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Engaging Migrant and Refugee Young People with Sexual Health Care: Does Generation Matter More Than Culture?

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Abstract

Young people from migrant and refugee backgrounds in Australia are recognised as under-utilising mainstream sexual and reproductive health care. A qualitative study was undertaken in Sydney, Australia, to explore the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health information and care. Several rounds of interviews were undertaken with 27 migrant and refugee young people aged 16–24 years. These included an initial semi-structured interview ($n = 27$) and a follow-up and/or walking interview with a sub-set of participants ($n = 9$ and $n = 15$ respectively). A theme of 'generational difference' recurred throughout the interviews. Particular ways of talking about age-related differences, including the 'young generation' and 'older generations', appeared to be deployed as a mechanism for explaining a perceived disjunction between service providers and young people. This group, from a very diverse range of cultural and linguistic backgrounds, appeared to be more similar than different when talking about sexual health. They saw themselves as generationally distinct, and commonly positioned 'older people' as judgemental and less accepting in relation to sexual health. Migrant and refugee young people may not be fully engaged with, or benefitting from, sexual and reproductive health services, despite a number of service options being available. It is likely that their perceptions and previous experiences, as well as stated preferences for services and service providers, would affect their willingness to engage with services. To enable information and services to better reach young people across the many cultural and linguistic groups living in contemporary Australia, attention must be paid to ensuring they feel included as a member of a 'young generation', and ensuring services are inclusive and welcoming.

Keywords Cultural diversity · Young people · Sexual and reproductive health · Generations · Health services · Australia

Introduction

Australia, as with many other advanced liberal democracies (Rose, 1996), is home to a rich diversity of cultures, ethnicities and languages. Whilst 'culturally and linguistically diverse' young people, including migrants, refugees and international students, come from a range of backgrounds and experiences, many appear to face similar challenges in relation to their sexual and reproductive health (Botfield, Zwi, & Newman, 2016). This group have varied and sometimes complex health needs; the little that is known regarding how they make use of services for sexual and reproductive health reproduces a narrative of 'low awareness' and 'low utilisation' or 'under-utilisation' (Manderson, Kelaher, Woelz-Stirling, Kaplan, & Greene, 2002; McMichael, 2008; McMichael & Gifford, 2009; Poljski, 2011; Reeders, 2011; Ussher et al., 2012; Wray, Ussher, & Perz, 2014). This suggests a need for increased engagement in this area; however, there is limited empirical research documenting the views of expert informants who work with these young people or in this policy area, as well as analyses of the views and experiences of young people themselves (Botfield, Newman, & Zwi, 2015).

It is widely accepted that access to appropriate health services is critical for achieving the sexual and reproductive

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health and well-being of young people (Bearinger, Sieving, Ferguson, & Sharma, 2007; Tylee, Haller, Graham, Churchill, & Sanci, 2007; World Health Organization, 2002). In Australia, most health care for refugee and migrant communities is provided through 'mainstream' health services (Lamb & Smith, 2002; South Eastern Sydney Local Health District, 2011) that cater for the broad population rather than specific populations (Department of Human Services, 1998, p. 12). Services that focus on information and care relating to sexual and reproductive health include general practitioners (GPs) (i.e. primary health care medical doctors), women's health, youth health, and family planning and sexual health services. Whilst these services have been developed with the needs of the majority population in mind, it is vital that they ensure provision of accessible and safe care that responds appropriately and effectively to the varying health needs of an increasingly diverse population in Australia (Botfield et al., 2016; Hach, 2012; NSW Health, 2011).

Despite the relative availability of services for sexual and reproductive health, these do not appear to be routinely accessed by young people from migrant and refugee backgrounds, as previously noted. Barriers to access have been reported to include unfamiliarity with the health system and lack of awareness of services (McMichael, 2008; Reeders, 2011), shame and fear (Rawson & Liamputtong, 2009; Reeders, 2011; Ussher et al., 2012), concerns about confidentiality (McMichael, 2008; Rawson & Liamputtong, 2009), low health literacy (McMichael, 2008; Ngum Chi Watts, Liamputtong, & Carolan, 2014; Poljski, 2011), language barriers (McMichael, 2008) and financial constraints (Poljski, 2011). Services associated with sexual health may also be avoided by unmarried people due to perceived reputational risks of others knowing they are interested in or engaging in premarital sexual activity (Rawson & Liamputtong, 2009; Ussher et al., 2012). What is less clear, however, are the perspectives of migrant and refugee young people on their need for and use of sexual and reproductive health services, or how these can more effectively engage and support young people in promoting their sexual health and well-being (Botfield et al., 2015).

This paper reports findings from an exploratory study undertaken to investigate the complexities and opportunities for engaging young people from migrant and refugee backgrounds[1] with sexual and reproductive health information and care. The broader study was informed by grounded theory principles, which means we took a more exploratory and open-ended approach, and an interpretive lens was used in developing the research design (Bryman, 2016). Interpretivism is a paradigm that views 'reality' as only able to be 'known' through the particular lens of the people who are experiencing it, and aims to produce reliable and robust knowledge by focussing on understanding the experiences of individuals in their everyday lives, rather than seeking to test or extend existing social theory (Ransome, 2013). Our preliminary thematic analysis of the data identified a dominant theme of 'generational difference', which led us to focus our analysis in relation to key ideas from the sociology of generations. We focus here on understanding what this concept offers in terms of explaining young people's views on and experiences of sexual and reproductive health care.

The concept of 'generations' has become a normative trope in recent decades for distinguishing cohorts of people grouped according to their year and place of birth or by key historic events, which is assumed to have created a shared set of experiences and attitudes (Edmunds & Turner, 2002). Mannheim (1997) [1952]), who is considered one of the most influential sociological thinkers on generations, argued that the term 'generation' should be applied to people who belong to a common period of history or whose lives are forged through shared experiences of key events. However, other, more recent, critical commentators have argued that generations are a social construction rather than an objectively verifiable phenomenon (Foster, 2013; McDaniel, 2004; Vincent, 2005). White (2013), in particular, has argued that what is more interesting to analyse than evidence of specific generations are the 'generationalisms' that get made about particular groups of people as a way to constitute particular truths and understanding about how societies are organised. In our study, particular ways of talking about age, and the 'young generation' and 'older generations' in particular, were very apparent. They appeared to be deployed as a mechanism for explaining the perceived differences between service providers—the 'older generation'—and the targeted users of sexual health and related health care, themselves and their peers. In line with our position that young people interpret, practice, contest and give meaning to their own lives and shape their own identities (White & Wyn, 2013; Wyn & White, 2015; Wyn & Woodman, 2006), we posit that it is important to think about how and why they may form ideas about being part of a distinctive generation, particularly as these may sit in tension with the assumptions often made regarding differences between young people from a range of backgrounds in multicultural societies such as Australia.

This paper explores how generational discourse was articulated by migrant and refugee young people in describing both their own experiences and their preferences regarding the characteristics of those who provide sexual and reproductive health information and services.

[1] In the context of this research, 'young people' refers to those aged between 16 and 24 years, and 'migrant and refugee' to those who self-identified as being from a refugee or migrant background (including those who migrated to Australia only a few months or years earlier, or were born in Australia, or are an international student).

Methods

This study was conducted in Sydney, New South Wales (NSW), the largest Australian city comprising over five million residents, and with the largest overseas-born population (Australian Bureau of Statistics, 2017). The ethical values of research merit and integrity, justice, beneficence and respect guided the design and conduct of the research (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors' Committee, 2007 (updated May 2015)). Ethics approval was received from the Western Sydney Local Health District Human Research Ethics Committee (approval no. 4407), the Family Planning NSW Ethics Committee (approval no. R2015-02), the ACON Research Ethics Review Committee (approval no. 2016/09) and the UNSW Australia Human Research Ethics Advisory Panel: Social and Health Research (approval no. HC15381).

Several rounds of interviews were undertaken with young people aged 16–24 years living in Sydney, who self-identified as coming from a migrant or refugee background and could speak a language other than English. In order to reach this target group, a combination of sampling strategies were used, including non-probability purposive sampling (Bryman, 2016) and snowball sampling (Liamputtong, 2009). Recruitment was facilitated by a number of services in Sydney (health and non-health, government and non-government), who promoted the research through putting a study poster in their waiting room, and handing out study flyers to prospective participants and verbally discussing the study with them. Use of posters was not an overly successful method, as it is not apparent that any participants were recruited based on seeing a poster alone. Other recruitment strategies included individuals and organisations promoting the study on social media, use of a study website to which to refer people and word of mouth. Young people interested in participating made contact with the first author to discuss and arrange an interview. Given the broad range of potential cultural and linguistic groups, a decision was made to keep the study materials in English. It was hoped that recruitment of non-English-speaking young people would be facilitated by word of mouth and use of the national Translating and Interpreting Service.

Three rounds of interviews were undertaken between September 2016 and October 2017. Consenting participants undertook a semi-structured 'first' interview, and were invited via email to participate in a semi-structured 'follow-up' interview and/or 'walking' interview at a later date. It was neither expected nor intended that all participants would take part in more than one interview, but those who enjoyed taking part in the research expressed satisfaction with having the opportunity to engage further than the first interview. All participants completed a short questionnaire after the first interview to capture their demographic characteristics (see Table 1). An interview guide was utilised for all interviews, and was piloted with the first three participants; few changes were required, and so these interviews were included in the complete dataset. First and follow-up interviews took place at a quiet location agreeable to the participant and interviewer (e.g. health service, library room, park or café), and walking interviews at one or more of the five health services (six sites) partnering with the research study. Participants recruited through one of these services were not invited to do a walking interview at that particular service. The majority of interviews were conducted one on one, with the exception of one first and one walking interview, undertaken by a pair of friends. All interviews were conducted by the first author, a female Anglo-Australian in her late 20s, whose interest in this topic was kindled through her experiences working in public health and as a sexual/reproductive health nurse. The research was undertaken for a doctoral research project.

First interviews explored young people's views and experiences of accessing sexual and reproductive health information and care, whilst the follow-up interviews allowed for more in-depth questioning. The walking interview (Evans & Jones, 2011; Garcia, Eisenberg, Frerich, Lechner, & Lust, 2012) involved the participant undertaking a 'tour' with the interviewer of the service and discussion of key observations and views. These interviews were very informal and were guided by a template of prompts, which included discussion of features of the service, and other issues such as location, fees and opening hours. Engaging young people in health service research in this way allowed the interviewer to build rapport and trust with participants, provided an opportunity to seek additional insights and identify issues that may not otherwise have come up (particularly when the first interview was relatively short due to participant time constraints), and seek targeted feedback on specific aspects of services. Participants were reimbursed for travel for each interview. First interviews ranged in duration from 20 to 60 min, follow-up interviews from 30 to 40 min and walking interviews from 20 to 40 min.

Interviews were audio-recorded with participant consent, transcribed verbatim, de-identified and coded using qualitative analysis software NVivo 10 (QSR International 2012). The interviews, transcription and integrity-checking of transcripts were undertaken by the first author. Preliminary analysis commenced when the first author felt that we were approaching data saturation, with very little new information being added as interviews continued. Saturation was considered to have been reached when it was felt by all authors that sufficient data had been collected to allow the exploratory aims and objectives of the study to be thoroughly fulfilled, and there were no significantly new perspectives being shared by participants (Mason, 2002; Patton, 2002). Whilst 'active recruitment' slowed down from May 2017, a small number of interviews were still conducted after this point as several

Table 1 Participant characteristics (as reported by participants)

Characteristics[a]	Female Frequency ($n = 16$)	Male Frequency ($n = 11$)	Total Frequency ($n = 27$)	%
Age (years)				
16–18	4	2	6	22%
19–21	5	7	12	44%
22–24	7	2	9	33%
Relationship status				
In a relationship	11	3	14	52%
Single	5	8	13	48%
Sexual identity[b]				
Bisexual	4	0	4	15%
Heterosexual	13	6	19	70%
Homosexual	0	5	5	19%
Sexual attraction				
Both sexes	4	3	7	26%
Opposite sex only	12	5	17	63%
Same sex only	0	3	3	11%
Time in Australia				
< 1 year	0	3	3	11%
2–3 years	1	1	2	7%
4–5 years	3	0	3	11%
6–10 years	3	2	5	19%
> 11 years	3	1	4	15%
Born in Australia	6	4	10	37%
Religious affiliation				
Agnostic	0	1	1	4%
Buddhist	1	2	3	11%
Catholic	3	0	3	11%
Christian	4	3	7	26%
Greek Orthodox	1	0	1	4%
Muslim	1	0	1	4%
No religion	6	5	11	41%
Region of origin/birth				
Africa	4	0	4	15%
Asia	5	6	11	41%
Australia/New Zealand	7	4	11	41%
South America	0	1	1	4%
Ethnicity/cultural background				
African	3	0	3	11%
Argentine	0	1	1	4%
Asian	0	1	1	4%
Asian/Chinese	0	1	1	4%
Brazilian	0	1	1	4%
Cambodian	1	1	2	7%
Chinese	1	1	2	7%
Chinese/Cambodian	1	0	1	4%
Filipino	0	1	1	4%
Greek	1	0	1	4%
Hazara	0	1	1	4%
Japanese	1	0	1	4%
Kachin	1	0	1	4%
Kenyan	1	0	1	4%
Korean	2	1	3	11%
Spanish	1	0	1	4%
Syrian	0	1	1	4%
Vietnamese	1	1	2	7%
Vietnamese/Chinese	1	0	1	4%
Not specified	1	0	1	4%

[a] All participants spoke English; all were unmarried; none had any children

[b] Where participants identified with more than one sexual identity, both are included

young people contacted the first author to participate. Participants chose their own pseudonym for reporting purposes.

Following the principles of thematic analysis, as described by Braun and Clarke (2006), deductive codes from the interview guides were initially utilised by the first author, then supplemented by inductive codes derived from line-by-line review of interview data. Development of the code structure was an iterative process, which began in the data collection phase (Bradley, Curry, & Devers, 2007). This process incorporated intercoder checking by all authors to strengthen the quality and rigour of findings. All authors individually reviewed a selection of interview transcripts to further develop and refine the coding frame and identify important themes. Iterative categorisation (Neale, 2016) was then applied to the coded data by the first author. This systematic technique for managing analysis supports common analytical approaches, including thematic analysis. One of the benefits of using iterative categorisation is that it leaves a clear audit trail, providing 'a route back to the raw data for further clarifications, elaborations and confirming/disconfirming evidence' (Neale, 2016). Final themes were discussed and agreed by all authors. Key findings were presented to the Youth Advisory Group convened for this study, to elicit their feedback and observations.

Results

Altogether, 27 young people participated in a first interview, nine in a follow-up interview, and six in one or more walking interviews. Fifteen walking interviews were

undertaken in total, across the six sites. Six participants completed all three interviews. Participant characteristics are documented in Table 1.

As previously described, an overarching theme of 'generational difference' was identified as recurring throughout the interviews. This theme is discussed in further detail below, organised into three distinct sub-categories of meaning.

My Generation: Young People from Diverse Backgrounds Are More Similar Than Different When It Comes to Talking About Sexual Health

It was apparent that young people from these very diverse backgrounds were more similar than different when talking about sexual health. They did not appear to think of themselves as particularly unique or different from other young people living in Australia, although it was clear that most did have to negotiate additional cultural boundaries and constraints. Many described their experiences as those of a 'young person', or being from the 'younger generation' or 'our generation', rather than as someone from a particular cultural heritage or background. Whilst a number did refer to their 'community', this was often described in broad terms as a way to frame their observations or views about particular aspects of their life, rather than how they personally and/or solely identified. Some participants did not identify with a particular cultural group or community, and those that did, did not always also subscribe to the same beliefs or values as that group or community. Most described making their own choices about how they lived their lives (within certain constraints), and did not necessarily place the same importance on religion or tradition as they felt their parents, extended families or communities did.

Supporting the idea of a shared generational sensibility, nearly all participants described sex and sexual health in their lives as being 'very taboo' (Amir, 24; William, 17), 'stigmatised' (Jack, 20) and 'hush hush' (Thanh, 20; Julia, 22). The vast majority stated they could not discuss sexual health or related issues with their parents at all, and often not with others in their family.

> 'That topic isn't spoken of in my household… Your parents don't even think about you having sex, so it doesn't get spoken' (Sarah, 24)
> 'She [mum] doesn't know I'm sexually active and if she did then it would be a bad situation' (Olivia, 17)

Most described similar scenarios regarding their parents' expectations for how they conducted themselves regarding gender and sexuality, which included no sex before marriage, no discussion of sex or related topics and a preference to date/marry someone of the opposite sex who was from the same cultural background or another 'acceptable' background. Most participants stated that their parents expected them to go to university, get a job, get married and have children. This was a common reflection by most, although it was viewed as more problematic by gay male participants who did not want to disappoint or hurt their parents:

> 'It's not the right time (to come out). Because I know for (my mum), she wants me to have a family' (TingTing, 20)
> 'I haven't come out yet. It's just kind of hard for me, my parents don't really understand … I don't want to disappoint (my mum) a lot, like to that extent, and that's why I don't ever bring it up' (David, 20)

However, despite the reportedly stigmatised and taboo nature of sexuality and sexual health in their lives, participants were all still able to seek information and support if/when they required it. Nearly all explained that they would look on the internet (usually Google) as a first step for finding information on sexual and reproductive health. Although several limitations to using the internet were raised, it was viewed by the vast majority as their main source of information and a way to find answers whilst remaining anonymous. Many also felt comfortable discussing relationships, sex, sexuality and sexual health with 'trusted' or 'close' friends, although most noted this was only if they had the same level of 'experience'. A small number mentioned being less likely to discuss with friends from the same cultural background, due to the taboo nature of the topic as well as concerns about their parents finding out. Many felt that living in Australia made it easier for them to find information and discuss these topics with others, as there was a perception that what several described as 'western culture', particularly among the 'younger generation', was more open and accepting than their families and countries from which they or their parents had migrated.

> 'I think it's easier to talk about these things because here the culture is different' (AJ, 19)
> '…society's views on sex are quite relaxed, compared to, maybe my parents' time' (Denise, 20)

Whilst health professionals were generally seen as a good source of information, most participants used the internet or spoke to a friend before seeking out a health professional: 'I Google search it unless it's starting to hurt, before I go to the doctors' (Liz, 21). A number noted they would not feel comfortable seeing a family doctor (i.e. a general practitioner their whole family goes to), and/or a doctor from the same background as theirs, to discuss sexual or reproductive health. The majority were also largely unaware that there are a range of

different services available for sexual and reproductive health, apart from GPs.

> 'I didn't actually know that services like this existed… I think that especially young people like me need to be told, like, be aware about these kind of services' (Sarah, 24)

Participants framed many of their comments regarding sex and unplanned pregnancy, which they saw as a key issue, in terms of risk to reputation and social well-being. However, this did not prevent them from making their own choices in relation to dating, engaging in sexual activity and/or accessing information and support; they simply did so in ways that ensured others would not find out, so they could maintain their reputation and that of their parents, and prevent gossip and judgement among their community or their parents' community. Examples of this included use of the internet for information, and not visiting a family doctor or a local doctor for sexual health care. When discussing views regarding an unplanned pregnancy, many participants stated, without being asked, that they would prefer to have an abortion than to be seen as pregnant outside of marriage. Some also felt that an abortion may be more acceptable to their parents than an unplanned pregnancy, as it could be done in secret and both their and their family's social status could remain intact.

> 'Yeah, actually our community and our religions are very against having abortion…but for me, if both of us are not ready, I won't do it. I won't give birth' (Merry, 21)
> 'It's funny, it's not acceptable, but people still do it [have abortions], because being pregnant out of wedlock is a shame… So your parents might abort it, but not tell people. They will do it just to keep their name on the special status' (Panda, 23)

These narratives about sex, sexuality and sexual health from young people from very different cultural backgrounds in Australia were quite consistent across the sample, and suggest that whilst participants do have to navigate cultural mores and expectations, they did not necessarily always feel limited or confined by this.

Unknowable Oldies: Experienced and Perceived Judgement from Older People

Parents, community members and service providers were frequently positioned in interviews as generationally distinctive and 'older' in terms of both age and attitudes. Older people were generally perceived to be more judgemental, less open and accepting and/or less knowledgeable in relation to sexual and reproductive health. This was described as a 'conflict' by one participant, with young people more 'open-minded' and older people 'very closed and traditional' (Amir, 24).

> 'That's why there's a conflict between young and old generation' (Amir, 24)
> '…it's almost normal for older people to maybe judge, you know, people for their choices because it's maybe a different generation' (Mimi, 22)
> 'I don't think my parents would have the knowledge about it, because they're a lot older' (Sarah, 24)

Concerns about being judged were raised in most interviews, both in relation to lived experiences and anticipated experiences or perceptions of older service providers (including clinicians, pharmacists and reception staff):

> 'If they were the same age as my parents, they'd probably be judging me' (Denise, 20)
> 'She was a bit of a younger doctor…she was a bit more accepting, a bit more open…there was no judgement' (Julia, 22)

When asked about general clinician preferences for discussing sexual health, most participants stated they would prefer someone younger, and felt less comfortable with older clinicians. In describing what makes someone 'old', most were unsure of a specific age but suggested someone in their 40s and above. Reasons given for this age preference were primarily related to younger clinicians being viewed as less judgemental and more knowledgeable, and feeling generally more comfortable with them:

> 'I think the younger doctors, I just feel more comfortable around them' (William, 17)
> 'If they were older, I'd be a bit uncomfortable' (Denise, 20)

The majority of participants had previously consulted a GP (mainly for general health; some for sexual health or contraception); however, most described these as either negative or unhelpful experiences. Some attributed this to their GPs' older age (and therefore having less knowledge and/or being judgemental), whilst others felt rushed through the appointment and so could not get what they wanted from it.

A number of participants had a family doctor about whom they spoke highly. However, despite this, none felt

comfortable discussing sexual health with them and stated they had or would seek out other providers for this purpose. They were most concerned about confidentiality (particularly that their parents would find out), fear of judgement and/or discomfort speaking about sex or sexual issues to a doctor they have known for a long time:

> 'You know, he's old now, and yeah… A bit more judgmental I reckon' (James, 21)
> '(I) love him to bits, but I didn't really want to talk to him about it, especially because he had seen me when I was really young' (Anzu, 24)

Participants clearly saw themselves as distinct from 'older people', rather than distinct from other young people, or those from different cultures or backgrounds. Based on both experience and perception, older people, including parents and health professionals, were frequently viewed as judgemental and less accepting when it came to sexual health.

What Young People Want: Bridging the 'Generation Gap' in Provision of Services

Participants shared similar views regarding their preferences for services and service providers for sexual health, and had clear ideas of what they liked and did not like.

As noted previously, most (though not all) had a strong preference for seeing 'younger' clinicians. Many participants, both male and female, preferred a female clinician for sexual and reproductive health matters, and whilst most were not concerned about the provider's background or nationality, several said they would rather not see a clinician with the same background as theirs for sexual health. Overall, participants wanted a clinician who was friendly, accepting and non-judgemental.

Although participants had little awareness of different 'specialist' services such as family planning and sexual health services, these were generally perceived to be friendly, welcoming, non-judgemental and knowledgeable, both by participants who had and had not used such a service before. Many suggested this was because sexual and reproductive health is 'normal' to the people working in those services, so young people would not feel judged, and that clinicians will have more trustworthy and up-to-date knowledge. The majority had the sense that because they were focused on sexuality issues, they were a more appealing option than the GP. Most indicated a preference for these types of services for accessing sexual and reproductive health information and/or care, even though many had no prior knowledge of them before the interview.

> 'Now I've found that there's some (sexual health) clinics that exist, I would research and find the clinic, a specialist clinic' (Amir, 24)
> 'I think I would probably go there instead of my GP' (Olivia, 17)
> '…because they're a specialised sexual health clinic, they'll be more knowledgeable about what I'm getting' (Gloria, 22)

Despite the stigma that young people recognised being associated with sexual health, and a strong concern about their families and others thinking they may be sexually active or thinking about sex, participants did not suggest this would prevent them from going to a 'specialist' service for sexual health.

The concept of health services being 'youth-friendly' was raised by the interviewer during interviews, and whilst this phrase was not offered by participants themselves, all appeared to be familiar with it or at least comfortable with both the phrase and responding to questions about it. They shared similar views when describing features of services they liked, particularly during the walking interviews, that would 'attract the young generation' (Panda, 23). This included lots of colour, brightness and visual features, making flyers and resources easily available and seeing younger people present at the service, including clinicians, reception staff and other clients, as well as on posters in the waiting room and walls. A number of participants commented that they like services that are inclusive of all people, and they like seeing things that make a service seem more inclusive, such as a 'LGBTQ flag' (Olivia, 17), 'Indigenous flag' (Denise, 20), 'posters of young people' (Merry, 21) and 'Aboriginal art' (Panda, 23). One young person suggested during a walking interview that

> 'There's nothing for specific cultures, so everyone would feel comfortable coming here. They're not targeting anyone particularly' (Panda, 23)

Whilst coming from a very diverse range of cultural and linguistic backgrounds, participants expressed similar preferences for services and service providers, which are likely to influence whether and how they might engage with services for sexual health.

Discussion

This study contributes to a growing body of research on the sexual and reproductive health of migrant and refugee young

people living in advanced liberal democracies which seek to promote multiculturalism, such as Australia. There are, however, a number of limitations that warrant noting. The research focused on one state of Australia, although there is likely to be considerable relevance to other Australian states and territories and other comparable country settings. Recruitment of a sample of migrant and refugee young people was purposely broad, as the services of interest to us—those aiming to promote sexual and reproductive health—do not limit their target client groups by cultural background. Findings should not be assumed to apply to specific sub-groups, as the numbers from specific cultural and linguistic groups were very small. Furthermore, although we hoped to recruit some non-English-speaking young people, all participants, including more recent arrivals to Australia, spoke English in addition to their first language/s. Inclusion of translated study recruitment materials, and working more closely with different community groups, may have helped to recruit non-English-speaking participants. Interview questions were purposefully broad so as not to make assumptions about cultural backgrounds or experiences; however, these may still have influenced responses. There may also be limitations and influences related to the role of the interviewer: female, white, in her late 20s and from an English-speaking background. Finally, some young people may have sought to provide more positive views and experiences to the researcher than may have been fully accurate, particularly during the walking interviews, so as not to appear disrespectful, though it was not evident that this occurred in any of the interviews.

Despite these limitations, we believe this study has important research, policy and practice implications for those working to enhance the sexual and reproductive health of young people of all backgrounds in Australia and comparable countries. A key finding was that participants appeared to see themselves more clearly as 'young people' or people from a 'younger generation', rather than identifying strongly with a particular cultural or language group or subscribing to certain values or beliefs. Despite being from very different backgrounds, and some having migrated to Australia only a few months or years earlier, many described their experiences as being distinct from people of other generations, rather than people of other cultures. Whilst issues relating to culture, gender and sexual identity were discussed by participants, age was a dominant issue and appeared to matter more than these in many ways. Participants commonly made 'generationalisms' (White, 2013) about 'older people', notably service providers, parents and other community members, making sweeping statements about their likelihood of being more judgemental and less knowledgeable about particular issues affecting young people.

White and Wyn (2013) suggest that identity can be seen as a social process that is shaped by relationships (with family and friends, in schools and workplaces), economic conditions and cultural traditions; this was apparent in the interviews as participants described their different interactions and experiences. The concept of intersectionality is also important, as it recognises that experience and subjectivity is rarely shaped by only one aspect of identity, but can feature multiple dominant features of a person's social and historical place and experience, such as gender, race, culture, education, sexual orientation and immigration status. This framework seeks to counter one- and two-dimensional approaches by bringing to the fore the complexity of intersecting factors for understanding distinctive needs and preferences in relation to, among many other things, health and well-being (Hankivsky & Cormier, 2009). Intersectionality is commonly described in the literature related to this research as the 'interactions between gender, culture, race and other categories of difference' (Davis, 2008; Ngum Chi Watts et al., 2014; Ussher et al., 2012); however, our interviews suggested that the social categories of 'age', and popular notions of 'generations', also play an important role in shaping the views and experiences of diverse young people.

Whilst identifying with the 'young generation', and not always clearly setting themselves apart due to cultural background or other affiliations, it was apparent that participants did still have to negotiate a number of cultural restrictions and expectations. This notion of young people from migrant and refugee backgrounds living between 'two cultures' has been well described in the literature (Iqbal, Joyce, Russo, & Earnest, 2012; Manderson et al., 2002; Rogers & Earnest, 2014). This was also a key theme in interviews with health professionals and other 'professional informants' for this study, who identified 'intergenerational differences' as a key barrier to young people accessing sexual and reproductive health care (Botfield, Newman, & Zwi, 2017). However, whilst this concept was clearly evident in interviews with young people, they did not seem to view themselves as being limited or confined by the cultural mores and expectations they described. Rather, they were able to negotiate this space to seek information and support, if needed, whilst still maintaining their relationship with their parent/s and family and their reputations. Findings from studies with secondary school students have reported that many do discuss sex and sexual health with their parents (Berne et al., 2000; Booth et al., 2004; Mitchell, Patrick, Heywood, Blackman, & Pitts, 2014), despite this being a challenging area for many parents (Charmaraman & McKamey, 2011; Pariera & Brody, 2017); however, the vast majority of participants in this study stated very strongly that this was not an option for them. This appears to be primarily due to the perceived stigma associated with sexual health in many migrant and refugee families and communities, linked to cultural and religious expectations. This lack of intergenerational communication has also been reported in other studies with migrant and refugee young people (McMichael & Gifford, 2009; Rawson & Liamputtong,

2009, 2010). Importantly, this did not appear to prevent participants from engaging in relationships and sexual activity, and accessing information and support, whilst still preserving their reputation and social well-being among their families and communities.

There is often a strong focus at policy and service levels on developing cultural competence across health care systems, services and individuals, and the importance of recognising and welcoming cultural difference in health service delivery (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Botfield et al., 2017; National Health and Medical Research Council, 2006). Attention should also be paid to what Shim (2010) describes as the 'cultural health capital' that both young people and health professionals bring to clinical interactions (including their cultural skills, attitudes, behaviours and interactional styles), to promote equity in health services and enhance the clinical experience and outcomes (Dubbin, Chang, & Shim, 2013; Madden, 2017; Shim, 2010). These remain critical to ensuring the health care system as a whole provides the quality of care it should. However, in relation to ensuring that migrant and refugee young people know about and can access services and information relating to their sexual and reproductive health, *generational differences possibly matter more than cultural differences*. This is an important distinction.

A number of studies exploring the health service experiences of adults from different cultural groups have reported a desire for providers to be knowledgeable about cultural beliefs, norms and practices, traditions and religious beliefs (see, for example, Henderson & Kendall, 2011; Rogers & Earnest, 2014; Ussher et al., 2012); however, this was not evident in interviews with young people for this study, suggesting these may be less important to younger people from migrant/refugee backgrounds. A concern about being judged was raised in most interviews, particularly in relation to health service interactions, and therefore has important implications for service provision. Due to issues of stigma, confidentiality and trust, it is important that young people from all backgrounds can access information and services, that privacy and confidentiality are emphasised both in promoting services and during clinical consultations and that young people feel completely safe when accessing information and care. Participants shared similar views regarding service and service provider attributes, and had clear preferences, as previously described. In combination, these different features of services and service providers paint a picture of how services might offer a safe and welcoming environment for diverse young people. Many participants expressed a desire for 'inclusive' services; thus, strategies for improving sexual health should be sufficiently flexible to be relevant and appropriate for all social and cultural groups, whilst ensuring that this does not have the unintended effect of making particular groups of people feel excluded (Newman, Persson, Paquette, & Kidd, 2013).

It was very apparent, and perhaps not surprising, that service providers played a critical role in determining whether a participant had a positive or negative experience with the health service. However, it is a particularly important consideration for young people from migrant and refugee backgrounds (who appear to have very little awareness of the range of services available for sexual and reproductive health in Sydney, and are perhaps therefore less engaged with these), in raising awareness of available services and promoting a positive experience with them. Whilst general practitioners are viewed as the most accessible primary health care provider in Australia (Chown, Kang, Sanci, Newnham, & Bennett, 2008; Dadich, Jarrett, Sanci, Kang, & Bennett, 2013), and it is broadly assumed that they will see the majority of young people for sexual health issues, findings from this study suggest this is not always the case and/or may not always be appropriate. Most participants did not feel comfortable going to their family doctor for sexual health issues, as has been reported in other studies with migrant and refugee young people (McMichael & Gifford, 2009; Rawson & Liamputtong, 2009); however, many had also had less positive experiences with GPs in relation to sexual health, and were less inclined to see their family doctor or a GP for such issues.

Current models of health service provision in Australia may not be meeting the sexual health needs of diverse young people. There appears to be a need for GPs to enhance their understanding of how to better reach and provide a welcoming and acceptable service for young people, including those from migrant, refugee and other 'culturally diverse' backgrounds. This may otherwise be a missed opportunity for GPs to engage these young people in critical conversations, particularly when many are sexually active or thinking about it, are not utilising other health services, are receiving little support in this area from home, and are attempting to negotiate and manage differing expectations from parents and others. These findings also have important implications for family planning and sexual health services, which may perhaps be better positioned to provide sexual and reproductive health information and services to migrant and refugee young people, who may otherwise fall through the gaps in sexual health care. This will also have resource implications, however, which will require policy attention.

Conclusion

Capturing the voices of young people from migrant and refugee backgrounds is essential to meeting their needs and ensuring provision of safe and acceptable services for sexual and reproductive health. Despite a number of options for sexual and reproductive health care in Australia, migrant and refugee young people may not be benefitting fully from current models of service provision and could be more

proactively engaged and supported. Whilst the cultural competency of systems, services and service providers is paramount, the dominant role of generational discourse revealed in the interviews conducted for this study suggests more is required to ensure that provision of information and care to this group makes young people from any and all backgrounds feel safe and accepted. To enable information and services to better reach young people from across the many cultural and linguistic groups living in contemporary Australia, attention must be paid to ensuring they feel included as a member of a 'young generation', and able to access inclusive and welcoming health services. Successfully promoting this approach will require attention to the intersection between individual agency and social context for young people from diverse backgrounds.

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Compliance with Ethical Standards

Conflict of Interest Author 1 is a doctoral candidate at UNSW Sydney and an employee of the Family Planning NSW Research Centre. Family Planning NSW is a partner organisation for this research. Authors 2 and 3 declare no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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