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PROMOTING SEXUAL HEALTH AMONGST RESETTLED YOUTH WITH REFUGEE BACKGROUNDS

A study of how resettled youth
with refugee backgrounds access,
interpret and implement sexual
health information



Foundation House
The Victorian Foundation for Survivors of Torture



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ISBN Number: 978 1 921377 49 5

Published by the Refugee Health Research Centre, La Trobe University
Melbourne, Australia

Recommended citation: McMichael, C. (2008) *Promoting sexual health amongst resettled youth with refugee backgrounds*.
Melbourne: Refugee Health Research Centre

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A study of how resettled youth with refugee backgrounds
access, interpret and implement sexual health information

Celia McMichael

2008

A study conducted by the Refugee Health Research Centre at La Trobe University, the Centre for Multicultural Youth, the Australian Research Centre in Sex, Health and Society, and Footscray Youth Housing Group. Funded by the Department of Human Services, Victoria.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AMES	Adult Multicultural Education Services
BBVS	Blood-borne viruses
CALD	Culturally and Linguistically Diverse
CMY	Centre for Multicultural Youth
DHS	Department of Human Services
DIAC	Department of Immigration and Citizenship
EHA1	Early Health Assessment and Intervention
ELC	English Language Centre
ELS	English Language School
IAWG	Inter-Agency Working Group on Refugee Reproductive Health
FARREP	Family and Reproductive Rights Education Program
FGM	Female genital mutilation
FH	Foundation House
FYHG	Footscray Youth Housing Group
HIV	Human Immunodeficiency Virus
IHSS	Integrated Humanitarian Settlement Scheme
LGA	Local Government Area
MHSS	Multicultural Health and Support Service
MISP	Minimum Initial Service Package
PPV	Permanent Protection Visa
RHNP	Refugee Health Nurse Program
RHRC	Refugee Health Research Centre
SRH	Sexual and Reproductive Health
STIS	Sexually Transmissible Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
TPV	Temporary Protection Visa
UNHCR	United Nations High Commissioner for Refugee
UNFPA	United Nations Population Fund
VELS	Victorian Essential Learning Standards
VFST	Victorian Foundation for Survivors of Torture and Trauma
WHO	World Health Organization

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ACKNOWLEDGEMENTS

Thank you to all the participants in focus group discussions and interviews for providing your time and generously sharing your experiences, views and knowledge.

We appreciate the contribution of those people who assisted with organising group discussions and interviews. In particular we thank: Meseret Abebe, Rocío Amézquita-Cortés, David Thang, and Siobhan Kavanagh.

Thank you to the case workers and service and health professionals who participated in interviews and provided their insight.

We would like to acknowledge the efforts of the research assistants and focus group facilitators: Athalia Zwartz, Ben Murphy, Faten Mohamed from the Centre for Multicultural Youth; Meseret Abebe from Footscray Youth Housing; and Mark Sturges from La Trobe University.

We would also like to acknowledge the important contribution of the Advisory Committee for their input and advice and to Sue Casey, Ida Kaplan and Chris Pierson at Foundation House for their feedback. Thanks to the Chief Investigators who provided guidance in the development of research themes, data collection process and analysis.

Funds for the project were provided by the Victorian Department of Human Services (Public Health Research Grants) and administered by the Refugee Health Research Centre, La Trobe University/Foundation House. Thanks to Bronwyn Kaaden and Sally Richardson from the Victorian Department of Human Services for their support.

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EXECUTIVE SUMMARY

This study focused on how resettled youth¹ with refugee backgrounds access, interpret and implement sexual health information. It had five primary aims:

1. To identify how youth find out about sexual health and illness.
2. To identify how youth understand and interpret the information they receive around sexual health risk and protection.
3. To describe how youth use sexual health information.
4. To examine the enablers and barriers to the implementation of sexual health information.
5. To develop recommendations for strategies to promote sexual health literacy and sexual health amongst young people with refugee backgrounds.

Qualitative data was collected through 23 focus group discussions and 14 in-depth interviews involving a total of 142 participants. All participants had refugee backgrounds and were aged between 16-25 years. Participants were purposively selected to reflect the ethnic composition of the humanitarian entrants to Victoria over the past 3 years. Their countries of origin include Iraq, Afghanistan, Burma, Sudan, Liberia, and Horn of Africa countries. The participants had been living in Australia for between 1 to 5 years. The majority had sufficient skills to participate in group discussions and interviews in English. Interpreters were used in two group discussions with newly-arrived Burmese young people. The sample included young people from diverse situations, including those who were homeless, living with family, living independently, attending school, and not attending school.

15 in-depth interviews were also conducted with health professionals and case workers who are involved in refugee specific programs or who engage regularly with communities from refugee backgrounds.

The findings of this study highlight young people's knowledge and attitudes in relation to sexual health issues, with a particular focus on HIV/AIDS, STIs, contraception, unplanned pregnancy, initiation of sexual relationships, sources of information, and use of health services. The group discussions did not seek to identify personal experiences in relation to sexual activity, but to discuss expectations and attitudes associated with relationships and sexual activity. The in-depth interviews with young people provide richer data around experiences of sexual health issues.

The study identifies issues that are specific to young people with refugee backgrounds, due to their experiences of forced migration and displacement and to the challenges of the post-migration context in Australia. It also indicates that a range of other factors, including gender, socio-cultural frameworks and socio-economic status, influence the ways in which newly arrived young people learn about sex, their experience of relationships and sexual activity, and their attitudes towards risk and protective behaviours.

THE REFUGEE EXPERIENCE: IMPACT ON SEXUAL HEALTH

Sexual and reproductive health encompasses the prevention, diagnosis and management of STIs, HIV and BBVs, contraception, unintended pregnancy, infertility, cancer resulting from STIs, sexual dysfunction, the ability to develop and maintain meaningful and respectful interpersonal relationships and appreciate one's own body, and the capability to reproduce and the freedom to decide if, when and how often to do so (SIECUS 2002). Sexual and reproductive health is a human

¹ Although we use the term resettlement, for many refugee youth the term settlement more accurately describes their experiences. Many young people have grown up in contexts where they have never experienced being settled, and for many the task of settlement is a new one.

right that is recognised by a body of national laws, and international treaties and agreements (United Nations - ICPD 1994; Janssens, Bosmans et al. 2005). However, refugees experience a range of vulnerabilities to their sexual and reproductive health (Janssens, Bosmans et al. 2005).

Sexual and reproductive health are issues of concern to young people with refugee backgrounds in the same ways that these are concerns for all young people, particularly those from culturally and linguistically diverse backgrounds. Yet their needs are often overlooked by youth and settlement services and programmes. While young people with refugee backgrounds do not necessarily identify as refugees, many face specific concerns and needs due to the pre-migration refugee experience and to the resettlement context in Australia.

Pre-migration Experience

- Young people with refugee backgrounds have often had disrupted education (McBrien 2005; Bond, Giddens et al. 2007; Victorian Foundation for Survivors of Torture 2007) and limited opportunities to receive sexual health information in educational or institutional contexts. Accordingly, many young people are inadequately informed about key sexual and reproductive health issues, including modes of transmission, symptoms, and prevention of STIs. They may have poor understanding of the importance of preventive health behaviours, such as STI screening.
- Strong association between HIV/AIDS and death due to higher mortality rates for HIV/AIDS affected people in countries/regions of origin.
- View that HIV/AIDS is of less serious concern in Australia than in countries of origin, and lack of awareness of presence and risk of HIV/AIDS and other STIs in Australia.
- Awareness of HIV/AIDS is increased through the visa medical examination process, but this also engenders an association between HIV/AIDS, shame, and not being welcome in Australia. Many young people believe that no HIV-positive Humanitarian applicants are allowed to migrate to Australia, and it is therefore unlikely that HIV/AIDS exists in refugee communities.
- Young people may have little experience or confidence in accessing health care services. Health care facilities in refugee camps may have been inadequate or non-existent, and access to health care services in countries of origin or first countries of settlement may have been inaccessible or unavailable.
- Young people may have experienced gender and sexual based violence, such as physical assault, sexual harassment, or rape.
- Young people come from social and cultural backgrounds that may have different explanatory models of health and illness, including in relation to sex and sexual health.

Post-migration Experience

- There is a focus on meeting practical and social settlement needs - such as education, acquiring employment, obtaining language skills, and finding adequate housing. Young people may also be expected to take on additional responsibilities such as caring for younger siblings, or interpreting for older family members. This can compromise overall health, including sexual and reproductive health, because young people with refugee backgrounds are less likely to seek information or utilise preventive health services when they feel constrained by pressing settlement needs.
- The refugee experience results in fragmented family networks through loss and separation of close family members. Changes in family and community relationships resulting from refugee and settlement experiences can adversely affect the availability, nature and quality

of support and advice available to young people. These issues are particularly marked for unaccompanied minors.

- Issues of shame around STIs and unplanned pregnancy can become magnified within small newly-emerging communities. Family values are often intensified in the settlement context, with some parents fearing the adverse influence of Australian culture and loss of cultural values. In particular, there is an expectation placed on young people of behaving responsibly and of building a good future in Australia not only for themselves, but also for their families. It can be difficult for young people and their parents to deal with changing values and practices related to sex and sexuality.
- Many young people highlight the importance of family and social networks while they settle into life in Australia. It can take some time to establish wider social and support networks. Where sexual health problems result in a deterioration of family and immediate social networks (eg young women who experience unplanned pregnancy and are forced out of home), the loss of social support and networks is particularly difficult.
- Young people who do not attend school following their arrival in Australia have little opportunity to participate in sexual health education programs.
- Youth with refugee backgrounds who are homeless or at risk-of homelessness experience particular risks to their sexual health. They are at increased risk of coercive sex, are inconsistent users of contraception, are less likely to be exposed to school-based sexuality education, face difficulties in accessing health care services, and prioritise the need to find secure housing above most other issues including their health.
- Many young people have settled with their families in areas with poor infrastructure, including public transport and youth-oriented services. The lack of access to and control over social, material and economic resources may disadvantage young people in accessing sexual health information and resources.
- Experiences of discrimination and feelings of social exclusion act as barriers to young people's confidence in accessing sexual and reproductive health information and care.

These specific issues present challenges and opportunities for education, prevention, and management of sexual health issues amongst young people with refugee backgrounds. Despite these challenges, young people with refugee background are often resilient and show tremendous capacity to learn and engage with new situations and environments. Multifaceted and flexible approaches are required to improve the sexual health and sexual health literacy of young people with refugee backgrounds.

KNOWLEDGE AND ATTITUDES

The level of understanding of sexual health issues amongst resettled youth with refugee backgrounds is generally low. There is a lack of knowledge about the most common infections, such as chlamydia, herpes simplex virus, and gonorrhoea. The majority of participants indicated they had not heard of sexually transmitted infections other than HIV/AIDS; a few were able to name one or two STIs; others were aware of the existence of infections and '*bad sicknesses*' but could not name them or describe their symptoms.

Most participants were aware of HIV/AIDS, although a few had not heard of it. HIV/AIDS was often the first sexual health issue mentioned, and for a large number of respondents it was the only STI they could name. In part this is due to the visibility of HIV/AIDS education and awareness campaigns in refugee camps and to mandatory HIV screening prior to settlement in Australia. There is a perception that HIV is not a significant risk in Australia. This sense of reduced risk is due to HIV

screening during the visa medical examination for humanitarian entrants, fewer visible public health campaigns in Australia, and awareness of the lower rates of HIV compared to countries of origin. However, HIV/AIDS is considered the most serious STI because it is incurable and fatal.

Young people have poor knowledge of modes of transmission, symptoms, and treatment options for STIs, including HIV/AIDS. There is a widespread assumption that people with STIs always display symptoms, and potential carriers of STIs can be identified by their reputation and behavioural or visual cues.

Participants commonly identified contraception as a way to prevent both STIs and unplanned pregnancy. Condoms were the most frequently mentioned contraceptive method, but several participants also referred to the 'rhythm method', pills and tablets, injections, the rod, gels, diaphragms, and the morning-after pill. Many young women emphasised the protective function that contraception offers against shame and stigma associated with STIs and unplanned pregnancy. Participants who appear to have the greatest awareness of contraception were those who had initiated sexual relationships and had gained experiential knowledge of contraceptive options.

Unplanned pregnancy is viewed as a risk associated with sex, and is a particular concern for young females. Male participants expressed concerns in terms of community responses and fear of fatherhood, but the risks and social consequences associated with unplanned pregnancy for males were not viewed as seriously. For young females across all ethnic groups, discourses of risk and protection in relation to unplanned pregnancy generally focus on impacts on social relationships: jeopardising one's reputation, limiting marriage prospects, bringing one's family into disrepute. Reducing the risk of unplanned pregnancy, either through abstinence or using contraception, is primarily a method for protecting social well-being. However, several women said they feared the response of family if their use of contraception was discovered. This constitutes a barrier to the practice of safe sex.

Many studies show low levels of awareness among young people about sexuality, reproduction, contraception, and sexually transmitted diseases (Oakely, Fullerton et al. 1995; Smith, Agius et al. 2002; Agius 2006). This study highlights the need to increase awareness of sexual health issues amongst young people with refugee backgrounds, including their knowledge of STIs and HIV/AIDS, fertility and menstrual cycles, contraceptive methods, and health care and screening services. Health professionals stressed the need for increasing the understanding that young people with refugee backgrounds have about 'their bodies and how they work', as well as improving awareness about the broader dimensions of sexual and reproductive health, such as strategies for negotiating safe sexual relationships. Health promotion strategies also need to engage with the wider social contexts of risk and protection. They should address assumptions about 'safe' and 'risky' partners, empower young people to negotiate safer sex, and directly address issues of shame and stigma associated with STIs and unplanned pregnancy.

LEARNING ABOUT SEX AND SEXUAL HEALTH

Many young people say that there are limited opportunities to learn about sexual and reproductive health prior to arrival in Australia. A few described participating in sexual health education in schools and refugee camps.

After arriving in Australia, opportunities for acquiring accurate information about sexual health remain limited. Participants indicated they were unlikely to actively seek information, due both

to limited opportunity and to the shame and embarrassment associated with sexual health issues. Poor English language skills contributed to the challenges for some newly-arrived youth to access information about STIs and other sexual health issues. However, there is keen interest amongst young people to learn more about sexual health.

Young people's sexual health literacy is affected by availability of information, preferred ways for obtaining information, accessibility of sources, perceived credibility and confidentiality of the source, and mode of delivery of sexual health information. Newly-arrived young people with refugee backgrounds may be exposed to information focusing on sexual health from a range of sources, but this information is not necessarily consistent and provides different messages. There is a disjuncture between the sources that are seen as accurate and those that are readily accessible.

- **GPs and other health professionals** are viewed as trustworthy and expert sources of advice with experience in sexual health issues, but are underutilised.
- **School-based sexuality education** is considered useful and valuable amongst those young people who have had the opportunity to participate. Some new arrivals with refugee backgrounds attend English language centres and schools (ELC/ELs) in the first twelve months following their arrival. Young people attending ELC/ELs that deliver sexuality education said that classes are informative and useful. Of the nine ELC/ELs located in the Melbourne metropolitan area, six currently provide some form of sexuality education.
- **Young people who are not in school** have little opportunity to learn about sexual health. A few indicated they had participated in educational sessions at AMES and in other tertiary education settings. However, these sessions are not consistently available or regularly attended.
- **Parents and elders** usually play a minor role in providing information about sexual health. Young people said it is difficult to talk openly with parents about sex and relationships, primarily due to cultural and religious expectations of abstinence from sex prior to marriage. Parents largely offered prohibitive messages and warnings, particularly to girls. However, young people, case workers and health professionals emphasised the importance of engaging with parents around the value of early sexual health education, and increasing their willingness to openly discuss sexual health before their children become sexually active.
- **Friends and peers** are potential sources of information, though not necessarily reliable. Relationships, rather than specific information around sexual health, are likely to be discussed with friends. Many participants emphasised the importance of only talking with friends who can be trusted and who will not spread private information to others.
- **Boyfriends/girlfriends:** young people do not talk with boyfriends, girlfriends or casual sexual partners about STIs, HIV, and pregnancy because it is "too serious".
- **Media:** TV, radio, internet and pamphlets and other written resources are potential sources of information. However, young people are unsure of their reliability, are unlikely to voluntarily seek information through these mediums, and indicate that it is not possible to ask questions and clarify issues. No participant mentioned sexual health websites or help-lines. No participant identified ethnic media (radio, newspaper, television) as a source of information about sexual health issues.

Initiation of sexual relationships is a significant point at which awareness of sex and sexual health appears to increase. Several participants who had been involved in relationships learnt about sexual health issues in direct response to unplanned pregnancy or contracting STIs. Young people emphasised that the opportunity to learn about sexual health at an earlier point could have prevented their learning 'the hard way'.

Young people identified key barriers to learning about sexual health. They said: ‘cultural attitudes’ prohibit open discussion of sexual health issues; shame and stigma associated with unplanned pregnancy and STIs make it difficult to seek advice and respond to specific concerns; and sexual health problems are regarded as too serious and scary to discuss with girlfriends or boyfriends. The pressing needs of settlement also take precedence over other concerns, including seeking health-related information.

Verbal and group-based education sessions were consistently identified as the preferred method for learning about sexual health. Young people said they want to be provided with **clear and factual information**. They want this information **before the onset of sexual relationships**. They stated a preference for **same-sex groups** with **gender-matched educators** in order to allow open discussion of sexual health issues. Respondents expressed a preference for obtaining information through **reliable sources**, such as health centres, doctors, community services, and schools.

Capacity building for early settlement services, English Language Schools and Centres and health care and community workers would increase opportunities for the effective delivery of sexual health information for youth with refugee backgrounds. Doctors, nurses and other health professionals are viewed as reliable and expert source of information in relation to sexual health, and should be involved in communication strategies around sexual health. Given the reluctance amongst young people to discuss sexual health with parents, and difficulties accessing internet and other media sources, the study highlights the importance of school-based sexuality education for improving sexual health literacy and capacity for risk-reduction behaviours. Young people with refugee backgrounds who do not attend school would need to be reached through other commonly frequented sites and services or targeted through out-reach programs.

RELATIONSHIPS

The age at which sexual activity would be expected to begin varied according to gender. Young men indicated the onset of sexual activity might begin around fifteen or sixteen years. Young women suggested that sexual activity might begin around eighteen to twenty years.

However, for many participants marital status rather than age was the key factor determining when sexual activity could be initiated. Young people spoke of community and family expectations that sex occurs only after marriage. Many participants said that they would adhere to social and cultural values and abstain from sex before marriage.

While conscious of community expectations of abstinence prior to marriage, some young people indicated they were involved in sexual relationships. Young women frequently emphasised the risks of non-marital sexual relationships, particularly jeopardising their reputation and the severe responses of parents and family were they to find out. A few young women described feeling pressured into unwanted sexual activity by boyfriends. The secrecy surrounding many relationships can put young people at increased risk as they are unwilling to turn to parents or health professionals for information and advice, and are fearful that their use of contraception might be discovered. Young people may also be denied opportunity to learn about positive relationships and effective negotiation within relationships due to lack of open communication.

Young people often commented on overt sexual expression in public spaces in Australia. They described seeing people who wear revealing clothing and couples who kiss and touch in the street. This was in contrast to the more strict moral codes in their culture and countries of origin, in which sex is regarded as a private subject.

IMPLEMENTATION: TAKING RISKS, TAKING CARE

Attitudes towards risk and protection are informed by gender. HIV/AIDS was consistently identified by young males as the worst thing that could occur through sexual activity; HIV/AIDS and unplanned pregnancy were identified by young females as their most significant concerns. Bacterial STIs ranked behind HIV and pregnancy as sexual health concerns.

A number of strategies were described for protective behaviours and safer sex. Condoms were frequently mentioned as a way to reduce the risk of STIs and pregnancy. Other contraceptive methods were occasionally mentioned. Participants who appear to have the greatest awareness of contraception were those who were sexually active.

Young people expressed concerns about the reliability of condoms and the risk that parents might find out they are using contraception; a few young males also indicated that sex with condoms does not feel as good. Condoms are widely regarded as a male-controlled method, and most young women indicated they were unlikely to take responsibility for obtaining and using condoms. Females are regarded as having greater responsibility for choosing and taking oral contraceptives and implants.

Abstinence from sex until marriage was widely cited as an effective risk reduction strategy as it ensures there is no exposure to infection or risk of unplanned pregnancy. Discourses around abstinence are informed by social expectations; many young people said that abstinence was essential in order to maintain a good reputation and to avoid bringing shame to themselves and their family. However, some young people regard abstinence messages coming from family, community and religion as an unrealistic effort to control their own lives.

A large number of participants linked safe sex to committed monogamous relationships. Establishment of trust between partners was viewed as an important element in avoiding health risks and unplanned pregnancy. Contraceptive choices depend on establishing that each person in the relationship is free from infection in the first instance, and is then based on trust and an assumption of fidelity. When sexual relationships are framed in terms of love and trust, this can compete with protective health behaviours and 'safe sex' messages. Trust and loving one's partner were provided as reasons for non-use of condoms within relationships.

Young people also said that safe sexual relationships requires avoidance of 'risky types', such as people who drink alcohol, take drugs, go clubbing, or who have bad reputations. People who reported having sex without condoms and with a person who they do not know well said they were anxious about the risk of contracting STIs. Risk is thought to be minimised through assessment of the likelihood that a person is carrying infections. A few people said they use personal judgements as a means of protection against STIs. Well-known and respectable people are thought to be less likely to be carrying infections.

The major factors identified by young people as contributing to sexual health problems include:

- risk-taking or careless attitudes
- alcohol consumption
- peer pressure
- difficulties negotiating safe sex and contraception
- homelessness and insecure housing situations
- lack of supportive family and social networks

UNPLANNED PREGNANCY

Unplanned pregnancies are a key concern for resettled youth with refugee backgrounds. Seven participants (five females and two males) recounted personal experiences of pregnancy outside of marriage; many participants referred to people in their community who had experienced unplanned pregnancy. Health professionals and case workers stated that they are increasingly seeing teenage pregnancies and terminations amongst young people with refugee backgrounds.

Termination of pregnancy was widely discussed: participants indicated this is not a decision that could be easily talked about with family or friends and fear of discovery is a significant concern, particularly for young women. However, many people said that a young unmarried woman who became pregnant had few options and a termination would be a way to avoid the shame associated with having a child outside of marriage. Other possible courses of action could be to adopt out the child, or to migrate overseas in order to avoid the judgement of family and community. However, young people also emphasised that a young woman could choose to have and raise the child, and she might do this either alone or she could marry the father of the baby.

Young women worry that they are too young to become a mother and fear the reactions of family and community members (especially if they are unmarried). Some are concerned that they might be unable to care adequately for the baby and that having a baby will prevent them from doing other things with their lives. Male participants expressed concerns around unplanned pregnancy in terms of community responses, fear of fatherhood and the need for the female to take responsibility. However, the risks and social consequences associated with unplanned pregnancy were not viewed as seriously.

ACCESSING HEALTH SERVICES

Improving access to sexual health services remains a key strategy for increasing sexual health literacy and reducing poor sexual health outcomes. Doctors are viewed as an important and expert source of information, advice and treatment, including in relation to sexual health. However, few participants indicated that they had accessed health services since arrival in Australia either to address sexual health problems or to request information. There is very low awareness of specialist sexual health services, including free services for youth. Young people and health professionals reported a number of barriers to accessing health services in relation to sexual concerns:

- social stigma and embarrassment attached to STIs and unplanned pregnancy
- anxiety about confidentiality (especially when using interpreters) and the risk of family and community finding out. Many participants said that if they had a sexual health issue they would choose a doctor who does not know their family
- structural issues: i.e. lack of awareness of how and where to access the health and sexual health services; language barriers
- competing priorities of settlement
- limited experience of using health services
- poor understanding of the benefits of early intervention and preventive health behaviours

Participants who were older, or who were sexually active, were most likely to mention STI screening. While lacking knowledge about the specific STIs for which screening is available, they indicated that screening is an important way to maintain sexual health. Some viewed screening as a preventive health behaviour and said that it should be undertaken prior to initiating sexual relationships in order to ascertain whether either person has an STI: others utilised screening as a way to check

sexual health status after engaging in sexual activity, particularly after a casual sexual encounter. Key barriers to screening are lack of awareness of the asymptomatic nature of some infections, fear that screening (and particularly HIV screening) might result in bad news, fear of community responses if screening results confirm the presence of an STI, and an assumption that screening is not necessary within trusting relationships.

In order to counter the fear, embarrassment and stigma associated with sexual health issues, there is a need to emphasise the confidentiality of health services. It is also important to increase awareness of how to access health care services, to emphasise the value of preventative behaviours and early intervention, and to increase understanding of the asymptomatic nature of some STIs.

SUMMARY OF KEY FINDINGS

KNOWLEDGE	
HIV/AIDS	<ul style="list-style-type: none"> • High awareness of existence of HIV/AIDS • Low knowledge of modes of transmission and symptoms
STIs	<ul style="list-style-type: none"> • Low awareness of STIs • Low knowledge of symptoms, modes of transmission, treatment • Widespread assumption that a person with an STI could be identified; they would appear physically different and unwell
Contraception	<ul style="list-style-type: none"> • High awareness of condoms amongst sexually active participants • Low awareness amongst younger participants and those yet to initiate sexual relationships
Sexual health	<ul style="list-style-type: none"> • Refers to absence of STIs/prevention of unplanned pregnancy • Entwined with social well-being: protection against negative family/social responses, stigma, shame and loss of reputation • Other settlement issues take precedence over sexual health concerns
ATTITUDES	
HIV/AIDS	<ul style="list-style-type: none"> • Viewed as incurable and fatal; a shameful illness • Seen as a greater risk in countries of origin than in Australia
STIs	<ul style="list-style-type: none"> • Regarded as curable/non-fatal; less serious than HIV/AIDS • Perceived to be shameful and embarrassing
Contraception	<ul style="list-style-type: none"> • Young men emphasise importance of protection against HIV; young women emphasise protection against pregnancy and HIV • Condoms viewed as the responsibility of males; other contraceptive methods (i.e. pills, implants) as the responsibility of females
Unplanned pregnancy	<ul style="list-style-type: none"> • Compromises social well-being: shame and stigma associated with unplanned pregnancy • Social risks around higher for young women than young men • Family of unmarried pregnant women also brought into disrepute • Young men widely regard women as responsible for unplanned pregnancy as a consequence of unprotected sex
IMPLEMENTATION: TAKING RISKS, TAKING CARE	
Relationships	<ul style="list-style-type: none"> • Some young people are involved in sexual relationships • Many participants said sex should only occur after marriage • Same-sex relationships not mentioned by any participant
Protective behaviours	<ul style="list-style-type: none"> • Protective strategies include: <ul style="list-style-type: none"> • Use of condoms and other contraceptive methods • Abstinence from sex • Fidelity and trust within relationships • Avoidance of sex with people who are regarded as at risk. There is an assumption that “risky people” can be identified

Risk factors	<ul style="list-style-type: none"> • Young people identified risk factors for STIs and unplanned pregnancy, including: risk-taking people, alcohol use, peer pressure, homelessness, inadequate social and family support, immoral behaviour • Young people have low sense of personal risk of sexual health issues • A few young women in the study had been pressured into having sex
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LEARNING ABOUT SEX AND SEXUAL HEALTH

Sources of information	<ul style="list-style-type: none"> • Limited exposure to formal sexual health information (both prior to and subsequent to arrival) • Sexual health not a topic for discussion with parents • Credible sources are valued (i.e. GPs, health workers), but these are not readily accessed • Less credible sources of information accessed (i.e. friends) • School-based sexuality education viewed as informative and useful by those who have had opportunity to participate • Less value placed on written information
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Health promotion	<ul style="list-style-type: none"> • Most young people are keen to increase understanding of sexual and reproductive health issues • Young people value interactive information and group-based discussion, and prefer single-sex groups • Sexual health campaigns must be relevant for and inclusive of young people with refugee backgrounds • It is important to engage parents and community to support sexuality education
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ACCESSING HEALTH SERVICES

Use of services	<ul style="list-style-type: none"> • Doctors viewed as professional source of information and treatment • Few participants had used health services for sexual health information • Very few participants knew of specialist sexual health services
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Barriers to access	<ul style="list-style-type: none"> • Shame associated with HIV, STIs and unplanned pregnancy • Concern about confidentiality (especially if using interpreters) • Risk of family/community finding out health service accessed for sexual health issues • Limited experience accessing health services • Structural barriers: i.e. transport, cost, access • Lack of familiarity with health services in Australia • Settlement issues take precedence over health concerns • Poor understanding of preventative health
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STI screening	<ul style="list-style-type: none"> • Sexually active people most likely to mention STI screening • Limited knowledge of infections for which screening is available • Screening used both as preventive strategy prior to engaging in sexual relationship, and to check sexual health status after sex • Barriers to screening include: fear of diagnosis of STIs and HIV, low self-perceived risk of sexual health problems, limited understanding of asymptomatic nature of some infections
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RECOMMENDATIONS

The following recommendations aim to provide a framework that can: facilitate improvements in sexual health promotion and health service access and responsiveness; build on current good programs and practice; respond to the changing patterns of refugee intake. The recommendations are grouped into seven broad strategic areas through which to strengthen the sexual health of young people with refugee backgrounds:

- Policy and program development: ensuring sexual and reproductive health programs and services effectively target young people with refugee backgrounds
- Health promotion and community-based interventions
- Development and delivery of school-based sexuality education programs for newly-arrived young people with refugee backgrounds
- Professional development: strengthening the capacity of general health and welfare services to meet the sexual and reproductive health needs of young people with refugee backgrounds
- Supporting resettled youth to access healthcare services and screening
- Integration of sexual health programs with broader policy and programmatic initiatives that focus on the health and well-being of young people with refugee backgrounds

POLICY AND PROGRAM DEVELOPMENT

1. Young people with refugee backgrounds are an 'at-risk' population, in terms of poor sexual health literacy, risk of STIs and unintended pregnancy, and limited access to mainstream services. It is important that young people with refugee backgrounds are recognised and targeted in program and policy development, with the aim of improving their sexual and reproductive health:
 - a. Ensure that strategies for addressing the sexual and reproductive health of people with refugee backgrounds are specifically identified in the 2007-2012 Sexual and Reproductive Health Action Plan (development is being led by the Public Health Branch, Department of Human Services)
 - b. Involve relevant community based organisations and stakeholders, including young people with refugee backgrounds, in the design of programs and policies.

HEALTH PROMOTION: COMMUNITY-BASED EDUCATION AND COMMUNICATION

2. Develop and deliver education resources and educational strategies for newly-arrived young people with refugee backgrounds that aim to increase awareness of STIs, unplanned pregnancy and the importance of protective behaviours, and to increase access to health care services:
 - a. Encourage and facilitate the involvement of community organisations, parents and young people with refugee backgrounds in the development of sexual health education programs and materials. This will foster a community and family approach to sexual health promotion for young people, and will increase understanding of the purpose and value of sexual health education.
 - b. Many young people expressed ambivalence about the value of written resources. They said it not possible to clarify issues or ask questions of written information. Written resources (both in English and in community languages) could primarily be used to support interactive and group-based learning and could also be provided during health service consultations.
 - c. Young people identified interactive and group-based education delivered by

- trustworthy sources (i.e. health professionals, school teachers) as the preferred mode for learning about sexual health. Many young people expressed a preference for gender-specific groups.
- d. Disseminate resources through frequently used sites: i.e. Centrelink, AMES, sports clubs, community centres, tertiary education facilities, and MRCs. Encourage these services to provide or strengthen existing sexual health education programs.
 - e. Young people who are disadvantaged in their access to health education opportunities are an important target group for educational and health promotion programs, including males and young people who are homeless or at risk of homelessness.
 - f. Involve sources of health information that are trusted by young people with refugee backgrounds – health professionals, teachers, community-based service-providers – in communication strategies around sexual health.
3. In addition to providing factual information about STIs, pregnancy and contraception, it is critical that communication and educational programs also include information about:
 - a. physiology and reproductive biology
 - b. responsible decision-making and negotiation within intimate relationships
 - c. positive aspects of sexuality and being sexually healthy
 - d. emotional aspects of relationships and sex
 - e. gender roles and interactions between young males and females
 - f. the incidence of HIV, STIs and unplanned pregnancy in refugee communities
 - g. availability of sexual health services and screening and youth-specific services, particularly free services
 - h. Australian laws regarding sexual relations, including age of consent and child support legislation
 - i. differences between mainstream ideas and culturally-informed perspectives
 4. Incorporate wider notions of safe sex in health promotion messages.
 - a. Safer sex refers to stability, protection from pregnancy, self-control, disease prevention, protection of reputation within a community and family context.
 - b. Question and address assumptions about 'risky' and 'safe' partners.
 - c. Emphasise that people with HIV or STIs are not always identifiable.
 - d. Address the association between STIs, unplanned pregnancy and immoral behaviour/shame.
 5. Pilot a 'peer education' program for sexual health. This pilot could build upon the strengths of existing peer education programs, such as; the bi-lingual peer educators at Western Region Health Centre who have completed train-the-trainer courses and have skills in peer-led health education; the peer-led 'Hip Hop for Health' project for African and Arabic youth run through the Multicultural Health and Support Service.
 6. Explore greater utilisation of on-arrival health assessment as an initial opportunity to provide information about sexual health and services. Given the competing demands of settlement, any information provided on-arrival should be regarded as an initial introduction to sexual health issues and services.
 7. Ensure that large-scale media campaigns relating to young people and sexual health (i.e. 'You never know who you'll meet' – DHS, 2007) are inclusive and relevant for young people

with refugee backgrounds: for example, distribute resources and programs through sites frequently accessed by young people with refugee backgrounds.

SCHOOL-BASED SEXUALITY EDUCATION

8. Schools are important health promoting environments. Develop a relevant and accessible school-based sexuality education program for newly-arrived young people with refugee backgrounds:
 - a. Conduct an audit of existing sexual and reproductive health educational materials that are used to teach students in English Language Centres and English Language Schools, and students with refugee backgrounds in mainstream schools (i.e. Western English Language School, Noble Park Secondary College).
 - b. Develop a flexible educational program for newly-arrived youth that can be adapted to the changing regional allocations within Australia's Humanitarian program.
 - c. Incorporate interactive methods (i.e. visual aides, jigsaw puzzles) and provide opportunity to rehearse strategies for safer sexual behaviours.
9. Deliver sexuality education in English Language Schools and Centres.
 - a. Provide educational materials and learning tools to relevant schools and educators.
 - b. Explore involvement of Secondary School Nurses, Refugee Health Nurses, FARREP workers and local health service providers in the delivery of educational sessions. This will ensure that sound programs are delivered and that young people have increased capacity to access health services.
 - c. Where interpreters are required, ensure that they have adequate level of fluency in sexual health terminology.
 - d. While it is not necessary to have ethno-specific groups, this study highlighted the importance of gender-specific groups when delivering sexual health information amongst newly-arrived youth.
10. Teaching staff and Secondary School Nurses who are attached to schools in areas of high refugee settlement would benefit from professional development opportunities that allow them to respond to the sexual health education needs of young people with refugee backgrounds.
 - a. Family Planning Victoria has been involved in the delivery of professional development for Secondary School Nurses in relation to sexual education for young people. Continue and increase delivery of professional development to Secondary School Nurses and other relevant staff, with a particular focus on sexual health literacy needs of young people with refugee backgrounds.
11. Extend the Secondary School Nursing Program to all English Language Schools and Centres.
 - a. Engage Secondary School Nurses in the provision of sexual health information and education to refugee children and young people in ELC/ELSS.
12. Increase parental understanding of the purpose and value of sexual health education in school-based settings:
 - a. Although sexuality education is core curricula in Victoria, parental consent for student participation in sexuality education is not mandatory. Information sessions for parents of newly-arrived youth will help to address concerns about the delivery

of sexual education, and allow parents to support their children in accessing accurate sexual and reproductive health information.

PROFESSIONAL DEVELOPMENT IN SEXUAL AND REPRODUCTIVE HEALTH ISSUES FOR RELEVANT HEALTH PROFESSIONALS AND COMMUNITY WORKERS

13. Deliver professional development to health professionals and community workers who are strategically important in the delivery of sexual and reproductive health education and services to young people with refugee backgrounds.
14. Ensure a core group of GPs, community health and refugee health nurses and mainstream health providers are informed about sexual health issues for newly-arrived refugees and are able to provide best practice level of care and sexual health education for refugee populations. Training could build upon current initiatives run by services such as Foundation House, the Centre for Ethnicity and Health, and the Multicultural Health and Support Service. Training could target:
 - a. GPs and community and women's health nurses in health centres with high number of clients with refugee backgrounds
 - b. Maternal and child health services and family services
 - c. Specialist clinics at Royal Women's Hospital (such as the Pregnancy Advisory Service)
 - d. Family and Reproductive Rights Education Program (FARREP) workers
 - e. Refugee Health Nurses (RHNs)
15. Provide support to service providers working directly with resettled youth with refugee backgrounds who are homeless or at risk of homelessness have sufficient resources to organise delivery of sexual health education programs, have increased awareness of sexual health issues for this target group, and are able to refer clients to appropriate services as required.

SUPPORT NEWLY-ARRIVED YOUNG PEOPLE WITH REFUGEE BACKGROUNDS TO ACCESS HEALTH CARE SERVICES AND SCREENING

16. Improving access to health care services is an important strategy for strengthening sexual health literacy and sexual health outcomes amongst youth. Community Health Services in areas of refugee settlement are well positioned to provide sexual health services and education as they have developed strong relationships with refugee communities. Improve the capacity of these sites to identify and respond to the sexual health needs of newly-arrived refugees (i.e. through education, clinical tasks, referral).
17. Provide young people with refugee backgrounds with on-site tours of hospitals, local health services and clinics. Emphasise the commitment of health services to maintaining client confidentiality. This will provide an interactive method for increasing awareness and understanding of the availability and nature of services.

18. Strengthen linkages between health care providers and case managers/youth workers in order that staff are better placed to provide support and advocacy for young people with refugee backgrounds.
19. Interpreting services need to be strengthened to ensure there are adequate numbers of interpreters in community languages and who are sufficiently fluent in technical health terminology. Interpreters must emphasise the professional requirement of confidentiality in order to build the trust of young people with refugee backgrounds.

INTEGRATED APPROACH TO SEXUAL HEALTH PROGRAMS

20. Integrate program and policy development in the field of sexual and reproductive health with broader programmatic and policy response in relation to young people with refugee backgrounds. Consider ways to combine sexual and reproductive health programs with other key health and social initiatives.
 - a. For example, identify ways to respond to the sexual health needs of young people who are homeless/at risk of homelessness or unaccompanied minors by delivering sexual health programs in conjunction with broader social and health initiatives.
 - b. DHS, in conjunction with other relevant Federal and State Government departments, could actively promote programs that combine sexual health education/promotion with interventions that address wider socio-economic issues, such as work experience, education support, sporting activities, and English-language learning.

FURTHER RESEARCH

21. The study identified a number of areas for further research:
 - a. Unprotected sex and unplanned pregnancies are of concern and further research is needed to identify effective strategies to promote and enhance negotiation in relationships and decision making among young people with refugee backgrounds.
 - b. Research is needed to identify family and community level concerns in relation to sexual health and sexuality education, and to investigate effective approaches for engaging newly emerging communities and youth to discuss and consider differences in cultural, religious and family values.
 - c. Specific concerns are faced by young women who have unplanned pregnancies, particularly single mothers who are at risk of homelessness and are not participating in the education system. Further research is required to identify how to best support these women and ensure that they do not experience further disadvantage.

1. INTRODUCTION

Young people are at risk of the adverse consequences of early sexual activity, including transmission of STIs, early and/or unplanned pregnancies, and coerced sexual relationships. Access to reliable information is an important component of young people's capacity to engage in protective health behaviours. Recently-arrived youth with refugee backgrounds have few opportunities to access information about sexual and reproductive health. A key issue increasingly identified by service providers, government agencies and community organisations is the need to improve health literacy and health outcomes among youth with refugee backgrounds in the areas of sexual and reproductive health. This report describes the findings from a research project that investigated how newly-arrived youth with refugee backgrounds living in Melbourne access, interpret and implement sexual health information.

Between 1996 and 2006, 102,368 people were granted humanitarian visas in Australia (see Appendix 1). They came from over 50 different countries and ranged in age from less than one year to over 80 years of age. Victoria receives approximately 30% of Australia's refugee and humanitarian intake. The main countries of origin of humanitarian entrants to Victoria have varied over the past decade, with increasing numbers coming from African countries, Iraq, and Afghanistan and a growing number of people from Burma (Myanmar). Over the past five years, the proportion of children and young people (under the age of 20) in Australia's refugee and humanitarian intake has increased from 21% in 2000-01 to 53% in 2005-06 (see Appendix 2).

This report outlines key issues that influence the ability of young people with refugee backgrounds to access, understand and implement sexual health information. The research process was supported by collaborative partnerships with multicultural and youth services and specifically organisations that work with youth with refugee backgrounds and young people who are homeless or at risk of homelessness. The report makes recommendations to guide health promotion policy and program development. These recommendations recognise the need for schools, government, non-government agencies and the community to work in partnership and provide initiatives that can promote the sexual health and well-being of youth with refugee backgrounds.

The report aims to support the development of Victorian government programmatic and policy decisions which would promote and improve the sexual health and sexual health literacy of young people with refugee backgrounds. The recommendations and issues discussed in this report are aligned with existing State government policies and frameworks. For example, 'A Fairer Victoria' (DHS 2008) is a long-term action plan that outlines the Victorian government's commitment to redressing disadvantage and increasing opportunities for all Victorians. The 'Cultural Diversity Guide' (DHS 2006) emphasises the social and economic value of cultural diversity and the importance of reducing inequality and encouraging participation in public and civil life. The 'Refugee Health and Well-being Action Plan' (DHS 2005) sets out a commitment to the health and wellbeing of people who are refugees or of refugee background living in Victoria, and aims to assist the Department of Human Services and other stakeholders to respond to their needs and to support refugee communities to engage with Victoria's health and community services system. The report also provides relevant information for service providers and planners involved in the development and delivery of sexual health programs and health promotion messages.

1.1 AIMS AND OBJECTIVES OF THE RESEARCH

The research investigated how newly-arrived young people with refugee backgrounds access, interpret and implement sexual health information. The study used qualitative methods – focus groups and in-depth interviews – to collect information around sexual health literacy, attitudes and practice.

142 people with refugee backgrounds participated in the study, including people from Iraq, Afghanistan, Africa (Sudan, Horn of Africa and West Africa) and Burma. Their ages ranged from 16-25 years. The study included youth with different levels of risk in relation to sexual health, including those who are: homeless, at risk of becoming homeless, and living at home and attending school. 15 support workers participated in semi-structured interviews. Informal consultations were also held with a wide range of service providers.

The study aimed to:

1. Identify how newly-arrived young people with refugee backgrounds find out about sexual health and illness.
2. Identify how newly-arrived young people with refugee backgrounds understand and interpret the information they receive around sexual health risk and protection.
3. Describe how newly-arrived young people with refugee backgrounds use sexual health information.
4. Examine the enablers and barriers to the implementation of sexual health information.
5. Develop recommendations for strategies to promote sexual health literacy and sexual health amongst young people with refugee backgrounds.

1.2 SCOPE OF THE REPORT

- **Chapter 2** provides a review of literature focusing on youth, refugees and sexual and reproductive health in Australia. It discusses the effectiveness of interventions for addressing sexual and reproductive health issues amongst youth, with particular focus on models that have been shown to be effective amongst culturally and linguistically diverse populations and refugee groups. It also reviews international programmatic responses in relation to the sexual health of refugees living in first countries of asylum.
- **Chapter 3** presents the research methods utilised during the project.
- **Chapter 4** provides an overview of national and state policy frameworks and key services in relation to sexual and reproductive health and refugee health.
- **Chapters 5 to 9** provide an analysis of the data gathered through group discussions and interviews with newly-arrived young people with refugee backgrounds and consultations and key informant interviews with service providers. These chapters provide a thematic analysis of the ways in which young people understand, access, and implement sexual health

information. They also include the insights and perspectives of community workers and health professionals.

- **Chapter 10** provides a summary of the key findings of the study. There is also discussion of cross-cutting issues that emerged during data collection and analysis, including the ways in which culture, gender, ethnicity and socio-economic background impact upon the sexual health of newly-arrived young people with refugee backgrounds.
- **Chapter 11** sets out recommendations for strategies and approaches which would promote and improve the sexual health and sexual health literacy of young people with refugee backgrounds.

It is intended that this report will identify key issues relating to sexual health and sexual health literacy among newly-arrived youth with refugee backgrounds and provide an evidence-base upon which policy makers and service providers can review and develop strategies for improving sexual health and sexual literacy among this population.

2. YOUTH WITH REFUGEE BACKGROUNDS AND SEXUAL HEALTH

2.1 SEXUAL HEALTH AND YOUTH IN AUSTRALIA

Young people worldwide are at risk of the adverse consequences of early sexual behaviour, including increased transmission of STIs, unsatisfactory or coerced sexual relationships, and early and/or unplanned pregnancies (Robinson and Rogstad 2002: 314; Henderson, Wight et al. 2006; WHO 2006).² Access to reliable and accurate sexual health information and effective health programs and interventions is critical to the health and wellbeing of young people (Cowan 2002: 315).

Large numbers of young people in Australia are sexually active. The median age of first sexual intercourse for males and females is 16 years (Rissel, Grulich et al. 2003). The third National Survey of Secondary Students and Sexual Health carried out with students in Years 10 and 12 in Australian secondary schools indicated that the large majority of these students are sexually active. 60% of young men reported that they always used condoms, and a further 31% sometimes did; 46% of young women indicated they always used condoms, and 44% sometimes did. The survey identified that knowledge around HIV transmission is good, but knowledge about STIs is generally poor. Around one quarter of sexually active students reported having had unwanted sex, with alcohol being the most commonly cited reason (Smith, Agius et al. 2002; Smith, Agius et al. 2003).

In Australia in 1995 there were 43.6 pregnancies per 1000 young women aged 15-19 years (Dyson and Mitchell 2005). This is relatively low in comparison to the same age group in the USA (83.6 per 1000), and is similar to other developed nations including New Zealand (54 per 1000), England (47 per 1000) and Canada (45.4 per 1000) (Dyson and Mitchell 2005). There were 19.8 births and 23.8 terminations per thousand women aged 15-19 years. Many births (88%) were to single women, and at least some of these pregnancies were planned and wanted (Dyson and Mitchell 2005). Similar figures were found in the 2002 National Survey of Secondary Students and Sexual Health, in which one in 20 students reported having had sex that resulted in a pregnancy (Smith, Agius et al. 2003). Many studies have demonstrated that early childbearing has negative associations with social, economic and health outcomes (Dyson and Mitchell 2005; AIHW 2007). There is no formal monitoring of abortion in Victoria or nationally, however data derived from Medicare and public hospital admissions indicates that in 2001-02, approximately 18 per 1000 women aged 15-19 had an abortion (FPV 2005).

While there have been considerable efforts towards sexual health promotion, notification rates for STIs have increased in Victoria during the last five years. Since 1999, there have been annual increases in most notifiable sexually transmissible infections in Victoria, and particularly chlamydia, gonorrhoea, syphilis and HIV (DHS 2006). Chlamydia is the most commonly notified STI in Victoria. Between 1995 and 2005, chlamydia notifications have risen dramatically from a rate of 29 per 100,000 persons in 1995 to 178 per 100,000 persons in 2005. The highest numbers of notifications are in the 20 to 24 year old age group. In 2005, 58% of notified cases were women. Due to the asymptomatic nature of chlamydia, it is probable that the notification data significantly underestimates the population prevalence (DHS 2006). Annual notifications of gonorrhoea in Victoria have also increased from 347 cases in 1995 to 1,193 cases in 2005, with higher occurring in men aged 20-45 years. Infectious syphilis notifications in Victoria have increased from 17 in 1995 to 117 in 2005, with the largest proportion of notifications amongst men aged 35-39 years (DHS 2006).

² This increased vulnerability is caused by a range of biological, behavioural, psychological and social factors, including hormonal changes, cervical anatomy, immunological naivety, lack of awareness of symptoms of infection, sexual experimentation, concurrent and/or frequent relationships, non-consensual sex, inability to perceive risk, immaturity of communication skills, contraception choices, poor health-seeking behaviour, and alcohol and illicit substance use (Cowan 2002: 315).

Poor sexual health is distributed unequally across populations (Smith, Rissel et al. 2003; Serrant-Green 2005). The Australian Study of Health and Relationships demonstrated that socio-economic status (measured in terms of educational attainment, occupation, income) was significantly associated with a number of sexual health measures, including condom and contraceptive use, having had an abortion, level of knowledge about STIs, and having been diagnosed with an STI (Smith, Rissel et al. 2003: 253). Amongst young people, there are certain groups at increased risk of STIs and unintended pregnancy, particularly the socially disadvantaged and marginalised (Williams and Davidson 2004; Gifford and Temple-Smith 2005). They are often marginalised for reasons of sexuality, occupation, culture, economic disadvantage, geographic location, age, substance use, homelessness (DHS 2006).

Young people who are not attending school and/or who are homeless have increased vulnerability to sexual health problems and unintended pregnancy, particularly those engaging in substance misuse or involved in the juvenile justice system (Cowan 2002: 316; NHS Centre for Reviews and Dissemination 1997; Rew, Chambers et al. 2002; Rew, Fouladi et al. 2002). Homelessness can range from the experience of people living in insecure or unaffordable housing who are at risk of homelessness to people living in the street, parks, or in squats who are in a state of “outright homelessness” (Zaman and Degagu 2002: 10). The Council for Homeless Persons (2000) defines homelessness as not only lack of shelter, but lack of a safe, settled and private home environment. Young people who experience homelessness tend to have poor knowledge about STIs, use contraception inconsistently, have limited or no access to school sex education and health care resources and services, and are at increased risk of coercive and survival sex, HIV and other STIs (Rew, Fouladi et al. 2002; Mallett 2005). They tend to become sexually active at an earlier age than adolescents living at home, and have more sexual partners and more incidents of unprotected sex (Rew, Chambers et al. 2002).

Fenton writes that inequalities in health can not be tackled unless they are identified (Fenton 2001: 63). In many developed countries, ethnic minority communities have poor sexual health outcomes, with increased rates of HIV/AIDS, sexually transmitted infections (Fenton 2001). Surveillance data and clinic-based studies in the USA, Canada and the UK show that higher rates of HIV/AIDS, STIs, and high-risk behaviours are reported among poor, urban, and ethnic minority communities (Elam, Fenton et al. 1999). Research indicates that economic disadvantage, social exclusion and racism experienced by ethnic minority populations contribute to health inequalities, and that culturally prescribed attitudes and behaviours also impact on sexual health outcomes (Fenton 2001). There are concerns about stigmatization through the use of ethnicity as an epidemiological variable in STI and sexual health surveillance data. However, the availability of ethnicity-specific data can enable identification of local and national health concerns, articulation of public health priorities, and improved targeting of interventions. Notifiable STIs in Victoria are chlamydia, gonorrhoea, syphilis, donovanosis, HIV/AIDS, and Hepatitis A and B. There is wide variation between States and Territories in reporting on ethnicity for STI notifications. National figures for rates of STI according to ethnicity are not readily available.

2.2 SEXUAL HEALTH AND YOUTH WITH REFUGEE BACKGROUNDS IN AUSTRALIA

Currently, youth with refugee backgrounds in Victoria are disadvantaged in relation to access to sexual health information. Recently-arrived youth have few opportunities to access information about sexual and reproductive health. While the sexual health issues affecting newly-arrived youth and particular refugee communities vary depending on the region of origin and the nature of the refugee and settlement experience, there are common concerns around sexual health literacy and access to services.

National data on the incidence of pregnancy and STIs amongst young people with refugee backgrounds is not available. However, a body of evidence emerging from direct service work indicates there are serious issues for youth with refugee backgrounds in Victoria around sexual health. Footscray Youth Housing Group is seeing homeless teenagers and young women from refugee backgrounds who have become homeless due to pregnancy outside of marriage or who are vulnerable to sexual health problems as a result of being homeless. This has been documented in a study of culturally diverse homeless young people in the City of Maribyrnong (Zaman and Degagu 2002). The DHS Refugee Minor Program, the Refugee Health Nurse Program and the Female and Reproductive Rights Education Program (FARREP) have all identified concerns around sexual health and the need for sexual health education amongst refugee youth (Parker 2007). Other agencies and services in Melbourne have identified concerns around the sexual health and wellbeing of young people with refugee backgrounds and concerns about the incidence of teenage pregnancy, terminations and sexually transmissible infections (STIs).

One of the key issues identified from the Good Starts Study for Refugee Youth (also conducted by the Refugee Health Research Centre), is the need to improve health literacy in the areas of sexual and reproductive health. This longitudinal study with over 100 refugee young people has also revealed that unplanned teenage pregnancy is having serious implications for the health and wellbeing of some of these young people (Refugee Health Research Centre 2008).³

Refugee health and wellbeing is often incorporated within the broader framework of multicultural health and wellbeing. However, while recently arrived youth with refugee backgrounds share many common experiences with other recently arrived migrant youth, they differ in some important ways. Other immigrants choose to migrate to Australia, whereas refugee youth have little or no choice. Immigrants often leave their country of origin in search of better opportunities, whereas refugee immigrants are forced to leave in search of safety and security. Most immigrants can return home to visit or to stay, whereas this is near impossible for most refugee immigrants (Beiser, Shik et al. 1999). These differences are important to recognize in addition to the trauma often experienced by refugee settlers prior to arrival in Australia.

People with refugee backgrounds may have complex and specific health needs (DHS 2005). Many refugee young people have experienced persecution, human rights violations, trauma, displacement from homes and communities, separation from family and friends, and disrupted schooling (Coventry, Guerra et al. 2002; Gifford and Temple-Smith 2005). Many have had poor access to healthcare services prior to arrival. Refugees often face circumstances that contribute to poor reproductive and sexual health, including: violence, displacement, disruption of family and community, relocation to unfamiliar and often crowded surroundings, and lack of infrastructure and access to services and survival needs (Krause, Jones et al. 2000). Many lack access to or knowledge about contraceptive methods (Krause, Jones et al. 2000), and the instability of their living conditions and situations in refugee camps increases their risk of unplanned pregnancies, STIs and HIV (Jones 1999).

Refugee women and girls may have been subjected to sexual and gender-based violence including physical assault, sexual harassment, rape, torture and mutilation, and sexual slavery (Population Reference Bureau 2000). It is inflicted by guards, soldiers, local populations or even fellow refugees, both during armed conflict and in camps and other places where women seek refuge (VFST 2005).

³ 8 of the 58 females in the study reported a pregnancy during their first two years of settlement in Australia. They were aged between 15 and 19 years when they became pregnant. Seven proceeded with the pregnancy and had their baby and one had a termination.

Rape has been increasingly used as a weapon of war and has contributed to the increase of refugees worldwide (Janssens, Bosmans et al. 2005). Young refugee women in particular need information and support to address their sexual health needs as they may have experienced or witnessed sexual violence (Gifford and Temple-Smith 2005; NYIN 2005; VFST 2005). Acute injuries and gynaecological problems, early pregnancy, prenatal care, childbirth complications, psychological effects and sexually transmissible diseases are concerns for this population of young women (Coventry, Guerra et al. 2002; VFST 2005). The cultural practices of some refugee-source countries, such as female circumcision, can also impact on sexual health. There is some evidence from Europe that refugee and asylum seeker women are at increased risk of unwanted pregnancies and abortion in countries of settlement, particularly those who are unmarried, are aged between 20 to 30 years, have no children, and who originate from African countries. Lack of information and inadequate medical care may cause a higher prevalence of abortion among refugee women (Janssens, Bosmans et al. 2005).

It is not uncommon for humanitarian entrants to have multiple health problems on arrival in Australia (Foundation House 2007). Cultural norms around sexual behaviour and relationships, gender roles, and social expectations may also position young people with refugee backgrounds at greater risk in terms of their sexual health and wellbeing. They may be faced with the difficult process of negotiating the conflicting cultural values of their families and communities and their host country (Gifford, Bakopanos et al. 2007). Furthermore, delayed adolescence or lack of a well-developed future orientation (due to the refugee experience) is a factor for some young refugees in their early twenties which may impact on their social and sexual behaviour during resettlement (UNHCR 1999; CMYI 2006).

Transmission of HIV in refugee communities is of concern. The DHS 2002-2004 HIV/AIDS Strategy identified those who have come from high prevalence countries, or who travel regularly to these countries, as people at particular risk of HIV infection and in need of 'appropriate health promotion programs and initiatives' (DHS 2002).⁴ Since the 1990s, there has been an increased number of people coming to Australia from high prevalence countries (McNally and Dutertre 2006). The visa medical examination for humanitarian entrants includes an HIV antibody test, and while a positive result does not preclude the granting of a visa the costs associated with health and community services are taken into account. Transmission of HIV in Australia continues to occur primarily through sexual contact between men.⁵ National surveillance data, however, shows that a significant number of new diagnoses of HIV are in people from high prevalence countries who are residing in Australia, either temporarily or permanently (Biggs, Hellard et al. 2006; McNally and Dutertre 2006). In 2004, the HIV Clinic at the Melbourne Sexual Health Centre noted that 'a large proportion of those coming to grips with a new HIV diagnoses were from culturally and linguistically diverse (CALD) backgrounds' (Melbourne Sexual Health Centre 2004). People born in sub-Saharan Africa are particularly over-represented among new diagnoses of HIV infection in Australia, and 60% of those with HIV infection are diagnosed late in the illness when it is more complex to treat and major symptoms have begun to appear (Biggs, Hellard et al. 2006). National data around diagnoses of HIV infection by ethnicity and age is not readily available, and accordingly it is difficult to establish the prevalence of HIV amongst CALD young people and youth with refugee backgrounds.

⁴ Prior to being granted a visa, Humanitarian entrants complete a visa medical examination in order to identify diseases or health conditions that could present public health risks to the Australian community, or place a burden on resources and expenditure within health and community services. All applicants aged 15 years or more undergo an HIV antibody test (DIAC 2007).

⁵ Around 64% of people newly diagnosed with HIV infection in the period 2003-2007 were men with a history of homosexual contact (National Centre in HIV Epidemiology and Clinical Research 2008).

2.3 INTERVENTIONS TO IMPROVE SEXUAL HEALTH

Health education interventions are regarded as a key strategy for promoting sexual health amongst young people, particularly in view of the fact that many studies show low levels of information among young people about sexuality, reproduction, contraception, and sexually transmitted diseases (Oakely, Fullerton et al. 1995). Sexual health education is delivered through various settings and mediums, including school-based education, peer education, community-based programs, family, and health professionals and services and can draw upon a range of resources such as internet, written information (pamphlets, brochures, posters), radio, television, text messaging, and print media.

Sexual health education programs aim to reduce the adverse consequences of sexual behaviour and to improve the quality of sexual relationships for young people (Cowan 2002: 315). A key concern for service provision, health promotion and research is to identify the interventions that are most effective in improving sexual health amongst adolescents and young people (Robinson and Rogstad 2002: 314).

Several systematic reviews have examined the impact of different approaches to sexual health education for young people, including sex education classes, school or family planning based clinics, and other community-based programmes. (Kirby, Short et al. 1994; Oakely, Fullerton et al. 1995; Grunset 1997; NHS Centre for Reviews and Dissemination 1997; DiCenso, Guyatt et al. 2002; Mullen, Ramirez et al. 2002). There is limited and contradictory evidence, however, around the effectiveness of sexual health education interventions (Goold, Bustard et al. 2005).⁶ For example, DiCenso et al's (2002) widely cited review concluded that primary prevention strategies did not delay sexual intercourse, improve use of contraceptives, or reduce pregnancies in adolescents. In contrast, Kirby (2001) has reported that some sex education and HIV education programs have shown positive effects on behaviour for as long as three years. A systematic review by Oakely et al (1995) of sexual health interventions amongst young people under the age of twenty also identified several programs that had positive impact on knowledge and reported behaviour.

Despite the variety of approaches used in the development and delivery of sexuality education programs, some key features associated with effectiveness are apparent. A number of reviews and studies have concluded that sex education can have beneficial effects on sexual behaviour (NHS Centre for Reviews and Dissemination 1997; Kirby 2002). There is evidence indicating that the following are central components of successful behavioural interventions (Kirby, Short et al. 1994; NHS Centre for Reviews and Dissemination 1997; Kirby 2002; As-Sanie, Gantt et al. 2004; Robin, Dittus et al. 2004):⁷

- focus on clear behavioural goals
- based on theoretical approaches to behaviour change that have been demonstrated to be effective in influencing other health-related risk-taking behaviours
- deliver clear and age-appropriate information about sexual activity and contraceptive methods, and continually reinforce messages
- provide accurate information about the risks associated with sexual activity and methods to

⁶ In complex behavioural interventions that aim to improve skills, and change attitudes and behaviours, it is challenging to determine impact and effectiveness due to the difficulty of measuring changes. Many studies measure changes in knowledge or self-reported behavioural outcomes, but actual changes in sexual behaviour or biological outcomes (rates of STIs and unintended pregnancy) are more difficult to measure (Cowan 2002).

⁷ However, a rigorous evaluation of the SHARE (sexual health and relationships) program developed and piloted in Scotland with 13-15 year olds did not find any benefit to rates of conception or termination compared with normal sex education. The SHARE program included many of the characteristics that were identified by Kirby (2002) as important (Henderson et al 2006).

- avoid pregnancy and STIs
- address social pressures influencing sexual behaviour
- provide opportunity to develop and rehearse strategies for practising safer sexual behaviour (i.e. communication, negotiation and refusal skills)
- draw upon a range of teaching methods, particularly those that provide opportunity for participants to 'personalise' information
- sufficient time to cover all information and activities
- provide training to teachers or peers who believe in the program they are delivering
- introduce programs at an early age while participants are still relatively sexually inexperienced and patterns of sexual behaviour are not firmly established
- tailor programs to participant's age-level, culture and level of sexual experience.

Kalmuss and Davidson emphasise that new programs need to be developed for 'minority teenagers' that aim to reduce risky sexual behaviours (Kalmuss, Davidson et al. 2003). Understanding and perception of sex, sexuality, power and risk is culturally informed and this shapes sexual behaviours. One aspect of good design in sexual health interventions is ensuring that the language and issues addressed are appropriate to the existing understanding, needs and concerns of the target population (DiCenso, Borthwick et al. 2001). Programs should provide young people with the opportunity to reflect on their cultural and personal assumptions around sex and risk (Cowan 2002). They should incorporate behavioural goals, teaching methods, and materials that are appropriate to the culture of the target group (Kirby 2002).

A large majority of evaluated programs have focused on behavioural interventions which seek to improve the knowledge, skills and practices of individuals around sexual health. However, there is a strong body of evidence which shows that the health of individuals and communities is determined by broader social and economic structural factors, and that individual behaviour change in relation to sexual health 'will best be supported within a community that is broadly supportive of those behaviours' (Cowan 2002: 316). For example, Fenton (2001) identifies social and economic factors as major determinants of poor sexual health, and argues that these underlie the hyperendemic persistence of syphilis in southern USA and high rates of gonorrhoea in the most deprived areas in London. Many factors predict sexual and reproductive health, including socioeconomic status, parental and peer attitudes, educational opportunity, and being the child of a teenage mother, as well as levels of literacy around sexual health (FPV 2005).

There have been few structural interventions that attempt to address underlying social and economic factors that are associated with poor sexual health outcomes. However, evaluations of a limited number of interventions that address social disadvantage have shown that they have long-term benefits (Dyson and Mitchell 2005). Programs that combine sex education with work experience, career planning, support to complete education or improve job opportunities have had some success in increasing contraceptive use and reducing pregnancy rates (NHS Centre for Reviews and Dissemination 1997). For example, the Children's Aid Society Carrera Program in New York worked with 600 disadvantaged adolescents over a three year period. The intervention group received a comprehensive development program including a job club, employment and career awareness, tutoring and homework help, preparation for exams and college entrance, family life and sex education, arts-based self-expression and sporting activities. In addition, the program provided health and medical care, including reproductive health care and contraception when needed. The control group received a typical less intensive after-school program for disadvantaged youth. After three years, the intervention group were half as likely as the control group to report a birth, and the girls were less likely to be sexually active or to have been pregnant. No effect was noted on the behaviour of the boys (Kirby 2002).

2.4 PROGRAMMATIC RESPONSES TO REFUGEE SEXUAL HEALTH

Since the mid-1990s, there has been increased recognition of the reproductive and sexual health needs of refugees and internally displaced people, particularly in refugee settings. In 1994, the Women's Commission for Refugee Women and Children published a report entitled 'Refugee Women and Reproductive Health: Reassessing priorities' that documented the lack of reproductive health services for refugees (Wulf 1994). The International Conference on Population and Development held in Cairo in 1994 recognized the specific reproductive and sexual health needs of migrant populations, including refugees and displaced people. Subsequent to the Cairo meeting, the Inter-Agency Working Group on Refugee Reproductive Health (IAWG) was formed comprising representatives of UN agencies, NGOs and governments. The IAWG has produced a manual specific to refugee settings that sets out standards for sexual and reproductive health programmatic areas including a Minimum Initial Service Package (MISP) of interventions to be implemented at the onset of a refugee or humanitarian crisis, safe motherhood, sexual and gender-based violence, sexually transmitted diseases including HIV/AIDS, family planning, other reproductive health concerns such as post-abortion and female genital mutilation (FGM), and adolescent sexual and reproductive health (UNHCR 1999).

Donors, agencies and international and local organizations are now involved in the development and delivery of sexual health programs amongst refugee populations in both camps and urban settings, including provision of medical equipment and contraception and increasing capacity of local health services through to information, education and communication campaigns (Krause, Jones et al. 2000).⁸ Few programs and initiatives have focused on the sexual and reproductive health of refugee adolescents and youth (Women's Commission for Refugee Women and Children 2000). However, there are some notable examples. The World Association of Girl Guides and Girl Scouts and Family Health International implemented a Health for Adolescent Refugees Project in Egypt, Uganda and Zambia that focused on peer-learning and peer-counselling. The International Rescue Committee supported the inclusion of health and sexual education curricula in primary and secondary schools and training of peer educators in Liberia and Sierra Leone. The International Federation of the Red Cross and the Tanzania Red Cross Society implemented a project in the Kigoma Region of Tanzania entitled Meeting the Reproductive Health Needs of Refugee Adolescents. The project trained peer educators, constructed youth centres and collected information about adolescents' knowledge, attitudes and practices (Krause, Jones et al. 2000).

A review of resources and literature indicates that the sexual and reproductive health concerns of refugees is predominantly framed in the context of developing countries, and particularly in terms of relief services for refugees and displaced women living in camps and first countries of asylum. The UNHCR Manual states that reproductive health is a right that applies to refugees who are caught up in conflict and living in emergency situations (UNHCR 1999). Programs, research and resources relating to sexual health for people with refugee backgrounds in second countries of settlement appear more limited (Ascoly, Van Halsema et al. 2001).⁹ For example, while the European Union (EU) promotes sexual and reproductive health policies in its development cooperation and humanitarian programs, the sexual health rights and needs of women with refugee backgrounds who are living in the EU have not been responded to in the same way. Research indicates that refugee women in the EU experience higher maternal morbidity and mortality, suffer poorer pregnancy outcomes,

⁸ For example, the Minimum Initial Service Package (MISP) has been implemented in Bosnia, Afghanistan, Albania, Guinea-Bissau, Honduras, Tanzania, Turkey, and Uganda by Marie Stopes International and UNFPA.

⁹ Ascoly et al (2001: 379) suggest this reflects the tendency to focus on countries of origin as the places from where refugee problems emerge.

have less access to family planning services and counselling, show a higher prevalence of sexually transmitted infections (STI) including HIV/AIDS, and are at increased risk of gender-based violence (GBV) (Janssens, Bosmans et al. 2005). This highlights the importance of providing sexual health and reproductive health programs in third countries of settlement.

2.5 DEFINING YOUTH WITH REFUGEE BACKGROUNDS

- *Who is a 'Refugee'?*

The Office of the United Nations High Commissioner for Refugees (UNHCR) defines a refugee under the 1951 Refugee Convention as a person who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country”.¹⁰ A person who meets the refugee definition in the 1951 Geneva Convention is sometimes referred to as a “convention refugee” or “statutory refugee”. As a signatory to the 1951 Refugee Convention, Australia has voluntarily accepted obligations to protect and assist refugees. In addition to those people who enter Australia under visa categories that identify them specifically as refugees, there are others who have lived through similar ‘refugee-like’ experiences.

- *Who is a 'Youth'?*

Use and meanings of the terms ‘adolescents’, ‘youth’ and ‘young’ people vary significantly between organisations, countries and cultures, depending on political, economic and socio-cultural context (Sommers 2001: 22). However, there are many commonalities in the psychosocial, emotional and biological changes that characterize this stage of life. Adolescence is an important time to establish healthy skills, attitudes and behaviours. But it is also a time with increased risks, particularly in areas of sexual and reproductive health and gender relations (UNFPA 2007). In this study, we use the UNFPA and WHO definition of a youth as a person aged 15-24 years.

2.6 DEFINING SEXUAL AND REPRODUCTIVE HEALTH (SRH) AND SRH RIGHTS

Reproductive health is a state of complete physical, mental and social wellbeing in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Sexual health is central to reproductive health and encompasses the prevention, diagnosis and management of STIs, HIV and BBVs, contraception, unintended pregnancy, infertility, cancer resulting from STIs, and sexual dysfunction. It also includes the ability to develop and maintain meaningful interpersonal relationships; appreciate one’s own body; interact with both genders in respectful and appropriate ways; and express affection, love and intimacy in ways that are consistent with one’s own values (SIECUS 2002). Sexual and reproductive health is influenced by interlinked factors including sexual behaviour and attitudes, societal factors, biological risk and genetic predisposition.

¹⁰ UN Convention relating to the Status of Refugees of 28 July 1951, Article 1A
<http://www.unhcr.org/cgi-bin/texis/vtx/protect/openssl.pdf?tbl=PROTECTION&id=3b66c2aa10>
 (accessed 1/06/07)

Sexual health

Sexual health is “a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, sexual rights of all persons must be respected, protected and fulfilled.” (WHO 2006).

Reproductive health

Reproductive health is “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with best chance of having a healthy infant. (...) reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.” (United Nations - ICPD 1994)

The right to health is a human right that is recognised by a body of international treaties and agreements. It does not imply that everyone has the right to be healthy, but that everyone has the right to the ‘highest attainable standard of health’ (Janssens, Bosmans et al. 2005). Over the past years, the right to sexual and reproductive health has gained significant attention and increased recognition. Sexual and reproductive health rights are embedded in a wide range of international conventions, declarations and conference documents in the area of humanitarian law, human rights, women’s rights and children’s rights.

Sexual rights

Sexual Rights embrace “human rights that are already recognised in national laws, international human documents and other relevant UN consensus documents. These include the right of all persons, free of coercion, discrimination and violence to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services
- seek, receive and impart information in relation to sexuality
- sexuality education
- respect for the bodily integrity
- choice of partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not and when to have children
- pursue a satisfying, safe and pleasurable sexual life.” (Janssens, Bosmans et al. 2005)

Reproductive rights

Reproductive Rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly about the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (United Nations - ICPD 1994)

3. RESEARCH DESIGN AND METHODS

3.1 OBJECTIVES

The DHS Cultural Diversity Guide states that collection of accurate information is central to planning for effective service provision for culturally and linguistically diverse groups (DHS 2006). This study used qualitative methods to investigate how youth with refugee backgrounds access, interpret and implement sexual health information, with a view to developing appropriate strategies to promote sexual health literacy and sexual health among refugee young people in Victoria.

The specific objectives of the study were to:

- identify how newly-arrived youth with refugee backgrounds find out about sexual health and sexual illness;
- identify what sense they make of the information they receive;
- examine the value placed on sexual health information;
- describe practices and strategies that young people engage in to implement the sexual health information they have received;
- examine barriers to the implementation of sexual health information;
- develop recommendations for strategies that promote sexual health literacy and sexual health amongst youth with refugee backgrounds.

Data collection was conducted between August and December 2007.

3.2 ADVISORY COMMITTEE

A project advisory committee was established prior to the initiation of the data collection. Invitations of membership for the project Advisory Committee were extended to community and settlement support workers, a representative from the DHS BBV/STI unit, young people with refugee backgrounds, and research partner organisations (see Appendix 2). The role of the Advisory Committee was to support and advise the research process, provide expertise in the area of refugee issues and sexual health, assist in the development and testing of the research tools, provide input into the development of recommendations based on the research findings, and guide the dissemination strategy (WHO 1996) (see Appendix 3).

3.3 BACKGROUND RESEARCH

In addition to the primary qualitative research described below, background research was carried out including a review of relevant published and unpublished literature and key State and Commonwealth documents, consultations with a range of service providers and organisations, and analysis of relevant data-bases.

Academic papers, government and agency reports and policy documents, and service provider manuals were reviewed and used to identify key issues relating to sexual and reproductive health and youth, and specifically in relation to refugee populations. Key State and Commonwealth policy and programmatic documents were sourced through relevant web-sites, organisations and government department. Literature searches were conducted using keyword searches via electronic databases (MEDLINE, CINAHL, ProQuest, Social Sciences and Humanities Collection, Current Contents, Sociological Abstracts, Anthropology Plus), the Cochrane Library and the NHS Centre for Reviews and Dissemination, the World Wide Web, and La Trobe University Catalogue. Unpublished reports

and literature were collected from key services and organisations in Melbourne. The literature and reports identified were reviewed and used to identify key issues relating to youth, sexual health, and intervention effectiveness. Given the limited amount of published and unpublished material relating specifically to refugees and sexual health, the review also included literature focusing on sexual health and people from culturally and linguistically diverse backgrounds. In addition to research conducted in Australia, findings of relevant studies undertaken in other developed and developing countries were collected and analysed.

Consultations were conducted with organisations providing services in the area of sexual and reproductive health, community and settlement support workers, researchers with professional engagement in the field of sexual health and refugee issues, state and local government authorities, and community leaders. The consultations were held both prior to and during the qualitative research phase. The consultations enabled exploration of the structural organisation of sexual and reproductive health services and sexuality education, programmatic initiatives in the area of sexual health, barriers and facilitators to the use of existing educational and health services by young people with refugee backgrounds, community-specific issues around sexual health, and discussion around appropriate ways to engage young people in the issue of sexual health and sexual health literacy.

Quantitative and demographic data were collected and analysed in order to provide a profile of the refugee and humanitarian intake in Victoria. The data sources include the 1996 and 2001 Australian Census, the DIAC Settlement Database, and relevant national and state reports. Data relating to sexual health and people from refugee-source countries was also obtained from the Pregnancy Advisory Service at the Royal Women's Hospital Melbourne, and the Melbourne Sexual Health Centre.

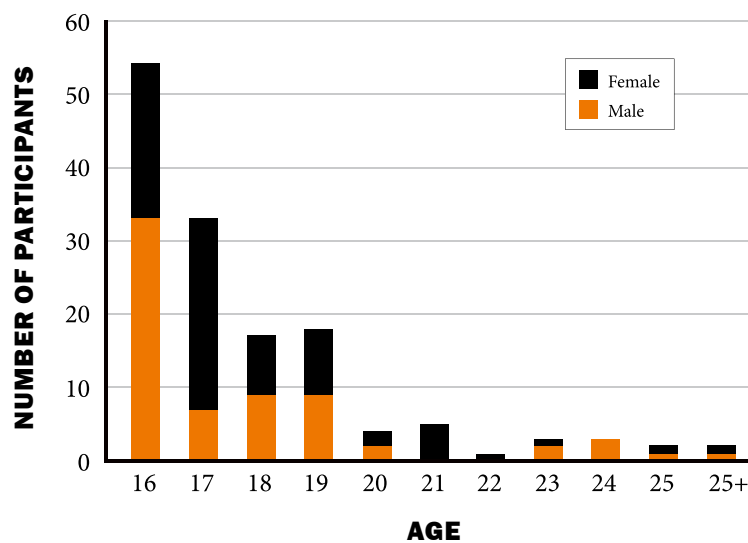
3.4 SELECTION OF PARTICIPANTS

The research participants consisted of 142 newly-arrived young people with refugee backgrounds who were living in metropolitan Melbourne at the time of study. The sample included 67 males and 75 females. The sample was purposively selected to reflect the ethnic composition of the humanitarian entrants to Victoria over the last 3 years, and consisted largely of Sudanese, Liberian, Horn of African, Iraqi, Afghani, and Burmese youth. The gender and country of origin of these participants are shown in Table 1.

TABLE 1 Number of participants by gender and country of origin

COUNTRY OF ORIGIN	MALES	FEMALES	TOTAL
Iraq	4	13	17
Afghanistan	9	9	18
Burma (Myanmar)	8	18	26
Sudan	17	8	25
Ethiopia	10	4	14
Liberia	0	5	5
Somalia	1	4	5
Eritrea	1	2	3
Other African countries	5	0	5
Iran	2	1	3
Other countries	10	11	21
TOTAL	67	75	142

Due to issues of parental consent, only participants who were aged 16 years and over were invited to participate in the study. The large majority of participants were aged between 16-25 years. Two of the participants were aged between 25-30 years.

FIGURE 1 Age range of participants by gender

Stratified purposeful sampling was used to select participants from subgroups of interest (Patton, 2002). Two sub-samples of purposively selected youth were recruited. The sub-samples were chosen to reflect different categories of vulnerability and risk (in relation to sexual health): youth with refugee backgrounds who are homeless or at risk of becoming homeless, and those who are living at home and attending school. These sub-samples included males and females.

In addition, key informant interviews were conducted with **15 case workers and health professionals** who work with young people with refugee backgrounds.

3.5 RESEARCH METHODS

- ***Focus Group Discussions***

Focus group discussions are useful for obtaining information on social norms and cultural expectations on various issues, including sexual health (WHO 2007). Sexuality is influenced and shaped by conversations and interactions with peers, and although individual views are diverse, group discussions can contribute important information around discourses and understandings. The aim of focus groups was not to gather information on individual experiences and behaviours, but to elicit information around dominant discourses, understanding, values, social pressures, and perspectives and to identify areas of agreement and disagreement.

A total of twenty-three focus groups were conducted: 11 with males and 12 with females. The focus groups lasted from thirty minutes to two hours. A facilitator used a theme list and encouraged discussion and exploration of issues and ensured that all participants contributed.

- ***In-depth Interviews with Youth***

In-depth interviews were conducted with 14 young people with refugee backgrounds: 8 females and 4 males. The interviews aimed to collect comprehensive and in-depth information that explored narratives around sexual health literacy and sexual health practice. The interviews were based on a semi-structured guide that set out key questions and themes (WHO 1996). This allowed an informal and conversational tone to develop during discussions.

- ***Key Informant Interviews: Case Workers, Health Professionals***

In-depth semi-structured interviews were conducted with 15 case workers and health professionals who engage directly with refugee communities. The aim of these interviews was to obtain expert or specialised perspectives on relevant issues. Participants' places of work included community health centres, hospitals, community-based and non-government organisations, and Migrant Resource Centres.

3.6 DEVELOPMENT OF RESEARCH TOOLS

The focus group discussions and in-depth interviews with youth with refugee backgrounds were based on interview guides (see Appendix 4 and 5). The key areas covered in the interview guides were:

- attitudes around relationships and initiation of sexual activity
- knowledge and attitudes around sexual health issues, particularly STIs, HIV/AIDS and contraception and safe sex practices
- knowledge, attitudes and values around pregnancy and terminations
- attitudes to sexual health risk and prevention, and barriers and enablers to protective sexual health behaviours
- knowledge of and access to reproductive and sexual health services, and enablers and barriers to access
- sources of sexual health information and preferred modes of delivery
- relevance and appropriateness of mainstream messages around sexual health

Group discussions and interviews aimed to draw out knowledge and attitudes around STIs, pregnancy, contraception, and barriers and enablers to the use of health services. However, their scope was broad enough to also allow associated issues and concerns to emerge, such as alcohol use and relationships.

The use of semi-structured questions and scenarios ensured that discussion remained focused on issues of sexual health while allowing new and important related issues to emerge (WHO 1996). This is a key strength of qualitative methodological approaches (WHO 1996; Patton 2002).

Support workers and health professionals were interviewed using a semi-structured interview guide (see Appendix 6). Interviews focused on their experiences of working with youth with refugee backgrounds – particularly youth who are homeless or at risk of homelessness - with specific emphasis on issues of sexual health, and barriers and enablers to accessing information and services.

The interview guides were developed in consultation with the advisory committee. A number of existing qualitative research instruments that focus on sexual health were reviewed in order to inform the development of the interview guides (see Yesilyurt, Dawson et al. 1996; UNDP, UNFPA et al. 2004; Amyuyunzu-Nyamongo, Biddlecom et al. 2005; McNally and Dutertre 2006)

3.7 DATA COLLECTION

Data collection was conducted in settings chosen by the participants and where they felt comfortable and safe. Given the sensitivities around discussing sexual health issues, settings were selected that allowed privacy. Such places included people's homes, community organisations, schools, AMES and MRC offices, and restaurants.

Focus groups and interviews were digitally audio-recorded (with the permission of participants) and fully transcribed. In a few interviews, participants asked that the discussion be recorded through manual note-taking rather than audio-recording.

Interviewers were recruited that had prior experience conducting research with people with refugee backgrounds. Collaborative approaches to research underscore the benefit of involving researchers that share the same ethnic background as the study population as they have a greater capacity to understand respondent's views and experiences (Elam and Fenton 2003). However, 'ethnic matching' overlooks other potential elements of discordance, such as gender, social status, or age. It can also make it difficult for participants to critique cultural norms and values and to describe behaviours that diverge from accepted values and can give rise to misgivings about confidentiality within community groups (Elam 1999; Elam and Fenton 2003: 23). In this research, given the wide range of ethnic backgrounds of study participants and the fact that focus group discussions were not always ethno-specific, interviewers and participants were not necessarily ethnically matched. All interviewers were briefed on confidentiality procedures, were familiar with the research guides, and had opportunity to practice asking questions and managing group dynamics.

In the first year of arrival, English language skills are usually very limited. Due to concerns that the use of adult interpreters from the same community or language group would not be appropriate when discussing sensitive and private issues, the sample predominantly comprised people who have been living in Australia for between one and five years and who had adequate capacity to communicate in English. However, in two of the focus group discussions with Burmese participants – the majority of whom had arrived in the previous year – researchers worked with gender-matched interpreters.

Recruitment of young people with refugee backgrounds occurred through three main research sites: Footscray Youth Housing, the Centre for Multicultural Youth and Foundation House/RHRC Good Starts Study for Refugee Youth. Male and female research officers were based at CMYI to recruit young people for data collection and conduct focus group discussions. A researcher was also based at Footscray Youth Housing and worked in collaboration with staff to recruit young people and conduct small group discussions and in-depth interviews.

3.8 ETHICS

Ethical protocols were developed in accordance with guidelines that ensure appropriate procedures for human research, including research with refugee communities and youth. These include documents of the National Health and Medical Research Committee, Victorian Foundation for Survivors of Torture and Trauma (Foundation House), The La Trobe University Human Ethics Committee. Ethics approval was sought and obtained through the La Trobe University Human Ethics Committee.

An information sheet was developed explaining the purpose and format of the project, providing assurance of confidentiality, and outlining the consent process. This was provided to youth who were identified as potential participants for the focus group discussions and interviews (Appendix 7). Preliminary review of this document with young people clarified that the information would be presented in a way that maintains the confidentiality of individuals. The information sheet and initial discussions also made explicit the right of an individual to withdraw from the research process and retract any information provided. An information sheet and consent letter was also developed for case workers (Appendix 8 and 9). Verbal consent was sought from youth with refugee backgrounds and written consent from case workers. The content of the information sheets was approved by the La Trobe University Human Ethics Committee and the Project Advisory Committee.

During the research phase, discretion and confidentiality was maintained. The information provided by participants was stored in a locked cabinet at La Trobe University.

3.9 ANALYSIS

The approach of methodological triangulation - collecting data from a variety of sources using different techniques and respondents - increases the validity of the qualitative data (WHO, 1996). Qualitative data in the form of focus group discussion and in-depth interview transcripts were analysed for thematic content. Data collection and analysis was iterative (Grbich 1999) in that collection and analysis took place concurrently with themes and issues emerging from initial data being used to inform subsequent data collection. The NVivo qualitative software application was used to facilitate coding and management of the final data set.

3.10 METHODOLOGICAL ISSUES

The interview guidelines set out key issues and thematic areas, along with follow-up questions in order that interviewers could explore themes in more detail. Consequently, the group discussions and interviews did not cover precisely the same content or approach issues in the same ways. This allowed for nuanced data collection and a richer understanding of participants knowledge, attitudes and experiences. However, it inhibited comparative analysis of each issue according to sex and ethnicity.

The nature of responses within groups varied substantially, reflecting a combination of the interviewers' approach, the comfort and willingness of participants to contribute to discussion, and the base-level understanding of sexual health issues. In particular, participants' responses were significantly influenced by whether or not they had experience of sexual relationships.

The group-based discussions did not seek to elicit personal experiences of sexual relationships such as heightened risks, implementation of protective behaviours, or use of screening services. While some participants offered information around personal experience, the group-based nature of these discussions inhibited in-depth discussion. The inclusion of in-depth interview, however, allowed in-depth discussion with some participants.

142 young people with refugee backgrounds were included in the study. However, different ethnic groups were not equally represented, and some focus groups included participants with different ethnic backgrounds (i.e. two or more African countries). Analysis of differences and commonalities according to ethnicity was therefore difficult. Although the study included a reasonable sample size, sub-group analysis by ethnicity would result in some loss of explanatory power.

Participation of parents and families of young people from refugee backgrounds could have provided a broader understanding of the social and cultural contexts within which young people learn about sexual health and develop sexual identities. Involvement of parents and older community members in future research would provide insight into possibilities and challenges for family and community oriented strategies for sexual health promotion.

4. SEXUAL HEALTH: POLICY AND FRAMEWORKS

This chapter provides a brief overview of the key National and State policies and strategic frameworks relating to sexual and reproductive health, and health care service responses and initiatives for people with refugee backgrounds.

4.1 POLICY AND STRATEGIC FRAMEWORKS: STIS, HIV/AIDS, BBVS

A range of strategies and frameworks form part of a comprehensive national approach to reducing the prevalence and impact of STIs, HIV/AIDS and BBVs and improving treatment, care and support for affected people. These include:

- National Sexually Transmissible Infections Strategy 2005-08
- National HIV/AIDS Strategy 2005-08: Revitalising Australia's Response
- National HIV Testing Policy 2006
- National Hepatitis C Strategy 2005-2008
- National Communicable Diseases Surveillance Strategy
- National Drug Strategic Framework
- National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008
- National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003-2006

There are a number of Victorian strategies that complement and fit within the national strategic frameworks. These strategies provide a state-level framework for the response to STIs, HIV/AIDS and BBVs in relation to prevention, education, control, treatment, care and support. They include:

- Victorian Sexually Transmissible Infections Strategy 2006-2009
- Victorian Hepatitis C Strategy 2002-2004 and Addendum 2005-2009
- Chlamydia Strategy for Victoria 2001-2004
- Victorian HIV/AIDS Strategy 2002-2004 and Addendum 2005-2009
- Victorian Prison Drug Strategy 2002
- Victorian Women's Health and Wellbeing Strategy Stage 2 2006-2010
- Health and Sexual Diversity: A health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians 2003

Both the National and Victorian sexual and reproductive health strategies make explicit the fact that certain population groups are at increased risk of STIs or carry a higher burden of disease related to STIs. These include young people, men who have sex with men, Indigenous people and sex workers. For example, the Victorian STI Strategy 2006-2009 identifies that young people's capacity to learn about STIs and access services can be affected by factors such as culture, language, sexuality, social exclusion, literacy, poverty, and homelessness. It states that the factors that create vulnerability of certain populations to STIs can also present barriers to equitable access to information, prevention and treatment services.

4.2 SEXUALITY EDUCATION FOR YOUTH IN VICTORIA

School-based sexuality education

School-based education is regarded as the most efficient way of reaching young people before they become sexually active (Dyson and Mitchell 2005: 136). The Department of Education and the Department of Human Services regard the provision of education around HIV/AIDS, STIs and

BBVs as essential to a comprehensive health education program (Department of Education 2006). A number of national and Victorian strategies specifically recognise schools as a partner in the process of improving the health of young people in Australia, including sexual health.

- Gender Equity: A framework for Australian schools
- National Framework for Health Promoting Schools 2000-2003
- Health Promoting Schools in Action: A guide for schools 2000
- Talking Sexual Health: a national framework for education about HIV/AIDS, STIs and blood-borne viruses in secondary schools
- AIDS/HIV Policy and Implementation Guidelines 1991

Sex education in schools in Australia is a state and territory responsibility. In Victoria, sexuality education in government schools is managed by the Department of Education and is a component of the broader health education curriculum set out in the Victorian Essential Learning Standards (VELS) for Health and Physical Education (Victorian Curriculum and Assessment Authority 2005; DHS 2006). These standards provide age-appropriate guidance on program curriculum and assessment for Prep to year 10. The Victorian Government Schools Reference Guide also provides an overview of effective sexuality education in schools. Using these guidelines, schools (government and non-government) develop comprehensive health education curricula that ideally use a whole-of-school approach that links sexuality education curriculum to other areas of learning, and to specific local and cultural needs (Department of Education 2006; DHS 2006: 18).

With the introduction of VELS across all Victorian schools, sexuality education has been identified as an essential curriculum component and is compulsory within the Health and Physical Education domain (Department of Education 2006). There is substantial variation, however, in the content and quality of sexuality education in schools throughout Victoria (FPV 2005). Due to political and social anxieties about the role of schools in sex education, the structure and scope of many existing school-based programs have focused on the safer option of disease prevention instead of addressing more socially oriented health enhancing behaviours (Dyson and Mitchell 2005: 138).

There are two recommended curriculum resources for sexuality education in secondary schools: 'Talking Sexual Health' a national framework for education about HIV/AIDS, STIs and blood-borne viruses, and 'Catching On', a Victorian teaching support resource for STD/HIV prevention education released by the Department of Education (Australian National Council on Aids 1999; Australian National Council on Aids 2000; Australian National Council on Aids 2001; Department of Education 2004). These resources are widely used within Victoria, specifically during years 9 and 10, and focus on STI/HIV prevention, personal decision making and behaviours, and the social and community contexts of young people (Dyson and Mitchell 2005; DHS 2006). However, they are not designed to address the particular issues and needs of students with culturally and linguistically diverse backgrounds (DHS 2006: 18).

The Secondary School Nursing Program and school-focused health services have an important role in sexuality education. The Secondary School Nursing Program is funded by the Department of Human Services and aims to reduce risk to young people and promote better health. The program employs 100 nurses in 199 Government Secondary Schools across Victoria (DHS 2007). While curriculum planning is the responsibility of teachers, school health nurses are encouraged to work as part of a team for the development and delivery of health and sexuality education (Department of Education 2006).

School teaching staff often have limited training in sexuality education and can find it difficult to access professional learning (DHS 2006: 18). However, teachers can use support resources and guest presenters to assist in the delivery of sexuality education. Sexuality education also involves partnership with parents, local health and welfare services and local groups.

English language schools and centres

The Department of Education provides English language teaching programs for students who are newly enrolled in Victorian government schools and who need to learn English. The New Arrivals Programs take place or are organised through English language schools or centres, and aim to teach students the English language skills they need in order to study in primary or secondary schools. School age humanitarian entrants who are new to learning English and who have been in Australia less than six months are eligible to attend the New Arrivals Program.

There are nine English language schools and centres located in the Melbourne metropolitan area.¹¹ The four English Language Schools (ELS) are stand alone and provide full time courses for both primary and secondary students from the Prep year to Year 10. The five English Language Centres (ELC) are attached to mainstream primary and secondary schools: 4 ELCs cater for students in years 7-10, one ELC caters for students in years Prep-6. Students typically attend an English language school or centre for two terms, but those who need extra time may stay for up to four school terms. Students are placed into classes according to their age and English language skills. English Language Schools/Centres have teachers who specialise in teaching English, and small class sizes of around 13 students. Some new arrivals programs also operate in country Victoria.¹²

The curriculum aims to prepare students for further study in primary and secondary schools. Students are taught the English they need to function in the community, and also learn English through the content areas of key mainstream curriculum learning areas. Students are given special assistance if they have had interrupted schooling, or if they need to learn to read and write. English language schools and centres can also help students to access a range of support services such as medical and dental services. At the end of their English language school or centre program, students move to a mainstream school.

Sexuality education is not currently part of the core curriculum for ELCs/ELs. However, some ELCs and ELs are providing education to students around sexual health. These programs are delivered in collaboration with other services and programs, such as the Secondary School Nurses, the Refugee Health Nurses, and Community Health Centres.

Sexuality education external to school-based settings

Young people who are external to the school system also require sexual and reproductive health education, and prevention and treatment services. Agencies that interact with these young people should be encouraged to provide sexual health education, and coordinated strategies need to be developed (DHS 2006: 19).

A wide range of general and specific services provide clinical care to young people. Sexuality education can be provided in clinical and health settings. General Practitioners (GPs) are the major providers of sexual health clinical services in Victoria. There are also six state-funded sexual health

¹¹ English Language Schools and Centre operate in Blackburn, Collingwood, Noble Park, Braybrook, Springvale, Broadmeadows, Brunswick, Glen Eira and Clayton South.

¹² There are English Language Programs in Geelong and Shepparton.

clinical services in Victoria: one in the Melbourne metropolitan area (the Melbourne Sexual Health Clinic (MSHC)) and five in the non-metropolitan departmental regions (Hume, Gippsland, Barwon-South Western, Loddon Mallee, and Grampians regions) (Poljski, Atkin et al. 2005). Practice nurses and other nurses in the community (community health nurses and nurse practitioners) work in sexual health and provide community-based education and build links between services. Community health centres and hospitals also offer sexual health education and clinical services (Poljski, Atkin et al. 2005).

There are a number of services and agencies that specifically address sexual health issues amongst young people, and have developed targeted models, for example: the Frontyard Youth Service in Melbourne's CBD focuses on preventive and early intervention; the Centre for Adolescent Health delivers adolescent friendly services to young people; the Action Centre is a sexual health service provided by Family Planning Victoria that provides confidential information, education, counselling, services and referral for young people.

There is a range of internet-based sexual health education resources developed both nationally and internationally:

- “Your Sex Health” is about reproductive and sexual health, and provides information on emotional, practical and relationship issues. The site was developed and produced by Australian researchers, writers, designers and programmers through the University of Melbourne, Australia. www.yoursexhealth.org/
- The Education and Resource Centre at The Alfred Hospital is a free community service for all Victorians. Their web-site provides information around HIV/AIDS, hepatitis, STIs and health services. <http://www.hivhepsti.info/>
- The *likeitis* website is designed to educate teens on sexual health issues and reduce the rates of teenage pregnancy and sexually transmitted infections. It is an initiative of Marie Stopes International. Developed, written and designed in consultation with young people, *likeitis* provides teenagers with access to information on sex education and teenage life, covering areas ranging from puberty to contraception. <http://www.likeitis.org.au/>

4.3 REFUGEE HEALTH: KEY PROGRAMS AND INITIATIVES

In Victoria, there have been significant gains in the development of a comprehensive approach to health service provision for people with refugee backgrounds.

- ***Family and Reproduction Education Program (FARREP)***
FARREP is a health promotion and education initiative for communities known to practise female genital mutilation (FGM) in their countries of origin. FARREP has an emphasis on community education, information and support, and aims to assist those women and girls who are at risk of, or have already been subjected to FGM (DHS 2005). It aims to minimise adverse health outcomes of FGM through increased access to health services and to enhance culturally responsive health services for these communities. Taking a human rights perspective, the program focuses on health promotion and health education to affected communities. The program collaborates with health and related professionals and agencies.

A number of agencies participate in the FARREP program, including Western Region Community Health Services, Women's Health West, Darebin City Council, Banyule Community Health Services, North Yarra Community Health Service, Women's Health

North, Mercy Women's Hospital, Southern Health Care Network, Springvale Community Health Centre, Dandenong Community Health Centre, Royal Women's Hospital and Working Women's Health.

- ***Refugee Health Nurse Program (RHNP)***

In October 2005, the Victorian Department of Human Services launched the Refugee Health and Wellbeing Action Plan. One of the key initiatives of the Action Plan is the Refugee Health Nurse Program. This initiative places nurses with experience in working with CALD communities in selected community health services located in areas with high refugee populations. This program is designed to assist newly-arrived refugees to access health and social needs assessments, and to identify clinicians, services and resources to support this high needs group. The RHNP was launched in 2005 and has a budget of approximately \$1 million per annum (DHS 2007). Refugee health nurses are currently located in the following LGAs: Greater Dandenong (Dandenong Community Health), Brimbank (ISIS), Maribyrnong (Western Region Health Centre and Doutta Galla), Hume (Dianella), Darebin (Darebin Community Health Service), Ballarat (Ballarat Community Health Centre), Goulburn Valley (Goulburn Valley Community Health), Warrnambool (South West Health)

- ***Refugee Minor Program***

The Refugee Minor Program assists 'unaccompanied' young people and children, up to the age of 18 years, with settlement through a casework-based approach. The program focuses on enabling Refugee Minors to develop key settlement competencies, and has established partnerships with other key agencies (i.e. Victoria Police Multicultural Liaison Unit, Centre for Multicultural Youth, DIAC, the Sudanese Community Association of Australia, local government). Clients are provided with assistance on a wide range of issues including: accommodation and financial support, physical and emotional health needs, cultural and religious continuity, education, provision of support with Refugee Applications, social and recreational needs, and developing or maintaining client/family connectedness (DHS 2007).

- ***Integrated Humanitarian Settlement Strategy (IHSS)***

The Integrated Humanitarian Settlement Strategy (IHSS) is funded by DIAC and provides intensive settlement support to newly-arrived humanitarian entrants¹³ during their initial period of settlement, generally for the first six months after arrival (DIAC 2007). Since October 2005, AMES Settlement and its consortium partners have been contracted to deliver the program in Victoria. In 2005-06, the service assisted approximately 3,600 individuals, equating to around 1,100 households (AMES 2007). AMES Settlement Services and their consortium partners have the responsibility to support newly arriving refugees to access health services on arrival.

- ***GP Access: MBS Item for Refugee Health Assessment***

In May 2006, the Australian government introduced new Medical Benefits Schedule item numbers for refugee health assessment within the first twelve months of arrival. This provides incentive for GPs to undertake comprehensive assessment of refugee clients. The uptake of the new MBS item in Victoria is relatively high compared to other states, however the large majority of claims are in the West, North and Dandenong. The assessment includes

¹³ IHSS has two main groups of clients: Refugees (sub-class 200, 203 and 204 visas) and Special Humanitarian Program entrants (SHP or holders of 202 visas) and their proposers.

taking a detailed personal and medical history, a physical examination, organising any necessary investigations, and developing a health management plan (VFST 2007).

- **Specialist Health Services**

From June 2006, all health services in Victoria are required to establish a cultural diversity committee and lodge a health service cultural diversity plan as part of their *Quality of Care* reporting requirements. Some major health services have specialist clinics, Multicultural Liaison Officers and language services relevant to health service utilisation and access amongst refugee populations. Given the dispersed settlement of newly arriving refugees there is a need for more specialist services in the outer metropolitan and rural areas, particularly in relation to infectious disease and tuberculosis assessment and management (Victorian Refugee Health Network 2007).

- **Non-government Organisations and Services**

There are a number of non-government organisations and services that focus on health and well-being of refugees, including youth. For example:

- The **Centre for Multicultural Youth** (CMY) focuses on supporting, working in partnership and conducting programs and projects for refugee young people.
- The **Multicultural Health and Support Service** (MHSS) works with people from culturally and linguistically diverse (CALD) backgrounds and aims to increase their opportunity to achieve better health outcomes in relation to HIV, hepatitis C and STIs. The MHSS focuses on providing support for individuals and families to access health services, developing and delivering culturally appropriate community health education programs, and working with CALD communities and organisations to develop and implement projects and initiatives that focus on HIV, hepatitis C and STIs.
- **Western Young People's Independent Network** (WYPIN) is managed and supported by Melbourne City Mission Community Development Division. Its main focus is as an advocate and voice for young people of refugee and migrant backgrounds in the Western region. WYPIN addresses settlement issues for young people, including access to education and services, employment, social and family relationships, housing and recreational services.
- The **Victorian Foundation for Survivors of Torture** (VFST) ('Foundation House') provides a range of direct services to refugees, including counselling, advocacy, family support, group work, psycho-education, information sessions and complementary therapies. Direct services to clients are coupled with referral, training and education roles aimed at developing and strengthening the resources of various communities and service providers.
- The **Multicultural Centre for Women's Health** focuses on improving the health and wellbeing of immigrant women, including refugees and asylum seekers. They have specific expertise in reproductive and sexual health.
- **Migrant Resource Centres** provide services and programs to people with refugee backgrounds. They support new families, children and individuals to settle in Victoria.

Many of these organisations and centres are actively engaged in programs in programs that focus on young people and health, including in the area of sexual health. The details of programs and projects of all organisations and their programs are beyond the scope of this report.

THIS SECTION PRESENTS AN ANALYSIS OF THE FINDINGS OF THE RESEARCH WITH NEWLY-ARRIVED REFUGEE YOUNG PEOPLE. IT CONSIDERS YOUNG PEOPLE'S AWARENESS OF SEXUAL HEALTH ISSUES, HOW THEY LEARN ABOUT SEX, ATTITUDES TOWARDS THE INITIATION OF RELATIONSHIPS AND ONSET OF SEXUAL ACTIVITY, IMPLEMENTATION OF SEXUAL HEALTH INFORMATION, AND AWARENESS AND USE OF HEALTH SERVICES IN RELATION TO SEXUAL HEALTH ISSUES. GIVEN THE DIVERSITY OF RESEARCH PARTICIPANTS – IN TERMS OF ETHNIC BACKGROUND, GENDER, HOUSING STATUS – THE ANALYSIS DRAWS OUT COMMON THEMES, BUT ALSO EXAMINES POINTS OF DIVERGENCE. THE ANALYSIS ALSO INCORPORATES KEY FINDINGS FROM INTERVIEWS WITH CASE WORKERS AND HEALTH PROFESSIONALS WHO WORK DIRECTLY WITH YOUNG PEOPLE WITH REFUGEE BACKGROUNDS, HIGHLIGHTING THEIR PERSPECTIVES AND INSIGHT.

5. KNOWLEDGE AND ATTITUDES

Knowledge is only one component of people's capacity to engage in protective behaviour. However, there is an established link between accurate knowledge, values, attitudes, and the adoption of health protective behaviours (Smith et al 2002 report: 15). Research with young people has shown, for example, a significant association between higher sexual health knowledge and reported contraceptive use at first ever intercourse (Coleman and Testa 2006). Knowledge is an important prerequisite for risk prevention (Grulich, De Visser et al. 2003).

This chapter discusses young people's knowledge of and attitudes towards HIV/AIDS, STIs, contraception and unplanned pregnancy. The level of understanding of sexual health issues amongst resettled youth with refugee backgrounds is generally low. There is a lack of knowledge about the most common infections, such as chlamydia, herpes simplex virus, and gonorrhoea. While most participants are aware of HIV/AIDS, there is a perception that HIV is not a risk in Australia. However, HIV/AIDS is considered the most serious STI because it is regarded as incurable and fatal.

Young people have poor knowledge of modes of transmission, symptoms, and treatment options for STIs, including HIV/AIDS. There is a widespread assumption that people with STIs always display symptoms, and potential carriers of STIs can be identified by their reputation and behavioural or visual cues.

Participants commonly identified contraception as a way to prevent both STIs and unplanned pregnancy. Condoms were the most frequently mentioned contraceptive method. Many young people emphasised the protective function that contraception offers against the shame and stigma associated with STIs and unplanned pregnancy. Young men emphasised the importance of protection against HIV, whereas young women tended to emphasise protection against pregnancy in the first instance and then HIV.

Case workers and health professionals stated that the level of understanding of sexual and reproductive health issues is low amongst young people with refugee backgrounds. They indicated that while many young people have heard of HIV/AIDS, awareness of STIs is poor. Health professionals who have delivered sexuality education highlighted inadequate awareness of the names, modes of transmission, symptoms, and treatment options for STIs. They indicated that there is limited awareness of *'their bodies and how they work'*. Many emphasised the importance of providing education that focuses on wider dimensions of sexual and reproductive health, such as negotiating relationship, decision-making and gender roles.

5.1 HIV/AIDS

Awareness of HIV/AIDS was reasonably high within all ethnic groups and amongst both males and females. It was often the first sexual health issue mentioned, and for many respondents it was the only STI they could name: *'HIV, that's the only one I know'* (Burmese female). Discussion within a number of groups indicated that awareness of HIV/AIDS is due in part to the visa medical examination:

When you come from Africa to come here, we take medication. They would check everything. HIV and stuff. . . . When you come to Australia you do a lot of checks. TB and AIDS and everything. (Ethiopian male)

Several participants recalled undergoing health checks and explained that if you are identified as having a *'big sickness'* such as HIV then *'you're not going to get the visa', 'you just get stuck there', 'there is no way to come here'* (Sudanese male).

A few respondents said they had been taught about HIV in refugee camps prior to arrival in Australia. For example, three young Karen women from Burma were living in refugee camps in Thailand for a number of years prior to their arrival in Australia. They recounted learning about HIV in the camps, including that it can be transmitted through sex, and can be prevented by wearing gloves when in contact with people with HIV and by using condoms during sex. A small number of young people said that they heard about HIV/AIDS through public health media campaigns in their countries of origin or countries of temporary residence:

Back in Eritrea, for example, it's something that is constantly there because there is a lot of condom adds encouraging young people to use condoms because the HIV is spreading. (Eritrean female)

However, several respondents said they had never heard of HIV/AIDS. They were unable to name HIV/AIDS when asked to identify sexual health issues or to affirm awareness of the infection when asked directly if they had heard of HIV/AIDS.

Although a large number of participants were familiar with the terms HIV and AIDS, there was limited knowledge about transmission, symptoms and treatment. Many participants stated that it is an infection that can be transmitted through unprotected sexual contact:

Sometimes you can have sex with someone with HIV and then you are going to get it, you know. There is some chance you are going to get it, HIV. (African male)¹⁴

However, other potential modes of transmission were mentioned by only six participants and included drug injection, contact with blood, blood transfusion, and mother to child transmission. Condoms were widely understood to offer protection against transmission of HIV. A number of people, however, were misinformed about risk and transmission, expressing views that transmission can occur through sharing of utensils or breathing in proximity to someone with HIV/AIDS:

They should be put in a place where they can't get to other people. They should have their own plates, their own cups, and they should write on the cups that is theirs. Yeah. So you don't use it. Because I don't know, I heard that even if you sit close to that person and breathe you can catch it. Say the people that got bad sickness, you can't be close to them, even where they breathe because you might just catch it from the air. So my idea is just to give them a place so other people can't catch that. (Sudanese male)

The main symptoms that were identified as being associated with HIV/AIDS were tiredness, laziness, weakness, weight loss, and looking sick or 'dead':

When you have HIV you go kind of get skinny and stuff. You might notice if you have HIV if you were able to do this and you can't do it no more. You might get suspicious. (African male)

For people who have HIV, usually they kind of get a dead look on them. Like, I don't know, just kind of a really bad look on them. Like they have something really wrong with them. Sometimes maybe your eye colour will change. (African male)

Participants did not distinguish between HIV and AIDS, and symptoms of AIDS were regarded as indicative of HIV infection. A few participants mentioned that it is not always possible to identify someone with HIV/AIDS by their appearance alone.

HIV is often perceived to be a more significant risk in countries of origin, particularly amongst young people with African backgrounds: *I guess back home it would be a risk, but it's not that risky*

¹⁴ Some focus groups included people from two or more African countries. Where quotes are drawn from these groups, respondents are identified broadly as African because the specific country can not be determined.

here' (African female). This sense of reduced risk of HIV in Australia is due to HIV screening during the visa medical examination for humanitarian entrants, fewer visible public health campaigns in Australia, and awareness of the lower rates of HIV compared to countries of origin. However, a few people emphasised that it is still *'better being safe than sorry'*. *As one young man said, 'it makes no difference. You just have to be safe at the end of the day'*. A number of participants expressed concern about people who make return visit to their countries of origin or countries of temporary residence as there is no HIV screening on re-entry to Australia. They identified these trips as providing opportunity for HIV infection and the virus can then be brought back to Australia.

Most male participants identified HIV as the worst thing that could result from being sexually active; female participants identified both HIV and pregnancy as their highest concerns. No participant mentioned availability of treatment for HIV infection. HIV is regarded as a scary and serious infection because it is seen to be both incurable and fatal. This view is reinforced by accounts of people who died from AIDS in countries of origin and countries of temporary residence. Accordingly, many young people regard a person who is diagnosed with HIV as a 'dead person':

AIDS. A disease. It's hard. It's a fatal disease. You get once and you can't get rid of the disease. It's just the person gets by having sex. (African male)

HIV. You're going to die, you'll lose your life. (African male)

A number of people also expressed the view that HIV is a shameful disease:

Having HIV or AIDS and being a patient of this, or to die of being that disease, is the most disgraceful thing, the worst thing in the world. (Burmese male)

5.2 SEXUALLY TRANSMITTED INFECTIONS (STIS)

Other than HIV/AIDS, participants had limited or no awareness of other STIs. There is an apparent lack of knowledge about the most common infections, including chlamydia, gonorrhoea, and herpes simplex virus. Many people indicated they had not heard of sexually transmitted infections other than HIV/AIDS. Others were aware of the existence of infections, diseases and "bad sicknesses", but could not name them or describe their symptoms:

I don't them, but I know they are around and I'm scared of that. The family doctor told me about infections, but I forget the names of them. (Ethiopian female)

I only know HIV and AIDS that's all. I don't know the other virus and stuff. And I would like to know. Because I never talked about it. This is my first time. (Ethiopian male)

Concerns around poor health literacy were voiced by health professionals and case workers who work with newly-arrived youth with refugee backgrounds. They said there is poor knowledge of STIs and their causes, symptoms and treatments:

I don't think the people are very aware of STIs. We've done information sessions . . . I think people were very much not aware of it. They may have heard the names, but they don't know the impact of it. They may have heard about AIDS, but how can you transmit AIDS, and what is AIDS, and what is HIV, and what are the consequences? I don't think they know that. (Refugee Youth Worker)

A small number of participants were able to name one or two STIs, including chlamydia, hepatitis B and C, herpes, cold sores, gonorrhoea, and syphilis. These STIs were viewed as less serious than HIV because they are regarded as curable and non-fatal. Participants in a number of groups indicated that STIs were transmitted through 'sex', and a few people also specified kissing, oral sex, and non-

penetrative sex as potential routes of transmission. A few young people cited non-sexual diseases, such as tuberculosis, as STIs. One young male also identified 'wet dreams' as a health risk associated with sex. Several female groups referred to cervical cancer and the newly-available vaccine, but there was uncertainty about whether cervical cancer would be classified as an STI.

Knowledge of symptoms associated with STIs was not specific, but included a range of physical changes, pain and discomfort. Most participants believed they would have noticeable symptoms if they contracted an STI. A few groups mentioned particular symptoms, including feeling itchy, stinging, pain, bleeding, changes in the menstrual cycle, weakness, changes to the colour of urine, blood in urine, weight loss, black dots on the body, vomiting, headaches, and fever. A few people noted the asymptomatic nature of some STIs, and explained that is why it is important to go to a doctor for a check-up. Two young women expressed concerns that STIs can lead to infertility, particularly if an STI is recurrent. But most participants merely stated that someone with an STI would feel different, sick or uncomfortable:

They can feel in the body something is wrong. (African female)

Unwell all the time. You can realise that your body's not acting the way it did before. (Afghani male)

Participants were asked whether and how they could identify someone who had an STI. Several groups suggested it is possible to identify people with STIs by hair loss, changes to their skin, hair and eye colour, and changes to their face. One male group suggested it is possible to guess which girls are likely to have STIs by the way they look:

Sometimes people go to clubs and they get drunk and dance and meet one girl or two girl and you want to go out with this girl and then begin relationship and have sex. You can feel it, these girls, like you can use without condom or with condom, you can guess by yourself. The way she looks. You can feel this girl doesn't have disease or something. (Sudanese male)

Others suggested that a person with an STI is not easily identified just by looking at them. This raised the issue that an affected person can transmit an infection without his or her partner realising the risk:

That person might know themselves already whether they have disease or not, but for me it will be difficult to tell that that person does have disease. (Burmese male)

5.3 CONTRACEPTION AND PROTECTION

Protection is an everyday term which many participants used to describe contraception. Participants most frequently mentioned condoms, indicating that they protect against sexual health problems and prevent pregnancy. Several people also referred to the 'rhythm method', pills and tablets, injections, implants, gels, diaphragms, and the morning-after pill. However, many participants said they did not have a boyfriend or girlfriend and indicated they did not yet know about contraceptive methods.

Participants regularly identified contraception or 'protection' as a way to prevent STIs and unplanned pregnancy:

Getting to protect yourself and partners. Yeah, when you have sex you have to have a condom on . . . Because it prevents you from having unwanted pregnancy and transmit disease and stuff. (Ethiopian male)

When I'm having sex, the first thing is having protection. That comes with it, you know what I mean? There are so many things out there, diseases. (Sudanese male)

That person might have a disease or sickness in his body and then he doesn't want to let you know and he wants to infect you. You don't know. So you have to protect yourself by using condom, stuff like that. (African female)

Motivations for the use of contraception are informed by gender. Young men identified fear of HIV as a primary reason to use contraception, whereas young women identified prevention of both HIV and pregnancy. A number of other studies have also documented that young women are more afraid of becoming pregnant than young men, and that young men most fear HIV (Gifford, Bakopanos et al. 1997; Gifford, Stephens et al. 1999; Munthali, Moore et al. 2006).

Discussion around contraception commonly led to statements about being careful in order not to jeopardise health:

Safe sex, it means . . . having sex, doing sex is not a bad thing. It's doing sex with good way. Yeah, that's what it is to me . . . Careful, yeah. You got to know the rules. (Ethiopian male)

One group of young men recounted a story about a friend who got his girlfriend pregnant: *'he was stressed out for two weeks until she decided to have an abortion.'* They explained that this friend did not take adequate care and a few different girlfriends had fallen pregnant and he *'chose not to do anything about it'*. They said *'we tell him he should be more careful. It's not just the girl he should be worried about, he could catch something'* (Ethiopian males).

However, discussion of contraception included broader references to protection not only from STIs and pregnancy, but also protection of well-being from a social and familial perspective. Many young women said it is important to take care to use contraception because if a girl was known to have become pregnant or contracted an STI then she would be viewed harshly and it would be difficult for her to find someone to marry. They also expressed concern about the possible ramifications if family or community members discovered that they were using contraception:

- *For us to use pills, they'll probably think that we're trying to avoid pregnancy and it's not living within our culture. Like, they'll think that something is wrong with you . . . Our community will, so will your family.*
- *You can be keeping it to yourself. I guess they won't know. But we are nosy people aren't we? So they will know. They will know. (Horn of Africa females)*

In addition to contraception, a number of participants indicated that the best way to protect against STIs and unplanned pregnancy is to *'stay in control'* and not have sex or to wait until marriage before having sex. This is discussed in more detail in Chapter 8.

5.4 UNPLANNED PREGNANCY

Unplanned pregnancy was identified by the majority of participants as one of the risks associated with being sexually active. It is a key concern for people who are sexually active, particularly females. They spoke of worries that they are too young to become a mother, fear of the responses of family and community members, and concern that they might be unable to care adequately for the baby or to pursue other opportunities in their lives:

After I sleep with my boyfriend I was stressed out every day. I worried this, I worried that and he said to me 'you think too much', stuff like that. The one thing I worry about most is getting pregnant. I'm nervous and he's only nineteen. (Burmese female)

Being newly-arrived in Australia, young people's concerns about unplanned pregnancy are heightened. They emphasise the demands of settling in Australia – such as securing employment,

education, language skills, housing – and explained that it would be particularly difficult to make a new life if they were to become parents before they felt ready.

Female participants said that pregnancy would be suspected if someone missed their period or felt sick, weak or dizzy, or had shortness of breath: *You wouldn't have your period for like the month that you're supposed to have it (Horn of Africa female)*. Males also mentioned fainting, hot, sweaty, pain in the stomach, and getting fat.

A small number of females described health problems associated with unplanned pregnancy, such as infertility arising from abortion:

She can't have any kids now. She had an abortion and then she had a miscarriage and she didn't have herself cleaned out, and she got an infection in her womb. Yeah. They did an operation to take out her womb. (Ethiopian female)

However, discourses of risk and protection in relation to unplanned pregnancy were not usually linked to health outcomes, but rather to the impacts on social relationships within family and community networks. For female participants across all ethnic groups, reducing the risk of unplanned pregnancy, either through abstinence or using contraception, is a method for protecting social status. They said that a girl who became pregnant outside of marriage would feel ashamed and would be talked about and viewed with a high level of disapproval:

They might not hit you or nothing like that but when you're talked about you feel like you're nothing. (African female)

In particular, her parents would feel anger and shame and she might be 'kicked out of home' or disowned:

And if she get pregnant and she is not married? Sometimes the parents put them out of the house. She has to go to the person that got her pregnant and even if he doesn't love her anymore, they just make her leave the house. (African female)

A young woman who was known to have become pregnant outside of marriage was generally considered to have bleak marriage prospects. One group of young women described the impact of an unplanned pregnancy on a family, explaining that not only did the girl find it difficult to marry, but also her sisters:

- *Her family is shy, embarrassed. Embarrassed to go in front of anyone, from Afghan families to everyone. And then nobody is going to get married to her sister.*
- *Nobody is going to let her be with their girls. Stop her going to friend's house. No, maybe stop coming to their house. (Afghani females)*

The difficulties faced by unmarried pregnant women are more severe than those faced by unmarried young men. Male participants expressed concerns about community responses and fear of fatherhood. However, the risks and social consequences associated with unplanned pregnancy were not viewed as seriously. Young men indicated that people might speak poorly of them. Several young men said that if a girl became pregnant accidentally, the boy would not necessarily take on the responsibilities of a father. They indicated that it is the female who is primarily responsible for pregnancy:

Getting your girlfriend or any, like somebody you had sex with, if they got pregnant maybe the girl would have abortion or she won't have abortion. It doesn't mean you've got to be the father, you've got to be living with her. (African male)

A few young males suggested that unplanned pregnancy could be resolved by the female taking the morning after pill or by having an abortion:

If the man says we have to take the baby out, I still love you but we have to plan something and get married, not now. And so they would take it out. (Afghani male)

I don't think it is a big issue getting pregnant, because there are pills that you can take and there is other ways that they stop it. (Ethiopian male)

A large majority of participants indicated that it was not only the young couple or pregnant girl that would be ashamed but *'the whole entire family will have a bad name'* (Horn of Africa female). They indicated that where a girl becomes pregnant the family will be isolated and their reputation tarnished. Parents will be blamed for their lack of control over their daughters, the daughter will be regarded as disrespectful of her parents, and the wider community will lose respect for the family:

Getting pregnant without getting married, it's really bad, yeah. Because the girl would be seen as really bad. Especially for girls it's really bad . . . I think [the community] thinks with a culture point of view. They lose their respect, for the family, not just the girl. (Ethiopian male)

In addition to the social stigma associated with pregnancy outside of marriage, young women also spoke of worries about getting pregnant because they are young and don't know how they would look after a baby and feel it would limit opportunities to do other things with their lives. A few recounted conversations with partners who said that having a child would mean they would not be able to spend time together or buy a house. One young woman who had an unplanned pregnancy and chose to have an abortion said:

It's about who you are, how you are going to care for it, who the father is. I needed to study. I wanted to do something with my life. I was really regretting what happened. It wasn't worth it. (Ethiopian female)

5.5 PRIORITISING SEXUAL HEALTH IN THE CONTEXT OF SETTLEMENT

Sexual health is widely understood by young people with refugee backgrounds to refer to the absence of sexually transmitted infections and prevention of unplanned pregnancy. In general, young people are aware of the risk of getting pregnant or contracting HIV. Awareness of other STIs is more limited. Risks to sexual health are also entwined with risks to social well-being, with many participants emphasising the shame and stigma associated with STIs and non-marital pregnancy.

Many participants indicated they are aware that sexual health is important, but only a few young people regard themselves as at risk. For most young people, it is not perceived to be an important issue in their lives:

It's very important, but I don't know, it's hard to take it seriously for some reason. I don't know why. I know it's important, but, umm, yeah. Taking it seriously is the hard part.' (Ethiopian male)

For many newly-arrived young people, the demands of settlement take precedence over other needs and concerns, including sexual health. Young females said that the main concerns and goals in their lives were to: learn English, finish their studies and get a good education, secure a job and earn sufficient income to support themselves, find someone who loves them, have a stable life, have children, and buy a house with their husband:

The most important thing for me actually is to finish my study and have a career instead of a job and, yeah, have a family. (Burmese female)

They indicated that they were worried about lack of money, understanding how Australian systems work, housing and homelessness, adjusting to a new culture, and the difficult situations of family back home. Young males said that their main concerns and aspirations were to: learn English; earn money; and find employment or own a business. They said they were worried about the pressure to send money back to family members in countries of origin and first countries of settlement and felt anxious about whether they will be able to bring family members to Australia. They also indicated that life in Australia was more difficult than they anticipated:

I imagined big things, but it's not true. When I was moving from there I was saying 'I'm going to go to this country, I'm going to have a nice life'. But when I came here, ooh, it's different. I thought I'm going to finish school, I'm going to be like the people you see in the movies. But it's the opposite. It's hard. (Ethiopian male)

Many young people spoke of the loneliness and anxiety associated with family separation and of their hopes for family reunification. Given these pressing settlement concerns, sexual health is not regarded as a priority issue by many newly-arrived youth with refugee backgrounds.

KNOWLEDGE: KEY MESSAGES

HIV/AIDS

- There is widespread awareness of HIV/AIDS.
- Knowledge of modes of transmission and symptoms of HIV/AIDS is limited.
- HIV/AIDS is viewed as incurable and fatal: a shameful illness.
- HIV/AIDS regarded as a greater risk in countries of origin than in Australia.

STIS

- Awareness of STIs is generally low.
- STIs (other than HIV/AIDS) are regarded as curable and non-fatal.
- STIs are known to be transmitted through 'sex', but few people specified routes of transmission in further detail.
- Knowledge of STI symptoms is non-specific, with most people indicating an STI would lead to feeling sick or uncomfortable.
- Widespread assumption that a person with an STI can be identified: a person would appear physically different and unwell.
- Few people mentioned the asymptomatic nature of some STIs.

CONTRACEPTION

- Contraception protects against STIs and pregnancy.
- Contraception also protects social well-being by preventing the shame and stigma associated with STIs and unplanned pregnancy.
- Condoms are the most frequently mentioned form of contraception.
- Young men frequently cited contraception as a way to protect against HIV/AIDS.
- Young women tended to mention both protection from HIV/AIDS and unplanned pregnancy.

UNPLANNED PREGNANCY

- Concerns around unplanned pregnancy generally relate to family and community responses: i.e. shame, stigma, family conflict, social isolation, poor marriage prospects.
- Unplanned pregnancy is of particular concern amongst young women.
- Social risks around unplanned pregnancy are higher for young women than men.
- Many young people feel too young to raise a child, and worry that it would limit their opportunities for work and study.

SEXUAL HEALTH

- Sexual health is widely understood as referring to the absence of STIs and prevention of unplanned pregnancy.
- It is also related to social well-being, through avoidance of shame, stigma and family and community-level repercussions associated with STIs and unplanned pregnancy.
- Sexual health is not a priority in young people's lives, in part because it competes with other settlement issues: learning English, study, finding employment, housing, family separation etc.

6. LEARNING ABOUT SEX AND SEXUAL HEALTH

Access to accurate and reliable sexual health information is critical to the development of a healthy sexual behaviours and attitudes. In this study, participants were asked to talk about how they found out about sex and sexual health: who they can and can not talk to, and who and what are the most reliable sources of information? Young people's sexual health literacy is affected by the availability, preferences, perceived credibility, and mode of delivery of sexual health information.

Potential sources of information include parents, friends, partners or spouses, health professionals, school teachers, written resources and the media. Another important source of knowledge was experiential learning within casual and longer-term sexual relationships and marriage. This section focuses primarily, however, on non-experiential learning.

Young people expressed a preference for obtaining information through reliable sources, such as doctors, nurses and schools. Verbal and group-based education sessions were consistently identified as the preferred method for learning about sexual health. Young people said they want to be provided with clear and factual information before the onset of sexual relationships. They stated a preference for same-sex groups with gender-matched educators in order to allow open discussion of sexual health issues. Written information (both in English and in community languages) should primarily be used to support interactive and group-based learning.

The study highlights the importance of school-based sexuality education for improving sexual health literacy and capacity for protective behaviours. Capacity building for early settlement services, English Language Schools and Centres and health care and community workers would increase opportunities for the effective delivery of sexual health information for young people with refugee backgrounds. Involvement and consultation with parents would allow increased understanding of the value of sexual health education for young people. Young people with refugee backgrounds who do not attend school need to be reached through other commonly frequented sites, services and educational programs.

6.1 AWARENESS OF SEX AND SEXUAL HEALTH PRIOR TO ARRIVAL

Many young people with refugee backgrounds arrive in Australia with limited knowledge about sexual and reproductive health. Case workers and health professionals stated that newly-arrived young people have often had little opportunity to participate in health education and limited exposure to resources or health services that might increase their knowledge and understanding. They indicated that youth with refugee backgrounds are often misinformed or have little knowledge about reproductive and sexual health issues. One Refugee Health Nurse who delivers sexual health education sessions said:

Say if you take a group of boys, there might be one or two that are quite on to it, and the rest would just be completely ignorant. And then the Liberians would be telling you all these wild things about HIV: if you do this you can get it, and if you do that you can't get it. Very misinformed type information . . . But then, they haven't had that much education or exposure to this type of information. So they're still going on with the African stories: 'you can't catch HIV on the first occasion'. You know, things like that. (Refugee Health Nurse)

A few young people reported having received sexual and reproductive health information prior to arrival in Australia, both in their country of origin and in refugee camps. They said they had learned about HIV through media campaigns or in school. A few people said they had attended sexual health

education while living in refugee camps in Thailand, India, Kenya, and Malaysia. They recalled learning about HIV, use of condoms, and abstinence:

One year when HIV started to spread enormously in Thailand then people got worried, young people. Then they came in to talk about HIV: 'if you have sex with someone just use the condom' and stuff like that. And that's it. (Burmese female)

They are talking about the young people, that they should not be having sex, they talk about HIV. That they don't have HIV or they will have AIDS. (Burmese female)

However, the large majority of participants indicated they had not had any opportunity to participate in sexual health education prior to arrival in Australia. They explained that there had not been any sex education in their schools, and that the adults 'back home' didn't think that young people should learn about sex prior to marriage:

In Burma, we have not much information or knowledge about this kind of education. Even parents didn't talk about it much. Even young people, we just live as we live and we are not aware of this kind of risk. (Burmese male)

Consequently, participants said that that while they might have learnt about sex through friends or 'in the street', knowledge was often limited and even at the point of marriage people were often not well-informed about sex and sexual health:

In Afghanistan I think they are like me, and like us, they don't know about sex. They don't want to listen about sex. And after getting married, then you have to do it, and you have no idea that you have to do this . . . It's very different. (Afghani female)

6.2 SOURCES OF INFORMATION

Sources of information can be classified as formal or informal (Elam, Fenton et al. 1999). Formal sources are those which might be regarded to be factual and reliable such as teachers and medical professionals; informal sources are those which are regarded as less reliable and authoritative, such as friends, media, and the internet. Many participants made a distinction between formal sources of information and informal sources. But **there is a disjuncture between the sources that are seen as accurate and those that are readily accessible**. Formal sources are perceived to have the most reliable information: doctors, nurses, hospitals, books and research. Doctors in particular are regarded as an accurate and expert source of information on sexual health due to their experience of working in the health sector:

I would love to hear about it from someone with a lot of experience, like a doctor. (Ethiopian female)

However, formal sources of information are not typically viewed as accessible. Young people described informal sources, such as friends and internet, as the most common source of information. But they indicated they are not reliable. As one young male said:

I suppose it is one thing that's kind of funny, isn't it? That there are people you can talk to and then there's the people that maybe would have the best information but maybe they're hard to talk to or . . . It's a bit like that. I would talk to my friends but they tell you all kinds of whacky things. (Ethiopian male)

It is significant to note that a number of newly-arrived youth, particularly those with limited English-language capacity, said they were not aware of anyone they could talk with about sex, particularly prior to marriage. They also indicated they did not know where they could go to seek information.

A large majority of female participants suggested that sexual health is not considered an appropriate topic until after marriage. Once married, they would be able to begin having sex and their husband would be the main person they could talk to about sexual matters such as pregnancy:

If I get married I can talk to my husband freely and shamelessly. But if I don't have any husband or am not married yet, I don't have any idea who I could talk to. (Burmese female)

Doctors and health care professionals

Doctors and other health care professionals were widely regarded as 'trustworthy' and 'expert' sources of information about sexual health. But many young people indicated that they would only seek information or assistance from a doctor if they were faced with an actual sexual health issue, such as an STI or unplanned pregnancy. A limited number of young people said they had actually sought or received sexual health information from a GP or health professional. For example, a few young women described how an unplanned pregnancy had belatedly led to the opportunity to obtain information about contraception and protection from a doctor. As one woman said:

For some parents it is like a taboo to talk to their young children about that, so those children either get to find out the hard way or from their friends. Some children get pregnant before they get to know about it, because once you get pregnant at a very early age and you go to the hospital for a pregnancy examination, from there the doctors and nurses will give you the education. (Liberian female)

Many young people said that they would only see a doctor if they had a serious health concern or disease, not to merely seek information:

I hate going to hospital. If I find I go to hospital I just think 'oh, it's pretty serious'. I wouldn't do it. It just never comes up. (Sudanese male)

This lack of contact with doctors and health care professionals means that young people do not have the opportunity to access sexual health information during consultations. It also results in a lack of familiarity which presents a further barrier to utilising doctors as a source of information:

I don't know him, you know what I mean, whoever that is. So talking about these kinds of issues with the person, it's always a bit hard for us, yeah. It's obvious actually. (Ethiopian male)

A small number of young women who had specific anxieties about their sexual health described talking first with their case workers, and then accessing health services with their support.

School-based sexual health education

School was identified as an important place in which to learn about sex and sexual health. Mainstream schools provide sexuality education as part of their core curricula. Of the nine English Language Schools and Centres located in the Melbourne metropolitan area, six currently provide some form of sexuality education.¹⁵ However, there are significant variations in the regularity and form of this education. Young people who have had opportunity to participate in school-based sexuality education said that these programs were useful and informative. Attendance at sexual health education classes appeared to increase their understanding and awareness of sexual health issues:

They taught us about all the disease you can get and how to avoid them and who we can talk to about it and where we can go for check-ups and stuff. (Ethiopian male)

Key areas of learning were mentioned, including: how male and female bodies develop, pregnancy

¹⁵ Sexuality education is currently provided at Noble Park ELS, Western ELS, Collingwood ELS, Brunswick ELC, Glen Eira ELC, and Westall ELC.

and birth, sexually transmitted diseases, contraception, legal issues relating to sexual activity in Australia, relationships, and decision-making within relationships.

CASE STUDY: SEXUAL HEALTH EDUCATION

One group of recently-arrived boys with refugee backgrounds are attending an English Language School that provides sexual health education as part of the curriculum. The majority of participants said that it was the first time that they had the opportunity to attend sexual health education classes. They said they had learnt about sex, safe sex, relationships, pregnancy, body development, using a condom, and respecting the laws. They had learnt through talking, interactive exercises, looking at pictures and diagrams, and watching videos. They thought the best thing they had learnt was how to be careful so as to not get sick from sex. All the boys said they would not be able to talk with their parents about these issues, and the only other available sources of information about sexual health would be friends or the internet. The boys thought that sexual health education was *'good to know now, before you become active, and before it's too late'* even if they didn't really need to implement the information until they were sexually active, older or married (although one boy joked that he'd like to put his new knowledge to use *'as soon as possible'*). In response to the question, *'how could the classes be improved?'* one boy said, *'if you add a few weeks more'*.

For many young people, school-based sexuality education was the only readily available formal source of information on sexual health. It was often their first opportunity to learn about sexual and reproductive health and anatomy. As one FARREP worker who delivers school-based education said:

So these young girls are having information, and their only source is high school. Reproductive health education is provided as a subject like biology and science. That was the first experience of them to hear how the body works, the period and other reproductive health issues. (FARREP Worker)

Participants said they value the opportunity to talk about sex without feeling embarrassed, and they said that they could trust the teachers to maintain confidentiality if they had a personal question or issue.

Many participants said they prefer boys and girls to have separate sexual health education, as it is embarrassing to ask questions in co-educational classes:

I think that when boys stay together they can talk about it more really open, yeah. When they, they have, there are girls there maybe they will shy. (Iranian Male)

Several participants also indicated that they prefer to participate in mainstream educational classes rather than being targeted for specialised classes. Nonetheless, a few girls recalled difficulties understanding the content of sexuality education in mainstream classes because they had limited language skills in the first year after arrival in Australia. They said:

I used to just sit there and think 'what the hell?' because I don't understand a thing, only the pictures. So it was a bit weird. And now I have forgotten all about it because we didn't understand what they meant. (Iraqi female)

Health professionals and education specialists often emphasised the importance of ensuring parents are comfortable with sexuality education in school-based settings. They explained that parents within newly-arrived refugee communities may have concerns about the content and morality of sexuality

education. One worker who has provided sexual education in an English Language School said:

I emphasise that the information is important knowledge, but it doesn't mean you have to go out and use it straight away. Parents are often annoyed because they think that sex education encourages sex and freedom. My response is that given sexuality education is part of the core curriculum, it is better to do it in a culturally appropriate way. (FARREP Worker)

They suggest this problem could be avoided by ensuring parents have a clear understanding of the purpose and scope of sexuality education, and are involved in planning and development of curricula.

Young people who had not attended school since arrival in Australia said they had not had any opportunity to learn about sexual health, saying '*when you're not going through school you miss that chance to learn about this kind of stuff*'. Other young people attending English-language schools and centres may not have had the opportunity to attend sexuality education as it is currently not a core component of their curriculum.

Parents and other family members

Across both genders and all ethnicities, parents were not identified as a commonly utilised source of information on sexual issues. A few people thought that parents could be a good source of information because they are older, they '*know everything*', and they are '*the ones who brought you up*'. However, the large majority of people said that it is very difficult to talk openly with parents about sex and relationships because they are unable to respond to children's questions and concerns without being judgemental or uncomfortable:

It's like this thing that's just too awkward. It's bad, but they don't talk to you about it. (African female)

Most young people said that they would feel uncomfortable or embarrassed to talk with their parents about sex, and they prefer that their parents are not aware of this aspect of their lives:

You don't even tell your family you got a girlfriend, so how you can you talk about this kind of stuff. (Ethiopian male)

Many young people explained that parents regard sex outside of marriage as unacceptable for cultural and religious reasons. To raise sex as a topic of discussion is therefore difficult because parents would become concerned that their child was interested or engaged in sexual activity. Further, young people thought that parents would not talk openly about sexual health for fear that it might encourage children to begin sexual relationships. Several participants who are sexually active said they would be unable to ask parents for information about specific concerns for fear of being punished or losing their trust. One group of young women from the Horn of Africa highlighted the difficulties in approaching parents with questions about sexual health:

Parents, you ask them a question, and they'll ask you a whole lot of other questions. How did you get it, what did you do, how did you do it, why did you do it? So you're better off not even asking. (Horn of Africa female)

Young people said that the messages they had received from parents focused on abstinence, the dangers of mixing with the opposite sex, appropriate behaviour and respecting culture, the importance of prioritising studies over relationships, and warnings about the stigma associated with pregnancy outside of marriage. Young women appeared to receive more prohibitive messages than young men. Many parents also emphasised the fact that an individual's behaviour will impact on the reputation of the family.

However, it appeared easier for young women to obtain some information about sex and reproduction from their mothers than for young men to get information from either parent. Fathers were not viewed as readily approachable for discussion about sex, and many young women identified their fathers as the person they are least likely to talk with. Several young women said they had talked with their mothers about menstrual cycles, pregnancy and mothering:

My mum she told me something, but not too much. She told me when you have a baby, then you feed the baby, then you clean the baby, then you change the nappies, then when baby crying you can do something and make her happy. Something like that. (Sudanese female)

You get taught something when you reach the age of puberty. They be like 'oh you so lucky to have periods now and blah, blah, blah. And you have to wait until after marriage blah, blah'. But they just give you that. They congratulate you and then they'll stop there and then once you get engaged or married, then they give you the whole. But until then they won't give you much. (Horn of Africa female)

Several young women suggested that while they had not yet talked with their mother about sex and reproduction, they expected that she would become a good source of information once they were engaged or married. However, they also told stories of the plight of young girls who get married without any real knowledge about sex. They said that it is 'a bit scary' if you do not understand what to do or what will happen on the wedding night:

One of my friends she got married, she didn't know about sex . . . Her mum told her don't shout, whatever happens, whatever happens to you, don't scream. And she was so surprised. She said: 'what's going to happen to me? Why my mum told me, don't scream or don't shout? Why? What is the reason? And the morning I wake up I know.' (Afghani female)

Young people brought up the possibility of seeking information from other family members, including older siblings, cousins, uncles, and grandparents. They said that they can trust and feel comfortable talking with them, but without the awkwardness that arises when talking with parents. Information could be obtained by spending time with relatives and adults who are married and sexually active, overhearing conversations, or by asking questions that are impersonal in nature:

You can talk to someone like if they already got married and stuff like that, and they have children. If you don't want to talk to your parents you can talk to them. (Afghani male)

Yet many people emphasised the inappropriateness of talking about 'that sort of stuff' with older people in their communities, and they felt that family members and other adults would not like talking about sex with younger people:

We wouldn't mention it around big people. I mean whoever is older than us is not supposed to know. (Ethiopian male)

Friends

Friends were frequently mentioned as an important source of information about sex and relationships. While friends are not deemed to be an accurate source of information, young people said they are approachable and easy to talk with. Most young people said they are able to talk with their friends about sex and share information:

I think with your friends, especially like my age, most people they go to their friends, their best friends, and they secretly share these things. Yeah, not public, yeah. (Ethiopian male)

Friends might gossip about sexual activity of other people in their community or friendship groups. Adolescent friends are a source of information when something is unclear or specific information is

sought. However, relationships, rather than specific information around sexual health, are most likely to be discussed with friends.

Many young people emphasised the importance of only talking with friends who can be trusted. They were anxious about the repercussions of sharing personal issues around sex and sexual health, as there is a risk that friends will spread private information, start rumours, or criticize you:

You talk about sex and it's 'ohh, you are a prostitute'. It's like you are becoming a prostitute. You're becoming a slut . . . It must be someone you really trust. Someone, maybe you might tell them, and they might go one day 'oh she tell me this', you know, and they might expose you. That's not a good person you're meant to say that to. Someone you know that is there for you. That can help you, that loves you, that you can trust. (African female)

Young women said you should only talk to friends that you really trust, who care about you and who can keep secrets. Young men also emphasised concerns about sharing information with friends:

'Maybe they are your best friend, but when you have an argument with them maybe they will tell everything about you to the other people'. (Iranian male)

A few young women who had experienced unplanned pregnancies felt they needed to let their friends know about the importance of being careful and using contraception. Their experience had precipitated engagement with GPs and exposure to sexual health information. They regarded themselves as having gained important information which should be disseminated amongst their friends in order to prevent them from experiencing similar problems:

I sometimes give my girlfriends advice about things like that and contraception. Some of them use tablets or injections to stop getting pregnant. I tell them don't just use tablets or injections to protect yourself only for pregnancy. Use condoms to protect yourself for everything. (Ethiopian female)

Boyfriends and girlfriends

People who have girlfriends and boyfriends said they did not want to talk with them about STIs, HIV, and pregnancy because it is too serious:

No, like when you see [your girlfriend] you just forget everything. You don't want to talk about HIV. We should. We should encourage that, yeah. (Ethiopian male)

Similarly, young men indicated that they would not talk about sexual health issues, such as STIs, with a casual sexual partner because it would ruin the dynamic. This lack of willingness to talk about sexual health with sexual partners is particularly concerning for young people who frequently have sex with casual partners:

Sometimes you meet a person and you don't talk so much about your problems. You with someone one night, or it's just you don't have that time to talk about stuff like that. Because when you start that thing will change, change into something really serious...you don't really want to go to that part. (Sudanese male)

A few young women said that if they realised they were pregnant or had an STI, they would not talk with their boyfriend due to concerns that their partner might spread that information to other people and ruin their reputation:

I think some people wouldn't tell their partners because if your relationship is not stable and you don't know how long it is going to last then some girls might think 'oh, he might go around telling people, oh she had an abortion, she once was pregnant from me'. So they don't really want to tell their partner about it. (African female)

Written resources, internet and media

Most young people expressed ambivalent views about the value of written resources, such as pamphlets and books. While they are viewed as providing accurate information, few people indicated that they had read any written resources focusing on sexual and reproductive health. Participants said they are difficult to understand if you are not fluent in the English language, and if your family finds you with books and pamphlets about sex it will raise suspicion that you are sexually active. The key issue identified, however, is that when written resources are confusing it is not possible to ask questions and clarify issues:

It's better to actually talk to someone. It's not the same as reading it, because if you don't really understand something somebody can explain it to you in a way that you understand. And a pamphlet doesn't do that. It's just 'this is how it is' and if you don't understand it you can't ask any questions. Who are you going to go and ask? (Ethiopian female)

No young people mentioned having seen material about sexual health in their own language or referred to internet sites offering translated health information. No participant identified ethnic media (radio, newspaper, television) as a source of information about sexual health issues.

The internet was occasionally identified as a useful source of information about sexual health, particularly amongst males:

It's easier to use . . . and has everything you want to know and it doesn't matter what sex or whatever, it's all you want to know. And you know all about many things. Also you can go to other websites. So you can see if you get taught stuff about sex and diseases. (Afghani male)

It is viewed as a medium through which a lot of information is available, and is valued for its anonymity. However, people expressed reservation about seeking information on the internet at home in case their parents find out. They also said that computers are not always accessible or available, the information required can be difficult to find, and searches might lead to 'really bad things' like porn sites:

Where I grew up, Africa, if a parent knows that you're looking on internet about sex and stuff, the parent will be strict because he knows that there's something that you're going about, something you're hiding from her or from him. So that's why . . . it's hard to use the internet at home and keep it a secret what you're looking up on the internet. (African male)

Sometimes, the internet, they don't really understand your issue, what you want really. And sometimes they bring the opposite stuff there. (Afghani male)

Participants also expressed ambivalent views about learning about sexual health via television and radio. While they might enjoy the opportunity to watch a video in a class-room situation, they said they would not choose to watch or listen to a program in their own time:

If it is on the radio or the TV you are just going to say 'oh, that's a boring a channel' and just change the channel. You don't want to listen to someone talking about STDs or whatever it is. (Ethiopian male)

No participant mentioned teen magazines as a source of information. One group of young women indicated that the media is not a reliable source of information, and it would be difficult to judge whether the information provided was correct or exaggerated:

The media will definitely discuss the topic, but you don't know which ones they added or which ones they exaggerated or which ones actually is the right facts or anything. Because the media are known for their exaggeration. (Horn of Africa female)

6.3 EXPERIENTIAL LEARNING

A number of participants identified initiation of sexual relationships as the most significant point at which their awareness of sex and sexual health increased. This was particularly true of people who had received no formal sex education. In discussions with older participants who indicated they are sexually active, awareness of the risk of sexually transmitted infection and unplanned pregnancy was somewhat higher than amongst younger participants. Information gained during the onset of sexual activity included knowledge about contraception, pregnancy, STIs, and emotional reactions to sexual relationships.

For a number of young men and women, however, increased awareness was in direct response to an adverse health outcome or unplanned pregnancy. Young women who had experienced unplanned pregnancies and terminations said that through this experience they learnt about STIs and contraception. Their experience motivated them to be more careful. It precipitated engagement with health care services and discussion with service providers about contraceptive options, STIs and pregnancy. They emphasised that opportunity to learn about sexual health at an earlier point could have prevented their learning ‘the hard way’.

6.4 BARRIERS AND ENABLERS TO LEARNING ABOUT SEXUAL HEALTH

Many young people are interested to increase their understanding of their bodies, sex and sexual health. They emphasised that there had been little opportunity to learn about sexual health, both prior to and subsequent to arrival in Australia. In a number of group discussions, participants said it had been their first chance to talk about sex and sexual health. Many participants asked questions during and after group discussions, saying that they wanted to know more:

Can you tell us any ideas about how to prevent getting pregnant before getting married, how to do it? If we don't know how to use condoms properly . . . I want to know more information about prevention of pregnancy. (Burmese female)

Young people expressed a particular interest in learning about how to prevent illness and infection. They thought that education would encourage young people to take the issue of STIs more seriously, and they would be able to use contraception effectively to prevent disease and illness:

For me, someone giving information about something I don't know, it's not boring. I would love to hear it. What kind of disease you can get, how you get sick, what you can do. I want to know. (Ethiopian female)

Health professionals and educators also said that in their experience young people are keen to learn more about sexual health, and when provided with the opportunity to discuss it they are often curious and ask questions.

Barriers to learning

A recurrent theme across all groups was that **cultural attitudes** inhibit open discussion about sex and sexual health. Many people said it is something that is ‘*not traditionally talked about*’ and that it is a ‘*taboo thing*’: ‘*because of the traditional thing, young people don't have opportunity to discuss openly with the family*’ (FARREP Worker). Young people indicated that their cultural background precludes them from talking about sex and sexual health, particularly with parents and older people within their communities. This sentiment was also voiced by ethno-specific case workers:

In our communities there is no open discussion. There is some shyness or we feel afraid to tell that stuff to our family. And plus there is expectation from the family, probably there is thinking that

you will have sex when you get married and then if you do have sex before that's a big disaster. So they don't want the family to know about that sexual stuff. (Youth Worker)

The **shame and stigma** associated with STIs and non-marital pregnancy also presents a barrier to talking and learning about sexual health. STIs and pregnancy outside of marriage carry negative connotations about personal character, and this was identified as an important factor that limits people's capacity to discuss sexual health concerns and problems with friends, family and community.

Young people may avoid talking about sexual health and STIs because it is **too scary and too serious**:

Do we talk? We don't. We talk sometimes but this kind of thing is scary so people are not wanting to talk about it . . . we might be saying 'don't go to unhealthy places, make sure you don't get HIV'. Those kinds of things we talk about, but we're not going to go more deeply into it. (Burmese Community Worker)

In particular, the view that HIV is a deadly infection is a cause of fear and stigma. This is particularly evident amongst young people with African backgrounds who have been exposed to public health campaigns around HIV/AIDS and are aware of people who have contracted HIV and died in their countries of origin.

Community workers and health professionals spoke about the **inadequate availability and resourcing of sexuality education** for youth with refugee backgrounds. They said that not enough is being done to reach at-risk youth and that sexual health promotion should be carried out more widely. Those who are involved in the delivery of sexual health education programs spoke of limitations they currently face in terms of staffing, resources and time, which means that programs are not as widespread or frequent as they would like. They suggested that people who do not frequently access services are less likely to receive educational programs, but they are often most at risk.

Enablers for learning

Young people identified a number of factors that could assist them to learn about sexual health.

- They expressed a clear preference for face-to-face group-based learning as it allows young people to talk together and discuss issues and experiences:

We like to get together, socialising and friendship. So that is the most enjoyable part for us, to do something in a group and to discuss that way. That's a good way to raise issues and discuss, and probably people would bring more ideas and pass on information. (Ethiopian male)
- There is a preference that groups are single-sex and that people are of a similar age. The facilitator should be the same gender as participants.
- They want clear and factual information, particularly around STIs and pregnancy and contraceptive methods. Information should be provided before the onset of sexual relationships.
- Written information can be used to support interactive learning approaches.
- Written information in community language is important for newly-arrived young people with limited English language skills. As is education delivered by bi-lingual community workers and doctors who are seen to be credible and have experience.

Case workers and health professionals also identified a number of factors that can increase the effectiveness of sexuality education for young people with refugee backgrounds.

- Group-based learning with small numbers of participants is effective, and single-sex groups with gender-matched facilitators are most appropriate.
- While it is important that sexuality education targets young women and mothers, it is essential that young males have equal opportunity to participate in sexuality education.
- Involve young people through various locations: community centres, sports clubs, schools, tertiary educational facilities.
- Provide on-site programs that offer the opportunity for young people to see and learn about health services.
- Interactive teaching methods are preferable to delivery of information by 'experts'; educational props can be used as effective learning tools that focus discussion (i.e. jigsaws of human reproductive organs).
- Skilled interpreters who are familiar with health terminology need to be used where required.
- Curriculum must be flexible so that it can be adjusted to suit different needs and level of understanding. It needs to cover basic reproductive health, as newly-arrived refugees may have limited background knowledge. It is important that the curriculum also include wider content around relationships, gender, life-skills, empowerment, legal rights and child support obligations.
- Sexuality education must be framed as important for everyone, even those who are not yet sexually active or who intend to wait until marriage before initiating a sexual relationship
- Provide training and skills development to people working in the sector (community organisations) so they are also able to provide accurate and appropriate sexual health information, advice, and referral

Young people and health professionals suggested that sexual health messages will be better absorbed if they are delivered after newly-arrived people have had sufficient time to begin to settle into life in Australia. The complex demands of the initial settlement period mean that it is difficult to focus on and process health awareness messages. However, participation in settlement programs, on-arrival health screening and English Language Schools and Centres means that newly-arrived refugees can be readily targeted during this early period. Many participants thought that some information on-arrival would be useful, and more comprehensive education should be delivered around six months after arrival.

Young people, case workers and health professionals suggested that an important way to improve awareness of sexual health issues is to ensure that parents understand the value of sexual health education for young people, and to increase their willingness to openly discuss the issue:

Another good thing is to make the parents understand. The kids, they go and do things behind their parents back, because they're scared to talk about sex with them. The only way they're going to learn is if their parents back off a bit, and understand a bit more. (Sudanese female)

LEARNING ABOUT SEX AND SEXUAL HEALTH: KEY MESSAGES

SOURCES OF INFORMATION

- Young people with refugee backgrounds obtain sexual health information from a range of sources including parents, friends, partners or spouses, health professionals, school teachers, written resources and the media.
- A few young people were not aware of anyone they could talk with about sex, particularly prior to marriage.
- There is a disjuncture between the reliability and accessibility of sources.
- Reliable sources of information are perceived to be doctors, nurses, hospitals, books and research. But these sources are not frequently utilised.
- Friends are a common source of information, but they are not reliable.
- It is difficult for young people to talk with their parents about sex and relationships.
- School identified as an important site for learning about sex and sexual health. However, not all young people have the opportunity to attend school-based sexuality education.
- Most young people expressed ambivalent views about the value of written resources, such as pamphlets and books: it is not possible to ask questions and clarify issues. Internet can provide information but it is not always accessible. Radio and television is not viewed as being necessarily reliable.

EXPERIENTIAL LEARNING

- Initiation of sexual relationships leads to increased awareness of sexual health issues.
- This increased awareness is sometimes in direct response to an adverse health outcome or unplanned pregnancy.
- Young people emphasised that opportunities to learn about sexual health at an earlier point could have prevented their learning 'the hard way'.

BARRIERS AND ENABLERS TO LEARNING

- Many young people expressed interest to increase their understanding of their bodies, sex and sexual health.
- Barriers to learning were identified: lack of opportunity to attend educational programs; cultural attitudes that designate sex as taboo; stigma associated with sex and STIs limits capacity to discuss issues; inadequate availability and resourcing of sexuality education for youth with refugee backgrounds.
- Young people identified preferred methods for learning about sexual health: group-based learning; single-sex groups; clear and factual information; opportunity to learn before onset of sexual relationships; increased community and family support for sexuality education.
- Health professionals and case workers emphasised the value of: group-based learning; targeting young males; use of skilled interpreters; interactive learning methods; including wide sexual health issues (i.e. relationships, gender, negotiation skills); increasing parental support for sexuality education; professional development for people delivering sexuality education.

7. RELATIONSHIPS

It is important to provide appropriate health promotion messages to young people as many adolescents are sexually aware and sexually active (Rosenthal and Smith 1995: 38). This chapter examines young people's attitudes towards relationships and the initiation of sexual relationships. The research did not seek to identify personal experiences in relation to sexual activity, but to discuss expectations and attitudes associated with relationships and sexual activity.

The age at which sexual activity would be expected to begin varied according to gender, with many young men indicating that the onset of sexual activity could begin around fifteen or sixteen years and many young women suggesting eighteen to twenty years. However, for a large number of participants marital status rather than age was the key factor determining when sexual activity could be initiated. Young people spoke of community and family expectations that sex occurs only after marriage. Many participants said that they would adhere to social and cultural values and abstain from sex before marriage.

Young women frequently emphasised the risks of non-marital sexual relationships, particularly jeopardising their reputation and the severe responses of parents and family were they to find out. The secrecy surrounding relationships can put young people at increased risk as they are unwilling to turn to parents or health professionals for information and advice, and are fearful that family might realise if they are using contraception. Young people may also be denied opportunity to learn about positive relationships and effective negotiation within relationships due to lack of open communication.

Young people often commented on overt sexual expression in public spaces in Australia. They described seeing people who wear revealing clothing and couples who kiss and touch in the street. This was in contrast to the more strict moral codes in their culture and countries of origin, in which sex is regarded as a private subject. A few participants suggested that the perceived increase in non-marital sexual activity among some newly-arrived young people is due to exposure to the cultural context in Australia and loss of connection with their own culture.

7.1 BEGINNING SEXUAL RELATIONSHIPS

Many discussions began with conversation about the age at which young people within participants' communities would typically initiate intimate relationships. Young people suggested that relationships might begin from between fifteen to twenty years of age. Having a boyfriend or girlfriend was not necessarily equated with having sex, and participants suggested that some relationships involve talking on the phone or spending time together in social settings. Many participants indicated they had not yet had sexual intercourse, although they might have had a boyfriend or girlfriend. Participants said that relationships were for the most part secretive, and that parents and family would be angry if they found out.

In a few cases, young people said that some families would be accepting of their children having a non-sexual relationship with a boyfriend or girlfriend.

Many participants talked about their views of relationships and initiation of sexual activity. There were differences according to gender. Young men indicated the onset of sexual activity might begin around fifteen or sixteen years. Young women suggested sexual activity might begin around eighteen to twenty years. However, for many participants marital status – not age – was the key factor determining when sexual activity should be initiated.

In discussions, participants focused on three types of sexual partner: 1) boyfriend or girlfriend, (2) husband or wife (or cohabiting long-term partner), and (3) occasional sexual partners. Same-sex sexual activity was not mentioned in any group. Young women generally spoke of sexual relationships as being part of a relationship where there was some type of commitment, such as marriage, marriage intention, long-term or serious boyfriend, or love. A few, however, spoke of sex as something that women were forced or pressured into having.

Many females spoke of the qualities they would look for in a boyfriend or husband, and used terms such as: loving, caring, trusting, good heart, family man, clever, supportive, handsome, educated, wealthy, honest, respectful, polite, kind, open-minded, discreet, or understanding. Some explained it is important to ascertain that a man has these good qualities before initiating a sexual relationship:

I think in a relationship you have to know the person very well before going out with them. Don't rush because maybe he might be nice in the beginning. He might be really caring, talking nice stuff and you might trust him a lot. And then at the end he might end up being bad. And he just wants to have you and leave you. So you have to be very careful and make sure you know who you're going out with. (African female)

While young males spoke of sexual activity as being part of relationships and marriage, they also referred to other reasons for initiating sexual activity, such as curiosity, satisfying biological needs, and for enjoyment.

Perceptions of non-marital sex

While there is an expectation of abstaining from sex until marriage, some young people are involved in sexual relationships with boyfriends and girlfriends. They indicated they would usually only initiate a sexual relationship with a serious boyfriend or girlfriend or someone they were intending to marry. Young women often said it is important to be sure that the boy is serious and will not leave after having been permitted to have sex. One young man explained that sex before marriage is a way to be certain of sexual compatibility and it would be difficult to commit to marry someone without seeing 'if it's good' first. A few people, however, described engaging in casual sex out of curiosity and without the emotional commitment of a longer-term relationship. As one young Sudanese man said:

I never looked at a girl and thought that 'yeah, I like her, I want to be in a relationship with her'. Like at that time, it was always just the curiosity of just trying to find out more about my sexual side, you know? (Sudanese male)

A few female participants reported instances where they had unwanted sex due to pressure from a sexual partner or boyfriend, including emotional and physical threats and violence. One female, for example, described how her Anglo-Australian boyfriend expected sex as an indication that she loved him:

When we first met I refused him, like for a couple of months. I said we shouldn't. And then he laughed at me. He said 'you're still a virgin, it's funny. It's very funny' . . . And then he said 'my God, maybe you don't love me'. So, yeah, I changed my mind. (Burmese female)

Many of the young women emphasised the risks associated with having sex prior to marriage. A key concern is jeopardising their reputation within the community. They said that girls who have sex outside of marriage are seen as bad and disrespectful and that people will exclude them and talk about them behind their backs:

Some people think you're bad when you're having sex with a guy you love. They think you're very young doing that kind of stuff. They think all this crap about you. They don't understand your feelings for that person or just thinking you're bad or something. You're like a bad child, you know?

So they say bad things about you. And then they encourage even your parents to separate from you and try to say mean stuff about you to your parents. (African female)

The responses of family and parents are of particular concern to young people. Many females said that if parents found out that their daughter was involved in a sexual relationship they would be very angry, would not let her go out, and she would lose their trust. A small number of females said that parents might hit their daughter if they found out she was having sex. Participants also said that an individual's sexual behaviours would have a direct impact on their family, bringing shame and embarrassment upon the family. For many participants, the solution is to keep relationships secret: *'you can't let anyone know that you're in a relationship' (African female).*

Sex after marriage

Many young people said that sexual encounters should only occur within marriage. Attitudes around the initiation of sexual relationships are closely tied to community and family expectations. Almost uniformly, participants emphasised that their community and family regard non-marital sex as inappropriate and unacceptable. Many participants said that they would adhere to social and cultural values and abstain from sex before marriage:

Once we get a boyfriend and girlfriend, we know each other, we just hold hands with each other. It's just heart. Sex is so far, we don't do it all. Kiss sometimes. Traditional. Very worried about the sex. (Burmese female)

They'll tell us, like, not to do that thing, and they'll warn us. They say, "You can see that person but if you do the same thing again, that's it, there's consequences." And we need to follow. (Iraqi male)

Young people occasionally said that having a boyfriend or girlfriend is inadvisable because they distract you from other important areas of your life, such as school, work and studies. Young women highlighted the possibility of becoming pregnant and then having to leave her studies or employment. Several participants highlighted the value of becoming self-sufficient or independent before beginning sexual relationships:

Don't put your mind on that. Better to put your mind on some study. At this age we like to have fun but you don't have to do that kind of stuff. (Ethiopian male)

A number of groups emphasised the expectation that young women are virgins at the point of marriage. One group of females discussed their concerns that a husband might accuse them of not being a virgin, and call them a slut because they were *'with someone else'*. A few young men described how they would be dissatisfied if they married a woman who was not a virgin, and might divorce her:

For me, if I discover that she is my girlfriend and she just had a relationship with someone before, I will not be happy because it's not really good ... someone has already broken her virginity and that's really like, aaah . . . I will maybe break up. (Afghani male)

Several young women explained that men do not want to marry a woman who has a sexual history. They told various accounts they had heard of girls who were divorced the day after their marriage because the husband accused them of not being a virgin:

In Afghan, the first thing is the man and what they want. You get sex the first night you are married. If the blood didn't come then . . . my mum said that the girl's virginity is not the blood. Sometimes it's going to be water or sometimes air . . . And you know because men, they just want blood. They don't care about anything else. If the blood didn't come they going to think she wasn't good, she wasn't a girl. She was a woman. She did something wrong. She's not a good girl. In the morning, in front of everybody, he's going to say 'oh, I'm not happy with her. I just divorce.' (Afghani female)

7.2 SEXUAL EXPRESSION IN AUSTRALIA

Many young people talked of their surprise at the level of overt sexual behaviour in public spaces in Australia. They commented that young couples in Australia can be seen in public places together, wear more revealing clothing, can move in together, can be physically demonstrative with each other in public, will begin sexual relationship soon after meeting, and have more freedom. They described how they had seen people kissing and touching in the street:

The relationship between boyfriends and girlfriends is really different. I saw some couple – boyfriend, girlfriend – kissing, staying the night, behaving not very good in front of other people. In Burma that wouldn't happen. (Burmese female)

They often compared the open approach to sexual relationships in Australia to the private nature of sexual activity in their countries of origin:

Where I come from, where I grew up, actually you no have kissing, pashing stuff unless you are in the house where nobody can see you. And when they see someone doing it just in front of them they find that disgusting because it's supposed to be a secret. (African male)

Some commented that the moral code in their country of origin is very strict and opportunities for socialising between young men and women were limited. For example, one group of females explained that in Afghanistan, a female could not be seen walking around with a boy, even if she covered herself with a hijab:

In Afghanistan if you have a relationship with a guy, if you like a guy, you can't just go around walking with them. Because if you wear a really long scarf to cover your face, no one knows who you are . . . But there will be some saying that 'oh, that guy was walking with a girl. . . I think in Afghanistan, I don't know, not many people have physical relationship with their boyfriend.' (Afghani female)

A number of participants suggested that the perceived increase in non-marital relationships and sexual activity among some newly-arrived young people is due to exposure to the cultural context of sexual relationships in Australia and loss of connection with their own culture:

Seeing Australians and relationships, all that matters is just to get by. You have to do something. And you can change however you want and things are not that serious here . . . It means when you get into relationship you won't get married to that person. But back home you meet someone there's like eighty per cent chance that you be married to that person. Here, have a girlfriend, break up, have a girlfriend, break up. (Sudanese male)

RELATIONSHIPS: KEY MESSAGES

BEGINNING RELATIONSHIPS

- Participants described three types of sexual partner: 1) boyfriend or girlfriend, 2) husband or wife, 3) occasional or casual sexual partner.
- Same-sex sexual activity was not mentioned in any group.
- Discussion about the age at which young people might typically initiate intimate relationships elicited diverse responses.
- Some young men indicated the onset of sexual activity might begin around fifteen or sixteen years. Some young women suggested sexual activity might begin around eighteen to twenty years.

INITIATING SEXUAL RELATIONSHIPS

- While there is an expectation of abstaining from sex until marriage, some young people are involved in sexual relationships with boyfriends and girlfriends.
- Young women emphasised the risks of non-marital sexual relationships, particularly jeopardising their reputation and angry responses of parents and family.
- A few young women described being pressured into unwanted sexual activity.

ABSTINENCE

- For many participants marital status – not age – was the key factor that determines when sexual activity should be initiated.
- The large majority of participants emphasised that their community and family regard non-marital sex as inappropriate and unacceptable.
- Many participants suggested that they would adhere to social and cultural values and abstain from sex before marriage.

SEXUAL EXPRESSION IN AUSTRALIA

- A large number of young people commented on the perceived overt sexual behaviour in public spaces in Australia. This was often contrasted to accounts of stricter moral codes and restrained public behaviour in their countries of origin.
- A few participants attributed a perceived increase in sexual activity among newly-arrived young people to exposure to the Australian cultural context and loss of connection with their own families and culture.

8. IMPLEMENTATION: TAKING RISKS AND TAKING CARE

This chapter focuses on young people's perceptions of safer sex and behaviours that reduce the risk of acquiring STIs and unplanned pregnancy. Young people identified key factors that contribute to sexual health problems include: risk-taking or careless attitudes, alcohol consumption, peer pressure, difficulties negotiating safe sex and contraception, homelessness and insecure housing situations, and lack of supportive family and social networks.

A number of protective strategies were described including: use of condoms, abstinence, fidelity and monogamy, and avoidance of sex with people who are regarded as at risk. Condoms were the most commonly mentioned contraceptive method. However, some young people expressed concerns about the reliability of condoms, reduced sensation during sex, and the risk that parents might find out they are using contraception. Condoms are widely regarded as a male-controlled method, and most young women indicated they were unlikely to take responsibility for obtaining and using condoms.

Abstinence from sex until marriage was widely cited as an effective risk reduction strategy as it ensures there is no exposure to infection or risk of unplanned pregnancy. Discourses around abstinence are informed by social expectations; many young people said that abstinence was essential in order to maintain a good reputation and to avoid bringing shame to themselves and their family.

Commitment and trust between partners were widely viewed as important elements in avoiding sexual health risks and unplanned pregnancy. However, when sexual relationships are framed in terms of love and trust, this can compete with protective health behaviours and safe sex messages. Trust and loving one's partner were provided as reasons for non-use of condoms within relationships.

Young people also said that safe sexual relationships requires avoidance of 'risky types', such as people who drink alcohol, take drugs, go clubbing, or who have bad reputations. A few people said they use personal judgements of the likelihood that a person is carrying infections as a means of protection against STIs. Well-known and respectable people are thought to be less likely to be carrying infections.

Unplanned pregnancies are a key concern for young people. Several participants recounted personal experiences of pregnancy outside of marriage, and many participants referred to people in their community who had experienced unplanned pregnancy. Young men and women expressed concerns about the reactions of family and community to non-marital pregnancy, and many indicated they are not yet prepared for the responsibilities of being a parent. The risks and social consequences associated with non-marital pregnancy were viewed more seriously by young women.

8.1 SAFE SEX

In discussing safer sex strategies, key themes frequently emerged: **being careful**; **protection** from unwanted health impacts of sex; protection from **social impacts** of sex, STIs and unplanned pregnancy; and **staying in control** in order to avoid adverse health and social outcomes.

- The notion of **being careful** was framed in terms of acting responsibly in order to preserve health and wellbeing. Careful approaches to sex encompassed having responsible and committed relationships and using contraception.
- Safe sex was also perceived as referring to **protection** against the sources of risk of STIs and unplanned pregnancy, and avoidance of adverse health outcomes. It encompassed using condoms and other contraceptive methods, and not having sex with people who are considered to be 'at risk' or who have unknown sexual histories.

- Safe sex protects against the **social impacts** of sexual activity such as the shame and stigma associated with unplanned pregnancy and STIs. However, it also refers to abstinence and discreet relationships in order to avoid jeopardising one's reputation.
- Safe sex also means **staying in control** over sexual urges by maintaining a monogamous relationship or abstaining from sex. People who cannot control themselves are regarded as at risk of infection.

It is apparent that while safe sex and protective behaviours are informed by concerns about sexual health (and specifically STIs and unplanned pregnancy), risk reduction practices are underpinned by views about the nature of relationships and sexual partners and social values around abstinence and appropriate sexual behaviour.

8.2 PROTECTIVE BEHAVIOURS

Using contraception

Condoms and other contraceptive methods were frequently mentioned as a way to prevent both STIs and pregnancy. A few participants also mentioned other contraceptive methods including oral contraceptive pills, the 'morning-after pill', implants, spermicidal gels and diaphragms:

The girls are supposed to take it. Before you have sex or when you're having sex she takes it and then you don't have to use condom. If you know her, like you have a girlfriend. (African male)

Condoms were often referred to as a good method of protection against HIV/AIDS and other STIs, with a few people further emphasising that only condoms can protect against STIs during sex.

Several people referred to the rhythm method, though there was lack of certainty about when in the menstrual cycle a woman was least fertile. A few participants misidentified a woman's fertile period as being during her menstrual period. A few people indicated that it is easier to use the rhythm method than to remember to have contraception at hand or to take contraceptive pills or injections:

For me I've never used like, you know, oral contraception or the injection, I've always used my natural cycle. Yes. I'm not able to take medicine or anything. I won't complete it, that's why I've never started it. (Liberian female)

For one participant at least, the rhythm method had not proved to be a successful contraceptive method and his girlfriend became pregnant and had a baby:

The thing happens . . . she didn't tell me that she liked me, alright. Because at that time I had a lot of girlfriends, and she liked me and she wanted to get pregnant. I know her dates, you know. When her period is going to finish or whatever. All this stuff I know it. But yeah, she just lied to me, to hold on to me. It just happened you know, you can't deny it just happened. But they're not living with me . . . I took her back to her parents. (Sudanese male)

The participants who were best informed about contraception were often those who were sexually active. In particular, participants who had experienced STIs and unplanned pregnancy explained that they are now careful to use contraception. One young Ethiopian woman who experienced an unplanned pregnancy said:

After that I was scared of things like pregnancy and HIV. After that I started to use condoms. I always use condoms. I had an HIV check and it came back fine, and I felt really good. After that I always use condoms to make sure that I never get anything. (Ethiopian female)

The large majority of participants indicated that both people in a relationship should be responsible

for decision-making and use of contraception. However, condoms are widely regarded as a male-controlled method, and most young women indicated they were unlikely to take responsibility for obtaining and using condoms:

Why would you have condoms in your bag if you're a girl? The people would be laughing at you. He should have it. (Ethiopian female)

Females are regarded as having greater responsibility for choosing and taking oral contraceptives and implants. Both males and females said that a girl would be more concerned to avoid pregnancy than a boy:

I think the girl's responsible because um, she's the one who can get pregnant, not the guy. (African male)

Condoms are said to be readily available through pharmacies and doctors, and it was not perceived to be difficult to obtain them. A small number of young males named places where they were able to obtain condoms free of charge, such as Melbourne City Mission, but this awareness was not widespread. A few participants wondered whether condoms might be too expensive, and others said it can be embarrassing to buy condoms from a woman at a shop or pharmacy.

Various disadvantages of contraceptive methods were mentioned. Young people said that contraception could be found by parents and this would lead to difficulties. Young women, for example, said that parents would be very angry if they discovered that their child with condoms or contraceptive pills. Females expressed concerns about the reliability of condoms, saying that they could break during sex which might result in an unintended pregnancy. As one young woman described:

Yeah, he's two years younger than me. And I feel sorry for him, you know, he's too young to be a dad. And then I went to see the doctor and nothing. Phew. And then since then um, he said we don't use the rubber, because it's not safe . . . Too much risk. So he suggest me to have the pill or something. (Burmese female)

Several young males said that using a condom during sex does not feel as good. They indicated that it is better to choose a partner who does not have STIs so that it is not necessary to use condoms:

You feel like you are in heaven if you don't use condom . . . I use condom, but condom is not good. It does nothing. Nothing. You don't feel nothing. But body to body you feel like you are very happy. (African male)

Abstinence

Abstinence from sex until marriage was cited as a good risk reduction strategy in most groups. It ensures there is no exposure to infections and diseases and is also seen as an important way of avoiding unplanned pregnancy:

I think the best way is definitely no more. If you don't want anything to happen to you, so you will control yourself. We should have a friend. But not a relationship with sex. So I can say 'OK. I will have a girlfriend but no sex until I will get married'. (Afghani male)

The ideal of abstaining from sex prior to marriage is significantly informed by social expectations. Abstinence is seen as virtuous, and a way to preserve personal and family reputation. It reflects respect and loyalty to parents and maintenance of cultural values. Many young people indicated that sex before marriage is inappropriate, and were anxious about the resulting disapproval within family and community networks if they were to have non-marital sex:

I know it's not right to give yourself to a guy that you, doesn't deserve, you know. And, and just

want to have you for fun, you know. But I've been loved, but I never give myself. I never have sex, never. You guys won't believe me but it's true. (Liberian female)

They just say 'oh my God, look how the parents haven't teach her manners, they haven't taught her who to go with or what to do when she's young and all that.' They start talking about you. They talk. (Iraqi female)

A few males also explained the importance of refraining from sex before marriage in order to maintain a woman's honour:

It's really good to control yourself. Because she is someone's . . . Maybe you will not marry that lady because you are not sure about what will happen tomorrow. So that's why you have to be very careful not to lie with someone . . . because she's not yours. (Afghani male)

Religious doctrine relating to abstinence prior to marriage was occasionally mentioned. Participants belonged to a range of religions – including Islam and Christianity – and they indicated that moral values around sexual activity constitute part of their faith, particularly abstaining from sex prior to marriage:

- *Yeah, in the church. All they say is you shouldn't have sex until you're married. Virgin till married.*
- *Yeah. And like if your parents are Christians or if your parents use the Bible it's really strict for you not to have sex because they try to do everything the Bible says.*
- *If you have a relationship with another girl they think that why have that relationship? It might turn to having sex and that's against the rule, yeah. (African males)*

However, a number of case workers emphasised that religious belief is not a clear predictor of behaviour, and that Muslim and Christian youth are still at risk of unplanned pregnancy and STIs.

Many young people said that abstinence is the safest and most appropriate way to maintain their sexual health and well-being. Nonetheless, some said that understanding and intention did not always translate into practice. The need to fulfil sexual feelings was occasionally raised as a factor that makes abstinence difficult. A number of Afghani, Sudanese and Iranian young men spoke of the possibility of 'losing control':

And sometimes the boys . . . like you can't control yourself when you are with a girl and you feel love or you want to have sex with her. You can't control yourself. (Sudanese male)

Some young people regard abstinence messages coming from family and community and religious values as an effort to control their lives, and they regard abstinence as an unrealistic option.

Fidelity and trust

Young people who are involved in relationships frequently linked safe sex to the establishment of trust between partners. Trust was viewed as an important element in avoiding health risks and unplanned pregnancy within longer-term or serious relationships. A few participants described how they negotiated safer sex within stable relationships by discussing and agreeing upon a contraceptive approach. The safety of contraceptive choices depends on establishing that each person in the relationship is free from infection in the first instance, and is then based on trust and an assumption of fidelity:

I was with this guy for ages and he was like my first proper boyfriend. That's why we got the blood test. For me, and for him at the time too, we thought that we were going to be together for ever. So

we didn't believe in using anything. I used to have Implanon¹⁶, but then I got that taken out because of him. He doesn't believe in that kind of stuff and we used condoms. Not all of the time but most of the time. (Ethiopian female)

The importance of not 'playing around' in order to reduce exposure to potential infection was frequently emphasised:

Just go with one girl that you know. You don't have to play around. If you don't play around you don't get the diseases. (Ethiopian male)

The notion of trust within a relationship competes with 'safe sex' practices and use of condoms. Young people in relationships often described how they used condoms at the beginning of a relationship, but their trust in the exclusivity of the relationship allowed them to later use contraceptive pills, implants or the 'rhythm method':

But say the people that you're serious with them, like a relationship, you can't just . . . at the start, yeah, you might use protection and then when you stay for a little while and then you know what I mean . . . after you make sure that you trust, then you go ahead. (Sudanese male)

Protection within a trusting relationship refers to protection from pregnancy more so than STIs. In contrast, casual sex with an unfamiliar person is regarded as risky because their sexual history is not known and they could be carriers of infection:

You're going to have heaps of boyfriends. It's not going to work out with everyone. If you just do it with anyone and everyone it's disgusting. What kind of diseases are you going to get? (Sudanese male)

Avoiding sex with risky types

Young people said that safety within sexual relationships can also be achieved by avoiding 'risky types'. HIV and STIs are commonly associated with immoral behaviour. As discussed further below, participants identified particular people who are at increased risk of sexual health problems, such as people who drink alcohol, take drugs, go clubbing, or sleep around. A few female participants talked of reducing their risk of sexual health problems by avoiding men with a bad reputation because, '*if he plays around you can get sick*'. Male participants frequently articulated the importance of choosing a sexual partner who does not have a bad reputation, and who is '*clean*', healthy and respectable:

You have to know about that person, you know. Like if you heard anything about what she's done. She's probably already done things with other guys. That's why it's better to know. It's like you being . . . if you want to have sex, be best to know. (African male)

Risk is thought to be minimised through assessment of the likelihood that a person is carrying infections. One way to make this assessment is to 'know' something about a person's sexual history:

You can't have sex with somebody you don't know. Maybe they had sex with somebody else, without protection you know. (Sudanese male)

Well-known and respectable people are said to be less likely to have had multiple sexual partners or to have put themselves at risk of STIs. Visual cues, such as clothing, were also cited as a way to assess the likelihood of a person having an STI.

¹⁶ Implanon is the only contraceptive implant available in Australia. It contains the hormone progestogen and provides protection against pregnancy for three years.

8.3 RISK FACTORS FOR STIS AND PREGNANCY

Participants discussed a wide range of contextual factors that they thought would put someone at increased risk of sexual health problems or unplanned pregnancy, including: homelessness, risk-taking people, alcohol use, peer pressure, and inadequate social and family support. However, most young people had a low sense of personal risk and did not identify themselves individually as at-risk.

Homelessness

Young men and women who are homeless or at risk of homelessness linked sexual health issues, particularly unplanned pregnancy, to insecure housing situations. Not living at home or not having a family network in Australia was frequently identified as a situation which can lead to sexual health issues. It creates a context where there is no guidance from parents and other family members, and no rules around use of time and activities:

A lot of young people, a lot of youth, are not living at home now at this time. I think that's when the real trouble happens, because you've got all the freedom in the world, you know, to do whatever you like whenever you like. (Ethiopian male)

In-depth interviews with homeless young people indicated there was some awareness of STIs, HIV/AIDS, contraception, and availability of screening and health services. However, in many cases this awareness was gained subsequent to an unplanned pregnancy or STI. The accounts provided by these young people describe increased likelihood of coercive sex or sex for companionship, inconsistent use of contraception, and no access to sexual health education programs.

The following case study illustrates the links between non-marital pregnancy and homelessness. It describes a young woman who became pregnant in order to avoid an arranged marriage with an older man. When her fiancée discovered she was pregnant he demanded that she leave the house and she became homeless.

CASE STUDY: PREGNANCY AND INSECURE HOUSING

Nyachol¹⁷ is a young woman who arrived in Australia a few years ago. She was engaged to be married to an older man but was not happy about the arrangement. She became pregnant to her boyfriend whom she loved in the hope of avoiding the marriage. When her fiancée discovered she was pregnant he was very angry with her. She described how he told her, 'OK, if you want to keep your child, I don't want you. Get out of my house'. She had nowhere else to go and said, 'I can't get out of your house'. He replied, 'if you don't want to get out of my house I will kill you.' Despite having nowhere to go and no family or friends who could help her, she left the house. She said 'I'm feeling sad. I'm not happy. Because I came here and then I got thrown out and I don't know anybody and I don't have a family here.'

Community workers who engage with young people who are homeless or living in insecure housing situations also suggest that there are increased risks to sexual health: lack of parental control, living with or as transient tenants and guests, going to parties, alcohol consumption, and isolation from the wider community:

You don't have that control over yourself. You don't have anyone saying you can not go out, have to stay home, you can't see that boy, you have to arrive at this time. In a transitional house, it's your responsibility. You can stay out all night, you can bring anyone home, no-one is going to check on you. (Housing Case Worker)

¹⁷ Names and identifying details have been changed in order to maintain the confidentiality of participants.

They also described how young women will sometimes be forced to accept accommodation from young males because there is no other housing available, during which time they are exposed to unsafe situations, including sex:

When they can't get accommodation, that is a risk. They don't have a place to go and at that time they put themselves at risk. They don't really think that will happen even when they get involved in a relationship. That person is just approachable and supporting for accommodation and then it turns into a relationship and they put themselves in that risky situation. (Youth Worker)

While insecure housing can create vulnerability to sexual health problems, unplanned pregnancy or engagement in sexual relationships can also lead to homelessness. As one young Ethiopian woman explained, she started a relationship with a young man but her family told her to end the relationship because they had heard 'something bad' about him. When she refused she was forced out of home:

That's the first time I get kicked out. That's the reason. Because of him. I didn't want to lose this guy. They said 'us or the boyfriend'. I was like 'what! That's too hard. I can't choose between my boyfriend and my family'. And I was still believing that this guy was really good for me. And my family, because they heard something, they just hate him. (Ethiopian female)

Community workers in the emergency housing sector confirmed that sexual relationships and unplanned pregnancy amongst young people can precipitate homelessness, particularly if the relationship develops without family approval. They referred to a number of clients with refugee backgrounds who became pregnant outside of marriage and were either kicked out of home or ran away and sought transitional or emergency housing:

A young lady got pregnant while she was sixteen. And her father and brothers are not happy about the pregnancy, and she ran away from them, and she was supported to get transitional housing by her herself. It's not easy, because she is too young. And she is not familiar with how to cope with the baby . . . Still she is upside down all the time. She doesn't have parenting skills, she doesn't have the boy's support. She didn't have all these things. So always she was in crisis and she blamed herself. (Youth worker)

A number of case workers spoke of clients who become homeless because the father denies that the baby is his, and they are neither able to live at home or with the father of the child.

In many communities, the girl has to go and live with the boy if she gets pregnant. If a boy is denying that the baby is his and their relationship breaks down, the young woman is left in the middle, stuck. I have had quite a large number of pregnant young women without housing. (Youth worker)

Risk-taking people

While many participants stated that anyone could contract an STI, particular 'risky types' of people were identified as more likely to be at risk of sexual health issues.

Male participants suggested that people who drink alcohol, take drugs, go to night clubs, visit prostitutes, or have sex outside of marriage are at increased risk of contracting an STI or unplanned pregnancy. One group also suggested that girls who are 'sluts' are at increased risk. A number of male groups described girls whom they would consider to be disreputable:

My community, it depends on the girl, because some girls are really wild. Like, you know, on the street all the day. So if they get pregnant the parents aren't really surprised. But if you got a girl who always stays home, does the work, and they get pregnant, their parents will be very, very surprised. (African male)

Female participants suggested that males are at increased risk of STIs because they have more freedom, are more sexually active and more likely to ‘play around’, and are greater ‘risk-takers’. Further, males do not have to worry about becoming pregnant. They also suggested that young girls who do not have a loving and supportive family could be at increased risk because they ‘*try to have a boyfriend and be happy*’, so they are more likely to have sex and contract STIs.

Some of the participants identified certain girls who ‘*are going to parties . . . always want to drink . . . who don’t care about their family*’ as most at risk of sexual health problems and unplanned pregnancy. They described these types of girls as not caring about their reputation:

Some of them get out with a lot of guys. A lot of guys! And they don’t care what is going on with them. All they want to know, they just want to have fun. Like in my school, I’ve seen a lot of girls like that. They even tell me what they do, stuff like . . . it’s not right . . . They meet guys on the street and ask them even for their numbers. That’s not right for a girl to do that. You have to wait for the guy to ask you. (Sudanese female)

Carelessness was frequently cited as a risk factor associated with risky sexual behaviours. Young males thought that careless people are more likely to be at risk of sexual health problems:

I think it is not because they don’t know. It’s just that they don’t care as much. Different people have different way of thinking. Some people prefer to just be careful. And others just think nothing will happen to them until it does . . . they don’t care. They drink too much alcohol and they don’t know who they are. They go to nightclubs. They know there are diseases but they don’t care. They think they are not going to get the disease, but they do know about it. (Ethiopian male)

A number of people emphasised that carelessness is not necessarily associated with poor knowledge of sexual health issues, but with a lack of understanding of personal risk.

Attitudes towards people who contract STIs were frequently underpinned by moral frameworks, with STIs and unplanned pregnancy being perceived to be the result of immoral behaviour:

Things like Hepatitis B, C and all this can be passed through blood and sexual transmitted. So if you got all these diseases through sexual immorality then you can pass them on to your children and your children can pass them on and that is really not good. (Afghani male)

A long time ago, sexual things, like sexually transmitted diseases, were not common. They were not like today. Things like HIV they were not there. But as sexual immorality grow worse and worse then things like HIV and other sexual transmitted diseases which don’t even have treatment, or better treatment, they came as a punishment or as a consequence of that. Because it’s like our problems, so they just came as a result. So that anyone who do it will find it like that. So you have to be really careful. (Afghani male)

Alcohol

Many participants and case workers correlated alcohol consumption with risky sexual behaviours. A few people also referred to drug use as contributing to risk-taking activity. In a few female groups, discussion emerged around how young men take advantage and have sex with girls who are drunk. Many young women also said that alcohol reduced the ability to make appropriate judgements and stay in control:

To be honest, last time I didn’t wait that time. Not much, yeah. I slept with him, I didn’t wait. I was drunk too. That’s the bad thing. You think you have the power to say no, that you’re not drunk, you know what I mean . . . But then you get drunk and you forget. That’s why I don’t like drinking. You don’t know what you’re doing much, you don’t understand what you’re doing. A guy can sweet talk you really easy when you’re drunk. (Ethiopian female)

Even if young people intended to use a condom, they said that people who are drunk might forget this intention because of the effects of alcohol. A few participants thought that young people with refugee backgrounds might be suffering particular stresses and social pressures, such as family conflict, which can lead to alcohol use and risky behaviours:

Some of them, they got stress from family. They don't care themselves. They had a fight with family. Stress, makes you drink. When you drink it will take you far. So yeah. (Ethiopian male)

Peer pressure and negotiating safe sex

A few female participants suggested that it can be difficult to negotiate 'safe sex' with boys. They explained that some boys don't like to use condoms, or they feel reluctant to suggest condom use as it implies that they think the young man may be infected or having sex outside of the relationship. Discussion around contraception might also be regarded as disrespectful or inappropriate when initiated by the female within a relationship:

If you have to say to your partner 'do you use protection?' he'd probably get offended by that. So that will make it difficult as well . . . They have this role and if you try to tell them what to do, they think that you're trying to control a part in the relationship. (Horn of Africa female)

Peer pressure was also recognized as a factor that contributes to risky or unwanted sexual activity. Young women in particular mentioned that a boyfriend might put pressure on a girl to engage in sex, even though she may not be ready or willing. One group described how boys pressure girls into sexual activity by arguing that sex is a demonstration of love:

I think most of the young boys, like when they are starting to like girls, they'll be like "oh, if you don't do this with me you don't love me". And so the girl will be like "oh, I really love you". And the boy says "so if that's the case then I'm going to go for it". (African female)

However, many young women emphasised that if a boy really loves a girl then he will understand her feelings:

I don't have to say because I love you so much I'm going to do that for you. What about you? Think about yourself. So it's not right. It's not right. If he say that I'm going to leave, that means he doesn't really love me because he has to understand my feelings. (Liberian female)

Judgemental attitudes amongst community and family and networks

Young people often returned to the theme of non-marital sex and community disapproval and criticism. Many suggested that the judgemental attitudes of the wider community creates an unsupportive environment in which young people are compelled to have relationships in secret and are limited in terms of who they can discuss concerns or questions with. They suggested that sexual health issues are compounded because there is poor understanding and response at the community level: for example, young people who experience unplanned pregnancy or who contract an STI would be blamed rather than being assisted and supported. Those who engage in non-marital sexual activity might be held in disrepute and will become isolated from wider family and community networks. As one case worker said:

They are isolated and they get together for parties and all that. But no-one in the community wants anything to do with them. And they are at high risk because they are having sex and yes ... so ... there are some terminations also amongst these girls. (Housing case worker)

Young people frequently said that older people in their communities do not want to confront issues of sexual health, sexual activity and risk amongst the younger generation. They felt that parents and the older generation prefer to assume that young people are conforming to social and cultural expectations of abstinence. Community workers said parents are reluctant to discuss sexual issues

with their children. This is particularly true of communities with strong religious and cultural prohibitions around non-marital sex. One case worker said:

Generally speaking Muslim communities are very much in denial when it comes to trying to hide behind the religion and assuming that the religion will protect young people. That there will never be any sex without marriage and that will be enough protection for them. So, there are a lot of issues there. (Refugee Youth Worker)

Young people suggested that parents need increased understanding of sexual health issues, and the importance of sexual health literacy for young people. This might reduce the need for secrecy about relationships and sex, and could create a more open and supportive environment:

Another good thing is to make the parents understand. The kids, they go and do things behind their parents back, because they're scared to talk about sex with them. The only way they're going to learn is if their parents back off a bit and understand a bit more. People make it look sex is a bad thing. They should say have fun, but make sure you know about diseases. If I had parents, that is what I would want. (Ethiopian female)

8.4 RESPONDING TO UNPLANNED PREGNANCY

Unplanned pregnancy is a concern amongst some newly-arrived young people with refugee backgrounds. In many of the groups and one-to-one interviews, unplanned pregnancy was discussed at some length. Seven people (five females and two males) recounted personal experiences of unplanned pregnancy and others referred to people they knew of in their communities who had experienced unplanned pregnancy. Health professionals and case workers stated that they are seeing teenage pregnancies and terminations amongst young people with refugee backgrounds. They are concerned that young people are likely to approach health services once they are pregnant and 'it is too late':

I work with women, specifically young women . . . So many of them have pregnancies . . . So for me it is huge. They don't talk about sexual health or anything to do with sexuality. But when they find themselves pregnant is when they approach me. And from my point of view it's too late. It's too late because they're pregnant. (Housing case worker)

CASE STUDY: UNPLANNED PREGNANCY

Mebrete is a young teenaged woman. She has no relatives who live in Melbourne, and has been living in emergency housing for a number of years. Mebrete described how a few years earlier she had an unplanned pregnancy. She said: *'The first time I had sex I got pregnant. I didn't know how it happened. It wasn't a serious relationship. I didn't know anything, I was a virgin. I was feeling sick and I told the family doctor. I didn't think I would get pregnant, but I was really sick. I didn't eat, I felt bad. The doctor said I should do a blood test and he said I was pregnant. I was scared. I felt like the world was ending. I was 16. I just thought, 'what happened to me, why has this happened to me?' I told [the case worker], and she helped. I just said I didn't want it. I had an abortion. I told the boy and he was angry, he wanted to keep the baby.'*

As discussed in Chapter 5, unplanned pregnancy is considered by young people to be a significant risk associated with sexual activity. The social risks around unplanned pregnancy appear to be higher for young women than young men, and they are particularly concerned with the consequences that premarital pregnancy would have on their lives. Key concerns are that the young woman's reputation would be ruined, she would feel ashamed and would be harshly judged by her family and community, she might be disowned or forced out of home, her prospects for marriage could be destroyed, her family would be brought into disrepute and her parents blamed for their lack of control and guidance,

and she would be unable to raise the child adequately or to pursue educational or employment goals that she previously aspired to. For young men the consequences are not as severe, but they also spoke of concerns about being harshly judged by their family and community, taking on demanding responsibilities of being a father, not having a job or income, and being too young to raise a child:

I think guys they just get so scared. Like, their family finding out. Or they are new to this and they don't know what to do with a baby and maybe most of them live with their family still and stuff. They can't take care of it. They don't have a job. A lot of things. Money. Too young to have a kid. They don't think about what the girl has to go through. They just think 'oh my god, just do something about it'. (Ethiopian male)

A few people mentioned adoption, migrating overseas so as to avoid the judgment of family and community, and committing suicide as possible responses to an unplanned pregnancy. However, the most commonly discussed responses were to either terminate the pregnancy or to decide to have and raise the child.

Young people suggested that abortion is a possible response to unplanned pregnancy. A few participants emphasised that abortion is morally indefensible because the procedure terminates a life; *'it is like a baby that you kill down there'*. But many participants indicated that young people might choose to terminate a pregnancy in order to avoid the shame associated with having a child outside of marriage or because they do not feel prepared for the responsibility of raising a child.

Many young people felt that it would be difficult to discuss the decision to have an abortion with family or friends. Health professionals who work in the area of pregnancy advice indicated that young women with refugee backgrounds tend to approach pregnancy advisory services alone or with support workers, are concerned about family discovering they are pregnant or have sought a termination, generally do not return for follow-up support and counselling, and are reluctant to use interpreters due to anxiety about lack of confidentiality:

Some clients have had abortions and have subsequently had depression and suicide issues. They haven't accessed counseling services after terminations. Counseling is not a familiar service for many refugee youth. But part of it is the shame, as they are trying to hide and forget it. (Youth Worker)

Alternatively, participants said that a young woman or couple might choose to have and raise the child. They said that an unplanned pregnancy could lead to a hasty marriage, particularly if their parents demand that they marry:

There's a lot of young people get married. You know why? They had like secret, you know, relationship and then they got pregnant and then the parents knew boyfriend and then they get the boy, the boyfriend and then make them marry. (Burmese female)

Young women might also make the choice to raise the child alone, either because she does not want to continue a relationship with the father, he denies responsibility, indicates he is not interested in being involved, leaves the young woman after the birth of the child, or lives in another country. One case worker told the story of young unmarried woman who came to her after she realised she was pregnant:

One time a girl came and she just kept crying because she felt ashamed to tell that she didn't get married and had one day out with a friend and got pregnant. One night stand. And she's Muslim. And how can she tell? She was crying. It couldn't come out from her mouth, her belief and her values made her struggle with how she can tell. I told her that everything in this office will be confidential. I said 'are you pregnant?' and she kept crying more and then she said yes. Her

relationship, she was not happy but she didn't want to go through a termination but she doesn't want that relationship. So the choice is she has to have that baby. But how will she cope with the baby if she doesn't want that pregnancy. It's a huge issue. And then that girl had a beautiful baby and she's a good mum and she's learning the language and now she's doing really good. (Housing case worker)

Other young women who became pregnant and had the baby experienced the challenges and isolation of non-marital pregnancy. They spoke about difficulties in accessing suitable accommodation. They indicated this is a major concern because they need to be able to care for the new baby in a secure and private environment. Housing support workers emphasised inadequacies with regard to the supply and the standard of **accommodation**, particularly for young women who are pregnant or who have recently given birth. They also spoke of the absence of reliable and strong **social support**. This can enhance the feeling of isolation and loneliness during pregnancy and following childbirth, particularly when young women are primarily in their homes due to childcare responsibilities.

IMPLEMENTATION: KEY MESSAGES

SAFE SEX

- Safe sex refers to protection from STIs and unplanned pregnancy.
- Safe sex also incorporates concepts of being careful, acting responsibly, protecting against adverse social responses such as shame and loss of reputation, and staying in control.
- Risk reduction practices are underpinned by views about the nature of relationships and sexual partners and cultural and religious values around abstinence and appropriate sexual behaviour.

PROTECTIVE BEHAVIOURS

- Key protective behaviours and safer sex strategies include: use of condoms, abstinence from sex, fidelity and monogamy, and avoidance of sex with people who are regarded as at risk.
- Condoms and other contraceptive methods were frequently mentioned by participants as a way to prevent STIs and pregnancy.
- Condoms are widely viewed as the responsibility of young males, and other contraceptive methods – i.e. pills, implants – as the responsibility of females.
- Abstinence was cited by most groups as a good strategy for avoiding the risk of STIs and unplanned pregnancy.
- The ideal of abstaining from sex prior to marriage is informed by social and family expectations: it is viewed as virtuous and a way to protect one's reputation.
- Many individuals linked safe sex to committed relationships and the establishment of trust between partners. Safe sex depends on establishing that each person in the relationship is free from infection. It is then based on trust and an assumption of fidelity.
- Participants identified particular people who are at increased risk of sexual health problems, such as people with a bad reputation. Safe sex involves avoiding these people. Both males and females identified the opposite gender as the main carriers of sexually transmitted infections.

RISK FACTORS FOR STIS AND PREGNANCY

- A range of risk factors for STIs and unplanned pregnancy were identified: risk-taking people, alcohol use, peer pressure, homelessness, and inadequate social and family support.

UNPLANNED PREGNANCY

- Unplanned pregnancy is a concern amongst some youth with refugee backgrounds.
- Health professionals and case workers stated that they are increasingly seeing teenage pregnancies and terminations amongst young people with refugee backgrounds.
- Unplanned pregnancy is associated with homelessness: young women who become pregnant may be forced out of home, and women who are homeless may be more likely to experience an unplanned pregnancy.

9. USING HEALTH SERVICES

Improving access to health services remains a key strategy for increasing sexual health literacy and reducing poor sexual health outcomes. This chapter focuses on young people's awareness of health services and barriers and enablers to their use.

Health services – and specifically doctors – were commonly mentioned as a potential source for finding out about and responding to sexual health issues.

A few sexually active participants indicated that they had sought STI screening. However, most participants said they had not accessed health services since arrival in Australia. There is very low awareness of specialist sexual health services, including free services for youth.

Key barriers to accessing health service include: shame and stigma around STIs, concerns about confidentiality, lack of awareness of services, language barriers, competing priorities of settlement, poor understanding of the benefits of early intervention and preventive health behaviours, limited experience using health services, and lack of awareness of the asymptomatic nature of some infections. Many of these barriers to access were reiterated in interviews with health professionals.

In order to counter the fear, embarrassment and stigma associated with sexual health issues among youth with refugee backgrounds, there is a need to emphasise the confidentiality of health services. It is also important to increase awareness of how to access health care services, to emphasise the value of preventative behaviours and early intervention, and to increase understanding of the asymptomatic nature of some STIs.

9.1 USE OF HEALTH SERVICES

Doctors are viewed as an important and professional source of health information, advice and treatment, including in relation to sexual health. The majority of participants stated that doctors are the best person to address and respond to sexual health concerns:

She knows there's something wrong with her. So the doctor will know. She must go to the doctor. If nothing happen, she feels happy and she feel release. (Burmese female)

I think this sexual health is very important . . . So if something really happened to me then I'll find a way to see the doctor. (Burmese male)

The people most likely to have attended a health service were those who had experienced unplanned pregnancy or who were concerned that they might have contracted an STI:

How you get it, what infection, what you need to do, where you need to go when that happens, nobody knows . . . I don't. The only thing - even me - the only thing I know is if something happens to me I go to the doctor. (Sudanese male)

Young people who had reason to access health services appear to rapidly gain skills in accessing and using services effectively.

However, few participants said that they had accessed health services for assistance with sexual health problems or to request information or clarify questions. Subsequent to the on-arrival health assessment, most participants said they had not had any reason to see a doctor. Few participants know about specialist sexual health services. Those who mentioned specialist services were

people who had lived in Australia for around five years and had been exposed to public awareness campaigns:

At uni, if you go into the toilets there are heaps of numbers and hotlines that you can call and make an enquiry if you want more information. So it's accessible if you're willing to go. (African female)

9.2 BARRIERS TO ACCESS

They can find their way across Africa, but they can't get to the health centre in the next suburb. (Refugee Health Nurse)

Young people identified a range of barriers to accessing and making best use of sexual health and clinical health services. They focused primarily on social concerns such as stigma, embarrassment, and the risk of family and community finding out. Many young people described prevailing societal views that discriminate against people infected with an STI and associate STI infection with promiscuity. Accordingly, there is a reluctance to seek sexual health care for fear of stigma or discrimination.

One of the key issues amongst both males and females is **confidentiality**. Young people expressed concerns that if a young person seeks information or treatment relating to sexual health and pregnancy, a doctor might disclose this to their parents:

I heard of someone who is seventeen years old - no, sixteen years old - and she had sex and she had to go to the doctor but she didn't want to go to someone who's close to their house. Because they know each other, you know? That's why she wanted to go to somewhere far away. (Iraqi female)

Discussing the issue of unplanned pregnancy and termination, one participant said a doctor might demand to speak to the parents before proceeding with a termination of pregnancy:

If you get a bad [doctor] it will be like 'we want to see her parents before we do this'. You'll be like 'wow, my God, that's going to be hard'. (African female)

Males also expressed concern about parents finding out. A few young males suggested that it might be necessary to give the doctor money to ensure they do not tell the parents. Others said that if they had a sexual health problem, or *'if it's something you want to hide'*, they would not go to a doctor who knew their parents.

Young people are not only concerned about keeping sexual health issues confidential from their parents. They also have concerns that the wider community could find out if they attend a clinic or health service for assistance with sexual health problems or pregnancy. There is a particular concern about accessing specialist sexual health services. Staff at a specialist pregnancy advisory service indicated that young people with refugee backgrounds are often anxious about the risk of discovery by community members, because people would realise or assume they were pregnant. Young people said they would be particularly reluctant to use a specialist service that was located close to their community networks:

Where the place is, where the service is located . . . Like if it's in Footscray you wouldn't want anyone to see you walking in there you know. (African female)

The use of interpreters is also seen as problematic when there is a need to talk with a health professional about sexual health concerns. Young people whose English was still limited were anxious that the interpreter might not maintain confidentiality:

They're more likely to spread confidential information. You hear about it, interpreters spreading information they have learnt from interpreting for people. (African male)

These concerns are particularly present amongst smaller communities, such as the Chin and Karen communities, where interpreters and patients and their families may be known to each other:

Mostly they use on-site if you got an appointment. That is a problem because the young people want to keep it confidential, and no matter if they are ethical, still there is that community attitude that the rumours will go outside. So that is a fear for the young people. And even if that interpreter didn't talk about it outside, if they know that person then . . . because it's a small community, people know each other. (Housing case worker)

Shame also presents a powerful barrier to accessing health services. Across all ethnic groups, people said that a person with an STI would not want anyone to know, including parents, friends, family and wider community. Young males and females said they would feel scared, ashamed or shy to admit they had a sexual health problem:

I would never let them know. Yeah. In people's eye, you're not the right girl. You're just a fun girl, since you are like that. (Burmese female)

Several young women indicated that the shame associated with sexual health problems and unplanned pregnancy is so acute, that it would be difficult to even tell a health professional:

She could be pregnant and . . . she would never tell anybody because she'd be so ashamed of it. You know. There's the whole thing of going and saying 'I'm pregnant, I'm having a baby, I need to get rid of it'. And if you're new in this country you're scared of everything you know. I heard of a lot of girls getting pregnant and just running away because they couldn't deal with the pressure. And their families will never see them again. And they don't know anybody else. (Sudanese female)

Participants emphasised that embarrassment could be partially alleviated by speaking with a doctor of the same gender as they are. Many females expressed their preference to see a female doctor so as to feel less inhibited or nervous. A few males also thought it would be better to speak with a male doctor, though for somewhat different reasons:

Going to a female doctor, it might make you feel horny talking about sex with her. You wouldn't be able to talk seriously. (African male)

Despite the shame associated with sexual health issues, many people acknowledged the importance of seeing a doctor if they had specific concerns:

They might feel shamed to mention about the pain or whatever they are feeling, but they should talk to the doctor. (Burmese female)

Another key theme to emerge was the **structural barriers** to health care. Few young people appear to have a 'family doctor' and have not had reason to seek information, treatment or referral from a health service; they said they do not know where they would go, how to book an appointment, or how the health system works. Newly-arrived young people indicated that due to language difficulties, it can be hard to find out about sexual health issues and health services. While language barriers in health care settings are addressed through interpreter and advocacy services, these may not be readily utilised by young people for issues relating to sexual health.

A further consistent theme was the **challenges of settlement** encountered by young people with refugee backgrounds. Use of health services is constrained by the need to first meet practical and social needs, which can compromise their health including sexual and reproductive health.

As discussed previously, health is a priority when experiencing a specific illness or problem, but otherwise settlement issues take precedence. For many young people, their focus is upon language acquisition, adequate housing, education, employment, and gaining an income:

They want to go to school and study, get their English so they can get a job, and look after their family or look after their siblings or whatever. Sexual health is not a priority in their books. (Refugee Health Nurse)

Newly-arrived youth with refugee backgrounds who are homeless or at-risk of homelessness are particularly likely to prioritise the need for stable accommodation ahead of preventive health behaviours. The challenges associated with settlement were widely identified as priorities that are placed ahead of health and sexual health concerns. Once young people are able to fulfil the most immediate practical and social needs they may experience better accessibility in seeking and using health services, including in relation to sexual health issues.

Finally, case workers and health professionals suggested that **preventive health behaviours may not be well established** in many refugee source countries and regions. Consequently, health services may only be accessed when there is a specific health concern and when it is regarded as serious:

Some of these people are coming from rural areas and they never had . . . if they came here as young adults they will never have seen a doctor before. So the concept of asking the doctor may not be there sometimes. So I think, I'm assuming that the only time they go will be the time they are scared or afraid of something happening after sex and then they think they might be pregnant and then they go to the doctor and do the test. (Refugee Youth Worker)

A number of research studies have also found that migrants, refugees and asylum seekers tend to seek professional help only when they are already seriously ill (Janssens, Bosmans et al. 2005: 103).

9.3 SCREENING

Despite widespread lack of knowledge about STIs, and concerns about disclosing sexual health issues to health professionals, a number of young people mentioned STI screening. The visa medical examination appeared to increase awareness of the process of screening for STIs, and particularly HIV/AIDS. However, those most likely to mention screening were participants who were sexually active, particularly those who had already had experiences of STIs or unplanned pregnancy.

In general, participants were not able to identify specific infections for which screening is available, other than HIV. They spoke more generally about tests and blood tests that check whether a person is 'clean' or has an infection. There was little awareness of the time it takes for different infections to become detectable. One young male mentioned the importance of early detection of STIs in order to begin treatment before an infection becomes hard to treat. However, a number of health professionals indicated that late presentation with symptoms of STIs is a problem amongst young people with refugee backgrounds. Late presentation is problematic because it can limit treatment options and lead to poor health outcomes, and results in missed opportunities to limit onward transmission. In some instances, STIs are only diagnosed when a young person attends a health service due to an unplanned pregnancy.

Screening was described by several people as a preventive strategy. They regarded screening as something that should be done with a partner prior to initiating a sexual relationship, in order to ascertain whether they have an infection that could be transmitted during sex. Females were particularly concerned to ensure a boyfriend is tested because they believe that he may have had sex

with a number of other women:

When we started going out first, the two of us decided that because we don't know each other, I decided that maybe we should have a test before we can. Yes, and he agreed, so that was in Ghana. So we went to the clinic and we had tests of HIV, we had tests for gonorrhoea and syphilis and all that, yes, and the two of us were well, so we decided to continue with the relationship. (Liberian female)

A few people suggested that screening should take place prior to marriage in order to ascertain whether both people (or the other person) are free from infection:

When I get married, so I make sure that going to the doctor to say 'so this lady, we decided to get married but before that you have to test our blood or hers.' And then when doctor test it and he says it is OK, fine, then we start the other way. (Afghani male)

Screening prior to initiating a sexual relationship was described as the responsible and sensible thing to do.

Screening was also regarded as a good way to check sexual health status after engagement in sexual activity. Several people said they would seek screening for STIs if they began to feel unwell, but a few indicated that only a doctor would be able to identify symptoms and it is important to be screened even if you feel normal:

Actually, you don't know what is going on with yourself. You're going to be wary at the time. You don't know what's exactly in your body. So you have to check. (Sudanese male)

After you've had sex, after a while you can probably check up on your doctor, and see if he sees any differences, like from your normal tongue. See any lumps, any things that are growing. And you can go see doctor. (African male)

Screening is regarded as particularly important if a person is not in a trusting and monogamous relationships because there is the risk that a casual sexual partner has an infection:

Me, a few days after, I go and have a check. Even if . . . you see a person looking all normal you don't know what's wrong with them, you know what I mean. Like I'm talking about people you meet today and you don't meet them again tomorrow. (Sudanese male)

Young people said that the main benefit of screening for STIs after sex is that it provides peace of mind if the results are clear.

Barriers to screening for STIs

A number of barriers to STI screening amongst newly-arrived youth with refugee backgrounds were identified. Health professionals described the difficulties in explaining the importance of screening for and treating asymptomatic infections such as chlamydia. They indicate that screening and management of infections is particularly difficult as young people are often focused on settlement issues:

These guys have just come over, they are settling into the country, we diagnose syphilis, we want to talk syphilis, they aren't interested: 'get me a job, I don't want to sleep with anyone, I know I have syphilis, I have had it for years, it is not a problem.' (Refugee Health Nurse)

Young people perceive a correlation between screening and bad news, particularly in relation to HIV screening. The association between screening, detection of infection, and illness and death leads to fear of screening. This is particularly true for young people who know of people dying of HIV/AIDS in their countries of origin:

They scared to check. They want to check, but they are scared. They say 'how about if I get it?' They're going to get stressed about that. They are going to say I'm out of this world. So they just keep it. (Ethiopian Male)

Young people who are involved in relationships said that screening is not necessary in a monogamous relationship because the other person can be trusted. To suggest testing for STIs would be insulting because it would imply lack of trust in the other person's faithfulness:

I don't even tell them that I'm going to go and have a check because some people might think 'oh, do you think I'm sick?' So you have to play it down, you know what I mean. It feels kind of rude if you tell her 'I'm going to go and have a check, do you want to come and have a check'. (Sudanese male)

USING HEALTH SERVICES: KEY MESSAGES

USE AND AWARENESS OF HEALTH SERVICES

- Doctors are viewed as a professional source of information, advice and treatment, including in relation to sexual health.
- However, few participants indicated that they had used health services to seek information or address specific health problems.
- Few participants know about specialist sexual health services.

BARRIERS TO ACCESSING HEALTH SERVICES

- Concerns about confidentiality (especially when using interpreters), and the risk of family and community finding out.
- Shame and embarrassment when discussing sexual health issues.
- Structural barriers: including lack of familiarity with health services, limited experience using doctors, language difficulties that inhibit capacity to seek assistance.
- Settlement issues override health concerns as a priority concern in young people's lives.

SCREENING FOR STIS

- A significant number of participants spoke about STI screening, particularly those who were older or who indicated they were sexually active.
- There is limited knowledge about the infections for which screening is available.
- Screening was mentioned by a number of young people as a preventive strategy: it should be done prior to initiating a sexual relationship in order to ascertain whether they have an infection that could be transmitted during sex.
- Screening was also regarded as a good way to check sexual health status after engaging in sexual activity.
- Screening is regarded as particularly important when not in a trusting and monogamous relationship.
- A number of barriers to screening were identified:
 - Health professionals described difficulties in explaining the importance of screening for and treating asymptomatic infections.
 - Young people perceive a correlation between screening and bad news about health status, particularly in relation to HIV screening.
 - Some young people said that screening is not necessary in monogamous relationships as the other person can be trusted.

10. SUMMARY AND DISCUSSION

The knowledge, attitudes and practices of young people with refugee backgrounds are influenced by refugee experience, ethnic background, age, gender, educational background, and socio-cultural contexts. The following discussion focuses on cross-cutting issues that emerged in this study of the sexual health and sexual health literacy of young people with refugee backgrounds, and considers their implications for policy and program initiatives. Many of the central findings from the main thematic areas of the research are reiterated: i.e. knowledge and attitudes, sources of information, risk and protective behaviours, use of health services. Key findings are summarised in more detail in the Executive Summary.

REFUGEE BACKGROUND: IMPACT ON SEXUAL HEALTH

Young people with refugee backgrounds share many sexual and reproductive health issues with other young people, particularly those from culturally and linguistically diverse backgrounds. However, while young people with refugee backgrounds do not necessarily identify as refugees, many face specific concerns and needs due to the pre-migration refugee experience and to the resettlement context in Australia. Growing attention is being paid to the sexual and reproductive health rights and needs of displaced people, refugees and asylum seekers (Janssens, Bosmans et al. 2005: 115). However, few sexual health policies and strategies in Australia take into account the impact of the displacement and settlement process (Dawson and Gifford 2001). This study highlighted specific issues and needs of young people with refugee backgrounds in relation to sexual health and sexual health literacy, due to a background of forced migration and displacement and to the post-migration context in Australia:

Pre-migration experience

- Young people with refugee backgrounds have often had disrupted education (McBrien 2005; Bond, Giddens et al. 2007; Victorian Foundation for Survivors of Torture 2007) and limited opportunities to receive sexual health information in educational or institutional contexts. Accordingly, many young people are inadequately informed about key sexual and reproductive health issues, including modes of transmission, symptoms, and prevention of STIs. They may have poor understanding of the importance of preventive health behaviours, such as STI screening.
- Strong association between HIV/AIDS and death due to higher mortality rates for HIV/AIDS affected people in countries/regions of origin.
- View that HIV/AIDS is of less serious concern in Australia than in countries of origin, and lack of awareness of presence and risk of HIV/AIDS and other STIs in Australia.
- Awareness of HIV/AIDS is increased through the visa medical examination process, but this also engenders an association between HIV/AIDS, shame, and not being welcome in Australia. Many young people believe that no HIV-positive Humanitarian applicants are allowed to migrate to Australia, and it is therefore unlikely that HIV/AIDS exists in refugee communities.
- Young people may have little experience or confidence in accessing health care services. Health care facilities in refugee camps may have been inadequate or non-existent, and access to health care services in countries of origin or first countries of settlement may have been inaccessible or unavailable.
- Young people may have experienced gender and sexual based violence, such as physical assault, sexual harassment, or rape.
- Young people come from social and cultural backgrounds that may have different explanatory models of health and illness, including in relation to sex and sexual health.

Post-migration experience

- There is a focus on meeting practical and social settlement needs - such as education, acquiring employment, obtaining language skills, and finding adequate housing. Young people may also be expected to take on additional responsibilities such as caring for younger siblings, or translating for older family members. This can compromise overall health, including sexual and reproductive health, because young people with refugee backgrounds are less likely to seek information or utilise preventive health services when they feel constrained by pressing settlement needs.
- The refugee experience results in fragmented family networks through loss and separation of close family members. Changes in family and community relationships resulting from refugee and settlement experiences can adversely affect the availability, nature and quality of support and advice available to young people. These issues are particularly marked for unaccompanied minors.
- Issues of shame around STIs and unplanned pregnancy can become magnified within small newly-emerging communities. Family values are often intensified in the settlement context, with some parents fearing the adverse influence of Australian culture and loss of cultural values. In particular, there is an expectation placed on young people of behaving responsibly and of building a good future in Australia not only for themselves, but also for their families. It can be difficult for young people and their parents to deal with changing values and practices related to sex and sexuality.
- Many young people highlight the importance of family and social networks while they settle into life in Australia. It can take some time to establish wider social and support networks. Where sexual health problems result in a deterioration of family and immediate social networks (i.e. young women who experience unplanned pregnancy and are forced out of home), the loss of social support and networks is particularly difficult.
- Young people who do not attend school following their arrival in Australia have little opportunity to participate in sexual health education programs.
- Youth with refugee backgrounds who are homeless or at risk-of homelessness experience particular risks to their sexual health. They are at increased risk of coercive sex, are inconsistent users of contraception, are less likely to be exposed to school-based sexuality education, face difficulties in accessing health care services, and prioritise the need to find secure housing and above most other issues including their health. Unaccompanied and homeless young people may seek the security and companionship that is lacking from family and parental relationships through sexual relationships or by having a child of their own.
- Many young people have settled with their families in areas with poor infrastructure, including public transport and youth-oriented services. The lack of access to and control over social, material and economic resources may disadvantage young people in accessing sexual health information and resources.
- Experiences of discrimination and feelings of social exclusion act as barriers to young people's confidence in accessing sexual and reproductive health information and care.

Policy and program initiatives must be responsive to the specific needs and situations of young people with refugee backgrounds. However, newly-arrived youth with refugee backgrounds are not a homogenous group, and the term 'refugee' should not obscure their diversity. Young people with refugee backgrounds differ significantly in the extent to which they identify as refugees. Their gender, age, level of sexual experience, ethnicity, socioeconomic background, religion, education, and duration of residence all combine to create a range of identities and impacts on health outcomes. Further, the annual composition of the refugee and humanitarian population in Australia varies according to changing regional allocations and intake priorities. This diversity presents challenges

and opportunities for education, prevention, and management of sexual health issues amongst young people with refugee backgrounds. Multifaceted and flexible approaches can improve the sexual health and sexual health literacy of young people with refugee backgrounds.

SOCIAL DIMENSIONS TO RISK AND PROTECTION

There is an increasing body of literature focusing on the social construction of risk around sexual health, including HIV/AIDS (Gifford, Bakopanos et al. 1998); (Rhodes and Cusick 2002; Shoveller, Johnson et al. 2004; Hyde, Drennan et al. 2008). This study also highlights the social significance of sexual health, risk and protection. Young people with refugee backgrounds emphasised social values, expectations, and responsibilities in relation to sexual behaviours and health outcomes. Risk and protection are contextualised within social and cultural spaces that value abstinence and emphasise the importance of maintaining personal and family reputation. HIV/AIDS, other STIs and non-marital pregnancy represent a risk to social wellbeing; they are associated with shame, embarrassment and stigma. These social constructions present both enablers and barriers to good sexual health.

Preventive behaviours, such as abstinence and use of contraception, are motivated by a desire to both reduce the physical risks of STIs and unplanned pregnancy and to avoid the associated stigma. Young people indicated that preventive behaviours are a means to protecting social health and the social wellbeing of their family, as well as maintaining physical well-being. Young women, in particular, spoke of the importance of maintaining their reputation. They indicated that they received strong messages through family and communities about the shame and stigma attached to sex, STIs and unplanned pregnancy. Young men appeared to receive less restrictive messages about sex from family and community, but they also regard HIV and other STIs as shameful and embarrassing health concerns.

However, the stigma associated with premarital sex, unplanned pregnancy and STIs is also a powerful barrier to the implementation of 'safe sex' and preventive behaviours. The social expectation that young people remain sexually inactive prior to marriage can inhibit open communication and learning. For example, many young people indicated they protect their social health through strategies of silence: they maintain secrecy around non-marital relationships, and are unwilling to discuss specific concerns with health professionals. They are reluctant to attend health services because of concerns that doctors and interpreters might not maintain confidentiality. Young people may be concerned about the possibility of infection, but may be unwilling to use condoms or discuss the issue with sexual partners because it implies a level mistrust. Thus, young people protect their social health over their physical well-being.

Threats to social well-being are particularly marked amongst young women who experience non-marital pregnancy. Loss of family and social acceptance, limited marriage prospects, and isolation are regarded as significant risks for these young women. In order to avoid severe social consequences, young women who become pregnant might seek an abortion without disclosing their situation to any friend or family member. Amongst those young women who decide to have the child most said they enjoy their new role as a mother, but a few described subsequent deterioration of family and community support. Being newly-arrived in Australia, and with limited social networks, they stressed how keenly they felt this loss of support from family and community. Young men expressed less concern about the social impacts of pregnancy, saying that females are responsible for making decisions about unintended pregnancy.

Health promotion strategies often focus on preventive physical behaviours such as improving knowledge of STIs and safe sex, increasing access to contraceptive methods, or increasing motivation to employ safe sex behaviours. There is a need to increase the awareness and understanding of sexual health issues amongst youth with refugee backgrounds. They require factual information around STIs, contraception and pregnancy. However, health promotion strategies also need to adequately engage with the wider social contexts of risk and protection. In particular, they need to address assumptions about 'safe' and 'risky' partners, empower young people to negotiate safer sex, and address issues of shame and stigma associated with STIs and unplanned pregnancy.

A supportive social environment is a key determinant of healthy adolescent development. Social connectedness provides a positive context within which people from refugee backgrounds can face the challenges of both adolescence and settlement in host countries (Gifford, Bakopanos et al. 2007). In particular, strong relationships with parents and good connections to community networks and structures can prevent young people from engaging in unsafe or unwanted sexual behaviour (WHO 2005). Health promotion need to encourage parental and community understanding and support for improving sexual health literacy amongst young people from refugee backgrounds.

GENDER

Gender has substantial influence on the way in which sexuality and sexual behaviours are constructed (Connell, McKeivitt et al. 2004). In this study, gender was an important factor influencing attitudes and knowledge around sex and sexual health. As discussed above, young women expressed concern about protecting their reputation. Their family and community provided them with prohibitive messages around relationships and sexual activity prior to marriage and strong warnings about the shame associated with non-marital pregnancy. Young men received less restrictive messages, and expressed less concern about the social impacts of acquiring an STI or getting a girl pregnant. Young men and women have different motivations in relation to protective behaviours: young men are concerned about HIV and young women are concerned about unwanted pregnancy. Several young women described difficulties negotiating the use of contraception with boyfriends, indicating that their partner preferred not to use condoms or other contraceptive methods. Young women also referred to occasions where they had been pressured into unwanted sex. A few young men spoke of a preference not to use condoms because it reduced their sexual pleasure. Both young women and young men identified the opposite gender as being more likely to have (and therefore to transmit) STIs. Policy and program must take into account the gendered nature of understanding and attitudes towards sexual health priorities, relationships, and protective behaviours.

ETHNICITY AND HEALTH

Cultural frameworks and ethnicity can have a significant influence on sexual health. Research with ethnic minority groups suggests that culture influences the ways in which people learn about sex, the nature of their initial sexual experiences, attitudes towards risk and protective behaviours, and variations in the frequency of adverse sexual health outcomes (Coleman and Testa 2006; Fenton 2001; Fenton, Mercer et al. 2005). For example, a UK-based study on sexual health among Jamaican, Black African and South Asian people found that ethnic origin, religion, and degree of acculturation were important factors that determine sexual attitudes, behaviours, opportunity for learning, and access and use of sexual health services (Elam, Fenton et al. 1999). Cultural background has also been shown to play an important role in family planning, contraceptive use and behaviour, with familial and cultural pressures to fulfil traditional childbearing roles influencing choices (Janssens, Bosmans et al. 2005).

In this study, ethnic background and culture were shown to influence attitudes to sexuality and sexual activity, gender roles, and expectations around sexual relationships and behaviours. For example, prohibitive messages relating to sexual activity prior to marriage were frequently discussed amongst Afghani and Iraqi participants. Young people indicated that 'cultural attitudes' discourage discussion about sexual issues with parents and elders in their community. Young people from Africa were particularly likely to emphasise that HIV is a deadly infection, both because of exposure to public health campaigns in their country of origin and because they are aware of people who have died from AIDS.

However, there are concerns in using culture, behaviour or beliefs to explain health outcomes. Ethnically-determined differences are often sought in research focusing on health, risk factors and health outcomes within different ethnic populations. However, it is problematic when culture and ethnic origin are used as primary explanatory variables for patterns of health and sexual behaviour, and the wider socioeconomic determinants of sexual health are not considered (Fenton, Mercer et al. 2005). This is a salient issue to consider in relation to the effectiveness of ethno-specific health programs and policies.

Given that Australia is a country with a multicultural population, there are arguments for education and prevention programs that are tailored to the cultural frameworks of specific communities (Gifford, Bakopanos et al. 1997). However, there is a concern that ethno-specific initiatives might become increasingly fragmented and may not be adequately resourced or sufficiently flexible to adapt to the changing needs of communities. Ethno-specific programs may privilege cultural differences over other important determinants of health, such as gender, migration and living conditions, marriage patterns and existing health care provision (Gifford, Bakopanos et al. 1997; Fenton, Mercer et al. 2005; Janssens, Bosmans et al. 2005: 95). There is also the danger of stigmatisation in regards to drawing a connection between cultural background and sexual health risks, such as unwanted pregnancy and abortion. There may be significant diversity in knowledge and attitudes within cultural groups. Further, cultural beliefs and values may change in new socio-cultural context following migration (Dawson and Gifford 2001). This raises questions about the role of ethno-specific approaches to sexual health education and preventative health. Gifford et al suggest that mainstream approaches that are ethno-sensitive and take into account socio-cultural issues, combined with selected ethno-specific strategies are both effective and sustainable (Gifford, Bakopanos et al. 1997: 247).

This study highlights the fact that while ethno-specific factors must be acknowledged in sexual health education and prevention, the most effective strategies for improving sexual health literacy and outcomes will be sufficiently flexible to be relevant for all cultural groups and will identify ways to engage youth with refugee backgrounds with mainstream services and resources. Health and education services must incorporate ethno-sensitive rather than ethno-specific approaches to sexual health promotion.

SOCIO-ECONOMIC STATUS: HOMELESSNESS AND SEXUAL HEALTH

Public health research is concerned with the influence of socio-economic status on health. Less favourable living conditions, educational and employment opportunity, social environments, level of social inclusion, and access to healthcare services have been shown to have a negative impact on sexual health amongst ethnic minority populations (Elam, Fenton et al. 1999; Fenton 2001).

This study highlights the need for sexual health promotion efforts to co-ordinate with other program

and policy initiatives that address socio-economic disadvantage amongst young people with refugee backgrounds. In particular, young people with refugee backgrounds who experience homelessness were identified as facing increased risks to their sexual health: they tend to have limited or no access to school-based sexuality education, they indicate that they use contraception inconsistently, they have difficulties accessing health care resources and services, the challenges of finding secure accommodation take precedence over other needs such as preventive health behaviours, and they are at increased risk of coercive sex. A few young people indicated that due to the loneliness of living alone or without family they are more likely to seek companionship and support through sexual relationships with other young people. The lack of monitoring from parents and other family members means that they are more likely to attend parties and participate in other risky behaviours such as alcohol consumption.

This study supports the argument for incorporating sexual and reproductive health education and programs into broader policy and programmatic initiatives that engage with young people with refugee backgrounds. Approaches that target determinants that are common to a range of health issues and disease are considered more effective than those that focus on specific and isolated health risk factors (Gifford, Bakopanos et al. 1997). Behaviour modification programs within communities with poor sexual health, in the absence of social and economic interventions, are argued to be ineffective (Fenton 2001: 65). Sexual health programs and policies must consider wider structures and supports. Opportunity to secure housing, education, employment, and supportive social networks are also critical components of young people's health. Attention must also be paid to attitudes towards refugees within the health care system and the host society as a whole, as they can have a negative impact in providing effective sexual and reproductive care (Janssens, Bosmans et al. 2005: 77).

11. RECOMMENDATIONS

In recent years, Victoria has seen positive developments in the provision of health services for refugees provided by specialist and mainstream agencies (VFST 2004). Key objectives of the Victorian Department of Human Services include reducing inequalities in health and improving access to health services by targeting the needs of specific communities, such as refugee and humanitarian entrants. In particular, the Refugee Health and Wellbeing Action Plan provides a context to understand the health and support needs of refugees and to ensure co-ordinated responses between different sectors, community and groups and levels of government (DHS 2005).

The following recommendations aim to provide a framework that can: facilitate improvements in sexual health promotion and health service access and responsiveness; build on current good programs and practice; respond to the changing patterns of refugee intake. The recommendations are grouped into seven broad objectives through which to strengthen the sexual health of young people with refugee backgrounds:

- Policy and program development: ensure sexual and reproductive health programs and services effectively target young people with refugee backgrounds
- Health promotion and community-based interventions
- Development and delivery of school-based sexuality education programs for newly-arrived young people with refugee backgrounds
- Professional development: strengthen the capacity of general health and welfare services to meet the sexual and reproductive health needs of young people with refugee backgrounds
- Support newly-arrived youth to access healthcare services and screening
- Integrated response: sexual health programs integrated with broader policy and programmatic initiatives in relation to health and well-being of youth with refugee backgrounds

POLICY AND PROGRAM DEVELOPMENT

1. Young people with refugee backgrounds are an 'at-risk' population, in terms of poor sexual health literacy, risk of STIs and unintended pregnancy, and limited access to mainstream services. It is important that young people with refugee backgrounds are recognised and targeted in program and policy development, with the aim of improving their sexual and reproductive health:
 - a. Ensure that strategies for addressing the sexual and reproductive health of people with refugee backgrounds are specifically identified in the 2007-2012 Sexual and Reproductive Health Action Plan (development is being led by the Public Health Branch, Department of Human Services)
 - b. Involve relevant community based organisations and stakeholders, including young people with refugee backgrounds, in the design of programs and policies.

HEALTH PROMOTION: COMMUNITY-BASED EDUCATION AND COMMUNICATION

2. Develop and deliver education resources and educational strategies for newly-arrived young people with refugee backgrounds that aim to increase awareness of STIs, unplanned pregnancy and the importance of protective behaviours, and to increase access to health care services:
 - a. Encourage and facilitate the involvement of community organisations, parents and young people with refugee backgrounds in the development of sexual health educa-

- tion programs and materials. This will foster a community and family approach to sexual health promotion for young people, and will increase understanding of the purpose and value of sexual health education.
- b. Many young people expressed ambivalence about the value of written resources. They said it not possible to clarify issues or ask questions of written information. Written resources (both in English and in community languages) could primarily be used to support interactive and group-based learning and could also be provided during health service consultations.
 - c. Young people identified interactive and group-based education delivered by trustworthy sources (i.e. health professionals, school teachers) as the preferred mode for learning about sexual health. Many young people expressed a preference for gender-specific groups.
 - d. Disseminate resources through frequently used sites: i.e. Centrelink, AMES, sports clubs, community centres, tertiary education facilities, and MRCs. Encourage these agencies to provide or strengthen existing sexual health education programs.
 - e. Young people who are disadvantaged in their access to health education opportunities are an important target group for educational and health promotion programs, including males and young people who are homeless or at risk of homelessness.
 - f. Involve sources of health information that are trusted by young people with refugee backgrounds – health professionals, teachers, community-based service-providers – in communication strategies around sexual health.
3. In addition to providing factual information about STIs, pregnancy and contraception, it is critical that communication and educational programs also include information about:
 - a. physiology and reproductive biology
 - b. responsible decision-making and negotiation within intimate relationships
 - c. positive aspects of sexuality and being sexually healthy
 - d. emotional aspects of relationships and sex
 - e. gender roles and interactions between young males and females
 - f. the incidence of HIV, STIs and unplanned pregnancy in refugee communities
 - g. availability of sexual health services and screening and youth-specific services, particularly free services
 - h. Australian laws regarding sexual relations, including age of consent and child support legislation
 - i. differences between mainstream ideas and culturally-informed perspectives
 4. Incorporate wider notions of safe sex in health promotion messages.
 - a. Safer sex refers to stability, protection from pregnancy, self-control, disease prevention, protection of reputation within a community and family context.
 - b. Question and address assumptions about ‘risky’ and ‘safe’ partners.
 - c. Emphasise that people with HIV or STIs are not always identifiable.
 - d. Address the association between STIs, unplanned pregnancy and immoral behaviour/shame.
 5. Pilot a ‘peer education’ program for sexual health. This pilot could build upon the strengths of existing peer education programs, such as; the bi-lingual peer educators at Western Region Health Centre who have completed train-the-trainer courses and have skills in peer-led health education; the peer-led ‘Hip Hop for Health’ project for African and Arabic youth run through the Multicultural Health and Support Service.

6. Explore greater utilisation of on-arrival health assessment as an initial opportunity to provide information about sexual health and services. Given the competing demands of settlement, any information provided on-arrival should be regarded as an initial introduction to sexual health issues and services.
7. Ensure that large-scale media campaigns relating to young people and sexual health (i.e. 'You never know who you'll meet' – DHS, 2007) are inclusive and relevant for young people with refugee backgrounds: for example, distribute resources and programs through sites frequently accessed by young people with refugee backgrounds.

SCHOOL-BASED SEXUALITY EDUCATION

8. Schools are important health promoting environments. Develop a relevant and accessible school-based sexuality education program for newly-arrived young people with refugee backgrounds:
 - a. Conduct an audit of existing sexual and reproductive health educational materials that are used to teach students in English Language Centres and English Language Schools, and students with refugee backgrounds in mainstream schools (i.e. Western English Language School, Noble Park Secondary College).
 - b. Develop a flexible educational program for newly-arrived youth that can be adapted to the changing regional allocations within Australia's Humanitarian program.
 - c. Incorporate interactive methods (i.e. visual aides, jigsaw puzzles) and provide opportunity to rehearse strategies for safer sexual behaviours.
9. Deliver sexuality education in English Language Schools and Centres.
 - d. Provide educational materials and learning tools to relevant schools and educators.
 - e. Explore involvement of Secondary School Nurses, Refugee Health Nurses, FARREP workers and local health service providers in the delivery of educational sessions. This will ensure that sound programs are delivered and that young people have increased capacity to access health services.
 - f. Where interpreters are required, ensure that they have adequate level of fluency in sexual health terminology.
 - g. While it is not necessary to have ethno-specific groups, this study highlighted the importance of gender-specific groups when delivering sexual health information amongst newly-arrived youth.
10. Teaching staff and Secondary School Nurses who are attached to schools in areas of high refugee settlement would benefit from professional development opportunities that allow them to respond to the sexual health education needs of young refugees.
 - a. Family Planning Victoria has been involved in the delivery of professional development for Secondary School Nurses in relation to sexual education for young people. Continue and increase delivery of professional development to Secondary School Nurses and other relevant staff, with a particular focus on sexual health literacy needs of young people with refugee backgrounds.
11. Extend the Secondary School Nursing Program to all English Language Schools and Centres.
 - a. Engage Secondary School Nurses in the provision of sexual health information and education to refugee children and young people in ELC/ELSSs.

12. Increase parental understanding of the purpose and value of sexual health education in school-based settings:
 - a. Although sexuality education is core curricula in Victoria, parental consent for student participation in sexuality education is not mandatory. Information sessions for parents of newly-arrived youth will help to address concerns about the delivery of sexual education, and allow parents to support their children in accessing accurate sexual and reproductive health information.

PROFESSIONAL DEVELOPMENT IN SEXUAL AND REPRODUCTIVE HEALTH ISSUES FOR RELEVANT HEALTH PROFESSIONALS AND COMMUNITY WORKERS

13. Deliver professional development to health professionals and community workers who are strategically important in the delivery of sexual and reproductive health education and services to young people with refugee backgrounds.
14. Ensure a core group of GPs, community health and refugee health nurses and mainstream health providers are informed about sexual health issues for newly-arrived refugees and are able to provide best practice level of care and sexual health education for refugee populations. Training could build upon current initiatives run by services such as Foundation House, the Centre for Ethnicity and Health, and the Multicultural Health and Support Service. Training could target:
 - a. GPs and community and women's health nurses in health centres with high number of clients with refugee backgrounds
 - b. Maternal and child health services and family services
 - c. Specialist clinics at Royal Women's Hospital (such as the Pregnancy Advisory Service)
 - d. Family and Reproductive Rights Education Program (FARREP) workers
 - e. Refugee Health Nurses (RHNs)
15. Provide support to service providers working directly with resettled youth with refugee backgrounds who are homeless or at risk of homelessness have sufficient resources to organise delivery of sexual health education programs, have increased awareness of sexual health issues for this target group, and are able to refer clients to appropriate services as required.

SUPPORT NEWLY-ARRIVED YOUNG PEOPLE WITH REFUGEE BACKGROUNDS TO ACCESS HEALTH CARE SERVICES AND SCREENING

16. Improving access to health care services is an important strategy for strengthening sexual health literacy and sexual health outcomes amongst youth. Community Health Services in areas of refugee settlement are well positioned to provide sexual health services and education as they have developed strong relationships with refugee communities. Improve the capacity of these sites to identify and respond to the sexual health needs of newly-arrived refugees (i.e. through education, clinical tasks, referral).
17. Provide young people with refugee backgrounds with on-site tours of hospitals, local health services and clinics. Emphasise the commitment of health services to maintaining client confidentiality. This will provide an interactive method for increasing awareness and understanding of the availability and nature of services.

18. Strengthen linkages between health care providers and case managers/youth workers in order that staff are better placed to provide support and advocacy for young people with refugee backgrounds.
19. Interpreting services need to be strengthened to ensure there are adequate numbers of interpreters in community languages and who are sufficiently fluent in technical health terminology. Interpreters must emphasise the professional requirement of confidentiality in order to build the trust of young people with refugee backgrounds.

INTEGRATED APPROACH TO SEXUAL HEALTH PROGRAMS

20. Integrate program and policy development in the field of sexual and reproductive health with broader programmatic and policy response in relation to young people with refugee backgrounds. Consider ways to combine sexual and reproductive health programs with other key health and social initiatives.
 - a. For example, identify ways to respond to the sexual health needs of young people who are homeless/at risk of homelessness or unaccompanied minors by delivering sexual health programs in conjunction with broader social and health initiatives.
 - b. DHS, in conjunction with other relevant Federal and State Government departments, could actively promote programs that combine sexual health education/promotion with interventions that address wider socio-economic issues, such as work experience, education support, sporting activities, and English-language learning.

FURTHER RESEARCH

21. The study identified a number of areas for further research:
 - a. Unprotected sex and unplanned pregnancies are of concern and further research is needed to identify effective strategies to promote and enhance negotiation in relationships and decision making among young people with refugee backgrounds.
 - b. Research is needed to identify family and community level concerns in relation to sexual health and sexuality education, and to investigate effective approaches for engaging newly emerging communities and youth to discuss and consider differences in cultural, religious and family values.
 - c. Specific concerns are faced by young women who have unplanned pregnancies, particularly single mothers who are at risk of homelessness and are not participating in the education system. Further research is required to identify how to best support these women and ensure that they do not experience further disadvantage.

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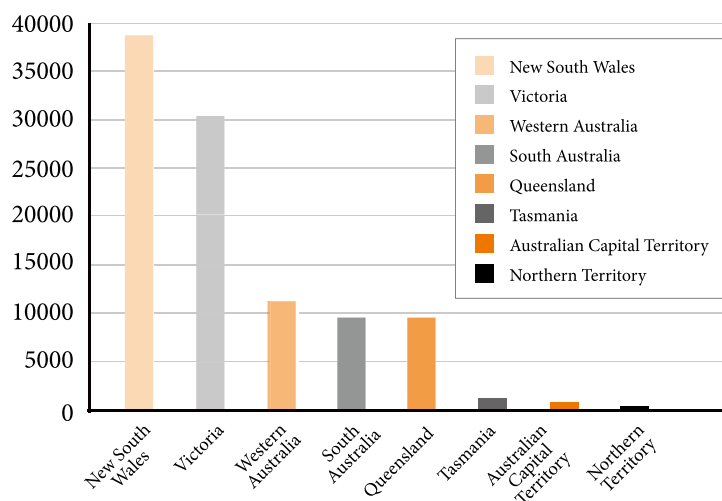
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APPENDIX 1: REFUGEE AND HUMANITARIAN MIGRATION
STREAM SETTLEMENT BY STATE; 1 JULY 1996 – 30 JUNE 2006

(Migration Streams: Humanitarian – Refugee; Humanitarian – Special Assistance; Humanitarian – Special Humanitarian Program; Onshore - Humanitarian)



STATE OF RESIDENCE	NUMBER OF SETTLES
New South Wales	38,634
Victoria	30,201
Western Australia	11,278
South Australia	9,352
Queensland	9,303
Tasmania	1,676
Australia Capital Territory	975
Northern Territory	703
Not Stated	246
TOTAL	102,368

APPENDIX 2: PROFILE OF REFUGEES AND ASYLUM SEEKERS IN VICTORIA

THE HUMANITARIAN PROGRAM

The United Nations High Commissioner for Refugees (UNHCR) is the international organisation responsible for providing protection to refugees, and for resettling them in third countries where this is considered the most appropriate way of ensuring long-term protection and security. At the end of 2007, the number of 'people of concern' to UNHCR stood at 25.1 million globally, of which includes 11.4 million people identified as refugees. The large majority of people assisted by UNHCR voluntarily return to their home country when possible or remain in their first country of asylum (usually another developing country such as Kenya, Egypt or Pakistan). Each year only 3-4% of refugees are permanently resettled in a third country by UNHCR. Australia is one of 16 countries that resettle refugees under the UNHCR program (UNHCR 2006). The Humanitarian Program comprises two components: off-shore and on-shore.

Permanent Offshore Resettlement Humanitarian Visas

Australia's offshore resettlement program has two main permanent visa categories: the refugee program and the special humanitarian program.

- **Refugee:** The majority of people who come to Australia via the Refugee visa category are identified and referred by UNHCR. The Refugee visa is for people who are subject to persecution in their home country, who are living outside their home country and for whom resettlement to Australia is considered the best durable solution. The Refugee category includes the Refugee, In-country Special Humanitarian, Emergency Rescue and Women at Risk sub-categories.
- **Special Humanitarian Program:** Individuals who are granted visas under this program are living outside their home country and are recognized as having been subject to substantial discrimination amounting to gross violation of human rights in their home country. Their applications must be supported by an Australian citizen, permanent resident or eligible New Zealand citizen, or an Australian-based organisation (DIAC 2007).

People who enter Australia via the Refugee and the Special Humanitarian Programs are offered settlement services through the Integrated Humanitarian Settlement Scheme (IHSS) including language tuition, translation services, and on-arrival accommodation, and as permanent Australian residents they have access the same services as all Australian nationals, including Centrelink assistance, public housing and Medicare.

Onshore Protection

Australia's Refugee and Humanitarian Program has provisions for asylum seekers who have entered Australia and who subsequently apply for the protection of the Australian government (DIAC 2007; Foundation House 2007). Few people seek asylum in Australia, both in terms of absolute numbers and in comparison to other countries (Sampson, Correa-Velez et al. 2007).

A system for processing onshore protection visa applications in Australia was developed during the 1980s and 1990s. The process differs according to whether people arrive with a valid visa (i.e. visitor or student visa), or whether they arrive via air or sea without a valid visa (as 'unauthorized arrivals') and then seek asylum on arrival (Sampson, Correa-Velez et al. 2007).

- Asylum seekers who initially arrive in Australia with a valid visa, and who then apply for

protection, are permitted to remain in the community while their application is processed. 'Authorised arrivals' who are found to be refugees, and who met health, character and security requirements, are granted a Permanent Protection Visa (PPV) (DIAC 2007).

- Asylum seekers who arrive in Australia's migration zone either by air or sea without valid entry documentation are kept in immigration detention until their application is reviewed.¹⁸ Those who are subsequently found to be refugees are granted a permanent protection visa.

In July 2008, the Immigration Minister announced proposed reforms to the immigration detention arrangements, in which a person who is not considered a threat to the community would no longer be detained. At the time of writing, the immigration detention program was under review by the Department of Immigration and Citizenship. On 9 August 2008, Temporary Protection Visas and Temporary Humanitarian Visas were abolished.

SIZE AND COMPOSITION OF THE HUMANITARIAN PROGRAM

The following table indicates the number of visas granted between 1999-2000 and 2007-08 for the main visa categories. In May 2008, the Government announced an increase in the Humanitarian Program to 13,500 places for 2008-09.

TABLE 2 Humanitarian Program visa grants by category, 1999-00 to 2007-08

CATEGORY	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08
Refugee	3802	3997	4160	4376	4134	5511	6022	6003	6004
Special Humanitarian	3051	3116	4258	7280	8927	6755	6,836	5275	4795
Safe Haven*	5900*	-	-	-	-	-	-	-	-
Onshore Protection	2458	5577	3885	866	788	895	1272	51701	2215
Other	649	1043	46		2	17	14	38	-
TOTAL	15860	13733	12349	12525	13851	13178	14144	13017	13014

Source: DIAC Settlement Database www.immi.gov.au/settle/data - data extracted July 2008; Refugee Council of Australia August Bulletin

* This figure includes 4,000 Safe Haven visas granted to Kosovars offshore and 1,900 to East Timorese onshore.

As a result of both changing international geo-political circumstances and nationally-based decisions, the countries of origin of people entering Australia via the Humanitarian Program vary substantially:

- In 1998-99, nearly 50% of people entering via the offshore humanitarian program were from Europe, 30% were from the Middle East and South West Asia, and 16% were from Africa.
- In 2005-06, 55% of people came from Africa, 34% were from the Middle East and South West Asia, and less than 1% were from Europe.

¹⁸ There were some circumstances in which asylum seekers who arrived 'unlawfully' in Australia's migration zone could remain in the community while their application is processed, (i.e. minors, people with health care requirements, spouses of Australian residents).

- In 2007-2008, the Department of Immigration and Citizenship (DIAC) reduced humanitarian intake from African countries and increased numbers of visa provided to applicants from Burma and Iraq.
- In 2008-2009, the new Minister for Immigration and Citizenship announced new regional allocations for the Humanitarian Program, with Africa, the Middle East and Asia each allocated a 33% intake. The Minister said the allocations showed the Australian Government is committed to offering protection to refugees, regardless of their origin.

Another significant change to the Humanitarian intake is the **increasing proportion of children and young people** (Foundation House 2007). In recent years, over 50 per cent of arrivals have been aged under 20 years, and 70 per cent under 30 years. Refugee young people have specific health needs, and this has significant implications for the provision of child and adolescent health services. Of particular concern are 'unaccompanied minors' who lack the protection and support of their families (RACP 2007).

HUMANITARIAN ENTRANTS IN VICTORIA

During the last ten years, more than 32,000 people granted visas through the Humanitarian Program have settled in Victoria, almost 30% of the Australian total in this category. Between 1 July 2006 and 30 June 2007, a total of 3,632 humanitarian entrants settled in Victoria. People of Sudanese background currently comprise the largest numbers within the Humanitarian Program intake. People from Burma are an emerging group that comprise a large proportion of the total refugee and humanitarian intake. People from a number of other African countries also arrived, including Ethiopia, Eritrea, Tanzania, Uganda, Congo, Liberia, Burundi, Sierra Leone, and Somalia.

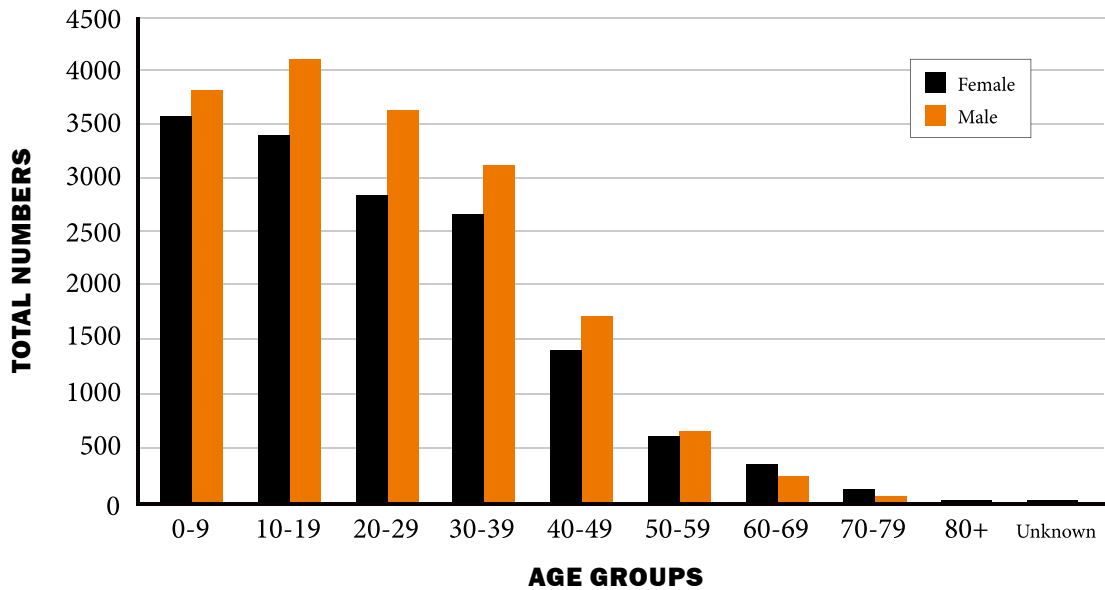
TABLE 3 Humanitarian arrivals by country of birth to Victoria, 2006-2007

	COUNTRY OF BIRTH	NO. OF ENTRANTS	% OF TOTAL
1	Sudan	759	21
2	Burma (Myanmar)	752	21
3	Afghanistan	537	15
4	Iraq	492	13
5	Thailand	267	7
6	Ethiopia	109	3
7	Other Central and West Africa	107	3
8	Kenya	77	2
9	Iran	74	2
10	Invalid	60	2
11	Sri Lanka	59	2
12	Egypt	51	1
13	Sierra Leone	38	1
14	Other Southern and East Africa	32	1
15	Uganda	32	1
16	Eritrea	25	1
17	China (exc Taiwan and SARs)	24	1
18	Pakistan	24	1
19	Somalia	17	0
20	Tanzania	17	0
21	Others	79	2
	TOTAL	3,632	100%

Source: DIAC Settlement Database www.immi.gov.au/settle/data - data extracted August 2007

Over the ten-year period 1 January 1997 – 31 December 2006:

- 66% were under 30 years old at time of arrival
- 46% were under 20 years old at time of arrival
- Males slightly outnumbered females in all age groups except in the 60+

FIGURE 2 Humanitarian entrants to Victoria, 1 Jan 1997-31 Dec 2006

Source: DIAC Settlement Database www.immi.gov.au/settle/data - data extracted August 2007

MIGRATION BY PEOPLE WITH REFUGEE BACKGROUNDS

In addition to people who enter Australia via the Humanitarian program, people from refugee source countries also arrive via other migration categories, including the Family Stream and the Skilled Migration Stream. People who arrived in Australia as refugees will often sponsor family members through the Family Stream or apply for spouse visas for their partners. There is also a small number of people who were admitted to New Zealand as refugees and subsequently migrated to Australia with New Zealand citizenship (DHS 2005).

Many of these people have also been exposed to persecution and violence in their countries of origin, and can be described as having a 'refugee-like' background.¹⁹ In 2000, it was estimated that one in every eight of the 32,000 people arriving through the Family Migration Program came from refugee-source countries (Foundation House 2007). Over the period 1 January 2000 to 1 January 2005, more than 4,500 people from refugee source countries arrived in Victoria through migration programs other than the Humanitarian stream (DHS 2005).

¹⁹ In a recent study of 200 newly-arrived young people who entered Australia through the Family Stream, nearly one third reported that their families had been persecuted in their countries of origin, compared with 64% of Humanitarian Program entrants (Coventry and Guerra 2002). A NSW study of non-humanitarian migrants and Temporary Protection Visa Holders with the same ethnic background found similar levels of trauma exposure in the two groups (Steel et al cited in VFST 2004).

TABLE 4 Family/Skilled Stream migration, refugee source countries, 2000-05

BIRTH COUNTRY	FAMILY STREAM	SKILLED STREAM	TOTAL
FYR of Macedonia	652	159	811
Iraq	524	52	576
Egypt	312	258	570
Former Yugoslavia	407	94	501
Serbia & Montenegro	387	103	490
Ethiopia	429	20	449
Iran	160	179	339
Afghanistan	281	14	295
Somalia	236	1	237
Bosnia-Herzegovina	106	25	131
Sudan	79	4	83
Croatia	63	12	75
TOTAL	3636	921	4557

Source: (DHS 2005)

PATTERNS OF REFUGEE SETTLEMENT IN VICTORIA

Newly-arrived refugees in Victoria have tended to settle in Melbourne's inner-north and inner-west, and the south-eastern suburbs (DHS 2005). This has been attributed to the availability of settlement support, housing and work opportunities in these areas. However, settlement is increasingly dispersed across a wide range of Local Government Areas (LGAs). Between 2000-05, humanitarian entrants settled in more than 50 of Victoria's 79 LGAs (DHS 2005). In 2006-07 newly-arrived refugees settled in both inner and outer metropolitan regions of Melbourne and rural areas (see Table 4).

TABLE 5 Top 10 LGAs, resettlement of humanitarian entrants, Victoria 2006-07

LOCAL GOVERNMENT AREA	NO. OF ENTRANTS, 2006-07	% OF TOTAL
Greater Dandenong	859	25.4%
Wyndham	391	11.6%
Hume	355	10.5%
Brimbank	327	9.7%
Maribyrnong	191	5.6%
Maroondah	182	5.4%
Casey	158	4.7%
Hobsons Bay	122	3.6%
Greater Shepparton	107	3.2%
Whittlesea	85	2.5%
Others	608	18%
Sub-Total	3385	100%
LGA Unknown	247	-
TOTAL	3632	-

Source: DIAC Settlement Database www.immi.gov.au/settle/data - data extracted August, 2007

Settlement across an increasing number of local government areas in metropolitan Melbourne is due to a combination of factors including: the emerging trend toward outer-suburban growth; reduced availability of public housing stock in the inner city; the relative affordability of housing in outer suburban areas; and the limited availability of housing in Melbourne's inner-city that can accommodate large families (DHS 2005). While most newly-arrived humanitarian entrants settle in metropolitan Melbourne, rural and regional settlement is increasing. With the support of the Australian and state governments, some rural councils in Victoria have been seeking to assist new arrivals to relocate to local communities (DHS 2005).

APPENDIX 3: LIST OF ADVISORY COMMITTEE MEMBERS

NAME	INSTITUTION/ORGANISATION
PROF. SANDRA GIFFORD	Director, Refugee Health Research Centre
DR CELIA MCMICHAEL	Refugee Health Research Centre
DR STEVE FRANCIS	Centre for Multicultural Youth
DR STEPHEN MCNALLY	Australian Research Centre in Sex, Health and Society
DR MEREDITH TEMPLE-SMITH	University Of Melbourne
ROCÍO AMÉZQUITA-CORTÉS	Footscray Youth Housing Group
FATEN MOHAMED	Centre for Multicultural Youth
BRONWYN KAADEN	Victorian Department of Human Services (BBV/STI Program)
ROWENA SOUTHGATE	Victorian Department of Human Services (BBV/STI Program)
KAREN O'NEILL	Victorian Department of Human Services (BBV/STI Program)
CLAIRE LYNCH	Noble Park Secondary College (School Nurse/Refugee Coordinator)
GILLIAN KERR	Foundation House
THON ADUT	Foundation House
JOYCE SADIA-PETERS	Foundation House
SARAH BERBERI	Foundation House
DAVID THANG	Foundation House
SAW REGINALD SHWE	Foundation House

APPENDIX 4: ADVISORY COMMITTEE TERMS OF REFERENCE

MEMBERSHIP

The Advisory Committee consists of no more than 15 members, and includes representation from the Victorian Department of Human Services, Refugee Health Research Centre (La Trobe University, Foundation House), the Centre for Multicultural Youth, Footscray Youth Housing Group, community workers, and young people with refugee backgrounds.

MEETINGS

The Advisory Committee will meet on three occasions over the duration of the project. If members are unable to attend they may invite an “alternative attendee”.

PURPOSE

The Advisory Committee’s functions are to:

- Provide expertise on relevant issues relating to sexual health among youth with refugee backgrounds
- Provide a platform where the research aims can be identified and discussed
- Provide advice on ethical and methodological issues relating to data collection protocols
- Ensure the ongoing quality and consistency of the research process
- Provide input into the development of appropriate strategies to promote sexual health and sexual health literacy among youth with refugee backgrounds in Victoria
- Review and provide feedback on written reports
- Provide advice on appropriate dissemination strategies for research findings

COMMUNICATION

The meeting agenda will be circulated no more than one week before a meeting. Requests to table topics for discussion should be sent to the chair/co-chair more than one week before the meeting.

APPENDIX 5: FOCUS GROUP DISCUSSION THEME/QUESTION GUIDE

1. ATTITUDES TO RELATIONSHIPS AND SEXUAL ACTIVITY

THEME	KEY DISCUSSION POINTS
Relationships	<p>Who would you define as a boyfriend/girlfriend (short-term, long-term etc.)?</p> <p>What do people want from a relationship (different expectations of males and females)?</p> <p>Activities within relationships (what do people do together?).</p> <p>Difficulties experienced.</p> <p>Views about young people in relationships (<i>community, parents, family, youth</i>)</p>
Attitudes to sexual activity	<p>Age that people start physical/sexual relationships</p> <p>Reasons for beginning (and not beginning) physical relationships</p> <p>Are there any cultural differences in the ways people with your background and “mainstream culture” approach sex and sexual activity?</p> <p>Views (<i>community parents, youth</i>) about sexual relationships amongst young people</p>

2. SEXUAL HEALTH KNOWLEDGE

Sexual Health Concerns	<p>Should sex only be part of a committed relationship?</p> <p>What problems can happen when someone starts having a sexual relationship? (<i>emotional impact, sexual health issues, pregnancy, community responses</i>)</p> <p>What health problems could someone get from having sexual relationships?</p> <p>How would somebody know if they had a sexual health problem?</p>
STIs	<p>What infections can you get from having sex? (<i>names of infections</i>)</p> <p>Are sexual health infections a concern for young people in your community? (<i>discuss symptoms, causes, responses, how common they are</i>)</p>
Pregnancy	<p>Is unplanned pregnancy an issue for young people in your community? (<i>discuss causes and responses, and how common it is</i>)</p> <p>Views (<i>community parents, youth</i>) about pregnancy amongst unmarried girls/women</p>
HIV/AIDS	<p>Is HIV/AIDS a concern for young people in your community? (<i>discuss symptoms, causes, responses, how common it is</i>)</p>

3. IMPLEMENTATION OF SEXUAL HEALTH KNOWLEDGE

Protective behaviours	How can young people avoid sexual health problems? What are the best ways to avoid getting pregnant? Who is responsible for protection/contraception? Who should be?
Risk taking	Why do you think boys/girls might get sexual health problems? Is there anything that makes it difficult for young people to avoid sexual health problems? Are any particular people more likely to have sexual health problems?

4. VIEWS AND USE OF SEXUAL HEALTH SERVICES

Use of services	What do people do if they think they have a sexual health problem? Where can people go for help if they think they have a sexual health problem? How do they find out about these services? What can happen if a person doesn't get help for a sexual health problem?
Enablers and barriers	Do young people from your communities use these services? What encourages people to use them? What discourages people from using them? What things would improve health services for young people in your communities? Who is the best person to provide these services? (male/female, ethno-specific?)

5. SOURCES OF INFORMATION

Sources of information	In your countries, how do people learn about sex and sexual health? Do young people in your community talk to each other about sex and relationships? Is there anyone that people don't like talking to? Where else can people find information about sexual health? (formal and informal sources) What are the best sources of information? Is there anything that makes it difficult for young people to get information?
Mode of information	How do you think young people would prefer to find out about sexual health? (i.e. written, verbal, internet, popular media) Are sexuality education classes in schools/health centre a good way to get information? How could they be improved?

6. RELATIVE IMPORTANCE OF HEALTH AND SEXUAL HEALTH

Perception: sexual health issue	What are the most important things in your lives right now? Is staying healthy important? Is sexual health an important issue for young people in your communities?
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7. OTHER SUGGESTIONS OR COMMENTS

- Does anyone have any other comments or suggestions about how young people learn about and use sexual health information and services?
 - Are there any other important issues relating to sexual health that we haven't talked about?
 - Are there any questions you would like to ask us?
-

Thanks for your time and for your contribution to the discussion.

APPENDIX 6: IN-DEPTH INTERVIEW QUESTION GUIDE

1. Background/Everyday life

Discuss: Move to Australia/Melbourne; School/education/study; Work; Family/relatives; Living arrangements/housing; Peer group/friends; Social support/connectedness; Financial situation

What are the most important things in life to you now?

2. Relationships/children

Discuss:

- current/past relationships: expectations, experiences, difficulties
- children: how many etc. / or plans to have children

When do you think it is appropriate for people to become involved physically?

- age; marital status; level of commitment

3. Knowledge of sexual health issues

What do you think are the main problems/concerns that can happen from having sex?
i.e. STIs, pregnancy, family conflicts, emotional responses . . .

Health problems associated with sexual relationships.

Explore knowledge of STIs: cause, symptoms, associated problems, treatment, how common

Discuss: Personal concerns/experience around STIs; community views of STIs; who is most likely to get an STI?

Is HIV a health issue that affects people in your community? Who is at risk?

How would people in your community respond if they thought someone had HIV?

Unplanned pregnancy: causes, how common it is, what people do, community views

4. Risk and protection

Knowledge/use of health protection behaviours/contraception:

- How to avoid sexual health problems; best methods; barriers to using contraception; who is responsible for ensuring use of contraception/protective behaviours?

Personal experiences of using contraception/protective behaviours:

- pressures to have/not have sex; thoughts/experiences on using contraception; social influences on sexual behaviour (friends, family, community);
- OR reasons for not becoming sexually active

5. Sources of information

How did you learn about sex?

What sources of information are available?

- *formal and informal sources; school-based sexuality education)*

What are the best/worse sources of information

- *accuracy, reliability, people that are good/bad to talk with*

What are the best/worse forms of information?

- *written, verbal, internet, popular media*

6. View of sexual health services/help-seeking

Use of health services for sexual health issues

- *how do people find out about services; where do people go*

What would you do if you thought you had an infection?

- *personal experiences of using services.*

What are the things that would put you off/encourage use of a service?

How can services and provision of information for people in your cultural group be improved?

APPENDIX 7: CASE WORKER/HEALTH PROFESSIONAL INTERVIEW GUIDE

Clients	What groups do you work with? <i>Ethnicity, age, housing situation</i>
Sexual Health Concerns	<p>What are the main concerns/difficulties of clients? <i>Social isolation, language, housing, family . . .</i></p> <p>In what areas of their lives do you think they are doing well?</p> <p>What are the main health concerns of clients?</p> <p>Is sexual health a concern for the young people you work with? <i>Different similar issues for males and females?</i></p> <p>What sexual health issues do they experience? <i>STIs, unplanned pregnancy</i></p> <p>How do sexual and reproductive health issues impact on their lives? <i>Family, relationships, community</i></p> <p>How do you raise/deal with sexual health issues?</p> <p>Is sexual health viewed as important by youth with refugee backgrounds?</p>
Understanding	How good is their level of understanding of sexual health issues? <i>Cause, symptoms, prevention, treatment</i>
Risk and protection	<p>Do young people take many risks associated with sexual behaviour? What? Why?</p> <p>Do they know and understand about protective behaviours i.e. contraception? Do they use protective behaviours?</p>
Relationships; Attitudes to sex and sexuality	<p>Relationships: when do youth with refugee backgrounds start relationships?</p> <p>Why do people initiate or defer sexual relationships?</p> <p>How do community/family view sexual relationships? (particularly amongst unmarried people)</p>
Issues associated with homelessness	<p>Are any of the youth with refugee backgrounds you work with homeless or at risk of homelessness? Why?</p> <p>What is the impact of homelessness on clients?</p> <p>Are there particular sexual health risks associated with being homeless?</p> <p>Do you know of any cases where homelessness/threat of homelessness is related to pregnancy/relationship issues?</p>

Sources of information	Where do young people with refugee backgrounds find out about sex? Who do they talk with? Do they talk with you? School-based sex education: Have young people you work with participated in it? What are their responses? Can you suggest any ways to provide better information to youth with refugee backgrounds? What strategies/mediums?
Awareness/ Use of Services	Are sexual health services (or other health services) accessible? Why/why not? Level of awareness amongst youth? Enablers/barriers to using services? Recommendations for improving sexual/reproductive health services for youth with refugee backgrounds?

APPENDIX 8: INFORMATION AND CONSENT SHEET FOR YOUTH PARTICIPANTS

Project information

We are carrying out a project that focuses on how young people with refugee backgrounds find out about, understand and use health information about relationships and physical illness and well-being.

We will be inviting about 140 young people with refugee backgrounds (from Iraq, Afghanistan, Horn of Africa, West Africa and Burma) to participate in group discussions and interviews.

How you can participate

We would like to talk with you about how young people find out about, make sense of, and use information about relationships and physical health. We would also like your opinions on how to improve health services and information for young people with refugee backgrounds. The findings will be used to develop good strategies to promote health amongst refugee youth in Victoria.

We would like to invite you to be part of a group discussion that will last from 1-2 hours. The group discussions will include other young people with refugee backgrounds and a researcher. You will not be asked or expected to discuss personal experiences in group discussions. Separate group discussions will be held for males and females. You can also participate in an individual interview where you will have the opportunity to discuss more personal experiences and issues.

- Participation in the study is entirely voluntary.
- Once you have read this information sheet (or discussed it with a worker or researcher), a researcher will ask you whether you have understood everything and can answer any questions. If you decide to take part in the study, a researcher will ask you to give your consent to participate.
- We will also ask for your consent to audio-tape the discussions. If you prefer, the researcher will take written notes about what is said.
- You can withdraw from the study at any time, up to 2 months after an interview.
- Your decision about whether or not to participate in the study will not affect your relationship with Foundation House, Footscray Youth Housing or CMYI in any way.
- If you feel any distress, the discussion or interview can be postponed or stopped at any time. Foundation House has trained counsellors available to assist if you need.
- What you tell us may be presented in reports, conferences or journal articles. However, you will not be named or identified. The findings will be used to improve policy and practice in education, health, settlement and support services.
- The information you provide will be stored in a locked cabinet at La Trobe University. Only members of the research team will have access to this information. The information will be kept for up to five years and then disposed of. Copies of the information you provide and a summary of the study results will be available.

Project team

The study is carried out by the Refugee Health Research Centre at La Trobe University /Foundation House, the Centre for Multicultural Youth (CMY), Footscray Youth Housing Group, and the Australian Research Centre in Sex Health and Society at La Trobe University. The project team includes the following people:

- Sandy Gifford, Refugee Health Research Centre, La Trobe University and Foundation House
- Celia McMichael, Refugee Health Research Centre, La Trobe University
- Steve Francis, Centre for Multicultural Youth
- Rocío Amézquita-Cortés, Footscray Youth Housing Group
- Meredith Temple-Smith, Department of General Practice, The University of Melbourne
- Stephen McNally, Australian Research Centre in Sex, Health and Society, La Trobe University

The study has been approved by the Human Ethics Committee at La Trobe University.

It is funded by the Victorian Department of Human Services.

Questions?

If you have any questions about the project at any stage, please contact:
Celia McMichael, Refugee Health Research Centre, La Trobe University
Tel: 9479 5861 Email: c.mcmichael@latrobe.edu.au

If you have any complaints or queries that the investigators have not been able to answer to your satisfaction, you may contact the Secretary, La Trobe University Human Ethics Committee, La Trobe University, Victoria 3086
(Ph: 9479 1443; e-mail: humanethics@latrobe.edu.au)

We hope that you find participating in this project interesting and enjoyable, and that you can help us understand and develop ways to better promote health and improve settlement outcomes among young refugees.

APPENDIX 9: INFORMATION SHEET FOR CASE WORKERS AND HEALTH PROFESSIONALS

Description of the project

The study focuses on how young people with refugee backgrounds access, understand and use sexual health information. The study is concerned with understanding and learning about the experiences of Iraqi, Afghani, African (Horn of Africa and West Africa) and Burmese youth. The study aims to:

1. Identify how refugee youth find out about sexual health and illness.
2. Identify how refugee youth understand and interpret the information they receive around sexual health risk and protection.
3. Describe how refugee youth use sexual health information.
4. Examine the enablers and barriers to the use of sexual health information.
5. Develop recommendations for strategies to promote sexual health literacy and sexual health among young people with refugee backgrounds.

The study is carried out by the Refugee Health Research Centre at La Trobe University/Foundation House, the Centre for Multicultural Youth Issues (CMYI), Footscray Youth Housing Group, and the Australian Research Centre in Sex Health and Society at La Trobe University.

The study has been approved by the Human Ethics Committee at La Trobe University. It is funded by the Victorian Department of Human Services. The findings will be used to develop good strategies to promote sexual health among young people with refugee backgrounds in Victoria.

Study design

The study uses qualitative methods – focus groups and case studies – to collect information around sexual health literacy and practice. Approximately 140 people with refugee backgrounds are invited to participate in the study. Interviews will also be held with people who have experience working in a professional capacity with youth with refugee backgrounds.

How you can participate

As someone who works with refugee youth, we would like to invite you to participate in an interview.

The aim of the interview is:

- to identify the sexual health concerns of refugee youth;
- to discuss your experiences of working with refugee youth who may have sexual health issues or concerns;
- and to discuss possible strategies to improving policy and practice in relation to sexual health and sexual health literacy amongst refugee youth.

The interviews will not seek to discuss the sexual health issues or concerns of individual clients.

We estimate the interview will take from 1-2 hours. With your permission, we will record the interview and transcribe sections as necessary. However, if you prefer we can also record the interviews using written notes.

Protecting the wellbeing of participants during the research

It is important that you are aware of the following:

- Participation in the study is entirely voluntary.
- Individuals can withdraw from the study at any time, up to two months after the interview has taken place.
- If the interviews cause you any distress, the discussion or interview can be stopped at any time and deferred if you wish.
- The information provided by participants will be stored in a locked cabinet at La Trobe University. The data obtained from the study may be used for reporting and publications, but names and personal details will not appear in any document. Copies of the information that participants provide during the study and a summary of the study results will be available on request. Only members of the research team will have access to the information provided by the participants. The data will be kept for up to five years and then disposed of adequately.

Project team

The project team includes the following people:

- Sandy Gifford, Refugee Health Research Centre, La Trobe University and Foundation House
- Celia McMichael, Refugee Health Research Centre, La Trobe University
- Meredith Temple-Smith, Department of General Practice, The University of Melbourne
- Stephen McNally, Australian Research Centre in Sex, Health and Society, La Trobe University
- Steve Francis, Centre for Multicultural Youth Issues
- Rocío Amézquita-Cortés, Footscray Youth Housing Group

Questions?

Any questions regarding this project may be directed to:

Celia McMichael, Refugee Health Research Centre, La Trobe University
Tel: 9479 5861 Email: c.mcmichael@latrobe.edu.au

If you have any complaints or queries that the investigators have not been able to answer to your satisfaction, you may contact the Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Victoria 3086

(Ph: 9479 1443; e-mail: humanethics@latrobe.edu.au)

APPENDIX 10: CONSENT FORM FOR CASE WORKERS AND HEALTH PROFESSIONALS

Name of Participant: _____

Project title: **Promoting Sexual Health and Sexual Health Literacy among Refugee Youth**

1. I have read the attached information sheet. I consent to participate in the project, the particulars and purposes of which have been explained to my satisfaction.
2. I acknowledge that:
 - a. The possible consequences of the research have been explained to me to my satisfaction
I have been informed that I am free to withdraw from the project at any time
I have been informed that the confidentiality of the information I provide will be safeguarded subject to the legal requirements which have been explained to me.

Signature: _____ Date: _____
(Participant)

Signature: _____ Date: _____
(Investigator)

Name of Investigator: _____
(Block Letters)

