Engaging young people from migrant and refugee backgrounds with sexual and reproductive health care

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A thesis in fulfilment of the requirements for the degree of
Doctor of Philosophy

School of Social Sciences
Arts and Social Sciences

UNSW Sydney
October 2018
Young people who identify with a minority cultural and/or language background may be at heightened risk of poor sexual and reproductive health and have limited engagement with sexual and reproductive healthcare. Whilst there is increasing recognition of this issue in Australia, little empirical research has explored the views and experiences of migrant and refugee young people in relation to this. This thesis reports on exploratory qualitative research undertaken in Sydney, New South Wales, to address this gap. Methods included a broad literature review, a scoping review, semi-structured interviews with ‘professional’ key informants (n = 34), and semi-structured first interviews (n = 27), follow-up interviews (n= 9) and walking interviews (n=6, with a total of 15 walking interviews) with migrant and refugee young people. Young people could participate if they were 16-24 years, lived in Sydney, identified with a migrant or refugee background, and spoke a language other than English. Despite being from diverse cultural and language backgrounds, the young people who participated were more similar than different regarding their views and experiences with information and services for sexual and reproductive health. They described a persistent taboo among family and community in relation to sexuality and sexual health. School was identified as their main source of information on this growing up. Most were unaware of the different services available for supporting young people in pursuing sexual and reproductive health. The option of seeing a ‘specialised’ service for this aspect of health appealed to many, as these were perceived to be more confidential and non-judgemental than general practitioners or ‘family’ doctors. Findings highlight the complexities of designing effective healthcare systems that incorporate the varied experiences and backgrounds of young people, and the importance of reaching diverse populations with sexual and reproductive health promotion and care. Findings could contribute to enhancing policy and practice approaches to engaging diverse young people with sexual and reproductive health care in Sydney and similar metropolitan settings. There is an important opportunity for ‘specialised’ sexual and reproductive health services and general practitioners to better engage migrant and refugee young people and ensure provision of welcoming and inclusive services.
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Details of publication #1:
*Full title:* Young migrants and sexual and reproductive health care
*Authors:* Botfield, J.R., Zwi, A.B., & Newman, C.E.
*Journal or book name:* Handbook of Migration and Health
*Volume/page numbers:* 438-458
*Date accepted/published:* 2016

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Details of publication #2:
*Full title:* Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: A structured scoping review
*Authors:* Botfield, J.R., Newman, C.E., & Zwi, A.B.
*Journal or book name:* Sexual Health
*Volume/page numbers:* 13 / 1-9
*Date accepted/published:* 2015

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Details of publication #3:
Full title: Drawing them in: Professional perspectives on the complexities of engaging ‘culturally diverse’ young people with sexual and reproductive health promotion and care in Sydney, Australia.
Authors: Botfield, J.R., Newman, C.E., & Zwi, A.B.
Journal or book name: Culture, Health & Sexuality
Volume/page numbers: 19 / 438-452
Date accepted/published: 2017

The Candidate’s Contribution to the Work
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Details of publication #4:
Full title: Ethical considerations of using walking interviews to engage migrant and refugee young people in health service research
Authors: Botfield, J.R., Zwi, A.B., Lenette, C., & Newman, C.E.
Journal or book name: SAGE Research Methods
Volume/page numbers: N/A
Date accepted/published: 2019

The Candidate’s Contribution to the Work
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**Details of publication #5:**

*Full title:* Engaging migrant and refugee young people with sexual health care: Does generation matter more than culture?

*Authors:* Botfield, J.R., Newman, C.E., & Zwi, A.B.

*Journal or book name:* Sexuality Research and Social Policy.

*Volume/page numbers:* Online first

*Date accepted/published:* 2018

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**Details of publication #6:**

*Full title:* Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: “I never got the talk about the birds and the bees”
Authors: Botfield, J.R., Zwi, A.B., Rutherford, A., & Newman, C.E.
Journal or book name: Sex education
Volume/page numbers: 18 / 705-720
Date accepted/published: 2018

The Candidate’s Contribution to the Work
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Location of the work in the thesis and/or how the work is incorporated in the thesis:
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• All of the co-authors of the publication have reviewed the above information and have agreed to its veracity by signing a ‘Co-Author Authorisation’ form.

Details of publication #7:
Full title: Talking to migrant and refugee young people about sexual health in general practice.
Authors: Botfield, J.R., Newman, C.E., Kang, M., & Zwi, A.B.
Journal or book name: Australian Journal of General Practice
Volume/page numbers: 47 / 564-569
Date accepted/published: 2018

The Candidate’s Contribution to the Work
Undertook all interviews, transcription, and coding in NVivo10; undertook preliminary analysis; prepared first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.

Location of the work in the thesis and/or how the work is incorporated in the thesis:
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• All of the co-authors of the publication have reviewed the above information and have agreed to its veracity by signing a ‘Co-Author Authorisation’ form.
Acknowledgements

I am extremely grateful to a number of people who made this research possible:

- My supervisors, Professor Anthony Zwi and Associate Professor Christy Newman, for their guidance, advice and continual encouragement. And to Dr Alison Rutherford, co-supervisor, for her valuable input at different stages of the research
- The young people and key informants who participated in interviews, who generously gave up their time to speak to me and share their views and experiences
- The young people who contributed as part of the Youth Advisory Group convened for the study: Doris, Lauren, Marvin, Sam, Victoria, Ali, Maryyam and Daniel
- Those who collaborated as partner investigators and provided their expert advice, feedback and support: Dr Catriona Ooi, Dr Melissa Kang, Dr Deborah Bateson, Dr Christopher Carmody, Dr Mitchell Smith, Brendan Crozier and Katherine Bennett
- The partner services that contributed to the research: High St Youth Health Service, Family Planning NSW, NSW Refugee Health Service, Liverpool Sexual Health Clinic, Sydney Sexual Health Centre, and Western Sydney Sexual Health Centre
- UNSW Arts and Social Sciences who contributed some funding towards fieldwork costs, which was the only funding support I received
- Jane Estoesta and other colleagues at Family Planning NSW who were always so encouraging and supportive of me in undertaking this research
- Dr Steve Bell for providing valuable feedback and ideas at various points of the research.
- Hannah Ireland, for generously reviewing and proofreading my thesis
- And finally, a very heartfelt thanks to Grant, for his unwavering support and endless encouragement.
Abstract

Young people who identify with a minority cultural and/or language background may be at heightened risk of poor sexual and reproductive health and have limited engagement with sexual and reproductive healthcare. Whilst there is increasing recognition of this issue in Australia, little empirical research has explored the views and experiences of migrant and refugee young people in relation to this. This thesis reports on exploratory qualitative research undertaken in Sydney, New South Wales, to address this gap. Methods included a broad literature review, a scoping review, semi-structured interviews with ‘professional’ key informants (n = 34), and semi-structured first interviews (n = 27), follow-up interviews (n= 9) and walking interviews (n=6, with a total of 15 walking interviews) with migrant and refugee young people. Young people could participate if they were 16-24 years, lived in Sydney, identified with a migrant or refugee background, and spoke a language other than English. Despite being from diverse cultural and language backgrounds, the young people who participated were more similar than different regarding their views and experiences with information and services for sexual and reproductive health. They described a persistent taboo among family and community in relation to sexuality and sexual health. School was identified as their main source of information on this growing up. Most were unaware of the different services available for supporting young people in pursuing sexual and reproductive health. The option of seeing a ‘specialised’ service for this aspect of health appealed to many, as these were perceived to be more confidential and non-judgemental than general practitioners or ‘family’ doctors. Findings highlight the complexities of designing effective healthcare systems that incorporate the varied experiences and backgrounds of young people, and the importance of reaching diverse populations with sexual and reproductive health promotion and care. Findings could contribute to enhancing policy and practice approaches to engaging diverse young people with sexual and reproductive health care in Sydney and similar metropolitan settings. There is an important opportunity for ‘specialised’ sexual and reproductive health services and general practitioners to better engage migrant and refugee young people and ensure provision of welcoming and inclusive services.
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List of Acronyms

ACON          AIDS Council of NSW
CALD          Culturally and linguistically diverse
GP            General practitioner
HREC          Human Research Ethics Committee
IEC           Intensive English Centre
KI            Key informant
LHD           Local Health District
NSW           New South Wales
RACGP         Royal Australian College of General Practitioners
SRH           Sexual and reproductive health
STI           Sexually transmissible infection
TAFE          Technical and Further Education
Chapter 1: Introduction

Sexual and reproductive health represents one of the most culturally sensitive and politically controversial areas of health policy and practice globally, across all societies and social structures. Although the matters addressed within this field, such as sexuality, sexual practice, relationships, consent, infections and fertility, are almost universal in their significance to life satisfaction and wellbeing, they remain difficult to talk about in many contexts and complex to meaningfully address in clinical practice.

This thesis presents doctoral research which sought to explore these complexities in relation to one particular set of experiences regarding sexual and reproductive health; that of young people living in an English-speaking country of the Global North, who identify with a non-English-speaking, non-Anglo migrant or refugee family and/or community background. “Young people from migrant and refugee backgrounds” are therefore the primary participant group. In the context of this research, this phrasing is intended to include any young person aged 16-24 years who had migrated to Australia, including those who were resident in Australia or an international student, those who were seeking or had been provided asylum as a refugee, or those who were born in Australia but identified with a non-English speaking migrant or refugee family background. This thesis tells the story of what this doctoral research project was able to achieve: adding to what is known about the views and experiences of this important group of young people in Australia, considering these insights in relation to policy and practice, and identifying what remains to be explored in future research.

This introductory chapter presents the rationale for the research and outlines the aim, objectives and key terminology used. A summary of my own background and positioning as the doctoral candidate, including the perspectives and assumptions I brought to the research, is then provided. This is followed by an overview of the conceptual framing of the research. Lastly, I outline the thesis structure and introduce the collection of peer-reviewed publications which were produced and published as part of my doctoral candidature. A detailed description of the research design, ethical considerations, methods and data analysis is provided in Chapter 2.

Research rationale

Contemporary societies in the Global North are becoming increasingly culturally and linguistically diverse due to extensive global migration. When considering the health and

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1 Also described as ‘advanced liberal democracies’ (Rose, 1996)
wellbeing of migrants and refugees in countries of resettlement, Australia provides a useful case study due to the scale and range of its migration history. European colonisation and settlement in Australia in 1788 dispossessed its Indigenous inhabitants, Aboriginal and Torres Strait Islander people, and Australia’s cultural landscape began to further diversify in the 1850s following the discovery of gold and from the mid-1940s following the end of World War II (Migration Heritage Centre, n.d.; Munro, 2017). Australia today is one of the most ‘culturally diverse’ countries in the world, with nearly half of Australians born overseas or having at least one parent born overseas (Australian Bureau of Statistics, 2017b). Young people make up a significant proportion of migrant and refugee communities, and indeed of the broader youth population in Australia. In 2016/17, young people aged 12-24 years comprised 15% of permanent arrivals to Australia under all migration categories, described below, with 59% of these being in the 18-24 year age group (Multicultural Youth Advocacy Network, 2018).

Australia comprises a rich diversity of cultures, ethnicities and languages, with people from different backgrounds arriving in Australia through a range of pathways, including through the Migration Program for skilled and family migrants and the Humanitarian Program for refugees and others in refugee-like situations (Department of Home Affairs, n.d.). People are able to gain permanent residency in Australia through obtaining a family-stream or work-stream permanent visa (Department of Home Affairs, 2019) or if they arrive through the Humanitarian Program (Department of Social Services, 2018). Permanent residents are then able to apply for Australian citizenship if they meet certain criteria (Department of Home Affairs, 2018a). Asylum seekers who arrive in Australia without a visa and want to apply for protection may be given a three-year Temporary Protection visa, however they are not eligible to apply for Australian citizenship (Department of Home Affairs, 2018b). Those who come to Australia by boat are subject to ‘offshore processing’ in neighbouring Nauru and Papua New Guinea and, according to the Government of Australia, will never be able to resettle in Australia (Kaldor Centre for International Refugee Law, 2018). In addition to migrants and refugees who come to Australia through the Migration Program and Humanitarian Program, international students also contribute to Australia’s growing diversity; in 2015, nearly 500,000 international students were studying on a student visa in Australia, representing a 10% increase from 2014 (International Research and Analysis Unit, 2016).

Access to government-funded health services in Australia is dependent on visa and residency status. Australian citizens and permanent residents of Australia are able to access all government services, including Medicare, the Australian public insurance system which subsidises the cost of health care access; while those on a Temporary Protection visa can access Medicare and some other services (Department of Home Affairs, 2018a, 2018b). However,
although migrant and refugee young people may be able to access Medicare, they may not be aware they can obtain their own Medicare card from age 15 years or visit health services without their parents (Chown, Kang, Sanci, Newnham, & Bennett, 2008) and can experience considerable barriers in accessing health services, as described further below. International students from select countries may be able to apply for Medicare in Australia if their country has a Reciprocal Health Care Agreement, however all others must have health insurance while in Australia and are not eligible for Medicare (Private Health Insurance Ombudsman, n.d.). Experiencing barriers or challenges in navigating unfamiliar or inaccessible systems can undermine effective integration and negatively impact the potential to achieve independence and a sense of belonging and inclusion (Strang & Ager, 2010; Strang, Baillot, & Mignard, 2018). One important aspect to overcome this is ensuring access to quality, comprehensive and responsive primary healthcare services across all areas of health (Grove & Zwi, 2006; Kay, Jackson, & Nicholson, 2010; Phillips, Smith, Kay, & Casey, 2011; Spike, Smith, & Harris, 2011).

As Australia continues to grow in its cultural diversity, however, debates regarding immigration and multiculturalism are gaining momentum (Ballantyne & Malhi, 2017). This is despite evidence that those coming to Australia as migrants and refugees have a positive economic, social and cultural impact on the country (Carrington, McIntosh, & Walmsley, 2007; Hugo, 2011, 2014). However, the portrayal of immigration in Australia is typically negative and polarising in popular media and politics, with anti-immigrant, and in particular anti-refugee, rhetoric widespread. Whilst the specific topics of contention and concern have varied over the years, issues regarding immigration in particular remain divisive (Tavan, 2016). Concerns about ‘African gangs’ (Baak, 2018), ‘boat people’ and ‘illegal maritime arrivals’ (Clark, 2013), for example, are commonplace and often fuelled by political leaders and conservative or tabloid media. Public sentiment that people with certain cultural or religious affiliations do not share or are not compatible with ‘Australian values’ is prominent, and experiences of racism and racial discrimination are particularly prevalent among certain cultural groups (Baak, 2018; Dunn, Atie, Mapedzahama, Ozalp, & Aydogan, 2015; Ozdowski, 2016; Tavan, 2016). Pauline Hanson, founder and leader of a right-wing political party in Australia, remains a prominent figure in Islamophobic and other forms of xenophobic rhetoric about migrant and refugee communities (Norman, 2016). However, fears regarding what are believed to be ‘incompatible values’ among particular migrant communities have been expressed on both the right and the left of politics. Whilst these various representations of the politics that play out in Australia between migrant and refugee communities and Anglo-heritage communities are often stereotyped and controversial, they also reveal the complexities of immigration and population matters. To reduce inequalities and promote positive and successful immigration experiences, it is important
that young people, along with others in their community, are not made to feel insecure, fearful, isolated or excluded (Ager & Strang, 2008).

Young people comprise a considerable proportion of the global population, and there are strong public health, human rights, and economic reasons to invest in promoting their sexual and reproductive health (Chandra-Mouli et al., 2015). Sexual and reproductive health were acknowledged as a fundamental human right at the International Conference on Population and Development (ICPD) in 1994, including the need to invest in young people (United Nations, 1995). More recently, the 2030 Agenda for Sustainable Development outlined targets in relation to ensuring universal health coverage, including, more specifically, access to sexual and reproductive health, rights and services (United Nations, 2015). It is recognised that promoting healthy relationships and prioritising the health and development of young people provides the foundation for healthy populations as young people become adults, and for social and economic development more broadly (Chandra-Mouli et al., 2015; Starrs et al., 2018). However, as young people transition from childhood to adulthood, they can experience significant physical, emotional, social and economic changes (Patton et al., 2016), and a complex set of factors therefore contribute to achieving sexual and reproductive health. There are a multitude of reasons why this can be complicated, including developmental vulnerabilities, social, cultural and economic contexts, and structural barriers to information and services. Despite widespread recognition of the importance of sexual and reproductive health for young people, these needs are often inadequately addressed (Bearinger, Sieving, Ferguson, & Sharma, 2007; Chandra-Mouli et al., 2015). This includes young people from migrant, refugee and other ‘culturally diverse’ backgrounds, who are often under-prioritised as target populations for mainstream services in countries of the Global North such as Australia (Newton et al., 2013; Rawson & Liamputtong, 2009; Wray, Ussher, & Perz, 2014).

There are limited data on the sexual and reproductive health of migrant and refugee young people in Australia, however the little that is known reveals a number of important insights. A national survey of 2,136 Australian secondary students, of which over one third had a parent born overseas and 15% spoke a language other than English at home, reported 69% of all students aged 16-19 years old had experienced some form of sexual activity, 13% of sexually active students had used no contraception the last time they had sex, and 5% had experienced sex that resulted in pregnancy (Mitchell, Patrick, Heywood, Blackman, & Pitts, 2014). Another national survey conducted with 3,134 same-sex attracted and gender questioning young people, of which 18% were classified as having a ‘culturally and linguistically diverse’ background, reported that 61% of all participants had experienced verbal abuse in school, home and community environments due to homophobia (Hillier et al., 2010). Participants from ‘culturally
diverse’ backgrounds were less likely to disclose a non-normative gender identity or sexual orientation to their parents and, if they did, were less likely to get family support (Hillier et al., 2010). Other research suggests young people from diverse cultural backgrounds may have increased rates of unintended pregnancies and sexually transmissible infections (Dean, Mitchell, Stewart, & Debattista, 2017; Meldrum, Liamputtong, & Wollersheim, 2016; Ngum Chi Watts, McMichael, & Liamputtong, 2014), and a recent survey conducted in Western Australia with 122 adolescent refugees found most had very low levels of knowledge regarding sexual and reproductive health (Hirani, Cherian, Mutch, & Payne, 2018). Data such as these have particular resonance in a broader community of young people who have had persistently high notification rates for some sexually transmissible infections (STIs), such as chlamydia (Kirby Institute, 2017). Female international students and other young women from ‘culturally diverse’ backgrounds may also be vulnerable to sexual harassment and gender-based violence but are less likely to report it or seek help (Australian Human Rights Commission, 2017; Chung, Fisher, Zufferrey, & Thiara, 2018; Forbes-Mewett & McCulloch, 2016). It is apparent that although migrant and refugee communities, and young people within these, constitute a sizeable proportion of the Australian population, they experience numerous social and health inequalities and yet remain under-represented in health research and public health interventions (Renzaho, Polonsky, Mellor, & Cyril, 2016).

Alongside these data, the little that is known about how young people from diverse cultural and language backgrounds make use of services for sexual and reproductive health in Australia suggests they may not commonly access those that are available. Most of the studies undertaken in relation to the sexual and reproductive health of people from ‘culturally diverse’ backgrounds in Australia (see Chapter 4), including those published since commencing this doctoral project in mid-2014, have focussed primarily on women and/or people from particular cultural or religious backgrounds. However, they reproduce a similar and perhaps even ‘dominant’ narrative of people from migrant and refugee backgrounds demonstrating a less than ideal level of engagement with services for sexual and reproductive health. Research with young people from these backgrounds suggests many have a limited understanding of the Australian health system, low awareness of the availability of sexual health services, little experience of accessing services for sexual health (Agu, Lobo, Crawford, & Chigwada, 2016; McMichael & Gifford, 2009) and difficulty in obtaining contraception (Meldrum et al., 2016). A study with migrant and refugee women, although not specific to young women, similarly reported poor uptake of sexual health services and delayed treatment for sexual and reproductive health issues (Metusela et al., 2017). Studies with international students have revealed only a third had accessed a health service in Australia (Poljski, 2011) or had accessed services as a last resort (Reeders, 2011). A systematic review undertaken to identify the barriers and facilitators experienced by ‘culturally
and linguistically diverse’ women in Australia in accessing sexual and reproductive health care (Mengesha, Dune, & Perz, 2016), and another that examined migrants’ from sub-Saharan Africa and South East Asia sexual health help-seeking behaviour in ‘high-income’ countries (Rade, Crawford, Lobo, Gray, & Brown, 2018), reported challenges in accessing information and services related to sexual health. The low- or under-utilisation of services has been attributed to a range of factors including unfamiliarity with the health system, financial constraints, language or literacy barriers and preference for a doctor with particular characteristics (Agu et al., 2016), as well as concerns about breaches of confidentiality (Agu et al., 2016; Meldrum et al., 2016), shame and embarrassment about discussing sex, sexuality and sexual health, and these issues being viewed as inappropriate for unmarried women to access or discuss (Meldrum et al., 2016; Metusela et al., 2017).

It is widely recognised that sexuality and sexual and reproductive health, although essential to broader health and wellbeing (Starrs et al., 2018; Temmerman et al., 2014), are sensitive issues in many settings, especially but not only in relation to the lives of young people (McMichael, 2014; McMichael et al., 2014; Morris & Rushwan, 2015). Pre-marital sexuality and relationships, particularly for ‘culturally diverse’ women, are shaped by cultural and religious discourse and practices (Hawkey, Ussher, & Perz, 2017). For example, in one of the few studies of sexuality and religion among migrant women in Australia, Ussher et al. (2012) described a ‘premarital chastity imperative’ for unmarried Christian Assyrian and Karen women living in Sydney, which underpins the prohibition of pre-marital coital heterosexual sex and taboos associated with same-sex relationships within these communities. Wray et al. (2014) observed similar themes regarding young, unmarried heterosexual Muslim women in terms of their understanding and expression of their sexuality in the context of religious and cultural communities in Sydney, including the need to protect virginity prior to marriage and to remain ‘naïve’ and uninformed in all matters which are sexual in nature. The influence of religion and culture on the sexuality of young Muslim women in Melbourne, and the challenges they can experience in balancing Muslim culture, Australian culture and Islamic religion, were also reported by Meldrum, Liamputtong, and Wollersheim (2014). Another study with migrant and refugee women from a range of cultural backgrounds living in Australia and Canada has described a discourse of shame, associated with silence and secrecy, influencing constructions of menarche and menstruation, sexuality, premarital virginity, and perpetuating a restriction on women’s sense of agency regarding fertility control and sexual health (Ussher et al., 2017). Young people who do not observe or personally identify with any religious traditions or affiliations, as was the case for a number of young people who participated in this doctoral study, must still navigate between the expectations of their parents and community, and associated cultural and religious traditions and beliefs, and those of their peers and non-religious
communities, regarding sexuality and relationships. Whilst recognising religious heterogeneity and variability, and the importance of not generalising cultural or religious groups or individuals (Arousell & Carlbom, 2016), these broad observations regarding religious and cultural perspectives on sexual and reproductive health highlight the influence these can have on understandings, practices and health service utilisation for young people who identify with migrant or refugee communities, including, for example, access to information, use of contraception, STI testing, cervical screening and support for an unintended pregnancy.

Research on the broader health and social needs of people from migrant and refugee backgrounds is under-represented in Australia (Renzaho et al., 2016), which is why the specific issues such as those described above warrant concerted attention. More research is needed to contribute evidence to inform policy and practice, given the incredibly complex range of issues located at the intersection of the already-complex topics of sexual and reproductive health, young people’s health and migrant and refugee experiences. A scoping review of the literature, undertaken as part of this doctoral research study and presented in Chapter 4, found that little is known regarding what influences ‘culturally diverse’ young people’s decision-making in relation to health service attendance for sexual and reproductive health, their service preferences, priorities when using services, or how they negotiate confidentiality and trust issues when attending services. As indicated by the literature discussed in Chapters 3 and 4, most research in this field has focussed on young people more generally, or on ‘culturally diverse’ adult women or people from specific cultural or religious backgrounds. Few studies have been conducted with migrant and refugee young people in the notably diverse Australian state of NSW in relation to their sexual and reproductive health.

Insights such as those described above build a picture of the context and intricacies of the sexual and reproductive health of ‘culturally diverse’ young people in Australia. However, there has been little empirical research that presents the perspectives of young people of any gender from migrant and refugee backgrounds on these issues in Australia, and which considers the gaps and opportunities for this group in sexual and reproductive health service provision from a policy and practice perspective. This exploratory doctoral research was undertaken to investigate the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health information and care in Sydney, NSW. As is described in more detail below, 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-identify as being from a refugee or migrant background. This research study was undertaken to contribute towards a stronger and more empirically grounded evidence base to better address and integrate the needs of young people from migrant and refugee communities into the development of
health policy, to plan effective measures to reduce health and social inequalities among these communities, and to promote equity across the design and delivery of the Australian sexual and reproductive health care sector (Renzaho et al., 2016).

**Aim, objectives and terminology**

Following a period of exploring the literature, consulting widely, and identifying the gaps in knowledge which this research would seek to address, the aim of this doctoral study was articulated as: *to explore youth and professional perspectives to better understand the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health information and services in Sydney, Australia.*

Three subsidiary objectives were then developed, in order to focus the broader research ambitions:

1. To document the perspectives and experiences of young people from migrant and refugee backgrounds on the meanings and practices associated with sexual and reproductive health, information and health care.
2. To explore whether and how migrant and refugee young people engage with sexual and reproductive health services.
3. To identify opportunities for strengthening engagement between migrant and refugee young people and sexual and reproductive health services.

The work undertaken in developing these aims and objectives involved considerable thought regarding language and terminology. The phrase “young people from ‘culturally and linguistically diverse’ backgrounds” was initially used as a shorthand for describing the backgrounds of the young people of interest. This phrasing was informed by the common use of the term ‘culturally and linguistically diverse’ or ‘CALD’ in many Australian government and service contexts. While recognising that this is not a homogenous population, and appreciating that this term may obscure the rich diversity of participants’ lives, identities, backgrounds and experiences, this phrasing is commonly used in Australia to describe people who were born in a country outside of Australia where English is not the main language and was therefore initially utilised for this research. However, following feedback from partner services and interviews with key informants (described in Chapter 2), and during the process of publishing the early research findings in international peer-reviewed journals, a different phrasing was developed prior to commencing recruitment of young people, in order to be more broadly acceptable and intelligible in both Australia and internationally. The phrase “young people from ‘migrant and refugee’ backgrounds” was substituted to describe the main ‘population’ of interest in the
research. This broad descriptor was intended to include any young person aged 16-24 years who had migrated to Australia, whether recently or many years ago, including those who were resident in Australia or an international student, those who were seeking or had been provided asylum as a refugee, or those who were born in Australia but identified with a non-English speaking migrant or refugee family background. Although Aboriginal and Torres Strait Islander people may be considered to be ‘culturally diverse’, they have distinct cultural contexts and social determinants of health. They are not commonly grouped together with migrant and refugee communities at a service and policy level in Australia, and from a research perspective very different processes and ethical considerations are required. Further to this, Aboriginal and Torres Islander people were the first inhabitants of Australia and therefore occupy a very different position in the contemporary social and political landscape to migrants or refugees. A decision was made that Aboriginal and Torres Strait Islander young people would therefore not be included as participants in this study, unless they also identified with a refugee or migrant background. A description of the eligibility criteria for participation is described in Chapter 2, and some of the related limitations of these in Chapter 11.

‘Young people’ were defined as being aged 16-24 years for this research. Whilst young people are commonly viewed as being between the ages of 12 and 24 years, both in Australia and internationally (NSW Ministry of Health, 2017; United Nations Department of Economic and Social Affairs, n.d.), and although research on the sexual and reproductive health of young people in the earlier adolescent period is important (Chandra-Mouli et al., 2015; Starrs et al., 2018), several reasons explain the decision to define the lower age limit as 16 years. This was primarily due to the additional complexities involved in undertaking research with young people under the age of 16 years in Australia, including the likelihood of requiring parental consent for their participation, and the associated ethical constraints presented by this. As relevant background for this thesis, in Australia, young people between the ages of 16 and 18 years will typically be in senior secondary school (years 11 and 12) or commencing tertiary education and/or employment. Migrant and refugee young people newly arrived to Australia may also be eligible to enrol in an Intensive English Centre (IEC) to receive English tuition if they fulfil the following: are newly arrived, speak a language other than English as their first language, intend to enrol in a government secondary school, and are an Australian citizen, permanent resident or approved temporary visa holder (NSW Department of Education, 2017).

A number of other definitions were also discussed and refined in developing the research. The World Health Organization’s working definition of “sexual and reproductive health” was used to inform the research design (World Health Organization, 2017). The elements of sexual and reproductive health of primary interest were those deemed to be of particular relevance to young
people, including healthy relationships, consent, sexuality, contraception, sexually transmissible infections, and accessing related information and services. Although other elements of sexual and reproductive health were relevant, such as fertility, antenatal and postpartum care, and sexual and other forms of gender-based violence and abuse, they were not the primary focus of the research. In addition, when referring to ‘specialised’ sexual and reproductive health services in the thesis, this is primarily referring to those services which articulate a specific focus on sexual and reproductive health issues, and which are relevant to young people, such as sexual health clinics and family planning organisations. All sexual health services in Australia provide free health care to those with and without a Medicare card, and many family planning organisations will waive fees in cases of financial hardship. There are a range of other services in Australia that provide sexual and reproductive health care also, which young people can and do access, including general practices, youth health services, mental health services, abortion services and community health centres. These latter services are referred to during the analyses but were not the primary focus of the research itself.

Despite this preliminary work on definitions, a key underpinning principle of the study was to learn from the perspectives of young people themselves. Therefore, interview questions were phrased as deliberately open-ended and exploratory, so that all discussions were informed by participant’s own definitions, understandings and experiences of cultural diversity, sexual and reproductive health, and the services working in this area.

**Positioning the researcher**

I provide here a brief account of my own background and the perspectives and assumptions I brought to the study as a young person, a sexual and reproductive health nurse, and an English-speaking researcher from an Anglo-Australian cultural background. I have an undergraduate degree in nursing and a dual master’s degree in public health and international public health. I have worked for the last several years as a qualitative researcher and nurse for a not-for-profit sexual and reproductive health service, which was also one of the partner services for this research. Prior to that, I worked as a research associate at UNSW Sydney and as a nurse at a private women’s reproductive health service. I therefore brought to this research a range of experiences from my work as a qualitative researcher with a special interest in sexual and reproductive health, and my clinical experiences working with young people and those from diverse backgrounds in the area of sexual and reproductive health. These will inevitably have shaped the way that I went about designing the research, collecting the data and making sense of it through the processes of coding, analysis and writing.
I believe my background and experiences added value to the research as well as posed several challenges. Working for one of the health services who partnered with this research was particularly valuable, both professionally and personally, as I was able to secure additional support for the research and establish links with other services and networks of organisations, researchers, clinicians and others working in this field. However, this also contributed to a slight over-representation of clients recruited to the study from that service, when compared to other services – likely due to my proximity to the clinics and clinicians who were supporting recruitment. This is described further in the limitations section in Chapter 11. My nursing background and work experience also meant I had clinical knowledge and direct experience of clinic service operations in a related area, which I was able to draw on throughout the research. Undertaking this research contributed to enriching my own clinical practice, as I was able to reflect on what young people were telling me in interviews and apply this to my own nursing work, in particular striving to be non-judgemental, friendly, welcoming and caring, and keeping these front of mind. However, having a nursing background did add some complexities, primarily in relation to not speaking out of turn when participants made misinformed statements about topics such as contraception, sexually transmissible infections and cervical cancer screening. This was an internal conflict and not one I voiced during interviews, unless participants asked me a direct question if they felt unsure about something they had said. I usually suggested we could discuss this after the interview if they were interested, so as not to interrupt the flow of discussion. This occurred on a small number of occasions; I felt comfortable providing educative or reassuring responses after the interview when I deemed it appropriate, and saw this as a form of reciprocity to research participants (Hay-Smith, Brown, Anderson, & Treharne, 2016).

Having both ‘insider’ and ‘outsider’ status (Bhopal, 2010; Manohar, Liamputtong, Bhole, & Arora, 2018, advance online; Milligan, 2016) with the young people participating enabled a level of trust and rapport to develop between myself and participants. As a female, white Anglo-Australian in my late 20s, I had initially assumed I would be taking on an ‘outsider’ role for the research and would be seen as such. However, after commencing interviews with migrant and refugee young people I realised they considered me to actually hold some ‘insider’ status. I attributed this to my age in particular, as they often spoke as though they viewed me as part of their own generation, which they also saw as setting both of us apart from many of the staff working in the services they were discussing (see Chapter 7 for more on this). My ‘outsider’ status as someone not from a notably ‘culturally diverse’ background may also have facilitated a sense of trust, with young people potentially able to speak more openly with me about matters relating to sexual health.
Finally, whilst the research initially took a ‘public health’ approach due to my clinical and public health background, it became more multi-disciplinary during the design phase and as the research progressed, drawing on social science perspectives of gender, sexuality, youth and culture, as described in the next section below. Bringing together these different perspectives broadened my own thinking and reflections and, hopefully, strengthened the study.

**Key concepts**

In exploring the sexual and reproductive health of migrant and refugee young people, particularly their need for, use of and engagement with sexual and reproductive health care, I examined several concepts and approaches to understanding this. As previously mentioned, the World Health Organization’s working definition of sexual and reproductive health guided this research with its focus across physical, emotional, mental and social aspects of well-being, the importance of taking a positive and respectful approach to sexuality and sexual relationships, and promoting pleasurable and safe sexual experiences (World Health Organization, 2017). In addition, whilst there are a number of different traditions and approaches to understanding sexual and reproductive health matters, this research was informed primarily by the more social tradition, which emerged in part in response to the HIV epidemic (Friedman, Kippax, Phaswana-Mafuya, Rossi, & Newman, 2006; Parker & Aggleton, 2003), and to global health developments that shifted attention away from a disease model and towards a more social and structural understanding of what influences and shapes health and wellbeing, including sexual health. While historically much research and policy attention regarding sexual and reproductive health has focused on individual behaviours and risk, there has been a shift over time towards greater recognition of the social and cultural settings within which these take place, and the broader contexts and structures that influence them (Aggleton, 2004; Parker, 2009). Cultural and social elements have also gained increasing acceptance as key conceptual tools for thinking about sexuality, and growing recognition of the social, cultural, political and economic dimensions of sexuality continues (Parker, 2009). There is now a greater understanding that human actions, thoughts and desires are influenced by key elements of social life including norms, values, networks, structures and institutions (Auerbach, Parkhurst, & Caceres, 2011). There is widespread recognition and acceptance of the social determinants of health as fundamental influences on all aspects of health and health care (Commission on Social Determinants of Health, 2008; Marmot, 2005; Viner et al., 2012).

When considering issues regarding the sexual and reproductive health of young people in this context, concepts of culture and gender were also essential to think through. Although ‘culture’ can be difficult to define, as it is neither “monolithic [n]or static but [instead is] variable and
dynamic” (Korbin, 2002, p. 638). Anderson and Reimer Kirkham (1999) usefully conceptualise culture as a “complex network of meanings enmeshed within historical, social, economic and political relationships and processes” (p. 63). This definition of culture supports the inclusion of a diverse range of elements, including ethnic identity, beliefs and values, traditions, nationality, gender, religion, sexuality, language, education, societal norms, social discourse and socio-economic status, shaped by ideas, meanings and beliefs which typically evolve over time (Eaton, Flisher, & Aaro, 2003). Culture in this way of thinking can be seen as a relational dimension of the life of an individual that shifts over time depending on their unique histories, experiences, social, professional and gendered locations, and perceptions of how they are viewed by others (Browne & Varcoe, 2006). Culture was identified as a key concept when designing the research study and its relevance and influence, as well as the inherent complexities and contradictions of this concept, remained clear throughout the research. However, it also appeared to hold less personal significance or relevance to the young people who participated, as described in the latter half of this thesis (see, for example, Chapters 7 and 10).

The concept of gender, as it relates to health, is similarly challenging to define, and definitions and implications vary immensely across societies, contexts and generations (Lyons, 2009). In the 1970s, for example, in the ‘western world’ the concept of gender began to be recognised as distinctive from the biological markers of male and female bodies, and the term ‘sex’, which referred to physiological characteristics, became differentiated from the cultural understandings of a binary gender system (Lupton, 2003). Gender, as it is conceptualised in this research, is therefore recognised as situational, relational, dynamic and agential, with the meanings and expressions of gender being both shaped by, and reproducing of, social structures and conventions (Springer, Hankivsky, & Bates, 2012). This more relational perspective on gender is able to support an interactive interpretation of how gender and health are co-produced, as the fluid and negotiated enactment of gender identities and expressions are intimately interwoven with experiences and understandings of health, and vice versa (Springer et al., 2012). Gender is also recognised as a fundamental component of the social construction and enactment of sexuality (Tolman, Striepe, & Harmon, 2003), which in turn features as an integral part of the everyday lived experience of health (Saltonstall, 1993) across all cultures and contexts. For this doctoral study, participants of any gender were invited to participate and their self-identified gender was recorded; in the final sample, all self-identified as either male or female.

Lastly, this research was also informed by the body of research on the importance of empowerment and agency in promoting health. From this lens, marginalised or ‘vulnerable’ groups can be viewed as being both constrained by the broader structures of the social worlds in
which they live, but also as having the opportunity to exercise agency regarding how they navigate those constraints (Petesch, Smulovitz, & Walton, 2005). The notion of sexual agency in particular, which refers to the practices and opportunities people have to forge their own sexual experiences and trajectories while navigating social expectations and influences (Bell, 2012), has important implications when working with young people, including those from migrant and refugee backgrounds. Having an understanding and appreciation of sexual agency may support the design and provision of sexual health programs and services that aim to recognise the realities of the lives of those they seek to support. In this research, it is assumed that a comprehensive and holistic approach to the promotion of sexual and reproductive health is essential in responding to the needs of young people from diverse backgrounds, and requires that both individual needs and contextual factors be recognised and addressed concurrently (Aggleton, 2004). In undertaking this research, particular attention was therefore paid to appreciating and understanding young people’s sexual agency and the strengths and assets they draw on in navigating complex social and sexual lives (Bell, Aggleton, Ward, & Maher, 2017; Persson & Newman, 2012). These aspects were also revealed in the interviews undertaken with young people, as reported in Chapters 7 and 8 and described further in Chapter 10, highlighting the importance of challenging deficit discourses regarding young people and promoting their strengths and agency. Whilst recognising there are a range of factors that influence sexual health and related health-seeking behaviours (Svanemyr, Amin, Robles, & Greene, 2015), the doctoral research focused primarily on migrant and refugee young people’s perspectives and lived experiences, as well as ‘professional’ views on this. Focusing at both individual and more institutional levels enabled an analysis of young people’s perceptions and experiences and the role that service providers play in creating enabling environments that support young people’s agency regarding their sexual and reproductive health and supporting a practice-oriented understanding of how these key concepts are enacted in everyday, lived contexts.

Thesis structure

This thesis is submitted as a series of publications. Each of the ‘findings’ chapters therefore incorporates a brief review of the literature, methodology, results and limitations of different aspects of the study. Two publications engage only with literature (Chapters 3 and 4) and four present primary data from the research (Chapters 5 and 7-9). Chapter 6 reflects on the walking interview methodology, with a focus on the method and associated ethical considerations. Each publication is included as a chapter here in the format required by the journal/publisher to which it was submitted, apart from table and figure heading numbers which have been updated to flow sequentially in the thesis. This has resulted in slight differences between chapters in terminology, spelling and referencing style, and in some repetition between chapters. Table 1
(below) lists each chapter, its alignment with the study objectives, and the full reference of each peer-reviewed publication.

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<td>2</td>
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*Summary of objectives: Objective 1: perspectives and experiences of young people from migrant and refugee; Objective 2: whether and how migrant and refugee young people engage with sexual and reproductive health services; Objective 3: opportunities for strengthening engagement between migrant and refugee young people and sexual and reproductive health services.

With the exception of Chapters 1 and 2 (Introduction and Research methodology) and Chapters 10 and 11 (Discussion and Conclusion), the thesis comprises seven completed publications. These have all been published in national and international peer-reviewed journals, with the exception of Chapter 3 which was published in an international Handbook and received two rounds of peer-reviewer comments before being finalised for publication. An authorship declaration form for each publication, indicating the proportion of contributions by each author, is included at Appendix 6. In all cases I was the first author; I led the writing of each paper and managed the incorporation of feedback from co-authors, thus contributing 75-85% of the work and effort of producing each publication.

As just noted, this thesis is organised into 11 chapters. Chapter 2 provides a detailed overview of the methodology employed in the research. Chapter 3 presents findings from a literature review published in a Handbook that focused on global issues relating to the sexual and reproductive health of young people from diverse migrant backgrounds, using Australia as a case study in contemporary multiculturalism. Chapter 4 is based on a scoping review of the literature undertaken to describe the range of research available on sexual and reproductive health among ‘culturally diverse’ young people in Australia. Chapter 5 reports findings from key informant interviews on the complexities of, and best practice approaches to, engaging young people from ‘culturally diverse’ backgrounds with sexual and reproductive health.
promotion and care. It is worth noting here that Chapters 3-5 use the language ‘culturally diverse’ young people, whilst the remaining chapters use ‘migrant and refugee’ young people (see earlier in Chapter 1 for further discussion regarding this phrasing). This change in phrasing commenced prior to the recruitment of young people, and so the revised terminology is used in the chapters which report on that data, i.e. Chapters 6-9. Chapter 6 provides an overview of my experiences in conducting walking interviews with migrant and refugee young people for this research. It focuses particularly on the ethical considerations of employing this method to elicit rich data on young people’s views of different services for sexual and reproductive health. Chapter 7 then explores how generational discourse was articulated by migrant and refugee young people in describing their own experiences and their preferences regarding the characteristics of those who provide sexual and reproductive health information and services. Chapter 8 reports on key issues relating to relationships and sexuality education and other sources and forms of information about sexual and reproductive health that are accessed by migrant and refugee young people living in Sydney. It provides accounts primarily from migrant and refugee young people, however key informant perspectives were also included to complement findings. The final results chapter, Chapter 9, reports on the experiences and views of migrant and refugee young people on accessing general practice for sexual and reproductive health care. The discussion chapter of this thesis, Chapter 10, draws together the key findings and is organised around three overarching themes: i) negotiating multiple dimensions of identity, ii) keeping secrets and maintaining ‘face’, and iii) building trust and safety in service settings. Chapter 11 concludes with a discussion of the study’s strengths and limitations, proposes future research, and summarises final conclusions.
References


Chapter 1: Introduction


Chapter 1: Introduction


Chapter 2: Research methodology

This chapter describes the methodological details of the doctoral study. The chapter commences with a description of the theoretical positioning adopted in the research, and then provides an overview of the research design, ethical considerations, data collection methods and analysis. The chapter concludes with a summary of the different ways in which analytic findings from the research have been developed and disseminated.

Theoretical orientation

A qualitative design, specifically qualitative interviewing, was adopted to support the exploratory aims of this research. Qualitative interviewing is widely used in health research and enables an exploration of complex issues or topics on which little is known (Nathan, Newman, & Lancaster, 2018, advance online). Data produced in this way provides rich contextual information and offers essential insights regarding the experiences and contexts shaping health (Temple-Smith & Hocking, 2014). A qualitative design was therefore chosen for this research as it enabled a more open-ended exploration of the perspectives and experiences of participants (Hennink, Hutter, & Bailey, 2011) in order to develop a better understanding of their views and actions in the context of their own lives (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2003). Qualitative methods were utilised to explore both insider (emic) and outsider (etic) perspectives (Degni, Suominen, El Ansari, Vehviläinen-Julkunen, & Essen, 2014; Leininger, 1997), that is, the perspectives of migrant and refugee young people, and of professionals working in related fields. The research was further informed by principles developed within grounded theory methodology, in that an exploratory and open-ended approach guided the development of the research design and fieldwork and themes were identified and developed during the conduct of the research (Liamputtong, 2009). However, the detailed practices of grounded theory were not followed overall, including using grounded theory coding systems for analysis or developing a new theory (Liamputtong, 2009), as generating theory from the empirical findings was not the aim of the research. Rather, the study was guided largely by an interpretivist epistemology and constructionist ontology, as described in the following paragraph. This approach supported the primary interest of documenting and more intimately understanding the views and experiences of an often-hidden population, and the professionals who seek to engage them, in their diverse social and relational contexts.
Utilising interpretive and constructionist approaches in qualitative research meant focusing on understanding lived experiences from the points of view of those who hold them (Ritchie et al., 2003). Interpretivism is a broad epistemological position that emphasises the role of both reflection and interpretation in understanding the social world (Hennink et al., 2011; Snape & Spencer, 2003). This position sets up a clearly contrasting epistemological position to positivism, which aims to produce objective measurements of social reality, believing that a kind of ‘truth’ is available to researchers should they find the right techniques and tools for observing and measuring reality in an objective manner (Hennink et al., 2011). Interpretivism, however, recognises that ‘reality’ is socially constructed, and therefore is only able to be ‘known’ through the particular lens of those who are seeking to represent it through their own socially-situated viewpoints and accounts. This epistemology therefore aims to produce research insights by examining these accounts, and seeking to understand how reality is represented from the point of view of those who experience it, rather than assuming there is a reality which is truthful and accessible ‘behind’ those accounts (Ransome, 2013).

Interpretivism recognises that every account is shaped by language, culture and context, which is in itself revealing and productive of how people make sense of their world. This view of research also very clearly recognises the role of the researcher in mediating, and even actively co-producing, the meanings derived from observing the phenomena being investigated. Adopting an interpretivist approach requires the researcher to be open-minded, curious, flexible and willing to listen to people’s own accounts, rather than seeing them as a conduit to a truth which sits behind those accounts (Hennink et al., 2011). Interpretivism is also informed by social constructionism, which similarly recognises that knowledge and meaning is actively produced or constructed by human beings and their engagement with the world (Crotty, 1998; Ritchie et al., 2003), asserting that social phenomena and their meanings are only able to be known through social interactions, and are therefore in a constant state of revision (Bryman, 2016). This approach challenges the notion that culture, for example, can be identified as a specific and stable reality that acts on and constrains people; rather, it is an emergent reality that is in a continual state of construction and reconstruction (Bryman, 2016). The exploratory nature of this doctoral research into the interplay between cultural diversity and sexual and reproductive health was well suited to a qualitative research design, which also provided a good fit with the interpretive and constructionist paradigms underpinning the research. In undertaking this research, I did not seek to determine a fact, truth or reality but rather to collate and analyse a series of accounts, while also recognising my own influence as the lead researcher (see Chapter 1), and the limitations of the research on what these accounts revealed (see Chapter 11).
Chapter 2: Research methodology

Research setting and design

The research was conducted in Sydney, the capital city of the Australian state of NSW. Sydney is the largest Australian city, comprising over five million residents, and it also has the largest overseas-born population (Australian Bureau of Statistics, 2017). Greater Western Sydney, a region of particular interest for the research, comprises the north-west, south-west, central-west and western sub-regions of greater metropolitan Sydney, and is one of the most ‘culturally and linguistically diverse’ regions of NSW (.id the population experts, 2015). Approximately 38% of its population was born overseas, 42% speak a language at home other than English, and 14% are aged 15 to 24 years (.id the population experts, n.d.).

Two different literature reviews were undertaken which informed and strengthened the research design. A broad literature review was conducted to review relevant research on sexual and reproductive health care among young people from migrant and refugee backgrounds globally, although with a particular focus on Australia as a case study (see Chapter 3). A scoping review of the literature was also undertaken to more systematically examine the existing knowledge base and identify gaps in the literature regarding young people from ‘culturally diverse’ backgrounds and sexual and reproductive health services in Australia (see Chapter 4). The scoping review in particular provided a useful way to map the field of study, enabling an examination of the extent, range and nature of research activity and assisting with identifying research gaps in the existing literature (Arksey & O'Malley, 2005).

To further inform the research design, extensive consultations were conducted with health services involved in providing and promoting sexual and reproductive health care for young people in NSW. Existing relationships between myself and my supervisors with those working in this field were drawn on in making initial connections and establishing and building trust, with the aim of adopting a collaborative approach to co-designing the most useful and appropriate research that was possible within a doctoral candidature. To build these relationships and partnerships, I first sent email invitations to prospective partner investigators known to myself or my supervisors. When I received positive responses, I then met with that person, as well as their head of department, if appropriate, to discuss the research ideas in more detail and ascertain their and their service’s interest in supporting the research as a more formal partner. In the end, six health services were approached and all agreed to formally partner in the research: Family Planning NSW, High St Youth Health Service, NSW Refugee Health Service, Liverpool Sexual Health Clinic, Western Sydney Sexual Health Centre, and Sydney Sexual Health Centre. The following descriptions of each service pertain to the
context at the time the research was conducted. Family Planning NSW was a non-government organisation with a specific focus on sexual and reproductive health for all communities in NSW, and two of its five clinical sites were involved in the research. The remaining five services were government public health organisations. Three were sexual health clinics which focused primarily on testing and treatment of sexually transmissible infections for ‘priority populations’ including Aboriginal and Torres Strait Islander people, men who have sex with men, young people, and sex workers. Another partner service was a youth health service, which provided multidisciplinary, primary healthcare to disadvantaged young people, and the other was a refugee health service, which supported the health of people from a refugee background living in NSW. After the preliminary meetings with each, I visited the services again to talk to other staff about the study and seek their feedback on the proposed aim, objectives and methods. This included attending staff meetings and informally discussing the research with those who were interested in speaking with me, as well as through more formal presentations to staff along with questions and discussion afterwards.

A member of staff from each of the partner services participated as a partner investigator on the study, to provide support and to function as the local investigator in relation to site-specific ethics applications, which was a requirement for securing ethics approvals to recruit participants through public health organisations in NSW. As the partner investigators, Dr Deborah Bateson, Ms Katherine Bennett, Dr Christopher Carmody, Mr Brendan Crozier, Dr Melissa Kang, Dr Catriona Ooi and Dr Mitchell Smith provided advice and feedback on the research design and methods, represented their service on ethics applications, supported recruitment of participants, and co-authored a short summary report (Appendix 2). Two also contributed as a co-author on journal articles in their area of particular interest.

These various consultations and meetings helped to confirm that the priorities and proposed aims of the research were considered valuable by those services and staff, and informed decisions such as the eligibility criteria for participation, research locations and recruitment strategies, which are described further below. This consultation process extended over a period of several months and informed the development of the research proposal and the associated ethics applications. Feedback sessions at each service were also built into the research design, given the level of interest among staff in what the research was aiming to understand; these sessions will be undertaken upon completion of this thesis. All partner services and partner investigators were very enthusiastic and supportive of the research, and this commitment remained robust throughout the period in which the research study was conducted.
It was initially thought that the study might include an ‘organisational analysis’ of the participating partner services as one of the methods. This would have involved a critical review and appraisal of the policies, structures and philosophies operating within each service, in order to better understand how they were structured and managed, how they presented themselves to potential clients, and what they saw as their specific role(s) in this field. Although this component of the research may have proved insightful, a decision was made to exclude this form of data collection, as the other components of the study, described below, were proving to be extremely time intensive and were also providing an adequately rich range of insights regarding the research aim and objectives. Furthermore, although the aim of the organisational analysis was to build a general picture of the way that services seek to engage migrant and refugee young people across the sector, rather than analysing the practices of specific organisations in isolation from one another, it was felt there were still some risks of identification in doing so, and therefore potential risks to organisational image or reputations. This particular component of the study was therefore not undertaken.

A Youth Advisory Group was established as one way of attempting to ensure the research was informed by ‘culturally diverse’ young people themselves. Initial members of the group were invited through personal networks, whereby my supervisors and several of their colleagues emailed young people over the age of 18 and from a migrant or refugee background who they thought might be interested in participating and suggested they contact me directly if so. Although the membership changed slightly over the course of the research, a total of four females and four males were involved in the Youth Advisory Group altogether. The majority were studying an undergraduate degree at university. No incentive was offered for their participation in the group, apart from the offer of refreshments and travel reimbursement for attending group meetings. Whilst a number of attempts were made to meet face-to-face in the early stages of the research, this proved challenging, primarily due to conflicting schedules and other commitments among the group. As an alternative to meeting face-to-face, a private, closed Facebook group was established and the group ‘met’ and discussed aspects of the research through that mechanism. The Facebook group was not searchable or viewable to those outside of the group. Introductions between members were shared via the Facebook group, and members provided feedback on the draft recruitment flyer and website by ‘commenting’ on these online. With few other options this worked reasonably well, although it was not ideal and it made it difficult to receive in-depth feedback. It was also likely that members did not truly feel a part of the group, as they had not met in person. I tried to overcome this by sharing short updates every few months via the Facebook group and email as the research progressed, however there was little response or engagement from group
members unless they were specifically asked for feedback or comments. It was not until
towards the end of the research that the Youth Advisory Group met face-to-face. At this
meeting I shared some of the key findings with the group and they provided their observations
and views on these. Feedback received at this meeting contributed in particular towards
refining the recommendations and more practical suggestions for services, which are
documented in a short report (Appendix 2). Meeting in person was very valuable as it enabled
greater discussion amongst the group and elicited a more detailed range of insights.

Participatory and collaborative approaches to research in which ‘consumers’ and services are
involved, such as those undertaken for this research, helps to ensure greater relevance of the
research and outcomes (Boote, Telford, & Cooper, 2002) and can help to promote uptake of
findings in policy and practice (Bowen & Zwi, 2005). These approaches were therefore
employed in this research. Doctoral students may not always be supported to invest in such a
thorough participatory research design as the one which featured through this research study,
and it was of great benefit that it was possible for this research. Although it required
considerable time in establishing relationships, visiting services, building trust, and seeking
and incorporating feedback throughout the research, the involvement and contributions from a
diverse range of people proved extremely beneficial in strengthening the research design and
ensuring the research was relevant and appropriate at all times.

Ethical considerations

After the extended period of meetings and consultations during the early stages of the
research, I began the equally extensive process of applying for and securing ethics approvals.
Given the number of health services that partnered in the research, and combination of both
government and non-government services, a complex strategy for seeking ethical approval
was required. Ethics approval was first obtained from the UNSW Sydney Human Research
Ethics Advisory Panel: Social and Health Research, a discipline-based panel concerned with
research with low-risk ethical impact, which enabled the commencement of ‘professional’ key
informant interviews. While these were underway, additional ethics applications for the
different sites involved in the research were developed and submitted. In Australia, particular
ethics approvals are required for multi-centre human research projects undertaken in
government public health organisations, of which five of the partner services in this research
were. As part of the ‘National Mutual Acceptance of scientific and ethical review of multi-
centre human research’ (NSW Health, 2017) a research proposal can be ethically and
scientifically reviewed by just one ethics committee; their approval will be recognised by all
participating sites, who will then undertake a site-specific assessment before granting final approval. Whilst this process is designed to reduce duplication in the scientific and ethical review of multi-centre research, in practice it was still a very lengthy process for this research. The Western Sydney Local Health District (LHD) Human Research Ethics Committee (HREC) was chosen as the ‘lead’ ethics office from which to obtain ethical approval for the research, as two of the partner services were located within their jurisdiction. Following this overarching approval, site-specific applications were then submitted for review by the Western Sydney LHD, South-Western Sydney LHD, and South-East Sydney LHD research governance offices to cover the partner services located within their jurisdictions. In addition to this, two non-government organisations engaged in the research, one involved as a partner service and the other who assisted primarily with recruitment, had their own ethics committees that required their own ethical review for their participation.

In the end, ethical approval for the research was received from the UNSW Australia Human Research Ethics Advisory Panel: Social and Health Research (approval #HC15381), Western Sydney LHD HREC (approval #4407), Family Planning NSW Ethics Committee (approval #R2015-02), and the AIDS Council of NSW (ACON) Research Ethics Review Committee (approval #2016/09). Site-specific approval was received for each of the five public health organisation sites. These various approvals allowed for staff at each service to be invited to participate in the research as ‘key informants’ as well as for the participation of each site in the research more generally, including providing support for recruitment of young people.

Securing these ethical approvals was a complex and at times challenging and time-intensive process. It required multiple re-submissions due to the varied, and sometimes conflicting, feedback from different committees (see Chapter 6 for more on this), with some taking a more conservative position in relation to certain aspects of the research (Treharne & Marx, 2018). This included one committee approving and another forbidding the provision of a $30 gift voucher for young people’s participation, and one committee approving participation by those 16 years and over without parental consent and another initially insisting on parental consent. As ethical approval was granted at slightly different times by the different committees, amendments then also had to be submitted for changes which were requested by one committee after the initial approval process had been completed by others. In addition, although the governance offices for each partner service recognised the ‘lead’ approval, they had queries and requirements specific to their own sites, which had to be addressed prior to receiving their approvals. Each ethics and governance office also had different requirements in terms of submitting paperwork and obtaining signatures, with some allowing a single
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electronic or scanned signature and electronic submission, while others stipulated hard copy submissions with original ‘ink’ signatures of all investigators. In total it took approximately 6 months to receive all approvals. This had to some extent been anticipated, based on past experience and discussions with colleagues, and had been built into the study timeframes accordingly, however it was still a long process. Overall, the various feedback received was valuable and provided a robust ethical framework and set of guidelines within which to conduct the research.

Over the course of the research, several ethics amendments were submitted to incorporate modest changes in design. These were submitted to the relevant ethics committees, and then also to the individual governance offices for each site following the ‘lead’ approval from Western Sydney LHD HREC. Amendments included adding additional sites for interviewing members of staff as key informants and for recruiting participants, changing several partner investigators due to staff changes at partner services, adding a study website to support ‘word of mouth’ recruitment, recruiting through community-based organisations and networks, and inclusion of non-English speaking participants and the use of interpreters.

The design and conduct of the research was guided at all times by the values outlined in the National Statement on Ethical Conduct in Human Research (2007)- Updated May 2015:\(^2\): research merit and integrity, justice, beneficence, and respect (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors’ Committee, 2007 (Updated May 2015)). A number of important ethical matters that were considered prior to and during the conduct of the research are outlined below under each of these values. As the research was undertaken with young people (16-24 years) from migrant and refugee backgrounds, additional issues were considered and addressed in preparing the ethics applications (Liamputtong, 2009; National Health and Medical Research Council et al., 2007 (Updated May 2015)); these are included below and a case study of some of these is also described in Chapter 6.

**i) Research merit and integrity:** It was anticipated that findings from this research would make a contribution to knowledge and understanding and to the improved health and wellbeing of individuals, primarily through the enhancement of health services. Additionally, the research produced findings that shared accounts and ‘gave voice’ to young people often hidden from policy and research (Wilson & Neville, 2009; Ziersch, Due, Arthurson, & Loehr, 2007). Since completing the study in 2018, the National Statement has undergone another iteration and was updated in 2018.
In this case, young people identifying as migrants or refugees. The research was justifiable by these potential benefits, which outweighed the potential risks described further below. The research design utilised qualitative methods which were deemed to be appropriate for achieving the research aims, as described in the previous theoretical section of this chapter. Qualitative methods are well recognised as being appropriate for research with ‘vulnerable’ populations, including those from minority ethnic backgrounds (Liamputtong, 2009). The consultations undertaken in designing the research also acted as a form of peer review to enhance the research and further ensure its merit (National Health and Medical Research Council et al., 2007 (Updated May 2015)).

The research was well-planned, informed by a thorough review of the existing literature and extensive consultations, and undertaken by experienced and competent researchers who had appropriate experience, qualifications and competence to conduct and support the research (Mooney-Somers & Olsen, 2017). The research team consisted primarily of myself and my doctoral supervisors, along with a team of partner investigators who provided support and advice. As the doctoral researcher, I led all aspects of the research, including the research design, obtaining ethics approvals, collection and analysis of data, and the drafting and refining of publications. My supervisors Professor Anthony Zwi and Associate Professor Christy Newman provided guidance and input at all stages. The expertise of my co-supervisor, Dr Alison Rutherford, who is a clinic-based sexual health physician and researcher, was drawn on as needed. All three supervisors had extensive experience in sexual and reproductive health research and were able to contribute different perspectives in drawing on public health and policy, development studies, sexual health medicine, qualitative social research, and health sociology. The partner investigatory team, who had a supportive and advisory role rather than an active role in the research, also comprised researchers and clinicians who contributed a range of expertise in qualitative research, working within service and policy environments in the Australian health system, and/or working with young people and migrant/refugee communities. As described earlier in this chapter, partner investigators provided advice and feedback on the research design and methods, represented their service on ethics applications, and supported recruitment of participants. They were not involved in data collection and were not aware of who did or did not participate in the research. All partner investigators recognised the need for enhanced understanding in this field and held a genuine commitment to the research and to supporting the dissemination and communication of results. Examples of this included sharing upcoming conference opportunities for me to consider presenting at, co-authoring a short report (Appendix 2), and inviting me to present research findings to their associated services.
ii) **Justice**: The process of recruitment for the research was undertaken at ‘arm’s length’ at all times, meaning I did not directly invite young people to be involved in the study so that none felt pressured to participate (Nathan et al., 2018, advance online). Given the professional role and expertise of key informants, it was expected that they would feel comfortable to ignore or decline my email invitation to participate if they wished. I also attempted to ensure there was no unfair burden or expectation placed on participants, for example by remaining as flexible as possible to accommodate their preferences for meeting times and locations and being understanding and providing reassurance if a participant requested an interview be rescheduled. Participation was voluntary and all prospective participants were made aware they were welcome to leave the study or disengage from discussions at any point. The eligibility criteria for young people were made clear through discussions with them and as documented on the participant information sheet (see Appendix 3 for all Participant Information and Consent Forms for one site), and it was apparent that all participants felt they fit the eligibility criteria as they elected to participate. Most key informants and all young people provided consent to participate in the research in writing, although several key informants consented verbally. Verbal consent to audio-record the interview was also sought at the start of each interview with both key informants and young people. All interviews were undertaken in agreed locations, and travel expenses up to $30 were reimbursed for young people. Interview transcripts were not routinely offered back to either key informants or young people due to concerns about confidentiality, although ethics permitted a de-identified copy to be provided if this was specifically requested. No participants asked for this. ‘Member checking’, whereby participants review their data for validity and accuracy (Liamputtong, 2009), was therefore not undertaken as a matter of course. Following interviews, I asked participants if they were interested in being sent publications from the research via email, in order to share research outcomes with those who wanted this. All key informants and several young people were interested in this and have been emailed publications as they have become available online.

iii) **Beneficence**: As previously noted, the potential benefits of the research were believed to outweigh the potential risks of harm or discomfort to key informants and young people. The potential risks to young people included feelings of discomfort or embarrassment when discussing potentially sensitive issues, or if they felt unsure of how to provide ‘correct’ answers. To minimise this risk, they were reassured that they did not have to answer any questions they did not wish to, that there were no right or wrong answers, and that they could leave the interview altogether if they wished, with no repercussions. Another less likely but
possible risk was that participating in the research might uncover memories of trauma or cause young people to re-visit unpleasant past experiences; young people from refugee or asylum seeker backgrounds in particular could experience recurrence of psychological distress (Phillips, 2014). The participant information sheet therefore included a local organisation and contact details for any participant who wished to seek support or counselling. All of the partner services involved in the research were also experienced clinical services and able to provide support if appropriate and desired by the young person. Fortunately, no key informants or young people withdrew from an interview, declined to answer any questions, or showed any signs of distress during or after the interview.

Whilst the research was not expected to directly benefit any participants and the study had value beyond providing insights into the sexual and reproductive health needs of individual participants as noted earlier in this section, a benefit may have occurred in that young people’s awareness was raised about different services during the interviews, and perhaps also their confidence in accessing these, particularly as a result of the walking interviews (described further below and in Chapter 6). Partner health services assisted with recruitment which potentially introduced some bias as participants may have had knowledge of and access to that service already. However, all participants who took part in a walking interview had never accessed, nor had most even heard of, the service they walked through prior to participating in this activity. Several participants expressed interest in using one of the services as a future client and some collected a brochure as they left. Several participants across the full sample also commented that they liked being involved in the research and felt like they were contributing to something important.

The confidentiality of participants was maintained at all times, and care was taken that no key informant or young person would be identifiable in the findings. Young people could choose whether to share their real name or not during the interview process, and they self-selected a pseudonym for reporting purposes. Interviews were undertaken at a location chosen or agreed by participants, and interview transcripts were fully de-identified. Participants recruited for a first interview through one of the partner health services did not undertake a walking interview at that service in order to preserve their anonymity as a research participant, and to ensure they were not already familiar with the service. The management and retention of research data was guided by the Australian Code for the Responsible Conduct of Research (National Health and Medical Research Council, Australian Research Council, & Universities Australia, 2007). This included, for example, that all interviews would be de-identified, and that all research data would be stored securely in the locations agreed in the ethics applications, for a minimum of
seven years. Spreadsheets with participant names were password-protected and saved separately to interview transcripts.

**iv) Respect:** I aimed to acknowledge the value and contributions of key informants and young people at all times, to respect their privacy, confidentiality and any potential cultural sensitivities, abide by the values of research merit and integrity, justice and beneficence, and consider their welfare, beliefs, perceptions, customs and cultural heritage (National Health and Medical Research Council et al., 2007 (Updated May 2015)). Given the challenges more newly arrived migrants and refugees may face during their early years of resettlement, I strove not to add to the burdens of resettlement but rather tried to ensure their participation was a positive experience for them (Gifford, Bakopanos, Kaplan, & Correa-Velez, 2007). This included, as previously noted, remaining flexible in terms of meeting times and locations, rescheduling interviews if required, and offering refreshments prior to starting interviews if the interview was undertaken at a service that provided this.

Research involving young people can raise additional ethical concerns about their capacity to understand what the research entails, and therefore whether their consent to participate is sufficient. The potential increased risk of coercion on young people to participate in research, and conflicting values and interests between parents and their children, can complicate this further (National Health and Medical Research Council et al., 2007 (Updated May 2015)). However, young people are able to consent for themselves without the additional consent of a parent or guardian (Flicker & Guta, 2008; Sprieggs, 2010) when the young person is “mature enough to understand and consent” (4.2.8) (National Health and Medical Research Council et al., 2007 (Updated May 2015)). In relation to this study, after much consideration it was decided that obtaining parental consent for young people aged 16-18 years might act as a barrier to their participation, given the focus of the research was on an often-sensitive topic area, and this argument was successfully made in the ethics application submissions. Due scope was given to young people’s capacity to make their own decisions and provide voluntary, informed consent for this research, and all prospective participants were therefore ‘screened’ prior to taking part in an interview. This was done informally either prior to meeting if we spoke first over the phone, or in person during the informed consent process. This process involved describing the research and what would be done with the interview data, the risks and benefits of participating, my role in the study, and answering any questions. It was made clear to all prospective participants that their participation should be voluntary and that they could choose not to answer questions or to withdraw from the study altogether if they wished. Based on my discussions and interactions with them I then made a judgement as to
whether I felt they had sufficient maturity to understand the information provided, what they were agreeing to participate in, and give their informed consent for this. This process of being deemed ‘Gillick competent’ is the process by which young people aged 16 and 17 are able to be engaged with sexual and reproductive health services without parental consent in NSW. To be deemed ‘Gillick competent’ the young person must have “sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (the ’mature minor principle’)\(^3\). After speaking to prospective participants, either over the phone or in person prior to their interview, I felt all were mature enough to understand the research, the implications of their participation and to provide voluntary, informed consent. For key informants, given their professional roles and expertise, it was expected that they would feel comfortable to ignore or decline the email invitation to participate in an interview if they wished.

The design and conduct of this doctoral research was guided at all times by these ethical values of research merit and integrity, justice, beneficence and respect and the associated principles outlined in the *National Statement on Ethical Conduct in Human Research (2007)-Updated May 2015*. No unanticipated ethical issues arose during the conduct of the research, or at the time of submitting this thesis, and so no incidents or issues were reported to any of the Ethics Committees.

### Data collection

Once ethical approvals were secured, data collection via qualitative interviews was undertaken with key informants and migrant and refugee young people in order to gain a better understanding of the complexities and opportunities for engaging the latter group with sexual and reproductive health information and care. Drawing on these different perspectives aimed to enrich the breadth of insights extracted from the research and strengthen the quality and credibility of findings (Liamputtong, 2009). Interviewing both ‘groups’ (key informants and young people) and undertaking several rounds of interviews with young people also supported the triangulation of data. Following a semi-structured format for all interviews meant that interview guides with pre-determined open-ended questions were utilised (see Appendix 4), however additional clarifying and follow-up questions were also asked to probe further on certain points (DiCicco-Bloom & Crabtree, 2006). The first few interviews conducted with each of the two groups were considered to be ‘pilots’, and the interview guides were subsequently refined slightly, primarily in relation to simplifying some of the wording of the questions. Piloting the interview guides ensured the interview questions were appropriate and

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\(^3\) Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112
clear to the interviewees (Bryman, 2016), and was also particularly beneficial to me as the interviewer in familiarising myself with the interview guides and gaining confidence in interviewing. All pilot interviews were included in the datasets.

It was intended that data collection would continue until the data was deemed rich enough to support the desired analyses of the research aim and areas of interest. The concept of ‘data saturation’ in qualitative research refers to this idea, in which the focus remains on quality and depth, rather than quantity (Liamputtong, 2009), and when a sufficient range and depth of data is judged by the researchers to have been collected in order to fulfil the research objectives and additional interviews are adding little that is new (Mason, 2002; Patton, 2002). Nonetheless, prior to starting data collection, a selection of qualitative studies included in the scoping review of the literature (see Chapter 4) were reviewed in order to appraise their sample sizes. These varied greatly, ranging from \( n = 10-29 \) participants in studies with young people and \( n = 2-15 \) participants in studies with key informants. Alexander and Cosgrave (2014) cite Guest, Bunce, and Johnson (2006) who suggest that for key informant interviews, data saturation can be reached within \( n = 6-12 \) interviews. However, they also note that this example is talking about research being conducted with homogeneous samples, and that a greater number may be needed when examining a diversity of perspectives, as was the case for this research. Adler and Adler, in Baker and Edwards (2012), suggest the “best bet is to advise in the broad range of between a dozen and 60, with 30 being the mean” (p. 10) Using these examples as a guide, the approximate sample sizes for the two groups in this research was proposed as: at least \( n = 15 \) key informants and \( n = 25-35 \) young people. The recruitment and data collection process for both key informants and migrant and refugee young people is described below.

**Group 1: Key informants**

Interviews with key informants were undertaken first in order to gather contextual information to support the ‘scoping’ of key issues and to develop a comprehensive picture of professional views on the challenges and opportunities for engaging migrant and refugee young people with sexual and reproductive health care. Most of these interviews were conducted before the interviews with young people commenced. There was some overlap, however, as additional prospective key informants were identified as the study progressed, and interviews with key informants therefore continued to be recorded throughout the period of fieldwork.

Key informants were ‘professionals’ who worked in either sexual and reproductive health, youth health, or migrant and refugee health, and who were invited to take part in an interview in order to contribute their views on the key issues shaping the sexual and reproductive health
needs and experiences of young people from diverse cultural backgrounds. I aimed to interview as broad a range of professionals as possible, including health service providers (clinicians and managers) working in both public and non-government sexual and reproductive health, youth health and refugee health services; sexuality, HIV and migrant health advocates and community organisation representatives; policy/decision makers working in NSW Health (state-level government); and academics with expertise in the area of sexual and reproductive health and/or young people. The majority of recruitment targeted professionals working in metropolitan NSW, although several non-NSW-based professionals in Australia were invited to participate based on their recognised expertise in order to seek their insights on these issues more broadly. ‘Culturally diverse’ key informants were not purposefully recruited, and nor were socio-demographic characteristics asked; given their professional roles a decision was made that it would be inappropriate to ask about their personal backgrounds and could reduce their anonymity as respondents. More on this is described in Chapter 11. All prospective key informants were purposively identified through formal and informal networks, that is, through consultation with colleagues and others known to myself and my supervisors, or who were identified through their nominated roles on institutional websites or in key documents. In most cases, contact details were already known or were available on public organisational websites or documentation, and in other cases, contact information was able to be sourced through professional networks. All prospective informants were sent an invitation to participate in an interview via my university email account, which included a description of the study and the reason for their ‘selection’ as a prospective key informant. The Participant Information and Consent Form (Appendix 3) was attached to the email. Key informants who were interested in participating were asked to send me a return email stating this, and I then followed up with them to arrange the interview. If I did not receive a response to my initial invitation within two weeks, one follow-up email was sent. If there was still no response after this, I did not contact them again. The majority of professionals contacted responded to my email invitation. Five of these who responded did not feel they could assist sufficiently, with most recommending an alternative contact who I then emailed and invited to participate. Altogether eight prospective informants did not respond to either my initial or follow-up email.

In total, I conducted interviews with 34 key informants between August 2015 and May 2017, either in person (n= 6) or over the phone (n= 28). Key informant characteristics are documented in Table 2. Each informant was given the option of doing the interview in person, for those based in NSW, or over the phone. The majority opted for a phone interview. The reason for this was not asked, however I believe it was most likely chosen for convenience (Sturges, 2004) and practicality for some due to geography (Stephens, 2007). Face-to-face
interviews took place in a quiet location agreeable to myself and the key informant, such as their place of work or a café. No differences were apparent between the phone and face-to-face interviews in terms of the rapport established or in the quality of the interviews. One phone interview was initially challenging due to a poor-quality line, however the interviewee was able to move locations to resolve this. The interviews undertaken with key informants explored their understandings and experiences of cultural diversity and sexual and reproductive health, whether that be in developing policy on youth health, providing clinical services to young people, or promoting the health and inclusion of migrant and refugee people. The phrasing ‘culturally diverse’ was used during these interviews with key informants to describe the young people of interest for the research. In fact, the data gathered during the key informant interviews in relation to their views and conceptualisations of this phrase contributed to re-phrasing this language to ‘migrant and refugee’, as described in Chapter 1. An interview guide was utilised for all interviews; one for health service providers and another for all others (see Appendix 4). Both guides had similar questions, however they were worded slightly differently to account for the differing work types. Interviews were kept short, in recognition of busy schedules and competing demands on key informant’s time, and ranged in duration from 20-45 minutes. No inducement was offered for their participation, given that they were being interviewed on the basis of their professional roles. Findings from the key informant interviews are described in Chapter 5 and more briefly in Chapter 8.

**Table 2: Key informant characteristics**

<table>
<thead>
<tr>
<th>Key informant category^</th>
<th>F</th>
<th>M</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service provider</td>
<td>15</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Policymaker</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Community organisation advocate</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Academic</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>10</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

^A number of key informants worked across a range of clinical, managerial and/or academic roles

*Chapter 5 reports findings from the first 23 key informants interviewed

**Group 2: Migrant and refugee young people**

Young people from migrant and refugee backgrounds were the primary participants for the research. As a key aim was to better understand the issues that particular services face in effectively engaging young people from diverse cultural backgrounds, and since these services do not restrict their focus to particular cultural or language groups, the eligibility criteria for participation were purposefully broad. It was hoped this would contribute to understanding
how cultural diversity was conceptualised in the service contexts of interest to the research, and through the diverse perspectives of young people from a range of cultural and language backgrounds. The eligibility criteria for participation was also purposely not defined on recruitment materials or to prospective participants as I was interested in young people self-identifying with this, rather than me pre-determining who should be included in that category. Participants were therefore not required to ‘prove’ they fit the eligibility criteria, but rather were able to participate if they felt they did fit the scope of the research. As described earlier, however, all participants were still ‘screened’ prior to participating to ensure I felt they had sufficient maturity and capacity to provide their own voluntary, informed consent.

Following feedback from partner investigators and partner services when designing the research, and after careful consideration of feasibility and ethical issues, the eligibility criteria for participation was decided as: 1) aged between 16 and 24 years at the time of the research, 2) reside in Sydney NSW (either permanently or temporarily), 3) identify with a migrant or refugee background, and 4) speak a language other than English. The rationale for each criterion is briefly included here; further detail regarding language and phrasing is included in Chapter 1 and some of the limitations of this in Chapter 11. Whilst ‘young people’ are generally considered to be aged between 12 and 24 years (NSW Ministry of Health, 2017; United Nations Department of Economic and Social Affairs, n.d.), the lower age limit of 16 years was chosen for this research primarily due to the additional complexities involved in undertaking research with young people under the age of 16 years, including the likelihood of requiring parental consent and the associated ethical constraints. In terms of location, when developing the eligibility criteria, it was initially decided that participants should reside in Western or South-Western Sydney and have been born outside of Australia. However, following discussions and feedback from partner investigators and services, this was revised to ‘reside in Sydney’ and the criterion for being born outside of Australia was removed. It was felt by many that these conditions would be too restrictive and would not support the reach and inclusion of the diversity of young people living in Sydney. The phrase ‘culturally diverse background’ was also initially chosen for the third criterion prior to recruiting any young people, however following feedback from partner services, interviews with key informants, and during the process of publishing early research findings in international journals, the phrase ‘migrant or refugee background’ was utilised instead on all study documents and recruitment materials. And finally, given the broad range of potential cultural and language groups, and therefore the cost of translating study documents into a range of languages, it was initially decided that only English-speaking young people would be eligible. This criterion was later amended to include non-English speaking young people, given the important insights
these young people could contribute and the realisation that it was feasible to include this group, with the support of interpreters for the informed consent process and undertaking interviews.

It was anticipated that migrant and refugee young people may be quite hard to engage with the research, and so a combination of sampling strategies were identified which aimed to reach young people who fit the eligibility criteria and who might feel that the study would be worth their time and effort in taking part. Recruitment strategies therefore included both non-probability purposive sampling and snowball sampling. Purposive sampling is a non-probability form of sampling, whereby participants are sampled in a strategic way, rather than on a random basis, so that those sampled are relevant to the research aims (Bryman, 2016). Snowball sampling, whereby participants can mention the research to acquaintances and peers, is another strategy often used in qualitative research and is ideal when researching hard-to-reach or ‘vulnerable’ populations, including those from ethnic minority backgrounds (Liamputtong, 2009). To support recruitment activities, a study website, flyer and poster were developed. All study material included an email address to a Gmail account set up for the study, and a mobile number for a mobile purchased for the study, to get in contact with me. Given the broad range of potential cultural and language groups, the website and all study materials were only produced in English, which was a limitation in terms of recruiting young people who knew little to no English. However, it was hoped that non-English speaking young people would hear about the study through the partner services who worked with interpreters and through word of mouth. I planned to use the Translating and Interpreting Service (the national interpreting service) to discuss the research and conduct those interviews if so.

The recruitment of young people for interviews took place between September 2016 and October 2017. Active recruitment slowed from May 2017, however interviews were conducted after this point as young people still contacted me to participate. All recruitment for the research was conducted at ‘arm’s length’ to avoid any real or perceived coercion or pressure to participate and to ensure that all participant consent was entirely voluntary (National Health and Medical Research Council et al., 2007 (Updated May 2015)). Prospective participants were identified through the combined effort of partner services and investigators, personal networks, community organisations and peer referrals in order to reach a broad range of young people and reduce selection bias. Although a number of services supported recruitment, participants resided across a much broader geographic reach in Sydney than just those in which the services were located. Recruitment strategies undertaken by partner services included hanging posters in clinic waiting rooms, handing out study flyers within clinical
consultations to potentially eligible clients, and answering questions about the study to those expressing interest. Use of posters in waiting rooms may not have been an overly successful method, as it is not apparent that any participants were recruited based on seeing a poster alone. A study website was developed to provide a central location for information to be included, which also aimed to assist with the ‘word of mouth’ recruitment: www.youngpeoplehealthandrelationships.com (note: link is no longer active). Colleagues and community organisations known to the research team were emailed to ask if they would be willing to help raise awareness of the study by circulating the study website through their own networks. These were general invitations and it is therefore not known who circulated the website link or promoted the study. Existing participants were also invited to tell their friends about the research, and for them to contact me if they were interested in participating. It is also not clear how successful this form of sampling was. Although it was evident from conversations with most participants how they had heard about the study, this was not the case for all of them. Young people who heard about the study and were interested in participating contacted me via mobile phone, email, website submission form or through a clinician (with their permission) to discuss the study and arrange an interview. I did not know any of the participants and participants did not know me prior to participating. My role in the study and motivations for doing the research were broadly discussed during the consent process when this arose during the conversation.

I undertook several types of interviews with the young people who consented to participate in these: a first interview and then a follow-up interview and/or a ‘walking’ interview at a later date. This ‘prolonged engagement’ of spending more time with participants (Liamputtong, 2009) helped to build and strengthen rapport with those who participated beyond the first interview, and allowed for more in-depth and targeted questioning and discussion of different issues. However, not all young people were engaged beyond the first interview, as only a small sub-set of the young people who undertook a first interview also participated in a follow-up or walking interview, as described below. This may be a limitation as it meant the views of those young people who participated in additional interviews may be somewhat over-presented. Motivations for participation are not known, as young people engage in research for any number of reasons (Lohmeyer, 2019). All interviews with young people were conducted face-to-face in order to encourage development of rapport and trust (Dickson-Swift, James, Kippen, & Liamputtong, 2007) and facilitate the possibility of a ‘follow-up’ or ‘walking’ interview at a later date. Findings from the interviews with young people are documented in Chapters 7, 8 and 9. All interviews were undertaken one-on-one, apart from one interview which was conducted with a pair of friends. No inducement was offered for participation, at
the request of one of the Ethics Committees, however participants were reimbursed up to $30 to compensate for travel costs incurred in taking part in an interview. This was provided in cash at the end of each interview, and participants initialled a paper receipt for auditing purposes.

Following the screening and informed consent process previously described, all young people completed a ‘first’ interview (n=27), which explored their views on and experiences of accessing sexual and reproductive health information and care. At the start of the interview I asked participants to tell me about themselves, whatever they wished to share, in order to put them more at ease and to slowly introduce the more potentially sensitive topics (DiCicco-Bloom & Crabtree, 2006; Elam & Fenton, 2003). I attempted to maintain open body language at all times, through smiling, nodding and providing quiet sounds of reassurance and encouragement. An interview guide was used to structure the interview (Appendix 4), and this was supplemented by probing questions to clarify points and elicit richer detail. With participants’ permission, I audio-recorded the interview. Interviews took place at a quiet location agreeable to myself and the participant, such as a private room at a partner health service, library room, park or café. Participant privacy and comfort were paramount and deliberate attention was paid to ensuring these were maintained. First interviews ranged in duration from 20-60 minutes. Demographic questions were asked at the completion of the interview, in a one-page written questionnaire format (see Appendix 5). On this document, participants were invited to nominate a pseudonym for reporting the research data, and to document their age, current gender identity, relationship status, sexual identity and sexual attraction, number of children, occupation, highest level of education attained, ethnicity/cultural background, length of time in Australia, religious affiliation, country of origin and language/s spoken at home. Examples were provided in each category, however it was made clear to participants that these were examples only and they could write anything they wished. All participants completed this document on their own. Their self-reported characteristics are documented in Table 3. Participants’ social networks were not discussed with them, although in hindsight this would have been useful information to have to contribute to data analysis and interpretation. Participants had attended a range of educational institutions, however, including different ‘types’ of secondary schools (e.g. government, faith-based, and single-sex), technical and further education institutes, universities and intensive English centres. All were unmarried and none had any children. Although I hoped to recruit some non-English speaking young people, all participants spoke English in addition to their first language/s.
Table 3: Participant characteristics (as reported by participants)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Female (n= 16)</th>
<th>Male (n= 11)</th>
<th>Total (n= 27)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-18</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>22%</td>
</tr>
<tr>
<td>19-21</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>44%</td>
</tr>
<tr>
<td>22-24</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a relationship</td>
<td>11</td>
<td>3</td>
<td>14</td>
<td>52%</td>
</tr>
<tr>
<td>Single</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>48%</td>
</tr>
<tr>
<td>**Sexual identity *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>13</td>
<td>6</td>
<td>19</td>
<td>70%</td>
</tr>
<tr>
<td>Homosexual</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Sexual attraction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opposite sex only</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td>63%</td>
</tr>
<tr>
<td>Both sexes</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>26%</td>
</tr>
<tr>
<td>Same sex only</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Time in Australia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in Australia</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>37%</td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>2-5 years</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td>&gt;11 years</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Region of origin /birth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia/New Zealand</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>41%</td>
</tr>
<tr>
<td>Asia</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>41%</td>
</tr>
<tr>
<td>Africa</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td>South America</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>**Ethnicity/ cultural background **</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian / Chinese / Cambodian / Filipino / Japanese / Kachin / Korean / Vietnamese</td>
<td>9</td>
<td>7</td>
<td>16</td>
<td>59%</td>
</tr>
<tr>
<td>African / Kenyan</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td>Argentinean / Brazilian</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Greek / Spanish</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Hazara / Syrian</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Religious affiliation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>41%</td>
</tr>
<tr>
<td>Christian / Catholic</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>37%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Greek Orthodox</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Agnostic</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4%</td>
</tr>
</tbody>
</table>
At the completion of the first interview, I advised participants that there were two additional types of interviews in which they could participate in: a ‘follow-up’ interview and/or a ‘walking’ interview. If interested in this, they were asked to contact me by email or phone to discuss further. With their permission, I also emailed them 1-2 weeks later as a reminder. If there was no response, I did not follow up further. Participation was entirely voluntary, and it was neither expected nor intended that all participants who took part in a first interview would take part in further interviews. Participants were only contacted once about participating in a follow-up or walking interview, which ensured there was no pressure to participate beyond the first interview, however this likely resulted in lower numbers of participation for these additional interviews. This limitation is discussed further in Chapter 6. The characteristics of those who participated in a follow-up and/or walking interview are provided in Table 4.

| Table 4: Sub-set of participant characteristics from follow-up/walking interviews |
|---------------------------------|-----------------|-----------------|
|                                  | Follow-up (n=9) | Walking (n=6)   |
| **Characteristics**             |                 |                 |
| Gender identity                 |                 |                 |
| Male                            | 3               | 2               |
| Female                          | 6               | 4               |
| Age (years)                     |                 |                 |
| 16-18                           | 1               | 0               |
| 19-21                           | 4               | 4               |
| 22-24                           | 4               | 2               |
| Relationship status             |                 |                 |
| In a relationship               | 5               | 2               |
| Single                          | 4               | 4               |
| Sexual identity                 |                 |                 |
| Heterosexual                    | 7               | 5               |
| Homosexual                      | 1               | 1               |
| Bisexual                        | 1               | 0               |
| Sexual attraction               |                 |                 |
| Opposite sex only               | 7               | 5               |
| Both sexes                      | 2               | 1               |
| Same sex only                   | 0               | 0               |
| Time in Australia               |                 |                 |
| Born in Australia               | 1               | 0               |
The follow-up and walking interviews generally took place several weeks after the first interview, depending on both participants and my availability. The follow-up interviews (n=9) followed the same process of consent and interviewing as the first interview. Undertaking a follow-up interview allowed for additional inquiry and more in-depth questioning, and although an interview guide was used, the content covered was informed in part by the answers provided in their first interview. Follow-up interviews ranged in duration from 30-40 minutes.

The third interview option was the walking interview (n=15); these were conducted in a clinical setting at one or more of the six clinical sites associated with the health services that partnered with the research study. Six young people participated individually in one or more walking interviews, with 15 undertaken in total. These six participants had also all participated in a follow-up interview. The walking interview is a relatively new methodology in health research (Garcia, Eisenberg, Frerich, Lechner, & Lust, 2012), whereby the researcher walks alongside participants in order to generate observational and first-hand accounts of their views.
and interpretations of a particular setting (Evans & Jones, 2011). For this research, the walking interview involved myself and the young person undertaking a ‘tour’ of a health service to discuss key features and their views of the service. Walking interviews were guided by a short template of prompts (see Appendix 4) and ranged in duration from 20-40 minutes. These were not audio-recorded, but rather field notes of participants’ comments and my observations were made during the interviews and typed up afterwards. Upon reflection, this approach to collecting data during the walking interviews was a limitation, as it meant that some insights or particularly important or relevant ways in which views were articulated may have been lost when being written down, rather than recorded. I may also have been less engaged with and focused on participants at different points as I was trying to take notes at the same time. The process undertaken for the walking interviews and my reflections on this method, particularly in relation to the methodology and ethical considerations, are described further in Chapter 6.

**Data analysis and reporting**

Prior to commencing an interview, all key informants and young people gave their verbal consent for the interview to be audio-recorded, which allowed for an uninterrupted flow of discussion (Liamputtong, 2009). Two devices were used to record the interviews – a voice recorder and a mobile device – in case one failed to record. Handwritten notes were taken during the walking interviews. All interview recordings were transcribed verbatim in a Word document by either myself or a professional transcription company, Digital Transcripts, who transcribed approximately half of the recordings across both participant groups. As the interviewer, I would ideally have transcribed all interviews myself (Liamputtong, 2009). However, due to the volume of interviews anticipated, funding was sought to contribute towards professional transcription, which ensured all interviews were transcribed in a timely manner and allowed me to focus on checking their accuracy against the recording and engaging in the data analysis. I undertook careful checking of all transcripts, both those transcribed by myself and by the professional transcribers, to ensure accuracy as well as consistency of style (Liamputtong, 2009). This involved listening to each audio recording and reviewing and refining the transcript. My handwritten notes from each walking interview were also typed up in a Word document. As part of the transcription and checking process I de-identified all transcripts by removing participant names, if mentioned, and replacing them with the designated participant code. Very few transcripts mentioned individual names, of either the participants or of other people, or anything else potentially identifying. Once all transcripts had been thoroughly checked and de-identified, I read through them again and noted down observations and thoughts on emerging patterns. This process of transcription and reviewing
allowed me to immerse myself in the data in order to become more familiar with the depth and breadth of the content (Braun & Clarke, 2006). Transcripts were not offered back to participants, although ethics did permit a de-identified copy to be provided if specifically requested by a participant. No participants asked for this, either at the time of their interview or afterwards. All interviews were transcribed and checked as soon as possible following the interview, and the de-identified transcripts were then imported into qualitative analysis software NVivo 10 (QSR International, 2012) for coding and thematic analysis.

The steps involved in thematic analysis, as described by Braun and Clarke (2006), guided the analysis of the interview data: familiarising myself with the data; generating initial codes; searching for themes; reviewing themes; and defining and naming themes. As part of the analysis, I also undertook an immersive secondary approach with the young people’s data called ‘iterative categorisation’ (Neale, 2016). Both of the analytic approaches undertaken are described below. Data sets from key informants and from young people were analysed separately, although were reviewed in combination at later stages.

Development of the code structure was an iterative process that began early during data collection and continued throughout the study (Bradley, Curry, & Devers, 2007). Developing the code structure took a primarily inductive approach, whereby it was data-driven rather than theory-driven, and evolved throughout the coding process drawing on the entire data corpus (Braun & Clarke, 2006). However, a more deductive approach was used in the first instance to develop a preliminary coding frame based on the interview guides. For interviews with key informants, preliminary codes included, for example, sexual health needs of migrant/refugee young people, barriers to service access, and challenges in service provision. For interviews with young people, the initial coding tree included codes such as sources of information, parental expectations, and use of health services. These preliminary codes were then augmented by inductive codes derived from closely and systematically reviewing the interview data line-by-line. This involved focusing on what was in the data and deriving codes directly from the data (Bazeley, 2007). During the coding process I also noted down my reflections on recurring themes, contrasting views observed, and assumptions that were shaping and informing the semantic content (surface meanings) of the data corpus in order to start identifying recurring patterns at a latent level (Braun & Clarke, 2006). The coding and analytic process was led by myself, and incorporated intercoder checking within the supervisory team to strengthen the quality and rigour of the analysis. My two primary supervisors individually reviewed a selection of both key informant and young people’s interview transcripts to contribute to developing and refining the coding frames.
The preliminary analysis of the coded data commenced when it was felt that data saturation was approaching for both participant groups, with very little new information being added as interviews continued. As discussed earlier, saturation was considered to have been reached when my supervisors and I agreed that sufficient data had been collected to allow the exploratory aim and objectives of the study to be thoroughly fulfilled, and there were no significantly new perspectives being shared by either group (Mason, 2002; Patton, 2002). Interviews with both professionals and several young people continued after this point, however, as additional prospective informants were identified or when young people contacted me directly to participate.

Identifying potential themes in the data involved reviewing the list of codes developed and my notes taken during this process and undertaking a more interpretative analysis of the data to identify themes at a latent level in order to explore the underlying ideas, assumptions and conceptualisations in the data (Braun & Clarke, 2006). The thematic analysis was conducted within a constructionist paradigm, as described earlier in this chapter, recognising the sociocultural contexts and structural conditions that produce and contribute to peoples experiences and accounts (Braun & Clarke, 2006). As part of this process, codes were sorted into broader categories, and the coded data extracts collated within these, to create potential themes and sub-themes (Braun & Clarke, 2006). Themes are recognised as being something important in the data which represents a level of patterned response or shared meaning (Braun & Clarke, 2006). Potential themes were reviewed and discussed in detail with my supervisors to further refine or re-work these and to create new themes as necessary. Once these were refined and broadly agreed, transcripts were re-read to ensure the prospective final themes felt appropriate (Braun & Clarke, 2006). No new themes were identified at that point, although additional coding occurred within the existing themes.

Prior to finalising and naming themes, an additional layer of analysis was undertaken by applying ‘iterative categorisation’ to the young people’s coded data set (Neale, 2016). This involved exporting the coded data from NVivo into individual Word files and analysing the coded data line-by-line. This is a rigorous and transparent systematic technique for analysing qualitative data; it is not a stand-alone method, but rather supports and builds on common analytical approaches, including thematic analysis (Neale, 2016). It is particularly suitable for novice qualitative researchers as it provides a standardised procedure to guide the analysis, as well as strengthens the rigour of qualitative analyses and provides “a route back to the raw data for further clarifications, elaborations and confirming/disconfirming evidence” (Neale,
After attending a seminar presented by the author of this method, I decided to undertake this additional layer of analysis to ensure I had systematically captured everything in the young people’s data. Although I was concerned that the process would be additionally time consuming, and it did in fact take considerable time, it was a very worthwhile process. It allowed me to re-immerse myself in the data, continue reflecting on patterns and themes, note any additional observations to further inform the analysis, and feel fully satisfied that I had addressed and made sense of all of the potential ways of interpreting the data. As the process of iterative categorisation involved reading the coded data line-by-line and summarising and organising the findings iteratively under key headings and sub-headings, I was also concerned that by truncating the data in this way I may inadvertently lose or change the meaning of statements made by participants. However, I was able to overcome this concern by not shortening sentences to such a degree that I changed the meaning, and I also retained full quotes where I found them to be particularly relevant or meaningful.

After completing this additional layer of analysis through iterative categorisation, final themes were discussed, named and agreed between myself and my supervisors. The process of iterative categorisation did not lead to the creation of new themes, however it provided reassurance and further strengthened the themes identified. Whilst a decision was made to not re-analyse the key informant data using this additional approach as it was deemed unnecessary, it was particularly useful for the young people's data in ensuring all elements of the data were captured and addressed through the analyses. The final agreed themes form the basis of the publications produced from this research, and are drawn together further in the final chapters of this thesis.

In order to be able to assess the trustworthiness and rigour of qualitative research findings, research should be systematically, completely and carefully documented (Tong & Craig, 2018, advance online). As such, the COREQ checklist, or consolidated criteria for reporting qualitative research, has contributed to informing the content of this and subsequent chapters in the thesis. This is a 32-item checklist developed to support comprehensive reporting of qualitative studies (Tong, Sainsbury, & Craig, 2007). A copy of the completed checklist based on Chapters 1 and 2 of the thesis can be found in Appendix 1.

Following the data analysis process, key themes and findings were discussed with several others to elicit their observations and feedback. I drew particularly upon the specialist expertise of two partner investigators and a third collaborator to contribute to co-authoring a journal article each in their particular field of expertise: one on sexuality education (Chapter
8), one on general practice medicine (Chapter 9), and the third on the ethical considerations of walking interviews (Chapter 6). A summary of findings was also presented at a meeting convened with all partner investigators to obtain their comments and suggestions for the recommendations coming out of the research. In addition to this, findings relating to the more practical aspects of service feedback were presented to the Youth Advisory Group to elicit their observations and reflections as an alternative form of the more traditional ‘member checking’ (Cope, 2014; Liamputtong, 2009) and to contribute in particular to the short report being developed as a more publicly available output of the research (Appendix 2). This short report will be finalised and made available online following examination of the thesis, and may be of particular interest to clinical services working in this field of health and with young people. Participants themselves did not provide feedback on the findings.

Lastly, the interpretive approach undertaken for this research recognises the inherent subjectivity of humans, both research participants and researchers, and acknowledges that the background and values of the researchers can influence the creation of data (Hennink et al., 2011). Throughout the research I therefore endeavoured to be critically self-aware, questioning my own behaviours and attitudes in relation to the influence I was having on the collection, analysis and interpretation of the data (Bell & Aggleton, 2013; Liamputtong, 2009; Ransome, 2013). This included, for example, attempting not to ask leading questions during interviews based on my own views or experiences or on what prior participants had mentioned, and to try and remain self-aware during interviews so as not to inadvertently influence participants based on my body language and the way I asked questions. Reflexivity is a process that involves conscious self-reflection by researchers to make explicit their potential influence throughout the research process, from research design to data interpretation and presentation (Hennink et al., 2011). I was aware that my own experiences and perspectives, which I outlined in Chapter 1, would play a role in the research process, including in the data collection and analysis. I have acknowledged these in the thesis and in related publications where appropriate. Reflexivity can also be recorded in research notes, by keeping a field diary or writing memos during data analysis (Hennink et al., 2011). Over the course of the research I therefore kept a journal to record important decisions and key changes made along the way, to document feedback received during consultations, in supervision meetings and at my annual PhD progress reviews, to capture field notes such as my own observations and thoughts arising during data collection and analysis, and to integrate my reflections and responses to these through the course of the research. I read over these notes at different stages of the research as a reflective process on how the research had developed and why certain decisions were made, which I found particularly useful to refer to when submitting ethics amendments and when
undertaking data analysis and writing up of the research findings, including the writing of this thesis.

**Dissemination**

In addition to publishing findings from my doctoral research throughout my candidature, I have sought to further disseminate the findings of the research through sharing these with others. I presented at national conferences between 2015-2018, including the *Australian Social Policy Conference* in 2015 (oral presentation); *Youth, Health and Practical Justice: An Interdisciplinary Conference* in 2016 (oral presentation); *Youth Health Conference* in 2017 (oral presentation); the *Australasian Sexual Health Conference* in 2017 (oral and poster presentation); and the *IUSTI Asia Pacific Sexual Health Congress* in 2018. My poster won a ‘best poster’ award at the 2017 *Australasian Sexual Health Conference*. In addition to these conferences, I have presented findings at the Centre for Social Research in Health and at the Kirby Institute at UNSW Sydney as part of their seminar series. Presenting my doctoral research at conferences and seminars has allowed me to share findings with a broad audience from a range of backgrounds including clinical, policy and community, as well as provided an occasion to meet others working in this field and broaden my professional network and my profile as a researcher in this area. Presenting early work, for example the findings from the scoping review and key informant interviews, also provided an opportunity to seek feedback on those aspects as well as the upcoming interviews I would be undertaking with young people. Attending and presenting at conferences increased my confidence in presenting and sharing research findings in more formal settings and contributed to strengthening the integrity of the research (National Health and Medical Research Council et al., 2007 (Updated May 2015)).

I will also be presenting findings to staff at partner services, both informally in staff meeting environments and more formally in seminar formats. This will provide an opportunity to ‘feedback’ to staff about the research they had supported and will be a valuable way of promoting the uptake and translation of research findings and recommendations. Already I am aware that the journal article on generational differences (see Chapter 7) has been critically reviewed and the implications for practice discussed by the health promotion team at Family Planning NSW at their monthly ‘journal club’ meeting. This article also contributed to informing a professional development course at Family Planning NSW for service providers working with ‘culturally and linguistically diverse’ communities, and to a submission by the organisation to the City of Sydney’s public invitation for feedback on their Draft International
Education Plan 2018 to better support international students. In addition to presenting findings at conferences and to partner services, I have also shared publications from the research via social media as well as emailed these to partner investigators, key informants, members of the Youth Advisory Group, and several young people who wished to receive these. Following examination of the thesis, the draft short report (Appendix 2) will also be finalised and made publicly available online. Lastly, local media interest in the research findings relating to general practice (see chapter 9) led to stories being published by the RACGP newsGP and in the Canterbury-Bankstown Torch in August 2018.

While undertaking my doctoral research, I was engaged in several other research projects and led or contributed to associated peer-reviewed journal articles. These focused on the use of digital stories to promote sexual and reproductive health and wellbeing among migrant and refugee young people (Botfield, Newman, Lenette, Albury, & Zwi, 2017); ethical implications and considerations when undertaking visual research (Lenette et al., 2018); and the needs of informal carers of people with HIV (Hamilton et al., in press). Although these projects were not part of my doctoral research, there were areas of overlap in each, and being involved in these provided additional opportunities for critical reflection, writing, networking and building my research profile. The following chapters of the thesis, however, comprise only those publications which I produced from my own doctoral research during my candidature.
References


Chapter 3: Young migrants and sexual and reproductive healthcare

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This publication was based on a review of the literature which focused on global issues relating to the sexual and reproductive health of young people from diverse migrant backgrounds, using Australia as a case study in contemporary multiculturalism. It provides an in-depth review of the field of research and key issues of relevance, exploring the complexities of designing and implementing effective sexual and reproductive healthcare that engages with the needs of migrant young people in the Australian context. The review was written as a Handbook chapter by invitation from the Editor of the Handbook of Migration and Health, which was published in 2016. This, along with the article in Chapter 4, contributed to informing and strengthening the study design for this doctoral research.

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Signed:
23 Young migrants and sexual and reproductive healthcare

Jessica R. Botfield, Anthony B. Zwi and Christy E. Newman

INTRODUCTION

Young people from culturally diverse backgrounds, including migrants, refugees and international students, are at heightened risk of poor sexual and reproductive health. However while they have varied and sometimes complex health needs, these are often overlooked and sexual and reproductive health services underutilised (McMichael and Gifford 2009; Wray et al. 2014). This chapter reviews key issues relating to the sexual and reproductive health of young people from diverse migrant backgrounds, and emphasises the importance of appropriately engaging them through culturally sensitive approaches to sexual health promotion and service provision. Focusing on Australia as a case study in contemporary multiculturalism, it explores the complexities of designing effective healthcare systems that take into account their varied experiences and backgrounds, and reviews approaches to the promotion of sexual and reproductive health for these diverse communities. Reflecting on the mechanisms employed to engage culturally diverse young people with sexual and reproductive services, the chapter reinforces the importance of a youth-friendly setting and the promotion of cultural competence in sexual healthcare.
Introduction

Young people from culturally diverse backgrounds, including migrants, refugees and international students, are at heightened risk of poor sexual and reproductive health. However while they have varied and sometimes complex health needs, these are often overlooked and sexual and reproductive health services underutilised (McMichael and Gifford 2009; Wray et al. 2014). This chapter reviews key issues relating to the sexual and reproductive health of young people from diverse migrant backgrounds, and emphasises the importance of appropriately engaging them through culturally sensitive approaches to sexual health promotion and service provision. Focusing on Australia as a case study in contemporary multiculturalism, it explores the complexities of designing effective healthcare systems that take into account their varied experiences and backgrounds, and reviews approaches to the promotion of sexual and reproductive health for these diverse communities. Reflecting on the mechanisms employed to engage culturally diverse young people with sexual and reproductive services, the chapter reinforces the importance of a youth-friendly setting and the promotion of cultural competence in sexual healthcare.

Given the complexity of the intersecting issues and experiences reviewed in this chapter, it is important to define the terminology used. The term ‘migrant’ in this chapter refers to people coming to Australia by choice, including for skilled migration and family reunion. International students and refugees are discussed separately, for the purposes of the chapter, due to their often unique experiences and needs. The term ‘migrants’ therefore refers to anyone who has chosen to leave their home country and move to Australia (primarily for work or family reunion purposes), and ‘international students’ as those coming to Australia to study on a temporary visa. A ‘refugee’ is someone who is outside the country of their nationality and is unable or unwilling to avail themselves of the protection of that country due to a well-founded fear of persecution. When referring to young people in the context of ‘migrants’ or ‘refugees’ in this chapter, they may personally fit under one of these terms, or their parents or grandparents do.

Sexual and reproductive health in young people

‘Sexual health’ and ‘reproductive health’ overlap considerably. Sexual health pertains to pleasurable and safe sexual experiences, free of coercion, discrimination and violence, while reproductive health is focused on having a satisfying and safe sex life, with the freedom to decide if, when and how often to reproduce (Glasier et al. 2006). While offering a single definition of sexual and reproductive health is difficult due to the range and breadth of issues encompassed (Collumbien et al. 2012), the United Nations defines reproductive health, of which
sexual health is a part, as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’ (United Nations 1995b). However, as with concepts of health generally, sexual and reproductive health relate not merely to the absence of disease (Temple-Smith and Gifford 2005; Hach 2012) but also include the promotion of wellbeing. It is centred around the availability of quality sexual and reproductive health services, eliminating preventable maternal and newborn mortality and morbidity, and addressing sexually transmitted infections, cervical cancer, sexual and gender-based violence, and the sexual and reproductive health needs of adolescents (Temmerman et al. 2014).

Health is a basic human right, and the right to sexual and reproductive health continues to gain recognition globally (Gruskin et al. 2014). The landmark International Conference on Population and Development held in 1994 placed rights at the heart of development, and affirmed sexual and reproductive health as a fundamental element within this agenda (DeJong 2000). The Conference endorsed a Programme of Action that recognised the importance of gender equality and equity, human rights and the empowerment of women (United Nations 1995b). This led to a shift from earlier policies targeting population control, to those that placed the individual at the centre and respected choice, rights and empowerment (World Health Organization 2014). The Fourth World Conference on Women was held the following year, and the Beijing Declaration and Platform for Action adopted, with the goal of advancing women’s rights worldwide (United Nations 1995a). The UN Millennium Declaration was adopted in 2000 and eight Millennium Development Goals established for achievement by 2015; one of the eight goals focused on the promotion of gender equality and empowerment of women. The Sustainable Development Goals agreed in August 2015 reinforce these efforts towards promoting gender equality, as well as ensuring universal access to sexual and reproductive health and reproductive rights, and sexual and reproductive healthcare services (United Nations 2015).

There is also increasing awareness of the more specific sexual and reproductive health needs of young people (Williams and Davidson 2004). Worldwide there are 1.2 billion adolescents, young men and women aged 10–19 years (Cappa et al. 2012). As they make the transition from children to adults, they experience significant physical, psychological, emotional and economic changes (United Nations Children’s Fund 2012), and are at heightened risk of sexual and reproductive ill-health (Bearinger et al. 2007; Glasier et al. 2006). Adolescents, however, may lack the cognitive capacity to make safe decisions, and may have limited understanding of their bodies or health. Many are disempowered and restricted by laws or customs, are vulnerable to sexual exploitation and high-risk behaviours (Badash 2006), and may have limited access to
information, contraception and services (Kennedy et al. 2011). Furthermore, as young girls have immature reproductive and immune systems, they are more susceptible to sexually transmitted infections, and their lack of physical maturity and incomplete body growth makes them vulnerable during pregnancy and delivery (Bearinger et al. 2007). Adolescent girls in many countries are also at risk of harmful practices including female genital mutilation and early or forced marriage (United Nations Population Fund 2013; United Nations Children’s Fund 2014), as well as exploitation by ‘sugar daddies’; older men who provide material benefits or financial security in return for sexual relations (Silberschmidt and Rasch 2001). Economic pressures can also drive young men and women into sex work, with additional vulnerabilities due to their age and other forms of dependence, and reduced opportunities to protect themselves from harm. Variations in biological maturation, age of sexual debut, type and number of sexual partners, and use of contraceptive methods, along with educational and marital options and norms, create a myriad of factors that can both protect against sexually transmitted infections and early pregnancy, or increase a young person’s risk of negative sexual and reproductive health outcomes (Bearinger et al. 2007). However, it is also important to appreciate that the research on young people and sexual health often emphasises these more negative aspects, particularly their vulnerabilities and risks. Young people’s sexuality and sexual behaviour involve far more than this (Keys, Rosenthal, and Pitts 2013), and there is often little recognition of the considerable strengths, capabilities and assets that many young people draw on in navigating their complex social and sexual worlds (Persson and Newman 2012), particularly but not only in the context of migration.

**Responding to culture and context within sexual health promotion**

Young people are not a homogeneous group, and it is widely recognised that diverse cultural, religious and social contexts and beliefs influence their health and the ways they access and use health information and services (Wray et al. 2014; Ussher et al. 2012; Khoei et al. 2008; Rawson and Liamputtong 2010; Rogers and Earnest 2014; Manderson et al. 2002). Ideas and values relating to sexual and reproductive health are likely to be shaped by the culture and society to which one belongs, or with which one identifies, and the factors that shape people’s health will be strongly informed by their living conditions and social determinants of health (Keys et al. 2008).

Historically, much of the focus of sexual health research and policy centred on understanding and influencing community knowledge, attitudes and practices around sex. This was based on the belief that people are rational decision-makers when it comes to sex and health, and only needed information and skills in order to make health-promoting decisions (Aggleton 2004;
Kippax et al. 2013). However, there has been a paradigm shift away from this focus on sexual behaviours and individual risk towards a greater recognition of the broader social and cultural settings within which these actions take place (Parker 2009; Aggleton 2004). Such thinking has reinforced wider recognition of social and cultural determinants of health and wellbeing, which is also important when examining the sexual health of diverse groups of young migrants.

While it is generally now acknowledged that society and culture shape our sexual experience and the ways in which we interpret and understand that experience (Parker 2009), the extent to which an individual’s desires, practices and experiences are shaped by outside forces (social determinants) and how much they are a reflection of individual decisions to act (agency) are not so well understood or accepted. There is common understanding, however, that most human actions, thoughts and desires are influenced, if not determined, by key elements of social life including norms, values, networks, structures and institutions (Auerbach et al. 2011), and that these have a powerful influence on the regulation and governance of sexual behaviour and identity (Kippax 2008; Collumbien et al. 2012).

Studies that have focused on agency have examined the ways that individuals are able to pursue purposeful courses of action – they are able to imagine different paths of action and choose a particular path, either individually or collectively (Petesch et al. 2005). This has important implications when working with young people, and those from culturally diverse backgrounds, as an understanding of their sexual agency and its consequences can help enable the design of sexual health programmes that are informed by the realities of those they seek to support. Taking a more comprehensive and holistic approach to the promotion of sexual and reproductive health is essential in responding to the needs of young people from diverse migrant backgrounds, and requires that both individual needs and contextual factors be recognised and addressed (Aggleton 2004).

**Australia: a case study in contemporary multiculturalism**

When considering the sexual and reproductive health of young people from culturally and linguistically diverse backgrounds, Australia provides a useful case study due to the scale and diversity of its migration histories (Australian Bureau of Statistics 2015a). Australia today comprises an incredibly rich diversity of cultures, ethnicities and languages, with people from many different backgrounds coming into the country under a range of circumstances, including as migrants, refugees and international students. Although coming from a broad range of backgrounds and experiences, this provides a useful context within which to examine sexual
and reproductive health issues in relation to diverse communities in a wealthy nation such as Australia.

Prior to 1788, Australia was populated by its Indigenous inhabitants, Aboriginal and Torres Strait Islander people. European colonisation and settlement in 1788 brought widespread violence and dispossession with consequent detrimental changes to indigenous society and culture (Australian Bureau of Statistics 2010; Aboriginal Heritage Office n.d.). Australia’s cultural landscape began to further diversify from the mid-1940s following the end of World War II, when refugees from Eastern Europe began to resettle in the country. In more recent times (2013–2014) the primary countries of origin for offshore refugee and humanitarian entrants (those applying for humanitarian entry to Australia from outside of Australia) have been Afghanistan, Iraq, Burma and Syria (Refugee Council of Australia 2014b), and in 2015 Australia committed to resettling another 12,000 Syrian refugees from the widespread violence and displacement engulfing that country (Bourke 2015). International students also contribute to Australia’s diversity, with just over 1,859,000 international students having undertaken study in Australia between 2002 and 2014. China and India were the top two contributing nationalities over this time (Department of Education and Training 2015). In 2013–2014, net overseas migration reflected an annual gain of 212,700 persons; of those migrating to Australia from non-Western countries, China and India were the top two countries of birth (Australian Bureau of Statistics 2015a, 2015b). Net overseas migration includes people entering Australia on temporary visas (such as student, visitor, working holiday) and permanent visas (such as family, skilled and humanitarian). Australia is now one of the most culturally diverse countries in the world, with nearly 30 per cent of its resident population, or 6.6 million people, born overseas (Australian Bureau of Statistics 2015b).

Migrants, refugees and international students will have had very different experiences prior to coming to Australia; most migrants and international students will have planned their move, while refugees will have fled to escape persecution. Despite these differences, each of these groups often still experience settlement challenges in Australia. These can include lack of adequate on-arrival information and support, difficulties with language acquisition and re-establishing themselves socially and professionally, loss of social and cultural networks, relationship conflict, discrimination and racism (Pittaway et al. 2009; Allotey et al. 2004; Iqbal et al. 2012; Poljski 2011). People living in a new country also often remain strongly anchored to traditional religious and cultural beliefs (Srikanthan and Reid 2008), while trying to navigate access to new ideas, information and services.
While marginalised young people from migrant or refugee backgrounds experience many of the same health concerns as the general youth population, their experiences are frequently more complex (Cummings and Kang 2012). They face the additional difficulties of displacement or migration and growing up between ‘two cultures’ (Chown et al. 2008; Lane 2008) – having to negotiate or accommodate the often conflicting expectations, priorities and values of their parents or family with those of their new society (Manderson et al. 2002). This can lead to stress, intergenerational disputes and a feeling of not completely belonging to either community (Iqbal et al. 2012). Humanitarian entrants to Australia also tend to be younger than the national Australian population and arrivals under other migration categories (Refugee Council of Australia 2014a; NSW Health 2011; Department of Immigration and Citizenship 2011), bringing an additional set of challenges. Family separation during the migration experience can mean an eldest child may have to take on responsibility as the head of a household, or children may assume these roles as they acculturate more quickly than their parents. Unaccompanied minors, young people under the age of 18 years who arrive in Australia without a parent or guardian, may similarly have to make decisions that would customarily fall to a parent (Refugee Council of Australia 2014a).

**Migrant and refugee healthcare in Australia**

Health services are acknowledged as vital elements to improving adolescent sexual and reproductive health (Bearinger et al. 2007; World Health Organization 2002; Tylee et al. 2007), and should therefore be accessible, acceptable and appropriate for young people, and include services for prevention, diagnosis, treatment and care (Bearinger et al. 2007).

Most healthcare for refugee and migrant communities in Australia is provided through mainstream health services (South Eastern Sydney Local Health District 2011; Finney Lamb and Smith 2002): any service ‘that aims to cater for the broad population in the provision of its services and programs’ (Department of Human Services 1998). Relevant mainstream services include general practitioners, youth health services and family planning and sexual health clinics, which vary by region, funding, structure, governance and service delivery (Kang and Sanci 2007). They have varying functions, such as education, health promotion and clinical services, and focus on one or more of a range of issues related to sexual and reproductive health. While mainstream health services have been developed with the needs of the majority population in mind, many refugees and migrants are routinely referred to them. It is vital, therefore, that such services ensure provision of accessible and culturally competent care that appreciates and responds effectively to the varying health needs people may present with (NSW Health 2011; Hach 2012).
General practice in particular is the cornerstone of primary healthcare for young people in Australia (Cummings and Kang 2012). General practitioners are viewed as the most accessible primary healthcare provider, and are usually a young person’s first point of contact with the health system (Chown et al. 2008; Dadich et al. 2013). While a fee for services is levied by general practitioners, this may be covered in full or in part by the Medicare system, a federal government health scheme that enables access to healthcare for Australian citizens and some overseas visitors at little or no cost (Department of Human Services 2015). In Australia, general practitioners see approximately 2 million people under the age of 25 each year (Chown et al. 2008), including for issues related to sexual and reproductive health. However, they are facing increasing difficulties with more people coming from a growing range of culturally diverse backgrounds (Chown et al. 2008; Milosevic et al. 2012), especially when this encompasses those with more complex health needs (NSW Health 2011; Thomas et al. 2007).

Many health professionals also find working with young people challenging due to communication difficulties and uncertainty about medico-legal status for those under 18 years (Cummings and Kang 2012; Chown et al. 2008). This latter concern around medico-legal status is a common one, and is even more complex when working with culturally diverse communities. In 1986, the British case of Gillick v West Norfolk and Wisbech Area Health Authority established the legal precedent that the parental right to determine their child’s treatment ends once a child under the age of 16 years is capable of fully understanding the medical treatment proposed. This common law principle is used in Australia (Bowles n.d.), and it is now generally accepted that most young people over the age of 16 are capable of giving their own informed consent. However there is still uncertainty in this area, particularly across different states and territories in Australia (Chown et al. 2008), and many young people have continued concerns about issues of confidentiality and potential disclosure to parents, which can be a barrier to them accessing health services (Booth et al. 2002, 2004; Sanci et al. 2005). This can be additionally complex for some culturally diverse young people, particularly those from migrant or refugee backgrounds, due to a range of additional factors including language barriers, lower health literacy and unfamiliarity with the health system.

**Challenges of engaging culturally diverse young people with sexual and reproductive health services**

Young people can have complex health needs, and literature from Australian studies suggests that most do not seek healthcare as often as they could (Bernard et al. 2004; Kang et al. 2003; Skinner and Hickey 2003; Booth et al. 2008; Dadich et al. 2013). A study investigating the
health concerns of adolescents in one state of Australia, for example, found that one-third of females and two-thirds of males would not seek help for any health concerns (Booth et al. 2002, 2004).

Sexual and reproductive health services are particularly underutilised, especially among culturally diverse communities in Australia (Ussher et al. 2012; Hach 2012; Wray et al. 2014; Martin et al. 2013; Manderson and Allotey 2003). This can be attributed to a number of sociocultural factors, including access to health-related information and services, the dynamics of the migration experience, and gender and cultural norms in different communities (Hach 2012).

Barriers to use of services for sexual and reproductive health needs can include the location and accessibility of services, level of dis/comfort in disclosing health concerns, attitudes of service providers (Booth et al. 2004), financial constraints (Hach 2012; Spike et al. 2011), and language barriers (Hach 2012; McMichael and Gifford 2009; McMichael 2008). Many young people, from any background, will not use a sexual and reproductive health clinic if they feel well or do not believe they are ‘at risk’ (Skinner and Hickey 2003), and for young migrants and refugees, unfamiliarity with the health system can further discourage service use (Hach 2012; McMichael 2008).

Challenges and barriers will also vary for different migrant and refugee groups and individuals for a myriad of reasons, including their length of time in Australia and visa status. For example, international students, including those from China and India (who represent the largest cohort of international students), experience raised rates of unplanned pregnancy and abortion and are at increased risk of intimate partner violence and sexually transmissible infections. However, their utilisation of health services is particularly low, largely due to limited understanding of the Australian health system and financial barriers, as well as generally lower health literacy, including that relating to sexual health, which is taboo within many countries (Poljski 2011; Reeders 2011). Unaccompanied minors also face challenges, often lacking the protection and support of a family (McMichael 2008) and requiring additional support and care (NSW Health 2011). Although Australia is often seen as a relatively safe and inclusive setting for lesbian, gay, bisexual, transgender and queer people, those from immigrant and refugee communities ‘are a minority within a minority’ in Australia (Victorian Department of Health 2013), and can experience added pressures and complexities, including tension between their religious beliefs and their sexuality, feeling unsafe at home, and having low levels of sexual health knowledge (Noto et al. 2014).
Young people from migrant or refugee backgrounds may not visit a general practitioner or local health clinic for sexual health concerns if the provider identifies with the same ethnicity or community, is of a different gender or if an interpreter is required (Rawson and Liamputtong 2009; McMichael and Gifford 2009; McMichael 2008). Sexual health services may also be perceived by some as culturally inappropriate for unmarried women, resulting in avoidance due to fear of others knowing they are interested in sexual health or engaging in premarital sexual activity (Ussher et al. 2012; Hach 2012).

Ways forward in policy and practice

While national and state policies on sexual and reproductive health issues in Australia focus on different priority groups (Botfield et al. 2015), several states are taking the lead in developing policies to address the needs of culturally diverse young people. In New South Wales (NSW), for example, the most populous state in Australia’s Federation, the NSW Refugee Health Plan (2011–2016) identifies refugee youth as a priority population and sexual and reproductive health as a priority health issue. It seeks to implement strategies to ensure the delivery of safe, high-quality services to refugees through both refugee-specific health services and through accessible, culturally and linguistically competent mainstream health services. The Youth Health Policy (2011–2016) similarly aims to guide the NSW health system to support young people to achieve optimal health and wellbeing, and recognises the increasingly diverse community of young people that must be taken into consideration.

Within this policy context, innovative strategies are being developed to address the needs of young people and overcome barriers to access. Since 2006, the youth health service model has gained support through the national ‘headspace’ initiative (Cummings and Kang 2012). This is a federally funded programme that allows young people to seek help early through new models of care provided in youth-friendly, integrated, multidisciplinary centres (Ministry of Health NSW 2010). Centres are built and designed with input from young people, and provide assistance with mental health, physical health (including sexual health), alcohol and drug, and work and study issues. There is a clear link between emotional distress, depression, substance abuse and sexual risk-taking behaviours in young people, and headspace is therefore an ideal setting for reaching those experiencing issues with relationships or sexuality, or at risk of sexually transmissible infections, who are unlikely to attend mainstream services and may therefore miss out on routine screening and advice. Sexual health assessments, advice, appropriate treatment and referral are available for headspace clients (Edwards et al. 2014). This service could be well-placed to more directly engage young people from migrant and refugee backgrounds.
Schools also play a critical role in shaping the health and wellbeing of young people, and are ideally placed to deliver sexuality education to educate young people about sexual and reproductive health (Smith et al. 2011; Goldman 2010). In Australia, sexuality and sexual health education is supported at a state level. In NSW, it is taught in all government schools, although to variable degrees, and is guided by the personal development, health and physical education syllabuses provided by the NSW Board of Studies, Teaching and Educational Standards. This is a mandatory subject from Kindergarten to Year 10 (NSW Department of Education 2015a), and senior students then participate in Crossroads, a mandatory 25-hour programme (NSW Department of Education 2015b). Several family planning and sexual health services across Australia are also working with schools to support them in implementing sexuality and sexual health education (Family Planning NSW n.d.; Sexual Health and Family Planning ACT n.d.; SHine SA n.d.; Family Planning Victoria n.d.).

Despite widespread acceptance of the importance of sexual health education and a framework and support for its delivery, the amount of school-based education young people receive on sexual health in Australia is variable (Skinner and Hickey 2003), and inconsistencies in training, knowledge and confidence of teachers to adequately deliver sexual health education remain (Smith et al. 2011). A National Survey of Secondary Teachers of Sexuality Education, involving 300 secondary school teachers from every jurisdiction in Australia including government, Catholic and independent schools, found that 16 per cent of respondents reported having received no training in sexual health education (Smith et al. 2011). Furthermore, the majority of teachers teaching sexual health are female, which suggests there is a lack of male role models in the school setting to discuss these potentially sensitive and personal topics (Smith et al. 2011). In the Fifth National Survey of Secondary Students and Sexual Health, undertaken in 2013 with more than 2,000 Year 10, 11 and 12 students from a cross-section of schools across Australia, only 45 per cent found the sex education they received to be ‘very’ or ‘extremely’ relevant (Mitchell et al. 2014). A study exploring the acquisition of knowledge about sexual issues for Vietnamese young women in Australia similarly found that many felt sex education in school was inadequate and lacked the breadth of information they desired (Rawson and Liamputtong 2010). Young people’s sexual pleasure is also largely unaddressed in sexuality education, as well as in society more generally (Keys, Rosenthal, and Pitts 2013).

However in contrast to these reports, a study with 142 young people from refugee backgrounds who had recently arrived in Australia reported that the sexuality education classes they had attended had increased their understanding of sexual health issues (McMichael and Gifford 2009). It is possible therefore, that despite its recognised shortcomings, for some young people
from culturally diverse backgrounds, including young refugees and migrants, school-based sexuality education might be the best opportunity to increase their sexual health literacy, not only because it overcomes cultural mores and other barriers to discussing sexual health with parents, but also because it helps to overcome the difficulties they may face accessing information from other sources (McMichael 2008; Rawson and Liamputtong 2010). However, it is also important to consider that not all young people arriving in Australia will have this opportunity to learn about sex and sexual health, as they may not attend secondary school upon their arrival, may not have the opportunity to ‘catch up’ on sexuality education programmes, or they may attend a school in which it is not offered (McMichael 2008, 2013). International students may also miss this opportunity if they have come from a country in which sexual health education is not provided or is not comprehensively covered (Reeders 2011; Poljski 2011), an issue that is particularly concerning given the often-new independence and subsequent risk-taking that can accompany student experience.

Achieving youth-friendliness and cultural competence in sexual health service settings

Youth-friendly services

To improve the use of sexual and reproductive health services by young people, it is widely recognised that they should be tailored to their particular needs and preferences (Bender and Fulbright 2013; Braeken and Rondinelli 2012). Shaping the design and delivery of these services in this way is essential for increasing access and promoting health (Bender and Fulbright 2013). An approach advocated by many, both in the Australian and international contexts, is the establishment of ‘youth-friendly’ health services, particularly in the context of sexual and reproductive healthcare (Bearinger et al. 2007; Women’s Health West 2010). While initially described as a framework for primary healthcare in low-income countries, there is growing recognition of the importance of this model in higher-income countries and specialist health services (Ambresin et al. 2013).

According to this framework, services should aim to be accessible, equitable, appropriate, comprehensive, efficient, effective and acceptable to young people (World Health Organization 2002), and cannot be considered youth-friendly if young people are not using them (Braeken and Rondinelli 2012). Examples of how a health service could be more youth-friendly include flexible opening hours, including outside school hours, close proximity to public transport, availability of male and female staff, option of bulk billing (no extra charges or out of pocket payment beyond government reimbursed amount), no Medicare card required, opportunity for ‘dropping-in’ and a welcoming and friendly atmosphere, including youth-specific visual
‘branding’ and information in the form of posters, images, reading material and brochures (Roberts and Crane 2012; Kang et al. 2005), that are available in a familiar language (World Health Organization 2012).

Ideally young people should also be involved in the development, implementation, review and evaluation of services in order to increase their sense of ownership and involvement in services (Kang et al. 2005; Ministry of Health NSW 2010). Youth participation can range from one-off consultations on specific issues, to surveys, focus groups and involvement on key committees (Kang et al. 2005), and may even extend to involving young people in designing their own sexual health education curriculum (University of South Australia n.d.).

**Culturally competent services**

Cultural competency has emerged as a potential strategy to contribute towards eliminating health disparities and improving quality of care. Culturally competent care aims to create a health system and workforce capable of delivering the highest quality care to all clients/patients, regardless of race, ethnicity, faith, culture or language proficiency (Betancourt et al. 2005). In multicultural societies such as Australia, sexual healthcare services must seek to be culturally sensitive at all times (Rawson and Liamputtong 2009), and this is typically well-recognised at national and state levels of government, as well as in professional frameworks that guide the practice of clinicians.

Cultural competence is an ongoing process whereby the provider works within a cultural context, which can involve the individual, their family and community, to provide care that is acceptable to the client/patient (Ngum Chi Watts et al. 2014). It entails understanding the importance of social and cultural influences on clients/patients’ health beliefs and behaviours, consideration of how these interact at different levels of the healthcare system, and developing interventions that take these issues into account to ensure quality healthcare delivery to diverse populations. A framework for cultural competence should include organisational, structural and clinical interventions, as sociocultural barriers to care have been identified at these three levels (Betancourt et al. 2003). Providing culturally competent care is vital to successfully working with young refugees and migrants, and recognising methods such as sensitivity training, use of confidential and appropriate interpreter services, and hiring professionals who share clients/patients’ ethnicity or language, if desirable, will help to enhance health outcomes (McKeary and Newbold 2010). Other strategies to address disparities in healthcare should include recruitment of minority community members into the health profession, development of interpreter services and language-appropriate health educational materials, and provider
education on cross-cultural issues (Betancourt et al. 2003). Such initiatives could also involve the inclusion of young people in the design of strategies and delivery of services.

Diversity among young people represents a significant challenge for health services. The relationships between culture, development and health, and the expertise required by health professionals to provide culturally appropriate services, all play out in adolescent practice (Bennett et al. 2005). While highly visible communities are often labelled as belonging to a collective, homogenous group by appearance and/or experiences (Dean et al. 2012), a myriad of variations occur within and between cultures through factors such as cultural beliefs and practices, religion and level of acculturation. It is therefore important to acknowledge that culture is dynamic and relational, rather than static and fixed (Ussher et al. 2012). As refugees and migrants are not a homogeneous group, healthcare providers must recognise that the differential impact of factors including country of origin, language, culture, gender, age and migrant status leads to diverse health needs. Health is not a ‘one size fits all’, and providers should therefore respond to the unique needs of individuals (McKeary and Newbold 2010; Newman et al. 2013).

Providers must also be cautious not to stereotype those in their care, and recognise that differing value systems may influence decision-making in people of different cultures and backgrounds. This awareness must then be tempered by the understanding that each person and their situation is unique, and the values that an individual holds may not be the same as others, nor even of the official teachings of their religion or the cultural norms reported by others of the same religion or culture (Srikanthan and Reid 2008), including that of their parents. Sensitivity to the cultural, ethnic, religious, linguistic and social diversity among young people will help to avoid misunderstandings, improve patient/client satisfaction, and lead to better outcomes (Bennett et al. 2005).

Tervalon and Murray-Garcia (1998) suggest that healthcare providers should go beyond ‘cultural competence’ to being committed to, and actively engaging in, a lifelong process of self-reflection and self-critique, referred to as ‘cultural humility’. Findings from a study exploring reproductive health providers’ communication with Somali women in Finland, for example, highlighted the need for cultural competence in delivery of services to client/patients from different ethnic or cultural backgrounds, as well as a genuine passion to be flexible, to accept differences and a willingness to learn from each other (Tervalon and Murray-Garcia 1998; Degni et al. 2012). Campinha-Bacote (2002) similarly states that healthcare providers should go beyond saying they respect the values, beliefs and practices of their clients/patients, or providing a culturally specific intervention, to having a genuine motivation or passion to
provide care that is culturally responsive. This includes having the desire to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants, including young people from different cultural backgrounds.

**Conclusion**

While a number of populations experience barriers to accessing sexual and reproductive health promotion and care (Temple-Smith 2014), the factors influencing the experiences of young people from culturally diverse backgrounds in Australia reveal issues of significance to understanding the intersecting dynamics between migration and health. While migrants, refugees and international students come from a wide diversity of backgrounds and experiences, many face a range of often similar challenges in relation to their sexual and reproductive health. This chapter has reviewed this issue in the Australian context, and highlighted the importance of pursuing cultural competence in the provision of healthcare to an increasingly multicultural society. While the vulnerability of culturally diverse young people to poor sexual and reproductive health outcomes in Australia is widely recognised, knowledge gaps remain regarding their use of, and engagement with, appropriate healthcare (Botfield et al. 2015), including the strengths and assets they bring and the potential for this to be harnessed through lively policy and practice debates. An integrated and national approach is required, with a focus on the sexual and reproductive health of culturally diverse young people and all that this encompasses, in order to more effectively engage them with sexual and reproductive healthcare and improve health outcomes.
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Chapter 4: Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: A structured scoping review

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In addition to undertaking the broader literature review described in Chapter 3, a ‘scoping review’ was conducted to systematically determine the extent, range and nature of research activity in this field in Australia and identify research gaps in relation to young people from ‘culturally diverse’ backgrounds and sexual and reproductive health services. The scoping review identified two particular gaps regarding the perspectives of culturally diverse young people in relation to sexual and reproductive health and health care, and their engagement with related services. Findings from the review, including the identified knowledge gaps, were discussed with five key informants as part of the broader research consultation process to elicit their views on this field of research. Undertaking the scoping review in particular informed the study design and identified the two knowledge gaps which then helped to refine the research aim and objectives. In addition to publishing these findings in a peer-reviewed journal, findings from the review were presented at the UNSW Australian Social Policy Conference in 2015.

This chapter contains the post-print (e.g. accepted) version of a journal article published by CSIRO Publishing in the journal Sexual Health on 28 September 2015. Sexual Health is ranked in the second quartile for Medicine (Infectious Diseases) journals (138/287), and for Medicine (Public Health, Environmental and Occupational Health) journals (170/526) (Scimago Journal Rankings 2017). The journal also ranks in the top 20 Google Scholar rankings for the sex and sexuality field (14/20).


Declaration: I certify that this publication was a direct result of my research towards this PhD, and that reproduction in this thesis does not breach copyright regulations.

Signed:
Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: a structured scoping review

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Abstract. Sexual and reproductive health needs are global health, development and human rights priorities, essential to the wellbeing of individuals, couples and families. Despite widespread recognition of this, young people, including those from culturally diverse backgrounds in wealthy nations such as Australia, remain largely hidden to, and underserved by, sexual and reproductive healthcare services. A scoping review was undertaken to describe the range of research on sexual and reproductive health among culturally diverse young people in Australia, in order to identify gaps in the literature. This comprised a systematic literature search and key informant consultations, followed by descriptive thematic analysis of the included literature. One hundred and twenty papers were deemed eligible for inclusion, and findings are presented as three separate analyses. The first provides an overview of four dimensions identified in the literature: (i) cultural diversity; (ii) the resettlement experiences of migrant communities; (iii) the sexual and reproductive health needs of these communities; and (iv) the practices of health services in this field. The second explores what is known from the literature about culturally diverse young people’s needs for, use of, and engagement with services for sexual and reproductive health, while the third identifies two knowledge gaps: (1) the perspectives of culturally diverse young people regarding sexual and reproductive health and health care; and (2) the engagement of culturally diverse young people with sexual and reproductive health services. New directions for a research agenda on sexual and reproductive health care for culturally diverse young people in Australia are proposed, based on the identified knowledge gaps.

Additional keywords: Australia, culture, diversity, health services, sexual health.

Received 1 May 2015, accepted 23 July 2015, published online 28 September 2015
Abstract

Sexual and reproductive health needs are global health, development and human rights priorities, essential to the wellbeing of individuals, couples and families. Despite widespread recognition of this, young people, including those from culturally diverse backgrounds in wealthy nations such as Australia, remain largely hidden to, and underserved by, sexual and reproductive healthcare services. A scoping review was undertaken to describe the range of research on sexual and reproductive health among culturally diverse young people in Australia, in order to identify gaps in the literature. This comprised a systematic literature search and key informant consultations, followed by descriptive thematic analysis of the included literature. One hundred and twenty papers were deemed eligible for inclusion, and findings are presented as three separate analyses. The first provides an overview of four dimensions identified in the literature: (i) cultural diversity; (ii) the resettlement experiences of migrant communities; (iii) the sexual and reproductive health needs of these communities; and (iv) the practices of health services in this field. The second explores what is known from the literature about culturally diverse young people’s needs for, use of, and engagement with services for sexual and reproductive health, while the third identifies two knowledge gaps: (1) the perspectives of culturally diverse young people regarding sexual and reproductive health and health care; and (2) the engagement of culturally diverse young people with sexual and reproductive health services. New directions for a research agenda on sexual and reproductive health care for culturally diverse young people in Australia are proposed, based on the identified knowledge gaps.

Key words

Australia, culture, diversity, health services, sexual health
Chapter 4: Scoping review (published article)

Background

Sexual and reproductive health are global health, development and human rights priorities, essential to the wellbeing of individuals, couples and families, and to social and economic development (Temmerman, Khosla, & Say, 2014). It is widely acknowledged that the sexual and reproductive health needs of young people, wherever they live, have been largely neglected (Bearinger, Sieving, Ferguson, & Sharma, 2007; Glasier, Gulmezoglu, Schmid, Moreno, & Van Look, 2006; Jordan, Bayly, & Sawyer, 2005), in part because their sexual and reproductive health rights and needs are often considered sensitive and contentious (Glasier et al., 2006; Jordan et al., 2005). Young people from diverse backgrounds are also vulnerable to poor sexual and reproductive health, in Australia and globally, and are an often neglected group (Newton et al., 2013; Rawson & Liamputtong, 2009; Wray, Ussher, & Perz, 2014).

The notion of sexual and reproductive health captures not merely the absence of disease (Hach, 2012; Temple-Smith, 2014; Temple-Smith & Gifford, 2005), but also the availability of sexual and reproductive health services, and the promotion of sexual and reproductive wellbeing. It is generally acknowledged, however, that certain populations in wealthy nations such as Australia are particularly vulnerable to poor sexual and reproductive health, including young people and people from culturally and linguistically diverse backgrounds (Newton et al., 2013; O’Rourke, 2008). In the context of Australia, the term ‘culturally and linguistically diverse’ describes anyone born outside Australia who is from a non-English speaking background, is identified as non-Caucasian in ethnic origin, or is a refugee (Thomas, Beckmann, & Gibbons, 2010). For this paper the definition has been expanded to include children of parents who fit this definition, that is, second generation migrant Australians.

Young people are disproportionately affected by sexual and reproductive health issues (Bearinger et al., 2007; Glasier et al., 2006), largely due to the physical, psychological, emotional and economic changes they undergo as they transition through adolescence to adulthood (United Nations Children’s Fund, 2012). Young people from culturally diverse backgrounds affected by experiences of migration or displacement face the additional challenges associated with growing up between two cultures (Bennett, Chown, & Kang, 2005; Chown, Kang, Sanci, Newnham, & Bennett, 2008), and for refugees this can be further compounded by their earlier, and often traumatic, experiences (Finney Lamb & Smith, 2002).

Although there are limited data on the sexual and reproductive health of culturally diverse young people in Australia, what is known reveals important insights into their experiences and needs. The Fifth National Survey of Australian Secondary Students and Sexual Health (of
which over one third of students had a parent born overseas, and 15% spoke a language other than English at home) reported 69% of 16-19 years olds had experienced some form of sexual activity and 13% of sexually active students used no contraception the last time they engaged in sexual activity (Mitchell, Patrick, Heywood, Blackman, & Pitts, 2014). These data have particular resonance in a broader community of young people which has seen persistently high notification rates for sexually transmissible infections (Australian Clearinghouse for Youth Studies, 2014; Hendry, Brown, Johnston, & Dowsett, 2013): for example, 64% of chlamydia notifications in 2011 were in people aged 15-24 years (Family Planning NSW, 2013). Contraceptive use is reported as lowest among young people (62% for those 18-24 years) compared to other age groups, and for women from non-English speaking countries (50%) (Family Planning NSW, 2013). In combination, these insights suggest important confluences between sexual health and migrant or refugee backgrounds for young people in Australia, which are important to better understand.

Methods

A structured scoping review was undertaken to describe the range of research on sexual and reproductive health among culturally diverse young people in Australia, with a particular interest in health service provision and engagement with this population, in order to identify knowledge gaps and inform future research, policy and practice. There is widespread recognition of the value of evidence to inform policy and practice (Bowen & Zwi, 2005; Head, 2010), and assessing available evidence in the form of a scoping review is a valuable exercise.

A scoping review is a structured method used to synthesise and analyse a wide range of literature to provide greater conceptual clarity about a complex topic (Davis, Drey, & Gould, 2009). While it does not seek to assess the quality of included studies, it should be undertaken in a rigorous and transparent way. The process should be iterative and reflexive, with search terms redefined and steps repeated as necessary to ensure comprehensive coverage (Arksey & O'Malley, 2005).

The framework proposed by Arksey and O'Malley (2005) was used to guide the conduct and reporting of this scoping review. The steps undertaken are detailed in Table 5, while Figure 1 provides an overview of the selection process, and Table 6 the characteristics of the included literature.
Table 5: Outline of steps undertaken for the scoping review

Stage 1 – Identifying the research question

Purpose of review: To describe the range of research on sexual and reproductive health among young people from culturally and linguistically diverse backgrounds in Australia, including their understandings and experiences of accessing health services for sexual and reproductive health matters, in order to identify gaps in the literature.

Research question: What are the understandings and experiences of young people from culturally and linguistically diverse backgrounds in Australia regarding sexual and reproductive health and related health care?

Stage 2 – Identifying relevant studies

After developing a search strategy, relevant literature was identified by searching key databases with consistent search parameters, using EndNote as a data management tool. Three processes were developed to search the literature: 1) searching online research indexing databases, 2) searching article reference lists, Trove, UNSW Library, Google Scholar and organisational websites, and 3) identifying additional references through consultations with key informants.

Search terms: [“culturally diverse” OR “linguistically diverse” OR “refugee”] AND [“sexual and reproductive health” OR “family planning”] AND [“service” OR “clinic”] AND [“Australia”]

Databases: Medline, Embase, CINAHL, Popline, Web of Science, Scopus, ProQuest

Publication period: after 2000

Language: English only

Electronic databases were searched on 22 December 2014, and results exported to EndNote. Additional literature found between December 2014 and March 2015, and findings from a second database search on 17 March 2015 to include the terms “migrant” and “non-English speaking”, were manually added. All references were combined and saved in a folder in EndNote, and duplicates removed.

Stage 3 – Study selection

Inclusion and exclusion criteria were established, and literature selected accordingly. Each reference was reviewed in EndNote, and included (y) or excluded (deleted) based on title. Any additional duplicates identified along the way were also removed. Each included reference was reviewed by abstract and excluded (yn), or included (yy) if deemed to be a ‘good fit’ or if its relevance was unclear, and the full text obtained. Included papers were read in full and a final decision made to exclude (yyn) or include (yyy). Figure 1 provides an overview of this process, and Appendix 7 lists all included papers.
**Exclusion criteria:** Study sample or focus outside of Australia, publication not in English, published before 2000, not relevant to research question, media article

**Inclusion criteria:** Study sample or focus within Australia, English language, published after 2000, and related to at least two or more of these four areas: people from culturally diverse backgrounds, young people, health services, and sexual and reproductive health.

To ensure a broad range of literature ‘young people’ was not a search term, however articles not relevant to this group (e.g. focused on aged care) were excluded. The aspects of sexual and reproductive health included were those of particular relevance to young people, for example contraception, sexually transmissible infections, safe abortion, and access to information and services. While other aspects were found during searches (e.g. infertility; parenthood; antenatal care; gender-based violence; mental health) they were not the primary focus of the review and were excluded. Articles related to Aboriginal or Torres Strait Islander people were excluded, as they do not technically come under the term ‘culturally and linguistically diverse’ (Multicultural NSW, n.d.).

**Stage 4 – Charting the data**

All included references were charted in Excel, that is, relevant information was synthesised and interpreted by sifting, charting and sorting according to key issues and themes. A ‘descriptive-analytical’ method was used, which involved applying an analytical framework to the literature and collating information on each (Arksey & O'Malley, 2005). The list of included references was exported into the ‘data charting form’, and a coding framework developed to characterise key features of each. Table 6 indicates the key characteristics of included papers.

**Stage 5 – Collating, summarising and reporting the results**

Results were collated and reported to present an overview of the material reviewed; two ways of presenting a narrative account of findings were utilised: basic numerical analysis in a table to map the extent, nature and distribution of literature, and literature was organised thematically, and descriptive thematic analysis and narrative synthesis used to present the literature (Arksey & O'Malley, 2005). Findings are presented in the article as three analyses of the eligible literature: 1) major categories in the literature on sexual health and cultural diversity, 2) what is known from the literature about culturally diverse young people’s needs for, use of, and engagement with services for sexual and reproductive health, and 3) knowledge gaps.

**Stage 6 – Consultation exercise**

Levac, Colquhoun, and O’Brien (2010) suggest consultations should be essential to any scoping review methodology, as they have the potential to add value, additional references, and new insights (Arksey & O'Malley, 2005). Informal consultations were conducted with
five expert key informants from relevant government and non-government health services in Sydney. These took place between December 2014 and February 2015, and centred on the field of research, literature and services of interest. Informants were also invited via email to comment on findings from this scoping review in order to validate the findings.

Table 6: Characteristics of included literature

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>(n 120)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of paper/study</strong></td>
<td></td>
</tr>
<tr>
<td>Qualitative studies</td>
<td>50</td>
</tr>
<tr>
<td>Reviews and reports</td>
<td>36</td>
</tr>
<tr>
<td>Quantitative studies</td>
<td>19</td>
</tr>
<tr>
<td>Policy documents</td>
<td>7</td>
</tr>
<tr>
<td>Theses</td>
<td>5</td>
</tr>
<tr>
<td>Books</td>
<td>2</td>
</tr>
<tr>
<td>Mixed methods (qualitative and quantitative)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Location/region of focus</strong></td>
<td></td>
</tr>
<tr>
<td>New South Wales (NSW)</td>
<td>35</td>
</tr>
<tr>
<td>National (or general)</td>
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<td>Queensland</td>
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<tr>
<td>Western Australia (WA)</td>
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<tr>
<td>Not specified</td>
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<td>NSW and WA</td>
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<tr>
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<td>Young people</td>
<td>47</td>
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<tr>
<td>Adults (may also include older adolescents)</td>
<td>43</td>
</tr>
<tr>
<td>Mix of ages</td>
<td>30</td>
</tr>
<tr>
<td><strong>Target population background</strong></td>
<td></td>
</tr>
<tr>
<td>Culturally diverse</td>
<td>73</td>
</tr>
<tr>
<td>General population</td>
<td>42</td>
</tr>
<tr>
<td>Mix of groups (‘marginalised’ or ‘priority’ populations)</td>
<td>5</td>
</tr>
<tr>
<td><strong>Focus area/s</strong></td>
<td></td>
</tr>
<tr>
<td>Sexual and/or reproductive health</td>
<td>75</td>
</tr>
<tr>
<td>Health services</td>
<td>65</td>
</tr>
</tbody>
</table>
Figure 1: Flow chart of selection process

4,111 documents identified through electronic database searches (on 22 December, 2015)

4,173 publications found altogether

3,668 publications screened

711 publications screened

164 publications screened

120 publications included altogether

62 additional publications manually added (on 22 December 2014, 29 January, 16 February, 17 March 2015)

505 duplicates automatically removed in EndNote

2,957 publications excluded based on title

547 publications excluded based on abstract

44 publications excluded based on full text
Discussion

Analysis 1: What are the major focal categories in the Australian literature on sexual health and cultural diversity?

A descriptive narrative approach was employed to identify the major categories evident across the breadth of included literature, and four inter-related dimensions were identified (see Table 7): (i) cultural diversity; (ii) resettlement; (iii) sexual and reproductive health; and (iv) health services. While some articles addressed more than one, or even all, of these categories, most addressed only one or two. Each of these is briefly discussed below, along with any gaps proposed by cited authors.

Table 7: Key categories identified in the literature

<table>
<thead>
<tr>
<th>Key categories</th>
<th>Sub-categories</th>
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</table>
| 1. Cultural diversity | • Migration, resettlement and acculturation  
• ‘Two cultures’  
• Identity  
• Family and community |
| 2. Resettlement experiences of migrant communities | • Immigration, resettlement and integration  
• Social relations and networks  
• Access to health care  
• Social and cultural contexts and challenges |
| 3. Sexual and reproductive health needs of migrant communities (including sexual health, sexually transmissible infections, HIV/AIDS) | • Knowledge and experiences  
• Access to / use of services  
• Testing, treatment, disclosure  
• Ethical and methodological considerations  
• Social and cultural contexts |
| 4. Practices of health services in this field (including general practice, family planning, and sexual health clinics) | • Accessibility and acceptability  
• Service preferences and utilisation  
• Adolescent and provider perspectives  
• Challenges and barriers  
• Social and cultural contexts |

Many papers discussed experiences of cultural diversity and resettlement in Australia, even if this was not their primary focus. Most documented the more challenging aspects of these, including difficulties in accessing health services, loss of social networks, challenges of racism.
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and discrimination (Allotey, Manderson, Bahlo, & Demian, 2004), negotiating between two cultures, and intergenerational relationship conflict (Iqbal, Joyce, Russo, & Earnest, 2012), however positive stories were also evident. Resilience and adaptability were identified as key attributes associated with people from refugee backgrounds, with many settling successfully in Australia and contributing to social, economic and cultural life (Pittaway, Muli, & Shteir, 2009).

The literature examined in this review explored a range of issues around knowledge of and experiences with sexual and reproductive health, including service accessibility, acceptability and utilisation, and the social and cultural influences on health and service use. Two papers explored the sexual and reproductive health and service use of culturally diverse young people in Australia. None specifically examined sexual and reproductive health, health services, and culturally diverse young people or young men, although two explored these intersecting issues for culturally diverse young women. Several authors similarly suggested there is limited research on sexual and reproductive health issues and outcomes for migrants and resettled youth with refugee backgrounds (McMichael & Gifford, 2009, 2010; Rogers & Earnest, 2015). While many agreed that cultural, social and religious factors have a significant influence on sexual and reproductive health (Khoei, Whelan, & Cohen, 2008; Manderson, Kelaher, Woelz-Stirling, Kaplan, & Greene, 2002; Rawson & Liamputtong, 2010; Rogers & Earnest, 2014; Ussher et al., 2012; Wray et al., 2014), this was identified as an area requiring further investigation (Ussher et al., 2012), and several raised the need to examine these with young people from different cultural and religious affiliations (Sexual Health and Family Planning Australia, 2013; Victorian Department of Health, 2013; Wray et al., 2014).

The literature addressing health services recognised that they are often under-utilised by culturally diverse communities (Hach, 2012; Manderson & Allotey, 2003; Martin, Knight, Read, & McNulty, 2013; Ussher et al., 2012; Wray et al., 2014), and that this group interpret symptoms and use services differently from the Australian-born population (Australian Medical Association, 2014; Hach, 2012; Lee, Sulaiman-Hill, & Thompson, 2013; NSW Health, 2012). The literature suggests that most healthcare for refugees and migrant communities in Australia is provided through mainstream health services (Finney Lamb & Smith, 2002; South Eastern Sydney Local Health District, 2011), defined as any service “that aims to cater for the broad population in the provision of its services and programs” (Department of Human Services, 1998). Relevant mainstream services include general practitioners, youth health services, and family planning and sexual health clinics. The services provided and their location make them a convenient option; while most do not cater for specific groups of people, many can access interpreter services (Kelaher & Manderson, 2000). General practitioners are viewed as the most

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accessible primary healthcare providers, and are usually a young person’s first point of contact with the health system (Chown et al., 2008; Dadich, Jarrett, Sanci, Kang, & Bennett, 2013).

**Analysis 2: What is known about engaging culturally diverse young people with sexual and reproductive health services in Australia?**

Whilst there appears to be limited research specifically on the sexual and reproductive health of culturally diverse young people in Australia, this second analysis focused on the literature available to explore what is known about engaging this group with sexual and reproductive health services; three areas of interest were identified.

1. **Influences on, and needs of, culturally diverse young people regarding sexual and reproductive health**

   The literature described a range of influences on culturally diverse young people’s sexual and reproductive health, and their access to appropriate information and services. Several papers identified that they require sufficient knowledge and skills to achieve good sexual and reproductive health, as well as knowledge of and access to services appropriate to their age and cultural background. This includes accessible, affordable and confidential advice and care, and environments that prioritise culturally competent care and safety (McMichael & Gifford, 2009; Rawson & Liamputtong, 2009; Reunders, 2011; Smith, 2006).

   Sexual and reproductive health promotion is essential for young people, to support their engagement with health services, emphasise the importance of preventive behaviours, and increase understanding of sexually transmissible infections (McMichael & Gifford, 2009). It is emphasised in the literature that sexual health promotion amongst resettled youth must be responsive to their social contexts and everyday experiences; while their sexual health needs may be similar to those of other young people, their backgrounds and the resettlement context can raise additional challenges in learning about and negotiating sexual health (McMichael & Gifford, 2010). Some argue that sexual health promotion should form a component of early resettlement services to improve sexual health literacy and reduce the risk of young people “falling in between health service gaps” (McMichael & Gifford, 2010), while others suggest that poor sexual health knowledge is not necessarily related to the inability to obtain information, but is more closely linked to community norms and cultural and religious influences (Wray et al., 2014).

   Young people are not a homogeneous group, and it is widely recognised that diverse cultural, religious and social contexts and beliefs influence their health and the ways they access and use health information. Ideas and values relating to sexual and reproductive health can be shaped by
the culture and society to which one belongs, or with which one identifies, and the factors that shape people's health are reported to be strongly informed by their living conditions and social determinants of health (Keys et al., 2008). It is widely thought that cultural, social and religious factors have a significant influence on sexual and reproductive health, self-understanding and expression (Khoei et al., 2008; Manderson et al., 2002; Rawson & Liamputtong, 2010; Rogers & Earnest, 2014; Ussher et al., 2012; Wray et al., 2014), although a biomedical approach has underpinned much of the research in this area (Rawson & Liamputtong, 2009).

The literature suggests that family and community can hold considerable sway when it comes to sexual and reproductive health for culturally diverse young people, which can create or exacerbate barriers to accessing services (Rawson & Liamputtong, 2009; Wray et al., 2014). Difficulties in learning about sexual health in Australia may reflect cultural beliefs and practices, including shame and stigma regarding premarital sex, sexual diversity and sexually transmissible infections. This can inhibit discussion of these issues and make it difficult for young people to access relevant information and services (McMichael, 2008; Newton et al., 2013). A study investigating late HIV diagnosis in New South Wales (NSW), with a particular focus on culturally diverse people, reported one reason for late diagnoses was perceived stigma and fear of discrimination, with participants worried about confidentiality and rejection by families. Participants were 18 years and older (Asante, Körner, & Kippax, 2009), so it is likely these experiences would be further intensified for younger people.

Other influences on the sexual and reproductive health and use of services for young people include location and accessibility of services, level of comfort in disclosing health concerns, attitudes of service providers (Booth et al., 2004), language barriers (Hach, 2012; McMichael, 2008; McMichael & Gifford, 2009), financial constraints (Hach, 2012; Spike, Smith, & Harris, 2011) and familiarity (or not) with services (McMichael & Gifford, 2009). Visa status and Medicare eligibility, which in Australia facilitate government contribution to entire (or in some cases partial) cost of services, also influence engagement with care (Ethnic Communities’ Council of Victoria, 2013; Hach, 2012; NSW Health, 2011), although it is not clear what effect this has on young people and their use of health services for sexual health.

2. Perceptions and use of sexual and reproductive health services among culturally diverse young people

While many young people have complex health needs, the literature suggests that most do not seek health care as often as they could (Bernard et al., 2004; Booth, Knox, & Kang, 2008; Dadich et al., 2013; Kang et al., 2003; Skinner & Hickey, 2003). A study investigating the health concerns of NSW adolescents found that one-third of females and two-thirds of males
would not seek help for any health concerns (Booth et al., 2002; Booth et al., 2004). Whilst these findings are for young people more generally, the situation is likely similar or worse for culturally diverse young people regarding sexual and reproductive health. Rising rates of sexually transmissible infections and generally low levels of testing suggests available information on services may be inaccessible, poorly targeted, under-utilised, or rejected by young people (Keys et al., 2008).

Many young people will not use a sexual and reproductive health clinic if they feel well, or do not believe they are ‘at risk’ (Skinner & Hickey, 2003). For example, international students in Australia are reported to only access health services “as a last resort” (Reeders, 2011), and other marginalised youth only during a crisis (Cummings & Kang, 2012). A study exploring the sexual health literacy of young people from refugee backgrounds reported many only saw a doctor if they had what they perceived to be a ‘serious’ issue, such as an unplanned pregnancy or sexually transmissible infection; this is especially worrying given many sexually transmissible infections are asymptomatic (McMichael & Gifford, 2009). Anecdotal stories from key informants consulted during the preparation of this review similarly highlighted that many young people only visit their clinic if they are worried about a symptom or are frightened after having engaged in unprotected sex.

Unfamiliarity with the health system can also discourage service use (Hach, 2012; McMichael, 2008). This, and/or a perception that health beliefs and cultural values are overlooked or disregarded by Australian health professionals, can lead some people to feel uneasy around health providers (Benson & Smith, 2007; Rogers & Earnest, 2014). Young people are likely to also have low levels of awareness of the services available to them (Booth et al., 2004), including specialist sexual health services (McMichael, 2008; McMichael & Gifford, 2009). A study exploring the sexuality of women from Iranian backgrounds residing in Sydney reported that many younger women did not know that sexual health services existed, or the role of different services for such needs (Khoei & Richters, 2008). Services are not always easily accessible for immigrants and refugees in Australia, and many find the system difficult to navigate (Hach, 2012).

General practitioners provide the majority of health care in Australia (Achat, Thomas, Close, Moerkerken, & Harris, 2010; Booth et al., 2008; Ministry of Health NSW, 2010). Studies have shown, however, that many culturally diverse young people would rather not visit a general practitioner or local health clinic for sexual health concerns, particularly if the provider identifies with the same ethnicity or community, is of a different gender, or if an interpreter is required (McMichael, 2008; McMichael & Gifford, 2009; Rawson & Liamputtong, 2009). This
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is largely due to issues around confidentiality and trust (Khoei & Richters, 2008; McMichael, 2008; McMichael & Gifford, 2009; Rawson & Liamputtong, 2009; Rogers & Earnest, 2014) and fear that “doctor-patient confidentiality would be trumped by cultural duty” (Rawson & Liamputtong, 2009). A study on the impact of traditional culture on the uptake of mainstream health services for sexual health matters by young women of Vietnamese background found that parental control over their choice of general practitioner resulted in fear of visiting the doctor for sexual health matters (Rawson & Liamputtong, 2009). Sexual health services are perceived by some as culturally inappropriate for unmarried women, resulting in avoidance due to fear of family or friends knowing that they are interested in sexual health or engaging in premarital sexual activity (Hach, 2012; Ussher et al., 2012).

3. Policy and practice perspectives on engaging culturally diverse young people with sexual and reproductive health services

A range of national and state policies operate in Australia regarding young people and sexual and reproductive health, although each prioritises ‘marginalised’ populations differently. Culturally diverse people and young people are listed as priority groups in the ‘Third National Sexually Transmissible Infections Strategy 2014-2017’ (Department of Health, 2014b), although neither are listed as a priority in the ‘Seventh National HIV Strategy 2014-2017’ (Department of Health, 2014a). The ‘Sexual Health Strategy: Sexually Transmissible Infections 2013-2018’ in NSW lists young people as a high priority population (NSW Health, 2013); culturally and linguistically diverse people are mentioned, but not listed as a priority group. Refugee youth are a priority in the NSW ‘Refugee Health Plan 2011-2016’, and sexual and reproductive health is identified as a priority health issue (NSW Health, 2011), although the ‘Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016’ does not mention sexual or reproductive health (NSW Health, 2012). These policies are likely to have considerable influence on the resources and attention that health services direct towards engaging culturally diverse and/or young people, particularly if they are state-funded and guided by a particular policy framework.

Nonetheless, many health services produce health promotion material in different languages, with many recognising this should be done in a culturally appropriate and accessible way, going “beyond translation into the language of the communities which they attempt to engage, to align with the values inherent within the cultures of these population groups” (Iqbal et al., 2012). Providing appropriate translated health information aims to support more people in gaining health knowledge, create greater awareness of available services, and assist in reducing the culture shock experienced by many when exposed to a new health system (Iqbal et al., 2012). Media and health promotion representations of sexual health are often very ‘anglocentric’, so
culturally diverse young people will rarely see relatable images in this material (Ethnic Communities’ Council of Victoria, 2013). One informant consulted for this review also raised the important point that not all clients have strong literacy skills. A key recommendation from a study with women of Sudanese and Eritrean background regarding their reproductive health and contraception experiences was for health information to be delivered in a manner that would be accessible to people with different literacy levels (Rogers & Earnest, 2014). Many services provide interpreters to overcome language barriers, however these are not always appropriate for young people when discussing sexual health due to the confidentiality concerns noted earlier (McMichael, 2008; McMichael & Gifford, 2009).

Whilst the barriers young people face in Australia in accessing health services are well documented, from both youth and/or service provider perspectives (Bernard et al., 2004; Booth et al., 2004; Chown et al., 2008; Jordan et al., 2005; Kang et al., 2003), few have sought to integrate these perspectives or discuss the congruence or conflict between them (Bernard et al., 2004). As described earlier, examples of barriers specifically identified by young people include embarrassment and shame, issues of confidentiality, lack of knowledge of services, inaccessibility of services, discomfort in disclosing health concerns, and health provider attitudes (Booth et al., 2004). Barriers to service provision identified by healthcare providers include inadequate time, flexibility, skills and confidence in working with young people, and few linkages with other services (Kang et al., 2003). One study that did explore the interface between health providers and young people’s views noted the importance of providers understanding and appreciating the perspectives of young people (Bernard et al., 2004).

**Analysis 3: What are the notable gaps in knowledge?**

This review has described key findings from the literature regarding the sexual and reproductive health of culturally diverse young people in Australia. While their health concerns are fairly well documented, there are gaps in the research regarding their use of, and engagement with, appropriate healthcare. Two specific gaps identified are discussed below: 1) the perspectives of culturally diverse young people regarding sexual and reproductive health and health care, and 2) the engagement of culturally diverse young people with sexual and reproductive health services. Several international studies are cited in this section to provide comparative insights regarding ways forward in understanding and addressing these gaps.

**Gap 1: Appreciating the perspectives of culturally diverse young people regarding sexual and reproductive health and health care**

In order to meet the sexual and reproductive health needs of young people, it is important that their perspectives be used to inform change (Biddlecom, Munthali, Singh, & Woog, 2007;
Braeken & Rondinelli, 2012). The majority of studies in this scoping review that examined culturally diverse young people did include young people as study participants, however little research has been undertaken with this group that focuses on health services and sexual and reproductive health, as noted previously. Studies report that young people and people from diverse backgrounds do not seek out health care as often as they could, and we can only assume this is similar or worse for culturally diverse young people, especially regarding sexual and reproductive health. There is little focus in the literature on what influences their decision-making regarding health service attendance for sexual and reproductive health, their service preferences, and their priorities when using services. It is also not clear how they make sense of confidentiality and trust issues in attending services, and how they conceptualise health, wellbeing and risk more generally. A study assessing the healthcare needs of refugees in Melbourne found there was “surprisingly little literature on the experiences of using local health services from the refugee client perspective” (Cheng, Russell, Bailes, & Block, 2011). McMichael and Gifford (2010) similarly note that the limited research on the sexual and reproductive health of resettled refugees has focused primarily on adult women. Research with, and perspectives from, young people on how they conceptualise health, wellbeing and risk, and their preferences for and perceptions of services, is essential to understand to develop appropriate policies, services and programs (Braeken & Rondinelli, 2012).

Few analyses have been conducted in Australia that investigate gendered differences in the perception of sexual and reproductive health services among culturally diverse young people, or who they view as the ‘types’ of people who use these services. Studies undertaken in comparable settings in England and Northern Ireland found that many young men see sexual health services as being more oriented towards, and used by, women, and therefore do not attend them (Donnelly, 2000; Pearson, 2003). In Australia some youth health services are funded to primarily support ‘at-risk’ young people, and may be perceived as addressing ‘others’ by those who do not view themselves in this way (Skinner & Hickey, 2003). Further research is required to explore this issue in the Australian context, particularly with young men and young women from culturally diverse backgrounds.

**Gap 2: Documenting and strengthening the engagement of culturally diverse young people with sexual and reproductive health services**

While it is widely recognised that sexual and reproductive health services should be tailored to the needs of young people to improve their engagement (Bender & Fulbright, 2013; Braeken & Rondinelli, 2012), little (if any) research has been conducted to document how sexual and reproductive health services seek to engage culturally diverse young people in Australia. National and state policies are likely to have considerable bearing on the level of engagement
that services prioritise with culturally diverse and/or young people; individual clinics may have different interpretations, and therefore prioritise different groups, impacting their acceptability and accessibility. Tailoring the design and delivery of sexual and reproductive health services to the needs and preferences of young people is essential to increasing access and promoting health and quality of life (Bender & Fulbright, 2013). An approach advocated by many key authors and organisations is for the establishment of youth-friendly health services, particularly for sexual and reproductive health care (Bearinger et al., 2007; Women’s Health West, 2010). The NSW Youth Health Policy similarly encourages health services to be youth-friendly, and to respect and respond to all forms of diversity including cultural, religious, and sexual (Ministry of Health NSW, 2010). However while the concept of ‘youth friendliness’ is used frequently in the literature, there is little consensus on what it means in practice, and services cannot be considered youth friendly if young people are not using them (Braeken & Rondinelli, 2012).

Strategies to enhance the youth-friendliness of services, and the cultural competence of providers, are well documented in both the Australian and international literature and have had some success (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013; Braeken & Rondinelli, 2012; Chown et al., 2008; Cummings & Kang, 2012; Ministry of Health NSW, 2010; Tylee, Haller, Graham, Churchill, & Sanci, 2007; World Health Organization, 2012). Another approach suggested is the use of peer educators to better reach young people about sexual health issues and disseminate health promotion messages (Drummond, Mizan, Brocx, & Wright, 2011; Newton et al., 2013). The best models of service provision, however, and whether and how sexual and reproductive health services in Australia are prioritising culturally diverse young people and implementing appropriate strategies, appears to be less understood.

**Review limitations**

As a scoping review, the aim was not to appraise the quality of the collated research (Arksey & O'Malley, 2005). Rather, a clear purpose, research question and set of search terms were developed in order to provide a systematic overview of current knowledge on this complex topic. While thorough search processes were prioritised, some papers may have been missed due to limitations in the search terms, inclusion and exclusion criteria, and/or database search syntax. Manually identifying and incorporating additional literature helped to broaden the scope of the reviewed research, but it is possible that key pieces were nonetheless missed. The decision to include or exclude literature, and the characterisation of eligible literature, was undertaken by just one author.
Conclusion

This scoping review has described the range of literature on the sexual and reproductive health of culturally diverse young people in Australia. Despite increasing recognition that this population is known to be vulnerable to poor sexual and reproductive health outcomes in Australia, there has been insufficient research to better understand this. In order to enhance the sexual and reproductive health of culturally diverse young people in Australia, and increase the accessibility and acceptability of services, additional research should seek to address the two identified knowledge gaps. Research is underway in Sydney, NSW, to understand the views of culturally diverse young people on their need for and use of services for sexual and reproductive health, as well as community, provider and policy perspectives on engaging this population. This research will generate important new insights regarding the challenges services face in seeking to become both youth-friendly and culturally inclusive, both of which bring their own set of complexities and opportunities. With this bold ambition, it is hoped that the research will produce insights of use to policy and practice in the youth, migrant and sexual health fields in Australia, and in comparable international settings.

Acknowledgements

Dr Alison Rutherford, Dr Deborah Bateson, Katherine Bennett, Dr Melissa Kang and Dr Catriona Ooi offered valuable feedback and advice on this area of research. Dr Deborah Bateson also provided feedback on the scoping review and research gaps identified. Rachel Jones (UNSW Australia Librarian) provided useful guidance on the electronic database search.
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Chapter 5: Drawing them in: Professional perspectives on the complexities of engaging ‘culturally diverse’ young people with sexual and reproductive health promotion and care in Sydney, Australia

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This chapter is the first in the thesis to present primary data from the doctoral research. It reports on findings from key informant interviews regarding the complexities of, and best practice approaches to, engaging young people from ‘culturally diverse’ backgrounds with sexual and reproductive health promotion and care in Australia. This chapter contributes towards objectives 2 and 3 regarding whether and how migrant and refugee young people engage with sexual and reproductive health services, and opportunities for strengthening this engagement. Although the primary group of interest in this research was migrant and refugee young people, key informants were invited to participate in order to document professional perspectives in this field. The majority of interviews with key informants were therefore undertaken first, so as to gather contextual information on key issues, and to develop a comprehensive picture of professional views on engaging migrant and refugee young people with sexual and reproductive health care. An oral presentation of key findings from this article was given at the Youth, Health & Practical Justice conference in Sydney in December 2016.

This chapter contains the post-print (e.g. accepted) version of a journal article published by Taylor & Francis Group in Culture, Health & Sexuality on 26 September 2016. Culture, Health & Sexuality is ranked in the top quartile for Health (Social Science) journals (26/281), and for Medicine (Public Health, Environmental and Occupational Health) journals (86/526) (Scimago Journal Rankings 2017). The journal ranks in the top 20 Google Scholar rankings for the sex and sexuality field (4/20).


Declaration: I certify that this publication was a direct result of my research towards this PhD, and that reproduction in this thesis does not breach copyright regulations.

Signed:
Drawing them in: professional perspectives on the complexities of engaging ‘culturally diverse’ young people with sexual and reproductive health promotion and care in Sydney, Australia

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ABSTRACT
Young people from minority ethnic, migrant and refugee backgrounds are widely recognised as being under-served by mainstream sexual and reproductive healthcare in developed economy nations. This paper documents the views of professionals in Australia on the complexities of, and best practice approaches to, engaging members of this group with sexual and reproductive health promotion and care. Semi-structured interviews were conducted with 23 purposively selected key informants (health service providers, policymakers, academics and community advocates). Interviews were transcribed verbatim and coded in NVivo 10 using interpretive thematic analysis. Principles of ‘cultural competence’ were employed to structure the interpretation of findings. Five key themes reveal pivotal aspects of how professionals work in, and make sense of, this complex field. These may be summarised as: (1) appreciating the complexities of cultural diversity; (2) recognising structural barriers and disincentives to engagement; (3) normalising sexual health; (4) balancing ‘youth-friendly’ and culturally-competent priorities; and (5) going beyond simple translation. As migration to Australia continues to diversify the population, an integrated, national approach to the design and delivery of sexual and reproductive health promotion and care would be of value, along with training and support for those involved. Implications may have resonance for other countries similarly engaged in facilitating the successful settlement of migrants and refugees.

ARTICLE HISTORY
Received 24 May 2016
Accepted 3 September 2016

KEYWORDS
Sexual and reproductive health; young people; inclusion; cultural diversity; health services; cultural competency; Australia
Abstract

Young people from minority ethnic, migrant and refugee backgrounds are widely recognised as being under-served by mainstream sexual and reproductive healthcare in developed economy nations. This paper documents the views of professionals in Australia on the complexities of, and best practice approaches to, engaging this group with sexual and reproductive health promotion and care. Semi-structured interviews were conducted with 23 purposively selected key informants (health service providers, policymakers, academics and community advocates). Interviews were transcribed verbatim and coded in NVivo10 using interpretive thematic analysis. Principles of ‘cultural competence’ were employed to structure the interpretation of findings. Five key themes reveal pivotal aspects of how professionals work in, and make sense of, this complex field. These may be summarised as 1) appreciating the complexities of cultural diversity; 2) recognising structural barriers and disincentives to engagement; 3) normalising sexual health; 4) balancing ‘youth-friendly’ and ‘culturally-competent’ priorities; and 5) going beyond simple translation. As migration to Australia continues to diversify the population, an integrated, national approach to the design and delivery of sexual and reproductive health promotion and care would be of value, along with training and support for those involved. Implications may have resonance for other countries similarly engaged in facilitating the successful settlement of migrants and refugees.

Key words

Sexual and reproductive health; young people; inclusion; cultural diversity; health services; cultural competency; Australia
Introduction

Health services are acknowledged as critical for improving the sexual and reproductive health of young people (Bearinger et al. 2007; World Health Organization 2002), and ensuring universal access to sexual and reproductive healthcare services is a global aspiration (United Nations 2015). Services are expected to provide accessible and culturally competent care that appreciates and responds to the varying health needs with which people present (NSW Health 2011; Hach 2012), yet research suggests that young people from migrant and refugee backgrounds, or identifying with a minority ethnic or cultural group, are at higher risk of poor sexual and reproductive health outcomes (O’Rourke 2008; Newton et al. 2013). The negotiation of sexual and reproductive health can be complex for this group, especially as they may fall through the cracks of existing ‘mainstream’ approaches to service provision in developed economy nations (Newton et al. 2013; Wray, Ussher, and Perz 2014). Services for sexual and reproductive health are typically under-utilised by migrant and refugee communities in Australia (Hach 2012; Wray, Ussher, and Perz 2014; Martin et al. 2013), and little is known about how these services seek to engage young people across the diversity of cultural and ethnic backgrounds represented in the Australian community (Botfield, Newman, and Zwi 2015).

Whilst young people from migrant or refugee backgrounds experience many of the same health concerns as the general youth population, their experiences are frequently more complex (Cummings and Kang 2012). In addition to the physical, psychological, emotional and economic changes characterising the transition from youth to adulthood (United Nations Children’s Fund 2012), sexual and reproductive health issues can be complicated by experiences of migration or displacement (Chown et al. 2008; Bennett, Chown, and Kang 2005), first-hand or intergenerational trauma (Lamb and Smith 2002), differing cultural conventions and norms relating to gender and sexual identity, and restricted understanding or access to mainstream health information and services (Hach 2012; Zhou, Majumdar, and Vattikonda 2016). Whilst these vulnerabilities are well recognised, there is limited research which explores the social and cultural factors that influence the use of, and engagement with and by, health care services for young people from – what we are describing here as a shorthand – ‘culturally diverse’ backgrounds in Australia (Botfield, Newman, and Zwi 2015).

This article examines how professionals working across clinical, policy, community and research contexts grapple with the complexities of engaging young people from diverse ethnic and cultural, and particularly migrant and refugee, backgrounds, with sexual and reproductive health care in Australia. Principles of cultural competence, as described below, have been employed as a framework to interpret the findings, given the significance of this concept to
professional activity. Much of the research on cultural competency has been undertaken in the USA; Australia’s knowledge base in this area has been slower to develop (Sawrikar and Katz 2014), and has focused primarily on Indigenous communities and/or general health care. Therefore, whilst the primary aim of this study was to understand professional views on engaging young people in this context, it also offered an opportunity to build new knowledge on the provision of culturally competent sexual and reproductive health promotion and care in Australia. Insights from this research have implications for health policy and practice in the Australian context, but may also be relevant to other postcolonial, multicultural societies, and to global discussions on universal health care access and coverage.

**Framing cultural diversity**

Australia is considered to be one of the most culturally diverse countries in the world, with nearly 30% of its resident population, or 6.6 million of the total 24 million people, being born overseas (Australian Bureau of Statistics 2015). The term “culturally and linguistically diverse” (or ‘CALD’ as shorthand), is a catchall phrase frequently employed in Australian research, practice and policy discourse to define people born in countries other than those classified by the Australian Bureau of Statistics as “main English speaking countries” (Ethnic Communities’ Council of Victoria 2012), and can sometimes also encompass citizens born in Australia who identify with cultural or language groups other than the Anglo/English majority (Körner 2007). The term CALD is intended to be broadly inclusive, flexible and adaptive, since there are no criteria to define or limit membership (Sawrikar and Katz 2009; Körner 2007), and people may integrate with or move between cultural communities (Körner 2007). However, limitations of this term have been noted, including the risk of “flattening out” the differences between cultural groups by promoting a more palatable notion of ‘diversity’, as well as the implicit categorical distinction between an assumed Anglo majority (Sawrikar and Katz 2009) and “others” who are made to feel distinct by their cultural or language differences from the supposed ‘mainstream’ (Grove and Zwi 2006). In this paper, the term ‘culturally diverse’ young people has been adopted, as opposed to ‘minority ethnic’ or ‘non-English speaking’ young people, as the research was designed to explore how the concept of cultural diversity is deployed in service and policy language to encompass young people with non-Anglo cultural and ethnic backgrounds who do not themselves have a recent a migrant or refugee history.

Another key concept in this context is ‘cultural competence’, which is currently widely accepted as a framework for improving the delivery of culturally appropriate and clinically effective health promotion and care to all who need it, regardless of race, ethnicity, culture or language proficiency (Betancourt et al. 2005). This concept supports the global commitment to achieving
‘universal access to quality health care’, as set out in the Sustainable Development Agenda 2030 (United Nations 2015). The term “cultural competence” was first employed in a health care context in 1989 (Cross et al. 1989; Thackrah and Thompson 2013; Rosenjack Burchum 2002) in relation to the provision of mental health services for children from culturally diverse backgrounds in the USA (Cross et al. 1989). It has since become embedded in many professional accreditation and competency standards around the world (Thackrah and Thompson 2013). Rather than being viewed as a static concept, cultural competency is framed in the literature as a non-linear, complex and dynamic process (Rosenjack Burchum 2002). The provision of culturally competent services should ideally be entrenched within the health care system to the extent that indicators of cultural competency are apparent at the individual provider-patient interface through to policy development at the government level (Komaric, Bedford, and van Driel 2012), and a framework for cultural competence is therefore expected to operate at systemic, organisational and clinical/provider levels (Betancourt et al. 2005).

In Australia, recommended principles for achieving the ambitious goal of a culturally competent health system were published by the Australian National Health and Medical Research Council. They include engaging consumers and communities and sustaining reciprocal relationships; using leadership and accountability for sustained change; building on strengths - knowing the community, knowing what works; and, sharing responsibility - creating partnerships and sustainability (National Health and Medical Research Council 2006). Therefore, while it is appropriate to suggest that there is broad policy support for the principle that health services should be accessible to all those who need them (Department of Health 2015; United Nations 2015), Australia also represents an important case study for the challenges of achieving this in practice. For example, whilst healthcare for refugee and migrant communities in Australia is most commonly provided through mainstream health services (South Eastern Sydney Local Health District 2011; Lamb and Smith 2002), i.e. any service “that aims to cater for the broad population in the provision of its services and programs” (Department of Human Services 1998), engaging young people from these diverse backgrounds is recognised as a significant and complex challenge.

Methods

Prospective key informants were purposively identified and invited via email by the first author to participate in a semi-structured interview. The email body included an invitation to participate, attached to which was an Information Sheet and Consent Form. Informants were defined as ‘professionals’ working in the area of sexual and reproductive health, and/or working with young people from culturally diverse backgrounds, and were selected on the basis of their
expertise and experience. As the research was conducted in the greater urban reaches of Sydney, New South Wales (NSW), the largest Australian city comprising nearly five million residents, the majority of recruitment targeted professionals working in metropolitan NSW. Several non-NSW-based professionals were also invited to participate based on their recognised expertise. The study received ethics approval from the Western Sydney Local Health District Human Research Ethics Committee, the Family Planning NSW Ethics Committee, and the UNSW Australia Human Research Ethics Advisory Panel: Social and Health Research.

Between August 2015 and May 2016, 23 semi-structured interviews were conducted with key informants, either in person or over the phone, ranging in duration from 20-40 minutes. Interviews explored participant understandings and experiences of providing services to young people, cultural diversity and sexual and reproductive health, as well as the engagement of young people from culturally diverse backgrounds with related health care, with the aim of developing a comprehensive picture of professional views on the complexities of this engagement and scope for innovative responses. As noted, the focus of interviews was on ‘culturally diverse’ young people: both young people with relatively recent family and community histories of migration to Australia, including refugees, and young people who may not identify with an Anglo cultural and linguistic cultural identity in Australia, even if their families migrated to Australia several generations ago.

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, who also developed an initial list of codes. All the authors individually reviewed a selection of transcripts, to further develop the coding frame and identify major themes. Thematic analysis, as described by Braun and Clarke (2006), guided the coding and identification of themes: becoming familiar with the data, generating codes, searching for themes, reviewing themes, and defining and naming them. An interpretive method was used to analyse the data, which involved seeking to understand the data from the point of view of participants and interpreting the meaning of these (Ransome 2013), with a focus on implications for the conceptualisation of cultural competency. The themes reported in this paper focused on how professionals understand and engage with, or diverge from, these complex issues.

**Results**

Twenty three key informants took part in an interview, including health service providers (clinicians, managers, and health promoters), government policymakers, non-government
advocates and community workers, and academics with expertise in sexual and reproductive health care and/or young people. Some informants had dual professional roles, but are categorised here according to their primary role (Table 2). The personal backgrounds of key informants were not explored during interviews, as it was felt that this would not be appropriate to ask of professionals being consulted for their expert views (Lancaster 2016), and could be potentially identifying.

Key themes identified in the data are discussed in detail below.

**Appreciating the complexities of cultural diversity**

Participants grappled with how to conceptualise cultural diversity, and a range of suggestions were shared regarding who should be included in the broad category of ‘culturally diverse’. Respondents provided a range of descriptors: people who have migrated to Australia recently; those born overseas and/or with parents or grandparents born overseas; or those who were raised in a non-‘Anglo’ community, sometimes distinguished by holding different cultural values to ‘mainstream’ Australia.

The characteristics of cultural diversity identified by participants were equally broad, and included terms such as beliefs, values, language, religion, culture, cultural practices, customs, identity and ethnicity, or just the “different ways that people perceive their cultures” (KI14: service provider). A number of participants mentioned both culture and “the culture that person identifies with” (KI15: community advocate), and language and “linguistic diversity” (KI18: policymaker) in their descriptions of cultural diversity.

Several participants were concerned that use of the popular Australian term ‘culturally and linguistically diverse’ risks collapsing all people from diverse backgrounds into a homogenous group. However, there were different views on the limitations and uses of this term:

*[CALD is] a category that pretty much nobody I know identifies with. It’s often referred to incorrectly as a community, as in ‘the CALD community’. But there is no CALD community. And it’s a category that kind of covers over more than it reveals [KI11: academic]*

*[It’s] the most politically correct terminology, I think, at the moment… one has to use something…[and] it’s the least problematic acronym or word going currently [KI7: academic]*
As has been already noted in the literature (Hach 2012; Dean et al. 2012; Wray, Ussher, and Perz 2014), a number of participants reported the issue of ‘cultural stereotyping’, with colleagues making assumptions about their clients based on physical appearance or other characteristics, leading them to draw particular conclusions about beliefs or experiences, or to assume that people from a certain cultural community identify with that community. One policymaker remarked:

_Society has sort of this one-dimensional view of whether someone’s acculturated or not, and they don’t sort of recognise that young people can have multiple identities if you like, or bring together ideas from different cultural backgrounds [KI18: policymaker]_

Whilst such observations were made by a range of participants, academic informants in particular emphasised the inherent risks of making these judgements, noting that although it might be easier to treat culturally diverse people as a homogenous group, it is neither appropriate nor the most effective way to provide care. One academic (KI8) suggested it can be challenging for service providers to know who their target groups are, and that although they may have some basic cultural awareness it might often be easier to treat everyone as being part of one group. Another provided an example of health providers being reluctant to engage what they perceive to be minority groups in discussions around sexual health due to concerns about cultural sensitivity or religious beliefs and not wanting to “overstep certain boundaries” (KI10: academic).

In relation to culturally diverse young people in particular, the majority of participants identified intergenerational differences as a key barrier to accessing and navigating the health system, particularly for sexual and reproductive health, due to the perception of conflicts between mainstream and family values, and between parents/community members and peers:

_They kind of hear two stories... they’ve got their parents that have particular traditional, cultural and often religious views on things to do with sexual health, but then they’re also being sent a lot of information from their peers in the local schools, and obviously online...which are often very different messages than what they’re hearing from their parents [KI13: community advocate]_

_Young people are developing their own identity and they often get torn between wanting to belong to their peer group... but there’s often a bit of conflict between the parents or the families perception about whether they’re traditional and honouring the traditional_
**Chapter 5: Key informant interviews (published article)**

*culture, which might have very different attitudes around sexual health and sexual behaviours [KI18: policymaker]*

This “dual life”, as one policymaker (KI17) phrased it, means young people may receive quite different messages from peers about sexuality and sexual health than from their parents. This can create divisions and conflict, making it difficult for young people to access the information and services they may need, and for service providers to reach them.

While most participants did not describe culture as a ‘risk factor’ for young people’s sexual health, which is often assumed in social and research discourse (Thackrah and Thompson 2013), many discussed aspects of culture as creating additional challenges or as contributing to intergenerational conflict and/or stigma regarding sexual health, which is discussed in the third theme.

**Recognising structural barriers and disincentives to engagement**

A number of structural barriers were identified by participants as preventing the successful engagement of young people from migrant and refugee backgrounds with sexual health services, including the fact that many health services focus on specific diseases and/or key priority populations, rather than being inclusive of a broader range of intersecting needs and interests. A community advocate suggested that priority populations are often “perceived to be pretty well a silo, but of course there’s so much cross-over between all the populations” (KI15). The sensitivities associated with sexual health, explored further in the next theme, were also seen to discourage young people who may “not (want) to come to a service that is specifically designated as a sexual health service” (KI20: service provider).

Fears about potential breaches of confidentiality in making use of a service were also proposed as a key consideration for young people from different ethnic and cultural backgrounds, particularly if seeing a family doctor, using an interpreter who might be from their community, or risking parents finding out about their visit:

*Young people are concerned about confidentiality. And for multicultural young people that might be quite a major concern, particularly if they’re accessing sexual health services, and in fact it could put them quite at risk, you know, if their parents knew about it... They’re only going to feel safe to access the health care if they’re sure that it will be confidential [KI18: policymaker]*
Another commonly held view among participants, and well established in the literature (Hach 2012; McMichael 2008; Henderson and Kendall 2011), is that young people can experience considerable challenges in navigating the health system and accessing information about appropriate services. Participants stressed that if young people do not feel comfortable accessing a service – because they do not know what is available or where to go, are unsure of what to expect, or do not feel confident or empowered to ask for support – they are unlikely to present to services.

Reduced health literacy, or a lack of understanding or use of healthcare information, along with differing expectations of health and healthcare, can also contribute to difficulties in navigating the system, as was raised by many participants. One community advocate explained there are:

...basic issues of knowledge; knowledge of what sexual health means, knowledge of what STIs are, knowledge of what safe sex is; all that stuff can be completely alien for a young person from these communities [KI15: community advocate]

Several participants raised the issue of Medicare eligibility\(^4\) and a lack of understanding among some young people from migrant or refugee backgrounds regarding their rights in accessing these services.

Of further concern to several participants was the absence of a national sexual and reproductive health policy, and clarity regarding the mix between federal and state responsibilities in this area. This has relevance to, and implications for, the broader population in Australia, including migrant and refugee young people. One policymaker (KI19) stated that “my concern’s been that a lot of policy is driven by STI and HIV, and not driven by the broader (term), what I’d call sexuality and reproductive health”. They noted the lack of a state-wide or national policy, and dearth of guidance regarding what constitutes reasonable coverage around sexual and reproductive health issues. A community advocate elaborated their concerns:

\(<\text{In the past the Commonwealth (the Australian Federal government) has seen sexual health and reproduction services and HIV, BBV and STI prevention as being a mix of Commonwealth and State, and you just kind of muddle along but there needs to be a lot more cooperation between the two [KI15: community advocate]}>\)

\(^4\) Medicare is the Australian public insurance system, which subsidises the cost of health care access for Australian citizens and some overseas visitors
These participants argued for a national sexual and reproductive health policy or strategy, supporting strong arguments that have been made previously (O’Rourke 2008).

**Normalising and de-stigmatising sexual health**

The ‘normalisation’ of sexual health was proposed by several participants as an important way to strengthen the engagement of culturally diverse young people with health promotion and care. They asserted that whilst sexual health is often seen by health professionals and service providers as a special topic that should be talked about separately, there would be many benefits of reframing these matters more positively and positioning them as completely normal aspects of health and wellbeing.

Many participants raised the issue of stigma as the underlying driver of ‘sensitivities’ in the sexual health arena, using words such as fear, shame and taboo when describing young people’s concerns about parental or family knowledge of their sexual activities or use of sexual health services:

*There is an increased sensitivity around reproductive and sexual health across a lot of diverse cultures... And also that perpetuation of, it is a sensitive topic, so even if there is a question they have, or an issue they have, actually accessing a service is really difficult because it’s taboo (and) ‘I can’t be seen walking in there’ [KI2: service provider]*

Stigma can lead to people not attending a service at all, or presenting late. Thus, normalising sexual health might entail positioning these services within more holistic health care frameworks, rather than providing specific sexual health care. A policymaker noted a current shift towards clinicians providing more holistic care, which is:

*...really good news for sexual health because if clinicians learn how to do the HEADSS, so the holistic psychosocial risk assessment, then it includes sexual health as part of that holistic assessment. So ideally if more health professionals practised that... then young people will have the conversations with health professionals around sexual health wellbeing, not just limited to say a sexual health service where a young person has specifically sought out help on that issue, but it’ll be much more available in a whole range of settings [KI18: policymaker]*
Two participants recommended the HEADSS assessment tool\(^5\) as particularly useful in working with young people, as it frames the more sensitive elements within a broader wellbeing framework. Participants from both sexual and reproductive health and women’s health services also noted that their experience is that providing advice and care in less contentious areas of sexual and reproductive health, such as puberty, menstruation and breast awareness, is often viewed as more culturally appropriate and acceptable to young people from diverse ethnic and cultural backgrounds, which can offer a useful pathway into talking about sexual health.

Several participants commented on the difficulties faced by health workers who are from different cultural backgrounds themselves, including in relation to their engagement and interactions with clients with shared backgrounds. One participant suggested that these practitioners can “struggle with their own issues around sexual health, and the barriers in talking about those topics, let alone delivering those services to other people” (KI8: academic). Another believed they may not like to talk about sexual health if it is a sensitive topic for them personally, or one that is not openly discussed in their culture (KI2: service provider). Several participants suggested that service providers should be encouraged to reflect on their own cultural lens and the effect this has on their approaches to communication and service provision.

**Balancing ‘youth-friendly’ and ‘culturally-competent’ priorities**

The need for services to be inclusive of the broad diversity of service users, across ages, languages, religious, ethnic and cultural backgrounds was clearly accepted and promoted by participants. It is widely recognised that as health is not ‘one size fits all’, providers should be responsive to the unique needs of individuals (McKeary and Newbold 2010; Newman et al. 2013). As this research confirms, ‘culturally diverse’ young people are not a uniform group, thus it is important for service providers to understand the multiplicity of factors that influence their experiences and construction of sexual health. Intersectionality seeks to counteract the often one- and two-dimensional approaches by promoting consideration of simultaneous interactions between different aspects of social identity (e.g. age, race, ethnicity, gender), and brings to the forefront the complexities of these factors in understanding differences in health needs (Hankivsky and Cormier 2009). Adopting a homogeneous view of these young people runs contrary to promoting a genuine sense of inclusion and belonging, and whilst participants recognised the risks and challenges of this, it was evident that balancing different needs and priorities remains a considerable challenge.

\(^5\) HEADSS = Home, Education, Activities, Drug use and abuse, Sexual behaviour, Suicidality and depression (Cohen, Mackenzie, and Yates 1991)
A split was apparent in many participant accounts in focusing on being either ‘youth-friendly’ or ‘culturally friendly’, rather than discussing how these two elements might interface. Among the few examples of this particular intersectionality being discussed in the interviews, one academic stated they would like to see more engagement of young people from different cultural and ethnic backgrounds with services, and the promotion of culturally friendly care, and another participant made observations such as:

*Service providers need to think not only about how to engage them as young people, but as culturally diverse young people. So that’s about having (the) skills and confidence (to work) with culturally diverse young people... [It is important to look] at the needs of the young person, but also [work] with the family and their traditional needs or their cultural needs as well (KI18: policymaker).*

In terms of strategies for promoting change in this area, several participants discussed cultural competency training for health professionals as an important mechanism for enhancing the provision of culturally appropriate care, with one noting that “cultural competency training would never go astray” (KI2: service provider). One academic also suggested that although from their understanding cultural competency training is currently optional for most providers, a more consistent and comprehensive focus is required.

Regarding youth-friendly care, whilst several used this specific term, many raised related strategies, including services seeking to make themselves affordable, permitting drop-in appointments, offering longer opening hours, and providing holistic, rather than specialised, care. However, there was no consensus about what the term youth-friendly actually encompassed, nor how it should be implemented in practice. For example, an academic stated: “the idea of the youth-friendly health service is a phrase that’s bandied around, but doesn’t really mean anything. It’s never really been adopted properly” (KI9: academic).

*Going beyond basic translation*

Language barriers were noted by many participants as a challenge for sharing information and providing an accessible service to young people from culturally diverse backgrounds, although several service providers noted that the availability of telephone and face-to-face interpreters makes language less of a barrier. Several other participants viewed interpretation and translation as complicating factors in providing care, and identified the costs associated with translation as a key constraint for service delivery models. When discussing the provision of appropriate resources, a service provider involved in community education felt that there was a history of
taking the cheapest option when translating resources, with little consideration of whether the resource and messaging was appropriate, or if people were even literate in their own language.

Several participants identified challenges in this context that extended beyond language itself, suggesting there were deeper issues related to nuances within language, including the issue of original meanings being ‘lost’ or ‘changed’ during interpretation and translation. One commented that “there is the reality that sex is often conceived differently, and sexual health is often conceived differently, across cultures, so there may be a challenge in the language that (clinicians) use” (KI10: academic). A service provider (KI2) similarly observed that “the way that we’ve been developing resources isn’t very culturally competent”. This can make the expression of ideas difficult and can disempower those from culturally diverse backgrounds (National Health and Medical Research Council 2006; Newton et al. 2013). Cross and Bloomer (2010) argue that “interpreters and translators need to be both bilingual and bicultural”. Services could go beyond translating materials into the language of communities they wish to engage with, by seeking to understand and align with the values associated with those cultures (Iqbal et al. 2012). Interpretation is made even more complex for young people from different ethnic and cultural backgrounds, as interpreters may not always be appropriate when discussing sexual health due to confidentiality concerns (McMichael 2008; McMichael and Gifford 2009); an issue raised by many participants.

Supporting this notion of achieving cultural understanding that extends beyond basic translation, all participants were strongly in favour of meaningfully involving consumers – in this case culturally diverse young people – in the design and delivery of services, with many stating that it is absolutely critical as “they’re the ones who are going to know what’s culturally appropriate and what they want and what they don’t want” (KI8: academic). Participants felt that seeking input in this way would add value and give young people a real voice. As one academic stated:

*If your entire committee of people working on a project or your entire workforce has grown up here, then it’s very easy for that stuff to seem normal and natural and universal. And the minute you bring in young people from a migrant background to sit on that committee...you immediately...see that 'actually no, my experience is not universal’ (KI11: academic)*

Participants emphasised the need for meaningful engagement and exchange to ensure young people have an authentic voice, rather than “using them in a tokenistic way” (KI7: academic). A policymaker suggested this includes “having a dialogue with young people, so it’s not just sort
of consulting and either listening or not listening, but there needs to be a real exchange” (KI18: policymaker). Others observed that to truly meet the sexual and reproductive health needs of young people, it is critical that their views and perspectives be drawn upon to mobilise change, a commonly held view in the literature (Biddlecom et al. 2007; Braeken and Rondinelli 2012).

However, whilst recognising the importance and value of consumer input, many participants also acknowledged the challenges of achieving this in practice. Examples included the logistics of accessing and recruiting young people, finding time/s to meet, negotiating consent processes, and the potential delays in programme or service development and implementation. Two policymakers also noted the importance of setting parameters and identifying what can or cannot be influenced. They observed that this open dialogue is critical, as young people “can be very idealistic and have big ideas about what they’d like to see happen”, which might not always be possible (KI18: policymaker). Participants also highlighted the need to recognise the contribution of consumers through payment or other forms of acknowledgement, such as provision of a certificate, nomination for an award, informal or formal training opportunities, and providing opportunities to learn and practice. While these are practical suggestions, their symbolic significance speaks to more complex issues of engaging young people in meaningful ways.

Discussion

The five key themes identified here reveal pivotal aspects of how professionals work in, and make sense of, the complexities of engaging with culturally diverse young people, including those from migrant and refugee backgrounds, regarding sexual and reproductive health promotion and care. There was broad agreement from participants that in order to address persistent disparities in healthcare access, mainstream health services should ensure provision of youth-friendly and culturally appropriate care which appreciates and responds effectively to the varying experiences and needs people may present with (NSW Health 2011; Hach 2012), though how to achieve these ideals in practice remains challenging.

Whilst the term “cultural competency” was explicitly used by only a small number of participants, the majority alluded to many of the more practical dimensions associated with this concept. Further to this, the ideas discussed by participants aligned with the principles for achieving a culturally competent health system discussed in the background of this paper, and the associated actions recommended within these (National Health and Medical Research Council 2006). For example, participants spoke about the value of fostering open dialogue and meaningful engagement with consumers, involving consumers in the design, development and
implementation of programmes and services, ensuring the use of culturally appropriate and responsive language and messaging, and promoting workforce development and training for service providers.

However, there were also several gaps in the interview data regarding specific actions or practices associated with a cultural competency framework. Whilst this in no way suggests these are not considered valuable by these professionals, it does imply that perhaps there are opportunities to strengthen understanding of these concepts as potential strategies for engaging young people from diverse backgrounds. These include, in particular: involving relevant communities in the planning, implementation and evaluation of programmes and services; building on and sharing existing knowledge of community views and evidence of what works; and creating partnerships and sharing knowledge, information and skills with communities. This emphasis on forming reciprocal relationships and working in partnership with communities will allow for the inclusion of expertise and contributions from different community members, and strengthen communities’ capacities to support members and liaise with the health sector.

Promoting broader representation will help to reflect a community’s diversity, as opposed to being confined to hierarchical channels (National Health and Medical Research Council 2006). And lastly, consideration of the unique strengths that culturally diverse young people and communities can hold, and appreciating what can be learned from them, should also be an important consideration, though this was not explicitly mentioned in the interviews.

The concept of cultural competence was used as a framework to interpret findings from this research, given its relevance to health care provision for culturally and linguistically diverse communities, and its salience and legitimacy in policy frameworks which guide the design and delivery of health services in multicultural societies. However there are some limitations to using this as a framework for enhancing health care delivery, and agreement regarding how to best define and operationalise this “critical yet broad construct” (Betancourt et al. 2003, 294) continues to be debated. Critiques of cultural competency as a framework to guide policy and practice have focused on a perceived lack of clarity regarding the definition of culture, and limited evidence of its effectiveness in improving health outcomes (Thackrah and Thompson 2013). Alternative concepts have been proposed, including cultural safety, cultural awareness, cultural respect and cultural sensitivity, however many suggest these could be viewed as sub-components of a cultural competency framework (Rosenjack Burchum 2002; Thomson 2005; Betancourt et al. 2003). Further to this, several additional concepts have been proposed as extensions of cultural competency. Rosenjack Burchum (2002) postulates that the notion of cultural proficiency involves a commitment to mobilise change, not just increase understanding (Rosenjack Burchum 2002), and Tervalon and Murray-Garcia (1998) similarly argue that a
The concept of cultural humility could promote professional engagement in a lifelong process of self-reflection that extends beyond simply respecting the values, beliefs and practices of others to taking personal responsibility for providing culturally responsive care (Campinha-Bacote 2002).

It is also important to note that whilst the concept of cultural competence is commonly discussed at the patient-clinician level, clinicians will only become culturally competent with the support of the health system in which they operate (Brach and Fraser 2000). The professionals interviewed for this study were deeply committed and invested in this area and acknowledged the need for improved engagement with culturally diverse young people, however many work within very defined policy frameworks, with limited resources, and often with marginalised or vulnerable communities with a range of needs. The feasibility of all of these endeavours therefore depends to a large extent on broader national and state policy frameworks, and would be ideally supported by a national sexual and reproductive health policy (O’Rourke 2008) that includes an explicit focus on responding to cultural diversity among young people.

The findings of this study may be limited by the geographic focus on NSW (although there is likely to be considerable relevance to other Australian and comparable country settings), and by the bias towards female participants, which was not intended, and may be reflective of the gender profile of the sexual health workforce. Furthermore, the personal backgrounds of key informants were not explored during interviews, as it was felt that this would not be appropriate to ask (Lancaster 2016) and could be potentially identifying. Nonetheless, we believe this study has important research, policy and practice implications for working towards the enhancement of sexual and reproductive health for young people of all backgrounds in Australia, and to supporting the global priority of achieving universal health care. Findings may also have resonance for other countries similarly engaged in facilitating the successful settlement of migrants and refugees. Finally, it is important to note that the findings presented here reflect the views of professionals, and not the views of young people themselves.

The next phase of this research will explore these issues from the perspective of young people who identify themselves as coming from a migrant or refugee background, to obtain their insights as to how service providers, organisations and systems might better achieve the ideals of cultural competence and youth-friendly service provision in practice. The concept of cultural diversity will also be explored, including how this group of young people might ‘define’ themselves, rather than how they are defined at organisational and policy levels. As Australia grows increasingly diverse, the health care system must be responsive to this (Komaric, 2019).
Bedford, and van Driel 2012), and take up new and enhanced approaches to improve access and utilisation of services (Renzaho 2008). An integrated, national approach to the design and delivery of sexual and reproductive health promotion and care would be of value, along with training and support for those involved. Doing more of the same without creatively engaging with young people from different ethnic and cultural backgrounds will undermine the ambitious goals of ensuring universal health care access and coverage.

Acknowledgements

We express our thanks and appreciation to those who agreed to take part in an interview for this research. We also wish to thank the research investigators for their support: Deborah Bateson, Katherine Bennett, Melissa Kang, Catriona Ooi, Alison Rutherford and Mitchell Smith.
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Chapter 6: Ethical considerations of using walking interviews to engage migrant and refugee young people in health service research

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This chapter provides a reflective account of the walking interview method employed with young people in this doctoral research. It provides an overview of my experience of conducting walking interviews with migrant and refugee young people, focussing particularly on the ethical considerations of employing this method to elicit rich data on their views of sexual and reproductive health services. Drawing on my experiences of conducting the walking interviews, I describe how these were implemented in practice, considerations when using this method for health service research with young people, and the strategies devised to manage ethical risks and promote good ethical conduct. This chapter acts as a useful supplement to the forthcoming chapters 7-9 as it provides a detailed account of the walking interview method which contributed to the findings presented in those.

This chapter contains the post-print (e.g. accepted) version of a journal article published in SAGE Research Methods on 2 January 2019. Publishing in this collection provides an opportunity to share an accessible account of the walking interview research method that could be used as a case study for students interested in this method or in undertaking health service research.


Declaration: I certify that this publication was a direct result of my research towards this PhD, and that reproduction in this thesis does not breach copyright regulations.

Signed:
Abstract

This case study provides an overview of the experience of conducting walking interviews with migrant and refugee young people in Sydney, Australia, and the associated ethical considerations of employing this method to elicit rich data on their views of different sexual and reproductive health services. The particular research method presented here formed one part of a PhD study that explored the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health care. Limited research has focused on this population, their sexual and reproductive health experiences and service needs. To investigate this, three ‘rounds’ of interviews were undertaken with migrant and refugee young people: a first interview, a follow-up interview, and walking interviews, the latter of which is the focus of this case study. We provide a brief overview of the doctoral research and roles of the research team, outline the rationale for using the walking interview method, and describe how it was implemented. We then discuss some of the associated ethical considerations, including gaining ethics approvals, particular deliberations regarding research with migrant and refugee young people, reciprocal benefits, ensuring voluntary participation, maintaining confidentiality, and building trust and rapport. Strategies used to enhance the research process, manage ethical risks and promote good ethical conduct are included as part of this discussion. The case study concludes with some ‘lessons learned’ for using the walking interview method.

Learning outcomes

By the end of this case students should be able to:

1. Increase their understanding of the ‘walking interview’ method and the rationale for using this participatory, qualitative research method

2. Appraise the value of the walking interview method in health services research, and be cognizant of the associated challenges and ethical considerations

3. Appreciate the importance of building rapport and trust with participants to maximise the value from their involvement in research

4. Strive to conduct research that has reciprocal benefits, for researchers and participants
Case study

Project overview and methods

Young people from minority cultural and/or language backgrounds, including migrants, refugees and international students, have been shown in many settings to be at heightened risk of poor sexual and reproductive health, and to be less well engaged with or benefitting from sexual and reproductive health care. While there is increasing recognition of this issue in Australia, empirical research that informs policy and practice change is still sorely lacking (Botfield, Newman, & Zwi, 2015). We were interested in exploring the views of migrant and refugee young people (16-24 years) living in Sydney, Australia, to better understand how they themselves view their sexual and reproductive health information and care needs and experiences.

The research was conducted by author 1, the doctoral candidate, who led the research design, collection and analysis of data, and drafting and refinement of publications. Her joint supervisors (authors 2 and 4) provided close support, guidance and input at all stages. The research was also a collaborative effort, with a number of partner investigators and services involved, as described further below. Author 3 was invited to collaborate on this publication due to her expertise in participatory research and the ethical aspects of conducting research with migrant and refugee communities.

To learn more about this topic, three ‘rounds’ of interviews were undertaken by the lead researcher (author 1) with migrant and refugee young people: a semi-structured first interview, a follow-up interview, and/or a walking interview with a sub-set of initial interviewees. Altogether, 27 young people participated in a first interview, nine in a follow-up interview, and six in one or more walking interviews. Several participants took part in walking interviews at three or more different services, with 15 walking interviews undertaken in total. The first interviews explored young people’s views and experiences of accessing sexual and reproductive health information and care, while the follow-up interviews allowed for more in-depth questioning. The walking interview is the primary focus of this case study. Here, we discuss our reflections on the walking interview method and some of the ethical matters to consider especially when engaging young people from migrant and refugee backgrounds in health service research in this way.

The walking interview (also known as go-along interviews or ‘walking with others’) is a method most commonly used in ethnographic and participatory or arts-based research (O'Neill
& Hubbard, 2010; Pink, 2015), and was selected for use in this study to elicit rich feedback from young people on their experiences of, and views on, health services providing sexual and reproductive health care and information in their city. The walking interview is a relatively novel method in health research contexts (Garcia, Eisenberg, Frerich, Lechner, & Lust, 2012). In brief, in walking interviews, the researcher walks with participants through sites associated with the research to generate richer data on experiences of the space, and perceptions of their current and potential configurations. Interviewees are prompted to provide commentary on how they construe or experience the surrounding environment, and are believed to be more likely to provide honest, immediate accounts of their impressions in situ, and less likely to try and give the ‘right’ or a mediated answer (Evans & Jones, 2011). Discussion of particular issues, especially sensitive topics, may also be more effectively triggered and facilitated by this “talk-as-you-walk” approach, rather than the more formal face-to-face sit-down interview (Garcia et al., 2012; O'Neill & Hubbard, 2010).

After completing the first interview for this study, young people were not actively followed up to undertake an additional interview, to ensure they did not feel pressured or coerced. The opportunity to do another interview was mentioned at the end of the first interview, and if participants were agreeable to be contacted separately about this, they were then emailed at a later date and invited to participate in an additional interview. If they did not respond, they were not contacted again.

The walking interviews were conducted in one or more of the six sites associated with the five Sydney health services that partnered with us on the research: all were focused either explicitly on sexual and reproductive health, or on youth health, incorporating sexual and reproductive health services. Participants who consented to participating in a walking interview were able to choose from one or more of the six sites (unless they were a client at one, as discussed further below); most chose a site closer to home for their first walking interview.

The walking interviews involved the participant undertaking a ‘tour’ with the lead researcher, through the clinic/service building, to discuss their observations and views of the service. The interview generally started at the front of the building/clinic, and then progressed through the entrance/front door, inside to the reception desk, waiting room, restrooms and clinic rooms (and any other spaces/rooms used by clients). The intention was not to ‘evaluate’ each service, but rather to build a picture of general perspectives on and understandings of the design, purpose and feel of these services. During the walking interviews, participants were invited to comment on their impressions of the physical environment and experiences of how welcoming the service felt. This was guided by a template of prompts, which focused on observations of the service
and its website (if available), issues such as cost and opening hours, and how participants felt in that space. General prompts included questions such as: “Was it easy to find?”, “What were your first impressions?”, “Did this service strike you as welcoming?”, “Would you feel comfortable coming here?”, and “What do you like / not like about the service on first impression?”. At the end of the interview, we ‘debriefed’ in a private room, identified and arranged in advance, to discuss in more detail.

Whilst the method was initially informed by past research (see ‘further readings’ list), the practicalities and process were adapted to fit better with partner services and individual participants.

**Ethical considerations**

There were a number of ethical factors to consider in designing and conducting this study. Here, we discuss some of the ethical issues considered prior to and during the walking interviews in particular, and the strategies undertaken to minimise risks and promote good ethical conduct. Many of these considerations are also applicable to the broader study. The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors’ Committee, 2007 (Updated May 2015)) was a valuable guide informing the design and conduct of the research.

**Gaining ethics approval:** Ethical approval was sought and obtained from four different human research Ethics Committees in Sydney. This extensive range of approvals was required given the multiple sites where the research was conducted, each of which required their own institutional or health authority approval. Essential to the study were the strong relationships established with partner services; the walking interviews (and other aspects of the research) would not have been possible without their meaningful engagement and support for the project. Services were engaged in the research early and this ensured that they were committed to supporting the processes involved in securing ethics approvals, over an extended period of time. This was a complex and at times tedious process, requiring multiple re-submissions due to the varied, and often conflicting, feedback from different committees. For example, one committee approved and another forbade the provision of a $30 gift voucher for participation; one committee approved participation by young people 16 years and over without parental consent while another committee initially required they provide parental consent; two committees required quite different data management/storage processes. As ethical approval was granted at different times by different committees, amendments then had to be submitted for changes which were requested by one committee after the initial approval process had been completed.
by others. It was anticipated that obtaining ethics approval might take some time, and in the end, it took approximately 6 months to receive all approvals. One committee invited the lead researcher to attend their meeting to discuss some of their queries and concerns in person, which was very valuable and facilitated a far quicker and satisfactory outcome than in those instances where written correspondence was the only form of communication. We believe that we were able to reassure committee members that we had thought through all the main ethical issues more effectively in person, which may suggest that in-person discussions have the potential to expedite ethical approvals for sensitive and complex research projects. Overall, the feedback received from the different Ethics Committees was valuable and resulted in a robust collection of ethical guidance.

**Research with migrant and refugee young people:** Research involving any young person can raise ethical concerns about their capacity to understand the research (and therefore whether their consent to participate is sufficient), risk of coercion to participate, and conflicting values and interests between parents and children (National Health and Medical Research Council et al., 2007 (Updated May 2015)). One of the Ethics Committees to which we submitted an application initially requested we obtain parental consent for prospective participants aged 16-18 years; however, we were able to successfully make the case that this would present a barrier to participation. Spriggs (2010) states that a child or young person can sometimes consent for him or herself without the additional consent of a parent or guardian. This is supported by the National Statement on Ethical Conduct in Human Research, which states that young people can provide consent without additional consent of a parent or guardian when the young person is “mature enough to understand and consent” (4.2.8). All prospective participants were therefore ‘screened’ during the informed consent process, to ensure they were deemed ‘Gillick competent’ (under common law, young people under the age of 16 can consent to their own medical procedure/treatment if they are deemed sufficiently mature) and had sufficient maturity to understand the information and give informed consent.

In addition, given the challenges that more recently arrived migrants and refugees may face during their early years of resettlement, the research strove to minimise additional burden by contributing to a positive experience of adjustment to Australia (Gifford, Bakopanos, Kaplan, & Correa-Velez, 2007). Some of the ways this may have occurred are discussed next.

**Reciprocal benefits:** Undertaking walking interviews had a number of potential benefits for both the researcher and participants. The walking interviews allowed the lead researcher to build further rapport and trust with participants, provided an opportunity to seek additional insights that may not have come up in previous interview/s, and allowed targeted feedback on specific
aspects of services to be elicited. This helped triangulate data, supporting and contrasting statements made earlier or obtained through other sources. For participants, this more participatory method of interviewing may also have been experienced as empowering (Balbale, Locatelli, & LaVela, 2016; Carpiano, 2009). Whilst none were familiar with this type of interviewing process prior to participating, all participants appeared fairly comfortable with the process after a short time. In particular, participants who undertook more than one walking interview became far more comfortable with discussing aspects of services, which allowed for more detailed observations and insights as they gained experience and perhaps felt more comfortable in their observer role. This was also a valuable opportunity for them to learn about the different services available for young people in the area of sexual and reproductive health (about which most knew very little), as well as enhance their familiarity with and confidence in using these services. Several participants expressed interest in using one of the services as a future client and some collected a service brochure as they left. Prior to undertaking the walking interview, participants had never accessed, nor most even heard of, the service they had walked through.

**Voluntary participation:** Participation in the study was voluntary; all prospective participants were made aware that they could leave the study or disengage from discussions at any point. No inducement was offered for participation, at the request of one of the Ethics Committees, but participants were offered a reimbursement to compensate for travel associated with taking part in an interview. We recognize that it is possible that this reimbursement did provide an additional incentive for some participants to take part in more than one interview, although it did not appear from their responses during subsequent interviews that their participation was tokenistic. Furthermore, researchers have the right to decline undertaking additional interviews with the same person, and so the risk of the travel reimbursement compromising the data was minimal.

**Confidentiality:** Confidentiality was particularly important for this research, which was confirmed during interviews when participants discussed the pervasive stigma and taboos surrounding sexual health in their everyday lives, particularly in their family homes. Care was taken to anonymise participants’ responses by enabling them to choose whether or not to share their real name and to self-select a pseudonym for reporting purposes. All interview transcripts were de-identified. Importantly, participants recruited for the first interview through one of the partner health services were not invited to undertake a walking interview at that service to ensure continued anonymity as a research participant, notwithstanding the fact that they may already have been very familiar with that service. Finally, walking interviews were generally undertaken outside of standard clinic opening hours. This was to maintain confidentiality of
both clients and the participant, as well as allow sufficient time to walk through the clinic. While this did mean that walking interview responses could not capture views on clinics as they would be functioning during standard opening hours, we deemed the potential risks of drawing attention to these young people among other service users not worth recording their impressions of the service while in operation.

**Developing rapport:** Undertaking three rounds of interviews proved extremely valuable to the research, as it allowed for: more in-depth and targeted questioning, discussion of different issues in diverse contexts, and an opportunity to seek participants’ views and feedback on services. This approach also allowed for trust and rapport to develop, which was particularly important when working with young people, especially those from diverse cultural backgrounds. Participants seemed more at ease during follow-up and walking interviews, perhaps because they felt more comfortable with the lead researcher and the research process overall.

As a white, female Anglo-Australian, not from a refugee or recent migrant background herself, the lead researcher thought she would be taking on an ‘outsider’ role for this research (Dwyer & Buckle, 2009; Gair, 2012). However, as she started interviewing, she realised she might occupy a kind of ‘insider’ status also. Aged in her late 20s, she seemed to have more in common with participating young people than first thought—they spoke a lot about “old people” during all rounds of interviews, suggesting that perhaps they saw her as ‘younger’ and ‘one of them’. Having elements of both outsider and insider status (Breen, 2007), or being an ‘inbetweener’ (Milligan, 2016), worked well for this research, as she could build rapport more easily with participants.

**Lessons learned**

The particular process undertaken for walking interviews in this research had some limitations; three are described here, along with possible strategies to minimise them.

1. Undertaking most interviews outside of standard clinic hours meant that participants had minimal interaction with service staff, and were not able to get a true sense of the client experience. This limitation could be overcome by undertaking the walking interview during clinic hours, or perhaps even accompanying the participant as an actual client, although both of these would have important and challenging logistical and ethical implications of their own.

2. The walking interviews were not audio-recorded, as participants walked through various rooms and spent time looking at different aspects. These were discussed partly while walking,
and partly in a private room afterwards. It was easier to hand-write notes and note any key quotes along the way, however this means that some insights or particularly important or relevant ways in which views were articulated may have been lost. Audio-recording interviews on a voice recorder or mobile device, in addition to handwriting notes, should be considered, even if associated with poor audio recording quality or long periods of silence. The option of checking transcripts or summarised notes with participants afterwards to ensure essential points were captured could also be considered.

3. As previously noted, participants were only contacted once about participating in a follow-up or walking interview. This ensured there was no pressure to participate beyond the first interview, but also resulted in lower numbers for additional interviews. All participants consented to being emailed about the follow-up/walking interview after their first one, so we could have been more persistent, for example obtaining consent for additional follow-up, such as sending at least two email invitations, or sending a follow-up text message. While participants could still ignore such communications, these may have reminded and encouraged interested participants to engage further.

**Conclusion**

Engaging young people in collaborative health services research can contribute valuable insights towards achieving quality improvements in service delivery, and can support service providers in ensuring they are focused on adapting to what users feel is important to them. Although not without its challenges, the walking interview method proved a valuable tool to obtain feedback and insights directly from young people on the aspects of health services they liked, did not like, or felt were particularly important to them. This process appeared to be beneficial to participants and is important for services to ensure that they are appropriate, accessible and acceptable to young people.

**Acknowledgements**

We are grateful for the contributions of the young people interviewed, who so willingly shared their views and experiences, as well as for the young people who contributed as part of the Youth Advisory Group convened for the study. Thanks also to the co-investigators (Dr Alison Rutherford, Dr Christopher Carmody, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Dr Deborah Bateson, Mr Brendan Crozier and Ms Katherine Bennett) and partner organisations (High St Youth Health Service, Family Planning NSW, NSW Refugee Health Service, South Western Sydney Sexual Health Service, Sydney Sexual Health Centre, and Western Sydney
Sexual Health Centre) who provided advice and support for the research. Acknowledgement of the many contributions to this research does not imply endorsement of the findings or recommendations of this paper by those named. We acknowledge UNSW Arts and Social Sciences, which contributed some funding towards the fieldwork for this research, as well as the support of an Australian Government Research Training Program Scholarship.

**Exercises and discussion questions**

1. What are some advantages and disadvantages of undertaking walking interviews?
2. What types of services may be especially sensitive and raise additional concerns both about the merits and difficulties of walking interviews?
3. What are the challenges you may face in recruiting participants for this kind of research, and how would you address these?
4. What additional ethical issues may be encountered during a walking interview through a health service?
5. In what other contexts might walking interviews be a suitable research method?
6. What other ways could young people, or other users/consumers, be engaged in collaborative health services research?
7. What kind of research processes can ensure that participants gain more from the research experience?

**Further readings**


References


National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors’ Committee. (2007 (Updated May 2015)). *National Statement on Ethical Conduct in Human Research 2007 (Updated May 2015).* Retrieved from Canberra:


Chapter 7: Engaging migrant and refugee young people with sexual health care: Does generation matter more than culture?

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Chapter 5 examined how professionals working in clinical, policy, community and research contexts described the engagement of young people from migrant and refugee backgrounds with sexual and reproductive health care. These next three chapters explore these issues from the perspectives of migrant and refugee young people themselves. A theme of ‘generational difference’ recurred throughout their interviews, which is the focus of this chapter. It explores how generational discourse was articulated by these young people in describing their experiences and preferences regarding the characteristics of those who provide sexual and reproductive health information and services. Together with the findings from Chapters 8 and 9, this contributes to addressing the three research objectives by documenting the perspectives and experiences of young people from migrant and refugee backgrounds, exploring how they are engaged with sexual and reproductive health services and examining how this engagement might be strengthened. Findings were also shared in an oral presentation at the Youth Health Conference in Sydney in July 2017 and in a poster presentation at the Australasian Sexual Health Conference in Canberra in November 2017, which won a ‘best poster’ award.

This chapter contains the post-print (e.g. accepted) version of a journal article published by Springer as an advanced online publication in Sexuality Research and Social Policy on 15 February 2018. Sexuality Research and Social Policy is ranked in the top quartile for Health (Social Science) journals (57/281), for Gender Studies (21/128), and for Sociology and Political Science journals (220/1104) (Scimago Journal Rankings 2017). The journal also ranks in the top 20 Google Scholar rankings for the sex and sexuality field (11/20).


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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 benefiting 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
Abstract

Young people from migrant and refugee backgrounds in Australia are recognised as under-utilising mainstream sexual and reproductive healthcare. 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.

Key words

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 health and wellbeing 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 wellbeing (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 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

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6 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).
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 healthcare, 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.

**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 #4407), the Family Planning NSW Ethics Committee (approval #R2015-02), the ACON Research Ethics Review Committee (approval #2016/09), and the UNSW Australia Human Research Ethics Advisory Panel: Social and Health Research (approval #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 Translating and Interpreting Service (the national 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 3). 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, while the follow-up interviews allowed for follow-up enquiry and 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 practical 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 20-60 minutes, follow-up interviews from 30-40 minutes, and walking interviews from 20-40 minutes.

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 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. 15 walking interviews were undertaken in total, across
the six sites. Six participants completed all three interviews. Participant characteristics are documented in Table 3.

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.

i) 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, though it was clear that most did have to negotiate additional cultural boundaries and constraints. Many described their experiences as that 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/ marrying 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, though 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 while 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.
Chapter 7: Generational difference (published article)

“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 wellbeing. 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.

ii) 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), while others felt rushed through the appointment so could not get what they wanted from it.

A number of participants had a family doctor about whom they spoke highly. However, whilst those with a family doctor generally reported good experiences with them, 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 judgemental 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.

iii) 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 the range 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, 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 wellbeing (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 wellbeing 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, that 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 healthcare existing 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.
Acknowledgements

We are grateful for the contributions of the young people interviewed, who so willingly shared their views and experiences, as well as for the young people who contributed as part of the Youth Advisory Group convened for the study. Thanks also to the coinvestigators (Dr. Alison Rutherford, Dr. Christopher Carmody, Dr. Catriona Ooi, Dr. Melissa Kang, Dr. Mitchell Smith, Dr. Deborah Bateson, Mr. Brendan Crozier and Ms. Katherine Bennett) and partner organisations (High St Youth Health Service, Family Planning NSW, NSW Refugee Health Service, South Western Sydney Sexual Health Service, Sydney Sexual Health Centre, and Western Sydney Sexual Health Centre) who contributed to this research. Lastly, we acknowledge UNSW Arts and Social Sciences who contributed some funding towards the fieldwork for this research, as well as the support of an Australian Government Research Training Program Scholarship.
References


Chapter 7: Generational difference (published article)


Chapter 8: Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: “I never got the talk about the birds and the bees”

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In the preceding chapter, I highlighted the stigma surrounding sex and sexual health in some family and community environments for migrant and refugee young people, and their associated concerns regarding judgement and confidentiality. It was clear, however, that despite these constraints and concerns, young people were still able to seek information and support if they felt they needed it. In this chapter, I explore issues relating to relationships and sexuality education and other sources and forms of information accessed by these young people. This chapter provides accounts primarily from migrant and refugee young people, however key informant perspectives were also included to complement findings and provide some insights into the policy context. I shared an oral presentation of these findings at the Youth Health Conference in Sydney in July 2017 and at the Australasian Sexual Health Conference in Canberra in November 2017.

This chapter contains the post-print (e.g. accepted) version of a journal article published by Taylor & Francis Group in Sex Education on 30 April 2018. Sex Education is ranked in the top quartile for Social Sciences (Education) journals (233/1262), and for Social Sciences (Miscellaneous) (94/497) (Scimago Journal Rankings 2017). The journal also ranks in the top 20 Google Scholar rankings for the sex and sexuality field (10/20).


Declaration: I certify that this publication was a direct result of my research towards this PhD, and that reproduction in this thesis does not breach copyright regulations.
Signed:
Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: 'I never got the talk about the birds and the bees'

Jessica R. Botfield, Anthony B. Zwi, Alison Rutherford and Christy E. Newman

ABSTRACT
In a multicultural nation such as Australia, it is important for young people from migrant and refugee backgrounds to have access to quality relationships and sexuality education, as they are known to be less well engaged with mainstream services. A study was undertaken to explore the complexities and opportunities for engaging this group with sexual and reproductive health information and care in Sydney, Australia. Interviews were undertaken with 27 migrant and refugee young people (aged 16–24 years), and 34 expert informants. Relationships and sexuality education was a dominant theme throughout both data sets. Nearly all young people reported that they were unable to discuss sexuality or sexual health with their parents, and most identified secondary school as the place where they first learned about these issues. Other sources of information were identified as the Internet, friends, health professionals and pornography. Participants appeared to have limited awareness of the different services available to them. Schools, as well as other education settings such as universities, private colleges and intensive English centres, are well placed to deliver relationships and sexuality education, and for migrant and refugee young people these may be valuable settings in which to access information rarely discussed in family or community environments.
Chapter 8: Relationships and sexuality education (published article)

Abstract

In a multicultural nation such as Australia, it is important that young people from migrant and refugee backgrounds have access to quality relationships and sexuality education, as they are known to be less well engaged with mainstream services. A study was undertaken to explore the complexities and opportunities for engaging this group with sexual and reproductive health information and care in Sydney, Australia. Interviews were undertaken with 27 migrant and refugee young people (aged 16-24 years), and 34 expert informants. Relationships and sexuality education was a dominant theme throughout both data sets. Nearly all young people reported that they were unable to discuss sexuality or sexual health with their parents, and most identified secondary school as the place where they first learned about these issues. Other sources of information were identified as the Internet, friends, health professionals and pornography. Participants appeared to have limited awareness of the different services available to them. Schools, as well as other education settings such as universities, private colleges and intensive English centres, are well placed to deliver relationships and sexuality education, and for migrant and refugee young people these may be valuable settings in which to access information rarely discussed in family or community environments.

Key words

Cultural diversity, young people, relationships and sexuality education, sexual and reproductive health, refugees, Australia
Chapter 8: Relationships and sexuality education (published article)

Background

Access to healthcare services and comprehensive relationships and sexuality education is critical to the attainment of positive individual and population sexual and reproductive health outcomes (Bearinger et al. 2007; UNESCO 2015). However for young people, a range of social, cultural, political and economic factors influence sexual and reproductive health and may pose barriers to accessing information and services. The situation may be especially problematic for young people from minority cultural and ethnic backgrounds, including migrants, refugees and international students, who make up a sizeable proportion of Australia’s population of young people (Hugo et al. 2014). Many may face barriers to accessing relationship, sexuality and sexual health information. Relatively little is known about their experiences compared to the broader youth population (Botfield, Newman, and Zwi 2015; McMichael and Gifford 2009), but young people from minority cultural and ethnic backgrounds are believed to make less use of sexual and reproductive health services (Poljski 2011b; Wray, Ussher, and Perz 2014; McMichael and Gifford 2009; Manderson et al. 2002; Reeders 2011; Agu et al. 2016). They may therefore be under-served, missing out on crucial information and services.

Comprehensive sexuality education, or relationships and sexuality education as it is more commonly known in Australia, is “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information” (UNESCO 2009). It can include learning about anatomy and physiology, normal development, gender, sexuality, healthy relationships, consent, safer sex, contraception, family planning, sexually transmissible infections (STIs), sexual practices, and sexual pleasure. This education is critical in raising knowledge and awareness, increasing contraception use, preventing STIs and unintended pregnancy, and ultimately helping to improve safety and pleasure in sexuality (Yeung et al. 2017; Bourke et al. 2014).

Schools in particular make an important contribution to the health and wellbeing of young people, and are well placed to deliver education to promote sexual health (Smith et al. 2011; Thomas and Aggleton 2016). They have regular contact with nearly all young people, and provide a strategic opportunity for providing them with the knowledge and skills to make and act upon decisions that promote sexual health (McKay 2000; Weaver, Smith, and Kippax 2005).

In Australia, the content of relationships and sexuality education is largely determined at State/Territory level and therefore varies across the country (Helmer et al. 2015). In New South Wales (NSW), its provision is guided by the Personal Development, Health and Physical Education (PDHPE) syllabi provided by the NSW Board of Studies, Teaching and Educational
Standards. A new national and standardised ‘Foundation – Year 10 Australian Curriculum’ has been developed and transition to this curriculum commenced in 2017. The revised Health and Physical Education curriculum includes relationships and sexuality as a focus area from Foundation to year 10 (Australian Curriculum n.d.-a), compulsory years of schooling in Australia. However, each state and territory is responsible for implementation in their schools so this content is used flexibly, including the development of tailored local curricula (Australian Curriculum n.d.-b). In practice, relationships and sexuality education varies considerably from one school to another.

This paper reports findings from a study which explored the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health information and care. Whilst relationships and sexuality education was not a specific focus of the study, it was raised frequently by the young people and the key informants who took part. This paper reports on key issues relating to relationships and sexuality education and other sources of information about sexuality and relationships that are accessed by migrant and refugee young people living in Sydney, Australia. It provides accounts primarily from young people, however key informant perspectives are briefly included to complement these findings.

Methods

The research was conducted in Sydney, NSW. Sydney is the largest Australian city and has the largest overseas-born population (Australian Bureau of Statistics 2017). The study had a particular focus on Greater Western Sydney given the broad cultural and linguistic diversity of its population. Ethics approval for the study was received. The study included young people, and a range of ‘professionals’ holding expertise in the topic area as key informants. The study was informed by grounded theory principles: an exploratory and open-ended approach was adopted in the research design and methods (Bryman 2016). Rather than seeking to test or extend existing social theory, an interpretivist approach aims to produce reliable and robust knowledge by focussing on understanding the experiences of people in their everyday lives (Ransome 2013).

Between September 2016 and October 2017, semi-structured first and follow-up interviews were conducted with young people aged 16-24 years living in Sydney, who self-identified as

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7 Includes those who migrated to Australia only a few months or years earlier, or were born in Australia, or are an international student.
8 Western Sydney Local Health District Human Research Ethics Committee; Family Planning NSW Ethics Committee; ACON Research Ethics Review Committee; UNSW Australia Human Research Ethics Advisory Panel for Social and Health Research.
coming from a migrant or refugee background and spoke a language other than English. In order to reach this target group, non-probability purposive sampling (Bryman 2016) and snowball sampling (Liamputtong 2009) were utilised. Recruitment was supported by local services that placed a study poster in their waiting room, handed out study flyers to prospective participants and discussed the study with those interested. Other recruitment strategies included social media, a study website and word of mouth. Young people who heard about the study and were interested made contact with the first author via phone, email, website submission form or through a clinician (with their permission) to discuss and arrange the interview.

Interviews took place at an agreed location (e.g. health service, park), and participants were reimbursed for travel. First interviews ranged in duration from 20-60 minutes, and follow-up interviews from 30-40 minutes. An interview guide was piloted with the first three participants and, following minor changes, was utilised for all interviews. The pilot interviews were included in the complete dataset. First interviews explored young people’s views and experiences of accessing sexual and reproductive health information and services, while follow-up interviews allowed for more in-depth questioning. Although an interpreter was offered, this was not required and all interviews were conducted in English. Participants completed a short questionnaire after the first interview to record demographic characteristics (see Table 3). The possibility of a follow-up interview was mentioned at the end of the first interview, and if participants were agreeable, they were emailed at a later date and invited to participate. Participants chose their own pseudonym for reporting purposes.

Prospective key informants were purposively identified through formal and informal networks (those known to the research team or found through institutional websites), and invited via email to participate in an interview. The invitation included an Information Sheet and Consent Form. Key informants comprised professionals working in the area of sexual and reproductive health and/or with young people. They included clinicians, managers, social workers and health promotion officers working in sexual and reproductive health, refugee and youth health, and community organisation representatives, academics, and state policymakers. The majority worked in metropolitan NSW. Between August 2015 and May 2017, semi-structured interviews were conducted with key informants, in person or over the phone, ranging in duration from 20-45 minutes. Interviews explored their understandings and experiences of providing services to young people, cultural diversity and sexual and reproductive health, as well as the engagement of young people from migrant and refugee backgrounds.

Interviews were conducted by the first author, and were audio-recorded, transcribed verbatim, de-identified and coded using qualitative analysis software NVivo 10 (QSR International 2012).
Chapter 8: Relationships and sexuality education (published article)

The transcription and integrity-checking of transcripts were also undertaken by the first author, and an initial list of codes developed. Preliminary analysis commenced when we felt we were approaching data saturation, with little new information being added by successive interviews. Saturation was reached when all agreed that sufficient data had been collected to allow the exploratory aims of the study to be thoroughly fulfilled, and there were no significantly new perspectives being elicited (Patton 2002; Mason 2002). While 'active recruitment' slowed from May 2017, several interviews were conducted after this point as young people contacted the first author to participate.

Following the principles of thematic analysis, as described by Braun and Clarke (2006), deductive codes from interview guides were utilised and then supplemented by inductive codes derived from reviewing the data line-by-line. Development of the code structure was iterative, starting in the data collection phase. This process incorporated intercoder checking by all authors to strengthen quality and rigour, and identify important themes. Iterative categorisation (Neale 2016) was then applied to the coded data by the first author. This is a systematic technique for managing analysis that supports common analytical approaches, including thematic analysis, and leaves a clear audit trail (Neale 2016). Rigour was maintained through the iterative process of data collection, analysis, revision and write-up, which involved all authors. Final themes were discussed and agreed by all.

**Findings**

*Accounts from young people*

Altogether, 27 migrant and refugee young people participated in a first interview and 9 in a follow-up interview. Of these, most were studying at a university or a technical and further education institution. Two were in Year 12. Participants came from a wide geographic area within Sydney, with most residing in the Greater Western Sydney region. Relationships and sexuality education was a dominant theme across the interviews, and key findings are presented as three sub-themes below.

*Making sense of sexual and reproductive health*

A number of participants suggested that limited or incorrect understandings of sexual and reproductive health matters was problematic for themselves and other young people. Although all were broadly familiar with the terms ‘sexual and reproductive health’, ‘safe sex’, ‘contraception’ and ‘STIs’, many lacked confidence in their own knowledge. Several proposed
that much of their current awareness was due to past experiences and learning from past mistakes:

*I can say I’m a lot more better now regarding to sexual health and how to take care of yourself because like what they said, experience is the best teacher, so I think it helps me to grow more even though I… failed in having safe, being safe* (Kyr, 20)

Participants overall had fairly limited knowledge of specific sexual and reproductive health issues. Many could only provide a few examples of contraception and STIs. For example:

*Condoms, the pill. That’s all I know about* (Sarah, 24);

*Herpes like, yeah…And I’m pretty sure it’s the only one that I think is really, really big* (Liz, 21)

*“Ah, hepatitis, umm, Chlamydia? I don’t know much, to be honest… I think hepatitis is like through, transmitted through like saliva or something?… And Chlamydia I’m not so sure”* (Daniel, 20)

Misinformation was also apparent, particularly amongst some female participants, in some of their statements and stories. One participant expressed concern about ‘the condom getting stuck in there and then going to the hospital and then your mum coming there’ (Liz, 21). Another said she thought cervical screening was not necessary for her ‘because my family don’t have a history of cancer’ (Mimi, 22). One female participant stated:

*I’d rather not know than know… People say if you get a flu and it heals before 6 months, then you’re okay, you don’t have AIDS… Yeah you don’t have any symptoms, so I think I’m alright* (Panda, 23)

The notion of ‘healthy relationships’ was raised by several participants as another important issue, and one that should be covered in relationships and sexuality education. Several mentioned that young people may feel ‘pressured into unnecessary things’ regarding sexual practice (Daniel, 20), may have sex before they are ready, or have the ‘misconception that once you’re in the relationship, you have automatic consent’ (Mimi, 22).

*...a lot of them at a young age think they kind of have to have sex when they’re in relationships and things like that. I think that could have been covered in the sexual*
education, but I don’t really remember that being really discussed... [it could have covered] consent, and what kind of relationship is healthy (Gloria, 22)

Many participants were unsure where to go for help, or how to access contraception or testing:

I think the mega thing is knowing what that is and actually knowing, like, which one is a problem and which one isn’t a problem. Which one to ask for help, which one you shouldn’t ask for help, like where to go (Liz, 21);

I think more is needed because, especially for us Asian students. Most of us, they don’t know about that. They don’t know about how to take care of themselves, what time you should do a test (Bruce, 18)

Overcoming silence

Nearly all participants stressed that they did not discuss sexuality or sexual health matters with their parents, and usually not within their community.

It's like one of those things that you don't mention, or talk about, or even make like the slightest comment about (with parents) (Liz, 21);

It's like, you know, no man's land. We don't speak of it, no one speaks of it (James, 21);

I would have liked to have asked my mum... But that would mean then like, admitting to my parents that sex happens outside of marriage (Gloria, 22)

However, all were able to access information in other ways, and identified a number of other sources of information and knowledge.

The majority of participants described having received some form of relationships and sexuality education in school, either in Australia or their country of origin. Most had attended at least several years of secondary school in Australia, with a mix of school ‘types’ attended across the sample (i.e. public, private, religious, co-educational). For those who received sexuality education in an Australian secondary school, it was most commonly taught in PDHPE. Participants identified a number of topics covered in these sessions, the most common being contraception and condoms, puberty and menstruation, and STIs.
Most participants identified their school-based relationships and sexuality education as their first and main source of information on sexual health when they were growing up and ‘the bulk’ (Thanh, 20) of their sexual health knowledge: ‘I guess most of the things we’ve learned, we’ve learned from school’ (Diana, 18). Whilst there were mixed views regarding the relevance of content and mode of delivery, most found it generally useful and that what they learned at school ‘stuck with them’:

*I still use that knowledge today. Like it’s useful, yeah…I’ve remembered it (David, 20)*;

... *when I started becoming [sexually] active, I started realising hey, like you got to do this, you got to do that, don’t do this, don’t do that. It all made sense, you know... it stuck with me ... I never got the talk about the birds and the bees [at home]. I remember it from high school, so I was prepared (James, 21)*;

Several gaps or issues with the relationships and sexuality education received at school were noted, however. A number of participants felt the teaching provided had been very generic, outdated and not in depth, with teachers ‘sort of breezing through it… and reading off a textbook’ (Gloria, 22). Anzu (aged 24) suggested it came ‘a bit late’ in year 10. Examples of other concerns raised by different participants included teachers/schools promoting abstinence, not teaching about different contraceptive methods (apart from pills and condoms), and/or not covering ‘the relationship side of things’ (Gloria, 22). The different services available for young people regarding their sexual and reproductive health were also not covered.

In addition to school-based relationships and sexuality education, other sources of information noted by participants included the Internet, friends, health professionals and pornography (see Bottfield, Newman, and Zwi (2018) for further insights). Online sources, particularly Google, were identified by the majority as their main source of information on sex, sexuality and sexual health. Several mentioned they used Reddit and YouTube to learn about different topics, and a small number had joined private Facebook groups to obtain information and recommendations. Limitations of the Internet were noted, however, including that negative reviews and ‘horror stories’ (Julia, 22) were often more readily available than positive reviews, the need to try to ‘differentiate what's true and what's not’ (Thanh, 20), and reviews and articles often being ‘opinion-based’ and potentially misleading (Anzu, 24). However, despite these limitations, the Internet was viewed by most as a way of anonymously finding answers.

*If someone just mentions something vaguely that I don’t know about, I’ll just go and Google it... It’s all anonymity on the Internet (David, 20)*;
Many participants described feeling comfortable discussing sexual health and relationships with friends, particularly those who were considered trustworthy, were similarly experienced, or, for some, from a different cultural background.

Health professionals were identified as a source of information by many young people, although most stated they would use the Internet or speak to a friend before seeing a health professional.

Two of the four participants from a more recent refugee background, who had all attended an intensive English centre in Australia, mentioned receiving support in that setting regarding sexual and reproductive health. One noted receiving ‘one session about sexual relationships…it was very informative and that's why I became more confident. Before, I had no knowledge’ (Amir, 24). Another said that her teacher at the intensive English centre helped her when she got her period for the first time and ‘she gave me pads and what not’ (Liz, 21).

A small number of male participants also mentioned pornography as one of the ways that they and others learned about sex while growing up: ‘I learned from watching porn before when I was 11’ (Kyr, 20) and ‘I think for most of the guys, it’s basically pornography. Like they know a lot about it already’ (David, 20).

Learning to navigate the health system

Several participants suggested that one of the gaps in their relationships and sexuality education at school was not learning about services they could go to for advice and support regarding their sexual and reproductive health. When asked what services they knew about, none had learned about them in school, apart from several who had been advised to see a general practitioner if needed. The vast majority were unaware of the range of services available for sexual and reproductive health.

Among those participants who had been recruited into the study through a family planning or sexual health service, most had found out about that particular service through a Google search or a friend. One participant learned through receiving a flyer at university, and another through a Grindr app advertisement. None had previously heard of these kinds of services and most did not know of any others.
I guess knowing about the service is a big thing as well. Yeah. I think a lot of, like when you're in high school, you're not really taught what services there are (Thanh, 20);

[At school they taught] ‘you have to practice safe sex, you have to use a condom, you’re going to get like all of these (STIs) if you don’t’. But they didn’t actually really delve into like how, you know, what places are available to help you out with these things (Julia, 22)

Despite participants having little awareness of different ‘specialised’ sexual and reproductive health services, these services were perceived to be less judgemental and more knowledgeable about sexual health as they are ‘used to that every single day’ (Apple, 19), which meant there would be ‘less explaining to do’ (Olivia, 17).

I have to say from my knowledge and experience, although I haven’t attended a sexual health clinic personally, but they are very open, and very welcoming and very supportive of young people and all people (Jack, 20);

I know there's a place that says ‘Women’s Health’. I saw it, but I don't remember where I saw it... I'm pretty sure it's pretty great (Liz, 21)

Tertiary education was not noted in many interviews as a site for accessing sexual health information and services, although several mentioned universities, as well as schools, as useful places to advertise services. They mentioned promoting services through flyers, fact sheets/resources with prominent service logos, and posters on toilet doors. A number of participants suggested that promotion of services should emphasise that they are confidential, non-judgemental and free or low-cost.

...maybe giving out information in schools or even at uni, like someone just handing out flyers (Denise, 20);

...you know they have like in the toilet you close the door and they have a lot of things stick on it, so you can find on the same thing as well for the service... perfect place to put sticker on (Merry, 21)
Several participants noted that even if they were not looking to use a service at that point in time, seeing a flyer or advertisement may prompt them to go then or in future when they needed it, as had been the experience for several participants.

_I would be thinking, ‘hey that's actually convenient. It's near me’, or ‘I know that place’, or ‘you know what, it's time to actually go for a check-up’ (James, 21);_

_Even if they're not thinking about it, just knowing that it's there is good (Diana, 18)_

**Insights from key informants**

Interviews were also conducted with 34 key informants (see Table 2). Whilst key findings on the broad range of issues covered by this group are reported elsewhere (Botfield, Newman, and Zwi 2017), the importance of relationships and sexuality education was raised in some of the interviews, and is included here to provide greater insight into the policy context and constraints.

Many key informants highlighted the importance of relationships and sexuality education for all young people. Several argued this as particularly critical for young people from migrant and refugee backgrounds in Australia given the sensitivity of the topic across many different cultures, and because many young people may not have received such education in their country of origin.

Several key informants recognised the opportunity for reaching young people while they are a ‘captive audience’ in schools and related settings, and the importance of utilising these opportunities in providing relationships and sexuality education. Some highlighted the potential for health services to improve links with local schools and other educational settings, in order to build relationships and networks, and to increase awareness of the services young people are able to access. They also identified other settings where sexuality education would be beneficial, including in intensive English centres, technical and further education institutes, and universities. Intensive English centres in particular were suggested as an ideal setting for reaching more recently arrived refugees:

_I mean they are seeing...children, teenagers, who have recently arrived in Australia... They are a captive audience. They could introduce some great sexual health programmes in there (KI24-F);_
(Intensive English centres) are a great setting for reaching newly arrived refugee young people, and they lend themselves very well to that (KI6-M)

However, whilst acknowledging the importance of relationships and sexuality education, the limitations of the school-based curricula in Australia were also described. These included a lack of comprehensive teaching across relationships, sexuality and sexual health, including issues of consent, respectful/healthy relationships, sexual identity and same-sex attraction.

“I do think that there’s room for better education in schools... it should be all joined up so that it’s quite comprehensive, so it includes issues around consent and violence and what a respectful relationship looks like... (and) the only thing I didn’t say and obviously I should say is around same-sex attracted young people and sexual identity...being an important part of what education and service responses should include as well” (KI19-F)

Some key informants also suggested that the different approaches schools can take around relationships and sexuality education is problematic:

I think the national curriculum has taken some good steps in the right direction to have better guidelines in there about what schools should do, but that doesn’t actually then mean that schools do it (KI12-F);

...teachers educate around reproductive and sexual health quite differently and some don’t do it well (KI2-F)

Discussion

In this paper, we have presented the largely un-documented perspectives of young people from a diverse range of migrant and refugee backgrounds living in Sydney, Australia, as well as the views of expert informants, on the provision of relationships and sexuality education for this group. Schools in particular were identified by young people as an important setting through which to learn about relationships and sexual health. Key informants similarly observed the importance of school-based sexuality education for young people, especially those from migrant and refugee backgrounds.

Although the shortcomings of relationships and sexuality education have been identified both in a global context (Pound, Langford, and Campbell 2016; Formby 2011; Weaver, Smith, and
Kippax 2005) and in many Australian schools (Hillier and Mitchell 2008; Mitchell et al. 2014; Shannon and Smith 2015; Helmer et al. 2015), school-based initiatives may offer the best opportunity to increase sexual health literacy and improve access to information (Rawson and Liamputtong 2010). Participants in this study repeatedly emphasised the lack of discussion or education at home, and there is clearly value in learning about these issues in an educational setting, particularly for those who may not have received any formal sexuality education prior to coming to Australia (McMichael and Gifford 2009; Poljski 2011b). To better meet the needs of young people and enhance health outcomes, findings from this study suggest that school-based relationships and sexuality education could focus more on different contraceptive options, healthy relationships, gender and sexuality, local services available for sexual health, and how to access trustworthy sources of information online. Informing young people that from the age of 15 years they can obtain their own Medicare card (which subsidises the cost of healthcare access for Australian citizens and some overseas visitors) may also be of value. Few participants mentioned this in their interview/s, and it is not clear whether many were aware of this option.

An additional gap, albeit not one raised specifically by the young people interviewed ⁹ is that information and support in relation to same-sex attracted and gender diverse young people may be missing from much of the education provided. Some research has suggested that relationships and sexuality education that ignores this aspect of lived experience can be extremely harmful for some young people (Hillier et al. 2010). Those from migrant and refugee backgrounds who are same-sex attracted or gender diverse may be at high risk of adverse sexual and reproductive health outcomes (Poljski 2011a; Hillier et al. 2010). New diagnoses of HIV in Sydney are particularly high amongst men who have sex with other men of Asian descent, for example, who may be reluctant to access services due to stigma in their home country and fear of racism and isolation. Members of this group may also be accessing HIV testing and prevention technologies such as pre-exposure prophylaxis at lower rates than Australian-born men (Stardust et al. 2017).

The delivery of relationships and sexuality education in an accessible and appropriate way could offer a powerful entry point to building understanding and confidence about using available services among young people from diverse backgrounds. Young people in this study were largely unaware of the range, location and scope of services available in this area. Links between schools and services (such as family planning, sexual health and youth health services) could therefore be strengthened and promoted, as suggested by a number of key informants and

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⁹ The sexuality of participants was not known during the interview, unless the participant chose to mention this. Participants may therefore not have been given sufficient opportunity to raise this during their interview.
the international literature (see, for example: Thomas and Aggleton 2016; Formby et al. 2010; UNESCO 2009). As one example, family planning organisations in Australia work with a number of schools to support them in implementing relationships and sexuality education (see, for example, Family Planning NSW n.d.; Sexual Health and Family Planning ACT n.d.; SHine SA n.d.; Family Planning Victoria n.d.). This could be expanded to other settings. Providing sexual health services through school-based health clinics may also be a potential model to consider (Johnson Moore et al. 2016), alongside evaluation of current school-based sexual health care (Shackleton et al. 2016). Victoria, another state in Australia, is currently trialling the placement of GPs in schools to increase accessibility of health care (Victorian Department of Education and Training 2017).

The internet is clearly an important source of health information for young people in Australia and all around the world (Buhi et al. 2009; Evers et al. 2013; Simon and Daneback 2013; Robards et al. 2017; Mitchell et al. 2014). Those from migrant and refugee backgrounds appear to be no different, although the fact that they repeatedly asserted in this study that they do not feel they have the option to seek information and support from family suggests they may be even more reliant on online information. Whilst some studies have reported the internet may not always be their first source of information (McMichael and Gifford 2009; Reeders 2011), findings from this study suggest the internet and other digital technology are critical for this group (recognising that these do not, however, do the more difficult work of opening up more direct and supportive conversations within their own everyday social contexts).

Not all young people coming to Australia from migrant and refugee backgrounds will have the opportunity to learn about sex and sexual health at school in Australia, as they may not attend school upon their arrival, or may attend a school in which it is not offered or was offered prior to their arrival. They may miss this opportunity altogether if they have come from a country in which this education is not provided or is not comprehensively covered (Reeders 2011; Poljski 2011b; Svensson, Carlzén, and Agardh 2017). While school-based relationships and sexuality education is vital and may reach a vast number of young people, other avenues should also be considered to ensure greater reach (Brown, Sorenson, and Hildebrand 2012; Secor-Turner et al. 2017; Svensson, Carlzén, and Agardh 2017), including, in the Australian context, intensive English centres, technical and further education institutes, private colleges and universities. Key informants in particular identified these as useful settings to reach and support more young people, particularly international students and recently arrived refugees. Given that migrant and refugee young people may experience barriers in accessing sexuality and relationships information and services, it is pertinent to consider the opportunities for health promotion and education in schools and other educational settings.
This research reiterates the importance of building on the strengths and capacities of educational institutions as settings with much potential to support and promote the health and wellbeing of young people (Aggleton, Dennison, and Warwick 2010; Langford et al. 2015), including their sexual and reproductive health (Smith et al. 2011; Thomas and Aggleton 2016). This will require coordinated action at different levels, particularly as health services are not sufficient on their own to enhance sexual and reproductive health outcomes (Svanemyr et al. 2015; Aggleton et al. 2014).

**Limitations**

This study contributes to the body of research on relationships and sexuality education for migrant and refugee young people, but there are some limitations to note. Recruitment of a sample of migrant and refugee young people was purposely broad, however findings cannot necessarily be taken to apply to specific cultural or language groups. Approximately two-thirds of participants had heard about the study through a service with which they were in contact (and others through a friend or other networks) thus reducing insights derived from ‘hard to reach’ populations or those disengaged from services.

Whilst the study did include some same-sex attracted young people (just over one-third reported being attracted to the same sex or both sexes), no young people identified as gender diverse so the voices of these young people are not represented. This is an important area for future research, as the intersections of cultural diversity and diversity in sexual or gender orientation can be particularly difficult to navigate.

Although we hoped to recruit some non-English speaking young people, all participants spoke English in addition to their first language/s. Participants in this study had also attended a range of educational institutions, including different types of secondary schools, technical and further education institutes, universities and intensive English centres, and were insufficient to allow site-specific analysis. Future research could focus on exploring the role and impact of different types of schools and tertiary education settings in relationships and sexuality education.

There are also possible influences relating to the interviewer, who was cis-female, in her late 20s, and from an English-speaking background.

Nonetheless, taking these limitations into account, we believe this study has important research, policy and practice implications for working towards enhancing the sexual and reproductive
health knowledge and health literacy of young people in Australia and other comparable liberal democracies (Rose 1996).

**Conclusion**

It is well-recognised that schools are well placed to deliver relationships and sexuality education to reach a high number of young people. Our research suggests this is especially important for migrant and refugee young people, who may see schools as a trusted and safe setting in which to access information that is often culturally prohibited and not discussed in their family and community environments. To achieve a broader reach among young people from diverse cultural backgrounds in Australia, relationships and sexuality education could also be provided in tertiary settings and intensive English centres. Delivering this education in an accessible and appropriate way could also offer a powerful entry point to building understanding and confidence in making use of different health services available for sexual and reproductive health.

**Acknowledgements**

We are grateful for the contributions of the young people interviewed, who so willingly shared their views and experiences, as well as for the young people who contributed as part of the Youth Advisory Group convened for the study. Thanks also to the co-investigators (Dr Deborah Bateson, Ms Katherine Bennett, Dr Christopher Carmody, Mr Brendan Crozier, Dr Melissa Kang, Dr Catriona Ooi and Dr Mitchell Smith) and partner organisations (Family Planning NSW, High St Youth Health Service, NSW Refugee Health Service, South Western Sydney Sexual Health Service, Sydney Sexual Health Centre, and Western Sydney Sexual Health Centre) who provided advice and support for the research. Acknowledgement of the many contributions to this research does not imply endorsement of the findings or recommendations of this paper by those named. We acknowledge UNSW Arts and Social Sciences, which contributed some funding towards the fieldwork for this research, as well as the support of an Australian Government Research Training Program Scholarship.
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Chapter 9: Talking to migrant and refugee young people about sexual health in general practice

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As has been described in previous chapters, the young people interviewed in this study commonly positioned ‘older people’ as judgemental and less accepting in relation to sexual health. Nearly all reported they were unable to discuss sexuality or sexual health with their parents or often anyone in their community, yet most were able to access other sources of information or support if needed. This chapter reports findings related to one of the services that was discussed most commonly by migrant and refugee young people: general practice. The chapter focuses on their views and experiences in accessing this service for sexual and reproductive health care. Local media interest in this article led to stories being published by the RACGP newsGP and in the Canterbury-Bankstown Torch in August 2018. I also presented this paper at the IUSTI Asia Pacific Sexual Health Congress in November 2018.

This chapter contains the published version of a journal article published by the RACGP in the Australian Journal of General Practice (previously Australian Family Physician) in August 2018. This journal was deemed particularly suitable due to its wide readership amongst general practitioners and other health professionals. Australian Family Physician ranked in the second quartile for Medicine (Family Practice) journals (16/36) (Scimago Journal Rankings 2017).

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Declaration: I certify that this publication was a direct result of my research towards this PhD, and that reproduction in this thesis does not breach copyright regulations.

Signed:
Talking to migrant and refugee young people about sexual health in general practice

Jessica R Botfield  Christy E Newman  Melissa Kang  Anthony B Zwi

Background and objectives

Young people are an important group to target with health promotion and preventive healthcare. This paper focuses on the engagement of migrant and refugee young people with sexual and reproductive healthcare in general practice.

Methods

Semi-structured first interviews (n = 27; 16 female, 11 male) and follow-up interviews (n = nine; six female, three male) were undertaken with migrant and refugee young people aged 16–24 years living in Sydney.

Results

The majority of participants had seen a general practitioner (GP) for general health issues. However, most were reluctant to discuss sexual health with a practitioner whom they described as their “family doctor”, primarily because of concerns about judgement and confidentiality. Most described negative experiences with GPs for sexual health matters, including not being listened to or being rushed through the appointment.

Discussion

There appears to be a lack of effective engagement with migrant and refugee young people by GPs in relation to sexual health. Building the skills and confidence of GPs to work with this group and promote sexual health and wellbeing should be considered, and efforts should be made to communicate confidentiality and trustworthiness.
Abstract

Background/objective: Young people are an important group to target with health promotion and preventive health care. This paper focuses on the engagement of migrant and refugee young people with sexual and reproductive health care in general practice.

Method: Semi-structured first interviews (n=27; 16 female, 11 male) and follow-up interviews (n=9; 6 female, 3 male) were undertaken with migrant and refugee young people aged 16-24 years living in Sydney.

Results: The majority of participants had seen a general practitioner (GP) for general health issues. However, most were reluctant to discuss sexual health with what they described as their ‘family doctor’, primarily due to concerns about judgement and confidentiality. Most described negative experiences with GPs for sexual health matters, including not being listened to or being rushed through the appointment.

Discussion: There appears to be a lack of effective engagement with migrant and refugee young people by GPs in relation to sexual health. Building the skills and confidence of GPs to work with this group and promote sexual health and wellbeing should be considered, and efforts made to communicate confidentiality and trustworthiness.
Chapter 10: Discussion

Introduction

This doctoral study contributes to the growing body of research on the sexual and reproductive health of migrant and refugee young people living in a Global North nation such as Australia. As previously outlined, we know that sexual and reproductive health and rights are fundamental to health and wellbeing, and that providing universal access to sexual and reproductive healthcare services is a global aspiration (United Nations, 2015). We also know that information and services related to these aspects of health should ideally be accessible to all, regardless of age, marital status, gender, faith, nationality, migration status, sexuality or ethnicity. This includes young people, who must be supported to access information, education and services in order that they have the rightful opportunity to optimise their sexual and reproductive health (Starrs et al., 2018). In Australia, nearly half of residents are born overseas or had at least one parent born overseas (Australian Bureau of Statistics, 2017), and a range of complexities have been identified in this research in relation to supporting the growing population of ‘culturally diverse’ young people to access the information and care they require for their sexual and reproductive health and wellbeing. As described in Chapters 1, 3 and 4, much of the research in this field has focussed on young people more generally, or on ‘culturally diverse’ adult women or those from particular cultural or religious backgrounds. Very little empirical research had previously been conducted which explored in depth the views and experiences of young people of any gender from migrant and refugee backgrounds on these issues in Australia. Findings from this doctoral research therefore contribute to filling this gap and make an important contribution to existing scholarship. The handbook chapter and six peer-reviewed journal articles (Chapters 3-9) have been published in order to communicate important insights to a broad range of policy, practice and research audiences. These articles appear in well regarded journals in the field; Sexual Health, Culture, Health & Sexuality, Sexuality Research and Social Policy, and Sex Education were all ranked in 2018 in the first or second quartile by Scimago Journal Rankings, which assess the quality of peer-reviewed journals in specified fields, and all rank in the top 20 cited publications in the sex and sexuality field in Google Scholar. A number of these articles have already attracted interest and have been cited in the literature, despite their recent year of publication. Overarching insights from this suite of publications are drawn together and briefly summarised here.

The literature review undertaken at the start of the doctoral study identified a range of global issues affecting the sexual and reproductive health of young people from diverse migrant
backgrounds, with a focus on Australia as a case study in contemporary multiculturalism (Chapter 3). It explored different approaches to promoting the use of sexual and reproductive health services by young people, including the importance of youth-friendly and culturally competent care. A more systematic literature review was also undertaken in the form of a structured scoping review, to examine the Australian literature in order to determine the extent and nature of research activity on this topic and assist with identifying research gaps (Chapter 4). The scoping review identified two specific knowledge gaps: i) the perspectives of ‘culturally diverse’ young people and ii) insights regarding their engagement with services. The aim of the empirical component of this doctoral research was therefore developed to focus on exploring youth and professional perspectives to better understand the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health information and services in Sydney, Australia. To achieve this aim, interviews with key informants were firstly undertaken to gather contextual information to support the ‘scoping’ of key issues and to develop an understanding of professional views on this. Key informant views and observations highlighted the complexities of, and best practice approaches to, engaging this group with sexual and reproductive health promotion and care. These related to appreciating the nuances of cultural diversity, recognising structural barriers and disincentives to engagement of ‘culturally diverse’ young people, the need to normalise sexual health and balance ‘youth-friendly’ and ‘culturally-competent’ priorities, and to consider issues of language and meaning in the provision of information and services (see Chapter 5).

Interviews with migrant and refugee young people were then undertaken to explore these and other related issues in more depth, and to ensure that the perspectives of a diverse group of young people could be heard on these matters. Despite identifying with a range of cultural and language backgrounds, the young people who participated in interviews were found to be more similar than different in relation to their views on and experiences with sexual health information and services. A theme of ‘generational difference’ was observed throughout their interviews, particularly when they described their experiences and preferences regarding the characteristics of those who provide sexual and reproductive health information and services. ‘Older people’ were commonly perceived to be more judgemental and less accepting of their sexual health, sexual practices and sexuality preferences (see Chapter 7). Young people from these diverse backgrounds also highlighted persistent taboos and stigma surrounding sex and sexual health in their family and community environments, with most unable to discuss sexuality or sexual health with their parents or others in their community. They also expressed concerns regarding being judged and confidentiality not being maintained in relation to service providers, but despite this, most reported being able to seek information and support in various ways if needed. School, and in particular the relationships and sexuality education provided
there, was identified by most as the main source of information for them growing up (see Chapter 8). Most were unaware of the range of different services available for supporting young people in pursuing sexual and reproductive health. General practice was identified as the most commonly known and accessed health service for this group, however many expressed strong concerns about asking for advice and care relating to sexual and reproductive health, from either a regular ‘family doctor’ (i.e. a GP who also provided care to their family) or a more ‘anonymous’ group-practice GP (see Chapter 9). One of the methods utilised in the research to elicit this data on young people’s views of different services for sexual and reproductive health, and which contributed to the findings presented in Chapters 7, 8 and 9, was the walking interview. The ethical complexities and empirical value of incorporating this method was demonstrated in Chapter 6 of this thesis.

In reviewing these publications and reflecting on their major contributions, this discussion chapter draws together three overarching themes from the data: i) negotiating multiple dimensions of identity, ii) keeping secrets and maintaining ‘face’, and iii) building trust and safety in service settings. The final chapter of this thesis, chapter 11, then concludes with a discussion of the implications of findings for practice and policy, the methodological strengths and limitations of the study, suggestions for future research, and a summary of conclusions.

i) Negotiating multiple dimensions of identity

Interviews with both professionals and young people often pivoted around complex questions and observations regarding identity. Developing a sense of one’s identity is recognised as a key developmental milestone for adolescents (Noble-Carr, Barker, McArthur, & Woodman, 2014) as they start to explore their own distinctive beliefs, values and choices (Young, 2006), form social connections and pursue a sense of belonging within the social worlds they value (DiFulvio, 2011; Noble-Carr et al., 2014). Whilst the notion of ‘identity’ can be conceptualised in many different ways (Noble-Carr et al., 2014), Jenkins (1996) suggests that identity is about “our understanding of who we are and of who other people are, and, reciprocally, other people’s understanding of themselves and of others (which includes us)” (p. 5). The category of ‘young person’ can itself be classified as an identity, recognising the ways in which young people are made distinctive from other groups in society, including ‘adults’ and ‘children’ (Hopkins, 2010). White and Wyn (2013) argue that identity among young people is also a social process shaped by particular relationships (for example with family and friends, in schools and workplaces), economic conditions and cultural traditions. Other research undertaken with migrant and refugee young people adds further insights regarding the complexities of adapting to their country of resettlement as they develop a new sense of identity which often spans two
distinctive cultural worlds (Gale, Bolzan, & Momartin, 2010; Iqbal, Joyce, Russo, & Earnest, 2012; Rawson & Liamputtong, 2010; Sleijpen, Boeije, Kleber, & Mooren, 2016).

Given these multiple dimensions of identity, it cannot be assumed that people from a particular cultural, religious or language background will necessarily share the same beliefs and practices, or that young people will relate only to the cultural identity of their parents (Bennett, Chown, & Kang, 2005; Julian, 2013; Sinha, Curtis, Jayakody, Viner, & Roberts, 2007). Indeed, the issue of ‘cultural stereotyping’ was raised in the interviews with key informants for this study. Several suggested that assumptions can often be made about clients in the healthcare setting, particularly based on their appearance, leading clinicians to make assumptions about the beliefs of those individuals or to assume that people from a certain cultural community will always identify with or feel connected to that community (see Chapter 5). Interestingly, the young people who participated in this research, despite coming from very different cultural and language backgrounds and with varied migration histories, shared many similar views and experiences in their interviews. They commonly described themselves as being a ‘young person’ or from the ‘younger generation’, rather than as someone identifying with a particular non-Anglo cultural heritage or background. Issues relating to culture, gender and sexuality were also discussed by these participants, however the concept of ‘age’ was observed as significant to their way of making sense of their world and their place in it (see Chapter 7). Whilst a number of participants did refer to their ‘community’, this was often described in broad terms as a way of framing their observations or views about particular aspects of their life, rather than how they personally identified or positioned themselves. Some participants did not identify with a particular cultural group or community at all, and among those who did, they did not always also subscribe to the dominant beliefs or values of that community. Most described making their own choices about how they lived their lives, albeit within certain constraints, and did not necessarily place the same importance on cultural values, tradition or religion as they felt their parents or communities did. However, most still maintained strong connections with their family and conveyed a deep sense of caring for their wellbeing, and that of others in the communities in which they were embedded (see Chapter 7). Connections to family and community can be viewed as an asset and strength of those from migrant and refugee backgrounds (Qin et al., 2015). It was apparent, however, that many participants were ‘living between two cultures’ and establishing their own identity within this context.

As identities are clearly layered and subjective, it is important to recognise this complexity (Weller, 2010). The concept of ‘intersectionality’ is particularly helpful in this, although this study did not set out to consider the range of intersectional experiences and implications of these. This concept recognises that experiences are rarely shaped by just one aspect of identity.
but instead are shaped by multiple, intersecting aspects of a person’s social and historical place and experience, and particular features such as their gender, race, culture, education, sexual orientation and immigration status. Intersectionality supports recognition of the complexity of the many interconnecting factors which influence peoples needs and preferences regarding health and wellbeing (Hankivsky & Cornier, 2009; Kapilashrami, Hill, & Meer, 2015), and is commonly described in the literature relevant to this research as the ‘interactions between gender, culture, race and other categories of difference’ (Davis, 2008; Ngum Chi Watts, Liamputtong, & Carolan, 2014; Ussher et al., 2012). Whilst key informants in this study raised various points in relation to culture and community when discussing migrant and refugee young people in their interviews, the interviews with young people suggested that the social categories of ‘age’ and popular notions of ‘generations’ were particularly important categories of difference for them and played a key role in shaping their views and experiences. Whilst a range of categories will influence the experiences and views of migrant and refugee young people, including sexual orientation, gender, cultural background and migration experiences, as the sample for this study was relatively broad the number of young people with similar characteristics was small and neither specific analyses nor an intersectional analysis were considered appropriate. The category of age was reported on in this thesis as it was a prominent theme across interviews with young people. Gender in particular may also play an important role in young people’s lives (Sinha et al., 2007; Wong, Macpherson, Vahabi, & Li, 2017), however there was little observation of gender differences as an organising theme in the interviews with young people and no key differences were observed in the data between male and female participants in relation to the issues covered by the study. Thus whilst the concepts of culture and gender described in Chapter 1 were important aspects of the research, other elements of young people's lives clearly also had resonance and relevance for them. When working with migrant and refugee young people, consideration of generational differences and awareness of their identity as a ‘young person’, as well as other categories of difference, appears to therefore be very important.

Although the concept of identity was not the primary focus of this research, it was apparent from young people’s accounts that they were indeed establishing their own sense of identity, drawing on their distinctive experiences and desires and beginning to form their own sexual identities whilst still living within and negotiating parental and community expectations. They did not view themselves as being entirely limited or confined by the cultural mores and expectations that they associated with their family and community environment, as discussed in Chapter 7 and in the theme below. Given the recognised need to appreciate the “multiplicity of

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10 This may be in part due to the design of the study. This is discussed in the limitations further below.
identity” described above that is characteristic of many young people (Wagaman, 2014), and the complexities and intersections of these multiple identities and experiences (Blackburn & McCready, 2009; Hendry, Brown, Johnston, & Dowssett, 2013; Weller, 2010), it is essential to look beyond single categories of ‘cultural background’ or ‘age’, for example, to consider how different aspects of one’s social world intersect to shape identity and experiences. There is a need for health professionals and service providers to have greater awareness and understanding of intersecting identities (Semlyen, Ali, & Flowers, 2018). Recognition of the multiple dimensions of identity by those working in service provision and in health promotion and education activities with young people from diverse backgrounds will likely contribute to enhancing the support and care they receive.

ii) Keeping secrets and maintaining ‘face’

The pervasive stigma associated with matters of sexuality and sexual health which has been described as characteristic of many migrant and refugee communities (Agu, Lobo, Crawford, & Chigwada, 2016; McMichael & Gifford, 2009; Svensson, Carlzén, & Agardh, 2017; Ussher et al., 2017; Ussher et al., 2012) was raised by both young people and key informants in this research and relates to the second overarching theme identified. Social and cultural norms and taboos related to sexuality and sexual health can create a ‘culture of silence’ (Kingori, Ice, Hassan, Elmi, & Perko, 2018; Svanemyr, Amin, Robles, & Greene, 2015), which was also evident within this research. The majority of young people in the study explained that sexual and reproductive health, including the common experiences of puberty and, for young women, menstruation, were not discussed by their parents at all. However, even though not always explicitly discussed, as highlighted in Chapter 7 they were also aware that their parents held certain expectations regarding how they should conduct themselves, including not engaging in sexual activity before marriage, not discussing sex or related topics with others, and aiming to meet and marry someone of the opposite sex from an ‘acceptable’ background.

It was apparent that although these young people may not necessarily set themselves apart from their families and communities in the way they spoke about their place in the world, maintaining their place in those social and intimate worlds required that they carefully navigate their compliance with a number of cultural restrictions and expectations within the home and community. It was clear in talking with young people that they did feel constrained in some ways with regard to their opportunity to speak openly about their desires and preferences regarding sexuality and relationships. There was a sense that all matters relating to issues of sex and sexuality were too culturally – and sometimes also religiously – sensitive to be discussed within most of those environments. Findings from studies with secondary school students have
reported that many young people in the broader population may discuss sex and sexual health with their parents (Berne et al., 2000; Booth et al., 2004; Mitchell, Patrick, Heywood, Blackman, & Pitts, 2014), however a clear majority of participants in this study felt very strongly that this was not an option for them. In addition to this, participants appeared to hold quite different opinions to their parents when it came to their views, practices and experiences in relation to sex and sexuality. For example, many participants were sexually active, and a small number identified as gay or bisexual. And yet, although they were very much engaged in their own private sexual lives, there was still a strong sense communicated by participants that they felt very loyal towards, and protective of, their families.

To that end, young people were actively involved in a twinned process of keeping secrets and maintaining ‘face’ (Kimmel & Yi, 2004; Montemurro, Bartasavich, & Wintermute, 2015), both of which intended to protect themselves and their loved ones from having to engage in difficult conversations, or to risk shaming their families within their broader communities or compromising their reputation. Klitzman and Bayer (2003) suggest there are two forms of secrets: a ‘secret’ that everyone knows but agrees not to talk about, and ‘secret secrets’ that nobody knows… and both were apparent in these interviews with young people. Hardon and Posel (2012) further argue that the ‘cultural politics of secrecy’ – who speaks, to whom, what is said, how it is said, and what is withheld – is embedded within all social relationships, hierarchies, cultural norms and sanctions. Secrecy can therefore be framed both as a social practice, that is, situational and relational, as well as an embodied practice as it pertains to the domain of sexual and reproductive health (Hardon & Posel, 2012). Indeed, forms of secret-keeping were apparent in most participant interviews conducted for this research, with participants choosing who they did and did not discuss these with and how they managed not speaking about certain matters in different situations.

Two examples of these secret aspects of some young people’s lives related to unintended pregnancy and to non-heterosexuality. These issues and experiences were raised in a number of interviews but were not necessarily discussed in-depth and therefore did not feature heavily in the publications presented in this thesis. Many participants identified the prospect of pregnancy outside of marriage as an issue for young people generally in their communities, including in the context of risk to reputation and social wellbeing. Most had successfully kept their sexual relationships hidden from their family, and suggested that a pregnancy outside of marriage would be very distressing particularly as it would reveal to both family and community their secret sexual lives. Non-heterosexuality was another aspect of sexual life that participants chose to keep secret from certain people; their parents in particular. On their demographic questionnaire, five participants identified as homosexual (all male) with one adding
“/confused”. Of these, none had directly discussed their sexuality with their parent(s), although one had a cousin who disclosed his sexuality to his whole family, and two thought their mother probably knew or suspected. Three stated the reason they had not explicitly discussed their sexuality with their mother or both parents was because they knew they had certain expectations and did not want to disappointment them. However, while maintaining this secrecy in the family context, all had been able to find and access a sexual health service for care, with three attending for medication, one for testing after being with a symptomatic partner, and another for post-exposure prophylaxis after condomless sex. This data reveals an area of sexual life that appears to be especially hidden from families and communities.

When considering barriers to young people accessing sexual and reproductive health information and care, key informants identified what some described as ‘intergenerational differences’ between migrant and refugee young people and their parents as being a barrier (see Chapter 5). However, despite clear ‘differences’ and the keeping of secrets in relation to this, when speaking to young people it appeared that these constraints did not prevent them from making their own choices in relation to dating, engaging in sexual activity and accessing information and support if required; they simply did so in ways that ensured others would not find out. This enabled them to maintain their relationship with their parents, their own reputation and that of their parents, and prevent gossip amongst their or their parents’ community. Young people did not describe themselves as being confined by cultural mores and parental expectations, but appeared to be able to negotiate and manage this space in various ways. And despite the silence and secrets around sexuality and sexual health that they described, none indicated this would prevent them from accessing a service for sexual and reproductive health if they needed to. This suggests that if young people were more aware of the different services available, which many in this study were not, they may be willing to use them for information and care. Whilst some services in Australia for sexual and reproductive health may be somewhat gendered – for example family planning services are often more female-oriented and sexual health services more male-oriented – this was not raised as a benefit or barrier by the young people familiar with any of these services.

Secret-keeping and maintaining ‘face’ appeared to be a form of both self-protection and self-care, as well as care for loved ones, among young people growing up in ‘culturally diverse’ families and communities. It is important to acknowledge the strengths and capabilities of migrant and refugee young people in enacting these often complex and perhaps intensive processes. This finding is counter to the more common deficit discourses and approaches in research, health promotion and service provision with young people and those from migrant and refugee backgrounds which often focus on risk and vulnerability. Despite living in what may be
viewed as restrictive or constraining environments, it was apparent that the young people who participated in this research were able to exercise a degree of agency regarding how they navigated those constraints (Petesch, Smulovitz, & Walton, 2005), as introduced in Chapter 1, and were able to seek information and care if desired. It is worth noting, however, that these experiences are specific to the young people in this study and are not representative of all migrant and refugee young people in Australia, including those who do not speak English or who may not be connected with health or social services or networks. Recognising the potential limitations of secret-keeping and ways in which young people demonstrate agency is also important, including the questionable quality of some information on the internet, and the many issues that may be specific to an individuals’ context and therefore difficult to translate from online advice. Given young people may be particularly reliant on the internet it is essential that they are able to access quality and relevant information online. Keeping secrets may also limit the support young people receive, particularly when considering the limited awareness of different services for sexual and reproductive health and discomfort speaking about such matters with a ‘family doctor’ (Chapter 9). As discussed in Chapter 8, as migrant and refugee young people may not be able to discuss issues of sexuality and sexual health in family or community environments either, different ways of reaching them with sexual health promotion, education and care should be considered, including through schools, technical and further education institutions, intensive English centres, universities and community-based groups. Providing this in an accessible and appropriate way may also provide the opportunity to build awareness of and confidence in making use of the different health services available. The importance of health professionals remaining non-judgemental and maintaining confidentiality (within legal obligations) when discussing issues of sexuality and sexual health with young people is also paramount to ensuring they are able to access the information and support they require, without compromising other aspects of their lives. This is essential to building trust and safety in health services settings, which is discussed in the third and final overarching theme below.

iii) Building trust and safety in service settings

The encounter between health care providers and their clients is central to the provision of care in all service settings. However, with some forms of health care, including that of sexual and reproductive health with young people, it is even more essential that attention be paid to ensuring the encounter feels safe. A perception of trust is associated with a young person feeling safe with their healthcare provider (Byczkowski, Kollar, & Britto, 2010) and can be seen as a ‘precondition’ for young people to discuss sensitive issues (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013). Trust within clinician-client relationships is fundamental, and encompasses concepts of satisfaction, communication, competency and privacy (Hall, Dugan, Zheng, &
Feelings of mistrust can translate into feeling ‘not safe’ in health services (Majumder, O’Reilly, Karim, & Vostanis, 2015). Establishing and maintaining effective clinician-client relationships in youth health therefore requires building a sense of trust (Gilson, 2003; Mey et al., 2013), which Hall et al. (2001) suggest is “the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster’s interests” (p. 615). To promote the trustworthiness and safety of services with young people, service settings are encouraged to communicate that they are confidential, non-judgemental, welcoming, inclusive and affirming of the diverse range of identities, backgrounds and experiences of the young people they serve (Byczkowski et al., 2010; Edwards et al., 2016; Wagaman, 2014). Achieving this sense of safety and trust can be challenging when engaging young people with any health service (Ambresin et al., 2013; Nair et al., 2015; Pallab, Michelle, Khalid, & Panos, 2015), but may be even more difficult to establish in the context of sexual and reproductive health.

The young people in this study expressed particularly strong concerns about the potential for, and experience of, judgemental views being held by service providers and risks to confidentiality regarding more ‘sensitive’ issues. Most had very low awareness of services available for sexual and reproductive health, apart from those provided by GPs, however, as described in Chapter 9, many expressed concerns regarding seeing a GP for sexual and reproductive health matters. This was primarily due to past negative experiences with a GP, as well as concerns about confidentiality, fear of judgement and/or discomfort speaking about sex or sexual health issues with their ‘family doctor’. It has been noted in the literature that young people and others from migrant or refugee backgrounds who require an interpreter may feel even less willing to discuss these matters (McMichael & Gifford, 2009; Mengesha, Perz, Dune, & Ussher, 2018), if they fear the interpreter may not be impartial or may be connected to their own community. ‘Older’ people were frequently viewed in interviews with young people as generationally distinctive from themselves, and less open and accepting, and/or less knowledgeable, in relation to sexual and reproductive health. It is perhaps not surprising, therefore, that most had a preference for a ‘younger’ clinician, as they were viewed as less likely to be judgemental and to be more knowledgeable about sexual health (see Chapter 7). The age, and to a lesser extent gender, of service providers appeared to be very important considerations for these young people, even though sub-optimal care provided by clinicians may be related more to lack of training, inexperience or personal attitudes (Haboubi & Lincoln, 2003; Khan, Plummer, Hussain, & Minichiello, 2008). Clearly in this study, however, ‘older’ clinicians were

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11 This was not identified as a major concern in this study, likely because participants were comfortable communicating in English.
perceived as being generationally connected to the parents and community elders of the young people who took part.

While recognising the complexities of engaging ‘culturally diverse’ young people and the challenges of building trust and safety in service settings, it is important that all young people are able to access information and services in a way that feels safe for them. The broad frameworks of ‘cultural competence’ and ‘youth-friendliness’ are both relevant to these considerations of providing safe, appropriate and effective health promotion and care, as described in Chapters 3 and 5 in particular. Services should operate in a way that makes young people feel safe and accepted, both in how services present and promote themselves and as young people interact with them. For example, providing assurances of confidentiality, privacy and ‘no judgement’ when promoting services and during all stages of a clinical interaction may be especially critical in establishing and maintaining trust with young people who are concerned about disclosure of sexual interest or practice to their families and communities (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015). For general practice and other primary care settings, this could also include initiating sexual health discussions during consultations and providing opportunistic sexual health information and support. By consistently raising this with young people the questions and discussion will become normalised over time, which will increase comfort and facilitate more open communication (Fuzzell, Fedesco, Alexander, Fortenberry, & Shields, 2016). Several key informants similarly raised the issue of needing to reframe sexual and reproductive health more positively and position this as a completely normal aspect of health and wellbeing, rather than viewing it as a ‘special’ topic. Throughout the service delivery ‘pathway’ services could therefore make efforts to normalise what are often stigmatising experiences and portray a more inclusive and welcoming approach in the promotion of sexual health services.

This study has highlighted how some members of the younger generation view and experience health services and how services could do more to strengthen engagement. Services should be sufficiently flexible to be relevant and appropriate for different social and cultural groups in Australia, recognising diversity and difference and promoting inclusivity and quality care (McMichael, Gifford, & Temple-Smith, 2014; Wagaman, 2014). However, they need not erase differences of language, ethnicity, culture or religion by simply providing a ‘one size fits all’ model of service delivery (Newman et al., 2013a), and should guard against the unintended effect of making particular groups of people feel excluded (Newman, Persson, Paquette, & Kidd, 2013b) or ‘othered’ (Grove & Zwi, 2006), or contribute to furthering the marginalisation of Aboriginal and Torres Strait Islander peoples or ‘vulnerable’ young people. Promoting sexual and reproductive health care with migrant and refugee young people will require assurances of
confidentiality and provision of non-judgemental care, ensuring they feel welcomed and included as ‘young people’. However, making longer term changes to the perception that health services cannot always be trusted or may not be ‘safe’ is likely to require a more comprehensive rethinking of how services are designed, and should include young people in these processes. In promoting the sexual and reproductive health of young people from all backgrounds, particularly those often considered more marginalised including those from Aboriginal and Torres Strait Islander backgrounds, ‘culturally diverse’ backgrounds, and gender- and sexuality diverse young people, it is essential that they are able to access information and services, that privacy and confidentiality are emphasised in relation to clinical consultations, and that young people feel as safe as possible when accessing information and care. The following chapter, which acts as the final chapter of this thesis, highlights the implications of these findings for policy and practice.
References


Chapter 11: Conclusion

This final chapter summarises the implications of the doctoral research findings for policy and practice in Australia. The methodological strengths and limitations of the research are then described, followed by suggestions for future research and concluding remarks.

Implications for policy and practice

As previously outlined, this doctoral research explored the perspectives of migrant and refugee young people and professionals with regard to the complexities and opportunities for engaging young people from migrant and refugee backgrounds with sexual and reproductive health information and services. Findings have highlighted the challenges and intricacies of designing effective healthcare systems that can recognise the varied experiences and backgrounds of young people and the value of engaging diverse populations with sexual and reproductive health promotion and care. The findings and recommendations presented in this thesis are not intended to suggest that young people from migrant and refugee backgrounds should be a higher priority than other groups of young people, including populations such as Aboriginal and Torres Strait Islander young people, whose experiences are shaped by an additional range of marginalisations and strengths, or that resources and efforts should be diverted from one to the other. All young people have unique and varied needs that warrant consideration and attention, and this study has focussed on just one particular group of young people. The insights of migrant and refugee young people which were captured and explored in this thesis have important implications for policy and practice in Australia and suggest opportunities for better engagement of this group.

Most of the migrant and refugee young people in this study had limited awareness of the different services available for sexual and reproductive health, despite a number of service options being available in Sydney that have a specific focus or some focus on sexual and reproductive health. There is an important opportunity for health services, including general practice and ‘specialised’ services, to better reach and engage this group of young people in their service provision and facilitate discussions regarding this area of health. General practice in particular is known to be a largely accessible and important setting for young people to access health information and care and has the potential to reach and support a large number of young people. Findings from this study suggest there is a need for GPs to refine their own approaches to talking about sexual and reproductive health, raising this opportunistically with young people, and communicating confidentiality and trustworthiness. Practice nurses in general practice could also be supported to contribute more to provision of primary healthcare.
for young people (Hart, Parker, Patterson, Hegarty, & Sanci, 2012) including in relation to sexual health care (Abbott et al., 2013). It is important that all clinicians working in primary healthcare feel comfortable and confident in engaging young people of all backgrounds with sexual health information and interventions and providing this opportunistically and consistently (Fuzzell, Fedesco, Alexander, Fortenberry, & Shields, 2016; Martel, Crawford, & Riden, 2017). They should also be well informed about other services available and how to access or refer to them if needed. ‘Specialised’ family planning and sexual health services may be well-placed to provide sexual and reproductive health information and services to migrant and refugee young people, however as not all young people may be aware of these services, it will be important to reach them with public information and promotion efforts. Continuing with current practices and models of service provision in NSW may lead to missed opportunities to engage young people in these critical conversations, particularly when many are sexually active or thinking about it, and may be receiving little support from their own families.

In all areas of health service provision, it is important that information and care is provided in such a way that young people are made to feel safe, comfortable and accepted – at least to the extent that is possible, given their immense diversity of needs and expectations. This should be evident both in how services present and promote themselves and as young people interact with them. Young people in this study noted preferences for service spaces that were bright and colourful, displayed posters and had pamphlets and resources available to read, and many expressed appreciation for seeing art and artefacts from different cultures and backgrounds, including Aboriginal artwork, a rainbow flag and materials translated into different languages. A preference for discreet waiting areas, less visible to other clients and staff walking by, was also expressed. As most young people use the internet to find information, it is also likely to be important for services to have an online presence, and to consider use of a ‘virtual tour’ online to show what to expect at the service and during an appointment. Consideration of appropriate language and messaging of resources and online material, and developing these in plain English, may benefit those young people who feel less confident in reading and speaking English. Services may also consider undertaking ‘cultural competency’ and ‘youth friendly’ audits of their service to review aspects of service provision they are doing well in and others that could be improved. This could also include a cultural audit to assess cultural responsiveness for Aboriginal and Torres Strait Islander people, although that was not the focus of the present study.

Framing sexual and reproductive health positively, positioning this as a normal aspect of health and wellbeing, and being open and non-judgemental in all discussions with young people will also be valuable in promoting trust, facilitating open discussion, and normalising sexual health.
Chapter 11: Conclusion

Research comparing sexual health and sexuality in the United States, which places emphasis on abstinence-only-until-marriage and sex-as-risk for young people, and in the Netherlands, which promotes and normalises teenage sexuality, found that normalisation made it easier for young people to negotiate sexual interactions and ask for assistance when they needed it (Schalet, 2004, 2011; Weaver, Smith, & Kippax, 2005). This contributed to lower teenage fertility and abortion rates and improved sexual and reproductive health outcomes (Schalet, 2004, 2011; Weaver et al., 2005). Recognition of the multiple dimensions of identity, without making assumptions about young people, including in relation to their background, values and beliefs, sexual activity or sexual orientation, will be important in all of these endeavours outlined above.

Consideration of the cultural competency of systems, services and service providers is also important in responding to varying health needs in a culturally appropriate way, regardless of race, ethnicity, culture or language proficiency (Betancourt, Green, Carrillo, & Park, 2005), as described in Chapter 5. However, the generational discourse prominent in interviews with migrant and refugee young people interviewed 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 as safe and accepted as possible. This includes, as described above, ensuring welcoming environments, promoting diversity of staff in services, and the use of non-judgemental, respectful and inclusive language and messaging. Further to this, improving cultural sensitivities and cultural competence in health care provision will not reduce the systematic racism and prejudice described in Chapter 1, that may negatively impact young people from different cultural backgrounds and reproduce health disparities. Experiences of racism can contribute to the likelihood of experiencing loneliness or depressive symptoms among young people, and can have significant, negative effects on health (Paradies et al., 2015; Priest, Perry, Ferdinand, Kelaher, & Paradies, 2017). Although this was not a finding from this research study, and participants did not discuss views or experiences regarding racism, these are important considerations when working with migrant and refugee young people, especially given the broader societal issues and debates highlighted in chapter 1. Systems and structures that do not effectively accommodate the realities of an increasingly culturally and socially diverse society will continue to inhibit meaningful participation and contribution by these groups (Strang, Baillot, & Mignard, 2018). Addressing this will require political and community leaders to promote a public discourse of anti-racism that directly challenges and counters the distrust, suspicion and division featuring in the current immigration landscape (Tavan, 2016). As part of this, and within the context of workforce development and promotion of cultural competence, health professionals should be equipped with skills to critically understand and analyse social realities with a focus on power, rather than simply learning about social and cultural issues and focusing on cultural or racial ‘difference’ (Hester, 2012). Danso (2018)
similarly suggests that a construct of cultural competence that incorporates anti-oppressive practice and intersectionality in practice will enhance the effectiveness of this framework in practice.

Promoting professional development and training for those working in general practice and other settings providing sexual and reproductive healthcare to the growing diversity of young people in Australia will contribute to enhanced knowledge, skills and confidence in meaningfully engaging and working with this important group. Training and education in this area could focus on legal and ethical issues related to youth sexual health, social and cultural influences on provision of sexual health care to young people, and building confidence and skills for effective communication (Martel et al., 2017). Health professionals and other service providers may also benefit from training or additional support in working with interpreters to better integrate this aspect of care into their routine ways of working. The health professionals interviewed for this study were deeply interested in and committed to enhancing the sexual health of young people, and other research has similarly found that many healthcare professionals are enthusiastic about undertaking training and professional development (Mengesha, Perz, Dune, & Ussher, 2018), with opportunities and appropriate support in place.

Promoting sexual and reproductive health will also require coordinated action at different levels and in different settings, as health services alone will not be sufficient to enhance sexual and reproductive health outcomes (Svanemyr, Amin, Robles, & Greene, 2015). It is well recognised, and confirmed in this study, that young people draw on different sources of information and support based on a range of factors, including what the situation is, where they are, and who they are with. Given that young people from ‘culturally diverse’ backgrounds may experience barriers in accessing information and services on relationships, sexuality and sexual health, it is pertinent to consider the opportunities for health promotion and education provided in schools and other educational settings and possible links with and promotion of local health services, as described in Chapter 8. School-based relationships and sexuality education can reach a vast number and diverse range of young people, and could ideally include a stronger focus on healthy relationships, different contraceptive options, gender and sexuality, local services available for sexual health, and how to access trustworthy sources of information online. However, as not all young people from migrant and refugee backgrounds will have the opportunity to learn about sex and sexual health at school, other avenues must also be considered (Brown, Sorenson, & Hildebrand, 2012; Secor-Turner, Randall, Christensen, Jacobson, & Loyola Meléndez, 2017; Svensson, Carlzén, & Agardh, 2017). These could include technical and further education institutions, intensive English centres, universities and community-based groups. These settings have the advantage of reaching young people who may
have arrived in Australia post-secondary education, or who were in other ways excluded from receiving school-based relationships and sexuality education. Utilising intensive English centres in particular would offer an opportunity to reach migrant and refugee young people more recently arrived in Australia. The provision of sexual health training to clinicians working in these settings, for example school and university health clinics, as well as increasing the emphasis on sexual health in student orientation programs and providing reliable internet-based resources to students, are also important strategies (Burchard, Laurence, & Stocks, 2011). A recently published opinion piece from a Muslim woman in Canada regarding her lack of sex education as a young person and the detrimental impact this has had on her life (Ahmad, 2018) highlights the importance of continued attention to the need for and value of information and education in this area. Providing this in an accessible and appropriate way may also enhance opportunities for young people to build awareness of and confidence in making use of different health services available for sexual and reproductive health.

Across all of these endeavours and opportunities for better engaging migrant and refugee young people, it will be essential to foster open dialogue, input and learning from young people themselves, and to meaningfully incorporate their insights and feedback into health promotion, education and service provision. Effective involvement will assist in better meeting their needs and supporting positive sexual health outcomes (Braeken & Rondinelli, 2012). Some of the mechanisms or approaches through which young people might more actively engage with shaping and/or refining service provision, or developing health promotion messaging and resources, include participation in reference groups or formal ‘consumer’ or other consultative committees, contributing as peer educators or research team members, or, at a more basic level, completing patient satisfaction or evaluation surveys in clinics. The NSW Youth Health Framework 2017-24 suggests additional examples including collecting patient stories from young people and reviewing them at service and board meetings, and directly involving young people in assessing and designing services (NSW Ministry of Health, 2017), although there is little description of how this might work in practice. Given that these different approaches each have limitations and there is little evidence regarding what works best, as was also recognised by key informants in this study, consideration of more innovative, participatory and meaningful models of engagement have been proposed (see, for example, Dunne, Bishop, Avery, & Darcy, 2017; Hall et al., 2018). Forming reciprocal relationships and working in partnership with communities may also help to develop trust, facilitate greater access to and for young people, and strengthen community capacities to support community members (Patton et al., 2016; Rade, Crawford, Lobo, Gray, & Brown, 2018; Snow, Tweedie, & Pederson, 2018). Partnering with migrant or refugee health organisations and resource centres to build on and share knowledge and evidence of what does or does not work is also likely to be an important strategy. Seeking,
listening and responding to the voices of those not traditionally engaged in health service or program planning will promote more inclusive and accessible environments (Hall et al., 2018; Snow et al., 2018), and meaningful engagement will contribute to more effective programs and services, and ultimately enhanced health outcomes for young people (Dunne et al., 2017).

Engaging young people from across the many cultural and linguistic groups living in contemporary Australia in respectful and inclusive ways will require recognition of their strengths, capabilities and capacity to exercise agency. Collin, Lala, and Fieldgrass (2018) argue that engagement of young people should maximise their agency within social and political structures, transform adult and institutional perceptions of young people in dialogue with young people, and generate new policy and organisational processes. Meaningful and effective engagement will require significant shifts in organisational practices and cultures, and commitment to supporting and resourcing engagement initiatives (Collin et al., 2018), and will require a deep commitment to a human rights-based approach, underpinned by values of social justice, equity and participation (Taket, 2013). Translating these principles into tangible and feasible strategies for enhancing or redesigning services will require government and service-based leadership, resources and commitment from all levels of the health system. Whilst the professionals interviewed for this study were committed and invested, many work within very defined policy frameworks, with limited resources, and often with quite different marginalised or more ‘vulnerable’ communities with a range of needs. The feasibility of these strategies therefore hinges on broader national and state policy frameworks. A national approach to the design and delivery of comprehensive sexual and reproductive health promotion and care, which also seeks the input of young people, is likely to be of value in providing the leadership and direction required.

Lastly, the experience of seeking ethics approval for this doctoral research highlights the incredible complexities and inefficiencies of this process, at least in the area of Australia where this study was conducted. The challenges of ethical review when employing different methods of research that do not align with a positivist approach have been well-described in the literature, including ethics committees adopting more risk-averse stances, aligning with biomedical models, and becoming increasingly regulatory (Guillemin & Gillam, 2004; Macleod, Marx, Mnyaka, & Treharne, 2018; Pitt, 2014; Treharne & Marx, 2018). Whilst elements of these were evident in the ethics review process for this research, perhaps the greater challenge was the process itself. Whilst the ‘National Mutual Acceptance of scientific and ethical review of multi-centre human research’ (NSW Health, 2017) adopted in NSW means that a research proposal can be ethically and scientifically reviewed by just one ethics committee, in practice it was a complex and lengthy process, as described in Chapters 2 and 6.
The overall process was inefficient and inconsistent across ethics and governance offices, which was incredibly time-consuming and contributed to delays both in commencing the research and in implementing any changes. A more streamlined and consistent approach to ethical review and approval for multicentre research would enable timely research implementation and be less labour and resource intensive (Clay-Williams, Taylor, & Braithwaite, 2018; Evans & Zalcberg, 2016; White et al., 2016); this is likely to be appreciated by researchers, ethics committee members, and research governance offices alike.

**Methodological strengths and limitations**

As discussed earlier in the thesis, a qualitative design was chosen to guide this exploratory doctoral research. This enabled participants to discuss their views and experiences regarding sexual and reproductive health in an open and more in-depth manner. Utilising several different types of interviews with young people, including follow-up and walking interviews, provided an opportunity to build rapport and a sense of familiarity and trust, and to explore issues raised in the first interview in more detail. Utilising other innovative participatory research methods, such as digital storytelling or other visual or arts-based methods, may also have been of value in exploring these issues (see, for example: Aldridge, 2018, advance online; Botfield, Newman, Lenette, Albury, & Zwi, 2017; Flicker et al., 2008; Lenette & Boddy, 2013; Roberts, Lobo, & Sorenson, 2017; Senior, Grozdanovski, Chenhall, & Minton, 2018; Ziersch, Due, Arthurson, & Loehr, 2018, advance online); the walking interviews, however, allowed targeted feedback to be elicited on specific aspects of services. This in turn supported the generation of additional insights and may have contributed to this being an ‘empowering’ or confidence-building experience for participants. Capturing the views of both young people and key informants also enabled a range of perspectives to be recorded and provided richer, more textured, findings to be produced (Liamputtong, 2009). Including key informants also provided an opportunity to raise awareness of the research in policy and service contexts and engagement with the findings as they became available, thus helping to facilitate consideration of the insights and implications to inform policy and practice (Bowen & Zwi, 2005). Nonetheless, invariably there were a range of limitations of the research design and methods, which are discussed below.

Considerable time and attention, including extensive consultation activities, was dedicated to determining appropriate use of language and terminology for the research and the eligibility criteria for participation. Focussing on ‘culturally and linguistically diverse’ young people, or those from ‘migrant and refugee backgrounds’ as was subsequently chosen prior to commencing recruitment of young people, meant that in some ways the distinctive differences between participants were obscured, which led to presenting them, somewhat artificially, as a
homogenous group. In discussions within the supervisory team and in consultation with partner investigators and services, it was decided that this was a justifiable compromise for this particular research study, because it reflects the similarly homogenising, and to some extent, ‘othering’ tendencies (Grove & Zwi, 2006) of discourse and programming regarding ‘cultural diversity’ in Australian health policy and practice. Furthermore, the specific services of interest in the research – those aiming to promote sexual and reproductive health – do not focus their attentions or services on clients according to their cultural background. Therefore, while being aware of the limitations and risks of uncritically reproducing the tendency to collapse cultural identities into a single category, it was decided to keep the definition of a sample of migrant and refugee young people purposely broad, and to be open to allowing young people to self-define themselves within that descriptor.

There are also some limitations regarding the final sample of young people who participated in the research. The study was conducted in such a way as to be inclusive of a wide range of participants, so purposive sampling of particular groups was not undertaken. It was hoped that some non-English speaking young people would take part, for which ethical approval had been secured, however all participants, including those who had arrived in Australia more recently, were comfortable speaking English in addition to their first language/s. Preparation and dissemination of study recruitment materials in a wide range of languages, and working more closely with specific language and community groups, may have helped to recruit non-English speaking participants. Females were also slightly over-represented in the research (16 female-identified and 11 male-identified young people). Including male participants was important, as much of the research available in this field has focused on females, and employing a male interviewer may have increased male participation. Although all of the males who participated appeared comfortable with having a female interviewer, feedback from one service provider suggested a male client of theirs was not interested in participating when they heard the interviewer was female, which may have been the case for others also. Lastly, the design of the research was not intended to stratify by gender or other characteristics. The demographic questionnaire (Appendix 5) was written in such a way as to not make any gender binary or other assumptions, and participants were invited to include any responses they wished. As the sample was relatively broad in the end, the number of young people with similar characteristics was relatively small and specific analyses of sub-groups were therefore not undertaken. Although a relational perspective on gender can support an interactive interpretation of how gender and health are co-produced (Springer, Hankivsky, & Bates, 2012), as was discussed in Chapter 1, when analysing the data there were no major differences between male- and female-identified participants regarding their views and experiences. This may have been partly due to the study design, including the recruitment strategies and questions asked in interviews.
As described in previous chapters, varied recruitment strategies were employed in order to reach migrant and refugee young people, including recruitment through services, personal and professional networks and word of mouth. However, these strategies did not necessarily reach those who were genuinely ‘hard to reach’, such as those completely disengaged from services, or not connected through community or social networks. Approximately two-thirds of the participants recruited had heard about the study through a service with which they were in direct contact, and others through their own networks, suggesting most participants were connected in some way with local services or groups. Building more extensive outreach activities and networks to recruit more broadly may have helped reach beyond those young people who are relatively comfortable accessing health or other community services. Young people who are more isolated may have substantially different views and experiences from those I was able to access for this research. Recruitment was also focussed in metropolitan Sydney, so findings may not be relevant to regional and rural areas of Australia (Jewson, Lamaro, Crisp, Hanna, & Taket, 2015). However, findings may have resonance for those working in similar metropolitan cities in other Australian states and territories, as well as in other advanced democracies with diverse populations that are similarly engaged in promoting health and wellbeing.

In utilising an interpretive qualitative approach in this research, the aim was not to generalise the experiences and views of participants to a particular group or population, but to seek to understand situations and lived experiences from the points of view of those positioned in the Australian context as representing a perspective different from the Anglo cultural majority population (Ransome, 2013; Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2003). However, given the various limitations described above, findings cannot be assumed to apply to specific ‘sub-groups’ of young people, whether related to cultural background, time in Australia or non-heterosexuality, as the numbers from each sub-group were relatively small.

In relation to the key informant interviews, professionals working in this field were invited to participate in order to record their expert perspectives. Although their own socio-demographic characteristics may have been helpful in interpreting the data they provided, it was deemed inappropriate to ask about their personal backgrounds, and could also increase the risk of them being identifiable, as has been recognised in the literature on interviewing ‘elite’ or professional participants (Lancaster, 2017; Morris, 2009). Also, the insights of general practitioners were not sought as general practice was not a key focus of the study. However, this particular service setting was commonly discussed in the interviews with young people and the views of GPs would therefore have been of value.
Lastly, there are a range of methodological limitations which relate to my role as interviewer. I have described my own background and interests in Chapter 1, recognising that these will have shaped the research process, data collection and analysis. As previously noted, I assumed I would be taking on an ‘outsider’ role for the research. However, after commencing interviews with migrant and refugee young people I realised they considered me to hold some ‘insider’ status too, likely due to my age (late 20s), which potentially worked in my favour in building their trust. The fact that I was an ‘outsider’ in other ways, for example not being from a notably ‘culturally diverse’ background myself, may have actually acted as a strength, as many participants expressed unease at the idea of talking to someone from their own cultural background or community about this topic. Finally, my employment with one of the services that partnered in this research may have contributed to the slight over-representation of clients recruited from that service, and possibly even shaped some of their comments in relation to the organisation in which I worked. However, although my role in the study and motivations for doing the research were discussed with some young people during the consent process if they were interested, I did not usually mention my employment. It is not known, however, whether others mentioned this to prospective participants when discussing the research with them. In examining the data it does not appear that there were any biases in relation to this.

Despite these limitations, findings from this doctoral research study have important implications for those working to enhance the sexual and reproductive health of young people in Australia. A number of observations and recommendations arising from the research have been documented in this chapter, the publication chapters, the three overarching themes discussed in chapter 10, and in the short report developed as a more publicly available output of the research (see Appendix 2). This research also provides a platform upon which additional research could build, as is discussed below.

Future research

As this thesis has described, very little empirical research had previously been conducted that explored in depth the sexual and reproductive health care needs and experiences of young people of any gender from migrant and refugee backgrounds. However, what we did already know to some extent, and what findings from this research similarly suggest, is that migrant and refugee young people may not be fully engaged with or benefitting from sexual and reproductive health care in Australia. There remain several key areas that could be examined further in future research, as outlined here.
The number of participants in the sample who identified with a non-heterosexual orientation was relatively small overall and a separate analysis of this ‘sub-group’ was therefore not undertaken. Furthermore, no young person identified as gender diverse so the voices of these young people are not represented at all. This is an important area for future research, as the intersections of cultural diversity and diversity in sexual or gender orientation may be particularly difficult to navigate (Noto, Leonard, & Mitchell, 2014; Poljski, 2011a; Rodriguez, Agardh, & Asamoah, 2018; Saewyc, Clark, Barney, Brunanski, & Homma, 2014; Travers et al., 2010; Wong, Macpherson, Vahabi, & Li, 2017). As much of the Australian research undertaken in this area with ‘culturally diverse’ communities has been with men who have sex with men (for example, Reeders, 2010; Stardust, Gray, Mackie, & Chen, 2017), further research is needed to better understand the experiences and needs of sexuality- and gender diverse young people from diverse cultural backgrounds. This includes those who are more recently arrived in Australia, as they may have additional support needs that are not being met (Noto et al., 2014).

International students also appear to be an under-researched yet important group in Australia in relation to sexual and reproductive health. Every year there are many thousands of international students coming into the country; in 2015, nearly 500,000 international students were studying on a student visa (International Research and Analysis Unit, 2016). These students are in a new country, often without family or friends, and may be exploring their own sexual identities and practices and embarking on new sexual activity and relationships. They may experience barriers to service access, while also being vulnerable to sexual harassment and violence, and may be unfamiliar with reporting mechanisms or support services (Australian Human Rights Commission, 2017; Chung, Fisher, Zufferey, & Thiara, 2018; Forbes-Mewett & McCulloch, 2016; Poljski, 2011b). Two of the international students who took part in this research identified cost as a significant barrier to accessing health services as, although they did have compulsory health insurance, they were required to pay for healthcare costs upfront and could then seek partial reimbursement. The cost of living in Sydney is high, which means that additional costs for these young people are likely to be avoided where possible. As the sample of international students in this research study was very small, better understanding of their sexual health needs and access to and use of services in this area is important.

When discussing health services with young people in this research, general practice was mentioned most often by them, indicating this is a known and accessible health service setting. However, as discussed in Chapter 9, although the majority had seen a GP for general health issues, most expressed concerns about seeing them for sexual and reproductive health matters. To better address this issue it would be useful to explore these findings with GPs and record their perspectives. Other studies have found that GPs may not have sufficient training in this
health field, can experience discomfort in discussing sexual health opportunistically, may not have sufficient time for what may lead to longer consultations, or may experience challenges in working with ‘culturally diverse’ patients (Collyer, Bourke, & Temple-Smith, 2018; Farley, Askew, & Kay, 2014; Hocking, Parker, Pavlin, Fairley, & Gunn, 2008; Mengesha et al., 2018; Mengesha, Perz, Dune, & Ussher, 2017). However, better understanding the experiences and perspectives of GPs in relation to this particular field of health with this population of young people is important, including those GPs who are ‘culturally diverse’ themselves. This should include seeking their views on how they could be better supported to work with young people from diverse cultural and language backgrounds to better meet their needs and promote their sexual health and wellbeing.

In relation to reproductive health, pregnancy outside of marriage and abortion may be particularly sensitive issues in migrant and refugee communities (McMichael, 2008; Ussher et al., 2012), and aspects of these were raised by both young people and key informants in this research. Whilst acknowledging the stigma that can be associated with pregnancy outside of marriage and in relation to abortion, having an abortion appeared to be viewed as an acceptable option for many of the young people interviewed, who suggested this may be preferable to being pregnant, or a partner being pregnant, when they were not married. The challenges of accessing termination of pregnancy services in many parts of Australia is well known, including high costs and limited service options in many areas (Doran & Hornibrook, 2014; Nickson, Smith, & Shelley, 2006; Phillips, Eltherington, Costa, & Woods, 2012). However, less is known regarding the level of awareness migrant and refugee young people have about pregnancy options in Australia, and their views and experiences of seeking support for an unintended pregnancy and in accessing abortion information and services.

It was clear from this research that sexual and reproductive health is often a very hidden topic within migrant and refugee families and communities. In promoting the sexual and reproductive health of young people from these communities in Australia and enhancing their broader health and wellbeing, it may be important to work with ‘gatekeepers’ in the lives of young people, such as parents, community elders and religious leaders (Chandra-Mouli et al., 2015; Dune, Perz, Mengesha, & Ayika, 2017; High-Level Task Force for the International Conference on Population and Development, 2013; Rade et al., 2018). This appears to be an under-researched area in Australia, both in relation to the perspectives of these different groups, as well as the opportunities or strategies for best engaging them. Exploring these issues may also allow for deeper social, cultural and generational insights to contrast or complement the perspectives emanating from the research presented in this thesis.
Lastly, as discussed in Chapter 1, Aboriginal and Torres Strait Islander young people were not included as a participant group in this study. However many of the issues explored in the study in relation to access to information and engagement with services for sexual and reproductive health are pertinent to this group of young people who experience increasingly higher rates of STIs and high rates of teenage pregnancy compared to other young Australians (Australian Institute of Health and Welfare, 2017; Kirby Institute, 2018). Future research could therefore build on the present thesis to examine in depth the sexual and reproductive health needs of Indigenous young people in Australia.

**Conclusion**

This doctoral study contributes to the growing body of research on the sexual and reproductive health of migrant and refugee young people living in a country of the Global North such as Australia. The study explored how some members of the younger generation of migrant and refugee people in Sydney, Australia, view and experience health services for sexual and reproductive health and how services could do more to strengthen engagement with this group of young people. Very little empirical research has previously been conducted which explores in depth the views and experiences of young people from migrant and refugee backgrounds on these issues in Australia. Findings from this doctoral research therefore contribute to filling this gap and make an important contribution to existing scholarship.

The young people who participated in the study were found to be more similar than different in relation to their views on and experiences with sexual and reproductive health information and services. A prominent theme of ‘generational difference’ was observed, particularly in relation to their experiences and preferences regarding the characteristics of those who provide sexual and reproductive health information and services, which has not been reported extensively in this context previously. ‘Older people’ were commonly perceived to be more judgemental and less accepting of young people’s sexual health, sexual practices and sexuality preferences, and persistent taboos and stigma surrounding sex and sexual health in family and community environments were also described. Most young people were unable to discuss sexuality or sexual health with their parents or others in their community. However, they did not view themselves as being entirely limited or confined by the cultural mores and expectations that they described, with most able to exercise a degree of agency in seeking information and support in various ways, including through school. This makes an important contribution to the body of literature focussing on the agency and strengths of diverse young people. Most in this study were unaware of the range of different services available for supporting young people in pursuing sexual and reproductive health and although general practice was a well-known health
service for this group, many expressed concerns about seeing a GP for this aspect of health. Current models of health service provision may therefore not be comprehensively meeting the needs of young people from migrant and refugee backgrounds in Australia.

As Australia continues to diversify, it is important that young people are supported in accessing quality information and safe and trusted services to maximise their sexual and reproductive health and wellbeing. This research contributes to a more empirically grounded understanding of migrant and refugee young people’s views and experiences in this area. Findings highlight the complexities of designing effective health care systems that incorporate the varied experiences and backgrounds of young people, and the importance of engaging diverse populations with sexual and reproductive health promotion and service provision. Insights from young people and professionals suggest a current lack of effective engagement with migrant and refugee young people by both services and decision-makers, or, at the very least, a significant opportunity for enhancing engagement. Recognising the strengths and agency of young people and learning from them regarding how they negotiate their sexual lives, often in secret from their families, and navigate a health care system from which they may be somewhat disconnected, will be essential in moving forward. These findings extend our understanding of how migrant and refugee young people interact with sexual and reproductive health information and care, and contributes towards promoting a more inclusive and participatory approach to engagement of young people from diverse backgrounds in Sydney and comparable metropolitan cities. It is hoped that this research will contribute to promotion and provision of accessible and inclusive health services for young people to achieve the optimal sexual and reproductive health care to which they are entitled.
References


Ahmad, S. (2018). I was pulled from sex ed class, did not learn about my body and was abused. *The Star, July 12, 2018.*


Chapter 11: Conclusion


Appendices

Appendix 1: Completed COREQ checklist (based on Chapters 1 and 2)

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist
(Tong, Sainsbury & Craig, 2007)

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Guide questions/description</th>
<th>Reported on page #</th>
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<tr>
<td><strong>Domain 1: Research team and reflexivity</strong></td>
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<td></td>
<td><strong>Personal Characteristics</strong></td>
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<tr>
<td>1.</td>
<td>Interviewer/facilitator</td>
<td>Which author/s conducted the interview or focus group?</td>
<td>38-39, 43-44</td>
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<td>2.</td>
<td>Credentials</td>
<td>What were the researcher’s credentials? <em>E.g.</em> <em>PhD, MD</em></td>
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<td>3.</td>
<td>Occupation</td>
<td>What was their occupation at the time of the study?</td>
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<td>4.</td>
<td>Gender</td>
<td>Was the researcher male or female?</td>
<td>12</td>
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<td>5.</td>
<td>Experience and training</td>
<td>What experience or training did the researcher have?</td>
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<td></td>
<td><strong>Relationship with participants</strong></td>
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<td>6.</td>
<td>Relationship established</td>
<td>Was a relationship established prior to study commencement?</td>
<td>43</td>
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<tr>
<td>7.</td>
<td>Participant knowledge of the interviewer</td>
<td>What did the participants know about the researcher? <em>E.g.</em> <em>personal goals, reasons for doing the research</em></td>
<td>43</td>
</tr>
<tr>
<td>8.</td>
<td>Interviewer characteristics</td>
<td>What characteristics were reported about the interviewer/facilitator? <em>E.g.</em> <em>Bias, assumptions, reasons and interests in the research topic</em></td>
<td>11-12</td>
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<td><strong>Domain 2: study design</strong></td>
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<td><strong>Theoretical framework</strong></td>
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<td>9.</td>
<td>Methodological orientation and Theory</td>
<td>What methodological orientation was stated to underpin the study? <em>E.g.</em> <em>grounded theory, discourse analysis, ethnography, phenomenology, content analysis</em></td>
<td>25-26</td>
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<td><strong>Participant selection</strong></td>
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<td>10.</td>
<td>Sampling</td>
<td>How were participants selected? <em>E.g.</em> <em>purposive, convenience, consecutive, snowball</em></td>
<td>38-44</td>
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<td>11.</td>
<td>Method of approach</td>
<td>How were participants approached? <em>E.g.</em> <em>face-to-face, telephone, mail, email</em></td>
<td>38-44</td>
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<tr>
<td>12.</td>
<td>Sample size</td>
<td>How many participants were in the study?</td>
<td>39, 44, 47-48</td>
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<td>13.</td>
<td>Non-participation</td>
<td>How many people refused to participate or dropped out? Reasons?</td>
<td>39, 46</td>
</tr>
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<td></td>
<td><strong>Setting</strong></td>
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### Appendix 1: COREQ checklist

| 14. | Setting of data collection | Where was the data collected? e.g. *home, clinic, workplace* | 39, 44, 48 |
| 15. | Presence of non-participants | Was anyone else present besides the participants and researchers? | 38-44 |
| 16. | Description of sample | What are the important characteristics of the sample? e.g. *demographic data, date* | 40, 45 |

#### Data collection

| 17. | Interview guide | Were questions, prompts, guides provided by the authors? Was it pilot tested? | 38-44 |
| 18. | Repeat interviews | Were repeat interviews carried out? If yes, how many? | 38-44 |
| 19. | Audio/visual recording | Did the research use audio or visual recording to collect the data? | 38-44 |
| 20. | Field notes | Were field notes made during and/or after the interview or focus group? | 38-44 |
| 21. | Duration | What was the duration of the interviews or focus group? | 38-44 |
| 22. | Data saturation | Was data saturation discussed? | 50 |
| 23. | Transcripts returned | Were transcripts returned to participants for comment and/or correction? | 34, 49 |

#### Domain 3: analysis and findings

**Data analysis**

| 24. | Number of data coders | How many data coders coded the data? | 48-52 |
| 25. | Description of the coding tree | Did authors provide a description of the coding tree? | 48-52 |
| 26. | Derivation of themes | Were themes identified in advance or derived from the data? | 48-52 |
| 27. | Software | What software, if applicable, was used to manage the data? | 48-52 |
| 28. | Participant checking | Did participants provide feedback on the findings? | 48-52 |

**Reporting**

| 29. | Quotations presented | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. *participant number* | See Chapters 5-9 |
| 30. | Data and findings consistent | Was there consistency between the data presented and the findings? | See Chapters 5-11 |
| 31. | Clarity of major themes | Were major themes clearly presented in the findings? | See Chapters 5-11 |
| 32. | Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | See Chapters 5-11 |
Appendix 2: Short report

Note: this short report is presented in draft form here.

Talking to young people from migrant and refugee backgrounds about sexual and reproductive health: what have we learned and where do we go from here?

Jessica Botfield¹,²,³, Professor Anthony Zwi¹, A/Prof Christy Newman², Dr Alison Rutherford³,⁴,⁵, Dr Catriona Ooi⁶, A/Prof Melissa Kang⁷,⁸, Dr Mitchell Smith⁹, Clinical A/Prof Deborah Bateson¹, Dr Christopher Carmody¹, Brendan Crozier¹, Katherine Bennett¹

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Why does talking about sexual and reproductive health with migrant and refugee young people matter?

Australia today comprises a rich diversity of cultures, ethnicities and languages, with people from different backgrounds coming into the country under a range of circumstances. It is widely recognised that sexual and reproductive health, although essential to broader health and wellbeing, are particularly sensitive issues in many cultures especially but not only in relation to the lives of young people. These young people from diverse cultural backgrounds in Australia, including migrants, refugees and international students, may be at heightened risk of poor sexual and reproductive health, and may not be fully engaged with, or benefitting from, available sexual and reproductive health care. The little that is known regarding how these young people use services for these matters generates a narrative of ‘low awareness’ and ‘under-utilisation’. There appears to be a need for increased engagement in this area, however there is limited empirical research documenting the views and experiences of young people themselves, and the views of professionals who work with these young people or in this service or policy area. This doctoral research explored the experiences of migrant and refugee young people living in Sydney, NSW, to understand how they, as well as service provider, community, academic and policy stakeholders, viewed their sexual and reproductive health information and care needs and experiences. This report summarises what was learned from different aspects of the research, suggests areas for enhancing policy and practice, and proposes some areas for future research¹².

To review what was already known, see:

¹² Research methods are included at the end of the report
What did key informants say?
We recruited health service providers, academics, community advocates and policymakers with
familiarity in sexual and reproductive health and/or migrants and refugees and/or young people
as ‘key informants’ to find out their views. Most were from NSW. The characteristics of those
who took part is listed below (2015-2017):

<table>
<thead>
<tr>
<th>Key informant characteristics (n=34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service providers (medical officers, sexual health nurses, health promotion officers, counsellors)</td>
</tr>
<tr>
<td>Policy-makers</td>
</tr>
<tr>
<td>Community organisation advocates</td>
</tr>
<tr>
<td>Academics</td>
</tr>
</tbody>
</table>

Many informants across different professions felt that ‘culturally diverse’ young people are
often missed, or in some ways neglected, in health promotion and service provision. A number
suggested that some of the available sexual and reproductive health services and clinics are not
particularly ‘youth friendly’ and that there is insufficient health promotion and advertising of
services to migrant and refugee young people. Many raised the importance of providing holistic
and comprehensive sexual and reproductive health care to this group, although a small number
raised capacity issues and funding and policy constraints in relation to this.

❖ Importance of partnerships, outreach, health promotion
The importance of partnerships and/or outreach activities was noted by a number of key
informants. Current or potential partnerships identified included government, schools,
universities, TAFEs, Intensive English Centres (IECs), multicultural health services, and youth
services. “I think a lot more effort into integrating the relationship with schools and the clinic,
and probably even the TAFE service” (KI: service provider). Several highlighted an
opportunity for working with IECs: “I think particularly intensive English language centers I
think are a great setting for reaching newly arrived refugee young people, and they lend
themselves very well to that” (KI: service provider). Outreach was seen as an important way to
reach and engage migrant/refugee young people in places they are already accessing.

❖ Working with interpreters
All service providers stated their service arranged professional interpreters for their non-English
speaking clients. The majority identified this as an important part of their service, however
some raised associated challenges. A preference for the NSW Health-funded Health Care
Interpreter Service (HCIS) was noted by several due to the health-specific professional training
of their staff. However, it was acknowledged that it was not always possible to book them for
various reasons, including limited availability, so the national Translating and Interpreting
Service (TIS) was commonly used instead. Some limitations of the TIS were identified but
overall it was viewed as a good service. Some of the challenges and limitations of using
interpreters included: difficulty booking face-to-face interpreters, long wait times on the phone,
reports of inappropriate interpreting at times, and unwillingness of some to interpret for sexual
health consultations. Despite these issues, many still felt the use of interpreter services was a
strength of their service provision to their non-English speaking clients.

❖ Developing resources
A number of service providers identified the importance of having written and online resources
available for clients from diverse cultural and language backgrounds, although some raised
associated difficulties of this, including cost. Most suggested they have limited access to
resources in different languages (hard copy and online), but also with appropriate messaging: ‘...whether that resource is appropriate, whether the messaging is appropriate, whether it’s accessible, whether the language you’re interpreting into is actually, if people are literate in their own language even’ (KI2: service provider). Several noted a gap in the availability of translated health information, such as factsheets, and procedural consent forms also. Recommendations included developing resources in plain English to increase their accessibility, and engaging communities and ‘consumers’ with resource production.

❖ **Staff training and service audits**
Several informants suggested that provision of training for those working with diverse young people, and with interpreters, would be beneficial. Several also felt that a ‘cultural competency’ or ‘culturally friendly’ audit or assessment tool would be of benefit in their service, including an audit of information and education resources.

❖ **Advertising and promoting services**
The majority of service providers felt that the migrant and refugee young people they saw in the clinical setting had a positive experience. Most felt that “the main barrier is to get them in” (KI33: service provider), and that more must be done in raising awareness of services and ‘getting them in the door’. “I think a lot of the staff here are very good at that, you know, once the person's in the door, making them feel this is a safe place to be. I think the work needs to be done to reach those people” (KI28: service provider).

For additional findings from key informants, see:

**What did young people say?**
We were particularly interested in talking to young people from migrant and refugee backgrounds in order to learn more about their experiences and perspectives. We advertised through services and word-of-mouth to recruit migrant and refugee young people, aged 16-24 years, who were living in Sydney NSW, and who spoke a language other than English. This is who took part (between 2016-2017):

<table>
<thead>
<tr>
<th>Participant self-reported characteristics^* (n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td><strong>Time in Australia</strong></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
</tr>
<tr>
<td><strong>Sexual identity</strong></td>
</tr>
</tbody>
</table>
Appendix 2: Short report (draft)

<table>
<thead>
<tr>
<th>Sexual attraction</th>
<th>Opposite sex only (17), same sex only (3), same-sex and opposite sex (6), opposite sex only and “a little to other” (1)</th>
</tr>
</thead>
</table>

^Based on participants own responses in demographic questionnaire, completed after first interview

*Some participants identified with more than one

Note: participants self-selected a pseudonym for reporting purposes

❖ **Navigating access to information & services**

The majority of participants emphasised they could not discuss sexuality or sexual health issues with their parents or within their community. “I think, in my community, it’s not something you talk about… So you wouldn’t have a discussion with your parents on sex… That’s something that’s an abomination to talk about” (Panda, F, 23). However, they were able to seek information and support elsewhere – primarily via the internet (Google), often through friends and sometimes a health professional. Although concerned about their parents or others knowing they were sexually active, or even just discussing sexual health issues, interviews suggested this would not stop participants from seeking information or help they wanted: for example, they would look online, talk to a friend, go to a service further from home, or see a non-family doctor (i.e. a GP who does not also provide care to their family). “It’s not something I can go ask my mum about so I usually rely on school and like research about it” (Shirley, F, 18).

❖ **Differences in knowledge / awareness**

Participants varied in their understanding of different sexual and reproductive health issues and the majority were unaware of the range of relevant services available, apart from the GP. “I didn’t even know that these type of services existed” (Gloria, F, 22). None had learned about this during relationships and sexuality education at school, which suggests this could be a key avenue for accessing such information. Participants had mixed knowledge of sexual and reproductive health issues, including contraception and sexually transmissible infections.

❖ **Preferred features of services**

- **Location:** Close to public transport; in a discreet and private location; easy to find and get to; many willing to travel outside their local area if necessary.
- **Cost:** Preference for a free service (particularly younger participants, and those from a refugee background), though many willing to pay a small fee for a ‘good service’.
- **Appointment type:** Participants had mixed views regarding making appointments versus drop-in; there was no strong preference. Several mentioned being able to book online was useful.
- **Operating hours:** Preference for services to be open longer, in evenings and on weekends, was expressed.
- **Reception/waiting area:** Participants liked services that promoted a sense of inclusiveness and welcome, that had lots of colour and visual features, and flyers and resources available. They liked seeing things from different cultures and backgrounds without targeting anyone in particular. ‘Just the LGBTI flag. It’s good. Especially in this area with so many different religions, it’s more accepting and inclusive… If they had an Indigenous flag, or flyers in other languages, or posters with different cultures, it would seem more inclusive” (Denise, F, 20). A preference for discreet waiting areas, that are less visible to other clients and staff walking by, was expressed.
- **Website:** Service websites were seen as important for finding information about the service. Participants liked bright and colourful websites. Several also appreciated videos that gave an overview of the service so they would know what to expect from a visit, and preferred watching a video over reading text: “I’d give them a thumbs up for the video… I’d always watch videos over reading” (Panda, F, 23).

❖ **Preferences for service providers**

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Many participants (male and female) preferred a female provider for sexual health issues, and most had a strong preference for a ‘younger’ provider because they were perceived to be more knowledgeable, open-minded, understanding, and less judgemental. “...all the older doctors that I’ve been to have been very quiet and just very direct and almost inconsiderate. I think the younger doctors, I just feel more comfortable around them” (Theo, M, 17). The majority of participants had no concerns regarding the nationality of the service provider, although several stated a preference for seeing someone from a different background to them due to confidentiality concerns and fear of judgement. A desire for someone who was welcoming, friendly and who provided non-judgemental care was expressed.

❖ Preferred ‘type’ of service for sexual health
Whilst the majority of participants had low awareness of ‘specialised’ services for sexual and reproductive health, they had a sense that because they were focused on sexuality issues they were a more appealing option than the GP, and they perceived them to be non-judgemental and more knowledgeable. “They’re used to it, used to doing this sort of thing, so you don’t feel so odd” (Liz, F, 21). Despite the stigma associated with sexual health, no participant identified this as a potential barrier to service use for sexual health. However, there were misconceptions by some about these services being expensive and/or requiring a GP referral.

Most participants recruited through a partner service for this research had found out about that service through the internet or a friend. All had had a very positive experience with the service. In contrast, many participants had more negative experiences with GPs and/or would prefer not to see a GP or ‘family doctor’ for sexual health. “I wasn’t too keen on going to my family doctor. It’s like the absolute last resort” (James, M, 21). Several indicated a preference for a ‘one stop shop’ rather than having to go to multiple services for different issues.

❖ Participant suggestions for promoting/advertising services
- Website, social media and mobile phone apps (examples provided included Google, Facebook, Reddit, Grindr, Tumblr, WeChat, YouTube, 4chan, 9GAG)
- YouTube videos and advertisements
- Schools/ universities/ IECs
- Posters in waiting rooms and bathrooms
- Word of mouth, friends
- Referral from other services

Case study 1: LGBT participants – talking to parents & using services
Participants’ self-identified sexualities were not explicitly discussed during the interview, unless the participant raised this themselves. On the demographic questionnaire, five participants identified as homosexual (all male) with one adding “/confused”, three as bisexual (all female), and one as heterosexual/bisexual (female). Additionally, one male who identified as heterosexual noted a sexual attraction to the opposite sex and “maybe a little to other”. All five gay-identifying men mentioned their sexuality during the interview. None had directly discussed their sexuality with their parent(s), though one had a cousin who disclosed to his whole family, and two believed their mum probably knew. Three stated they had not explicitly discussed their sexuality with their mother or parents because they knew they held certain expectations regarding the normative behaviors of their family members, and did not want to disappoint (“It’s not the right time. Because I know for her, she wants me to have a family” (TingTing, M, 20); “I haven’t come out yet. It’s just kind of hard for me, my parents don’t really understand that like, diversity of like sexuality... I don’t talk to them because I don’t want them to feel uncomfortable... I think it’s every parent, are like ‘Oh when are we going to get grandchildren? When are you going to get a girlfriend?’ I don’t want to disappoint her a
“lot, like to that extent” (David, M, 20); “They’re happy for me to date a girl, but they’re not happy for me to meet a boy... They want me to find maybe some girl, a good girl, and maybe you’re going to have some kids... it’s like, because the hardest part of being gay in China is your parents, because yourself, it doesn’t really matter, but your parents would. They’ll give them pressure, and sometimes you don’t want to hurt them” (Bruce, M, 18)). Kyr (M, 20) stated he did not discuss this with his mum as it goes against her “beliefs and cultures”. All had been to a sexual health service in Sydney, and had learned about the service through Google, a partner, or Grindr app. Three attended regularly for medication, one first went to get tested after a partner disclosed symptoms (and continues going regularly for testing), and one attended for post-exposure prophylaxis (PEP) for HIV after his partner removed his condom during sex.

**Case study 2: Refugee participants – sexual health education & support in IECs**

Four participants were from a refugee background themselves, arriving in Australia between 8 years and 6 months ago. All had attended an Intensive English Centre in Australia, and two specifically mentioned receiving support there around sexual and reproductive health: one for assistance with menstruation and sanitary products (the teacher “was really great” (Liz, F, 21)), and one for a short session on sexual relationships and reproduction (“it was very informative and that’s why I became more confident. Before I had no knowledge. Sometimes when you go and Google it you get different information and it’s so confusing. But that’s more credible” (Amir, M, 24)).

For additional findings from young people, see:

**What are our key messages?**

- Young people from ‘culturally diverse’ backgrounds are more similar than different when talking about sexual health, and describe their experiences as that of a ‘young person’.
- Stigma and silence around sexual health within families and communities does not appear to prevent these young people from accessing information and support if they need it; they are likely to do their own research first (usually internet, sometimes friend), instead of, or prior to, seeing a health professional
- School-based relationships and sexuality education is essential for migrant and refugee young people, particularly as they may not learn this information at home; this is also important in a wider range of educational settings (i.e. universities, TAFEs, IECs)
- There was a very low awareness of the range of available services for sexual and reproductive health among this group, apart from GPs
- Migrant/refugee young people may be reluctant to see a GP or ‘family doctor’ for sexual health; more ‘specialised’ services (i.e. sexual health, family planning) may be an appealing option
- Current models of sexual and reproductive health service provision in Australia may not be effectively reaching and engaging migrant and refugee young people
It is important for health services to be seen as broadly inclusive, welcoming, non-judgemental and confidential.

### How can findings be applied by health services in practice?

#### Service space
- Creating ‘welcoming’ environments – e.g. use of colour, posters, rainbow flag, Aboriginal artwork, seeing young people at service (in person/ on posters)
- Discreet waiting rooms that are less visible to staff/clients walking by
- Consider undertaking a ‘cultural competency’ or ‘culturally friendly’ service audit (e.g. ‘Cultural Competence Organisational Review Tool’\(^\text{13}\))

#### Service staff
- Diversity of staff at services important, as well as in outreach/ health promotion/ education activities
- Importance of ‘friendly’ staff who are interested, non-judgemental and respectful
- Consider staff training in this area (e.g. ‘Your Cultural Lens’\(^\text{14}\))

#### Online presence
- Important for services to have an online presence (website and social media) – emphasise confidentiality
- Useful having a ‘virtual tour’ video online showing what to expect at the service and appointment

#### Working with schools, tertiary education & community organisations
- Build and strengthen links between health services, schools, universities, IECs, TAFEs and community organisations such as community centres and migrant resource centres
- Utilise these relationships to advertise and promote local services

### What else could be done?
- Training for health professionals in working with interpreters for sexual health consultations
- Building the skills and confidence of GPs to work with ‘culturally diverse’ young people and provide opportunistic sexual health information and support
- Inclusion of sexual and reproductive health promotion and education at IECs (and/or promotion of other local sessions and services)
- Involving diverse young people in the design, development and implementation of programs and services
- Engaging ‘culturally diverse’ communities and young people with resource development, including key messaging; developing resources in plain English so broadly accessible

### Policy recommendations
- Opportunity for ‘specialised’ services to better reach and engage young people from migrant/refugee backgrounds in design and delivery of services, resource development, and as clients. This would require government support and funding, though would bring preventive health benefits for young people who may not otherwise use any service at all.
- Work across the Health and Education sectors, and with relevant services, in the development and provision of sexuality and relationships education and resources, including in IECs. Encourage teachers and educators to promote local services in this education. Promote provision of age-appropriate sexuality and relationships education in faith-based schools and schools located in more ‘culturally diverse’ areas.
- Need for a comprehensive, holistic national sexual and reproductive health strategy to provide a consistent approach to supporting sexual and reproductive health and wellbeing of all people in Australia.

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Where is more research needed (in relation to sexual and reproductive health)?

- Examine the perspectives of key ‘gatekeepers’ (e.g. parents, community leaders) in different communities and settings, and opportunities and strategies for best engaging them.
- Explore the different experiences and needs of international students, and sexuality- and gender diverse migrant and refugee young people (including those more recently arrived), in relation to accessing information and services.
- Understand the views and experiences of migrant and refugee young people in accessing support for an unintended pregnancy, and for termination of pregnancy information and services.
- Evaluate interventions aimed at engaging young migrant, refugee and student populations in relation to sexual and reproductive and sexuality health issues.

Acknowledgements: We are grateful for the contributions of the young people interviewed, as well as for Doris, Lauren, Marvin, Sam and Victoria who contributed to aspects of the research as part of the Youth Advisory Group convened for the study. Thanks also to the key informants who took part in an interview, and to the partner organisations who provided advice and support for the research (see below). Acknowledgement of the many contributions to this research does not imply endorsement of the findings or recommendations of this paper by those named. We thank UNSW Arts and Social Sciences for contributing funding towards the fieldwork for this research, as well as the support of an Australian Government Research Training Program Scholarship.

For more information on this research, or to request full texts of articles, please contact Jessica Botfield: jessica.botfield@unsw.edu.au

Summary of research design & methods

This report summarises findings from doctoral research undertaken by Jessica Botfield and jointly supervised by Professor Anthony Zwi and Associate Professor Christy Newman.

Investigators: Jessica Botfield, Anthony Zwi, Christy Newman, Alison Rutherford, Christopher Carmody, Catriona Ooi, Melissa Kang, Mitchell Smith, Deborah Bateson, Brendan Crozier, Katherine Bennett

Partner services: High St Youth Health Service, Family Planning NSW, NSW Refugee Health Service, Liverpool Sexual Health Clinic, Sydney Sexual Health Centre, Western Sydney Sexual Health Centre

Aim: Explore youth & professional perspectives to better understand the complexities & opportunities for engaging migrant & refugee young people with sexual & reproductive health information and services.

Objectives:
1. To document the perspectives and experiences of young people from migrant and refugee backgrounds on the meanings and practices associated with sexual and reproductive health, information and health care.
2. To explore whether and how migrant and refugee young people engage with sexual and reproductive health services.
3. To identify opportunities for strengthening engagement between migrant and refugee young people and sexual and reproductive health services.

**Methods:** A qualitative approach was used for this formative research, with methods of data collection including a literature and scoping review; preliminary informal consultations; semi-structured interviews with 34 key informants; semi-structured first and follow-up interviews with migrant and refugee young people (27 and 9 respectively); and 15 ‘walking’ interviews with a sub-set of these. Demographic information was recorded on a short questionnaire completed by participants after the first interview. Findings were presented to the Youth Advisory Group convened for this study to obtain additional insights to assist with data interpretation and recommendations.

**Key informants:** Health service providers/clinicians, policymakers, academics and community advocates working in the area of sexual and reproductive health and/or with young people.

**Participants:** Migrant/refugee background, 16-24 years, live in Sydney, speak language other than English.

**Key informant recruitment:** Key informants were identified through formal and informal networks, and purposively selected and invited via email to participate.

**Participant recruitment:** Non-probability purposive sampling and snowball sampling were used to recruit participants. Participants were primarily recruited through a partner service or word of mouth. Participants were reimbursed to compensate for travel costs associated with taking part in the interview.

**Ethics approval:** Western Sydney LHD HREC, Family Planning NSW HREC, ACON Research Ethics Review Committee, UNSW Australia Human Research Ethics Advisory Panel

**Data analysis:** All interviews were audio-recorded, transcribed verbatim, de-identified, and coded using NVivo 10. Preliminary analysis commenced when it was felt that data saturation was near. Data collection continued until the data was deemed rich enough to support the desired analyses of the areas of interest and research objectives, and saturation was reached. The principles of thematic analysis, as described by Braun and Clarke (2006), were utilised to identify key themes. Iterative categorisation (Neale, 2016) was then applied to the coded data. Final themes were discussed and agreed.

**References**

Part 1  What does my participation involve?

1  Introduction
You are invited to take part in this research study: “Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia”. You are invited to participate in a key informant interview, due to your expertise and knowledge in this area.

Young people from culturally diverse backgrounds remain vulnerable to poor sexual and reproductive health outcomes and are an often neglected group, even in wealthier countries like Australia. While a wide range of evidence has been generated in related areas, many gaps in understandings regarding this population still remain, some of which this research will aim to address.

This document tells you about the research project and explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research. Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or professional you trust. Participation in this research is voluntary. If you don’t wish to take part, you don’t have to. If you decide you do want to take part in the research project, you will be asked to sign the consent section. The consent form must be signed prior to taking part in the study, and you will be given a copy to keep. By signing it you are telling us that you:
- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

2  What is the purpose of this research?
Aim: This research will aim to better understand how and why (or why not) culturally diverse young people access sexual and reproductive health care, and explore youth, provider and
Appendix 3: Participant Information and Consent Forms

Policy perspectives on how they engage and are engaged with sexual and reproductive health services.

Research question: How and why are culturally diverse young people accessing sexual and reproductive health care in Sydney, and how do sexual and reproductive health services engage this population?

Significance: Research findings will promote healthy and safe sex lives for young people from culturally diverse backgrounds, and aim to increase their ability to exercise choice and control over their sexual and reproductive health. It will contribute to conceptual and methodological understandings, and have the potential to influence health care provision, policy, and practice for sexual and reproductive health services and for culturally diverse young people in NSW and nationally. This may also be of some relevance to other Western countries where refugees and migrants seek resettlement.

Filling gaps in knowledge: This research will aim to address two gaps: 1) the perspectives of culturally diverse young people regarding sexual and reproductive health and health care, and 2) the engagement of culturally diverse young people with sexual and reproductive health services.

The results of this research will be used by the researcher, Jessica Botfield, to obtain a Doctor of Philosophy degree, and will be published in various formats to achieve that objective.

3 What does participation in this research involve?
If you are eligible to take part in the research study, and consent to do so, we will contact you to determine an appropriate date and time to either meet in person or over the phone to conduct an interview. The interview will take approximately 30 minutes of your time. There are no costs associated with participating in this research project, nor will you be paid. The interview will take place in one of the following locations:

• Your office
• Over the phone
• Another mutually agreeable location

During the interview a member of the research team will ask you questions about your organisation and your role within it, and your views and experiences of culturally diverse young people, their sexual and reproductive health, and their engagement with health services.

With your permission we would like to digitally record the interview using an audio recorder. The main themes of the interview will be documented during the interview as rough notes, and will be elaborated on immediately following the interview. All interviews will be transcribed as soon as possible following the interview.

4 Other relevant information about the research project
This research is taking place in Sydney, New South Wales (NSW), with a particular focus on Greater Western Sydney. Interviews will be conducted with approximately 30 culturally diverse young people. Key informants are also being invited to participate in order to record a diverse range of perspectives on these issues. At least 15 health service providers will be invited to participate in an interview as key informants. Six organisations (Family Planning NSW, High St Youth Health Service, NSW Refugee Health Service, South Western Sydney Sexual Health Service, Western Sydney Sexual Health Centre and Sydney Sexual Health Centre) are supporting this research, though will have no financial involvement.

5 Do I have to take part in this research project?
Participation in this research project is entirely voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take
part and then withdraw, will not affect your routine care, your relationship with professional staff or your relationship with UNSW Australia. If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

6 What are the possible benefits of taking part?
We cannot guarantee or promise that you will receive any benefits from this research. We hope to use information we get from this study to benefit young people, including those from culturally diverse backgrounds, and provide better health services to you. There will be no clear benefit to you from your participation in this research.

7 What are the possible risks and disadvantages of taking part?
Aside from giving up 30 minutes of your time, we do not expect that there will be any risks or disadvantages associated with your taking part in a key informant interview.

8 What if I withdraw from this research project?
If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team before you withdraw. A member of the research team will inform you if there are any special requirements linked to withdrawing. If you do withdraw, you will be asked to complete and sign a ‘Withdrawal of Consent’ form; this will be provided to you by the research team. If you decide to leave the research study, the researcher team will not collect additional information from you.

If you decide to leave the research project, the researchers will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researchers when you withdraw from the research project.

9 Could this research project be stopped unexpectedly?
It is unlikely that this research project will be stopped unexpectedly, as there are no risks involved.

10 What happens when the research project ends?
When the research project is finished, a summary of the findings can be made available to you. Please let us know if you would like a copy, and provide an email address this can be sent to.

Part 2 How is the research project being conducted?

11 What will happen to information about me?
Your full name and position will be taken at the start of the interview (though these will likely already be known). Your identity will be removed from the data through de-identification of the transcript and careful checking through the coding of data. By signing the consent form you consent to the research team collecting and using information about you for the research study. Your information will only be used for the purpose of this research study and it will only be disclosed with your permission.

All electronic data (digitally recorded audio files and electronic transcripts) will be stored on a secure password-protected laptop. All hard copies of collected research data (eg. written notes taken) will be stored securely at UNSW Australia. Only office staff have access to this room, which is kept locked at all times. All collected research data will be stored in these locations for a minimum of seven years. Hard copy data will ultimately be shredded after this time, or permanently deleted in the case of digital files.
Appendix 3: Participant Information and Consent Forms

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified (except with your express permission, if this is deemed particularly useful). All data will be de-identified to maintain your confidentiality. You will not be identified in the dissemination of results, though a quote may be used and attributed to your very generic role.

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback at the time of your interview, or by email at any other time. This feedback will be in the form of a one-page summary of findings, and we will automatically send this summary to all key informants involved in the research, using the email address we have on file for you.

12 Complaints and compensation
In the unlikely event you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

If you have any complaints or concerns about this research study, please contact the Family Planning NSW Ethics Committee at ethics@fpnsw.org.au or +61 2 8752 4348.

13 Who is organising and funding the research?
This research project is being conducted by Jessica Botfield for her doctoral research. It is not being funded externally. There is no financial benefit expected to arise for any individual or organisation from the conduct of this research. No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages). You will also not benefit financially from your involvement in this research project.

14 Who has reviewed the research project?
All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the Family Planning NSW Ethics Committee (approval number R2015-02). This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact
The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact any of the following people:

Research contact person

<table>
<thead>
<tr>
<th>Name</th>
<th>Jessica Botfield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Associate Researcher</td>
</tr>
<tr>
<td>Telephone</td>
<td>0413 660 169</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:jessica.botfield@unsw.edu.au">jessica.botfield@unsw.edu.au</a></td>
</tr>
</tbody>
</table>

Head research person

<table>
<thead>
<tr>
<th>Name</th>
<th>Professor Anthony Zwi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Chief Investigator</td>
</tr>
<tr>
<td>Telephone</td>
<td>0423 696 490</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:a.zwi@unsw.edu.au">a.zwi@unsw.edu.au</a></td>
</tr>
</tbody>
</table>
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

**Reviewing HREC approving this research and HREC Executive Officer details**

<table>
<thead>
<tr>
<th>Reviewing HREC name</th>
<th>Family Planning NSW Ethics Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td><a href="mailto:ethics@fpnsw.org.au">ethics@fpnsw.org.au</a></td>
</tr>
<tr>
<td>Email</td>
<td>+61 2 8752 4348</td>
</tr>
</tbody>
</table>
Appendix 3: Participant Information and Consent Forms

**Consent Form - Adult providing own consent (key informant interview)**

**Title**  
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

**Short Title**  
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

**Project Sponsor**  
UNSW Australia

**Coordinating Principal Investigator**  
Professor Anthony Zwi

**Associate Investigator(s)**  
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

**Declaration by Participant**

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of participant (please print): ___________________________
Signature: ___________________________ Date: ___________________________

**Declaration by Researcher†**

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of researcher (please print): ___________________________
Signature: ___________________________ Date: ___________________________

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.
Form for Withdrawal of Participation –
Adult providing own consent (key informant interview)

It is recommended that this form NOT be included as part of the PICF itself, but that it be
developed at the same time and made available to researchers for later use, if necessary.

Title
Engaging young people from culturally and
linguistically diverse backgrounds with sexual and
reproductive health services in Sydney, Australia

Short Title
Engaging culturally diverse young people with sexual
and reproductive health services in Sydney

Project Sponsor
UNSW Australia

Coordinating Principal
Professor Anthony Zwi

Investigator
A/Professor Christy Newman, Dr Christopher
Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr
Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier,
Ms Jessica Botfield, Ms Katherine Bennett

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such
withdrawal will not affect my routine care, or my relationships with the researchers or UNSW
Australia.

Name of participant (please print): ___________________________
Signature: _________________________ Date: _________________________

In the event that the participant’s decision to withdraw is communicated verbally, the Senior
Researcher must provide a description of the circumstances below.

Declaration by Researcher†

I have given a verbal explanation of the implications of withdrawal from the research project
and I believe that the participant has understood that explanation.

Name of researcher (please print): ___________________________
Signature: _________________________ Date: _________________________

† An appropriately qualified member of the research team must provide information concerning
withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.
Appendix 3: Participant Information and Consent Forms

Participant Information Sheet / Consent Form (PICF)

Health/Social Science Research - Young person providing own consent (participant interview - first)

Title
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

Short Title
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

Project Sponsor
UNSW Australia

Coordinating Principal Investigator
Professor Anthony Zwi

Associate Investigator(s)
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

Part 1 What does my participation involve?

1 Introduction
You are invited to take part in our research study, which is called: “Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia”. We are inviting you because we’re interested in learning about your life and what’s important to you, especially your experiences of and opinions on health care services that focus on sex and relationships, health and infections, pregnancy and parenting. We are especially interested in your opinions as a young person from a migrant or refugee background.

This document tells you about this research and explains what’s involved in taking part. Please read this information carefully, and ask questions about anything that you don’t understand. You can talk to a relative, friend or professional you trust before deciding, if you want. Participation is voluntary; if you don’t want to take part, you don’t have to. If you do want to take part, you will be asked to sign the consent (agreement) section at the end of this document. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described

2 What is the purpose of this research?
Aim: This research aims to better understand how and why young people from refugee and migrant backgrounds access sexual and reproductive health care.

Significance: Research findings will promote healthy and safe relationships, and positive health outcomes, for young people from refugee and migrant backgrounds, and aim to increase their choice and control over their sexual and reproductive health.

The results of this research will be used by the researcher, Jessica Botfield, to obtain a Doctor of Philosophy degree.

3 What does participation in this research involve?
If you are interested in taking part in the research, please contact Jessica Botfield (phone and email details below), if you haven’t already, and she will follow up with you to discuss the project. If you are eligible to participate (aged between 16 and 24 years at the time of the research; reside in Sydney NSW; come from a refugee or migrant background; speak a language other than English), she will discuss a good date and time to meet for the interview. You will be asked to sign the consent form at the end of this document before starting the interview. The interview will take approximately 30-60 minutes, and can be done on your own or with a friend. Interviews in other languages (apart from English) will be undertaken using the Translating and Interpreting Service (TIS National). During the interview, Jessica from the research team will ask you some questions about your experiences and views of relationships, sex, and health services. If you are willing we will record the interview, so we can type up the recording afterwards. We will take out any names or stories that are ‘identifying’ (so that no-one will know it was you). Written notes may also be taken during your interview. The interview will take place at a health service (private room) or another mutually agreeable location.

4 Other relevant information about the research project
This research study is being undertaken in Sydney, NSW, with a particular interest in Greater Western Sydney. We are interested in hearing the views of young people living in this area. We will also speak to some health and policy professionals to learn their views. Six organisations (Family Planning NSW, High St Youth Health Service, NSW Refugee Health Service, South Western Sydney Sexual Health Service, Western Sydney Sexual Health Centre and Sydney Sexual Health Centre) will help with the research, but they will not have any financial involvement or influence on your privacy.

5 Do I have to take part in this research project?
Taking part in this research is completely your choice. If you don’t want to, you don’t have to. If you do want to but then later change your mind, you can leave any time. Any decision you make will not affect your relationship with any person or organisation involved in this research.

6 What are the possible benefits of taking part?
There will be no obvious benefit to you from your participation in this research, and you will not be paid. We hope to use information from this study though to benefit young people and provide better health services to you. You will be reimbursed for your costs in travelling to and from the interview (up to $30).

7 What are the possible risks and disadvantages of taking part?
Aside from giving up 30-60 minutes of your time, we do not expect there to be any significant risks or disadvantages if you take part. You may think some of the questions we ask are embarrassing or make you feel uncomfortable. If you don’t want to answer a question, you can skip it and go to the next one. You also have the option to stop the interview at any time. If you become upset because of this research we can help you to arrange for counselling or other support if you want. Contact details for some helpful services are also provided at the end of this document.

8 What if I withdraw (leave) from this research project?
If you consent (agree) to participate, you may also leave at any time. If you want to leave, please tell Jessica from the research team. She will ask you to sign a ‘Withdrawal of Consent’ form. If you decide to leave, we will not collect additional information from you, but any information already collected will be kept and used to form part of the research results. However if you do not want this to be included please tell Jessica when you leave.

9 Could this research project be stopped unexpectedly?
It is unlikely that this research project will be stopped unexpectedly.

10 What happens when the research project ends?
When the research project is finished, a summary of the findings can be sent to you. Please let Jessica know if you would like a copy, and provide an email address so we can email you at the end of the study.

Part 2  How is the research project being conducted?

11  What will happen to information about me?
No identifiable information will be collected from you. Your first name will be asked, though you can make one up if you want to. You will be asked some questions at the end of your interview about your background, which will be linked to your interview. However when your interview is written down (transcribed) we will give it a code number, so you won’t be identified. By signing this consent form, you are giving us permission to collect and use information about you for this study.

All electronic data (like your interview recording and transcript) will be stored on a secure password-protected computer at UNSW Australia. All hard copies of data (like any written notes taken) will be stored in a locked room at UNSW Australia. All data will be stored in these locations for seven years, and then shredded / deleted.

We hope that the results of this study will be published and/or presented in a thesis, journals and at conferences. In any publication and/or presentation, you will not be identified in any way.

12  Complaints and compensation
In the unlikely event you suffer any distress or need emotional support because of this study, please tell Jessica as soon as possible. She will help to arrange appropriate treatment and/or support. If you have any complaints or concerns about this research study, please contact the Family Planning NSW Ethics Committee at ethics@fpnsw.org.au or +61 2 8752 4348.

13  Who is organising and funding the research?
This research is being conducted by Jessica Botfield for her doctoral research. It is not being funded, and there is no financial benefit expected for any person or organisation. No member of the research team will receive a personal financial benefit from your involvement (other than their normal wages).

14  Who has reviewed the research project?
All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee. The ethical aspects of this research project have been approved by the Family Planning NSW Ethics Committee (approval number R2015-02). This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007), which has been developed to protect the interests of people who agree to participate in human research studies.

15  Further information and who to contact
If you want more information about the study, or if you have any problems related to the study, please contact one of the following members of the research team:

<table>
<thead>
<tr>
<th>Research contact person</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Jessica Botfield</td>
</tr>
<tr>
<td>Position</td>
<td>Associate Researcher</td>
</tr>
<tr>
<td>Telephone</td>
<td>0448 718 562</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:youthstudy1624@gmail.com">youthstudy1624@gmail.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head research person</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Professor Anthony Zwi</td>
</tr>
<tr>
<td>Position</td>
<td>Chief Investigator</td>
</tr>
</tbody>
</table>
If you have any complaints about the study or the way it is being done please contact:

<table>
<thead>
<tr>
<th>Reviewing HREC name</th>
<th>Family Planning NSW Ethics Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td><a href="mailto:ethics@fpnsw.org.au">ethics@fpnsw.org.au</a></td>
</tr>
<tr>
<td>Email</td>
<td>+61 2 8752 4348</td>
</tr>
</tbody>
</table>

If this research causes you any distress or emotional harm, or if you want to speak to a qualified professional about anything following your interview, below is a service you can contact:

**STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)**

<table>
<thead>
<tr>
<th>Website</th>
<th><a href="http://www.startts.org.au/">http://www.startts.org.au/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>02 9794 1900</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:startts@sswahs.nsw.gov.au">startts@sswahs.nsw.gov.au</a></td>
</tr>
<tr>
<td>Location</td>
<td>Carramar</td>
</tr>
</tbody>
</table>
Appendix 3: Participant Information and Consent Forms

**Consent Form** – *Young person providing own consent (participant interview - first)*

**Title**
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

**Short Title**
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

**Project Sponsor**
UNSW Australia

**Coordinating Principal Investigator**
Professor Anthony Zwi

**Associate Investigator(s)**
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

**Declaration by Participant**
I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of participant (please print): ___________________________
Signature: _________________________ Date: _____________________________

**Declaration by Researcher**†
I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of researcher (please print): ___________________________
Signature: _________________________ Date: _____________________________

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

**Interpreter**
Name of interpreter (please print): ___________________________
Signature OR job #: __________________ Date: ________________________

Note: All parties signing the consent section must date their own signature.
Form for Withdrawal of Participation –
Young person providing own consent (participant interview - first)

It is recommended that this form NOT be included as part of the PICF itself, but that it be developed at the same time and made available to researchers for later use, if necessary.

Title
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

Short Title
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

Project Sponsor
UNSW Australia

Coordinating Principal Investigator
Professor Anthony Zwi

Associate Investigator(s)
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

Declaration by Participant
I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or UNSW.

Name of participant (please print): ___________________________
Signature: ___________________________ Date: _____________________________

In the event that the participant’s decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher†
I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of researcher (please print): ___________________________
Signature: ___________________________ Date: _____________________________

† An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Interpreter

Name of interpreter (please print): ___________________________
Signature OR job #: ___________________________ Date: _____________________________

Note: All parties signing the consent section must date their own signature.
Participant Information Sheet / Consent Form (PICF)

<table>
<thead>
<tr>
<th>Health/Social Science Research</th>
<th>Young person providing own consent (participant interview – repeat/walking)</th>
</tr>
</thead>
</table>

**Title**  
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

**Short Title**  
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

**Project Sponsor**  
UNSW Australia

**Coordinating Principal Investigator**  
Professor Anthony Zwi

**Associate Investigator(s)**  
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

**Part 1  What does my participation involve?**

1 **Introduction**  
You have previously taken part in our research study, which is called: “Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia”. We are inviting you to take part in a follow-up interview, because we want to hear more about your experiences and views of sex, relationships and related health care services.

This document reminds you about the research project and explains what’s involved in taking part in a follow-up interview. Please read this information carefully, and ask questions about anything that you don’t understand. You can talk to a relative, friend or professional you trust before deciding, if you want. Participation in this research is voluntary; if you don’t want to take part, you don’t have to. If you do want to take part, you will be asked to sign the consent (agreement) section at the end of the document. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described

2 **What is the purpose of this research?**  
Aim: This research aims to better understand how and why young people from refugee and migrant backgrounds access sexual and reproductive health care.  
Significance: Research findings will promote healthy and safe relationships, and positive health outcomes, for young people from refugee and migrant backgrounds, and aim to increase their choice and control over their sexual and reproductive health.  
The results of this research will be used by the researcher, Jessica Botfield, to obtain a Doctor of Philosophy degree.

3 **What does participation in this research involve?**  
If you are interested in taking part in a follow-up interview, we will contact you via phone to find a good date and time. The follow-up interview will be either a repeat interview (similar to the first one you did with us), and/or a ‘walking’ interview at a health service. You can choose whether you want to take part in one or both of these, and tick this in the consent form at the end of this document. Each type of follow-up interview will take approximately 30-60 minutes,
and can be done on your own or with a friend. You will be asked to sign the consent form at the end of this document before starting the interview.

The repeat interview will be similar to the first interview you completed, and we will ask you more questions about your experiences and views. It will take place at a health service (private room) or another agreeable location. Like before, interviews in other languages (apart from English) will be undertaken using the Translating and Interpreting Service (TIS National). The ‘walking’ interview will involve walking through a health service and chatting about the service with Jessica from the research team. It will take place at a health service in Sydney. If you are willing we will record the interview, so we can type up the recording afterwards. We will take out any names or stories that are ‘identifying’ (so that no-one will know it was you). Written notes may also be taken during your interview.

4 Other relevant information about the research project
This research study is being undertaken in Sydney, NSW, with a particular interest in Greater Western Sydney. We are interested in hearing the views of young people living in this area. We will also speak to some health and policy professionals to learn their views. Six organisations (Family Planning NSW, High St Youth Health Service, NSW Refugee Health Service, South Western Sydney Sexual Health Service, Western Sydney Sexual Health Centre and Sydney Sexual Health Centre) will help with the research, but they will not have any financial involvement or influence on your privacy.

5 Do I have to take part in this research project?
Taking part in this research is completely your choice. If you don’t want to, you don’t have to. If you do want to but then later change your mind, you can leave any time. Any decision you make will not affect your relationship with any person or organisation involved in this research.

6 What are the possible benefits of taking part?
There will be no obvious benefit to you from your participation in this research, and you will not be paid. We hope to use information from this study though to benefit young people and provide better health services to you. You will be reimbursed for your costs in travelling to and from the interview (up to $30).

7 What are the possible risks and disadvantages of taking part?
Aside from giving up 30-60 minutes of your time, we do not expect there to be any significant risks or disadvantages if you take part. You may think some of the questions we ask are embarrassing or make you feel uncomfortable. If you don’t want to answer a question, you can skip it and go to the next one. You also have the option to stop the interview at any time. If you become upset because of this research we can help you to arrange for counselling or other support if you want. Contact details for some helpful services are also provided at the end of this document.

8 What if I withdraw from this research project?
If you consent (agree) to participate, you may also leave the study at any time. If you want to leave, please tell Jessica from the research team. She will ask you to sign a ‘Withdrawal of Consent’ form. If you decide to leave, we will not collect additional information from you, but any information already collected will be kept and used to form part of the research results. However if you do not want this to be included please tell Jessica when you leave.

9 Could this research project be stopped unexpectedly?
It is unlikely that this research project will be stopped unexpectedly.

10 What happens when the research project ends?
Appendix 3: Participant Information and Consent Forms

When the research project is finished, a summary of the findings can be sent to you. Please let Jessica know if you would like a copy, and provide an email address so we can email you at the end of the study.

Part 2 How is the research project being conducted?

11 What will happen to information about me?
No identifiable information will be collected from you. Your first name will be asked, though you can make one up if you want to. You will be asked some questions at the end of your interview about your background, which will be linked to your interview. However when your interview is written down (transcribed) we will give it a code number, so you won’t be identified. By signing this consent form, you are giving us permission to collect and use information about you for this study.

All electronic data (like your interview recording and transcript) will be stored on a secure password-protected computer at UNSW Australia. All hard copies of data (like any written notes taken) will be stored in a locked room at UNSW Australia. All data will be stored in these locations for seven years, and then shredded / deleted.

We hope that the results of this study will be published and/or presented in a thesis, journals and at conferences. In any publication and/or presentation, you will not be identified in any way.

12 Complaints and compensation

In the unlikely event you suffer any distress or need emotional support because of this study, please tell Jessica as soon as possible. She will help to arrange appropriate treatment and/or support.

If you have any complaints or concerns about this research study, please contact the Family Planning NSW Ethics Committee at ethics@fpnsw.org.au or +61 2 8752 4348.

13 Who is organising and funding the research?

This research is being conducted by Jessica Botfield for her doctoral research. It is not being funded, and there is no financial benefit expected for any person or organisation. No member of the research team will receive a personal financial benefit from your involvement (other than their normal wages).

14 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee. The ethical aspects of this research project have been approved by the Family Planning NSW Ethics Committee (approval number R2015-02).

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007), which has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact

If you want more information about the study, or if you have any problems related to the study, please contact one of the following members of the research team:

**Research contact person**

<table>
<thead>
<tr>
<th>Name</th>
<th>Jessica Botfield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Associate Researcher</td>
</tr>
<tr>
<td>Telephone</td>
<td>0448 718 562</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:youthstudy1624@gmail.com">youthstudy1624@gmail.com</a></td>
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**Head research person**

<table>
<thead>
<tr>
<th>Name</th>
<th>Professor Anthony Zwi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
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</tr>
<tr>
<td>Telephone</td>
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If you have any complaints about the study or the way it is being done please contact:

<table>
<thead>
<tr>
<th>Reviewing HREC name</th>
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</tr>
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<tbody>
<tr>
<td>Telephone</td>
<td><a href="mailto:ethics@fpnsw.org.au">ethics@fpnsw.org.au</a></td>
</tr>
<tr>
<td>Email</td>
<td>+61 2 8752 4348</td>
</tr>
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</table>

If this research causes you any distress or emotional harm, or if you want to speak to a qualified professional about anything following your interview, below is a service you can contact:

**STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)**

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<thead>
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Appendix 3: Participant Information and Consent Forms

**Consent Form** – *Young person providing own consent (participant interview – repeat/walking)*

**Title**
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

**Short Title**
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

**Project Sponsor**
UNSW Australia

**Coordinating Principal Investigator**
Professor Anthony Zwi
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

**Declaration by Participant**
I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Consenting to:
- Repeat interview
- ‘Walking’ interview

Name of participant (please print): ___________________________
Signature: _________________________ Date: _____________________________

**Declaration by Researcher†**
I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of researcher (please print): ___________________________
Signature: _________________________ Date: _____________________________

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

**Interpreter**
Name of interpreter (please print): ___________________________
Signature OR job #: _________________________ Date: _____________________________

Note: All parties signing the consent section must date their own signature.
Appendix 3: Participant Information and Consent Forms

Form for Withdrawal of Participation –
Young person providing own consent (participant interview – repeat/walking)

It is recommended that this form NOT be included as part of the PICF itself, but that it be developed at the same time and made available to researchers for later use, if necessary.

Title
Engaging young people from culturally and linguistically diverse backgrounds with sexual and reproductive health services in Sydney, Australia

Short Title
Engaging culturally diverse young people with sexual and reproductive health services in Sydney

Project Sponsor
UNSW Australia

Coordinating Principal Investigator
Professor Anthony Zwi

Associate Investigator(s)
A/Professor Christy Newman, Dr Christopher Carmody, Dr Deborah Bateson, Dr Catriona Ooi, Dr Melissa Kang, Dr Mitchell Smith, Mr Brendan Crozier, Ms Jessica Botfield, Ms Katherine Bennett

Declaration by Participant
I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or UNSW Australia.

Name of participant (please print): ___________________________
Signature: _________________________ Date: _____________________________

In the event that the participant’s decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher†
I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of researcher (please print): ___________________________
Signature: _________________________ Date: _____________________________

† An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Interpreter

Name of interpreter (please print): ___________________________
Signature OR job #: _________________________ Date: _____________________________

Note: All parties signing the consent section must date their own signature.
Appendix 4: Interview guides

**Interview guide: Key informants (health service providers)**

- Introduce myself
- Provide overview of research and objectives, and answer any questions
- Confirm consent for interview and recording (verbal, if written consent already obtained. If conducting interview by phone and written consent not obtained, follow script for recording verbal consent)

1. Informant background
   I wanted to start off with a little bit about you…
   - Can you please tell me a bit about your professional background and current role?
   - As you know, this research is looking at the area of cultural diversity and sexual and reproductive health care. I have two broad questions to help situate the research and context. Can you tell me a bit about what cultural diversity means to you? Does it have particular meanings in the work you do?
   - And just one more broad question: Can you tell me how you would define sexual and reproductive health?

2. Culturally diverse young people & SRH service provision
   And now thinking about culturally diverse young people and service provision…
   - What do you see as the main needs and challenges for culturally diverse young people in Australia today, particularly in relation to their sexual and reproductive health?
   - What factors do you think influence how culturally diverse young people’s make use of SRH services? Do you think these influences cause any barriers to their using services (and how)?

So now more related to your workplace…
- Can you please provide an overview of your organisation/services provided? Location, staff, types of services, target populations, most common groups/demographics of clients, priority populations
- Are culturally diverse young people using your service? What kind of things do they commonly present for? Do you think there are concerns they might not present for (like what)?
- Is this group seen as a priority group in your organisation? If yes, how do you seek to engage this group / if no, why not?
- What challenges does your service face in the provision of SRH services to culturally diverse young people? How are these overcome (if at all)?
- Have you ever received training (and/or does your organisation provide training) around cultural competency? How confident do you feel in communicating / working with culturally diverse young people?
- How could staff be better equipped to provide more culturally competent care?
- What additional knowledge or skills would you find useful for your work?
- Do you have any thoughts about the impact of the location / setting of your service in attracting young people, and/or culturally diverse people? What about the physical design, signage, operating hours or other structural aspects of the service? Do you think these present any structural barriers to access?
- Can you think of specific ways your service could be more ‘youth-friendly’, if this is something that’s desirable?
- What do you believe your service does that is different from other services in order meet the sexual and reproductive health needs of culturally diverse young people?
- What successful strategies have you used to access and engage culturally diverse young people in the past? Are there plans for new approaches in the future?
Appendix 4: Interview guides

- Can you think of any practical ways your service could better engage culturally diverse young people, both clinically as well as with outreach and/or health promotion?
- What do you think can or should be done to better engage this group and promote utilisation of your service?
- Do you have any ideas about how health promotion and service delivery can be best designed and delivered to culturally diverse young people in Australia, particularly around the area of SRH?
- In your view, what are the best ways to reach or share information with culturally diverse young people?
- Is there an opportunity for culturally diverse young people to participate in the design and delivery of your service (and how)?
- Do you have any views about better involving young people in the design and delivery of services? [wait for response; then follow up] Could they participate on advisory groups, for example? Are there other models of engagement, and would these be appropriate for young people from different cultural backgrounds?

4. Wrap up

- Are there any other issues you would like to raise, or questions you have for me?
- Is there anyone else you recommend I contact for an interview?
- Would you like to be added to a confidential email list to be notified of key publications, and the final research summary, as they are made available? If yes, I will include your email address on a confidential email list.
- Thank you so much for participating. Your interview will be kept strictly confidential, and quotes will not be linked to any identifying information.
Appendix 4: Interview guides

Interview guide: Key informants (excl. health service providers)

- Introduce myself
- Provide overview of research and objectives, and answer any questions
- Confirm consent for interview and recording (verbal, if written consent already obtained. If conducting interview by phone and written consent not obtained, follow script for recording verbal consent)

Informant background
I wanted to start off with a little bit about you…
- Can you please tell me a bit about your professional background and current role?
- As you know, this research is looking at the area of cultural diversity and sexual and reproductive health care. I have two broad questions to help situate the research and context. Can you tell me a bit about what cultural diversity means to you? Does it have particular meanings in the work you do?
- And just one more broad question: Can you tell me how you would define sexual and reproductive health?

Culturally diverse young people & sexual and reproductive health
And now thinking about culturally diverse young people and service provision…
- What do you see as the main needs and challenges for culturally diverse young people in Australia today, particularly in relation to their sexual and reproductive health?
- What factors do you think influence how this group make use of SRH services? Do you think these influences cause any barriers to their using services (and how)?
- What do you see as the main challenges for service providers in this area? How could these be overcome?
- What would you like to see changed or improved in terms of SRH service provision to young people (and how)?
- What do you think can or should be done to better engage this group with services and promote utilisation of services?
- In your view, what are the best ways to share information with culturally diverse young people?
- Do you have any ideas about how health promotion and service delivery can be best designed and delivered to culturally diverse young people in Australia, particularly around the area of SRH?
- Do you have any views about involving young people themselves in the design and delivery of services? [wait for response; then follow up] Could they participate on advisory groups, for example? Are there other models of engagement, and would these be appropriate for young people from different cultural backgrounds?

3. Wrap up
- Are there any other issues you would like to raise, or questions you have for me?
- Is there anyone else you recommend I contact for an interview?
- Would you like to be added to a confidential email list to be notified of key publications, and the final research summary, as they are made available? If yes, I will include your email address on a confidential email list.
- Thank you so much for participating. Your interview will be kept strictly confidential, and quotes will not be linked to any identifying information.
First interview guide: Young people

**Introductions**
- Introduce myself
- Provide overview of research and objectives, and answer any questions
- To reiterate, this interview is open-ended, so it is an opportunity to talk about any issues that you feel are important in relation to this topic. All participants are asked the same questions but you don’t have to answer any you don’t want to. You can also terminate the interview at any time.
- Confirm consent for interview and recording

Note: questions are a guide only; the interviewer will assess participants experience and comfort during the interview, and only ask questions (or adjust the wording of questions) as deemed appropriate.

**Participant background**
- To start, can you tell me a little bit about yourself? Whatever you wish to share.
- Which country were you born in? When did you move to Australia, and why did you move here?
- With which community or communities do you identify with?

**General questions**
- What does it mean to you to be healthy? What does it mean to be unhealthy or unwell?
- What is most important to you in terms of your health at the moment?
- Have you heard the term “sexual and reproductive health” before? What does this mean to you?
- What do you think are some of the main sexual and reproductive health issues for people your age?
- How do young people generally learn about sex, relationships and health in your community?
- How confident do you feel about your knowledge of sex, relationships and health? Are there things you find confusing or that you’d like to know more about?
- Has moving to Australia changed your views on or understandings of any of these issues, do you think?
- Is sexual and reproductive health something that is openly discussed in your family? What expectations do your parents have for you in relation to sex and relationships (and/or family or other close people in your life)?
- Are these matters openly discussed in your community? What opportunities are there to talk about them?
- Which sexual and reproductive health issues do you think are particularly sensitive, or not openly discussed in your community or family?
- Deciding to have a family, or not to have children at the present time, is a big decision. How is having children viewed in your culture or community? Who decides these issues, and do you think this has changed with your migration experience? What happens if an unmarried or single woman gets pregnant? How would that be seen?

**Experiences and perceptions**
I’m now going to ask you some broad questions about sex, and your experience with health services, is that ok? You don’t have to answer if you don’t want to, but don’t forget this is confidential and there are no right or wrong answers.

- Have you had relationships that you would consider romantic or intimate? What have been your experiences with these?
- Do you feel comfortable talking to me about sex more generally today?
Appendix 4: Interview guides

- What factors do you think would affect your decision whether or not to have sex with someone?
- Do you know what I mean by ‘safe sex’? What does this mean to you?
- Do you know what I mean by contraception? Do you know any examples?
- Have you heard about infections or illnesses that you can get from having sex?
- How do you normally get information about relationships, sex and sexual health?
  - Do you discuss with your parents, family, friends, or boyfriends/girlfriends?
  - Do you receive any information about this at school? What issues/topics? What is this like?
  - Do any of these issues get discussed at your church, mosque or other place of worship? Other community gatherings? In what way/context?
  - Do you learn about these issues from the media (TV, radio, internet, magazines)?
- Who would you speak to / where would you go if you had questions about sex, relationships or related health issues? Who do you find it easiest to speak to about these things?
- Is there anywhere you would definitely not go to or not trust to talk to about these things?
- Are there any issues around sex, relationships and health that you would like support with, but aren’t getting that support at the moment? If yes, what kind of support would be helpful?
- Do you know of any services that you could go to when you have questions or problems to do with sex or relationships? Which services? How have you heard about these? Discuss various types of services (GP, medical centre, SH clinic, FP clinic, youth service, etc). Have you had any personal experiences with any of these services for SRH issues?

Accessing services

**Option 1: If they HAVE attended a service (any service for a SRH-related issue):**
- Can you tell me what kind of service it was that you visited?
- Can you share some of your feelings and experiences around finding and accessing this service?
  - What made you decide to go?
  - Why did you pick that particular service? How did you find out about it?
  - How did you feel before the visit?
  - Did anyone go with you? Did you tell anyone?
  - Were there any difficulties or challenges? How were you treated?
  - Did you feel satisfied when you left / did you get what you wanted?
  - Were there things that were good or done well there (like what)? Things that you didn’t like (like what)?
  - Were you fearful of others finding out? Did anyone find out you had been who you didn’t want to know?
  - Have you visited that service again? Would you recommend it to your friends?
- What are your general impressions of these kinds of services more broadly, in your experience or what you’ve seen/heard – do they seem welcoming? Suitable for young people? Appropriate? Confidential?
- Do you think health services are sensitive to and respectful of your experiences, background, culture and religion?
- What do you expect from a sexual and reproductive health service? What are the most important aspects of such a service for you (or for young people more generally)? What will make young people go? Are there differences in the needs of young men and women, and how can they both be provided for? How could they be improved, or more appropriate / accessible to you?
- What do you think are the best ways of advertising and promoting services for young people?

**Option 2: If they HAVE NOT attended a service (any service for a SRH-related issue)**
Appendix 4: Interview guides

- If you have not used a service, why not? Would you consider going in the future?
- What are your general impressions of these kinds of services more broadly, from what you’ve seen/heard – do they seem welcoming? Suitable for young people? Appropriate? Confidential?
- What would you expect from a sexual and reproductive health service? What do you think are the most important aspects of such a service for you, or young people more generally? What would you look for if you wanted to use a service?
- What do you think are the best ways of advertising and promoting services for young people?

**Scenario**
- If you start going out with a new boyfriend / girlfriend and start to think about having sex with them, what kinds of things might you be thinking about? Who would you talk to?

**Wrap up**
- Are there any other issues you would like to raise, or questions you have for me?
- Ask demographic questions and document on separate sheet
- Is there anyone else you think might be interested in being interviewed? Share flyer
- Would you like to be added to a confidential email list to be notified of key publications, and the final research summary, as they are made available? If yes, please spell out your email address, and I will add this to a confidential email list.
- We will be undertaking two types of follow-up interviews; one will be a ‘repeat’ interview, which will be similar to this one, and the other will be a ‘walking’ interview, which will involve walking through a health service and chatting about key features and your views of it. When you leave today can you have a think about whether this is something you would be interested in doing, either one or both of these, and email or call me if you are interested? Would you mind if I also send you a follow-up email in the next week or two, just as a reminder? I won’t make any more contact with you after that.
- Thank you so much for participating. Your interview will be kept strictly confidential, and quotes will not be linked to any identifying information about you.
Follow-up interview guide: Young people

- Re-introduce myself
- Answer any questions
- Confirm consent for repeat interview and recording (verbal, if written consent already obtained)

Note: questions are a guide only; the interviewer will assess participants experience and comfort during the interview, and only ask questions (or adjust the wording of questions) as deemed appropriate. Questions will also be adapted depending on participant’s responses in their first interview.

Thank you for agreeing to do another interview. In the last interview we talked about what health means to you and your family, the term “sexual and reproductive health” and issues around that, and some of your views and experiences in this area. I’d now like to focus more today on your experiences in more detail, if that’s okay. Like before, this interview is an opportunity to talk about any issues that you feel are important in relation to this topic. It is confidential, and there are no right or wrong answers. Remember you don’t have to answer any questions you don’t want to, and you can end the interview at any time. So we talked last time about issues to do with relationships, sex and health services; are you happy to talk about your experiences in a little more detail today?

- How do you normally get information about relationships, sex and sexual health? Who would you speak to / where would you go if you had questions about these?
- Is sex and sexual and reproductive health something that is openly discussed in your family and community?
- Would you feel comfortable within your family and community if you liked someone who was from a different cultural background, or of the same sex as you?
- What do you think are the main influences on sexual and reproductive health for people your age? Do you think these also influence using services for related health needs?
- Do you know of any services that you could go to when you have questions or problems to do with sex or relationships? Which services? How have you heard about these? Discuss various types of services (GP, medical centre, SH clinic, FP clinic, youth service, etc). Have you had any personal experiences with any of these services for SRH issues (and discuss)?

- How old were you when you had your first experiences to do with sex? Did you tell anyone about this? Was there anyone you were worried would find out?
- Do you know what I mean by ‘safe sex”? What does this mean to you?
- Are there things you do in order to protect yourself / your partner from infections passed on through sex?
- Have you had any experiences, or know someone who has, with such infections? (prompts: chlamydia, gonorrhoea, HPV, HIV). What was done in this situation?
- Do you know what I mean by contraception? What has your experience been with this? (Use ever/never/always; What kind; why?). Are there things you do to protect yourself / your partner from an unplanned pregnancy?
- Who would you speak to / where would you go if you had questions about preventing pregnancy or infections, or other related issues? Who do you find it easiest to speak to about these things?
  - Are you comfortable talking about these things with your sexual partner/s?
  - Have you been to a doctor or clinic for issues like this? Can you share some of your experiences?
  - Is there anywhere you would definitely not go to or not trust to talk to about these things?
Appendix 4: Interview guides

- Are there any issues around sex, relationships and health that you would like support with, but aren’t getting that support at the moment? If yes, what kind of support would be helpful?
- What would be your ideal service to attend for issues relating to your sexual and reproductive health?

Scenarios
- What would you do if you found out you (or a partner or a friend) were accidentally pregnant? Who would you speak to? Where would you go?
- What would you do (or your friend or partner) if you thought you had an infection related to having sex?

Wrap up
- Are there any other issues you would like to raise, or questions you have for me?
- Thank you so much for participating. Your interview will be kept strictly confidential, and quotes will not be linked to any identifying information about you.
Walking interview: Young people

- Re-introduce myself
- Answer any questions
- Confirm consent for walking interview and recording (verbal, if written consent already obtained)

Thank you for agreeing to do this walking interview. I hope to just walk around the clinic, and informally chat about key features and your view of it. We’ll start outside the clinic, then make our way through reception, the waiting area, the clinical rooms, and any other rooms or areas of interest. Please point out any things you especially like or don’t like, anything of particular interest, or any issues you have. I’ll also ask you some questions as we go along.

Consider five dimensions of accessibility: approachability, acceptability, availability, affordability, and appropriateness

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<tr>
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<th>Researcher observations</th>
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### Appendix 5: Demographic questionnaire

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Appendix 6: Authorship declaration forms

UNSW Authorship Declaration

Title: Young migrants and sexual and reproductive health care

In the case of the above-mentioned paper contributions to the work involved the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contribution (%)</th>
<th>Nature of contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jessica Bottfield</td>
<td>80%</td>
<td>Led writing of chapter; undertook literature search; prepared first and subsequent drafts of chapter; revised chapter critically for important intellectual content.</td>
</tr>
<tr>
<td>Anthony Zwi</td>
<td>10%</td>
<td>Advised on structure and content; contributed to first and subsequent drafts; revised chapter critically for important intellectual content.</td>
</tr>
<tr>
<td>Christy Newman</td>
<td>10%</td>
<td>Advised on structure and content; contributed to first and subsequent drafts; revised chapter critically for important intellectual content.</td>
</tr>
</tbody>
</table>

Declaration by co-authors

The undersigned hereby certify that:

- they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field or expertise;
- they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;
- there are no other authors of the publication according to these criteria;
- potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and
- the original data are stored at the following location(s) and will be held for at least five years from the date indicated below:

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<tbody>
<tr>
<td>1</td>
<td>Jessica Bottfield</td>
<td><img src="bottfield" alt="Signature" /></td>
<td>2/07/2018</td>
</tr>
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<td>Anthony Zwi</td>
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<td></td>
<td>Christy Newman</td>
<td><img src="newman" alt="Signature" /></td>
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Appendix 6: Authorship declaration forms

UNSW Authorship Declaration

Title: Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: A structured scoping review

In the case of the above-mentioned paper contributions to the work involved the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contribution (%)</th>
<th>Nature of contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jessica Botfield</td>
<td>75%</td>
<td>Led scoping review and writing of manuscript; undertook literature search, exclusion/inclusion, categorisation and analysis of literature; undertook informal key informant consultations; prepared first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Christy Newman</td>
<td>15%</td>
<td>Provided advice on scoping review methodology, literature search, analysis, and structure of manuscript; contributed to first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Anthony Zwi</td>
<td>10%</td>
<td>Contributed to first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
</tbody>
</table>

Declaration by co-authors

The undersigned hereby certify that:

- they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field or expertise;
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<tr>
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<tr>
<td>Anthony Zwi</td>
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<td>2/07/2018</td>
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</table>
UNSW Authorship Declaration

Title: Drawing them in: Professional perspectives on the complexities of engaging culturally diverse young people with sexual and reproductive health promotion and care in Sydney, Australia

In the case of the above-mentioned paper contributions to the work involved the following:

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<tr>
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<tbody>
<tr>
<td>Jessica Botfield</td>
<td>75%</td>
<td>Undertook key informant interviews, transcription, and coding in NVivo10; undertook preliminary analysis; prepared first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Christy Newman</td>
<td>15%</td>
<td>Contributed to data analysis and interpretation of data; advised on structure of manuscript; contributed to first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
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Name: Jessica Botfield Signature: Date: 2/07/2018

Name: Christy Newman Signature: Date: 2/07/2018

Name: Anthony Zwi Signature: Date: 2/07/2018
### UNSW Authorship Declaration

**Title:** Engaging migrant and refugee young people with sexual health care: Does generation matter more than culture?

In the case of the above-mentioned paper contributions to the work involved the following:

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Appendix 6: Authorship declaration forms

UNSW Authorship Declaration

Title: Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: “I never got the talk about the birds and the bees”

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<tr>
<td>Anthony Zwi</td>
<td>10%</td>
<td>Contributed to data analysis and interpretation of data; advised on structure of manuscript; contributed to first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Alison Rutherford</td>
<td>5%</td>
<td>Contributed to subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Christy Newman</td>
<td>10%</td>
<td>Contributed to data analysis and interpretation of data; advised on structure of manuscript; contributed to subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
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Name:   Signature:          Date:
Jessica Botfield         2/07/2018
Anthony Zwi              2/07/2018
Alison Rutherford        2/07/2018
Christy Newman           2/07/2018
Appendix 6: Authorship declaration forms

UNSW Authorship Declaration

Title: Talking to migrant and refugee young people about sexual health in general practice

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<table>
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<tr>
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<td>Jessica Botfield</td>
<td>80%</td>
<td>Undertook all interviews, transcription, and coding in NVivo10; undertook preliminary analysis; prepared first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Christy Newman</td>
<td>10%</td>
<td>Contributed to data analysis and interpretation of data; advised on structure of manuscript; contributed to first and subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Melissa Kang</td>
<td>5%</td>
<td>Contributed to data analysis and interpretation of data; contributed to subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
</tr>
<tr>
<td>Anthony Zwi</td>
<td>5%</td>
<td>Contributed to data analysis and interpretation of data; contributed to subsequent drafts of manuscript; revised manuscript critically for important intellectual content.</td>
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Name:                        Signature:                        Date:
Jessica Botfield             2/07/2018                         |
Christy Newman               2/07/2018                         |
Melissa Kang                 2/07/2018                         |
Anthony Zwi                  2/07/2018                         |
Appendix 6: Authorship declaration forms

UNSW Authorship Declaration

Title: Ethical considerations of using walking interviews to engage migrant and refugee young people in health service research

In the case of the above-mentioned paper contributions to the work involved the following:

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<tr>
<th>Name</th>
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<tr>
<td>Jessica Batfield</td>
<td>85%</td>
<td>Undertook walking interviews; led writing of article; prepared first and subsequent drafts revised critically for important intellectual content.</td>
</tr>
<tr>
<td>Anthony Zwi</td>
<td>5%</td>
<td>Contributed to subsequent drafts; revised critically for important intellectual content.</td>
</tr>
<tr>
<td>Caroline Lenette</td>
<td>5%</td>
<td>Contributed to subsequent drafts; revised critically for important intellectual content.</td>
</tr>
<tr>
<td>Christy Newman</td>
<td>5%</td>
<td>Contributed to subsequent drafts; revised critically for important intellectual content.</td>
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Appendix 7: Literature included in the scoping review

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<th>No.</th>
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<td>Achat, H. M., Thomas, P., Close, G. R., Moerkerken, L. R. &amp; Harris, M. F.</td>
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<td>General health care service utilisation: where, when and by whom in a socio-economically disadvantaged population</td>
<td>Australian Journal of Primary Health</td>
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<td>Asante, A., Körner, H., &amp; Kippax, S.</td>
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<td>Understanding late HIV diagnosis among people from culturally and linguistically diverse backgrounds</td>
<td>National Centre in HIV Social Research, University of New South Wales</td>
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<td>Asante, A. &amp; Körner, H.</td>
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<td>Knowledge and access are not enough: HIV risk and prevention among people from culturally and linguistically diverse backgrounds in Sydney</td>
<td>Medical Journal of Australia</td>
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<td>Australian Medical Association</td>
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<td>Sexual and Reproductive Health 2014</td>
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<td>8</td>
<td>Bernard, D., Quine, S., Kang, M., Alperstein, G., Usherwood, T., Bennett, D. &amp; Booth, M.</td>
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<td>Access to primary health care for Australian adolescents: How congruent are the perspectives of health service providers and young people, and does it matter?</td>
<td>Australian and New Zealand Journal of Public Health</td>
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<td>Drummond, P. D., Mizan, A., Brocx, K. &amp; Wright, B.</td>
<td>2011</td>
<td>Using peer education to increase sexual health knowledge among West African refugees in Western Australia</td>
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<td>Common Threads: The sexual and reproductive health experiences of immigrant and refugee women in Australia</td>
<td>Multicultural Centre for Women's Health</td>
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<td>Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery</td>
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<td>Kelaher, M. &amp; Manderson, L.</td>
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<td>Migration and mainstreaming: matching health services to immigrants’ needs in Australia</td>
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<td>Aids Care-Psychological and Socio-Medical Aspects of Aids/HIV</td>
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<td>If I had my residency I wouldn't worry': Negotiating migration and HIV in Sydney, Australia</td>
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<td>It is Good to Know Now… Before it's Too Late: Promoting sexual health literacy amongst resettled young people with refugee backgrounds</td>
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<td>Noto, O., Leonard, W. &amp; Mitchell, A.</td>
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<td>Perks, J. &amp; Bedford, K.</td>
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<td>The Campsie Well Women's Clinic -- an innovative approach to women's health services</td>
<td>nursing.aust</td>
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<td>Pittaway, E., Muli, C. &amp; Shteir, S.</td>
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<td>“I Have a Voice—Hear Me!” Findings of an Australian Study Examining the Resettlement and Integration Experience of Refugees and Migrants from the Horn of Africa in Australia</td>
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<td>Sawleshwarkar, S., Kakar, S. R., Jones, R., Lagios, K., Mindel, A. &amp; Hillman, R. J.</td>
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<td>Indian-born patients attending a sexual health clinic in Australia have differing characteristics to their Australian-born counterparts</td>
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### Appendix 7: Literature in scoping review

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Two books were included in this review - the first published in 2005, and the second its sequel published in 2014. Both were included to highlight the changing nature of this field over the past decade; the updated title, ‘sexual health: a multidisciplinary approach’, reflects the ongoing recognition of the multidisciplinary nature of sexual health, and the additional content (for example sexual health in adolescence, and ‘vulnerable populations’ including refugees) highlights the growing priority of these two groups in Australia.
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