, 9, 14]. For example, engagement in risky sexual behaviours may result from seeking knowledge from unreliable sources [13, 16, 17]. Delayed sexual health screening may result in late diagnosis and treatment of cervical cancers [31, 32] or sexually transmissible infections [33, 34]. Inadequate contraception knowledge and use may lead to unwanted pregnancy and abortion [19, 21, 35]. Inadequate knowledge about sexual satisfaction or sexual pain may have negative implications for women's psycho-sexual well-being and quality of life [7].

There is a need for health providers to understand socio-cultural barriers to SRH in order to provide comprehensive healthcare for all migrant and refugee women [24, 36, 37]. Previous research has tended to focus on specific cultural groups, for example the Vietnamese or South-East Asian populations in Australia [30, 38], which results in the marginalisation or invisibility of health experiences and needs in other migrant groups [38]. SRH research has predominantly examined pregnancy, childbirth and post-partum experiences [39, 40], meaning that experiences of sex, sexuality and sexual health practices have largely been overlooked [17, 28, 38]. Research that has been conducted on migrant women's sexual health has primarily focused on unmarried women, from single cultural groups [20, 28, 32, 41]. SRH experiences and needs are also likely to differ for migrant and refugee women depending on their type of resettlement, such as humanitarian or professional migration [12, 42]. In order to identify unmet sexual health needs and specific cultural barriers to accessing sexual health services, there is a need for qualitative studies that provide in-depth analyses of the constructions and experiences of SRH among married and unmarried migrant and refugee women, from a range of cultures and backgrounds, across the reproductive lifecycle [43–45].

Identifying how SRH is constructed and experienced by migrant and refugee women is essential in order to provide culturally safe medical care, sexual health education and health promotion and to increase capacity for all women in accessing SRH services [46–48]. The aim of the present study was to examine constructions and experiences of SRH in recent migrant and refugee populations in Sydney, Australia, and Vancouver, Canada, across a range of cultural and religious backgrounds. The research question was: how do migrant and refugee women's constructions and experiences of SRH influence SRH behaviour?

Method

Participants and Recruitment

A total of 169 migrant and refugee women took part in the study, as part of a larger research project examining the SRH of migrant and refugee women living in Australia and Canada [49]. Participants were 18 years and over and had settled in Australia or Canada in the last 10 years from Afghanistan, Iraq, Somalia and Sudan. Sri-Lankan (Tamil), Indian (Punjabi) and South Sudanese women were included in the Australian sample and women from South America (Latina) in the Canadian sample. Participants ranged from 18 to 70 years old, with a mean age of 35 and with an average length of time since migration of 6.3 years. Participants practised a range of religions, predominantly Islam, Christianity and Hinduism. The majority of women had migrated as humanitarian refugees, and only one participant (Latina) reported as being in a same-sex relationship. Table 1 provides the demographic information by cultural background for all participants.

Australia and Canada were chosen as the research sites due to being similar geographically and having comparable migrant populations. The countries of origin and cultural backgrounds of the participants were chosen through consultation with stakeholders who support or provide sexual and reproductive healthcare to non-English-speaking migrant and refugee

Table 1 Demographics for participant interviews and focus groups by cultural background

	Afghani (n = 35)	Iraqi (n = 27)	Latina (n = 17)	Somali (n = 38)	South Sudanese (n = 11)	Sudanese (n = 20)	Tamil (n = 12)	Punjabi (n = 9)
Age range	19–50	18–70	28–46	19–68	30–45	26–54	26–50	25–45
Variable	*M*(SD)	*M*(SD)	*M*(SD)	*M*(SD)	*M*(SD)	*M*(SD)	*M*(SD)	*M*(SD)
Age	31.4 (9.1)	38.7 (12.5)	37.1 (5.6)	31.9 (10.4)	36.6 (6.2)	38.7 (7.5)	36.8 (7.3)	35.67 (6.22)
Years since migration	5.1 (4.1)	4.3 (2.1)	8.3 (4.9)	5.4 (3.1)	10.8 (2.1)	8.9 (3.4)	5.1 (2.5)	8.11 (2.37)
Number of children	3.3 (1.3)	2.7 (1.2)	1.5 (0.7)	3.7 (2.0)	4.5 (2.2)	2.9 (1.1)	2.1 (0.5)	2.40 (0.89)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Have children								
Yes/pregnant	20 (57.1)	20 (74.1)	11(73.3)	23 (60.5)	11 (100.0)	19 (95.0)	11 (91.7)	5 (55.6)
No	15 (42.9)	7 (25.9)	4 (26.7)	15 (39.5)	–	1 (5.0)	1 (8.3)	4 (44.4)
Religion								
Islamic	35 (100.0)	23 (85.2)	–	38 (100.0)	–	16 (80.0)	–	–
Christian	–	3 (11.1)	10 (58.8)	–	11 (100.0)	4 (20.0)	5 (41.7)	–
Buddhist	–	–	1 (5.9)	–	–	–	–	–
Hindu	–	–	–	–	–	–	7 (58.3)	5 (55.6)
Sikh	–	–	–	–	–	–	–	3 (33.3)
Non-practicing	–	1 (3.7)	6 (35.3)	–	–	–	–	1 (11.1)
Education								
Primary	7 (20.0)	6 (22.2)	–	8 (21.1)	3 (27.3)	4 (20.0)	–	1 (11.1)
Secondary	15 (42.9)	3 (11.1)	2 (11.8)	3 (7.9)	2 (18.2)	5 (25.0)	7 (58.3)	–
Tertiary	6 (17.1)	18 (66.7)	10 (58.8)	3 (7.9)	2 (18.2)	10 (50.0)	5 (41.7)	8 (88.9)
Nil	2 (5.7)	–	–	1 (2.6)	2 (18.2)	1 (5.0)	–	–
Other	1(2.9)	–	–	2 (5.3)	2 (18.2)	–	–	–
No response[a]	4 (11.4)	–	5 (29.4)	21 (55.3)	–	–	–	–
Relationship status								
Married/de facto	17 (48.6)	14 (51.9)	13 (76.5)	13 (34.2)	6 (54.5)	13 (65.0)	12 (100.0)	9 (100.0)
Single	12 (34.3)	7 (25.9)	2 (11.8)	14 (36.8)	1 (9.1)	1 (5.0)	–	–
Divorced/separated	2 (5.7)	5 (18.5)	2 (11.8)	8 (21.1)	4 (36.4)	6 (30.0)	–	–
Widowed	4 (11.4)	1 (3.7)	–	3 (7.9)	–	–	–	–

[a] No response due to the question on education not asked by some community interviewers

communities. The cultural groups selected for this study were recognised as being underrepresented in previous research, with women underutilising current SRH services, despite reflecting a significant percentage of recent migrant population in Australia and Canada. Women were recruited to participate through community support workers and pre-existing community groups, as well as through snowballing and the use of flyers. Participants provided informed consent to take part in interviews and focus groups involving discussion of SRH. Any queries about participation were addressed with a community worker in the first language of the participant to ensure understanding. The research was approved by Western Sydney University Human Research Ethics Committee and ethics committees of the project partners. Data were collected from July 2014 to March 2016.

Procedure

To enable the collection of in-depth stories of migrant and refugee women's constructions and experiences of SRH, a qualitative approach was used [50]. There were 84 one-to-one interviews and 16 focus groups composed of 85 participants conducted. The majority of these interviews (73%, n = 124) were conducted in the first language of the participants by community interviewers who received training by the research team prior to commencing data collection. Individual feedback was provided to the interviewers after their first interview, and support was given throughout the data collection process of interviewing, translating and transcribing. Two members of the research team conducted the remaining interviews and focus groups with women who preferred to speak English or to be interviewed by a non-community member. To enhance data richness, one-to-one interviews were used to elicit personal accounts that women may not have been willing to disclose in a group setting due to the culturally sensitive topic, while focus groups gathered insights into socio-cultural norms through group discussion [51, 52]. The groups were homogenous, consisting of women from the same cultural background, and divided by marital status and age where possible [53]. Among the recruitment sample, there were very few cases of participants seemingly fearing a lack of confidentiality; one participant (interviewed by a community interviewer) revoked consent and another (interviewed in English by a non-community interviewer) refused to be recorded.

Interviews and focus groups took place at venues preferred by participants and lasted an average of 90 minutes. The interview and focus group schedule focussed on the reproductive lifecycle, sexuality and SRH, including open-ended questions exploring migrant and refugee women's constructions and experiences of menarche, menstruation and menopause; fertility and contraception; sexuality; sexual health and sexuality education; and health practices and information seeking.

Women gave current accounts of their constructions and experiences of SRH as well as retrospectively describing past experiences and behaviours. Recruitment within cultural groups continued until data saturation was achieved.

Analysis

A social constructivist epistemology informed our research design, where meaning is socially and culturally produced [54]. Thematic analysis, a qualitative method for identifying, reporting and interpreting patterns or themes within interviews, was used to analyse the data [55]. Community interviewers transcribed and translated audio-recordings of interviews that were conducted in the participants' first language while those conducted in English were professionally transcribed verbatim. Two members of the research team read through a subset of the interview transcripts independently to identify first-order codes such as "menstrual learning", "talking about sex" and "screening behaviours". The coding process involved discussion and decision-making to create more distinct codes. The data set was coded using NVivo, a software program that helps organise coded data, with continual refinement during the coding process to help elicit and identify themes. The coded data were organised and presented using a conceptually clustered matrix [50, 56]. This enabled the visual display of patterns within and between the different cultural groups by using exemplar quotations provided in tables to illustrate each of the themes. Quotations presented in this article are substantiated by use of pseudonym, cultural background and age. No distinction is made in reference to country of residence as analysis revealed no significant difference between accounts of participants from Australia and Canada.

The research team consisted of academic researchers and community migrant workers from different ethnicities. The community interviewers were migrant women who worked within their communities and spoke the language of the participants. Throughout the research process, we engaged in reflexivity, aware that our own experiences and socio-cultural backgrounds shaped our research findings [57]. In this article, we present key themes across the cultural groups. The key themes identified were "Women's assessments of inadequate knowledge of SRH and preventative screening practices", "Barriers to SRH" and "Negative SRH outcomes".

Results

Women's Assessments of Inadequate Knowledge of Sexual and Reproductive Health and Preventative Screening Practices

Across all cultural groups, participants described themselves as having a lack of knowledge about SRH (Table 2). Absence of knowledge of menstruation prior to menarche was commonly acknowledged, and many women had not learnt about the function of menstruation until they were pregnant with their first child. Many participants also described having inadequate

Table 2 Women's assessments of inadequate knowledge of sexual and reproductive health

Inadequate menstrual knowledge prior to menarche	I didn't know anything about it. I thought that when I saw my underwear I had 'poopoo'. Latina Focus Group
	I didn't know anything about bleeding. I got shocked. Hani, Somali, age 32
Inadequate knowledge of menstruation and fertility	I didn't know that I will become pregnant the first time I started bleeding. Our parents were not educated. They didn't know how to communicate with their children. Somali Focus Group
Inadequate knowledge of menopause	I would not want my period to stop because this makes me imagine that I will be getting ill, and blood will be accumulated in my body. Arifa, Iraqi, age 48
Inadequate sexual knowledge prior to marriage	All of the information that I had about getting married and sex was from books, but not from my family or my mum, because she was shy to tell me anything about it. Wafa, Sudanese, age 40
	So you don't get enough information about it, especially sexual relationships, especially if a girl is not married, no-one will talk to you about these things. Ara, Afghani, age 34
Inadequate contraception knowledge	I have no idea about contraception. Akeck, South Sudanese, age 30
	I wanted to know more [about contraception] but at that time there was no internet and nobody was around to give me any kind of knowledge and no books that I could rely on…until I got married, I never asked anybody. Wafa, Sudanese, age 40
Inadequate knowledge of cervical screening and HPV vaccine	No, I don't know, what is a Pap test? Maano, Somali, age 19
	I think those injections [HPV vaccine] themselves cause the cancer. Somali Focus Group
Inadequate knowledge of sexually transmissible infections	I don't know much about how to prevent myself getting it [STI]…what kind of problems or infections there are, but I try to keep myself very clean. Banoo, Afghani, age 28

knowledge of menopause, often positioning it in a negative way as an illness. Sexual knowledge prior to marriage was frequently acknowledged to have only been learnt through books, film and peers. Many women recognised that they had inadequate knowledge about contraception, cervical screening practices and human papillomavirus (HPV) vaccination. Some women demonstrated incorrect knowledge; for example, several Somali women were under the misconception that the HPV vaccine caused cancer. Participants also reported inadequate knowledge of sexually transmissible infections, with knowledge limited mainly to having heard about HIV/AIDS.

Barriers to Sexual and Reproductive Health

A number of cultural and relational barriers to obtaining knowledge and access to SRH were identified (Table 3). Menstruation was positioned as shameful and a forbidden topic, with little discussion taking place between mother and daughter or between peers. For many participants, talking about sex as an unmarried or married woman was not permitted. Even thinking about sex before marriage was considered as "harming your religion" (Ara, Afghani, age 34), as culture and religion dictated remaining virginal until marriage. Women who engaged in premarital sex were no longer seen as desirable marriage partners and could experience familial and social exclusion. Cervical screening and the HPV vaccination were seen as a threat to the virginity imperative, thus not supported practices for unmarried women. Some participants stated that their religion or culture forbade them to use contraception.

Across all cultural groups, there were cultural and relational pressures on women to reproduce and a preference for a male child. More specifically, it was expected that Somali, Sudanese and South Sudanese women bear many children. For most participants, contraception use was negotiated with husbands and in some cases with parents and in-laws, with family planning taken into consideration only after the first child was born. Due to patriarchal and cultural values, some participants reported that they felt unable to refuse marital sex or to address sexual pain and discomfort. Some women also felt unable to ask their husbands to be tested for sexually transmissible infections (STIs), and prioritised their family's health over their own, particularly for participants who had many children.

Negative Sexual and Reproductive Health Outcomes

There were a number of negative health implications for women with inadequate SRH knowledge or whose knowledge was

Table 3 Barriers to sexual and reproductive health

Cultural and religious barriers	
Talking about menstruation is shameful	Everything is shame[ful] and you are hiding, and even you can't talk [about menstruation] to a group of girls who are the same age. Erina, Somali, age 39
	She [mother] always afraid to speak like this to me…She said, this thing is shame[ful]. Nadiya, Iraqi, age 70
Talking or thinking about sex is taboo	We are not allowed to talk about sex, not even in our bedroom…it's a taboo. Arifa, Iraqi, age 48
	I never thought about it [sex], the woman shouldn't know all these things, that's not appropriate. Ara, Afghani, age 34
Relationships and sex before marriage forbidden	It is forbidden to do this because my religion says you are forbidden to have sex or try before you get married…It's un-love. Wafa, Sudanese, age 40
Contraception forbidden	No the religion does not allow women to use contraceptives. Hido, Somali, age 68
Cervical screening and vaccination inappropriate for unmarried women	It can affect the virgin state and the hymen [cervical screening]. Bashira, Iraqi, age 44
	It is not important to give this [HPV] vaccine at that time [when unmarried] Iraqi Focus Group
Relational barriers	
Pressure to have children	So if you don't have baby, you can't be in the culture. Tamil Focus Group
	Sometimes you don't have a choice [about having children]. The family, they're controlling. You are not you and your husband only. Somali Focus Group
Inability to refuse marital sex	In our culture you can't talk about it [sex] and you can't say no, because the woman is always a woman Eira, Sudanese, age 26
	If you say no and you happen to die the same night, we used to hear that you would go to hell. Hani, Somali, age 32
Inability to enforce STI testing	This is a big problem asking him [husband to be tested for STIs]. We can ask him to go but he won't. Sudanese Focus Group
Low prioritisation of sexual healthcare	We always think about the kids and husbands but we forget about our self. Faaiso, Somali, age 32

shaped by cultural barriers (Table 4). Many participants gave accounts of inadequate menstrual knowledge and communication and bleeding that was concealed and kept secret. Consequently, women's experiences of menarche were described as frightening or shocking, and participants rarely spoke to health professionals about premenstrual or menstrual difficulties. Due to limited premarital sexual knowledge, participants disclosed feelings of anxiety on their wedding night, describing the experience of first sexual intercourse as scary and painful. Many married women considered the focus of sex to be male pleasure or reproduction. Experiences of painful sex were common, yet many women had little knowledge and use of lubricants to ease vaginal discomfort. These women also often felt unable to discuss painful sex or sexual consent with their partners.

Many participants had worries and misconceptions about contraception use that they attributed to inadequate contraception knowledge. Some participants gave accounts of inadequate family planning, associated with unplanned pregnancies and abortions. Sexual health screening practices were deemed inappropriate for unmarried women, who were forbidden to be sexually active. Addressing sexual issues with a doctor was often seen as shameful or embarrassing, with exposing the body a major factor in delayed healthcare-seeking.

Discussion

Among the majority of women in our study, irrespective of cultural background, there was evidence of reports of inadequate SRH knowledge. A major barrier to sexual health

Table 4 Sexual and reproductive health outcomes

Traumatic experiences of menarche	I saw the blood coming out from me. I was so scared. I say to myself my mum will kill me. Iraqi Focus Group
	I said to myself that something went wrong in my body. I was scared to death. Hooria, Sudanese, age 35
Menstrual difficulties not discussed with healthcare providers	When I had my three miscarriages I didn't realize that those were [miscarriages] because I've always had very heavy periods, a lot of blood and bleeding for many days. Latina Focus Group
Traumatic first sex experiences and ongoing sexual pain	It was sore and I was bleeding… I was crying, it was a nightmare for me. Najiba, Iraqi, age 64
	It just hurts every time, sometimes it lubricates, sometimes it doesn't. Darya, Afghani, age 24
Contraception misconceptions, unplanned pregnancy and abortion	So all those periods just stay in and they gather up, right? Anosha, Afghani, age 30
	My husband would try to pull out to not get pregnant, but despite that I got pregnant. Afghani Focus Group
	I took pills, while I am using them I fell pregnant five times, I did abortion because I didn't want more children. Najiba, Iraqi, age 64
Poor uptake of sexual health services and delayed treatment	If she's not married, no reason for that[cervical screening]Iraqi Focus Group
	The bleeding actually did not stop [post-partum] …I did not actually go to see a doctor… I'm very slow when it comes to seeking medical services. Akeck, South Sudanese, age 30
	They don't want to expose the body. So even if they know that they are going to die, they don't want it. Andrea, Tamil, age 26
Reluctance to be examined by male health professional	I was scared to see the doctor…that it is a man. I felt the same anxiety as one feels on the first night of the wedding. Zinat, Punjabi, age 45
Need for sexual and reproductive health information	One-on-one chat is probably more comfortable for people because it's more personalised. Manjit, Punjabi, age 33
	Groups would be the best. Some ladies are not educated and will not understand leaflets and booklets. Afghani Focus Group
	The best method that I would prefer is Facebook because everybody uses Facebook and YouTube, so that this generation will know the information. Maano, Somali, age 19
Desire for support in educating daughters about sexual and reproductive health	Before I told my daughter, I was scared to tell her about the period because my daughter might misunderstand me. I was scared and shy to talk about this topic. Sudanese Focus Group
	Since I am a mother, I think I would like to have information about sexual education, some advice or guidance on how to approach these kind of issues with my daughter. Mariana, Latina, age 38

literacy was socio-cultural norms that prohibit open discussion about SRH, as reported previously [17, 18, 20, 21]. Not being able to openly talk about the menstrual body, sex and sexuality impacted upon women's SRH and their health-seeking practices [9, 12, 41]. Among our participants, inadequate knowledge and silence around menstruation were associated with reports of traumatic experiences of menarche [58–60]. However, some women, post-migration, were eager for support in educating their daughters in preparation for menarche. This is consistent with previous research findings where women who had themselves received inadequate menstrual education and support wanted to spare their daughters from traumatic experiences at menarche [59–61]. This highlights a need for service providers to facilitate ongoing menstrual health education and support for young girls and their mothers.

For many participants, whether unmarried or married, talking about sex was viewed as disrespectful and culturally inappropriate, as reported in previous research [7, 18, 23, 24]. Due to this taboo, many of our participants disclosed feelings of anxiety on their wedding night and traumatic first sexual experiences, due to their lack of sexual knowledge [7]. Silence around sex can also mean that sexual health concerns are less likely to be addressed with partners, family members and health providers [62]. Some participants requested information on how to talk to their adolescent children about sex, indicating a need for culturally appropriate sexuality education to support families in communicating about sex [63]. However, a premarital virginity imperative occurred across all cultural groups in our study, with SRH services seen as culturally inappropriate and unnecessary for unmarried women. Parental and community attitudes influenced and prevented access to cervical screening and the HPV vaccine, consistent with findings in previous research [18, 21, 31, 32]. Unmarried women may be ashamed to buy contraceptives [45] and be fearful of parents or the community finding out [15], with personal reputation and family honour jeopardised if it is known they are engaging in premarital sex [7, 8, 17]. In addition, intergenerational differences in attitudes and beliefs around sexuality, post-migration, have been found to create family conflict [64]. Women's sexual health is at risk by not being able to freely access sexual health screening clinics, resulting in women being ill equipped to articulate their sexual rights [65]. This includes having little knowledge of, or access to, contraception and risk of social exclusion if sex (whether consensual or not) or pregnancy occurs outside of marriage [7]. Cultural prevention of access to sexual health information can also result in women resorting to informal sources of information, risking the transmission of incorrect knowledge [15, 19]. There is a need, therefore, for service providers working with non-English-speaking migrants and refugees to encourage and support families to use culturally safe approaches to sexual health, including provision of information on sexual health screening and contraception [21], and to provide SRH education in ways that help address intergenerational conflict [64].

SRH is often a low priority, particularly for newly arrived migrant and refugee women who prioritise family commitments and resettlement concerns ahead of their own needs [11, 13, 66]. A delay in healthcare seeking for SRH concerns was common among our participants. Culturally prescribed gender roles, combined with patriarchal values, may influence women's ability to have control over their sexual and reproductive needs [7, 43]. Some married participants, for example, faced family pressure not to use contraception, and were thus unable to control the number of children that they had, due to the cultural importance placed on having children. This demonstrates that contraception knowledge does not necessarily translate into contraception use [67]. Some participants felt unable to refuse marital sex, and endured unwanted or painful sex as they saw it as not their "right" to refuse consent. Likewise, women said that they would be powerless to persuade their husbands to agree to STI testing, even when there might be suspicions of extramarital sex. These culturally gendered restrictions mean that women may have little sexual agency and autonomy, and are at risk of unplanned or unwanted pregnancies, STIs and sexual pain. Thus it is important for healthcare providers to be aware of the cultural and social sensitivities that migrant and refugee women have in regard to SRH. There is also a need for engaging with migrant communities. For example, the use of peer educators and navigators [6, 68] creates a bridge between communities and the health system, and embedding SRH education in culturally acceptable programs, in consultation with community and religious leaders, is a way of receiving community support on SRH issues [49, 69].

Despite cultural and religious taboos around SRH, many participants within the safe space of the interview and focus group setting showed an interest in receiving information on a range of topics including cervical screening, HPV vaccination, sexually transmissible infections, contraception, painful sex, negotiating sex within their marital relationships, preparing daughters for menarche, menopause and sexuality education. Some women, particularly Sudanese participants, were keen for their husbands to receive sexual health education, which has implications for future research in considering men's perspectives on SRH and for SRH resources to be developed for migrant and refugee men. Participants indicated preferences for a variety of resource delivery options such as groups and one-on-one talks, as well as reading and visual (including web-based) material, highlighting the need for developing resources in a range of modalities, including material in community languages as well as for women with low literacy levels [21]. An important consideration is appropriate timing for disseminating SRH information, for example, providing cervical screening information at antenatal classes and following childbirth while women are engaged with

healthcare providers or talking about lubricants at cervical screening examinations [49]. A strong preference for female practitioners has implications for practice, in providing female healthcare providers and accessible women's health clinics.

There are a number of strengths and limitations to this study. Strengths include interviewing women from different cultural backgrounds, which made comparisons between cultures possible. Being able to interview participants in their first language allowed women who were not fluent in English to participate, as they were not constrained by language issues. The community interviewers were able to explain terms such as menstruation, menopause, contraception, cervical screening and sexual identity labels in language that the participants understood. Providing participants who were able to speak English with the option of being interviewed either in their first language or in English meant that we were able to give women the option that they felt most comfortable with. Having these flexible options was important considering the sensitive nature of the interview questions and in being able to demonstrate cultural sensitivity. We spent a considerable amount of time building rapport and establishing a strong working relationship with community interviewers and the community, and allowed ample time for translation of interviews, along with flexibility in choice of interviewer—important for future research using community interviewers. In collaboration with community stakeholders and SRH service providers, we have reflected on the research findings and produced recommendations for healthcare practice [70], a further strength in the research. Limitations include the fact that researchers could not back-check translated transcripts for accuracy, women often retrospectively reflected on their experiences, and given the small subset of women from each cultural background, experiences of SRH may not be representative of their community as a whole. There were also differences in interviewing skill and comfort regarding discussion of sexuality across the community interviewers. Future research should ideally use community interviewers who have more substantive training in qualitative methods or who are experienced in discussing sexual issues.

In conclusion, this research has demonstrated that migrant and refugee women are at risk of experiencing unmet SRH needs and negative health outcomes due to socio-cultural norms that contribute to the potential for inadequate SRH knowledge and low uptake of sexual health services. This highlights the need for healthcare providers in consultation with communities to develop culturally appropriate sexual health promotion initiatives [71] and approaches that are tailored for specific cultures [47, 72] that are accessible to all migrant and refugee women at resettlement irrespective of their socio-cultural background or category of migration [9]. SRH information needs to be provided in a range of modalities to meet women's diverse needs [70]. To improve sexual health outcomes and increase utilisation of SRH services for migrant and refugee women, the focus needs to be not only on health education and increasing knowledge, but on understanding the socio-cultural constraints that may impede SRH knowledge and behaviour [3, 43]. This suggests that migrant and refugee women and their SRH needs should be treated holistically, focussing on the whole person within their socio-cultural context [73].

Compliance with Ethical Standards

Ethical Approval All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (Western Sydney University and Australia) and with the Helsinki Declaration of 1964 and its later amendments. Informed consent was obtained for all participants in the study.

Conflict of Interest The authors declare that they have no conflict of interest.

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