Culture, Health & Sexuality:
An International Journal for Research, Intervention and Care
Volume 17, Issue 2, 2015

Sexual and reproductive health communication among Sudanese and Eritrean women: an exploratory study from Brisbane, Australia

Claire Rogers[a,b*] and Jaya Earnest[a]

DOI:10.1080/13691058.2014.967302

[a]*International Health Program, Curtin University, Perth, Western Australia;* [b]*Family Planning Queensland, Brisbane, Queensland, Australia*

*Corresponding Author. Email: Claire.Rogers@curtin.edu.au

To link to this article: http://dx.doi.org/10.1080/13691058.2014.967302

Abstract

This exploratory study piloted in Brisbane, Australia reports on findings from in-depth focus group discussions conducted with Sudanese and Eritrean women in Brisbane. We investigated and documented their experiences and knowledge of sexual and reproductive health and contraception, and explored their views on sexuality and relationships education within the family environment of minority ethnic communities in Australia. Underpinned by a qualitative psychosocial framework, the study also involved key informant interviews with health and multicultural not-for-profit sector professionals. Through the knowledge and experiences shared by the participants, the key themes of cultural insensitivity, exclusion and poor communication within the family were highlighted by participants as determining factors in the achievement of sexual and reproductive health and good quality sex and relationships education. Participants proposed recommendations for how minority ethnic communities in Australia can more effectively support and communicate within the family environment to increase their own and their children's knowledge and understanding.

Keywords: sexuality and relationships education (SRE), sexual and reproductive health (SRH), refugee and migrant health, communication

Introduction

Minority ethnic communities

Australia is a country of cultural, linguistic, religious and ethnic diversity, with over 27.7% of the population being born in a foreign country (Australian Bureau of Statistics [ABS] 2013, Kaur 2012). Census data from 2011 indicated that approximately 6.4 million migrants, born in over 200 countries and speaking over 400 different languages, currently live in Australia (ABS 2011, 2013). Between 2012 and 2013 alone, there were 2789 and 450 protection visas lodged from individuals from North Africa and the Middle East, and Sub-Saharan Africa, respectively (Australian Government 2013). In the context of Australia's population growth, for the top 50 countries of birth (excluding Australia) in 2013, people born in Sudan had the fifth highest rate of increase between 2003 and 2013 with an average annual growth rate of 9.2% (ABS 2013). From 2007 to 2013, 7,065 refugees resettled in the state of Queensland, with the vast majority of refugees settling in the capital city, Brisbane (Harte, Childs and Hastings 2011, Queensland Government 2008, Refugee Council of Australia 2014).

Globally, disparities have been shown to exist in the provision and access of health services and health education to ethnic and racial minority groups (Kelaher, Williams and Manderson 1999, Carroll, et al 2007, Whelan and Blogg 2007, Newbold and Willinsky 2009, Thomas, Beckmann and Gibbons 2010, Henderson and Kendall 2011). Strategies that reduce language, cultural, religious and economic barriers to health information and services for minority ethnic communities are vital to improving health status (Newbold and Willinsky 2009, Henderson and Kendall 2011, Henderson, Kendall and See 2011). With the growing number of former refugees and migrants from African countries resettling in Brisbane, there is an increased need for the specific health care and education requirements of these communities to be addressed (Benson and Smith 2007, Henderson and Kendall 2011).

Sexual and Reproductive Health (SRH)

Deeply entrenched social and cultural discrimination creates major barriers to the achievement of reproductive and sexual health for women, especially those from low-and-middle income countries (United Nations Population Found [UNFPA] 2011, Ali, Seuc, Rahimi, Festina and Temmerman 2014, United Nations [UN] 2014). Societal attitudes towards pre-marital sex; religious opposition to contraception, sexual and reproductive health services; and gender based discrimination, continues to compound sociocultural barriers to the provision of good quality sex and relationship education (SRE) and the promotion of sexual and reproductive health (SRH) (UNFPA 2011, Ali et al. 2014, UN 2014).

Women from disadvantaged communities experience increased obstacles in obtaining SRH and contraception knowledge and also experience difficulties in accessing health care facilities and education (World Health Organization [WHO] 2011, Ali et al. 2014, UN 2014). Many refugee and migrant women arrive in Australia from countries where deep-rooted cultural norms, gender inequalities and patriarchal social structures do not recognise women's SRH rights (UNFPA 2011, UN 2014). This culture of discrimination can often continue in their countries of resettlement (Kaur 2012). Lack of support networks, socioeconomic disadvantage, cultural pressure, and lack of knowledge regarding available services can inhibit women from minority ethnic

communities from accessing SRH information and services (Murray, Windsor, Parker and Tewfik 2010).

In the Australian context, it is essential that service providers and educators understand the barriers to positive SRH care seeking attitudes, contraception use and inclusion in SRE, to enable greater sexual and reproductive health outcomes for this population (Henderson et al. 2011, Murray et al. 2010)

Sexuality and Relationships Education (SRE)

Comprehensive SRE is a lifelong process and involves age appropriate education encompassing sexual behaviour, relationships, gender equality, respect, human rights, gender identity, sexual orientation and sexual and reproductive health (Brennan and Graham 2012, High-Level Task Force for the International Conference on Population and Development [ICPD] 2013). SRE has been shown to help young people better understand appropriate and inappropriate behaviours, be less vulnerable to exploitation and sexual abuse, and to avoid or report sexual exploitation and abuse (Brennan and Graham 2012, Finkelhor 2007).

The High-Level Task Force for the International Conference on Population and Development (ICDP) states that SRE must begin early in life and be supported both in and outside of schools by policy and legal frameworks with particular efforts made to reach the most vulnerable of children and young people. Training, supervision and evaluation of SRE programmes is also of paramount importance in the delivery of comprehensive, effective and accurate SRE (ICDP 2013).

Brennan and Graham (2012) note that age appropriate, ongoing and comprehensive SRE can support children to be aware of safety issues and help them to understand themselves and their changings bodies. For young people, effective and early commencement of SRE, can help them to make informed and responsible sexual decisions and take control over their own reproductive and sexual health (Brennan and Graham 2012, ICPD 2013). Although parents may feel ill-equipped or uncomfortable imparting SRE and SRH information to their children, they are often strong supporters of SRE as they see it as an important component in keeping their children safe and healthy (Brennan and Graham 2012, Footprints Marketing Research [Footprints] 2011).

Young people who receive clear and accurate information about sexuality and relationships are also more likely to feel positive about themselves and their bodies and be able to talk about sexual matters if they have concerns or questions (Brennan and Graham 2012). Exposure to SRE has also been shown to help facilitate young people in making informed and responsible sexual decisions; increase the use of contraception and safe sex practices; and delay sexual activity (Brennan and Graham 2012, Footprints 2011, Emmerson 2010). Studies highlight the importance of providing support for schools and parents to facilitate the provision of effective and comprehensive SRE to children and young people (Finkelhor 2007, Walsh and Brandon 2012). While there has been much research into the importance of SRE, there is a significant gap in the research relating to effective, culturally appropriate SRE for young people from minority ethnic communities (Kaur 2012, McMichael and Gifford 2009).

Recent studies highlight that resettled young people from refugee backgrounds may face particular SRH vulnerabilities (Joyce, Earnest, De Mori and Silvagni 2010, McMichael and Gifford 2010). For many resettled young people, experiences of forced migration, displacement and resettlement are often compounded by experiences of

violence, persecution, disruption to schooling, limited access to health care services and separation from family and social networks during their journey to resettlement (Harris and Smyth 2001, McMichael and Gifford 2009, Joyce et al. 2010, McMichael and Gifford 2010). During, and subsequently after, the resettlement stage, SRH and SRE needs are often overlooked as young people from refugee backgrounds and their families face the many challenges and tensions that living in a new and foreign country brings (McMichael and Gifford 2010).

This exploratory, pilot study examined the SER and SRH experiences of women from Sudanese and Eritrean backgrounds and how families from minority ethnic communities can more effectively be supported within the family environment to facilitate an increase in knowledge and understanding of SRH and SRE.

Study Design & Methods

Due to the sensitive nature of the research topics discussed, and taking into account issues of culture, religion and language, a qualitative research approach was considered most suitable for this study (Jirojwong and Liamputtong 2009). The conceptual framework that informed and guided this study was the Psychosocial Framework as this is particularly applicable to research involving vulnerable populations such as refugee and migrant women (Psychosocial Work Group [PWG] 2003). Underpinned by the Psychosocial Framework domains of culture, values, economic and physical resources, objectives of the study were to explore, document and examine intergenerational experiences and knowledge of SRH and SRE among Sudanese and Eritrean women.

Methods

The participant recruitment strategies of snowballing and purposive sampling were used within the Sudanese and Eritrean communities to recruit focus group members for this study (Burns 2000, Hinton and Earnest 2009). Focus group discussions were held for approximately an hour with participants separated in two groups based on the age ranges 18-35 years (younger women) and 35-55 years (older women). The older women's group had eight participants and the young women's group had a total of five participants. Inclusion criteria for research participation were: being female from a Sudanese or Eritrean background; currently live in Brisbane; aged between 35-55 years or 18-35 years; have the capacity to give informed consent; and the ability to speak and understand English.

Focus group discussions (FGDs) were conducted to obtain qualitative data on the SRH and SRE knowledge and experiences. Ruppenthal, Tuck and Gagnon (2005) state that the emotional support, sense of community and reassurance displayed between group members during a FGD are key assets of this research method and is therefore an effective means of information gathering, particularly regarding sensitive issues. The interaction of group participants in response to other participants' comments and not merely the question posed by the facilitator, enables the participants to elaborate and clarify viewpoints individually and with the group (Ruppenthal et al. 2005, Halcomb, et al 2007).

Conducting separate FGDs for the different age cohorts enabled us to compare their intergenerational experiences, knowledge and opinions about SRH and SRE and avoid possible inter-generational differences. Separating the two age groups was also a

consideration for group dynamics as younger participants may feel they could not disagree or express an alternative view to older members of the group during the discussion (Halcomb et al. 2007).

Open-ended questions were developed for both the 18-35 years (younger women) and 35-55 years (older women) groups within the context of SRE and SRH and underpinned by three core domains (PWG, 2003). The psychosocial conceptual framework rests on the assumption that the psychosocial well-being of an individual is defined by human capacity, social ecology and culture and values. These domains map **human capital** (physical and mental health and well-being, the skills and knowledge of people, and their livelihoods), **social capital** (relations within families, links with peer groups, religious, cultural civic and political institutions) and **cultural capital** (cultural values, beliefs, practices, human rights) available to people responding to challenges of prevailing event (PWG, 2003). Pilot testing of the semi-structured questions was held before the FGDs were conducted enabling feedback and the refinement of questioning style and themes to ensure cultural understanding (Henderson and Kendall 2011). The five participants of the pilot testing group included a female member of the Eritrean community; a SRH care professional; a women's multicultural health care worker; a Sudanese bilingual health care worker; and sexual health care professional with extensive experience working with minority and indigenous populations. Prior to the commencement of FGDs, the research team (comprised of the principal researcher, Arabic interpreter and Tigrinya interpreter) and research participants shared a meal together. Cultural and religious similarities between the two nationalities as well as community ties assisted in the creation of a positive group dynamic and a culturally safe environment and helped establish rapport between participants and the research team (Halcomb et al. 2007, Wilson and Neville 2009, Mengisteab 2010, Vara and Patel 2011).

Open-ended questions were utilised to create dialogue and to generate a diversity of information (Ruppenthal et al. 2005, Hinton and Earnest 2009). While research participants were able to speak and understand English, two female, trained interpreters, fluent in Arabic (for communication with Sudanese participants) and Tigrinya (for communication with Eritrean participants) were made available to participants in the older women's FGD (Henderson and Kendall 2011). The role of the interpreters was to provide translation and understanding of words/concepts support only. Availability of interpreters helped to minimise language barriers by ensuring that participants had a thorough understanding of the process and provided cultural interpretation where needed (Henderson and Kendall 2011, Pittaway, Vara and Patel 2011). Several of the participants asked interpreters to clarify certain words or to gain a greater understanding of a question. The Arabic interpreter works in the field of SRH and the Tigrinya interpreter (of Eritrean decent) was a generalist interpreter. Confidentiality of the research in relation to the participant and interpreter dynamic was discussed with the group (Vara and Patel 2011). Interpreters were not required for the younger women's FGD as the young women were fluent in English.

In-depth interviews with two female key informants from within the migrant and health sectors highlighted issues relating to the specific SRH and SRE needs of people from minority ethnic communities (Jirojwong and Liamputtong 2009). Both key informants had worked in fields related to SRH and SRE for over 15 years with one working as a multicultural women's health worker and the other as an advanced practice nurse. Key informants were asked open-ended questions in relation to their experiences

of SRE and SRH with people from minority ethnic communities. The information from the in-depth interviews was used to cross check data collected from FGDs (Strohschein, Merry, Thomas and Gagnon 2010, Thomas et al. 2010).

Quality criteria during the research process included the establishment of an audit trail to ensure that information relating to the study, research methods and data analysis were documented to allow for research replication (Rodgers and Cowles 1993, Sharts-Hopko 2002, Hinton and Earnest 2010). Member checking, through the of sharing information gathered from transcriptions with participants, key informants, interpreters and amongst the authors was undertaken to ensure data accuracy, along with a concurrent review of relevant and recent literature (Sharts-Hopko 2002).

Ethics approval was obtained from Curtin University and the SRH Organisation involved with the study. The Australian National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research was also utilised as a standard of practice framework (National Health and Medical Research Council [NHMRC] 2007). All research participants were voluntarily recruited and, to ensure anonymity, pseudonyms have been used (NHMRC 2007). As well as access to interpreters on the day, information about the research was provided to potential participants to ensure adequate comprehension of research aims and objectives. This information was reiterated to participants on the day of their FGD before informed consent was obtained. Participants were informed of their right to withdraw from the research process at any time and to ensure confidentiality, all research data is password protected and stored securely with access only to the authors (NHMRC 2007).

After completion of FGDs and in-depth interviews, audio-recordings of the sessions were transcribed verbatim for analysis and erased (Hinton and Earnest 2010). The transcripts were read and re-read by the principal researcher and by a multicultural health care professional who was able to give the principal researcher feedback on cultural nuances. This ensured that cultural understanding of data was accurately interpreted and ensured the integrity of data (Jirojwong and Liamputtong 2009, Hinton and Earnest 2010). A thematic analysis underpinned by the Psychosocial Framework was then undertaken to collate the transcriptions into specific themes (Braun and Clarke 2006). Ongoing member checks with participants were undertaken to enhance trustworthiness (the process of exploring alternative explanations) and ensured data collected was interpreted accurately (Strohschein et al. 2010, Hinton and Earnest 2010). While we were careful to retain the integrity of participants' voices, minor grammatical edits were made to quotes with the consent of research participants (Hebbani, Obijiofor and Bristed, 2009).

Results

SRE and SRH in Minority Ethnic Communities: Educators and health care providers

Health literacy and cultural competency were highlighted as a key factors in effective SRE, the dissemination of SRH knowledge and increasing utilisation of health care services for people minority ethnic communities.

> Culture competency of service providers and educators is an essential component for culturally sensitive SRE and SRH knowledge to be shared.

> Health care information accessible for people from non-English speaking backgrounds with varying degrees of literacy is fundamental in increasing SRH knowledge within minority ethnic communities. (Multicultural Women's Health Worker)

Addressing barriers to the attainment of SRE and SRH such as gender, culture, financial and language were also key issues discussed in both the groups and in-depth interviews.

> Speaking the language, knowing the culture and also being of the same gender as the group or individual you are speaking with helps create an environment where people feel comfortable talking about sensitive issues. (Multicultural Women's Health Worker)

Participants in the younger women's group reported on confidentiality and trust issues young people experienced when attending health clinics and how these concerns inhibit young people from accessing contraceptive and reproductive health services. Participants in both FGDs highlighted the importance of creating a safe environment where people feel comfortable to access services and discuss health concerns with a trusted health care professional. Being able to communicate openly to health care providers was noted by research participants as an important factor in the provision of effective and culturally sensitive SRE and SRH.

Whole community engagement, as a successful SRE strategy, was also noted as a key component in increasing knowledge and access to services for people within minority ethnic communities. It was suggested that establishing trust within the community can assist health care providers and educators to more effectively meet and understand people's SRH needs. The importance of effective and culturally sensitive SRE was highlighted in the in-depth interviews.

> Good quality and culturally appropriate SRE is important in order to interact with, teach and support children from culturally and linguistically diverse communities. Effective, comprehensive and culturally sensitive SRE must also involve communication with parents from minority ethnic communities to let them know that we're not coming from a place that's going to interfere with their cultural beliefs or indeed perhaps damage any of their cultural beliefs. In fact we would like to hear how we could support them and even include them in some of the SRE classes if it was deemed appropriate to do so. (Advanced Practice Nurse)

Members of the younger women's group also expressed the need for increased parental understanding, along with community of support of SRE and SRH issues, in order for young people to receive the education they require to make informed decisions about their sexual health.

SRE and SRH in Minority Ethnic Communities: Sociocultural issues

Sexual and reproductive health is considered a taboo or difficult to talk about topic in both Sudanese and Eritrean cultures, and this was a predominant and recurring theme throughout both FGDs and in-depth interviews. Participants in both FGDs commented

frequently on the sociocultural issues impacting SRE and SRH and how these cultural norms directly inhibit access to and utilisation of SRH services, and education. Members of both groups discussed how sociocultural pressures and traditions impact the facilitation of SRE discussions within the family environment.

> It's a taboo thing, but what do we get from that not discussing, not knowing? Discussion is very important for our community and for the health of our children. (Makda, older women's FGD)

Several group participants spoke about their experiences going through puberty and how discussion within the family relating to puberty and reproductive health is difficult or in some cases non-existent. Cultural issues were highlighted as barriers to discussion in the family environment, however, in both FGDs, participants expressed their desire for a shift in these sociocultural attitudes. The younger women expressed how their attitudes towards SRE and SRH differed greatly from that of the 'older' people within their community.

Interestingly, Lily, a participant in the younger women's group, stated that 'I'm lucky, I can talk to my mother about anything, but that's not normal in our community'. A participant from the older women's group also indicated that, while a part of the 'older generation' her attitudes regarding SRE and SRH did not align with perceived 'social norms' towards SRE and SRH.

> I think in the past we were not talking about reproductive health because people were ignorant. They thought speaking about reproductive health or sexual health was bad manners but today I think we are free to speak to our General Practitioner and also I think we can speak to the children. (Simo, older women's FGD)

Participants in both FGDs commented on male and female relationship dynamics (e.g. over the use of contraceptives, ability to negotiate safe sex, risky behaviour) in relation to SRE and SRH and the challenges these present in acquiring health knowledge and accessing healthcare for both parents and young people.

> There should be health education not only for women, but men and women. Separate groups are needed to be held; otherwise they will be too shy to talk. (Simo, older women's FGD)

Parental influence resulting in the exclusion of children from SRE in schools due to cultural issues was noted as a key factor inhibiting SRE and SRH knowledge.

> A lot of refugee and migrant parents will choose not to let their children participate in school SRE so these children are excluded from learning with their peers. They don't get to learn about protective behaviours, relationships, their bodies or the changes they will experience during puberty. This sets some of those children off on a back foot when it comes to their future healthcare needs and knowing how to access contraception and services for their sexual and reproductive health.

(Advanced Practice Nurse)

SRE and SRH in Minority Ethnic Communities: Communication within families

The older women's group specifically mentioned the lack of communication within the family about sexual health or practicing safe sex. It was considered culturally inappropriate for children and parents to discuss puberty, sexual activity, contraception, reproduction and sexual health issues. Members of this group spoke of cultural and religious expectations of sexual abstinence before marriage and fear of judgment from parents as inhibiting factors to communication. They shared what was considered appropriate ways for young women to conduct themselves around males (through limited contact/socialisation) and expressed these social constructs as being the culturally appropriate way for women to behave. Participants also commented on the lack of awareness parents have about the sexual activity of their children.

> The problem in our culture is the parents are not really talking to their kids about these things (sexual health). (Sara, young women's FGD)

Parental influence on beliefs young people have regarding SRH, and the choices they make relating to contraception use and safe sex practices, was a key theme in both FGDs. It was also noted that often children will miss out on SRE in school due to cultural beliefs or, if they do attend, they often find the clash of culture perplexing.

> There's always that confusion, which side to take. The school side (SRE) or what the parents are saying or what the parents are not saying. It confuses a lot of young people and when the young person is confused they're just going to do whatever they want. (Lilly, young women's FGD)

The younger women stated that lack of SRE and SRH education for young people within their community resulted in many of their peers being ill-equipped to deal with the realities of being sexually active, such as the risks of STIs and unintended pregnancies. Participants stated that this lack of education compounds the pressure that young people in their community feel regarding being sexually active. Suzy stated that many young people in their community viewed sexual activity as 'a status thing.'

> For the young people nowadays it's cool to be sexually active, if you're not there's something wrong with you… It's like in almost half the families in the community there is a pregnant girl … And these are really, really young teenagers (Lilly, young women's FGD)

> They (the parents of the pregnant girl) never try to sit down and talk to them about it. They don't talk about how the girl can prevent getting pregnant again or how the other girls in the family can avoid getting pregnant. (Suzy, young women's FGD)

Participants in the young women's group disclosed that within their community, it is quite common for unmarried teenage girls to fall pregnant, with participants stating that several adolescent girls within their community have become pregnant, some at

even 14 years of age. The young women shared that adolescent pregnancies occurred through consensual sexual activity between two peers possibly of similar age. They commented that young girls find it difficult to say no to their boyfriends due to power imbalances between boys and girls. They discussed how parents of the pregnant teenagers' struggled to communicate with their children on sexual health and contraception and are often shocked to learn that their teenager is sexually active.

A key informant from a Multicultural Women's Health Project, during an in-depth interview, indicated that while pre-marital sex is not culturally acceptable, in the case of adolescent pregnancy, the families played a critical role in providing support for the young couple. The key informant also indicated that some young women who become pregnant out of marriage may seek to terminate the pregnancy due to the shame and social stigma associated with being a young, single mother. However, due to under-reporting and limited research on the issue, it is difficult to determine the frequency with which this occurs (Allimant and Ostapiej-Piatkowski 2011).

Throughout the in-depth interviews and FGDs, participants reiterated the lack of communication between parents and their children about sexual health, sexuality, reproduction and relationships education issues. This lack of communication was a key barrier to the access of SRE and SRH services, inhibiting young people within the community from making informed and responsible decisions regarding their SRH and sexual activity.

Discussion

Research participants shared their views concerning a myriad of social, cultural, religious and economic influences impacting upon the use of contraception and reproductive health services, inhibiting discussion of SRH within the home environment and barriers to young people from minority ethnic communities inclusion in SRE in schools. These contributing factors also play an inhibiting role in knowledge and understanding of safe sex, protective behaviours and SRH rights (Allimant and Ostapiej-Piatkowski 2011).

Research participants in the young women's group stated that unintended pregnancy is common among young people within their community, with some adolescents as young as 14 years of age becoming pregnant. In Queensland, the legal age for sex is 16 years (Australian Institute of Family Studies [AIFS] 2013). Age of consent laws have been established in Australia to protect children and young people from sexual exploitation and abuse, however, without education regarding these issues, parents and young people from refugee and migrant backgrounds may be unaware of these laws (AIFS 2013). While the group did not discuss issues of age and power dynamics of adolescent couples in the examples shared, it raises issues of consent, particularly in the case of minors (AIFS 2013). Lack of support networks, socioeconomic disadvantage, cultural and community pressures, and lack of knowledge regarding the law and sexual and reproductive health rights, can lead to an increased risk of sexual and physical violence towards migrant and former refugee women, adolescents and children (Allimant and Ostapiej-Piatkowski 2011, Kaur 2012).

Study findings highlight that both male and female educators and community health care providers who possess an understanding of social and cultural issues impacting communities, can effectively and sensitively communicate issues relating to SRH and address the SRE needs of community members. Research by McMichael and

Gifford (2009, 2010) also highlights that a lack of SRE can inhibit knowledge regarding sexuality and relationships as well as sexual health, safe sex practices, protective behaviours and issues of consensual consent.

Participants' views and opinions on the importance of SRE and SRH knowledge within the home and school environment reinforced the desire for parents, children and young people from refugee and migrant backgrounds to be supported in the attainment of their sexual and reproductive health rights. In 2011, research commissioned by Family Planning Queensland showed that 90% of participants felt that receiving information about SRE would encourage them to discuss the topic with their school-age children and expressed the need for teachers and parents to work together to provide comprehensive SRE to their school-aged children (Footprints 2011).

Recent global recommendations proposed by the High-Level Task Force for ICDP unanimously supported the concept that sexual and reproductive health and rights are a matter of equity, equality and social justice and are fundamental rights and freedoms that should be experienced by all people (ICPD 2013). Actively engaging parents, communities, traditional and religious leaders as well as children and adolescents in the process of design, implementation and evaluation of SRE programmes was also a key recommendation to provide young people with the skills and support needed to exercise their sexual and reproductive health rights (ICPD 2013).

Similar to findings reported in McMichael and Gifford's 2009 study, members of the older women's group FGD spoke of their experiences in their country of origin, marrying at a young age and having children soon after and how that was considered a social and culturally acceptable path for a young women. They shared their experience of having no SRE or SRH knowledge before, or even after, marriage. Participants expressed that the sociocultural attitudes in Australia towards SRH was very different from their home country. While the research participants in this study highlighted the need for a change in attitude regarding SRE within their community, members from both groups indicated that there needed to be a shift from the traditional concept of not discussing sexual health within the family environment.

For people from refugee backgrounds, the process of displacement, resettlement and the reshaping of social and cultural practices to acclimate to new sociocultural and physical environments, can alter expectations of success and aspirations for their new lives (McMichael and Gifford's 2009; Joyce et al. 2010; McMichael 2012). Members of the 18-35 years group expressed their desire to finish university and get a good job before finding a husband and having children. While these participants have come from countries where adolescent marriage and parenthood is common and culturally accepted, they are redefining traditional familial and societal expectation placed on sexual activity and culturally appropriate reproductive age in the context of their new environment (McMichael and Gifford's 2009; Joyce et al. 2010; McMichael 2012).

There were a number of barriers to participant recruitment. Most significant was the reluctance of community members to discuss sensitive topics. Scheduling difficulties also compounded participant recruitment issues. While rich and diverse data was gathered, it must be noted that due to the short time frame for completion of the research; the exploratory nature of the study; and small numbers of participants, the results although applicable to most minority ethnic communities cannot be generalised.

While the use of FGDs for this study was an effective means to gather data on sensitive topics within a supportive environment, the limitations of this methodology must be acknowledged (Halcomb et al. 2007). Although the research team strived to create an environment where all participants felt culturally safe, the discussion of sensitive topics within the group may possibly have inhibited some of the participants from sharing their opinions and experiences (Halcomb et al. 2007, Wilson and Neville 2009). The use of interpreters to help support members of the older women's FGD may have impacted on responses and it is possible some bias may still have occurred (Vara and Patel 2011).

Some recommendations are proposed by study participants on how SRE and SRH interventions could better address the health needs of people from minority ethnic communities. These are: to establish links between minority ethnic communities, schools and sexuality and relationships educators; to provide culturally appropriate strategies for minority ethnic parents to communicate with their children about relationships, sexuality and SRH; to engage men in SRH; and to establish links between minority ethnic communities, health care professionals and health services.

Conclusion

This study revealed some of the complexities faced by women from minority ethnic communities as they access SRE and SRH health services and knowledge. The results highlight the need for further examination of the SRH challenges faced by refugee and migrant men, women, adolescents and children and for SRE and SRH services to be supportive, non-discriminatory, respectful of diversity, culturally appropriate and understanding of the specific health care needs of minority ethnic communities. The challenges identified in this pilot study highlight the need for more research into the SRH and SRE needs of people from minority ethnic communities.

Government, policy makers, health practitioners and educators need to identify and respond to key factors in refugee and migrant women's experiences of sexual and reproductive health in order for them to obtain equitable, effective and holistic reproductive and sexual health. Many of the social factors affecting women's health also affect the entire community and health programming, as proposed in the recommendations, needs to incorporate interventions that involve families and include educational, economic and culturally appropriate components. It is our hope this exploratory study will add to the growing body of research in understanding the complex issue of SRH and SRE and the findings reiterate the need for more research into the health care needs of people from minority ethnic communities.

Acknowledgement

We are sincerely grateful to the women who so generously gave us their time and allowed us to learn so much from them. We wish to thank Odette Tewfik and Family Planning Queensland who facilitated this research; the Centre for International Health, Curtin University; and the anonymous reviewers who provided feedback on this article.

References

Ali, M., A. Seuc, A. Rahimi, M. Festina & M. Temmermana. 2014. "A global research agenda for family planning: Results of an exercise for setting research priorities." *Bulletin World Health Organization* 92: 93–98. http://dx.doi.org/10.2471/BLT.13.122242

Allimant, A. & B. Ostapiej-Piatkowski. 2011. *Supporting women from CALD backgrounds who are victims/survivors of sexual violence: Challenges and opportunities for practitioners.* Melbourne: Australian Institute of Family Studies.

Australian Bureau of Statistics (ABS). 2011. *Migration, Australia, 2009-10.* Canberra.

Australian Bureau of Statistics (ABS). 2013. "3412.0 - Migration, Australia, 2011-12 and 2012-13." http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/1446A29E1BD5D333CA257C44001900AA/$File/34120_2011-12%20and%202012-13.pdf

Australian Government. 2013. *Asylum Trends – Australia: 2012-13 Annual Publication.* Canberra: Protection Moring and Analysis Section of the Department of Immigration and Border Protection.

Benson, J. & M. Smith 2007. Early health assessment of refugees. *Australian Family Physician* 36 (1-2): 41-43. http://www.racgp.org.au/afpbackissues/2007/200701/20070129benson.pdf

Braun, V. & V. Clarke. 2006. "Using thematic analysis in psychology." *Qualitative Research in Psychology* 3 (2): 77-101. doi:10.1191/1478088706qp063oa

Brennan H & J. Graham. 2012. *Is this normal?* Queensland: Family Planning Queensland.

Burns, R. 2000. *Introduction to research methods* 4th ed. Sydney: Longman.

Carroll, J., R. Epstein, K. Fiscella, E. Volpe, K. Diaz & S. Omar. 2007. "Knowledge and beliefs about health promotion and preventive health care among Somali women in the United States." *Health Care for Women International* 28 (4): 360-380. doi:10.1080/07399330601179935

Department of Immigration and Citizenship (DIAC), 2008. *Population flows: Immigration aspects, 2006–2007.* Canberra: Department of Immigration and Citizenship.

Emmerson, L. 2010. *Does sex and relationships education work? A sex education forum evidence briefing.* London: National Children's Bureau.

Finkelhor, D. 2007. "Prevention of sexual abuse through educational programs directed toward children." *Pediatrics* 120 (3): 640-645. doi: 10.1542/peds.2007-0754

Footprints Market Research. 2011. *Attitudes of parents and careers towards sexuality and relationships educations in schools.* Brisbane: Family Planning Queensland.

Halcomb, E.J., L. Gholizadeh, M. Digiacomo, J. Phillips & P.M. Davidson. 2007. "Literature Review: Considerations in undertaking focus group research with culturally and linguistically diverse groups." *Journal of Clinical Nursing* 16 (6): 1000-1011. doi:10.1111/j.1365-2702.2006.01760.x

Harte, W., I.R.W. Childs & P.A. Hastings. 2011. "African refugee communities in southeast Queensland: Forces of concentration and dispersion." *Australian Geographer* 42 (3): 325-342. doi:10.1080/00049182.2011.595769

Hebbani, A., L. Obijiofor & H. Bristed. 2009. “Generational differences faced by Sudanese refugee women settling in Australia.” *Intercultural Communication Studies* 18 (1): 66-82. http://www.uri.edu/iaics/content/2009v18n1/05%20Aparna%20Hebbani,%20Levi%20Obijiofor,%20&%20Helen%20Bristed.pdf

Hebbani, A., L. Obijiofor & H. Bristed. 2010. “Intercultural communication challenges confronting female Sudanese former refugees in Australia.” *Australasian Review of African Studies* 31 (1): 37-61. http://afsaap.org.au/assets/ARAS_Vol_XXXI_1_Hebbani_Obijiofor_Bristed.pdf

Henderson, S. & E. Kendall. 2011. “Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: Exploring the need for improvement in health service delivery.” *Australian Journal of Primary Health* 17 (2): 195-201. doi: 10.1071/PY10065.

Henderson, S., E. Kendall & L. See. 2011. “The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: A systematic literature review.” *Health and Social Care in the Community* 19 (3): 225-249. doi: 10.1111/j.1365-2524.2010.00972.x

High-Level Task Force for the International Conference on Population and Development (ICDP) 2013. *Policy recommendations for the ICPD beyond 2014: Sexual and reproductive health and rights for all.* New York: High-Level Task Force for ICPD.

Hinton, R.L. & J. Earnest. 2009. “Beyond risk factors to lived experiences: Young women's experiences of health in Papua New Guinea.” *Rural and Remote Health* 9 (4): 1257-1257. http://www.rrh.org.au/publishedarticles/article_print_1257.pdf

Hinton, R. & J. Earnest. 2010. “Stressors, coping, and social support among women in Papua New Guinea.” *Qualitative Health Research.* 20 (2): 224. doi:10.1177/1049732309357572

Jirojwong, S. & P. Liamputtong. 2009. *Population health, communities and health promotion* Melbourne: Oxford University Press.

Joyce, A., J. Earnest, G. De Mori, & G. Silvagni. 2010. “The experiences of students from refugee backgrounds at universities in Australia: Reflections on the social, emotional and practical challenges.” *Journal of Refugee Studies* 23 (1): 82-97. doi: 10.1093/jrs/feq001

Kaur, J., 2012. *Cultural diversity and child protection: A review of the Australian research on the needs of culturally and linguistically diverse (CALD) and refugee children and families.* Queensland: JK Diversity Consultants.

Kelaher, M., G. Williams & L. Manderson. 1999. “Towards evidence-based health promotion and service provision for new migrants to Australia.” *Ethnicity and Health* 4 (4): 305-305. doi: 10.1071/PY10065.

Mengisteab, K. 2010. *Diversity management in Africa: Findings from the African peer review mechanism and a framework for analysis and policy making.* Geneva: United Nations, Economic Commission for Africa Governance and Public Administration Division.

McMichael, C. 2012. “Unplanned but not unwanted? Teen pregnancy and parenthood among young people with refugee backgrounds.” *Journal of Youth Studies* 16 (5): 663-678. doi:10.1080/13676261.2012.744813

McMichael, C. & S. Gifford. 2009. 'It is good to know now...Before it's too late': Promoting sexual health literacy amongst resettled young people with refugee backgrounds." *Sexuality & Culture* 13 (4): 218-236. doi: 10.1007/s12119-009-9055-0

McMichael, C. & Gifford, S., 2010. "Narratives of sexual health risk and protection amongst young people from refugee backgrounds in Melbourne, Australia." *Culture, Health & Sexuality* 12 (3), 263-277. doi: 10.1080/13691050903359265

Murray, L., C. Windsor, E. Parker & O. Tewfik. 2010. "The experiences of African women giving birth in Brisbane, Australia." *Health Care for Women International* 31 (5): 458-472. doi: 10.1080/07399330903548928.

National Health and Medical Research Council (NHMRC), 2007. *National statement on ethical conduct in human research.* Canberra: Australian Government.

Newbold, K.B. & J. Willinsky. 2009. "Providing family planning and reproductive healthcare to Canadian immigrants: Perceptions of healthcare providers." *Culture, Health & Sexuality* 11 (4): 369-382. doi: 10.1080/13691050802710642

Pittaway, E., L. Bartolomei & R. Hugman. 2010. "'Stop stealing our stories': The ethics of research with vulnerable groups." *Journal of Human Rights Practice* 2 (2): 229-251. doi: 10.1093/jhuman/huq004

Psychosocial Work Group (PWG), 2003. *Psychosocial interventions in complex emergencies: A conceptual framework.* Edinburgh: Psychosocial Working Group.

Queensland Government 2008. *New futures: The Queensland Government's engagement with African refugees*. Brisbane, QLD: Queensland Government Department of Communities.

Refugee Council of Australia 2014. "Statistics on Australia's Current Refugee and Humanitarian Program" http://www.refugeecouncil.org.au/r/stat-rhp.php

Rodgers, B.L. & K.V. Cowles. 1993. "The qualitative research audit trail: A complex collection of documentation." *Research in Nursing and Health* 16 (3): 219-226 Available from:

Ruppenthal, L., J. Tuck & A.J. Gagnon. 2005. "Enhancing research with migrant women through focus groups." *Western Journal of Nursing Research* 27 (6): 735-754. doi: 10.1177/0193945905277157

Sharts-Hopko, N.C., 2002. "Assessing rigor in qualitative research." *The Journal of the Association of Nurses in AIDS Care* 13 (4): 84-86. doi: 10.1016/S1055-3290(06)60374-9

Sheikh-Mohammed, M., C.R. Macintyre, N.J. Wood, J. Leask & D. Isaacs. 2006. "Barriers to access to health care for newly resettled Sub-Saharan refugees in Australia." *The Medical Journal of Australia* 185 (11/12), 594-7. https://www.mja.com.au/journal/2006/185/11/barriers-access-health-care-newly-resettled-sub-saharan-refugees-australia

Strohschein, F.J., L. Merry, J. Thomas & A.J. Gagnon. 2010. "Strengthening data quality in studies of migrants not fluent in host languages: A Canadian example with reproductive health questionnaires." *Research in Nursing and Health* 33 (4): 369 - 79. doi: 10.1002/nur.20390.

Thomas, P.E., M. Beckmann & K. Gibbons. 2010. "The effect of cultural and linguistic diversity on pregnancy outcome." *The Australian & New Zealand Journal of Obstetrics and Gynaecology* 50 (5): 419-422. doi: 10.1111/j.1479-828X.2010.01210.x

United Nations (UN) 2014. *Sexual health and reproductive rights: Articles 21, 22 (1), 23 and 24 of the United Nations declaration on the rights of indigenous peoples. Department of Economic and Social Affairs*. New York: United Nations.

United Nations Population Fund (UNFPA) 2011. *Making reproductive health rights and sexual and reproductive health a reality for all.* New York: United Nations Population Fund.

Vara, R. & N. Patel. 2011. "Working with interpreters in qualitative psychological research: Methodological and ethical issues." *Qualitative Research in Psychology* 9 (1): 75-87. doi: 10.1080/14780887.2012.630830

Wilson, D. & S. Neville. 2009. "Culturally safe research with vulnerable populations." *Contemporary Nurse: a Journal for the Australian Nursing Profession* 33 (1): 69-79. doi: 10.5172/conu.33.1.69

World Health Organization (WHO) 2011. "Fact sheet no 351: Family planning." World Health Organization. http://www.who.int/mediacentre/factsheets/fs351/en/index.html

Walsh, K. & L. Brandon. 2012. "Their children's first educators: Parents' views about child sexual abuse prevention education." *Journal of Child and Family Studies* 21 (5): 734-746. doi: 10.1007/s10826-011-9526-4