Migrant and refugee youth's sexual and reproductive health and rights: decision-making and agency

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Authorship attribution statement

This is to certify that, to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

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Signature:

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If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together.

– Lilla Watson

For Patti and Tata. You have all my love.

Abstract

Sexual and reproductive health (SRH) is a human right and crucial to social wellbeing. Yet rights to SRH are unevenly attained, with young people from migrant and refugee backgrounds facing barriers to fully actualising their rights. In Australia, migrant and refugee youth (MRY) have low SRH service use, limited SRH knowledge and education, and contend with stigma in their families and communities. While there is nascent scholarship on the sexual and reproductive health of migrant and refugee youth, there is limited rights-based research. Existing scholarship around migrant and refugee sexual and reproductive health has largely reported on vulnerabilities and deficits, articulating oppressions and structural barriers hindering health. There is, however, a need to further examine the strengths and capacity of migrant and refugee youth in this context. This research addresses this need, examining the sexual and reproductive health and rights (SRHR) decision-making and agency of migrant and refugee youth.

This research used mixed methods to examine the SRHR decision-making of MRY, aged 16-26 years, in Sydney, Australia. Two systematic reviews and three primary studies comprise main findings. A mixed methods group concept mapping study examined socioecological factors informing MRY's decision-making. SRH knowledge, attitudes, behaviours, and service use were explored using quantitative survey methods, with analysis focusing on gender as a determinant of rights. Qualitative interviews examined rights attainment in action through the decision-making and experiences of abortion among young migrants.

The group concept mapping findings revealed that emotional and relational factors were equally important as physiological and biomedical factors in MRY decision-making. Despite having overall negative impact on decision-making, family and culture were not as important as other factors. Survey findings indicated female MRY are significantly more likely to be pressured into sex while male MRY have significantly lower contraceptive knowledge, lower STI knowledge, lower service use and vaccination. Overall, female and male MRY had concerningly low service knowledge and use. Qualitative interviews showed myriad factors informed abortion decisions, but that young migrant abortion-seekers felt certain and autonomous in their choice. Participants had generally positive care experiences, were grateful for their care and did not regret their decision – yet many went through their abortions with inadequate, or non-existent, social and emotional support. In all studies, MRY reported limitations in their SRH knowledge, inadequacies in education, and encountered stigma and silence around SRH in their social environments. Yet, consistently, these youth found ways to navigate around SRH restrictions. While much existing scholarship has highlighted culture, family and community as imposing repression and censure on MRY, young people in this research did not consider culture and family as definitive of their decisions or experiences.

MRY encounter myriad infringements on their rights to sexual and reproductive health. Nevertheless, MRY continue to engage with SRH and make their own decisions. Findings indicate that we must shift away from simplistic explanations of culture and family as repressing SRHR. To better support migrant and refugee youth to actualise their rights, policy and practice must go beyond biomedical models of SRHR, recognising multiple factors informing decision-making.

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This thesis was written on Gadigal land. I have had the privilege of living my life on this land, being nurtured by this land. I acknowledge that sovereignty was never ceded: this always was, and always will be Aboriginal land.

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Publications and presentations

Publications

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Napier-Raman, S., Hossain, S. Z., Lee, M.-J., Mpofu, E., Liamputtong, P., & Dune, T. (2023). Migrant and Refugee Youth Perspectives On Sexual and Reproductive Health and Rights in Australia: A Systematic Review. *Sexual Health*, *20*(1), 35-48. https://doi.org/10.1071/sh22081 **[Chapter 2]**

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Napier-Raman, S., Rosas, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., Dune, T., & Mapedzahama, V. (2023). Concept Mapping Method. In P. Liamputtong (Ed.), *Handbook of social sciences and global public health* (pp. 899-923). Springer, Cham. https://doi.org/10.1007/978-3-030-96778-9_63-1 **[Chapter 4** (Book chapter)**]**

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Napier-Raman, S., Bidewell, J., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2024). Migrant and Refugee Youth's Sexual and Reproductive Health and Rights: A Gender Comparison of Knowledge, Behaviour, and Experiences. *Sexuality & Culture*. https://doi.org/10.1007/s12119-024-10295-z **[Chapter 6]**

Publications under review

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List of abbreviations and acronyms

ARC	Australian Research Council
CALD	Culturally and linguistically diverse
COCP	Combined oral contraceptive pill
ECP	Emergency contraceptive pill
FPNSW	Family Planning New South Wales
GCM	Group concept mapping
GP	General practitioner
HCW	Healthcare worker
HIC	High income country
ICPD	International Conference on Population Development
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
LMIC	Low-middle income country
MRY	Migrant and refugee youth
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
PAR	Participatory action research
PRISMA	Preferred reporting items for systematic reviews and meta-analyses
SPSS	Statistical Package for Social Sciences
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights

STI	Sexually transmitted infection
TAFE	Technical and Further Education
UN	United Nations
WHO	World Health Organisation
YPL	Youth project liaison

Chapter 1. Introduction

"But "rights" are always historically and culturally located." (Ginsburg & Rapp, 1995, p. 9)
I begin this thesis with a reminder that rights cannot be divorced from context. Through this research, I strive to illuminate the ways in which migrant and refugee youth experience, understand and articulate rights in relation to sexual and reproductive health. I do so with the awareness that the realisation, and the very construction, of rights is mediated by context.

Sexual and reproductive health (SRH) is a human right. That is, all people are entitled to sexual and reproductive health, wellbeing, safety, and functioning, as well as the necessary services, care, information, and provisions to attain this. Rights to SRH are, however, not evenly distributed and actualised. Nor are SRH rights comprehensively and uniformly enshrined in any international legal framework. This thesis examines the sexual and reproductive health and rights (SRHR) of migrant and refugee youth (MRY) living in Sydney, Australia. Focusing on decision-making and agency, this research explores how these young people engage with SRHR and the socioecological factors that inform their experiences.

This introductory chapter provides the background, rationale, aims, research questions, key definitions and structure of this thesis. The opening section includes an overview of SRHR and the context of SRHR decision-making and agency for Australian MRY. This is followed by an explication of the research gaps addressed by this thesis, and a statement of the aims and research questions. The key terms used in this thesis – 'migrant', 'refugee', 'youth' and SRHR – are then defined in relation to the present research. This chapter concludes with an outline of the presented research and thesis structure.

Background

Young people's SRH experiences can have significant, lasting impacts on their lives, as well as broader social impacts (Napier-Raman, Hossain, Lee, et al., 2023; Starrs et al., 2018). Youth face particular barriers to realising SRHR – the transition to adulthood involving a range of social, emotional, and physiological changes that shape rights attainment. For migrant and refugee young people, the intersections of age and migrant or refugee identity can exacerbate vulnerabilities to sexual and reproductive ill-health and manifest in specific experiences, perspectives and engagement with SRHR. Decision-making and agency regarding SRHR are informed by myriad intersecting factors across socioecological levels, including individual aspects of age, gender, migration or refugee status, interpersonal interactions and relationships, structural aspects such as healthcare access and services, and macro-level cultural and social influences (Bronfenbrenner, 1994; McLeroy et al., 1988; Napier-Raman, Hossain, Lee, et al., 2023).

Sexual and reproductive health and rights (SRHR)

In many ways SRHR is still an incipient concept, garnering international focus over the past three decades (Cottingham et al., 2010; Starrs et al., 2018). This research thus contributes to an emerging body of scholarship centring rights in discussions of SRH. The attainment of SRH can only be achieved through realisation of SRH rights (Starrs et al., 2018). These include rights to make informed decisions regarding what happens, and when, to one's body; rights to access SRH care, services, and supplies; and rights to information and education (Napier-Raman, Hossain, Lee, et al., 2023; Starrs et al., 2018). SRHR include interconnected aspects of reproduction, fertility, contraception, pregnancy, sexual dysfunction and sexually transmitted infections (STIs), as well as intimacy, relationships, sexuality and gender (Napier-Raman, Hossain, Lee, et al., 2023; Starrs et al., 2018; World Health Organization, 2023).[1]

Investing in SRHR: controversies and consequences

SRHR are crucial to individual and social wellbeing and investing in SRH offers considerable benefits (Family Planning NSW, 2018; Fathalla et al., 2006; Starrs et al., 2018; World Health Organization, 2023). Yet, historically, SRHR "have been treated as a narrow set of siloed health issues, with little recognition of their centrality to people's overall health and wellbeing" (Starrs et al., 2018, p. 2643). SRHR are unevenly distributed and unequally realised and continue to be troubled and stunted in their full actualisation and integration into national and international policy and practice (Starrs et al., 2018). Furthermore, SRHR are controversial. SRH occupies the contradictory position of being at once something considered deeply personal and private, while simultaneously being socially and politically contested in the public arena (Mane & Aggleton, 2019). As such, any discussions of SRH are complex, often fraught and contentious.

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[1] For a full definition of sexual and reproductive health and rights, as used in this research, see *Definitions* section below.

SRHR have far-reaching effects beyond individual wellbeing, positively impacting population health, economic growth, social prosperity and sustainable development (Sully et al., 2020). For example, investment in contraceptive access and education can drastically reduce rates of unintended pregnancies, births and abortions – including unsafe abortions (Starrs et al., 2018). This can have corollary impacts of better chance of infant survival due to birth-spacing, improved childhood health and educational outcomes, greater productivity of parents and higher household income (Starrs et al., 2018). SRHR are central in advancing gender equality: allowing people to make free, informed choices about sex and reproduction, have access to contraceptives, pregnancy care, and safe abortion are crucial for women's health outcomes and agency (Fathalla et al., 2006). Poor SRH and rights violations can, conversely, have severe negative consequences on individual and population wellbeing (Starrs et al., 2018).

Despite the clear evidence on the importance of SRHR for individual, community and social wellbeing, Australia lacks a national SRH strategy (Matich et al., 2015). National programming tends to focus on sexually transmitted infections (STIs), for which there *is* a national strategy (Department of Health, 2018). The lack of a comprehensive national strategy, or recognition of the links between SRH and other health outcomes, reveals a fractious policy landscape and "fragmented approach" to SRH in Australia (Family Planning NSW, 2018, p. 6). While Australia has made significant advances in SRHR outcomes over recent decades, there are still areas of concern (Bateson et al., 2019). Abortion, for example, was not decriminalised in all Australian states and territories until 2024 (SBS News, 2024), and there continues to be no national routinely collected data on abortion rates or standardised national policy (Family Planning NSW, 2018). There remains a 10% unmet need for family planning in Australia (Family Planning NSW, 2018). The attainment of SRHR is uneven across communities and populations in Australia, with indigenous Australians, youth, immigrants and refugees being particularly underserved (Bateson et al., 2019). As such, the state of SRHR in Australia is defined by "gaps that affect our most vulnerable populations" (Bateson et al., 2019, p. 252). MRY are one such "vulnerable" population.

Migrant and refugee youth sexual and reproductive health and rights

The 21st Century has seen a significant increase in the numbers of migrants, refugees and internally displaced peoples (McAuliffe & Oucho, 2024). Internationally, since the beginning of this century, numbers of migrants have risen from an estimated 150 million in 2000 to 281 million in 2024, and refugees have more than doubled from approximately 14 million to 35.4 million (McAuliffe & Oucho, 2024). Rates of forcibly displaced people are at record highs and are increasing annually (United Nations High Commissioner for Refugees, 2024). International conflict and ongoing climate crises threatening access to resources and inhabitable land will see migration and displacement continue to escalate in the coming years (Parkinson et al., 2023; United Nations High Commissioner for Refugees, 2024). Meeting – and understanding – the needs of migrant and refugee populations is thus vital.

Migrants and refugees experience significant health inequalities and barriers to fully actualising rights. Histories of displacement and migration – including experiences in refugee camps and the potentially life-threatening journeys from home countries – can drastically shape health outcomes, and care access is curtailed during migration (Iqbal et al., 2022; McMichael & Gifford, 2009, 2010; World Health Organization, 2017). Crucial education is often disrupted for youth who leave their homes, including SRH education (McMichael & Gifford, 2009). Navigating unfamiliar health, legal and governmental systems of new host countries can be challenging and is often exacerbated by language barriers and cultural clashes (Au et al., 2019; Brandenberger et al., 2019). In their new homes, migrants' access to necessary care may be further hindered by limited financial resources, transport barriers, and uncertainty around entitlements to care (Rogers et al., 2020). Additionally, migration can fracture crucial social networks and support systems.

Health disparities and disadvantages facing migrants and refugees may be particularly stark in SRH, which is an often overlooked and socially contentious area of health (Starrs et al., 2018). In high income countries like Australia, migrants have higher HIV rates, pregnancy-related risks, and sexual violence risks than non-migrant populations (Baroudi et al., 2022). Stigma and taboo around SRH are particularly prevalent in migrant and refugee communities – and may be exacerbated in the face of culturally incongruous sexual norms in host-countries (Dean et al., 2017a; Metusela et al., 2017; Mulholland et al., 2021; Ussher et al., 2017). The difficulty of balancing cultural influences from home and host countries can lead to delayed help-seeking, which may increase risks of STIs remaining untreated and other SRH concerns being left unaddressed (Dune et al., 2017). Stigma similarly has implications on SRH knowledge acquisition and agency. Culture is, therefore, an important determinant of health: "SRH is socially constructed and ideas and values around it are very much informed by the culture and society to which one belongs or identifies with" (Hach, 2012, p. 8). MRY, however, grapple not only with lived experiences regarding their migrant and refugee identity, but also challenges and specific needs related to their age and life stage.

Youth sexual and reproductive health and rights

Just as SRHR have received burgeoning global attention in recent decades, so too have adolescence and young adulthood. Indeed, *youth* is a "relatively new" concept (Villa-Torres & Svanemyr, 2015, p. S52), and the realm of youth health and rights is still nascent. Until recently, due to the low burden of mortality and relatively good health among this age group, youth have "been overlooked in global health and social policy" (Patton et al., 2016, p. 2423). Yet ensuring the wellbeing of adolescents and young adults is crucial, not simply for individual health across the life-course, but for social functioning, and the future of subsequent generations (Patton et al., 2016). Poor SRH and adverse outcomes in adolescence and young adulthood can drastically inform the trajectory of individual's lives and future wellbeing (Patton et al., 2016; World Health Organization, 2001).

Youth face distinct obstacles to SRHR attainment and actualisation. The transition from childhood to adulthood involves, among other changes, key sexual and reproductive developments. These involve physiological development related to the onset of puberty and menarche, and an array of social, emotional, cognitive and cultural changes (Patton et al., 2016; The Royal Australasian College of Physicians, 2015). Due to their age, youth may have lower SRH knowledge, independence, confidence, and limited experience with intimacy and support-seeking; "lack of information and access to relevant services" render youth especially vulnerable (United Nations Population Fund, 2004, p. 46 [7.3]). This life-stage involves increased desire to engage in exciting, potentially risky behaviours at a time when cognitive skills and judgement capacities are developing, leading to increased sexual risk-taking (Patton et al., 2016). Risk-taking behaviours can also be inadvertent, due to limited knowledge, resources and services necessary to make informed, safe, positive decisions.

In terms of SRH outcomes, young people have greater contraceptive failure rates than older adults (Patton et al., 2016), often due to inadequate understanding of SRH and risks, misconceptions about contraceptives, coercion from partners, and limited access. This places youth at risk of early unplanned pregnancy – for which young people have greater risk of complications, and which can have long-term negative impacts on educational, employment and financial outcomes (Morris & Rushwan, 2015). Young Australians are disproportionately represented in national STI rates, with people under 30 consistently holding the highest rates (King et al., 2023). Moreover, Australian youth face barriers to SRH information, report inadequacies in their SRH education (Power et al., 2022), have limited STI testing, and low SRH help-seeking (Fisher et al., 2019; Power et al., 2022). At the societal (macro) level, stigma around youth sexual behaviour may further impede care, positive SRH experiences and information-seeking. The fallacy that sexuality education encourages promiscuity and unsafe sexual behaviour among young people has variably led to restrictions on youth education and SRH information, despite widespread consensus that education does not have such consequences (Chandra-Mouli et al., 2015). Thus, in conjunction with potential limited knowledge due to age and lack of experience, young people in certain communities and contexts are actively barred from furthering SRH knowledge. This is particularly so for MRY.

Australian MRY

Australia is a highly multicultural nation. Over 50% of Australians are considered first- or second-generation migrants or refugees, being born overseas or having one or both parents born overseas (Australian Bureau of Statistics, 2021b). Migrants and refugees thus make up a substantial proportion of Australia's citizenry, of which youth are a significant part. Young people aged 15-24 make up 13% of Australia's overall population (Australian Institute of Health and Welfare, 2024) and in the 2021-2022 financial year, youth aged 12-24 comprised one fifth of total permanent arrivals to Australia (Multicultural Youth Advocacy Network (MYAN), 2023).[2]

Intersecting oppressions and barriers related to migrant/ refugee status, ethnicity and age inform MRY's attainment of SRHR. Australian MRY have significant SRH knowledge

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[2] Youth permanent arrivals comprise entrants under humanitarian (36%), family (43%) and skilled (21%) streams. There has been substantial decline in migration rates over the past few years, due to the COVID-19 pandemic.

deficits, resulting from factors including disrupted education, inadequate SRH education in home and host countries, taboos around SRH in family and community settings, internalised stigma, and lack of trusted, accurate, accessible information sources (Botfield, Zwi, et al., 2018; McMichael & Gifford, 2009; Ngum Chi Watts, McMichael, et al., 2015; Rawson & Liamputtong, 2010; Wray et al., 2014). Low SRH service use and awareness is common in this population (Botfield et al., 2017; Botfield, Newman, & Zwi, 2018; Rawson & Liamputtong, 2009).

Research examining MRY SRH has noted issues of unintended pregnancy (Manderson et al., 2002; Ngum Chi Watts et al., 2014; Ngum Chi Watts, Liamputtong, et al., 2015), contraceptive myths, misuse and under-use (Manderson et al., 2002; Ngum Chi Watts et al., 2014), high STI rates (Dean et al., 2017b) and difficulties navigating safe, consensual relationships (Botfield, Newman, Kang, et al., 2018; Botfield, Zwi, et al., 2018; Chung et al., 2018). Stigma and taboo – both internalised, and externally experienced – are common in MRY descriptions of SRH. There is also evidence that MRY have particular constructions of SRH, often prioritising social and relational safety in their approach to sexual 'risk' (McMichael & Gifford, 2010). This indicates specific needs and decision-making processes of MRY, which must be addressed.

Sexual and reproductive health and rights decision-making and agency

Agency and decision-making regarding SRHR are informed by myriad intersecting factors. Throughout this thesis, agency is conceptualised in a way that acknowledges context and structure, being "a capacity for action that specific relations of subordination create and enable" (Mahmood, 2016, p. 216). Thus, MRY agency is potentially limited or 'thinned' by various socioecological factors, yet never entirely eroded (Klocker, 2007).[3] Research explicitly examining MRY decision-making and agency regarding SRHR is scarce, with existing scholarship highlights various barriers and vulnerabilities that suggest a 'lack' of agency and imply difficulties in making agentic decisions. For MRY, agency and the ability to make informed decisions may be significantly curtailed or 'thinned' by limited SRH knowledge and education – inadequacies in education being reported in research with MRY *and* the broader Australian youth population (Botfield, Zwi, et al., 2018; Ezer et al., 2019; Meldrum et al., 2015; Napier-Raman, Hossain, Lee, et al., 2023; Power et al., 2022).

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[3] For a full discussion of agency as applied in this research, see Chapter 3, *Theoretical Frameworks.*

Moreover, much literature has highlighted the influence of culture, family and community on MRY agency regarding SRH, emphasising repression, stigma and taboo (Agbemenu, Hannan, et al., 2018; Dune et al., 2017; Metusela et al., 2017; Mulholland et al., 2021; Renzaho et al., 2017; Wray et al., 2014; Ussher et al., 2012). There is thus a substantial body of work emphasising deficits and implying compromised sexual and reproductive agency among MRY. This thesis, however, seeks to articulate MRY agency within contexts of repression, examining the myriad ways MRY actively make decisions around SRHR.

Research gap and significance of the study

The background above illuminates the importance of SRHR and the exigency of supporting MRY in attaining these rights, while revealing the lack of strengths-based research in this area. According to the Australian Institute of Health and Welfare, there remains a “critical data gap” regarding the wellbeing of culturally and linguistically diverse young people (2021). None of the existing research on MRY SRH has taken an explicitly rights-based approach (Napier-Raman, Hossain, Lee, et al., 2023). Moreover – as indicated above –, in the realm of SRH, much research on MRY – both internationally and within Australia – has focused on deficits. Given the specific vulnerabilities of MRY, scholarship has – not unreasonably – focused on culture clash and acculturation (Dune et al., 2017; Tsai et al., 2016), intergenerational tensions (Dean et al., 2017a; Mulholland et al., 2021; Renzaho et al., 2017), sexual risks and unplanned pregnancy (McMichael, 2013; McMichael & Gifford, 2010), knowledge deficits (McMichael & Gifford, 2009), and cultural repression, stigma and taboo (Wray et al., 2014). However, such research can reinforce narrow, biomedical conceptions of SRH, which focus on risk as evinced in STI rates, unplanned pregnancies, low contraceptive use and low SRH literacy. This attitude is mirrored in Australia’s public policy – the existence of a national STI strategy, but no broader SRH strategy.

While research highlighting vulnerabilities and structural health inequity is indubitably important, a focus on biomedical risk can obscure autonomy and agency. This promotes a paternalistic portrayal of MRY as an ‘at-risk’ population in need of intervention, rather than active health decision-makers. Biomedical understandings of SRH elide social, emotional and relational aspects of health and wellbeing, thus precluding a holistic presentation of MRY health, needs and decision-making.

Finally, deficit research on MRY SRH emphasises family and cultural repression, stigma and taboo, which (often inadvertently) fuels dominant stereotypes that migrant communities are more “conservative” and traditionalist (Dune et al., 2017, p. 60). However, more recent research examining MRY suggests that culture and family do not prevent MRY from making SRH decisions for themselves, and perhaps have less influence on SRH attitudes than previously assumed (Botfield, Newman, & Zwi, 2018; Rawson & Liamputtong, 2009). How MRY navigate and negotiate cultural expectations – of home and host country –, beliefs and desires requires further examination. There is thus a need for strength-based, rights-based research that takes a nuanced approach to MRY SRHR.

A rights-based, strengths-based approach

This research assumes the fundamental, inalienable human right to SRH. A rights-based approach offers the means to redress inherent health inequities that arise from social determinants (Hach, 2012), empowering MRY as rights-holders. A rights-based approach is particularly important for populations that are typically denied autonomy, positioned as lacking agency, or constructed as ‘vulnerable’. This research endeavours to highlight and acknowledge power imbalances and structural vulnerabilities without denying the agency and autonomy of those subject to said vulnerabilities.

This research adopts a strength-based approach by framing MRY as rights-holders (Australian Human Rights Commission, 2019; Smith, 2018), filling a lacuna in existing scholarship. This research seeks to uncover the ways MRY navigate barriers, what strengths they hold, and how these strengths may be employed and emboldened to address health risks and challenges. Examining decision-making and agency affirms MRY’s rights to participate in their own health. Taking participation as a human right (Villa-Torres & Svanemyr, 2015), this research aims to provide insight into decision-making around SRH, and, in doing so, guide future policy, practice and research to better support MRY in making decisions that are positive, safe, healthy and affirming.

Significance of study

This research offers a novel contribution to the scholarship on sexual and reproductive health and rights, examining MRY decision-making and agency through a strengths and rights-based lens. The use of a mixed methodology – combining quantitative, qualitative and mixed methods studies – allows for multiple perspectives to be represented and provides rich, complex data. Further, this research incorporates a range of theories – socioecology, intersectionality, reproductive justice, and agency – to thoroughly explore the SRHR experiences of MRY. These theories are crucial in moving beyond a deficit approach to MRY SRH and elucidating agency, autonomy and capacity.

Aims and research questions

This thesis examines understandings and experiences of sexual and reproductive health and rights among migrant and refugee youth living in Sydney, Australia. Specifically, this was achieved through the following aims:

a) to identify key factors migrant and refugee youth perceive as informing their sexual and reproductive health and rights wellbeing, decision-making and agency
b) to examine migrant and refugee youth's sexual and reproductive health knowledge and literacy
c) to identify key socioecological factors characterising migrant and refugee youth's sexual and reproductive health needs, service use and access
d) to provide in-depth explication of youth SRHR decision-making and agency in action

Given the above aims, this thesis explores the following research questions. These questions are addressed throughout the two literature reviews and three studies presented in this thesis.

i. How do migrant and refugee youth understand and perceive sexual and reproductive health and rights?
ii. What socioecological factors inform migrant and refugee youth's decision-making regarding SRHR? What factors do migrant and refugee youth perceive of as informing their SRHR wellbeing, decision-making and agency?
iii. What level of literacy and knowledge do migrant and refugee youth have around key sexual and reproductive health issues?
iv. What factors shape migrant and refugee youth's SRH service needs? What factors shape service use and access for migrant and refugee youth?
v. How do migrant and refugee youth make decisions and enact agency around sexual and reproductive health and rights? What are their experiences of rights-attainment?

Definitions

Migrants and refugees

This research focuses on *international* migration, including first and second-generation migrants and refugees. Participants had to either self-identify as a migrant or refugee or have one or both parents identifying as a migrant or refugee.

Migrants are those who have voluntarily left their home countries (Refugee Council of Australia, 2019; United Nations, 2024), though there is no formal international legal definition (United Nations, 2024). As such, this research included migrants who are permanent residents, and those on various temporary visas, such as international students and those on working visas. The decision to include a broad range of citizenship and visa statuses was due to shared experiences of migration, acculturation, cultural and linguistic barriers, challenges in accessing and navigating Australian health, legal and governmental structures.

Refugees flee their home countries, leaving not by choice, but due to conflict, persecution, violence or other threat. The legal definition of refugee is enshrined in the 1951 Convention Relating to the Status of Refugees (United Nations, 2024). The reality of forced displacement means that the refugee experience is distinct and, in many ways, involves greater challenges and barriers than the migrant experience. In their home countries, refugees often face various rights violations, which inform their physical and mental wellbeing. Moreover, trauma encountered in home countries – often compounded by traumatic journeys and experiences in refugee camps – is a significant factor shaping health outcomes and behaviours.

Research involving both migrant and refugee populations

The decision to include both migrant and refugee participants was intentional and comes with distinct advantages and disadvantages. In including migrants and refugees, this research does risk erasing the specific experiences of migrants and refugees. As noted, experiences of displacement, hazardous journeys, rights violations and trauma can lead to starkly different SRH outcomes among refugees compared to migrants. Including migrants alongside refugees can further lead to a homogenisation of these populations as 'other', overlooking diversity within and between these groups.

However, while migrants and refugees have differing reasons for leaving and disparate experiences, they also share commonalities. Both migrants and refugees contend with barriers to care, health risks, access challenges, cultural and linguistic incongruity with respect to their host countries. The experience of being part of a marginalised, non-dominant group is shared between migrant and refugee populations. Moreover, Australian government policy and programming typically groups migrants and refugees together, often using term 'culturally and linguistically diverse' (CALD) (Botfield et al., 2020; Metusela et al., 2017). Research examining SRH among migrant and refugee populations has also highlighted similar experiences of stigma, silence, and taboo (Botfield, Zwi, et al., 2018; McMichael & Gifford, 2009; Metusela et al., 2017; Napier-Raman, Hossain, Lee, et al., 2023; Ngum Chi Watts, McMichael, et al., 2015; Rawson & Liamputtong, 2010; Ussher et al., 2017; Wray et al., 2014).

Finally, the experiences of migrants and refugees are manifold, and boundaries between the two can be unclear. There may be migrants who do not fall under legal definitions of 'refugee' but have nevertheless experienced rights violations or have been forced from their homes. This research examines the shared attitudes and experiences of migrants and refugees regarding SRHR, while acknowledging the diversity within and between these groups.

Youth

In this research, we defined youth as those aged 16-26 years.[4] However, despite these age demarcations, the term 'youth' is understood as reflecting a range of *experiences*, being less an age group, but a life-stage. As such, the age range chosen for this study was intended to capture those transitioning to adulthood.

Even in formal institutions and governmental policies, 'youth' is variably defined. The United Nations definition includes those aged 15-24 years (n.d.); the Australian Institute of Health and Welfare defines "young people" as those aged 12-24 years (2021); the OECD defines young people as aged 15-29 years (Clarke, 2022). Moreover, there are cultural and social understandings of what childhood, adolescence, youth and adulthood entail (Patton et al., 2016).

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[4] While the age range was set as 16-26 years for this study, the quantitative survey included participants who were 15 years and 27 years of age. Rationale for this inclusion is provided in Chapter 4 and Chapter 6.

The age range chosen for this research reflects, at the lower end, the age of sexual consent in New South Wales: 16 years. A slightly higher cut-off of 26 years was chosen to reflect extended periods of young adulthood over the recent decades, later transitions to marriage and employment and delayed leaving home – particularly in high-income countries (Patton et al., 2016; Qu, 2019). While the age range in the literature review (Chapter 2) was 15-24 (Napier-Raman, Hossain, Lee, et al., 2023), many of the participants defined as "youth" in the included studies were older than 24 years. This encouraged an extension of the inclusion criteria to an age of up to 26 years for the three research studies. Furthermore, a decade range was considered useful to capture a comprehensive depiction of youth experiences.

Sexual and reproductive health and rights

Defining SRHR has often proved elusive. As noted above, SRHR has only more recently begun to gain significant attention. The 1994 Cairo Internation Conference on Population Development (ICPD) cemented the significance of SRH in global development agendas (Chandra-Mouli et al., 2015; Starrs et al., 2018; United Nations Population Fund, 2004, 2016). The Programme of Action from the ICPD defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters related to the reproductive system", and included the implication "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" (United Nations Population Fund, 2004, p.45 [7.2]). From this, reproductive rights were acknowledged as encompassing human rights already recognised in international human rights documents and laws. The ICPD defined reproductive rights as "rights to attain the highest standard of sexual and reproductive health", rights "to decide freely and responsibly the number, spacing and timing" of children, and "the information and means to do so" (United Nations Population Fund, 2004, p. 46 [7.3]). This included rights to make reproductive decisions "free of discrimination, coercion and violence" (United Nations Population Fund, 2004, p. 46 [7.3]).

However, the ICPD, while affirming the importance of reproductive *rights* and sexual *health*, did not provide an integrated, comprehensive definition or strategy for SRHR. Sexual rights were notably absent from the ICPD Programme of Action. Since then, SRHR have had inconsistent and inadequate integration into international policy, programming and development agendas – stymied by a lack of an official definition and by contradicting sociocultural norms and belief systems (Adewole & Gavira, 2018). For example, the original

Millennium Development Goals (2000) completely excluded SRH – though a reproductive health target (5b) was added following the 2005 progress evaluation – due to conservative backlash following the relatively progressive agenda set out by the ICPD (Adewole & Gavira, 2018; Yamin & Boulanger, 2013).

The approach used in the present research builds upon the 2018 Guttmacher-Lancet commission's integrated definition of sexual and reproductive health and rights:

> Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity…All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights… (Starrs et al., 2018, p. 2646)

This definition further assumes that a positive approach to sexuality must encompass the role of "pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing" (Starrs et al., 2018, p. 2646). The World Health Organisation (WHO) definition of sexual health affirms this, emphasising sexual rights and pleasure and acknowledging positive sexuality and experiences as crucial public health outcomes (Mitchell et al., 2021). The incorporation of pleasure and social and emotional wellbeing in SRHR is particularly important, given the continued narrow biomedical, risk-focused approaches to SRH in public health programming and policy (Mitchell et al., 2021).
While SRH rights are not uniformly enshrined in any international charter (Kismödi et al., 2017; Starrs et al., 2018), they encapsulate fundamental human rights to:

a) Privacy, bodily autonomy and integrity
b) Freely define one's own sexuality, including gender identity, expression and sexual orientation
c) To information, including education
d) Choose sexual partners
e) Choose whether, when, and in what contexts, to be sexually active
f) Safe, pleasurable sexual encounters
g) Choose whether, when, and whom to marry
h) Choose whether, when, and by what means to have children, and how many
i) The highest attainable standard of health

j) Have access, across one's life to the resources, information, services and support necessary to achieve all the above, free from violence, discrimination, exploitation and coercion [5]

Thesis outline

This thesis reports on mixed methodology research involving two systematic literature reviews and three research studies: 1) a mixed methods group concept mapping (GCM) study examining MRY SRH decision-making (Study 1); 2) a quantitative cross-sectional survey examining SRHR knowledge, attitudes, behaviours and service use (Study 2); 3) a qualitative study using in-depth interviews examining MRY abortion experiences and decision-making (Study 3). This thesis includes research undertaken as part of an Australian Research Council (ARC) Discovery Grant project (DP200103716) examining MRY's understanding of and experiences with SRHR (Dune et al., 2022), and additional research extending upon ARC project findings.

This thesis is divided into ten chapters (Figure 1.1). Chapter 1 is introductory. Chapter 2 presents a comprehensive review of the literature on Australian MRY SRH, as well as global research on migrant and refugee abortion decision-making, attitudes and experiences. This chapter consists of two published systematic reviews, synthesising existing data and identifying research gaps that this thesis seeks to fill. This is followed by an in-depth explication of the theoretical frameworks underpinning this research in Chapter 3: socioecological theory, intersectionality, agency, and reproductive justice. Chapter 4 details research methods. A summary of each study – mixed methods GCM, cross-sectional quantitative survey, and qualitative in-depth interviews – is provided. Chapter 4 includes a published book chapter detailing GCM methodology, which constitutes a complex, novel approach to conducting research.

Chapters 5, 6, and 7 form the results section of this thesis. Chapter 5 includes a published journal article while chapters 6 and 7 contain articles currently under review. Chapter 5 reports on Study 1, GCM, identifying main factors influencing MRY decision-making, and key barriers and facilitators to decision-making and agency. Chapter 6 is based on

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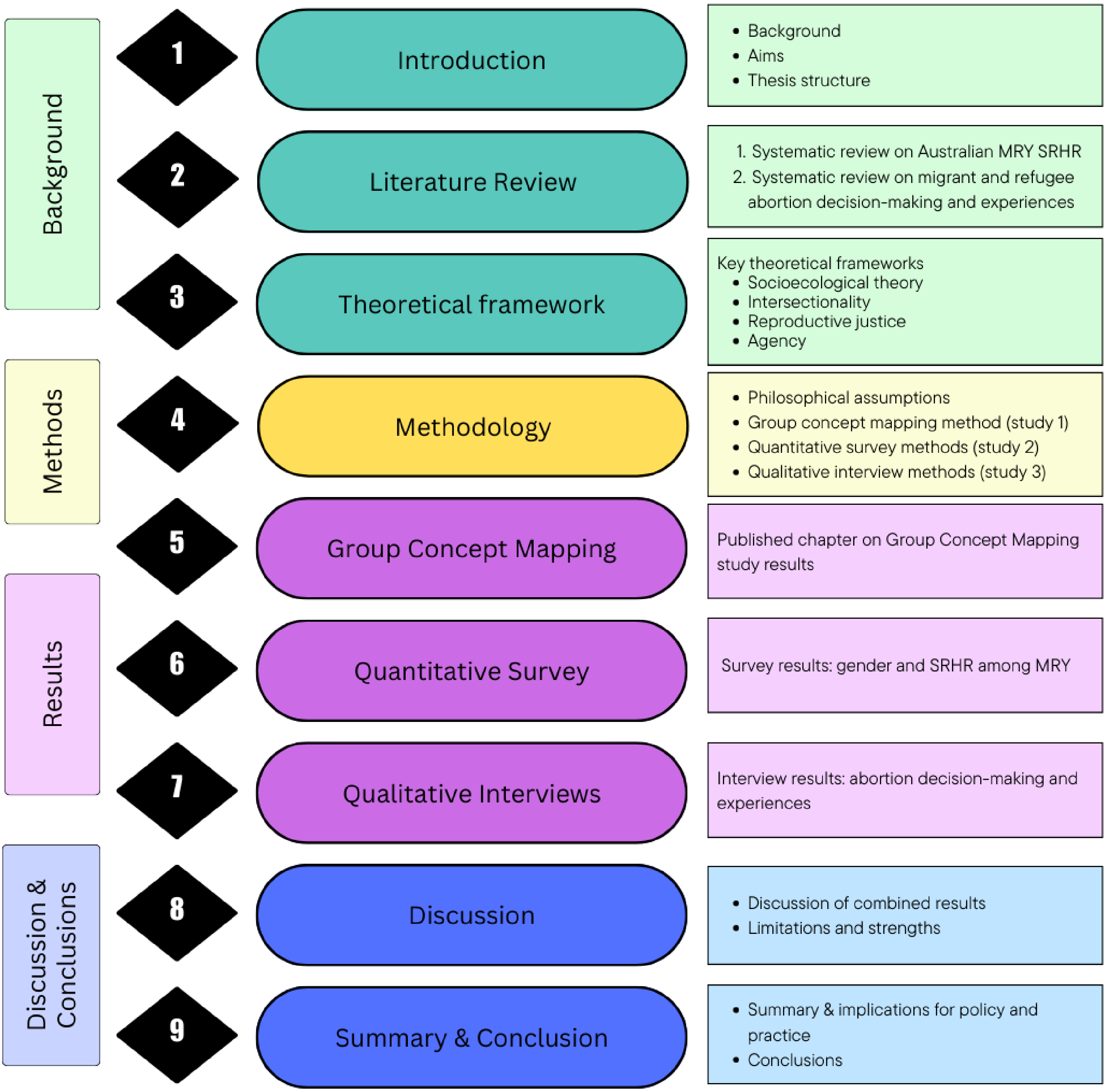
[5] These rights are adapted from the World Association for Sexual Health and the *Lancet* commission on sexual and reproductive health and rights (see: Kismodi et al. 2017; Stars et al. 2017). They are linked to universal human rights, such as rights to privacy, non-discrimination, and education.

quantitative data collected from the online survey (Study 2), and examines SRH decision-making, knowledge, behaviour, attitudes and service use among MRY, with a focus on gender. Chapter 7 presents SRHR decision-making and agency in action, using results from interviews with migrant abortion-seekers. The discussion chapter (Chapter 8) involves a synthesis of results, presenting overarching findings and cross-cutting themes. This chapter also outlines overall strengths and limitations. Chapter 9 provides a conclusion and summary, including research implications with suggestions for future policy and programming. Research materials, interview guides, questionnaires, recruitment flyers, and ethics approvals are provided in the Appendix (Chapter 10). A systematic review protocol published in *Pacific Health Dialog* which provides additional background information on the significance of the present research, gaps in the literature, and systematic review methods can be seen in Appendix A (Napier-Raman et al., 2022). Appendices F and G include additional figures, tables, and graphs from studies 1 and 2.

Conclusion

This chapter introduces the thesis, illustrating the significance and need for the present research. This will be further expounded in the next chapter, which incorporates two published systematic reviews to identify current evidence gaps regarding migrant and refugee youth sexual and reproductive health and rights.

Figure 1.1 Thesis structure



Chapter 2. Literature review

Chapter overview

Two systematic reviews of literature were conducted to explore the evidence gaps in the specific aspects of the thesis.

Building on the background provided in the previous chapter, the first review includes a synthesis of Australian scholarship on MRY, identifying socioecological factors shaping constructions of SRHR. A protocol for this systematic review, published in *Pacific Health Dialog,* provides further detail on the importance of addressing MRY SRHR, the need to synthesise present evidence on this topic, and the review methods (see Appendix A). The second review broadens the location and population scope to examine a specific SRH right. Themes of silence, secrecy and taboo identified throughout the first review are, unsurprisingly, exacerbated by the stigma surrounding abortion. This second review helps locate the present research within the global context of migration and dispossession. The SRH experiences of migrants and refugees in high-income settings like Australia are vastly different to those in lower-income settings, though migrants and refugees across high- and low-income contexts encounter infringements on their rights and agency. Both systematic reviews of literature providing extensive data on the existing research and evidence gaps concerning MRY SRHR. Both are published and presented in this chapter.

Together, these publications offer a comprehensive overview of the literature on MRY SRHR, which highlights the myriad barriers and oppressions impeding rights. This chapter reveals the exigence of rights-based, strengths-oriented SRH research among MRY, including further research into the attainment and articulation of abortion rights. This doctoral research attempts to fulfil some of these needs.

Publication 1: Australian MRY perspectives on SRHR

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SEXUAL HEALTH

Migrant and refugee youth perspectives on sexual and reproductive health and rights in Australia: a systematic review

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ABSTRACT

Migrant and refugee youth (MRY) in Australia face specific experiences that inform their sexual and reproductive health and rights (SRHR). Migrant and refugee communities experience poor health outcomes and low service uptake. Additionally, youth are vulnerable to poor sexual health. This review examines the understandings and perspectives of MRY. A systematic review was conducted as per Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The protocol is registered with PROSPERO: CRD42021241213. Nine databases were systematically searched. Inclusion criteria specified literature reporting on migrant and/or refugee youth perspectives and attitudes towards sexual and reproductive health; peer-reviewed qualitative, mixed-methods and/or quantitative studies or grey literature reports; records using Australian research; literature published in English between January 2000 and March 2021. Records that did not report on MRY and did not examine participant views or perspectives; were abstract-only, reviews, pamphlets, protocols, opinion pieces or letters; did not include Australian research; were published before 2000 and/or in a language other than English were excluded. Two reviewers screened titles, abstracts and full-text articles. The Mixed Method Appraisal Tool was used to assess studies' methodological quality. Thematic synthesis methods guided data extraction and analysis. Twenty-eight papers were included in the final review. Three themes were identified in MRY constructions of SRHR: (1) experiences of silence and shame; (2) understandings of and responses to SRHR risks; (3) navigation of relationships and sexual activity. Socioecological factors shaped MRY perspectives at individual, interpersonal, institutional and societal levels. Societal factors and interpersonal relationships significantly influenced decision making.

Keywords: Australasia, human rights, migrant and mobile populations, refugee, reproductive health, sexual health, youth.

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Introduction

Adolescent and young adult health has significant, lasting impacts on individuals' life trajectories.[1] Accordingly, investing in young people's health is crucial to future societal wellbeing.[1,2] Youth are vulnerable to compromised sexual and reproductive health and rights (SRHR).[3] This is especially so for migrant and refugee youth (MRY) who, despite diverse backgrounds and experiences, face similar barriers to services and care.[4] Australia has a multicultural population, with 30% born overseas.[5] Thus, a significant proportion of Australian youth come from migrant and refugee backgrounds. Research indicates these youth have worse sexual and reproductive health (SRH) outcomes, lower service engagement and difficulties navigating health care.[4,6,7] Australian MRY face complex socioecological challenges that shape how they experience and understand SRHR.[8]

SRH is a crucial aspect of wellbeing with broad social and economic benefits.[9,10] SRH can only be attained through realisation of SRH rights.[10] These include reproductive rights and sexual rights regarding making informed decisions about what happens, and when, to one's body.[11,12] Service, education and information access are also vital rights.[10,11] SRHR are tied to women and young people's welfare and gender equality, and thus key to sustainable development.[10] SRHR encompasses a range of aspects from wellbeing (including fertility, pregnancy and contraception) and sexually transmitted infections (STI) to relationships, gender and sexuality. These aspects are interrelated and inform one another and as such, are examined as a whole in this review.

Australian migrant and refugee populations face poor health outcomes and barriers to care.[13,14] Low SRH service uptake, fuelled by structural barriers, linguistic challenges, and lack of cultural safety, heightens health risks.[15,16] Many cultures have specific SRH constructions, including taboos around sexual activity;[17] moreover, displacement and migration shape SRH knowledge and experiences.[18] While migrant and refugee populations face similar barriers to SRHR attainment, refugees may have particular experiences that further exacerbate vulnerabilities: psychological and physical trauma from conditions in their origin country, hazardous journeys, refugee camps, educational disruption, citizenship and settlement struggles.[19]

Australian youth are disproportionately represented in national STI rates,[20] and are at risk of undiagnosed and untreated STIs.[20] However, MRY have less SRH service knowledge and lower STI testing than their non-migrant counterparts.[21] MRY thus experience barriers to rights attainment on numerous levels.[22] MRY do, nevertheless, find ways to navigate these barriers and enact agency.

Although some research has examined MRY SRH, none has specifically addressed how MRY understand and construct rights. By examining SRH studies through a human rights lens, this review emphasises how MRY construct rights, their strengths and resilience. Our aims were to explore Australian MRY's SRHR, using a systematic review methodology. The review was guided by the following questions: (1) How do MRY construct SRHR in Australia? (2) What socioecological factors contribute to these constructions?

Materials and methods

A mixed-methods systematic review was undertaken to examine MRY's SRHR constructions, barriers and enablers in an Australian setting. A protocol for this review provides detailed methods.[23]

Key subject areas – 'sexual health', 'youth'/'young people', 'migrant(s)' and 'refugee(s)', and 'Australia' – were searched across nine databases (Medline, EMBASE, CINAHL, APAIS, ProQuest, PsycInfo, Web of Science, SCOPUS and PubMed), in addition to hand and grey-literature searches. Two reviewers (SNR and SZH) used Covidence review software to screen the title and abstracts of records.[24] Full-text screening was undertaken consequently.

Inclusion criteria specified studies that: (1) examined migrant and/or refugee youth; (2) presented MRY perspectives, experiences and attitudes towards SRH; (3) were peer-reviewed qualitative, mixed methods and/or quantitative studies, or grey literature, such as reports and government documents; (4) based on Australian research; and (5) published between January 2000 and March 2021 in English. Studies that did not examine MRY and their attitudes or perspectives; for example, purely epidemiological studies, reports on disease incidence, morbidity and treatment rates were excluded, as were abstract papers, reviews, protocols, letters and opinion pieces. Non-English literature and records published before 2000 were excluded. Table 1 details search terms and selection criteria.

A broad definition of youth was taken, with studies included where the participant group was age 15–24 years, or where researchers defined participants as 'youth', 'young', 'young adult', 'young people' or an analogous term. Migrants and refugees included those who voluntarily left home countries, including international students, and those forced to flee conflict or persecution. Studies of first, second and 1.5 generation migrants and refugee, and studies of culturally and linguistically diverse (CALD) populations were included. Records in which MRY were an identifiable sub-group of the study sample were included, such as broader studies of migrant and refugee populations or youth populations, where specific data from MRY was distinguishable and extractable.

Quality assessment was conducted independently by two reviewers using the Mixed Methods Appraisal Tool (MMAT).[25] Studies were given an overall score based on percentage of quality criterion met, where one criteria met is 20% and five is 100%.[26]

Data extraction and synthesis were guided by Thomas and Harden's thematic synthesis methods,[27] and use of QSR's NVivo 12.[28] Full text records were uploaded to NVivo. General study characteristics – date, author(s), setting, study design, data collection method(s), population characteristics, and sampling strategy – were recorded. All findings regarding MRY were extracted. This included all relevant data under 'results' or 'findings' headings and any participant quotes in other study sections. A process of 'qualifying' quantitative data was undertaken in which tabular data was 'translated' into sentences and coded along with qualitative data.[29,30]

Synthesis was inductive and carried out in three stages. First, the results were coded line-by-line. Codes were then grouped into descriptive themes, resulting in 14 final key themes including 'sexual behaviour and relationships, 'contraception and protection', 'parents and family' and 'healthcare, services and support'. Descriptive themes were then developed into analytical themes, 'going beyond' primary study data.[27] This 'going beyond' involved using the socioecological model and a rights-based framework to develop themes.

Table 2a.1

Table 1. Search terms and selection criteria.

Parameters	Inclusion	Exclusion	Key terms/strategy
Location	Australia		Australia*
Language	English	Non-English	English only selected
Date	Published January 2000–March 2021	Published before 2000	Date restrictions: 01 January 2000-
Population	Studies including migrant and/or refugee and/or asylum seeker youth, including international students living in Australia	Studies solely focusing on non-migrant/refugee youth; studies focusing	'Young adult' OR adolescen* OR 'adolescent behaviour' OR 'young people' OR youth OR juvenile OR teen* AND migrant* OR immigrant* OR refugee* OR 'culturally and linguistically diverse' OR CALD **AND**
Outcome	Studies examining participants' perspectives, experiences, and attitudes towards SRH	Studies not concerned with SRH; studies not examining participants' views or perspectives	'Sexual health' OR 'sex education' OR 'reproductive health' OR 'reproductive service*' OR 'family planning' OR 'sexual health service' OR contracepti* OR 'contraceptive behaviour' OR 'unplanned pregnancy' OR abortion OR 'sexually transmitted disease' OR sexuality OR 'sexual behaviour'
Study design		Purely epidemiological studies (disease incidence, morbidity, treatment rates)	NA
	Primary qualitative, mixed methods and/or quantitative studies and grey literature	Abstract-only papers, reviews, pamphlets, protocols, opinion pieces or letters	

CALD, culturally and linguistically diverse; NA, not applicable.

Results

Initial data base searches yielded 584 articles. An additional 16 records were identified through hand searching. We included 28 papers in the final review (Fig. 1).

Study characteristics and quality scores are in Table 2. Eight papers focused on refugees, six on migrant and refugee participants, three on second-generation migrants, four on international students, and eight provided no details of migration/refugee status. Three focused on intergenerational experiences; one mixed-age study included participants aged 19–51 years, and in five studies, participants classified as 'young' included some individuals over the age of 25 years. Data specific to MRY was distinguishable from older participants in included mixed-age studies. One study specifically addressed rights but did not examine how MRY themselves perceived or understood rights.[31]

We present findings thematically under broad headings of the research questions. Fig. 2 depicts individual, interpersonal, institutional and societal factors identified in this review. This structure ensures research questions are answered comprehensively and presents findings in a way that will be useful to health practitioners. We have endeavoured to present results in a manner that aligns with participants' views and perceptions.

(1) How do MRY construct SRHR in Australia?

Three major areas constituted MRY constructions of SRHR: (1) experiences of silence and shame; (2) youth understandings of and responses to risks; (3) navigating relationships and sexual activity.

Silence and shame

A common theme across studies was experiences of silence and shame. Stigma surrounding sex,[21,32–39] pregnancy,[34,36,40–42] STIs,[6,19,36] relationships,[33] and sexuality[43,44] were common within participants' communities and families. MRY understandings of shame were gendered; women were consistently the subject of shame.[6,19,21,32–34,41,45,46] The only descriptions of shame befalling men related to sexual orientation.[43] Throughout this review, gender is a key individual socioecological factor shaping SRHR constructions.

MRY internalised shame to different extents; from intense shame[33] to mild discomfort and embarrassment[38,39,47] and beliefs that 'doing sex is not a bad thing'.[6] Young Muslim women expressed the most shame,[32] some believing even accidental transgressions – bumping into a man – were unacceptable.[33] On sexual desire, one woman commented 'we think it's wrong, wrong, wrong.'[33] Conversely, many MRY understood SRH as socially taboo without personally considering sex shameful. Youth distinguished their own views from those of their community, navigating interpersonal factors as will be discussed further (see section (2)).[19,21]

Shame inhibited discourse. The sentiment expressed by one Vietnamese woman about her community, 'we don't talk about sex',[47] was reiterated across studies, shared by youth from East and West African, Middle Eastern, East and South Asian backgrounds.[4,19,32,33,35,36,39,40,48–50] Generally, MRY did not discuss SRH with families.[21,36,39,40,47,48,50,51]

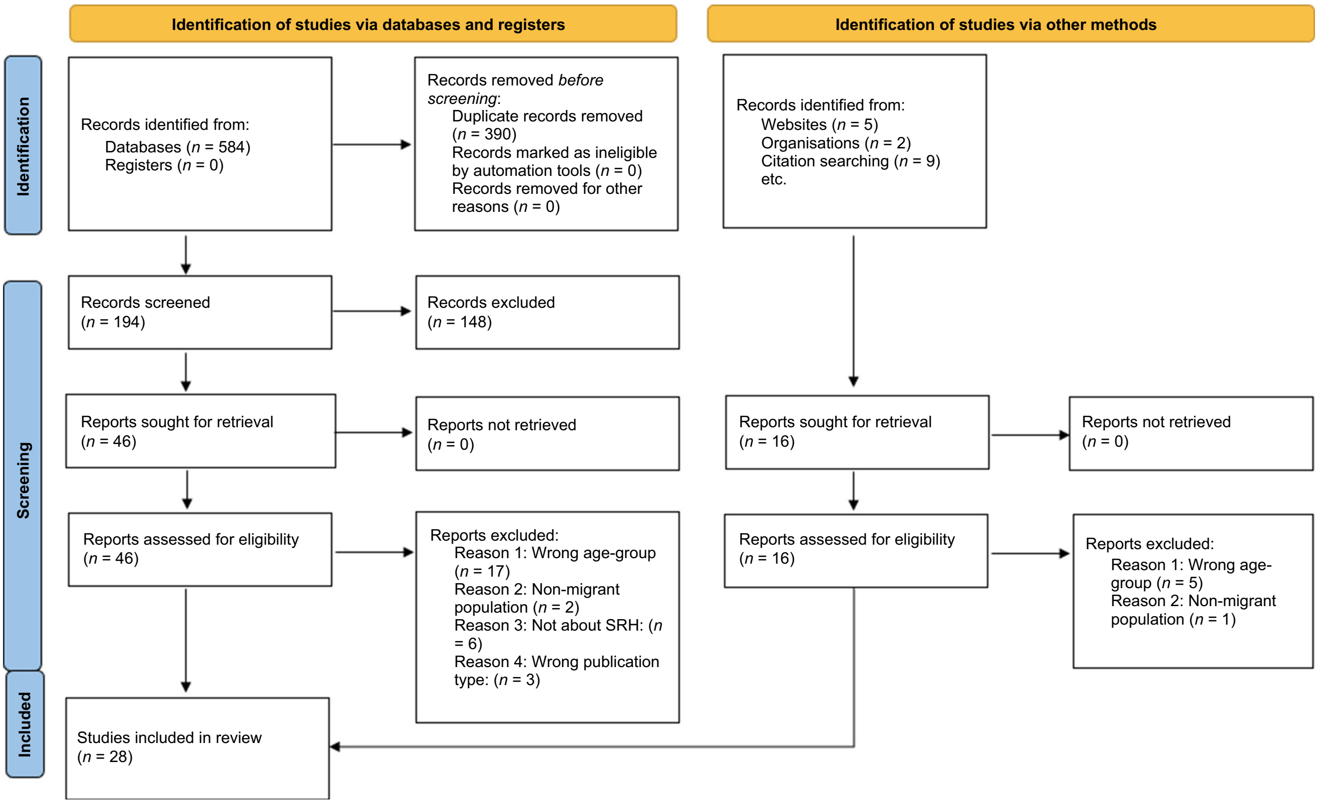

Fig. 1. Flow diagram of search and study inclusion process.

Figure 2a.1

Parents stifled and avoided conversations,[39,48] telling children 'sex is an adult topic'.[33] Parents reiterated shame and warned children against sex.[19,33,48] Families and communities believed openness would encourage promiscuity.[19,40,42,49] Discussing sex was an admission of sexual activity.[34] If MRY mentioned SRH, parents would be judgemental,[4,19,21,35] disappointed,[36] uncomfortable and unresponsive.[19,39,40] Some LGBTQI+ youth had supportive yet limited conversations with immediate family about sexuality.[43] There were few exceptions of MRY discussing SRH with mothers (none mentioned fathers).[19,32,40]

Many MRY discussed SRH with friends, relying on peers for information.[4,19,21,32,36,45,48] However, occasionally, fear of judgement prevented this, especially with peers from the same background.[4,19] Some asserted SRH discussions were only acceptable with one's spouse, leaving unmarried youth unable to discuss issues.[19,33] Youth felt silence and shame had negative consequences, impeding understandings of SRHR and risk avoidance.[19,39,46,50]

Constructions of risks

STIs. SRH understandings prominently featured STIs, or 'bad sicknesses'.[6,36,39] Beyond awareness, however, knowledge was inconsistent and often limited.[4,6,32,33,36,40,42] While HIV was widely known, many struggled to name other diseases,[6,21,32,33,36,49] and misconceptions were rife; e.g. HIV being a cancer,[32] transmissible by mosquitoes,[52] shared utensils, and proximity.[6]

Botfield *et al.*[21] found some MRY were concerned about not knowing whether they needed testing or treatment. Conversely, many believed that 'you can realise'[6] when infected.[6,19,52] Despite not knowing symptoms, MRY believed their bodies would exhibit tangible signs such as 'changing in your menstrual cycle'.[6] Someone with HIV would have 'a dead look', and those with STIs could be determined by appearance, reputation or behaviour.[6]

Disengagement with STI risk was evident, even when MRY feared infection. For some, fear was immobilising, one woman being 'too scared' to learn about STIs,[33] another admitting she would 'rather not know' she had an asymptomatic STI.[21] Many believed they were not personally at risk.[6,19,36] Among refugee youth, whose perceptions were shaped by socioecological factors of differing educational experiences and migration history, there was a common misconception HIV was 'not that risky' in Australia.[6,40,52]

Pregnancy. Overall, pregnancy was a greater concern than STIs.[49] As evidence of pre-marital sex, unintended pregnancy brought personal and communal shame.[33,34] Filipinas and African-background women considered early pregnancy a major problem within their communities.[36,42,51] MRY understood pregnancy as a gendered risk; discussions

Table 2a.2

Table 2. Study characteristics.

Author	**Year**	**Study design**	**Setting**	**Outcome/domain**	**Size**	**Age group (years) included in review**	**Gender**	**Population background**	**Quality score (%)**
Asquith *et al.*[43]	2019	Mixed methods	Sydney, NSW	Experiences of LGBTQI+ CALD community living in Western Sydney and relationships with family and sexuality	55	19–51	24 cis female; 23 cis male; five non-binary two trans female; one trans male	Multiple backgrounds (including: Lebanese, Mixed, Cambodian, Vietnamese)	80
Botfield *et al.*[34]	2020	Qualitative	Sydney, NSW	MRY perspectives on pregnancy and abortion	27	16–24	16 female; 11 male	Multiple backgrounds (including: African, Korean, Chinese, Vietnamese)	100
Botfield *et al.*[35]	2018	Qualitative exploratory study	Sydney, NSW	MRY engagement with SRH care in General Practice (GPs)	27	16–24	16 female, 11 male	Multiple backgrounds (including: African, Korean, Chinese, Vietnamese)	100
Botfield *et al.*[4]	2018	Qualitative exploratory study	Sydney, NSW	MRY perspectives on the significance of generation on SRH care	27	16–24	16 female, 11 male	Multiple backgrounds (including: African, Korean, Chinese, Vietnamese)	100
Botfield *et al.*[21]	2018	Qualitative exploratory study; grounded theory	Sydney, NSW	MRY SRH information sources, and education	27 (+34 'key informants')	16–24	16 female, 11 male	Multiple backgrounds (including: African, Korean, Chinese, Vietnamese)	100
Burchard *et al.*[45]	2011	Qualitative	Adelaide, SA	Female international students' SRH knowledge and practices	21	Median 22[A]	All female	Chinese (14) and Malaysian (7)	100
Chung *et al.*[37]	2018	Mixed methods exploratory study [only qualitative relevant to this review]	Western Australia and South Australia[B]	Young African-background women's understandings of sexual violence and coercion	17 (+81 agency participants, 23 service providers)	Median 22[A]	All female	African background (born: Zimbabwe (5), Kenya (8), Sierra Leone (2) and South Sudan (2)	60
Chung *et al.*[46]	2018	Mixed methods [only qualitative relevant]	Western Australia and South Australia[B]	Young African-background women's understandings of sexual violence and coercion	18 (+81 agency participants, 23 service providers)	Median 22[A]	All female	African background (born: Zimbabwe (5), Kenya (8), Sierra Leone (3) and South Sudan (2)	60
Dean *et al.*[52]	2017	Quantitative	Queensland[B]	SRH knowledge and practices among young Sudanese Queenslanders	229	16–24	80 female, 149 male	Sudanese	100
Dean *et al.*[49]	2017	Qualitative; integrated behavioural model	Queensland[B]	Intergenerational perspectives on SRH among Sudanese community	11 (+19 older generation)	19–24	Six female, five male	Sudanese	100
Manderson[36]	2002	Mixed methods	Queensland[B]	Young Filipina's SRH issues and understandings	40	14–25	All female	Filipino	60

(*Continued on next page*)

Table 2. (*Continued*).

Author	Year	Study design	Setting	Outcome/domain	Size	Age group (years) included in review	Gender	Population background	Quality score (%)
McMichael[41]	2013	Qualitative [follow-up on a mixed-methods study]; informed by anthropology and social epidemiology	Melbourne, Vic	Experiences of Sudanese refugee teen/early mothers	9	16–20	All female	Sudanese	80
McMichael and Gifford[19]	2009	Qualitative	Melbourne, Vic	Refugee youth's SRH information access and understanding	142	16-25	67 males, 75 females	Multiple backgrounds: representative of humanitarian entrants to Victoria 2004–07	100
McMichael and Gifford[6]	2010	Qualitative	Melbourne, Vic	Refugee youth's understandings of SRH risk and protection	142	16–25	67 males, 75 females	Multiple backgrounds: representative of humanitarian entrants to Victoria 2004–07	100
Meldrum *et al.*[32]	2016	Qualitative; cultural sensitivity framework	Melbourne, Vic	Young Muslim women's SRH needs and knowledge	11	18–25	All female	Mixed-backgrounds: including Saudi Arabia, Iran, Iraq, Malaysia, Fiji, Somalia, Pakistan	100
Mulholland *et al.*[54]	2021	Qualitative pilot study; intersectionality theory	South Australia[B]	Intergenerational perspectives on SRH among South Australia's African community	11 youth (+18 'parent' generation)	16–55 [age of youth participants not specified]	Mixed gender, distribution not provided	African background: (Nigeria, the Democratic Republic of Congo, Zambia, Burundi, Ghana, Tanzania, Kenya, Somalia, Ethiopia, South Sudan)	40
Ngum Chi Watts *et al.*[53]	2014	Qualitative; cultural competency framework	Melbourne, Vic	Contraceptive knowledge and attitudes of African background teen/early mothers	16	17–30	All female	African background (born: Sudan (10), Liberia (3), Ethiopia, Burundi, Sierra Leone)	100
Ngum Chi Watts *et al.*[42]	2015	Qualitative; intersectionality theory, phenomenology, cultural competency framework	Melbourne, Vic	Experiences of African background teen/early mothers	16	17–30	All female	African background (born: Sudan (10), Liberia (3), Ethiopia, Burundi, Sierra Leone)	100
Ngum Chi Watts *et al.*[40]	2015	Qualitative	Melbourne, Vic	African background teen/early mothers' contraceptive use/ awareness	16 (+11 key informants, six older African women)	17–30	Female	African background (born: Sudan (10), Liberia (3), Ethiopia, Burundi, Sierra Leone)	100
Okeke[39]	2021	Qualitative; sexual script theory	Sydney, NSW	International students' SRH knowledge, practices and perspectives on Australian norms	20	18–<32	11 female, nine male	East Asia (China, Indonesia, Japan, Macau, Mongolia, Thailand, Taiwan); sub-Saharan Africa (Botswana, Cameroon, Kenya, Nigeria, Tanzania, Zimbabwe)	60

(*Continued on next page*)

Table 2. (*Continued*).

Author	Year	Study design	Setting	Outcome/domain	Size	Age group (years) included in review	Gender	Population background	Quality score (%)
Pallotta-Chiarolli[44]	2016	Qualitative; decolonising research design	Melbourne, Vic	Needs and experiences of multi-faith/multicultural SSAGD (same-sex attracted and gender diverse) youth	10 youth; 10 community leaders	17–25	Three female, two male, one trans-female, two trans-male, two non-binary	Multiple backgrounds: (Malaysian Chinese, Turkish/Filipino, Mexican, Dominican/Filipino, Pakistani (2), Vietnamese, Romanian/Malay Chinese, not-specified)	100
Parker *et al.*[65]	2020	Qualitative	Sydney, NSW	International students' SRH knowledge and practices	13	18–24	Nine female, four male	Multiple backgrounds: China (2), Europe (1), Indonesia (2), Malaysia (3), Middle East (1), Myanmar (1), Singapore (2), Vietnam (1)	100
Poljski *et al.*[31]	2014	Mixed methods; rights-based approach	Melbourne, Vic	Female international students' SRH knowledge and practices	210 survey participants, 36 focus group participants, 10 interviewees	16–31	All female	Multiple countries: (including: China, India, Vietnam, Colombia)	40
Rawson and Liamputtong[47]	2009	Qualitative; grounded theory	Melbourne, Vic	Influence of Vietnamese culture on use of mainstream health services for SRH by young Vietnamese-Australian women	15	18–25	All female	Vietnamese	100
Rawson and Liamputtong[48]	2010	Qualitative; Grounded theory	Melbourne, Vic	Vietnamese-Australian women's SRH knowledge seeking, education and sources	15	18–25	All female	Vietnamese	100
Rogers and Earnest[51]	2014	Qualitative; psychosocial framework	Brisbane, Qld	Intergenerational experiences and knowledge of SRH among Sudanese and Eritrean women	Five young women, eight older women, key informants)	18–30	All female	Sudanese and Eritrean	100
Rogers and Earnest[50]	2015	Qualitative; psychosocial framework	Brisbane, Qld	SRE (sexuality and relationships education) and SRH experiences among Sudanese and Eritrean women	Five young women, (eight older women, key informants)	18–30	All female	Sudanese and Eritrean	100
Wray *et al.*[33]	2014	Qualitative; feminist discourse analytic approach	Sydney, NSW	SRH constructions and experiences of young Muslim migrant women	10	18–25	All female	Birth country: Iraq (2), Iran (2), Afghanistan (4), Bangladesh (1) and Pakistan (1)	100

[A] Median age provided only.
[B] City not provided.

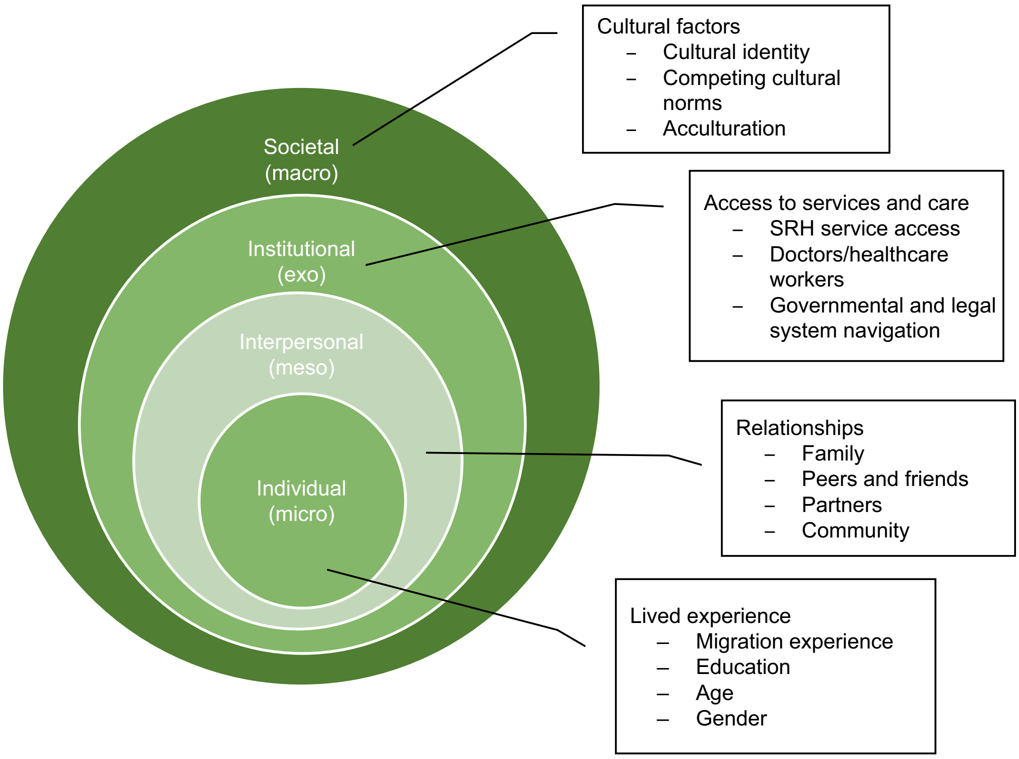

Figure 2a.2

Fig. 2. Socioecological factor model.

focused on women, with consequences solely impacting mothers.[6,34] Children were prized in many communities, but non-marital pregnancy was 'the worst thing that could happen to anyone'.[34] Pregnancy was predominantly considered a social risk, having ramifications beyond the mother.[34,41] Forced marriage, ostracism, being 'kicked out', parental wrath and mistreatment were commonly hypothesised consequences of non-marital pregnancy.[34,36,41] Only those who had experienced pregnancy discussed personal consequences of disruption to livelihood, education and opportunity loss.[36,41,42]

The social acceptability of pregnancy varied. Filipina and Sudanese mothers described their lives as limited and irrevocably altered by pregnancy.[36,40] However, among young African mothers, pregnancy was generally viewed positively; motherhood turned girls into women, gave them purpose, responsibility and respect.[40–42] Women who experienced early pregnancy had low SRH literacy before conception. Pregnancy was the first time these women discussed SRH, learned about contraception and, for some, discovered intercourse led to pregnancy.[19,40,53]

Contraception and protection. Concerns about SRH risks did not necessarily bring precautionary action. While some youth demonstrated good understanding of preventative measures,[6,36,51] studies revealed prevalent misconceptions,[33,40,45,49,51,53] inconsistent use, suspicion and apathy.[36,51,53] Condoms were most widely known, mentioned in all studies that discussed protection.[6,19,21,32,33,36,38–40,45,49,51–53] Many MRY lacked understanding of how preventative measures worked,[33,40,51,53] and were unaware or unconvinced they needed consistent use.[36,51,53]

Fatalism was evident in attitudes towards protection, one woman asserting infection 'would happen no matter... what you're using'.[33] Misconceptions that the contraceptive pill causes infertility were common.[33,40,45,49,51,53] Other concerns included weight gain, cancer, hormonal imbalance and unspecified long-term harm.[40,53] Young women feared implants and contraceptives that disrupted cycles.[40,53]

Perceived social risks of protection and contraception informed attitudes towards physiological risks. Youth forewent protection because they feared others discovering sexual activity.[32,42,51,53] Many MRY asserted commitment negated need for protection. Trust and fidelity were sufficient: 'if you don't play around, you don't get the diseases'.[6] Conversely, protection indicated mistrust, or implied partners had diseases,[19] and was associated with promiscuity.[19,40] Partners refused protection and used accusations of infidelity or lack of love to coerce young women into unprotected sex.[53]

Social risk featured prominently in the study by Botfield *et al.*[34] of pregnancy and abortion. MRY described abortion as deeply stigmatised within communities, and technically more unacceptable than non-marital pregnancy.[34] Unlike pregnancy, abortion can be hidden and therefore termination was preferable.[34] Youth asserted they would undergo abortion and believed parents would encourage this to avoid social consequences of pregnancy.[34]

Sexual activity and decision making

MRY constructions of intimacy frequently featured abstinence and virginity.[33,46] Abstinence mitigated physical and social risks of sex.[6] For those who considered sex sinful, abstinence removed risks of personal degradation.[33] These values were salient across diverse backgrounds.[32,33,36,43–46] LGBTQI+ youth described being alienated from hypersexuality of mainstream white queer identities.[43,44] As one woman noted, sexuality did not change her values, leading her to forego 'sex outside marriage because it's part of my faith'.[44]

Constructions of virginity were gendered. Male and female participants valued abstinence, but only women were considered ruined by pre-marital sex.[6,19,33,45] Female virginity was significant for marriage prospects.[6,45,47] Some male MRY would not marry or date women who were not virgins.[6]

Abstinence was practiced varyingly. Some abjured premarital sex as completely unacceptable.[33] Young Muslim women held the most strict practices,[32,33] avoiding male interaction and suppressing 'desire to have sex and stuff'.[33] Purity was upheld through ignorance: one woman deliberately distracted herself during school sex education,[33] while others were happy to have not received education.[32] Young women in two studies avoided tampons because they compromised virginity.[33,36] Some considered non-sexual relationships acceptable. Others asserted premarital sex was justified if one was in love and planned on marriage.[33,39,45]

MRY felt navigating 'healthy relationships' was an important aspect of SRH,[21,37,46] albeit something not taught.[21,48] Frequently, relationships were hidden, particularly from parents.[4,19,33,36,37] This was especially so for LGBTQI+ youth, who often kept relationships and sexual orientation secret.[21,43] MRY lacked understandings of unhealthy relationships, displaying limited sexual autonomy. Young African-background women noted that among peers, controlling, violent behaviour was common and romanticised.[37,46] Youth only discussed consent in two studies,[37,38,46] but there were multiple descriptions of non-consensual experiences across studies.[6,21,40,50,52] MRY were pressured into sexual acts, unprotected sex, and having children.[6,21,40,50] Youth saw sexual violence as limited to stranger rape, did not acknowledge marital rape, and discussed pervasive beliefs that consent in relationships is automatic and irrevocable.[21,33,37,46] Rather than their own rights, young Muslim women asserted husbands' rights to wives' bodies, and wives' duties to provide sex.[33] MRY described victim blaming being common within their communities, asserting ostracism and shaming prevented victims reporting and getting support.[38,46]

(2) What socioecological factors contribute to MRY's SRHR constructions?

Fig. 2 summarises the most prevalent socioecological factors found across this review.

Individual

Migration. Migration history shaped MRY's SRHR constructions. Length of time in Australia influenced knowledge, with Dean *et al.*[52] reporting a positive association between SRH knowledge and years in Australia for Sudanese refugee youth. International students and refugee youth reported greater awareness of SRH issues and changed attitudes and behaviour the longer they spent in Australia.[38,39,45,49]

Education. Overwhelmingly, MRY felt school education was important and useful, particularly because, as discussed in section (1), silence and shame prohibited sex education at home.[19,21,48] MRY reported that sex education improved SRH understandings and decision making.[21] However, across all studies which discussed education, MRY described limitations to access and content.[19,21,32,34,38,39,44,45,48] These limitations explain deficits in knowledge and misconceptions around SRH risks described in section (1).

Youth educated outside Australia asserted SRH education was lacking; purely physiological information on reproduction and risk.[19,38,39,45] In one study, refugee youth received no sex education before arrival.[19] Information refugee youth received was mediated by context; in camps and home countries, particularly among youth from sub-Saharan Africa, sex education focused on HIV.[6,40] Accordingly, refugee youth had limited awareness of other STIs and believed that because there was comparatively less focus on HIV in Australia, HIV was not a risk.[6,19,40,49,52] All youth educated in Australia received sex education, except a select few who attended Islamic schools.[32] Education in Australia was also limited;[21,37,48] information was mainly physiological.[21,37,48] Social and relationship aspects were absent, as was information about support and services.[21,48] Generally MRY, excepting some Muslim women[32,33] wanted more education with greater breadth.

Attempts to supplement education were common, with mixed results. Many MRY described learning 'the hard way'[19] – developing knowledge through mistakes and negative experiences.[6,19,21,34] Some mentioned internet sources,[19,21,38,45] which allowed privacy and extensive information, but were unreliable. Magazines were mentioned in three studies, with varying perceptions of usefulness.[32,45,48]

Age. A number of studies discussed 'generational sensibility'[4] among MRY.[4,49,51] In one study, MRY felt generational identity shaped experiences more than culture.[4] MRY considered older generations less knowledgeable, more traditional and judgemental regarding SRH.[4,49] Older people were associated with parents and expected to share their conservative values.[47] MRY preferred young healthcare workers (HCW), providers and educators.[4,47,48]

Gender. As discussed in section (1), SRH constructions were frequently gendered. Female MRY reported differential experiences to male counterparts; less freedoms, greater censure and worse consequences for unsanctioned behaviour.[6,34,36,37,54] Youth reported gender norms of women's value being determined by marriage and children.[34,37,40] Male control over women's bodies featured frequently: paternal control,[33,37] husbands' rights over wives' bodies,[33,46] and power dynamics forcing women into sexual activity.[40,51] While discussions of coercion almost solely focused on women, Dean *et al.*[52] found male participants reported higher rates of unwanted sex.

Interpersonal

The notion of social risk examined in section (1) illustrates the significance of interpersonal factors in MRY decision making.

Family. Parents were mentioned in every study. Families were described as holding taboos, which varyingly impacted SRHR constructions. As detailed in section (1), silence and shame restricted avenues for advice.[19,21,33,36,37,48] Living with family precluded privacy for SRH matters and information seeking.[19,47] Parental control was common. Parents forbade relationships, restricted movement, policed behaviour, controlled internet use and for some, would choose spouses.[19,33,36,37,43] However, in one study, Sudanese refugee youth noted erosion of parental control upon encountering Australian norms.[49] Another exception was international students, whose lives in Australia were defined by freedoms from lack of parental control.[38,39,45]

MRY constructions of SRHR involved awareness that choices had ramifications on their families.[4,6,33,34,41,42] This was especially stark for LGBTQI+ youth who worried about upsetting family, bringing shame and ruining reputations.[4,43,44] One woman's mother accused her of 'killing' her siblings by coming out.[44] However, family also provided support. LGBTQI+ youth emphasised the importance of family acceptance,[43] young mothers found parental care crucial,[41,42] and many youth were sure that parents (while upset) would support them if they became pregnant.[34]

Partners and peers. MRY's articulation of rights was restricted by coercion from partners,[6,21,40,50,52] and peer pressure to be sexually active.[50,52] Yet, peers also provided support and information.[4,19,21,32,45] Peer advice was most accessible,[19,48] and allowed a safe space for discussions.[4,48] Nevertheless, friends might 'tell you all kinds of whacky things'.[19] Lacking knowledge themselves, friends were not necessarily reliable.[19,45]

Institutional

SRH services frequently failed to reach MRY, with many youth unaware services existed.[4,19,21,31,34,35,51] This indicates a serious restriction of rights to care and information.

Healthcare providers. While general practitioners (GPs) were the most commonly mentioned, and often only known,[21] provider of SRH care,[32,34,35,38] many factors made youth reluctant to use GPs. MRY described embarrassment and discomfort getting SRH care.[19,35,36,47] Many believed doctors should only be visited for 'serious' problems,[19,31,34,38,45] MRY feared being discovered accessing care.[19,32,35,47,51] Fears were exacerbated with family GPs, youth worrying GPs would breach doctor–patient confidentiality by informing parents.[32,35,36,47] GPs of the same background were expected to share cultural taboos and thus be judgemental.[34,35] In one study on using GPs for SRH care, GPs were judgemental, refused SRH discussions, dismissive, and provided rushed assessments.[35] In other studies, MRY being prescribed contraceptives without understanding their use or importance, including the misconceptions, indicated HCWs failure to provide sufficient care and information; see section (1).[53]

Cultural safety. MRY noted a lack of culturally-appropriate care and education. Some were adamant that services and education should not be culturally specific, including MRY who felt providers from the same background would be a barrier.[4,35,47,48] Conversely, other MRY wanted culturally-specific services, asserting providers from the same background would better understand them.[19,32,46,48] Nevertheless, there was general consensus that services and education should be culturally sensitive and considerate of specific issues facing MRY.[4,19,32,38,48,50,51] In both studies involving LGBTQI+ participants, MRY reported strong desire for services specifically for culturally diverse LGBTQI+ communities.[43,44] MRY described being excluded from mainstream LGBTQI+ discourses and services where 'LGBTI health is reduced to white men'.[44]

Structural barriers. MRY lacked understanding of and confidence navigating legal and governmental systems. MRY held misconceptions about laws, including believing abortion is illegal and that HIV-positive refugees are not allowed into Australia.[34,49] Youth lacked legal knowledge around sexual violence and believed reporting would worsen the situation or lead to deportation; these fears combined with those of social shaming and ostracism discussed in section (1), precluding MRY from seeking support.[37,38,46] However, MRY in two studies asserted Australian legal and governmental structures enabled greater sexual freedom.[33,49]

Societal

Experiences and identification with culture were diverse, as was the impact of culture on SRHR constructions. Some

MRY did not identify with any particular culture,[3] others considered themselves principally Australian,[4,48] and others firmly identified with their parental culture.[36]

Every study mentioned cross-cultural navigation, including perceived tensions between 'Australian' or 'Western' and family/ethnic cultures.[4,19,32,36–39,45,46,49,50] The cultural silence and shame, discussed in section (1), was compared with perceived permissiveness of mainstream Australian culture.[19,38,39,49] MRY felt cultural openness in Australia allowed them more freedom, information access and open discourse.[4,33,45,46,49] However, some criticised Australia as too permissive.[36,39] Many struggled with competing cultural norms,[32,45] not knowing 'which side to take'.[50,51] Differing acculturation rates between MRY and parents brought intergenerational tensions.[36,49,54] LGBTQI+ youth felt further 'torn' multiple ways; between sexuality, family cultures and religions which may not accept them, and mainstream Australian and white LGBTQI+ cultures that spurned tradition and religion.[43]

Discussion

Ensuring young people's SRHR is invaluable to sustainable development.[2,9] Thus, SRHR outcomes for MRY, which represents a significant proportion of Australia's population with specific needs and experiences, are critical to the overall wellbeing of Australian society. This review synthesised Australian MRY's constructions of SRHR and examined socioecological factors informing these constructions. While there was a paucity of literature on MRY constructions of rights, we found that SRHR constructions were diverse and complex, with key areas of congruence. As our model highlighted (Fig. 2), MRY contended with myriad factors intersecting across socioecological levels. The differing ages, educational experiences, and settings of participants across included studies may influence the ways in which they navigate and construct SRH beliefs, relationships, and social structures. Nevertheless, we identified certain shared experiences, particularly in education, family interactions, institutional engagement, and cross-cultural navigation. Gender dimensions pervaded MRY constructions of SRHR.

Our synthesis identified SRH taboos as ubiquitous in MRY experiences, indicating youth across various backgrounds navigate stigma and prohibitions. Significantly, shame was mostly externally placed on individuals or certain subjects, with MRY distinguishing between what they themselves felt and the prevalent discourses in their contexts. These findings are consistent with those of Ussher *et al.*[55] on migrant women's active negotiation of shame, rather than passive internalisation. Our findings differ from those of general Australian youth populations, where families were more frequently a source of SRH information.[56,57] MRY experiences of family silence are more similar to youth in LMIC in Africa,[58–60] Asia,[60–62] Middle East,[63] the Pacific.[64] Shame around SRH has been noted to impinge on discourse and information-seeking.[16,17] Lack of avenues for SRH discussions impedes rights to information. Moreover, low SRH literacy impinges other rights, increasing vulnerabilities to SRH risks.[17]

We found that MRY constructions of risk and navigation of relationships involved balancing biomedical and social factors. Overall, there were concerning deficits in understanding of health risks, preventative measures and agency in relationships. Consistent with data from the broader Australian youth population, MRY perceived themselves as having low STI risk.[56] Our findings parallel research on social risk as significant in SRH decision-making, where protecting 'culturally valued social resources' is prioritised.[65,66] A social risk approach may explain why MRY did not necessarily engage in risk prevention. For example, cultural values of childbearing and stigma around infertility fuelled fears of oral contraceptives, turning a risk-prevention method into a perceived risk. This highlights the complexity of rights and agency. While youth found ways to navigate restrictions, rights around bodily autonomy were significantly compromised. We found multiple descriptions of non-consensual experiences, and a concerning lack of consent vocabulary and understandings. We found that MRY do hold agency, but, as with young people in areas of East Africa,[58,67] East and South Asia,[60,62,68] and the Pacific,[64] this was compromised by contextual, structural and social factors. Often, MRY engaged 'subtle' or 'thin' agency, navigating within and around constraints.[58,67]

Relationships were highly significant to MRY; relationships with family, community, peers and partners could impede and enable rights actualisation. Migration disrupts social networks, heightening the importance of family and community connections in resettlement, or bringing pressure to maintain bonds.[6] Australian cities contain stratified areas with high concentrations of specific cultural groups.[8] Many Australian migrants and refugees come from non-Western cultures that are collectivist-oriented.[69] The importance of relationships to MRY's SRHR constructions is thus unsurprising. Greater intergenerational communication in families around SRH issues has been shown to bring myriad benefits.[54] Given the importance of interpersonal relationships to youth's SRH constructions and behaviours, educational and service improvements that centre these areas may be particularly valuable.

We found striking similarities across MRY experiences of education and services. The common experience of inadequate education may explain MRY's knowledge gaps. The focus on biomedical and physiological SRH in formal education likely contributed to MRY's difficulties articulating sexual autonomy and navigating relationships. Given MRY concerns regarding social risks, education that takes a purely physiological approach will fail to fully engage this population. While the general Australian youth population also report variable content and depth in school sex education,[56] various factors, including parental silence, service barriers and cultural mores, may make it harder for MRY to supplement inadequate education. MRY's ignorance of SRH services is consistent with comparable studies in other high-income countries.[70] Youth's misgivings about health and legal support overwhelmingly related to social risk; fears of negative repercussions for seeking support and that doctors would breach confidentiality. Mistrust indicates services have not effectively engaged MRY or presented themselves as safe spaces. MRY clearly asserted the need for greater cultural sensitivity. Having culturally sensitive education and care allows awareness of the influence of cultural factors in decision making without reducing youth's SRHR constructions to their cultural background.

Our findings suggest that to successfully engage and support MRY, future policy and practice must recognise the social and relational aspects of SRH. School curricula should be adapted to include education on emotional and social factors. Having services that are aware and sensitive to cultural factors, without being reductive, are also essential. Given low awareness of services, promotion programs that inform MRY on local services are necessary, perhaps through targeted social media advertisements or within schools. Health workers must assure MRY of confidentiality, and options for anonymous support, such as virtual or phone helplines, may be beneficial.

Gaps in the literature

We identified a significant gap in the literature on rights. How MRY understood and constructed rights was not directly discussed in any studies, limiting our analysis to implicit discussions of SRHR. There was no indication MRY recognised their entitlement to SRH rights. Additionally, there is a clear under-representation of male MRY's SRH perspectives. Half the eligible studies comprised solely female participants. Women are disproportionately impacted by SRHR issues, contending with prohibitive gender norms and power imbalances,[71] as evidenced by gendered constructions of SRH throughout this review. Nevertheless, understanding how men experience and uphold gender dynamics is important to holistic SRHR improvements.

Limitations of the review

This review took a broad definition of MRY. Therefore, we were unable to capture nuanced perspectives of specific groups within this population. There was limited scope to examine differing perspectives and understandings such as those between older and younger MRY, and MRY with differing educational attainment. Due to the small literature pool, sub-group analysis based on ethnicity, religion or cultural background was unfeasible. There was an uneven distribution of backgrounds, and participants were not representative of Australia's migrant and refugee demographic makeup.[5] Nine papers exclusively involved African-background participants, with under-representation of youth from other areas. Similarly, we were unable to perform significant gender comparisons due to limited data on male participants. Future studies using large samples should consider possible differences by sociodemographics in how MRY may understand their SRH rights.

Some included studies also lacked detail on the methodology used, specifically theoretical frameworks, limiting our findings. Moreover, studies of lower quality, receiving MMAT scores of 40 or 60%, were still included in the final analysis. Future studies must include a detailed methodology and theoretical framework for a better understanding of MRY's SRH rights.

Conclusion

While there was a paucity of exploration of youth rights constructions and inadequate investigation of male MRY experiences, this review provides crucial information on how Australian MRY experience and construct SRHR. We found social aspects of SRHR are deeply significant to MRY, yet appear under-represented in education and service approaches. To ensure sustainable impact, health practices must be situated in MRY's structural, emotional, cultural, and social conditions. Our findings will guide service delivery to optimise MRY's SRHR outcomes, not just in Australia but more widely in the region and other multicultural populations.

References

1 Kleinert S, Horton R. Adolescent health and wellbeing: a key to a sustainable future. *Lancet* 2016; 387: 2355–6. doi:10.1016/S0140-6736(16)30297-5

2 Patton GC, Sawyer SM, Santelli JS, *et al.* Our future: a Lancet commission on adolescent health and wellbeing. *Lancet* 2016; 387: 2423–78. doi:10.1016/S0140-6736(16)00579-1

3 United Nations. International conference on population and development programme of action: twentieth anniversary edition. Report no. 978-0-89714-022-5. UNFPA; 2014.

4 Botfield JR, Newman CE, Zwi AB. Engaging migrant and refugee young people with sexual health care: does generation matter more than culture? *Sex Res Soc Policy* 2018; 15: 398–408. doi:10.1007/s13178-018-0320-6

5 Australian Bureau of Statistics. Migration, Australia, 2019-20 financial year. ABS; 2021. Available at https://www.abs.gov.au/statistics/people/population/migration-australia/2019-20

6 McMichael C, Gifford S. Narratives of sexual health risk and protection amongst young people from refugee backgrounds in Melbourne, Australia. *Cult Health Sex* 2010; 12: 263–77. doi:10.1080/13691050903359265

7 Robards F, Kang M, Steinbeck K, *et al.* Health care equity and access for marginalised young people: a longitudinal qualitative study exploring health system navigation in Australia. *Int J Equity Health* 2019; 18: 41. doi:10.1186/s12939-019-0941-2

8 Dune T, Perz J, Mengesha Z, *et al.* Culture Clash? Investigating constructions of sexual and reproductive health from the perspective

of 1.5 generation migrants in Australia using Q methodology. *Reprod Health* 2017; 14: 50. doi:10.1186/s12978-017-0310-9

9 Patton GC, Sawyer SM, Ross DA, *et al.* From advocacy to action in global adolescent health. *J Adolesc Health* 2016; 59: 375–7. doi:10.1016/j.jadohealth.2016.08.002

10 Starrs AM, Ezeh AC, Barker G, *et al.* Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet* 2018; 391: 2642–92. doi:10.1016/S0140-6736(18)30293-9

11 Starrs AM, Ragnar A. Definitions and debates: sexual health and sexual rights. *Brown J World Aff* 2016; 22: 7–23.

12 Chandra-Mouli V, Svanemyr J, Amin A, *et al.* Twenty years after international conference on population and development: where are we with adolescent sexual and reproductive health and rights? *J Adolesc Health* 2015; 56: S1–6. doi:10.1016/j.jadohealth.2014.09.015

13 Hirani K, Payne DN, Mutch R, *et al.* Medical needs of adolescent refugees resettling in Western Australia. *Arch Dis Child* 2019; 104: 880–3. doi:10.1136/archdischild-2018-315105

14 Au M, Anandakumar AD, Preston R, *et al.* A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions. *BMC Int Health Hum Rights* 2019; 19: 22. doi:10.1186/s12914-019-0206-6

15 Ilami A, Winter S. Iranian migrants' lived experiences of access to sexual and reproductive healthcare services in Western Australia: a conventional content analysis. *Sex Res Soc Policy* 2021; 18: 533–46. doi:10.1007/s13178-020-00478-2

16 Ussher JM, Rhyder-Obid M, Perz J, *et al.* Purity, privacy and procreation: constructions and experiences of sexual and reproductive health in Assyrian and Karen women living in Australia. *Sex Cult* 2012; 16: 467–85. doi:10.1007/s12119-012-9133-6

17 Metusela C, Ussher J, Perz J, *et al.* "In My Culture, We Don't Know Anything About That": sexual and reproductive health of migrant and refugee women. *Int J Behav Med* 2017; 24: 836–45. doi:10.1007/s12529-017-9662-3

18 Odger A, Frohlick S, Lorway R. Re-assembling "Risky" subjects: African migrant youth in Winnipeg, Canada. *Med Anthropol* 2019; 38: 311–26. doi:10.1080/01459740.2018.1551390

19 McMichael C, Gifford S. "It is Good to Know Now . . . Before it's Too Late": promoting sexual health literacy amongst resettled young people with refugee backgrounds. *Sex Cult* 2009; 13: 218–236. doi:10.1007/s12119-009-9055-0

20 Australian Government Department of Health. Fourth national sexually transmissible infections strategy 2018-2022. Canberra: Commonwealth of Australia, Department of Health; 2018.

21 Botfield JR, Zwi AB, Rutherford A, *et al.* Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: 'I never got the talk about the birds and the bees'. *Sex Educ* 2018; 18: 705–20. doi:10.1080/14681811.2018.1464905

22 Mengesha ZB, Perz J, Dune T, *et al.* Refugee and migrant women's engagement with sexual and reproductive health care in Australia: a socio-ecological analysis of health care professional perspectives. *PLoS ONE* 2017; 12: e0181421. doi:10.1371/journal.pone.0181421

23 Napier-Raman S, Hossain SZ, Mpofu E, *et al.* Migrant and refugee youth perspectives on sexual and reproductive health and rights in Australia: a systematic review protocol. *Pacific Health Dialog* 2022; 21: 614–21. doi:10.26635/phd.2022.135

24 Veritas Health Innovation. Covidence systematic review software. Melbourne: Veritas Health Innovation; 2022. Available at www.covidence.org.

25 Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Industry Canada: Canadian Intellectual Property Office; 2018.

26 Pluye P, Gagnon M-P, Griffiths F, *et al.* A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed methods primary studies in Mixed Studies Reviews. *Int J Nurs Stud* 2009; 46: 529–46. doi:10.1016/j.ijnurstu.2009.01.009

27 Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol* 2008; 8: 45. doi:10.1186/1471-2288-8-45

28 QSR International Pty Ltd. NVivo; 2020 (Released in March 2020). Available at https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

29 Pluye P, Hong QN. Combining the power of stories and the power of numbers: mixed methods research and mixed studies reviews. *Annu Rev Public Health* 2014; 35: 29–45. doi:10.1146/annurev-publhealth-032013-182440

30 Sandelowski M. Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed-method studies. *Res Nurs Health* 2000; 23: 246–55. doi:10.1002/1098-240X(200006)23:3<246::AID-NUR9>3.0.CO;2-H

31 Poljski C, Quiazon R, Tran C. Ensuring rights: improving access to sexual and reproductive health services for female international students in Australia. *J Int Stud* 2014; 4: 150–63. doi:10.32674/jis.v4i2.475

32 Meldrum RM, Liamputtong P, Wollersheim D. Sexual health knowledge and needs: young muslim women in Melbourne, Australia. *Int J Health Serv* 2016; 46: 124–40. doi:10.1177/0020731415615313

33 Wray A, Ussher JM, Perz J. Constructions and experiences of sexual health among young, heterosexual, unmarried Muslim women immigrants in Australia. *Cult Health Sex* 2014; 16: 76–89. doi:10.1080/13691058.2013.833651

34 Botfield JR, Newman CE, Bateson D, *et al.* Young migrant and refugee people's views on unintended pregnancy and abortion in Sydney. *Health Sociol Rev* 2020; 29: 195–210. doi:10.1080/14461242.2020.1764857

35 Botfield JR, Newman CE, Kang M, *et al.* Talking to migrant and refugee young people about sexual health in general practice. *Aust J Gen Pract* 2018; 47: 564–9. doi:10.31128/AJGP-02-18-4508

36 Manderson L, Kelaher M, Woelz-Stirling N, *et al.* Sex, contraception and contradiction among young Filipinas in Australia. *Cult Health Sex* 2002; 4: 381–91. doi:10.1080/13691050210000041034

37 Chung D, Fisher C, Zufferey C, *etal.* Young women from African backgrounds and sexual violence. Criminology Research Advisory Council; 2018.

38 Parker A, Harris P, Haire B. International students' views on sexual health: a qualitative study at an Australian university. *Sex Health* 2020; 17: 231–8. doi:10.1071/SH19209

39 Okeke SR. How perceived Australian sexual norms shape sexual practices of East Asian and sub-Saharan African international students in Sydney. *BMC Public Health* 2021; 21: 395. doi:10.1186/s12889-021-10445-0

40 Ngum Chi Watts MC, McMichael C, Liamputtong P. Factors influencing contraception awareness and use: the experiences of young African Australian mothers. *J Refug Stud* 2015; 28: 368–87. doi:10.1093/jrs/feu040

41 McMichael C. Unplanned but not unwanted? Teen pregnancy and parenthood among young people with refugee backgrounds. *J Youth Stud* 2013; 16: 663–78. doi:10.1080/13676261.2012.744813

42 Ngum Chi Watts MC, Liamputtong P, McMichael C. Early motherhood: a qualitative study exploring the experiences of African Australian teenage mothers in greater Melbourne, Australia. *BMC Public Health* 2015; 15: 873. doi:10.1186/s12889-015-2215-2

43 Asquith NL, Collison A, Lewi L, *et al.* Home is where our story begins: CALD LGBTIQ+ people's relationships to family. *Curr Issues Crim Justice* 2019; 31: 311–32. doi:10.1080/10345329.2019.1642837

44 Pallotta-Chiarolli M. Supporting same-sex attracted and gender diverse young people of multicultural and multifaith backgrounds: executive summary and full research report. Melbourne: Equity Branch of the Department of Premier and Cabinet; 2016.

45 Burchard A, Laurence C, Stocks N. Female international students and sexual health - a qualitative study into knowledge, beliefs and attitudes. *Aust Fam Physician* 2011; 40: 817–20.

46 Chung D, Fisher C, Zufferey C, et al. Preventing sexual violence against young women from African backgrounds. Trends and Issues in Crime and Criminal Justice, no. 540. Canberra: Australian Institute of Criminology; 2018: 1–13. Available at https://www.aic.gov.au/publications/tandi/tandi540

47 Rawson HA, Liamputtong P. Influence of traditional Vietnamese culture on the utilisation of mainstream health services for sexual health issues by second-generation Vietnamese Australian young women. *Sex Health* 2009; 6: 75–81. doi:10.1071/SH08040

48 Rawson HA, Liamputtong P. Culture and sex education: the acquisition of sexual knowledge for a group of Vietnamese Australian young women. *Ethn Health* 2010; 15: 343–64. doi:10.1080/13557851003728264

49 Dean J, Mitchell M, Stewart D, *et al.* Intergenerational variation in sexual health attitudes and beliefs among Sudanese refugee communities in Australia. *Cult Health Sex* 2017; 19: 17–31. doi:10.1080/13691058.2016.1184316

50 Rogers C, Earnest J. Sexual and reproductive health communication among Sudanese and Eritrean women: an exploratory study from Brisbane, Australia. *Cult Health Sex* 2015; 17(2): 223–36. doi:10.1080/13691058.2014.967302

51 Rogers C, Earnest J. A cross-generational study of contraception and reproductive health among Sudanese and Eritrean women in Brisbane, Australia. *Health Care Women Int* 2014; 35: 334–56. doi:10.1080/07399332.2013.857322

52 Dean J, Mitchell M, Stewart D, *et al.* Sexual health knowledge and behaviour of young Sudanese Queenslanders: a cross-sectional study. *Sex Health* 2017; 14: 254–60. doi:10.1071/SH16171

53 Ngum Chi Watts MC, Liamputtong P, Carolan M. Contraception knowledge and attitudes: truths and myths among African Australian teenage mothers in Greater Melbourne, Australia. *J Clin Nurs* 2014; 23: 2131–41. doi:10.1111/jocn.12335

54 Mulholland M, Robinson K, Fisher C, *et al.* Parent-child communication, sexuality and intergenerational conflict in multicultural and multifaith communities. *Sex Educ* 2021; 21: 44–58. doi:10.1080/14681811.2020.1732336

55 Ussher JM, Perz J, Metusela C, *et al.* Negotiating discourses of shame, secrecy, and silence: migrant and refugee women's experiences of sexual embodiment. *Arch Sex Behav* 2017; 46: 1901–21. doi:10.1007/s10508-016-0898-9

56 Fisher CM, Waling A, Kerr L, *etal.* 6th National survey of Australian secondary students and sexual health 2018. Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University; 2019.

57 Matich P, Harvey C, Page P, *et al.* Young people's perceptions of sexual and reproductive health in regional and rural Queensland: capturing the views of adolescents through reference groups and a user-friendly electronic survey. *Sex Health* 2015; 12: 231–9. doi:10.1071/SH13131

58 Bell S, Aggleton P. Social influences on young people's sexual health in Uganda. *Health Educ* 2013; 113: 102–14. doi:10.1108/09654281311298795

59 Godia PM, Olenja JM, Hofman JJ, *et al.* Young people's perception of sexual and reproductive health services in Kenya. *BMC Health Serv Res* 2014; 14: 172. doi:10.1186/1472-6963-14-172

60 Santhya KG, Jejeebhoy SJ. Sexual and reproductive health and rights of adolescent girls: evidence from low- and middle-income countries. *Glob Public Health* 2015; 10: 189–221. doi:10.1080/17441692.2014.986169

61 Thongmixay S, Essink DR, Greeuw Td, *et al.* Perceived barriers in accessing sexual and reproductive health services for youth in Lao People's Democratic Republic. *PLoS ONE* 2019; 14: e0218296. doi:10.1371/journal.pone.0218296

62 Le TM, Yu N. Sexual and reproductive health challenges facing minority ethnic girls in Vietnam: a photovoice study. *Cult Health Sex* 2021; 23: 1015–33. doi:10.1080/13691058.2020.1753813

63 El Kazdouh H, El-Ammari A, Bouftini S, *et al.* Perceptions and intervention preferences of Moroccan adolescents, parents, and teachers regarding risks and protective factors for risky sexual behaviors leading to sexually transmitted infections in adolescents: qualitative findings. *Reprod Health* 2019; 16: 138. doi:10.1186/s12978-019-0801-y

64 O'Connor M, Rawstorne P, Iniakwala D, *et al.* Fijian adolescent emotional well-being and sexual and reproductive health-seeking behaviours. *Sex Res Soc Policy* 2019; 16: 373–84. doi:10.1007/s13178-018-0360-y

65 Parker CM, Garcia J, Philbin MM, *et al.* Social risk, stigma and space: key concepts for understanding HIV vulnerability among black men who have sex with men in New York City. *Cult Health Sex* 2017; 19: 323–37. doi:10.1080/13691058.2016.1216604

66 Mitchell E, Bennett LR. Young women's perceptions and experiences of sexual risk in Suva, Fiji. *Cult Health Sex* 2020; 22: 504–19. doi:10.1080/13691058.2019.1614669

67 Kok MC, van Eldik Z, Kakal T, *et al.* Being dragged into adulthood? Young people's agency concerning sex, relationships and marriage in Malawi, Mozambique and Zambia. *Cult Health Sex* 2022; 24: 767–81. doi:10.1080/13691058.2021.1881618

68 Banerjee SK, Andersen KL, Warvadekar J, *et al.* How prepared are young, rural women in India to address their sexual and reproductive health needs? A cross-sectional assessment of youth in Jharkhand. *Reprod Health* 2015; 12: 97. doi:10.1186/s12978-015-0086-8

69 Wali N, Renzaho AMN. "Our riches are our family", the changing family dynamics & social capital for new migrant families in Australia. *PLoS ONE* 2018; 13: e0209421. doi:10.1371/journal.pone.0209421

70 Baroudi M, Hurtig A-K, Goicolea I, *et al.* Young migrants' sexual rights in Sweden: a cross-sectional study. *BMC Public Health* 2021; 21: 1618. doi:10.1186/s12889-021-11672-1

71 Patton GC, Darmstadt GL, Petroni S, *et al.* A gender lens on the health and well-being of young males. *J Adolesc Health* 2018; 62: S6–8. doi:10.1016/j.jadohealth.2017.06.020

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Summary

The publication above examines how MRY construct and experience SRH in Australia, using the socioecological model (see Chapter 3) as an analytical frame. MRY constructions of SRH extend beyond purely biomedical models, including social and emotional safety in constructions of sexual and reproductive risk and wellbeing. The review also highlights the prevalence of silence and secrecy around SRH in migrant and refugee communities. Finally, the limited engagement with rights in current literature reveals the significance of the present rights-based research.

The second systematic literature review included in this thesis narrows the focus to a specific SRH right: the right to choose if and when to have children, realised through abortion access. However, the narrowing of this focus required population and location parameters to be broadened to account for the lack of research on Australian MRY abortion. The following publication thus provides a deeper analysis of how a specific SRH right is articulated and understood, while expanding the focus to migrants and refugees of all ages globally.

Publication 2: Migrant and refugees' experiences of and perspectives on abortion rights

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2024). Abortion Experiences and Perspectives Amongst Migrants and Refugees: A Systematic Review. *International journal of environmental research and public health*, *21*(3), 312. https://www.mdpi.com/1660-4601/21/3/312

International Journal of
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Review

Abortion Experiences and Perspectives Amongst Migrants and Refugees: A Systematic Review

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Abstract: (1) Background: Access to abortion care is a crucial reproductive health right. Refugees and migrants may have restricted access to and utilisation of abortion care, associated with histories of displacement, precarious migrant and citizenship status and difficulty navigating unfamiliar host country healthcare systems. However, there is limited evidence on the abortion experiences and perspectives of refugees and migrants. Moreover, existing research has not been synthesised to identify trends informing sexual and reproductive care access among this marginalised population. This systematic review aimed to address this gap in the cumulative evidence on refugee and migrant experiences and perspectives of abortion in host countries. (2) Methods: Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, we searched the following databases for studies on refugee and migrant abortion attitudes, decision making and experiences: Embase, Medline, CINAHL, Web of Science, Sociological Abstracts, and Scopus. We also searched the grey literature on the same. Inclusion criteria specified qualitative studies involving migrant and/or refugee populations, examining their abortion experiences, attitudes or perspectives, written in English, published between January 2000 and December 2022. Two reviewers screened titles, abstracts and full-text articles, resulting in 27 articles included in the review, following consensus checks by two co-authors. The included studies were assessed for methodological quality using the Critical Appraisal Skills Programme tool. (3) Results: Abortion was stigmatised and generally considered impermissible and undesirable. However, participants discussed socioculturally determined 'exceptions' to this, positing circumstances where abortion was acceptable. There were striking differences in experiences between participants in higher-income settings and those in lower- and middle-income settings. Difficulties accessing care were ubiquitous but were heightened in lower-resource settings and among participants with precarious citizenship, financial and legal statuses. (4) Conclusions: The findings highlight the need for an international convention to guide policy and programming that acknowledges the specific abortion requirements of migrant and refugee communities, with attention to their financial, legal and social precarity.

Keywords: abortion; migrants; refugees; reproductive rights; reproductive health

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Correction Statement: This article has been republished with a minor change. The change does not affect the scientific content of the article and further details are available within the backmatter of the website version of this article.

1. Introduction

Access to abortion care is a reproductive right, linked to rights to health, privacy and bodily autonomy and freedom from cruel, inhumane, and degrading treatment. Comprehensive abortion care is essential to reproductive autonomy: the ability to control whether, when and how many children one has. Annually, between 2015 and 2019, there were an estimated 121 million unintended pregnancies globally, 61 per cent resulting in abortion [1].

Induced abortion—through medication or surgical procedures [2]—is a low-risk, simple intervention when performed safely [3]. Abortion is sought globally, irrespective of legal and structural restrictions. It remains, however, highly contested, stigmatised, and censored. Despite universal need, abortion experiences and understandings are not universal. Abortion trajectories involve the interrelationship between individuals' abortion-specific experiences, individual context, and the regional, national and international context [4]. Intersecting socioecological factors including gender, race, class, immigration status, legal structures, and health access shape how individuals actualise their reproductive rights [5].

The abortion attitudes and experiences of migrants and refugees are likely influenced by factors that can be described using the socioecological model (SEM). These include individual-level factors such as education and beliefs, interpersonal-level factors of family and community networks, institutional-level factors relating to healthcare services, and societal-level factors of abortion legislation and migration policy. Migrants and refugees experience barriers to healthcare, particularly surrounding sexual and reproductive health (SRH) [6–9]. Displacement and migration can interrupt SRH education and care access. Moreover, in many migrant and refugee communities, taboos and stigma surround SRH [6,8,10], especially abortion [11,12]. Nevertheless, compared to women born in Australia and New Zealand, the United States, and Northern and Western Europe, immigrant women born in all world regions except Southern Africa were 2–5 times more likely to have an induced abortion [13]. Low SRH and contraceptive knowledge have been noted among migrant and refugee communities [7], which may increase the likelihood of unintended pregnancy and abortion. The SEM provides a framework for examining how abortion experiences, attitudes and decision-making among migrants and refugees are influenced by multiple factors across individual, interpersonal, institutional, and societal levels.

This review focuses on induced abortion. While past reviews have synthesised the decision-making, attitudes and experiences of abortion-seekers generally [14–16], research on the experiences and perspectives of migrants and refugees is not yet aggregated. Given the focus on experiences and perspectives, we considered qualitative research methods most appropriate. As such, this systematic review aims to synthesise qualitative research related to the induced abortion experiences and perspectives of migrants and refugees.

2. Materials and Methods

2.1. Search

A systematic review of qualitative literature was conducted in line with PRISMA guidelines (Figure 1). The review protocol was registered on PROSPERO: CRD42023480376. Key subject areas were searched across six databases (Embase, Medline, CINAHL, Web of Science, Sociological Abstracts, Scopus) in addition to Google Scholar searching, hand and grey-literature searches. Searches were limited to sources from the year 2000 onwards.

The original purpose of this review was to examine migrant and refugee youth perspectives. However, initial searches focusing on migrant and refugee youth yielded insufficient results, leading to revised scope and search terms. Thus, searches were conducted around two key subject areas: migrants and/or refugees, and abortion. Search results were uploaded to EndNote 21 and duplicates removed [17].

2.2. Study Selection

Due to broad search terms, the initial database search yielded large numbers (n = 4520) (Figure 1). After duplicates were removed, titles and abstracts were screened for inclusion by two reviewers. Discrepancies between reviewers were resolved through discussion. Post initial peer review, an additional study was added.

During initial title and abstract screening, studies that focused on sexual and reproductive health but did not necessarily mention abortion in titles or abstracts were included to prevent premature exclusion of potentially valuable studies. Non-English-language publications were excluded. The inclusion criteria and search strategy are outlined in Table 1. Studies of second-generation migrants were included in the selection criteria as they experience similar barriers to care and influences of social networks to first-generation migrants.

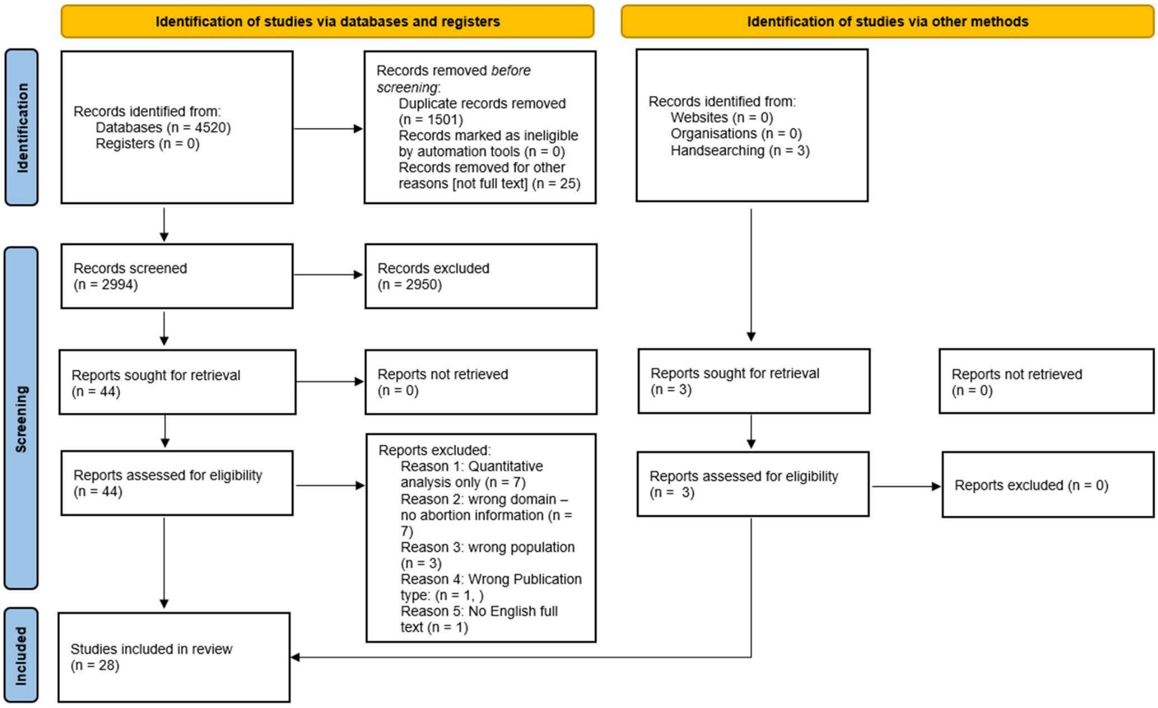


Figure 2b.1

Figure 1. PRISMA flow diagram of search and study inclusion process [18].

Table 2b.1

Table 1. Inclusion criteria and search terms.

Parameters	Inclusion	Exclusion	Key Terms/Strategy
Location	Global		
Language	English	Non-English	English only selected
Date	Published January 2000–December 2022	Published before 2000	Date restrictions: 1 January 2000–
Population	Studies including migrant and/or refugee populations; second-generation migrants; international students	Predominantly non-migrant/refugee study populations; internally displaced people; domestic migrants; service providers	Migrant* OR refugee* OR immigrant* OR 'asylum seeker*' OR 'ethnic minorit*' AND
Outcome/domain	Studies examining migrant and refugee abortion experiences, attitudes and/or perspectives; broader studies examining migrant and refugee SRH attitudes and/or experiences that include data on abortion	Studies examining non-migrant perspectives; Studies not examining participant perspectives or experiences	Abortion OR termination OR 'termination of pregnancy' OR 'induced abortion' OR 'unplanned pregnancy'
Study design	Primary qualitative studies; grey literature	Quantitative studies; Abstract-only studies, reviews, opinion pieces	

* Boolean search terms (asterisk acts as truncator).

2.3. *Quality Assessment*

Included studies were independently assessed for methodological quality using the Critical Appraisal Skills Programme tool (CASP) Qualitative Studies Checklist [19]. A second reviewer verified quality assessment scoring; any disagreements were resolved through discussion. The CASP tool offers a simple, systematic means for evaluating a study's validity and quality. The tool consists of ten questions assessing methodological rigour, relevance, and credibility of findings for which reviewers answer 'yes', 'can't tell' or 'no'. A quality score out of ten was calculated based on answers to each question, with one point awarded for 'yes' and none for 'can't tell' or 'no' responses (Table 2).

Table 2b.2

Table 2. Study characteristics.

Author (Year)	Data Collection Metho	Setting	Setting Income Level	Abortion Legality *	Outcome/Domain	Relevant Sample Size *	Participant Residency/ Migration Status	Population Background	CASP Score
Ahmed (2008) [20]	Interviews; self-completion questionnaire	United Kingdom	High income	Permitted on broad social or economic grounds *	Decision making regarding prenatal testing and termination for genetic conditions between Pakistani and white European mothers	10 (19 in total study)	Migrants: first generation (*n* = 5), second generation (*n* = 5)	Pakistani	8
Arnot (2017) [21]	Interviews	Thailand	Middle income	Restricted at time of publishing (to preserve health/social economic grounds); currently permitted on request	Experiences with safe abortion referral program	14	Cross-border **, refugees, migrants	Burmese	9
Asnong (2018) [22]	Interviews; focus group discussions	Mae La Refugee Camp, Mae Ker Thai clinic: Thailand-Burma border	Middle income	Restricted at time of publishing; currently permitted on request	Refugee and migrant adolescents' perceptions and experiences of pregnancy	20 female (pregnant adolescents); 20 male (husbands of pregnant adolescents, adolescent boys, non-pregnant adolescent girls)	Refugees, migrants	Burmese	8
Belton and Whitaker (2007) [23]	Ethnography: interviews; focus group discussions; free-list activities	Tak Province, Thailand	Middle income	Restricted at time of publishing; currently permitted on request	Barriers to contraceptive access; motivation and means for termination	43 inpatients with post-abortion complications, 10 male partners, 10 health workers, 20 community members	Migrants (women post-abortion, partners, community members and lay midwives)	Burmese	8
Belton (2007) [24]	Ethnography: interviews; focus group discussions; free-list activities	Tak Province, Thailand	Middle income	Restricted at time of publishing; currently permitted on request	Barriers in contraceptive access; traditional techniques to terminate pregnancy	43 inpatients with post-abortion complications, 10 male partners, 10 health workers, 20 community members	Migrants	Burmese	8
Botfield (2020) [11]	Interviews	Sydney, Australia	High income	Permitted on request	Migrant and refugee youth experiences and perspectives on unintended pregnancy and abortion	27	Refugees, migrants	Mixed: East and Southeast Asian, African, South American, Mediterranean, Middle-Eastern	9
Böttcher (2019) [25]	Focus group discussions	Gaza strip	Middle income	Permitted to save the pregnant person's life	Causes and consequences of unintended pregnancy	21	Refugees	Palestinian	8
Deeb-Sossa (2014) [26]	Ethnography: participant observation; interviews	North Carolina, United States	High income	Legal at time of publishing; 12-week restriction from July 2023	Barriers to abortion access	12	Migrants	Mexican	9
Dhar (2017) [27]	Interviews	Philadelphia, Pennsylvania, United States	High income	On request at time of publishing; currently accessible, with restrictions and no protections	Sexual and reproductive health attitudes and beliefs of unmarried, young Bhutanese women	14	Refugees	Bhutanese	8

Table 2. *Cont.*

Author (Year)	Data Collection Metho	Setting	Setting Income Level	Abortion Legality *	Outcome/Domain	Relevant Sample Size *	Participant Residency/ Migration Status	Population Background	CASP Score
Fordyce (2012) [28]	Interviews; ethnographic	South Florida, United States	High income	On request at time of publishing; currently protected, with restrictions	Family planning; unintended pregnancy	27	Migrants	Haitian	8
Gedeon (2016) [29]	Interviews	Tak Province, Thailand	Middle income	Restricted at time of publishing; currently permitted on request, gestational limit 20 weeks	Barriers to reproductive healthcare; sexual and reproductive decision making	31	Refugees, migrants	Burmese	9
Gitsels-van der Wal (2014) [30]	Interviews	The Netherlands	High income	Permitted on request	Role of religion (Islam) on decision making regarding prenatal anomaly screening and termination	10	Migrants: first generation ($n = 6$), second generation ($n = 4$)	Turkish	9
Gitsels-van der Wal (2015) [31]	Interviews	The Netherlands	High income	Permitted on request	Role of religion (Islam) on decision making regarding prenatal anomaly screening and termination	12	Migrants: first generation ($n = 6$), second generation ($n = 6$)	Moroccan	8
Hegde (2012) [32]	Ethnography: interviews, semi-structured questionnaires	Thai-Cambodia border	Middle income	Restricted at time of publishing; Currently permitted on request, gestational limit 20 weeks	attitudes and practices towards unsafe abortions; abortion as contraceptive method	10 interviewees; 15 questionnaire respondents (30 questionnaire participants in total)	Migrants/cross-border **	Cambodian	7
Hounnaklang (2021) [33]	Observation, field notes, in-depth interviews	Surat Thani province, Thailand	Middle income	Permitted on request, gestational limit 20 week	Sexual and reproductive health attitudes and beliefs; practices	22	Migrants	Myanmar women	8
Khin (2021) [34]	Interviews	Japan	High income	Permitted on broad social or economic grounds	Access to reproductive healthcare	17	Mixed residency status, including dependents, work visas, permanent/long-term residents	Myanmar women	8
Liamputtong (2003) [35]	In-depth interviews, participant observation	Melbourne, Australia	High income	Permitted on request; available but criminal at time of publishing; decriminalised 2008	Cultural practices and beliefs regarding abortion	27	Refugees, residing in Australia for 1–10+ years; spent minimum 1 year in Thai refugee camp	Hmong women	8
Nara (2019) [36]	Interviews; focus group discussions (FGDs)	Kampala and the Nakivale Refugee Settlement, Uganda	Low income	Permitted to save the pregnant person's life	Reproductive healthcare; contraception and abortion/post-abortion services	21 interviewees; 36 in FGDs	Refugees	Congolese women	9
Ostrach (2020) [37]	Interviews; rapid ethnographic assessment	Catalunya, Spain	High income	Permitted on request	Experiences with legal, publicly funded abortion	13 (28 total participants)	Migrants	Not provided	9
Puri (2011) [38]	Interviews	California, New York, New Jersey, The United States	High income	Permitted on request at time of publishing; currently protected	Sex-selective abortion practices and experiences	65	Migrants	Indian women; Sikh (65%), Hindu (22%), (12%) Muslim (1%)	7

Table 2. *Cont.*

Author (Year)	Data Collection Metho	Setting	Setting Income Level	Abortion Legality *	Outcome/Domain	Relevant Sample Size *	Participant Residency/ Migration Status	Population Background	CASP Score
Remennick (2001) [39]	Interviews	Israel	High income	Permitted preserve health	Abortion experiences of native Israelis and recent Russian immigrants	25 (48 total participants)	Recent migrants	Russian women (former Soviet Union)	9
Rocha (2013) [40]	Focus group discussions and demographic questionnaire	Portugal	High income	Permitted on request	Sexual and reproductive health; maternity, pregnancy, induced abortion	35	Migrants	Brazil and Portuguese-speaking African countries (Lusophone): 15 Brazilians, 20 Africans	7
Royer (2020) [41]	Focus group discussions	The United States	High income	Permitted on request at time of publishing; currently dependent on state law	Family planning knowledge, attitudes, and practices	66	Refugees	Somali and Congolese women	10
Schoevers (2010) [42]	Semi-structured interviews	The Netherlands	High income	Permitted on request	Sexual and reproductive health problems and needs	100	Illegal immigrants	Mixed: Eastern Europe, Yugoslavia, former USSR; Middle East and North Africa; China, Mongolia; South America; Philippines; Surinam	8
Tousaw (2017) [43]	Interviews	Mae Sot, Thailand	Middle income	Restricted at time of publishing; currently permitted on request, gestational limit 20 weeks	Experiences of and perceptions on Safe Abortion Referral Program (SARP)	22	Documented ($n = 10$) and undocumented ($n = 12$) migrants	Burmese	9
Tousaw (2018) [44]	Interviews	Thailand-Burma border	Middle income	Restricted at time of publishing; currently permitted on request, gestational limit 20 weeks	Experiences of and perspectives on community-based misoprostol program	16	Cross-border, refugees, migrants	Burmese	9
Tucker (2015) [45]	Interviews	The United States	High income	Permitted on request at time of publishing; currently dependent on state law	Motivations for sex-selective abortions	20	Migrants	Indian	8
Udmuangpia (2017) [46]	Focus group discussions	Sweden	High income	Permitted on request	Perspectives on sexual behaviour and pregnancy	18	Adolescent migrants	Thai	9

* Colour coding follows the Center for Reproductive Rights classification scheme. Abortion legality is categorised as per the Center for Reproductive Rights' five levels of legal permissibility, from least to most restrictive: On request, broad social or economic grounds, to preserve health, to save pregnant person's life, prohibited altogether [47]; ** Cross-border migrants refer to those who migrate temporarily for work across borders; participants are not necessarily living as migrants at the time of the study but spend substantial time moving across borders.

2.4. Data Extraction and Analysis

Characteristics were extracted from all included studies (Table 1). Thematic synthesis methods were used to analyse findings [48]. Full-text studies were uploaded into QSR's NVivo, version 12 software (Lumivero, Burlington, NJ, USA) for analysis [49]. Thematic synthesis was conducted in three stages, beginning with line-by-line coding of all text under the 'findings' or 'results' sections of studies. Descriptive themes were then developed by grouping codes based on similarity. Finally, descriptive themes were developed into analytical themes. Following initial data extraction and analysis by one reviewer, the findings were reviewed and verified by the review team. A model of the key findings, mapped onto the levels of the SEM, is presented alongside the results.

A Note on Gender

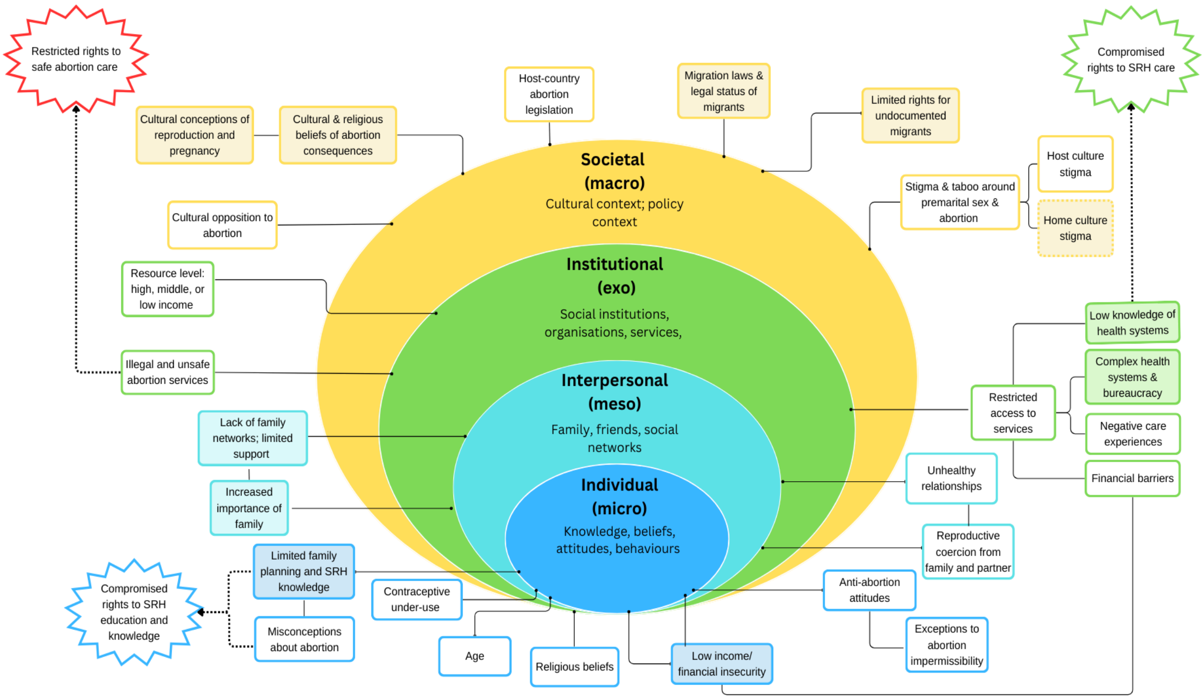
While we acknowledge that abortion-seekers may not identify as female, all studies in this review identified participants who underwent abortion as female. The results and discussion of this paper will thus refer to migrant and refugee women when referring to participants who had abortions.

3. Results

3.1. Participants' Characteristics

A total of 28 studies were included in the final review. Study characteristics and quality scores are detailed in Table 2. Most studies ($n = 17$) were conducted in high-income settings; ten were in middle-income settings and one was in a low-income setting [50]. Where possible, details on participants' migrant status have been noted (Table 2), but these were not provided in all studies. Fourteen studies identified participants as 'migrants' (three of which included first- and second-generation migrants, though study results did not distinguish between these groups); five studies focused on 'refugees'; seven studies included an unspecified combination of migrants/refugees/cross-border migrants; one study included documented and undocumented migrants and another illegal immigrants. The ethnographic nature of some studies meant detail on sample sizes and full participant demographics were absent. A significant proportion of studies ($n = 9$) were conducted along the Thai border and in the United States ($n = 6$). Studies included a range of participant backgrounds, though participant groups from Asia ($n = 14$), specifically Burma/Myanmar ($n = 9$), were most represented. As per the Center for Reproductive Rights classification system [47], fifteen studies were conducted in settings where abortion laws were most permissive, being in Category 5, "permitted on request". Two studies were conducted in Category 4 settings, where abortion is legal on "broad social or economic grounds". Nine studies were in Category 3 settings, where abortion is legal only "to preserve health", and two were conducted in a Category 2 setting, where abortion is legal only to "save a woman's life". No studies were from Category 1 settings, where abortion is "prohibited altogether".

Not all studies focused specifically on abortion, while some focused on specific types, methods and reasons for abortion. Termination of pregnancy for genetic anomalies was the focus of three studies [20,30,31], and sex-selective abortion the focus of two [38,45]. While a few studies mentioned abortion-seekers' SRH rights [24,29,41], only Deeb-Sossa and Billings included an extensive examination of rights, using a reproductive justice lens [26]. No studies explicitly used a rights framework to examine migrant and refugee abortion experiences, attitudes and/or perspectives. The following section presents results under themes identified through the data analysis. Figure 2 summarises key findings and maps them onto the SEM, illustrating how findings span across socioecological levels and how these relate to key SRH rights.



*Shaded squares represent factors that are particularly significant or unique to migrants and refugees

Figure 2b.2

Figure 2. Key findings across socioecological levels and corresponding sexual and reproductive rights.

3.2. Attitudes, Perceptions and Beliefs towards Abortion and Abortion Permissibility

3.2.1. Attitudes and Perceptions

Attitudes towards abortion among migrants and refugees were diverse and nuanced, often holding contradictions between anti-abortion moral stances and lived realities. Perspectives ranged from strongly anti-abortion [28], to pro-choice, though only in one study did participants firmly hold pro-abortion stances [39]. Regardless of whether participants were themselves anti-abortion, sociocultural stigma and taboo were mentioned in all studies. In most studies, there were participants who believed abortion was wrong, immoral or impermissible [11,20,22,23,28,30,31,33–35,39–41,44,46], even those who themselves accessed abortion care.

Participants from diverse backgrounds and settlement locations viewed abortion negatively [28,31,34,40], describing it as ‘very ugly’ [40] and a sign of a ‘bad heart’ [35]. Some participants perceived abortion as an unforgivable transgression, wrong to even consider [28,41]. As one Somali woman asserted, ‘we don’t even know anything about abortion’ [41]. Frequently, the strongest anti-abortion stances were tied to religiosity, with termination considered a ‘sin’ in multiple studies [28,33,40,41,46]. Imagery of murder or killing was used to describe abortion [31,35,40,46]. In some cases, foetal agency was asserted, with conception considered an indication that a child wants to live [35]. Participants asserted future punishment would befall those who terminated [22,30,35,40], ranging from future sterility or sickness for the abortion-seeker, illness in future children, to indeterminate punishment by God. In one study, participants believed abortion-seekers would be punished in their next life by having ‘to eat back the things she aborted in a previous life’ [22]. Foetal agency was again invoked, with claims the aborted baby would inflict punishment upon the person who conceived them [35]. Despite broad negative perceptions, it was admitted that abortion was common but never discussed [28,38–40].

3.2.2. Knowledge and Beliefs Surrounding Abortion and Family Planning

Participants held a range of knowledge and beliefs surrounding abortion and broader SRH, often informed by cultural, social and contextual factors. Low contraceptive awareness and limited SRH knowledge were pervasive [22,27–29,32–34,40,41,43–46]; participants themselves attributed unplanned pregnancy and abortion in their communities to these deficits [28,40,43,46] (see Figure 2). Religious participants believed family 'planning' was a fallacy: Muslim Somali, Moroccan and Turkish women, and Christian and Catholic Haitians and Lusophone African women asserted pregnancy should not be controlled [28,30,31,40,41]. In one study, the emergency contraceptive pill was considered abortion and thus impermissible [40]. For some, abortion was considered contraception [24,32]: 'abortion is the contraceptive choice and birth control method we can use' [32].

Some migrants and refugees held culturally informed understandings of pregnancy and abortion. Burmese women believed pregnancy commences when the foetus begins moving like a 'jumping shrimp' [23]. Pregnancy termination before this stage was considered a means of treating amenorrhea rather than actual abortion. There were different understandings of when abortion could be performed. Some believed abortions could be performed at any stage before birth [32], while others asserted that abortion could only be performed in the first trimester [35], the first 40 days [31], or before 5 months' gestation [35]. There were also beliefs that multiple abortions—even safe, clinically provided medical abortions—would 'damage the womb' [44]. While studies reported on misconceptions around contraceptives and cultural conceptions of reproduction, there was little on what participants knew about formal abortion procedures.

3.2.3. Abortion Permissibility

Abortion permissibility varied, particularly as participants navigated tensions between anti-abortion values and the necessity of abortion in their lived realities. Generally, abortion was presented as generally impermissible, but with circumstantial exceptions—both by abortion-seekers and broader communities. Burmese women seeking abortion care described abortion as for 'those who do not have a beautiful life' [44]: acceptable if parent(s) cannot care for children [33,43]. In studies examining foetal anomaly testing and termination, participants believed certain disabilities and genetic conditions made abortion permissible [20,30,31]. Some participants, however, asserted 'a child has a right to live, no matter what condition' [30,31], reframing disability as a 'test' from God. Abortion to save the mother's life was mentioned in three studies [30,31,35]. Muslim women in Gitsel-van der Wal et al.'s studies asserted Islam permitted abortion in rape cases [30,31]. In Liamputtong's study, Hmong women had cultural beliefs about abortion as a right earned by women of a certain age—acceptable for older women who have already had 'enough' children [35]. Participants also identified time frames in which an abortion was permissible [26,31], Mexican and Burmese women similarly viewing the foetus in early pregnancy as 'no baby', only 'blood' and not yet 'human' [23,26]. Thus, despite stigma in all studies, very few migrants and refugees considered abortion always, irrefutably wrong.

3.3. Decision Making

3.3.1. Financial/Economic Factors

While migrants' and refugees' reasons for seeking abortion were diverse, socioeconomic strain and poverty consistently shaped decisions [23,24,33,39,40,42–46] (Figure 2). Financial burdens of childrearing and pregnancy costs were insurmountable, especially when participants already had children. Under- and unemployment were common. Participants endured precarious, often unregulated work conditions that were not conducive to childrearing, or had to work constantly to survive, leaving no time for childcare [21,39,42–44]. This was exacerbated for illegal or undocumented migrants, who were not entitled to governmental support or worker's rights [23,24,42]. Participants described employers coercing them into undergoing abortion [23,24,32,43], threatening deportation, denying work permits [23,24], and firing them for becoming pregnant [40]. Conversely, in Royer et al.'s study, Congolese refugees described children as an 'investment' rather than a financial burden, citing the potential future benefit of a child as a reason to not abort [41].

For many participants, the financial strain of childrearing was compounded by the precarity of their lived reality. The loss of social networks brought about by migration was a crucial factor contributing to decision making. Participants were unable to afford childcare in host countries and lacked the social and familial networks that would typically provide parental support and care [28,40,41]. In one study, social support workers forced undocumented migrants to undergo abortion, with women's illegal status leaving them unable to refuse such demands [42].

Life stage also influenced abortion decision making. In studies of young participants, age and lack of preparedness and maturity were frequently mentioned as reasons to seek abortion [11,22,46]. This was also the case for younger participants in some studies with broader participant age groups [21,26].

3.3.2. Sociocultural Factors

Decision making was also influenced by sociocultural factors and social pressure. Values of chastity and stigma around premarital sex were mentioned in multiple stud- ies [11,29,32,35,46]. Despite abortion being similarly stigmatised in cultures and communi- ties that held these values, abortion allowed participants to escape the social consequences of nonmarital pregnancy [11,27,46]. Abortion was a way to avoid ostracism and stigma brought by premarital pregnancy, and as such was often encouraged by families to save face [11,27,46]. Some participants described family pressure to abort [11,23,27,38,45,46], or they ended pregnancies to avoid disappointing families or to continue fulfilling fa- milial caregiving responsibilities [11,26]. Others asserted that relatives would pressure them not to abort [46]. Some migrant and refugee women were pressured into abortion by partners, who were frequently women's sole financial and social support in their host countries [38,39,42,45]. Moreover, unstable relationships and domestic abuse were key reasons for abortion [21,23,24,39,43]. Indian women in studies of sex-selective abortion, and Palestinian women in Gaza, described being physically and emotionally abused and threatened by husbands and in-laws for having female children, which informed decisions to terminate based on sex [25,38,45]. Sex-selective abortion was also tied to sociocultural gender norms valuing male children as breadwinners over female children [38,45].

3.3.3. Contraceptive Failure and Under-Use

Under-use of contraceptives significantly contributed to unintended pregnancy and, subsequently, abortion decisions. As illustrated in Figure 2, inadequate family planning knowledge was a common reason for contraceptive non-use [22–24,28,29,32,42]. Misconceptions, particularly beliefs that contraceptives cause infertility [22,32,34,42], and stigma associating premarital contraceptive use with prostitution and promiscuity served as barriers to family planning [22,32,33]. Sexual assault, coercion and forced unprotected sex were common reasons for unintended pregnancy resulting in abortion [21,23,24,32,34,41,42]. Many women could not afford regular contraceptives [23,33,34,42] and faced supply limitations, restricted access to services, and risk of deportation and detention when travelling to procure contraceptives [23,29,32–34,42]. This lack of contraceptive options rendered abortion one of the only viable methods for managing fertility.

3.4. Accessing Abortion Care

Access to and experiences with abortion care were influenced by factors including immigration and legal status, employment and socioeconomic circumstances, and the legislature and health systems of host countries. Abortion accessibility varied significantly across studies, particularly access to safe, facility-based care. Studies from high-income countries (HICs) that discussed abortion access focused on the difficulty migrant and refugee participants had in navigating health systems and receiving formal care. Contrastingly, studies in middle- and low-income settings focused on informal and unsafe abortion methods or reported on non-profit programs to mitigate these practices. While participants in high-income countries faced barriers to accessing care, those in middle- and low-income countries (LMICs) frequently had no care to access.

3.4.1. Accessing Formal Care

Across all studies examining access to abortion, migrants and refugees faced barriers. Abortion-seekers navigated complex, unfamiliar health systems with little support. Participants in numerous studies lacked knowledge of how to access care, were unaware of entitlements they had to care, and found the health systems of host countries confusing [21,26,36,37,42,43] (Figure 2). In two studies, participants mistakenly believed abortion was illegal in their host countries [11,28]. Participants in another study believed male partner consent was required for abortion [27]. Accessing services often required multiple steps and appointments [21,26,37]. Due to her age, one 17-year-old Mexican immigrant in North Carolina was required to obtain a judicial bypass to access care, a costly and complicated process requiring the abortion-seeker to be interrogated by a judge [26]. Those who were able to access care often faced delays [21,36,37]. Language barriers and unfamiliarity with host country healthcare and legislature compounded these issues, as did financial strain and precarious legal and citizenship status. No studies mentioned decision making between medication or procedural abortion; women accessed whatever care was available to them, particularly when they were beneficiaries of subsidised, safe abortion programs [21,37,43,44]. There was little discussion of self-managed abortion outside unsafe abortion methods. Formal, self-managed abortion was only specifically examined in one study reporting on a community-based misoprostol distribution program along the Thai border [44].

3.4.2. Healthcare Experiences

For those who accessed healthcare, experiences were varied. Participants in high- and lower-income settings described being shouted at, chastised, treated roughly and misinformed by healthcare workers [21,26,36,37]. One Congolese woman seeking post-abortion care believed nurses intentionally made her wait, bleeding for hours, as punishment for self-inducing her abortion [36]. However, some migrants and refugees reported positive experiences, particularly those who received care from non-profit safe abortion programs established along the Thai–Burma border [21,43,44]. Studies examining the success of such programs found participants had overwhelmingly positive responses and advocated for the expansion of free safe abortion care [21,43,44]. The significance of such programs is further highlighted by the prevalence of unsafe abortion methods found by this review, which almost exclusively occurred in LMICs and under-privileged settings [21,23,24,27].

3.4.3. Barriers to Accessing Care—Financial Barriers

Financial barriers to care were common [11,23,32,39,43,44]. The extent of financial burdens varied, from participants in HICs being unable to afford preferred private care [39] to illegal immigrants in LMICs being forced to perform unsafe self-induced abortions [23,24,32]. Some participants were unable to afford transport to receive care, while others could not afford pregnancy tests [36,43,44]. Additionally, undocumented migrants were barred from formal care and feared being deported, bribed, or arrested by authorities at clinics [21,23,24,26,43,44].

3.4.4. Unregulated Abortions

This review found a vast array of unregulated and 'folk' abortion methods used by migrants and refugees. Informal abortion methods comprised abdominal massage/physical manipulations, ingestion, insertion, or a combination of methods. Pummelling abortions were described by Hmong and Burmese migrants as vigorous, often painful, abdominal massage by lay abortionists [23,24,29,32,35]. Some participants described self-inducement attempts by beating their abdomens [32]. Physical exertion, including lifting weights and long hours of physically taxing labour, was another method commonly used by Southeast Asian migrants [23,24,29,32,35].

A range of abortifacients were described across studies, most commonly herbal concoctions. In some cases, as with Mexican and Hmong participants, these methods were deeply specific, provided by traditional healers to certain women at particular stages of pregnancy [26,35]. Other herbal remedies were less regulated. Burmese participants in Thailand ingested unlabelled herbal concoctions or used the ubiquitous 'multipurpose' 'blood purifier' Kathy Pan [23,24,32]. Participants also ingested large doses of contraceptive pills [32,36,40]. Congolese refugees in Uganda reported practices of ingesting detergent and crushed bottles [36]. Using alcohol as an abortifacient was discussed in three stud- ies [23,24,26,40]. Self-managed abortion using legitimate but illegally obtained abortion medications was common [21,24,26,33], though often, women incorrectly administered pills, receiving no instructions and variable doses.

Stick abortions were the most common insertion abortion method [23,24,26,32,44]. Additionally, flower stems [23], chicken quills [23], bottles [36], blades and sharp instruments [32,36] were inserted into the vagina.

Seeking lay abortionists—untrained midwives, traditional healers and medicine women—was common in multiple studies. In Liamputtong's study of Hmong women, traditional medicine women had extensive training and expertise to perform abortions and would only practice under specific conditions [35]. However, most non-professional abortions lacked regulation [21,23,24,29,43,44]. These forms of unregulated abortion were excruciatingly painful—both during and after the procedure—and potentially fatal [23,24,29,44]. Participants frequently spent all their savings on unsafe abortions [23,24]. In numerous cases, participants who underwent such procedures experienced severe illness and injury—including punctured bowel, uterus or bladders, incessant bleeding, blood clotting, permanent infertility, infection, and fevers [23,24,32,36].

Unregulated abortions often resulted in hospitalisation [23,24,32]. Accessing post-abortion care often meant significant financial burden [21,23] and navigating legal restrictions [36].

Participants underwent unregulated abortions for myriad reasons. In Deeb-Sossa and Liamputtong's studies [26,35], traditional healers and folk methods were a 'first re- sort' [35]. However, for refugee and undocumented migrants across the Thai border and in Uganda, unregulated and self-induced abortions were the only option [32,36,43]. For these participants, lack of documentation and financial stability, as well as macro-level legal restrictions on abortion (Figure 2), made formal procedures financially and legally unviable. Stigma around SRH and abortion also meant the covert nature of unsafe abortion was desirable [32,36]. Social and internalised stigma precluded information and service access and fostered secrecy, which led to unsafe, clandestine abortions.

4. Discussion

This review explicates the abortion attitudes, decision making and experiences of migrants and refugees, finding striking differences in experiences across lower- and higher-income settings. In LMICs, access to general reproductive care, knowledge and necessities, and access to safe abortion, was severely curtailed. This was compounded by precarious citizenship: many women in LMICs lacked legal migrant status, lived in camps and endured unstable, informal labour settings. While abortion is often lauded as a symbol of reproductive freedom, the experiences and attitudes of participants in this review provide a more nuanced depiction of abortion and 'choice'. The intersections of gender, race, migration status, class and precarity make discourses of 'choice' inadequate for explaining the abortion attitudes and experiences of migrants and refugees. A reproductive justice approach, which acknowledges rights to (a) not have children, (b) have children, and (c) to parent children in healthy, safe environments, allows for the complexity of migrant and refugee abortion experiences [5]. These findings emphasise the importance of a rights-based, reproductive justice approach: an understanding of the ways 'compounding injustices' emergent from ‘societal, institutional and systemic contexts’ shape decision making and autonomy [9].

4.1. *Attitudes and Beliefs*

While migrants and refugees in this review often held negative attitudes towards abortion, the strength of these attitudes varied. Attitudes were shaped by individual-level factors including religious beliefs and SRH knowledge as well as macro-level cultural factors (Figure 2). Cultural and religious proscriptions against abortion were nuanced. Despite abortion being considered wrong, shameful or undesirable by most participants, there were a range of ‘exceptions’ to this, making the immorality of abortion context-dependent. This situational acceptability of abortion suggests that, rather than uncritically adhering to religious and sociocultural stricture, migrants and refugees actively negotiate values and attitudes. By adding situational exceptions to anti-abortion stances, participants managed the contradictions between sociocultural values and lived realities.

The strictest anti-abortion stances were rooted in religiosity, particularly Christian and Islamic doctrines. At the most extreme, this manifested in purposeful ignorance of abortion among Christian Sudanese women. Intentional ignorance has similarly been reported in young Muslim migrant women’s SRH attitudes, where ignorance becomes a method of maintaining purity [51]. In this review, ‘not knowing’ about abortion was a way to deny its existence. In many studies, there was tension between abortion taboos and attitudes, and actuality: abortion was stigmatised and never discussed, yet still commonly practised. Secrecy is a common manifestation of abortion stigma [52]. Moreover, many migrant and refugee communities maintain secrecy, silence and shame around SRH generally [7,10]. The taboos around abortion and the seeming contradictions between outward expression and actual practices seen in this review are therefore unsurprising.

Attitudes towards abortion were also shaped by societal (macro)-level cultural conceptions of reproductive health, including cultural understandings of foetal development and notions of foetal ‘agency’. We found a number of culturally specific consequences of abortion, particularly around future punishment by the aborted foetus or God. Furthermore, cultural conceptions of development provided participants with guidelines on the acceptable timespan in which a foetus could be aborted. Understanding these specific cultural constructions is crucial for improving care for migrant and refugee populations in settlement countries.

4.2. *Knowledge*

Previous research has shown that migrant and refugee populations often have inadequate SRH knowledge, attributed to limited SRH education in home countries, disruption of schooling, and stigma surrounding SRH within communities [7]. In this review, restricted discourse around SRH and lack of knowledge indicate that women’s agency and ability to make informed abortion decisions are impeded. Inadequate knowledge about unsafe abortion risks has serious implications for health and mortality. While no studies explicitly examined knowledge around medication abortion, illegally obtained, legitimate medication was used without any knowledge or instruction on administration. There were limited data on self-managed abortion in studies beyond unsafe abortion, which may indicate a lack of knowledge of medication abortion or limited access. Misinformation on abortion has been shown to delay abortion care trajectories [4,53] and lead to accessing unsafe abortion care [54]; Pagoto et al. describe an emerging abortion ‘infodemic’ where increasingly present misinformation exacerbates maternal mortality and targets the most vulnerable populations [55].

Research among non-migrant populations has indicated that women have limited knowledge of abortion legality and national legislation, even in countries with permissive laws [56]. Similarly, in this review, participants had low knowledge of abortion laws and health systems while facing the additional barrier of precarious citizenship and limited understanding of legal rights in host countries. Restricted rights to make informed choices were compounded by a lack of available, affordable contraceptive methods and SRH services, at times leading women to rely on abortion as a contraceptive method.

4.3. Decision Making

As with research on non-migrant populations, abortion decision making among migrant and refugee women was multifaceted [14]. Socioeconomic strain, however, is a primary reason for abortion decisions among non-migrants [14,16,54], which was also the case in this review. In their review of women's abortion experiences, Lie et al. found the importance of pragmatism in decision making, with choices regarding termination and method influenced by financial considerations and perceptions of efficacy [15]. The significance of pragmatic decision making is similar in this review: participants made decisions around material conditions such as impoverishment or lack of support. Additionally, this pragmatism was seen in multiple studies where abortion was considered morally worse than non-marital pregnancy, yet preferable because the social shame and stigma of non-marital pregnancy could be avoided by a secret abortion. Participants' ability to make pragmatic decisions, however, was often limited by material and social conditions. Undocumented and illegal immigrants did not have the option to pragmatically weigh up different abortion methods, unlike the participants in high-income countries in Lie et al.'s study. In this review, legal and financial restrictions meant some participants could only access clandestine, cheap, often unsafe terminations.

Research in LMICs has illustrated the importance of interpersonal-level factors of social networks, particularly partners and families, in abortion decision making [53]. More broadly, much existing literature highlights the importance of social influences on SRH decision making and experiences among migrant and refugee communities, with mi- grant and refugee conceptions of SRH incorporating notions of social risk alongside more conventional biomedical risk [6,7]. This strengthened presence of social ties is similarly evident in the abortion attitudes among internally displaced people living in camps or settlements [57,58]. Likewise, in this review, social stigma, partner coercion and family pressure were important abortion decision-making factors.

However, we also found that a lack of social support significantly shaped abortion decisions, with women being unable to care for children without family and social networks (Figure 2). Social isolation combined with financial dependency restricted women's ability to counter partner coercion. In cases of sex-selective abortion, being cut off from birth families made it harder for women to counter coercion from in-laws and husbands. Social relationships take on heightened importance in settlement contexts where displacement has destroyed and disrupted home-country networks [7]. The disruption of social networks leaves parents without resources to care for and afford children while also intensifying the importance and influence of 're-created' networks in host countries, increasing susceptibility to coercion and the power of social stigma. Relative social support and isolation undoubtedly vary depending on whether individuals live in ethnically homogenous communities (i.e., refugee camps) or are transient migrants or separated from others from their original communities. Our findings suggest a tension between the strong social cohe- sion created by migration and displacement and the loss of key home-country supports. Abortion decision making must thus be understood as situated in social context, informed both by pressure from social networks and by pressures experienced because of a lack of social network.

This review clearly illustrates how institutional- and societal-level factors shape abortion experiences (Figure 2). Decision making and agency were significantly curtailed by the lived experiences of migrant and refugee women. There were vast differences between populations in low-income and high-income nations. Those in conditions of heightened precarity—women in refugee camps, undocumented and temporary migrants—were barred from accessing safe abortions and were more likely to self-induce or seek unregulated, health-threatening abortions and experience serious post-abortion harm. Women's ability to make abortion choices freely and autonomously was restricted by precarity.

In Schoevers et al.'s study, illegal immigrants were forced into abortions by service providers [42]. Similarly, in the studies of migrant women living along the Thai border [23,24,32,43,44], illegality forced abortion decisions: women feared deportation and employment loss, which shaped decisions both to undergo abortion and use illicit methods. Crucially, however, participants in Schoevers et al.'s study resided in a high-income country and had access to safe, legal abortions via the Dutch healthcare system. Participants in studies along the Thai border, and those in refugee camps in Uganda, had no such access. Instead, women in these contexts opted for what the WHO would classify as 'unsafe abortions': terminations performed by 'individuals lacking the necessary skills', and/or in environments that fail to meet 'minimal medical standards' [3]. Though folk and traditional abortion methods by lay abortionists were discussed in two studies in high-income settings, only participants in low-income settings reported actual experiences with unsafe abortion as per the WHO definition. Given that 97% of unsafe abortions occur in LMICs [53], these findings are unsurprising.

It is important, however, to consider the social, economic and legal components that influence abortion decision making. An unregistered medically unsafe abortion may be considered a 'safer' legal or financial option for an illegal immigrant, allowing them to avoid job loss, deportation and punishment. Moreover, clandestine abortions may protect individuals from social stigma, ostracism and shaming that may come from non-marital pregnancy and abortion, thereby being socially 'safer'. Multifaceted understandings of risk and safety that include financial, legal and social aspects are thus essential to ensure that safe abortion programs can effectively support migrants and refugees.

Despite finding significant differences in abortion experiences between participants in HICs and LMICs, across high- and low-income settings, migrants and refugees consistently faced barriers to care and had negative care experiences. Even in studies where participants could legally access abortion, navigating health systems was arduous [26,37,39]. Negative experiences with healthcare workers were similarly ubiquitous, irrespective of the host country's abortion legislature or income level. Financial concerns were relevant to participants accessing abortion care across this review, revealing the significance of socioeconomic issues in both informing abortion decision making and determining care access.

The SEM provides a structure for understanding how various individual and structural factors shape experiences and attitudes towards abortion among migrants and refugees. Moreover, these factors have implications on numerous SRH rights, not simply abortion rights (see Figure 2). Our findings, illustrated in Figure 2, indicate that to create transformative change, reproductive justice interventions for migrants and refugees must address factors across all socioecological levels.

4.4. Limitations

Generally, this review is limited by the paucity of research on migrant and refugee abortion. We intentionally excluded internal migrants or internally displaced people (IDPs), as this would have too greatly expanded the study scope. However, for comprehensive understanding of abortion across population groups, future studies should examine how the experiences of internally displaced people in humanitarian settings compare to international migrants and refugees.

Broad inclusion criteria allowed for a larger set of studies and thus a more holistic view of migrant and refugee communities' abortion attitudes, decision making and experiences. However, this meant some studies solely provided data on attitudes and potential decision-making factors, not the perspectives of actual abortion-seekers. There was an uneven distribution of study settings and ethnicity of participant groups: disproportionately, the included studies were from Asia, and the majority of those included participants from Southeast Asia. There was a noted scarcity of data from Africa and Latin America, perhaps due to the focus on international migrants/refugees. Some included studies examined only specific reasons for abortion, making the comparison of decision-making factors difficult. Many studies lacked thorough demographic reporting; there were no specific findings related to different generations of migrants (first, second or 1.5). Moreover, further research on age groups such as youth, who have specific needs and vulnerabilities, is necessary. There was limited detail on medication abortion in the included studies.

No included studies were conducted in countries in which abortion is completely prohibited, preventing a comprehensive view of how the most restrictive contexts shape abortion attitudes, decision making and experiences [47]. Moreover, in many study settings, abortion legislation has changed since the time of data collection, which may influence the current experiences of migrants and refugees [47]. Whether the introduction of permissive laws in Thailand has improved access to abortion and the experiences of migrant abortion-seekers must further be investigated. Conversely, examining the impact of post-*Roe* restrictions on vulnerable migrant and refugee groups in the United States is crucial.

Finally, there is a need for explicitly rights-based research, which was lacking in this review. While studies of abortion may implicitly address reproductive rights, further research that centres SRH rights, examining the ways migrants and refugees understand and actualise these rights, is needed.

5. Conclusions

Abortion attitudes and experiences among migrants and refugees are complex, informed by factors across all socioecological levels. Despite negative attitudes towards abortion apparent across this review, these attitudes were nuanced and malleable. Migrants and refugees frequently negotiated contradictions between anti-abortion moral stances and lived realities, asserting the conditional acceptability of abortion. Decision making was similarly multifaceted, though often dominated by financial concerns and social and relational influence. Cultural and social understandings of health, reproduction and pregnancy informed attitudes and decision making, and they must be acknowledged and accounted for in mainstream health provision.

Regardless of settlement location and residency status, migrants and refugees faced barriers to accessing abortion care. However, the intersections of poverty and immigration status significantly altered the extent and extremity of these barriers. This review indicates a clear need for better SRH education, information, care and support for migrants and refugees across settlement contexts. This includes improving health system literacy. Ensuring all migrants and refugees—including those in precarious citizenship, legal and financial situations—have access to safe, affordable abortion care is crucial. Moreover, a reproductive justice lens necessitates that migrants and refugees not only have abortion rights but also the right to have children and raise them in safe, healthy environments. Future health policies and programming must acknowledge the specific abortion and reproductive needs and experiences of migrant and refugee communities and the heightened vulnerability that emerges from financial, legal and social precarity.

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References

1. Bearak, J.; Popinchalk, A.; Ganatra, B.; Moller, A.-B.; Tunçalp, Ö.; Beavin, C.; Kwok, L.; Alkema, L. Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990–2019. *Lancet Glob. Health* **2020**, *8*, e1152–e1161. [CrossRef]
2. Bateson, D.; McNamee, K.; Harvey, C. Medical abortion in primary care. *Aust. Prescr.* **2021**, *44*, 187–192. [CrossRef]
3. World Health Organization. *Abortion Care Guideline*; World Health Organization: Geneva, Switzerland, 2022.

4. Coast, E.; Norris, A.H.; Moore, A.M.; Freeman, E. Trajectories of women's abortion-related care: A conceptual framework. *Social. Sci. Med.* **2018**, *200*, 199–210. [CrossRef] [PubMed]
5. Ross, L.; Solinger, R. *Reproductive Justice: An Introduction*; Reproductive Justice: A New Vision for the 21st Century; University of California Press: Berkeley, CA, USA, 2017.
6. Metusela, C.; Ussher, J.; Perz, J.; Hawkey, A.; Morrow, M.; Narchal, R.; Estoesta, J.; Monteiro, M. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. *Int. J. Behav. Med.* **2017**, *24*, 836–845. [CrossRef]
7. Napier-Raman, S.; Hossain, S.Z.; Lee, M.-J.; Mpofu, E.; Liamputtong, P.; Dune, T. Migrant and Refugee Youth Perspectives On Sexual and Reproductive Health and Rights in Australia: A Systematic Review. *Sex. Health* **2023**, *20*, 35–48. [CrossRef] [PubMed]
8. Botfield, J.R.; Newman, C.E.; Kang, M.; Zwi, A.B. Talking to migrant and refugee young people about sexual health in general practice. *Aust. J. General. Pract.* **2018**, *47*, 564–569. [CrossRef] [PubMed]
9. Mengesha, Z.; Perz, J.; Dune, T.; Ussher, J. Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. *PLoS ONE* **2017**, *12*, e0181421. [CrossRef]
10. Ussher, J.M.; Rhyder-Obid, M.; Perz, J.; Rae, M.; Wong, T.W.K.; Newman, P. Purity, Privacy and Procreation: Constructions and Experiences of Sexual and Reproductive Health in Assyrian and Karen Women Living in Australia. *Sex. Cult.* **2012**, *16*, 467–485. [CrossRef]
11. Botfield, J.R.; Newman, C.E.; Bateson, D.; Haire, B.; Estoesta, J.; Forster, C.; Schulz Moore, J. Young migrant and refugee people's views on unintended pregnancy and abortion in Sydney. *Health Sociol. Rev.* **2020**, *29*, 195–210. [CrossRef]
12. Agbemenu, K.; Hannan, M.; Kitutu, J.; Terry, M.A.; Doswell, W. "Sex Will Make Your Fingers Grow Thin and Then You Die": The Interplay of Culture, Myths, and Taboos on African Immigrant Mothers' Perceptions of Reproductive Health Education with Their Daughters Aged 10-14 Years. *J. Immigr. Minor. Health* **2018**, *20*, 697–704. [CrossRef]
13. Wanigaratne, S.; Wiedmeyer, M.L.; Brown, H.K.; Guttmann, A.; Urquia, M.L. Induced abortion according to immigrants' birthplace: A population-based cohort study. *Reprod. Health* **2020**, *17*, 143. [CrossRef] [PubMed]
14. Chae, S.; Desai, S.; Crowell, M.; Sedgh, G. Reasons why women have induced abortions: A synthesis of findings from 14 countries. *Contraception* **2017**, *96*, 233–241. [CrossRef] [PubMed]
15. Lie, M.L.S.; Robson, S.C.; May, C.R. Experiences of abortion: A narrative review of qualitative studies. *BMC Health Serv. Res.* **2008**, *8*, 150. [CrossRef] [PubMed]
16. Kirkman, M.; Rowe, H.; Hardiman, A.; Mallett, S.; Rosenthal, D. Reasons women give for abortion: A review of the literature. Arch. *Women's Ment. Health* **2009**, *12*, 365–378. [CrossRef] [PubMed]
17. The EndNote Team. *EndNote*, Version 21; Clarivate: Philadephia, PA, USA, 2013.
18. Page, M.J.; McKenzie, J.E.; Bossuyt, P.M.; Boutron, I.; Hoffmann, T.C.; Mulrow, C.D.; Shamseer, L.; Tetzlaff, J.M.; Akl, E.A.; Brennan, S.E.; et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ* **2021**, *372*, n71. [CrossRef] [PubMed]
19. Critical Appraisal Skills Programme. CASP (Qualitative) Checklist [Online]. 2018. Available online: https://casp-uk.net/casp-tools-checklists/ (accessed on 1 February 2023).
20. Ahmed, S.; Hewison, J.; Green, J.M.; Cuckle, H.S.; Hirst, J.; Thornton, J.G. Decisions about testing and termination of pregnancy for different fetal conditions: A qualitative study of European White and Pakistani mothers of affected children. *J. Genet. Couns.* **2008**, *17*, 560–572. [CrossRef]
21. Arnott, G.; Tho, E.; Guroong, N.; Foster, A.M. To be, or not to be, referred: A qualitative study of women from Burma's access to legal abortion care in Thailand. *PLoS ONE* **2017**, *12*, e0179365. [CrossRef]
22. Asnong, C.; Fellmeth, G.; Plugge, E.; Wai, N.S.; Pimanpanarak, M.; Paw, M.K.; Charunwatthana, P.; Nosten, F.; McGready, R. Adolescents' perceptions and experiences of pregnancy in refugee and migrant communities on the Thailand-Myanmar border: A qualitative study. *Reprod. Health* **2018**, *15*, 83. [CrossRef]
23. Belton, S.; Whittaker, A. Kathy Pan, sticks and pummelling: Techniques used to induce abortion by Burmese women on the Thai border. *Soc. Sci. Med.* **2007**, *65*, 1512–1523. [CrossRef]
24. Belton, S. Borders of fertility: Unplanned pregnancy and unsafe abortion in Burmese women migrating to Thailand. *Health Care Women Int.* **2007**, *28*, 419–433. [CrossRef]
25. Böttcher, B.; Abu-El-Noor, M.A.; Nasser Ibrahim, A.-E.-N. Causes and consequences of unintended pregnancies in the Gaza Strip: A qualitative study. *BMJ Sex. Reprod. Health* **2019**, *45*, 159. [CrossRef]
26. Deeb-Sossa, N.; Billings, D.L. Barriers to abortion facing Mexican immigrants in North Carolina: Choosing folk healers versus standard medical options. *Lat. Stud.* **2014**, *12*, 399–423. [CrossRef]
27. Dhar, C.P.; Kaflay, D.; Dowshen, N.; Miller, V.A.; Ginsburg, K.R.; Barg, F.K.; Yun, K. Attitudes and Beliefs Pertaining to Sexual and Reproductive Health Among Unmarried, Female Bhutanese Refugee Youth in Philadelphia. *J. Adolesc. Health* **2017**, *61*, 791–794. [CrossRef] [PubMed]
28. Fordyce, L. Responsible Choices: Situating Pregnancy Intention among Haitians in South Florida. *Med. Anthropol. Q.* **2012**, *26*, 116–135. [CrossRef] [PubMed]
29. Gedeon, J.; Hsue, S.; Foster, A. "I came by the bicycle so we can avoid the police": Factors shaping reproductive health decision-making on the Thailand-Burma border. *Int. J. Popul. Stud.* **2016**, *2*, 78. [CrossRef]

30. Gitsels-van der Wal, J.T.; Manniën, J.; Ghaly, M.M.; Verhoeven, P.S.; Hutton, E.K.; Reinders, H.S. The role of religion in decision-making on antenatal screening of congenital anomalies: A qualitative study amongst Muslim Turkish origin immigrants. *Midwifery* **2014**, *30*, 297–302. [CrossRef]
31. Gitsels-van der Wal, J.T.; Martin, L.; Manniën, J.; Verhoeven, P.; Hutton, E.K.; Reinders, H.S. A qualitative study on how Muslim women of Moroccan descent approach antenatal anomaly screening. *Midwifery* **2015**, *31*, e43–e49. [CrossRef] [PubMed]
32. Hegde, S.; Hoban, E.; Nevill, A. Unsafe abortion as a birth control method: Maternal mortality risks among unmarried Cambodian migrant women on the Thai-Cambodia border. *Asia-Pac. J. Public Health* **2012**, *24*, 989–1001. [CrossRef]
33. Hounnaklang, N.; Sarnkhaowkhom, C.; Bannatham, R. The beliefs and practices on sexual health and sexual transmitted infection prevention of Myanmar migrant workers in Thailand. *Open Public Health J.* **2021**, *14*, 294–299. [CrossRef]
34. Khin, Y.P.; Nawa, N.; Fujiwara, T.; Surkan, P.J. Access to contraceptive services among Myanmar women living in Japan: A qualitative study. *Contraception* **2021**, *104*, 538–546. [CrossRef]
35. Liamputtong, P. Abortion--it is for some women only! Hmong women's perceptions of abortion. *Health Care Women Int.* **2003**, *24*, 230–241.
36. Nara, R.; Banura, A.; Foster, A.M. Exploring Congolese refugees' experiences with abortion care in Uganda: A multi-methods qualitative study. *Sex. Reprod. Health Matters* **2019**, *27*, 262–271. [CrossRef]
37. Ostrach, B. Publicly funded abortion and marginalised people's experiences in Catalunya: A longitudinal, comparative study. *Anthropol. Action.* **2020**, *27*, 24–34. [CrossRef]
38. Puri, S.; Adams, V.; Ivey, S.; Nachtigall, R.D. "There is such a thing as too many daughters, but not too many sons": A qualitative study of son preference and fetal sex selection among Indian immigrants in the United States. *Soc. Sci. Med.* **2011**, *72*, 1169–1176. [CrossRef]
39. Remennick, L.I.; Segal, R. Socio-cultural context and women's experiences of abortion: Israeli women and Russian immigrants compared. *Cult. Health Sex.* **2001**, *3*, 49–66. [CrossRef]
40. Rocha, C.M.F.; Darsie, C.; da Silva, V.C.; Koetz, A.P.M.; Gama, A.F.; Dias, S.F. Displaced maternity: Pregnancy, voluntary abortion and women's health for immigrant women in Portugal. *Rev. Bras. Em Promocao Da Saude* **2013**, *26*, 470–479.
41. Royer, P.A.; Olson, L.M.; Jackson, B.; Weber, L.S.; Gawron, L.; Sanders, J.N.; Turok, D.K. "In Africa, There Was No Family Planning. Every Year You Just Give Birth": Family Planning Knowledge, Attitudes, and Practices Among Somali and Congolese Refugee Women after Resettlement to the United States. *Qual. Health Res.* **2020**, *30*, 391–408. [CrossRef] [PubMed]
42. Schoevers, M.A.; van den Muijsenbergh, M.E.; Lagro-Janssen, A.L. Illegal female immigrants in The Netherlands have unmet needs in sexual and reproductive health. *J. Psychosom. Obstet. Gynecol.* **2010**, *31*, 256–264. [CrossRef] [PubMed]
43. Tousaw, E.; La, R.K.; Arnott, G.; Chinthakanan, O.; Foster, A.M. "Without this program, women can lose their lives": Migrant women's experiences with the Safe Abortion Referral Programme in Chiang Mai, Thailand. *Reprod. Health Matters* **2017**, *25*, 58–68. [CrossRef]
44. Tousaw, E.; Moo, S.; Arnott, G.; Foster, A.M. "It is just like having a period with back pain": Exploring women's experiences with community-based distribution of misoprostol for early abortion on the Thailand-Burma border. *Contraception* **2018**, *97*, 122–129. [CrossRef]
45. Tucker, J.; Moon, S.S.; Kim, M.; Kim, K.S. The study on the motivation of sex-selective abortion among Indian immigrants in U.S.A. *Int. J. Bio-Sci. Bio-Technol.* **2015**, *7*, 293–300. [CrossRef]
46. Udmuangpia, T.; Haggstrom-Nordin, E.; Worawong, C.; Tanglakmankhonge, K.; Bloom, T. A Qualitative study: Perceptions Regarding Adolescent Pregnancy Among A Group of Thai Adolescents in Sweden. *Pac. Rim Int. J. Nurs. Res.* **2017**, *21*, 75–87.
47. Center for Reproductive Rights. The World's Abortion Laws. 2023. Available online: https://reproductiverights.org/maps/worlds-abortion-laws/ (accessed on 1 June 2023).
48. Thomas, J.; Harden, A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med. Res. Methodol.* **2008**, *8*, 45. [CrossRef] [PubMed]
49. *NVivo*, Version 12; QSR International Pty Ltd.: Burlington, NJ, USA, 2020.
50. The World Bank. WDI—The World by Income and Region. Available online: https://datatopics.worldbank.org/world-development-indicators/the-world-by-income-and-region.html (accessed on 21 October 2023).
51. Wray, A.; Ussher, J.M.; Perz, J. Constructions and experiences of sexual health among young, heterosexual, unmarried Muslim women immigrants in Australia. *Cult. Health Sex.* **2014**, *16*, 76–89. [CrossRef] [PubMed]
52. Hanschmidt, F.; Linde, K.; Hilbert, A.; Riedel- Heller, S.G.; Kersting, A. Abortion Stigma: A Systematic Review. *Perspect. Sex. Reprod. Health* **2016**, *48*, 169–177. [CrossRef]
53. Lokubal, P.; Corcuera, I.; Balil, J.M.; Frischer, S.R.; Kayemba, C.N.; Kurinczuk, J.J.; Opondo, C.; Nair, M. Abortion decision-making process trajectories and determinants in low—And middle-income countries: A mixed-methods systematic review and meta-analysis. *EClinicalMedicine* **2022**, *54*, 101694. [CrossRef] [PubMed]
54. Rehnström Loi, U.; Lindgren, M.; Faxelid, E.; Oguttu, M.; Klingberg-Allvin, M. Decision-making preceding induced abortion: A qualitative study of women's experiences in Kisumu, Kenya. *Reprod. Health* **2018**, *15*, 166. [CrossRef] [PubMed]
55. Pagoto, S.L.; Palmer, L.; Horwitz-Willis, N. The Next Infodemic: Abortion Misinformation. *J. Med. Internet Res.* **2023**, *25*, e42582. [CrossRef]
56. Assifi, A.R.; Berger, B.; Tunçalp, Ö.; Khosla, R.; Ganatra, B. Women's Awareness and Knowledge of Abortion Laws: A Systematic Review. *PLoS ONE* **2016**, *11*, e0152224. [CrossRef]

57. Casey, S.E.; Isa, G.P.; Isumbisho Mazambi, E.; Giuffrida, M.M.; Jayne Kulkarni, M.; Perera, S.M. Community perceptions of the impact of war on unintended pregnancy and induced abortion in Protection of Civilian sites in Juba, South Sudan. *Glob. Public Health* **2022**, *17*, 2176–2189. [CrossRef]
58. Casey, S.E.; Steven, V.J.; Deitch, J.; Dumas, E.F.; Gallagher, M.C.; Martinez, S.; Morris, C.N.; Rafanoharana, R.V.; Wheeler, E. "You must first save her life": Community perceptions towards induced abortion and post-abortion care in North and South Kivu, Democratic Republic of the Congo. *Sex. Reprod. Health Matters* **2019**, *27*, 106–117. [CrossRef]

Conclusion

This chapter comprises the first results of this thesis. The two systematic reviews expose marked gaps arounds *rights* in SRH literature regarding Australian MRY. Research examining MRY SRH in Australia lacked rights-based analysis, and there was no literature examining abortion rights among Australian MRY. In revealing stark differences in abortion experiences between migrants and refugees in lower- and higher- income settings, the second literature review helps establish the context of rights attainment for the present research. This chapter thus helps establish how MRY's experience of SRHR is culturally and historically situated (See Chapter 1 [Ginsburg & Rapp, 1995]). MRY in Australia, while encountering varying barriers to SRHR – as articulated by the first literature review – have the benefit of residing in a high-income country.

The gaps identified in these reviews are addressed in the research presented in this thesis (Chapters 5-7). The next chapter outlines theoretical frameworks shaping the presented research, followed by detailed methods (Chapter 4).

Chapter 3. Theoretical Frameworks

This research is grounded in several theoretical approaches and frameworks, some of which are inherent and inseparable from this research topic. It is impracticable, for example, to thoroughly discuss health rights and agency among people of colour without implicitly engaging with intersectionality. The theories described here informed the present research methodology, data collection, and analysis. The four theoretical approaches – socioecological frameworks, intersectionality, reproductive justice and agency – are interrelated, and all hold particular use for rights-based research. Intersectionality explores intersecting oppressions across socioecological levels; reproductive justice is an intersectional framework, examining intersecting barriers to SRH rights; conceptualisations of agency allow examination of how MRY actively navigate intersecting oppressions across socioecological levels. There is thus overlap and consonance between these frameworks and the ways they inform this research.

The literature reviews in the previous chapter (Chapter 2) draw upon the theoretical approaches discussed here. As will be indicated in Chapter 4 (methodology), the theoretical approaches outlined here are evident to different extents in each study; Table 3.1 details how these approaches informed research foci.

Table 3.1 Theoretical frameworks and study phases

	Group Concept Mapping	Quantitative survey	Qualitative interviews
Socioecological theory	Which socioecological factors inform MRY decision-making? What socioecological factors are most important for decision-making?	Which socioecological factors inform MRY decision-making? How does the individual-level factor of gender identity interact with other socioecological factors?	Which socioecological factors inform MRY abortion decision-making? What socioecological factors shape abortion experiences?
Intersectionality	How do intersections of migrant/ refugee identity and age shape SRHR decision-making?	How do the intersections of gender, migrant/refugee identity and age shape SRHR knowledge, care access, and behaviour?	What are the intersections of gender, migrant identity, age and stigma in health care? How do intersections of gender, age, migrant identity, and abortion stigma inform decision-making and experiences?
Reproductive justice	How are the SRHR decisions of MRY shaped by cultural, socio-political experiences?	What ways are rights understood?	How do cultural, social, and political lived realities inform MRY abortion decisions?
Agency	How do MRY make active SRHR decisions around different constraints?	What factors potentially restrict MRY agency around SRHR? How might gender impact MRY agency?	What factors 'thin' the agency of MRY in making decisions around abortion? How do MRY negotiate barriers and constraints to articulate agency regarding abortion decisions and experiences?

Socioecological approach

The socioecological model is used throughout this research to examine the multiple, intersecting factors that shape MRY decision-making and agency. An ecological approach situates people within their lived environment, examining interactions between individuals and environment (Bronfenbrenner, 1994; McLeroy et al., 1988; Sallis & Owen, 2015). This research primarily draws upon Bronfenbrenner's ecological model of human development which considers "the entire ecological system in which growth occurs" (1994, p. 37). In articulating interactions between people and environments, ecological models posit that individual behaviour is influenced by the social environment, and, simultaneously, the social environment is influenced by individual behaviour (McLeroy et al., 1988).

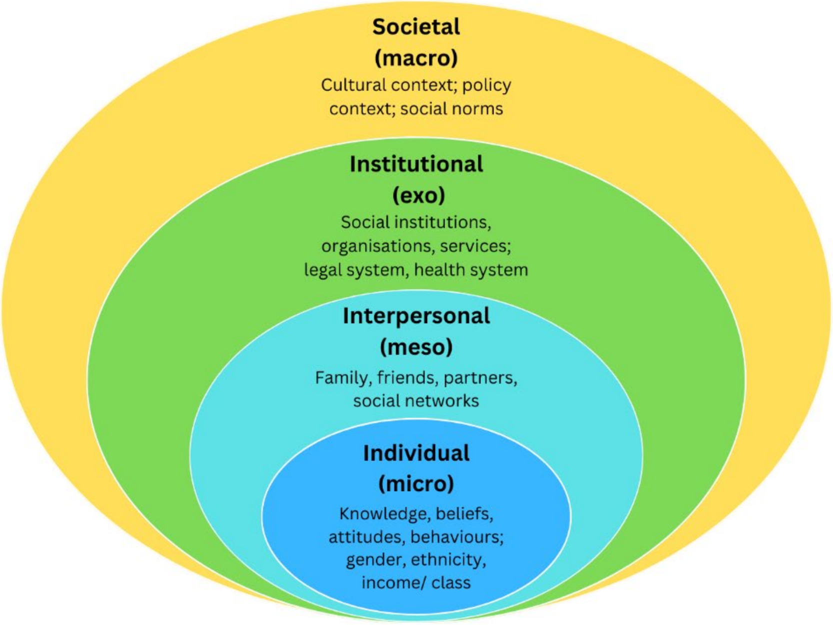
Original model and adaptation

While there are numerous versions of ecological models, Bronfenbrenner's is arguably the most well established and widely applied (Sallis & Owen, 2015). This research – as with much contemporary scholarship incorporating ecological models – adapts Bronfenbrenner's socioecological model to suit research aims. Bronfenbrenner's original model consists of four 'nested' levels, presented as concentric circles with the individual at the centre:

1. Microsystem: pattern of social roles, activities and interpersonal relations in the immediate environment (Bronfenbrenner, 1994, 2005)
2. Mesosystem: linkages and processes between different settings involving the individual; a set of microsystems (Bronfenbrenner, 1994)
3. Exosystem: linkages and processes between different settings that indirectly influence the individual (Bronfenbrenner, 1994);
4. Macrosystem: "the superordinate level of the ecology" (Bronfenbrenner, 2005, p. xiv); pattern of micro-, meso-, exo- systems of a culture (Bronfenbrenner, 1994); includes culture, customs, macro-institutions such as government, social norms and policy

Bronfenbrenner's model consists of four contextual levels that shape a person's development. However, context, as represented by these four systems is only one part of Bronfenbrenner's original theory of human development, which includes *person*, *processes, context* and *time* (Tudge et al., 2009). Time and processes are not features of the model used for the present research. The adaptation used in this research follows Bronfenbrenner's representation of nested concentric circles (Figure 3.1), examining interdependent factors across socioecological levels that inform MRY decision-making and agency.

Figure 3.1 Adapted socioecological model



In line with Bronfenbrenner's theory, the model used in this research has four levels (Fig. 3.1): individual (micro), interpersonal (meso), institutional (exo), and societal (macro).[6] However, what constitutes these levels is a slight departure from Bronfenbrenner, incorporating McLeroy's 1988 version of the socioecological model for health promotion.[7] These changes make Bronfenbrenner's model more applicable to health behaviour. In Bronfenbrenner's original model, the microsystem includes other people within the individual's immediate environment, such as family, peers, and schoolteachers, while the mesosystem is where these people *interact*, being a "system of microsystems" (Bronfenbrenner, 1994, p. 40). The adapted model in this research retains the aspects of the mesosystem involving interactions and linkages. However, the microsystem in the adapted model (Fig. 3.1) is limited to intrapersonal/individual factors: aspects related directly to the individual such as gender, age, education, personal beliefs and economic status. The mesosystem is defined by interpersonal factors, those relating to social networks (McLeroy et al., 1988). The present model (Fig. 3.1) incorporates aspects of Bronfenbrenner's and

[6] The use of 'micro', 'meso', 'exo', and 'macro' are significant in this adapted socioecological model. Micro, at the smallest scale, refers to the individual and their immediate characteristics and experiences. Meso, the 'middle' level extends into interpersonal relationships and interactions but is still imbedded in the immediate social/ relational world of the individual. Exo, meaning outside, refers to external, structural factors. Finally, macro implies large-scale *overarching* factors: culture, for example, is a broader factor that nevertheless filters into every level.

[7] McLeroy's adaptation uses the 1979 version of Bronfenbrenner's model. The present research adopts some aspects of McLeroy's variation but applies these to Bronfenbrenner's more contemporary (and more frequently used) 1994 model, as well as Bronfenbrenner's later writings (e.g. Bronfenbrenner, 2005).

McLeroy's definitions of exosystem, including Bronfenbrenner's conception of the exosystem as containing "linkages and processes" between settings (2005, p. 80), while defining the exosystem to more closely reflect public health promotion scholarship (Golden & Earp, 2012; McLeroy et al., 1988; Sallis & Owen, 2015). McLeroy defines the exosystem as an institutional level comprising workplaces, education institutions, community and religious organisations, which this research extends to include health services, social support, and governmental services. The final layer of the model used in this research (macrosystem) closely mirrors Bronfenbrenner's original model, comprising policy, government, social norms, and culture. McLeroy's adaptation of Bronfenbrenner's model includes a fifth layer, separating policy as another level beyond societal factors. Other models incorporate policy into the institutional/ exosystem, below societal factors. This research uses a model which combines policy and cultural and social factors, as per Bronfenbrenner's original, to reflect how policy is reflective of cultural and social values, and to allow comparison of host-country culture and policy with migrant and refugee community culture and values. Moreover, while the present research provides implications for policy directions, MRY participants did not directly discuss or include policy in their constructions of SRHR decision-making (see results Chapters 5-7). A fifth level separating policy was thus considered unnecessary for the present research.

Ecological models for health research

Ecological models are prevalent in health social sciences literature, particularly in health promotion research (Golden & Earp, 2012; McLeroy et al., 1988; Sallis & Owen, 2015). Such models illuminate social determinants of health behaviour and examine the multiple interdependent factors informing health and wellbeing. Ecological models are thus distinct from behavioural models that focus on the individual actor, instead acknowledging context, material and structural conditions influencing health (Sallis & Owen, 2015). As noted above, this influence is not unidirectional: the individual and sociocultural environment are mutually constituting (McLeroy et al., 1988). Ecological models are particularly useful in allowing for complexity and nuance when examining health behaviours. There is interplay between levels of the model, which are depicted as 'nested': interdependent and interactive (Sallis & Owen, 2015). For example, personal beliefs and values are not isolated at the micro-level, but are shaped by, and shape, macro-level societal factors.

Existing research using socioecological approaches have indicated that migrant and refugee SRH decision-making, health behaviours, experiences and care access are influenced by factors across multiple ecological levels (Gray et al., 2021; Mengesha et al., 2017; Souleymanov et al., 2023; White et al., 2017). Such research affirms the need for policy and practice that addresses migrant and refugee SRH at multiple socioecological levels. The use of the socioecological model in the present research heeds these calls for complexity in addressing migrant and refugee youth health. In addition to this, the socioecological model centres the individual (within the context of their lifeworld), and thus is particularly suited to rights-based research. Moreover, this model has benefits in being simple and comprehensible, making it ideal for presenting results back to youth, migrant and refugee communities, policy makers and stakeholders.

While recognising how factors across different ecological levels shape health outcomes, a socioecological approach does not, however, provide a framework for understanding how these different factors intersect. Socioecological models must be combined with other theoretical approaches, such as intersectionality, to explore how different aspects of MRY experience interact to shape SRHR.

Intersectionality

There is no thing as a single-issue struggle because we do not live single-issue lives. (Lorde, 1984, p. 133)

Intersectionality theory is crucial to this research: MRY hold an intrinsically intersectional identity as both migrant/refugee *and* youth. Within this group, there are of course additional aspects of experience that shape identity and health outcomes: individual MRY will have further intersecting identities relating to race, ethnicity, class, gender, sexuality, and ability. Moreover, as Dune et al. note, SRHR is “inherently intersectional”, acknowledging the multiple, mutable identities and experiences informing the ways people encounter SRH (2022, p. 6). Intersectionality is a form of critical inquiry that interrogates the complexity in the world and human experiences (Collins & Bilge, 2016). Intersectionality holds that multiple factors influence the events and conditions of social and political life, foregoing single axis thinking for awareness of multiple axes of power (Cho et al., 2013). Rather than analysing axes of identification such as race, class, gender, sexuality, ability and age as separate phenomena, intersectionality views these as interdependent entities that mutually construct systems of power (Collins, 2015, 2019). As such, intersectionality recognises that justice and equality cannot be attained through “single-issue” solutions, “because we do not live single-issue lives” (Lorde, 1984, p.133).

Origins and present approach

Having developed as a feminist theory for analysing the specific oppressions faced by black women, intersectionality is fundamentally concerned with connections between “intersecting systems of power” and “intersecting social inequalities” (Collins, 2019, p. 43). While intersectionality is inherently feminist and originally sought to redress the ways “minority women fall into the void between concerns about women’s issues and concerns about racism” (Crenshaw, 1991, p. 1282), intersectional frameworks can be more broadly applied. As Cho et al. argue, an intersectional analysis is not defined simply by use of the term ‘intersectionality’, but by “its adoption of an intersectional way of thinking about the problem of sameness and difference and its relation to power” (2013, p. 795). This research strives to engage an intersectional “way of thinking”, examining how multiple axes of experience inform the rights attainment of MRY. An intersectional approach precludes one aspect of experience and identity (such as culture or ethnicity) from eclipsing other variables of analysis. Intersectionality is also crucial in interrogating the power relations inherent in knowledge production (Hankivsky & Grace, 2016). As such, intersectional thinking has been invaluable in reflexivity, understanding privilege and power and social location as a researcher (see Chapter 4 for discussion of reflexivity). Taking Garry’s (2011) definition of intersectionality, this research uses an inclusive intersectionality framework that examines oppression *and* privilege.

Intersectionality encourages and acknowledges complexity and multiplicity. It thus fits well with the mixed methodology used in this research, chosen to provide “multiple ways of seeing” (see Chapter 4) (Greene, 2007, p. 20). Intersectionality offers a framework for exploring how, for example, intersections of gender, migrant or refugee identity, and age intersect to shape SRH outcomes and decisions (Study 2), or how young migrant women encounter and negotiate stigma in healthcare (Study 3).

The intersectional framework used in this research is *not* an additive approach where facets of identity accumulate to establish a 'level' of oppression. Heeding Gloria Anzaldúa's warning, this research abjures dividing MRY identity "up into little fragments" (2001, p. 205), instead examining the complex ways oppression and privileges merge and interact,[8] and exploring intersections as they span socioecological levels.

Pairing intersectionality with socioecological theory is particularly useful in elucidating how context shapes intersectional experiences. Relationality and interdependent factors are essential to both theories. Intersectionality adds specificity and complexity to ecological models. Moreover, intersectionality explicitly engages with power, which ecological models do not. Conversely, the socioecological model provides necessary broader context for how intersecting axes of race, gender, age and other factors interact.

Strengths-based intersectionality

Intersectionality, in its original conception, addresses intersecting oppressions and how multiple forms of domination converge (Crenshaw, 1991). However, such an explicit focus on marginalisation and domination is perhaps inimical to strength-based research. This elucidates the importance of combining intersectionality with other theories and frameworks, such as ecological models, reproductive justice and agency (below).

Nevertheless, intersectionality still holds potential for strength and rights-based research, being dedicated to social justice, which Collins identifies as a 'core construct' of intersectionality's critical inquiry (2019). Theory and practice are not presumed separate – in fact, intersectionality strives for social change, seeking to guarantee rights for all (Collins, 2019). Understanding systems of power, as intersectional approaches strive to do, is essential to examining rights. Moreover, Njeze et al. propose an "intersectionality of resilience framework" to use intersectional theory for strengths-based research (2020, p. 2001). This research draws on this conception of intersectionality as being able to simultaneously

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[8] Anzaldúa's writing on borderlands and immigrant experience uses a different visual metaphor to explore themes and ideas that mirror intersectionality; in many way's Anzaldúa's work is a precursor or prelude to what is now considered intersectional theory. While Kimberle Crenshaw's work on intersecting oppressions has become the blueprint for intersectionality theory, this work emerged from a rich history of scholarship by black, indigenous, and women of colour feminists theorising different ways of conceptualising the myriad imbricated injustices faced by non-white women.

"expose multiple layers of inequity and disadvantage" *and* enable "complex, strengths-based understandings of individual and social resilience promoting processes" (Njeze et al., 2020, p. 2003). The use of intersectionality through this research attempts to engage the ways axes of privilege and oppression intersect, elucidating both vulnerability *and* strengths.

Reproductive justice

Reproductive justice – a movement initiated by black female activists in response to reproductive inequalities and the inadequacies of Western feminist reproductive rights discourses – combines reproductive rights and social justice. Reproductive justice centres on three key principles: 1) the right *not* to have a child, 2) the right to *have* a child, and 3) the right to *parent* children in a safe, healthy environment (Ross & Solinger, 2017). Additionally, reproductive justice recognises and strives for the attainment of rights to sexual autonomy and gender freedom (Ross & Solinger, 2017). While the movement originally focused on redressing *reproductive* injustice, nascent reproductive justice scholarship acknowledges the mutuality of sexual and reproductive rights, positing that attempts at justice are not complete without sexual freedoms (Morison, 2021).

Reproductive justice extends reproductive health and rights frameworks. The theory adds aspects of agency and rights to intersectionality frameworks, using a human-rights discourse in combination with intersectionality to address reproductive injustice (Bhakuni, 2023). Reproductive justice can thus be considered a movement arising from, and grounded in, intersectionality. A reproductive justice approach makes evident the political, public and social dimensions of SRH issues (Morison, 2021).

Reproductive justice versus reproductive rights

Reproductive justice centres marginalised and vulnerable groups and by so doing, transforms the reproductive rights paradigm (Selberg et al., 2023). Reproductive justice reveals that the conventional rhetoric of the reproductive rights movement is a cultural product, reflecting the needs and concerns of middle-class, liberal white feminists (Ross & Solinger, 2017; Selberg et al., 2023). Proponents of reproductive justice assert that the emphasis on abortion rights and free 'choice' in the reproductive rights movement reflects the concerns of white/Western liberal feminists but overlooks the oppressions faced by women of colour. These conceptions of free choice assume that the experiences of white feminists are universal, eliding how inequality shapes reproductive decision-making. Pro-choice discourses are pertinent only to a select group of privileged people who have the luxury of multiple choices (Price, 2020). Further, the use of 'choice' as the framework for understanding SRH leads to reproductive health issues being "configured from a commodity perspective" (Bakhru, 2019, p. 7), promoting individualistic conceptions of rights (Morison & Le Grice, 2023). As such, the processes and contexts in which individuals make SRH choices – the social, political and economic factors involved – are obscured (Bakhru, 2019). Reproductive justice counters this by framing SRH issues as social and political. This framework envisages reproductive and sexual rights as inseparable from other social justice concerns such as economic and environmental justice, immigrant rights, and racial justice (Morison, 2021). Reproductive justice seeks not to substitute, but to expand upon existing service provision frameworks of reproductive health and legal frameworks of reproductive rights (Ross, 2017).

Reproductive justice and migrant and refugee youth

Extending and expanding upon reproductive rights discourse is crucial to the present research. While this research is grounded in human rights, the reproductive justice critique of the decontextualised liberal focus on *individual* autonomy within the reproductive rights movement is particularly salient (Morison, 2021). Having a reproductive justice focus has enabled this research to approach rights through a social, communal, and justice-oriented lens. Moreover, reproductive justice emphasises contexts of oppression and inequality that shape sexual and reproductive freedom. Just as socioecological frameworks and intersectionality theory, reproductive justice grounds inquiry in social, economic, material, and political realities.

Reproductive justice is relevant to the entirety of this research, not simply the interviews with abortion-seekers (Study 3). Firstly, interrogating the conflation of 'choice' with SRHR is crucial. As reproductive justice activists argue, freedom of choice is often framed as the paragon of sexual and reproductive liberation, but these ideas are often centred on Western cultural conceptions and values (Ross & Solinger, 2017; Ross, 2017). This research does not assume that free choice is the ultimate goal or desire for MRY – nor is this concept necessarily realistic. As both socioecological and intersectionality frameworks illuminate, MRY make SRH decisions in specific sociocultural, political, and economic contexts. Decisions are shaped by intersecting oppressions and privileges borne from social location.

Reproductive justice frameworks are used throughout this thesis to interrogate ideas of free choice and offer a nuanced depiction of agency and decision-making.

Finally, in framing health care – including SRH care – as a human right that is unequally attained, reproductive justice encourages practitioners and policy makers to confront healthcare inequality as a fundamental violation of human rights. Being not merely a way of theorising, but political praxis, reproductive justice strives to erase the "artificial separation between theory and practice" (Ross, 2017, p. 287). A reproductive justice framework is thus intrinsic to the rights-centred aims of the present research.

Agency

Agency in some sense is universal… part of a fundamental humanness. (Ortner, 2006, p. 136)

It would be remiss present this research without a thorough discussion of *agency* and how this concept is applied throughout this thesis. Agency is crucial to the forthcoming exploration of MRY decision-making. Yet agency is often ambiguous and elusive in its definition and, as articulated above, is often coopted by neoliberal, individualist white feminist discourses. This research integrates multiple conceptualisations of agency, attempting to provide a nuanced, multidimensional understanding of agency that is situated in MRY's sociocultural and material realities. This approach to agency is informed by scholarship in youth sociology (Coffey & Farrugia, 2014; Spencer & Doull, 2015), anthropology (Appleton, 2022; Ortner, 2006), sexual agency (Bay-Cheng, 2019; Bell, 2012), social geography (Klocker, 2007), feminism (Mahmood, 2011), and psychology (Ringrose, 2007). I seek to avoid an uncritical use of agency that elides context and structure – using reproductive justice, intersectionality, and socioecological thinking to 'ground' agency within context. The concept of agency used is thus one that is embedded in social interaction (Ortner, 2006), is dynamic and in flux (Abebe, 2019), and conceives power as relational and *productive* (Foucault, 1995).

Conceptualising agency

Taking inspiration from aspects of structuration theory (Giddens, 1984), this research avoids dichotomising agency and structure. Structuration theory offers a middle ground between interpretivist theories that privilege the individual actor as shaping reality and the social world, and structuralist theories that position the individual as a social object, produced by structure (Giddens, 1984). As such, structure both enables and constrains action. This idea is furthered in Ortner's conceptualisation of agency, which does not give "precedence" to either "individuals" or "social forces", but acknowledges "a dynamic, powerful, and sometimes transformative relationship between the practices of real people and the structures of society, culture, and history" (2006, p. 133).

This research avoids a conceptualisation of agency that indiscriminately emphasises the individual subject. Firstly, the concept of 'agency', particularly when used in an uncritical manner, strongly reinforces individualist, liberal concepts of the rational, autonomous actor (Bilge, 2010; Coffey & Farrugia, 2014; Ortner, 2006; Spencer & Doull, 2015). Agency as such is considered external to and in opposition to structure. These perspectives emphasise individual 'choice' – a concept that is problematised through this thesis (as discussed above). This conceptualisation of agency centres on empowerment, responsibility, individualisation and progress (Asad, 2000), and obfuscates internal incoherence, interdependence, relational autonomy and structural influences (Mackenzie & Stoljar, 2000).

Liberal constructions of agency, which posit the primacy of individual actors over sociocultural context, have been critiqued for reproducing ethnocentrism (Ortner, 2006) and essentialism (Asad, 2000), and for promoting the fallacy of a socially unfettered, autonomous agent (Coffey & Farrugia, 2014; Ortner, 2006). As Asad argues, agency in social sciences scholarship too often draws upon an "essentialised notion of the human subject and on a questionable vision of history as moral progress" (2000, p. 51). Moreover – and particularly salient to this thesis – research and corollary interventions that take this neoliberal individualised notion of agency focus on empowering populations to make 'healthy' choices (Cense, 2019). Yet this obscures the role of structural and sociocultural factors and in decision-making, and the fact that 'choices' are rarely straightforward, but the result of complex motivations (Cense, 2019).[9]

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[9] I would particularly argue that individualist understandings of agency which emphasise the independent, autonomous rational actor are especially unhelpful for conceptualising MRY's agency, given the literature illustrating the importance of social influences and interpersonal relationships for this population.

Related to this individualist conception of agency is the conflation of agency and resistance, which emphasises individual autonomy and opposition to structure. Such conceptions of agency are frequently used in emancipatory politics to give voice and power to marginalised groups (Bilge, 2010). While these uses of agency have been instrumental in repudiating narratives of oppressed groups as passive and powerless, the concept of 'agency' becomes more political statement than analytical tool (Mahmood, 2016). Furthermore, a fixation on agency as resistance narrows who can be considered agentic, and in so doing excludes those who do not perform normatively 'agential' acts. As Bay-Cheng asserts in her analysis of the construction of young women's sexual agency, the emergence of the "Agent" as "a prescribed type" – self-efficacious, autonomous, independent – not only obfuscates misogyny, but 'typecasts' marginalised women (those who are not white, able-bodied and wealthy) as victims (2019, p. 465). Viewing agency as consubstantial to resistance elides agential action that may reinforce inequality or instances where subjects intentionally conform rather than confront power (Coffey & Farrugia, 2014; Mahmood, 2016).

Nevertheless, agency is still a vital to understanding the experiences, actions, and outcomes of populations, and a singular focus on social structure is problematic. Overemphasis on structure can be disempowering, obscuring the ways in which people actively engage with, counter, and strategically conform to systems of power. In scholarship that emphasises structure, marginalised groups are too often flattened into one-dimensional, passive victims. Given this rejection of an oppositional relationship between structure and agency, this research attempts to articulate and theorise agency with attention to oppression and complexity.

Bounded agency, thin agency

There are innumerable ways scholars and theorists have grappled with the conundrum of agency in contexts of oppression or constraint. The present research is significantly informed by theorising in child and youth studies (Abebe, 2019; Bordonaro & Payne, 2012; Klocker, 2007; Payne, 2012; Spencer & Doull, 2015).

"Middle ground" theories (Coffey & Farrugia, 2014) that attempt to complicate dualist notions of structure and agency include bounded agency (Evans, 2002) and thin agency

(Klocker, 2007).[10] Evans takes agency to be a “socially situated process” (2002, p. 262). Bounded agency is thus when agency is constrained by structure; agency is inherent, but ‘bounded’ by structural contextual factors (Evans, 2002). This research adopts Evans’ understanding of agency as “socially situated” while drawing more strongly upon Klocker’s idea of “thin agency” in how agency is shaped by different contexts. Klocker conceptualises agency as existing along a continuum (2007), echoing Ortner’s assertion that agency can be “nourished or stunted” by different regimes of power (2006, p. 137). Agency can be “thinned” or “thickened” by structural factors. Agency can thus be thinned by oppression, but never completely eradicated. Abebe similarly calls for agency to be ‘reconceptualised’ as a continuum (2019). Agency on a continuum has the capacity for mutability and change over time; agency can be thinned or thickened by diverse, intersecting oppressions and privileges. As such, agency is “a capacity for action that specific relations of subordination create and enable” (Mahmood, 2016, p. 216).

This research therefore adopts a conceptualisation of agency that is, as Ortner notes, “in some sense universal” (2006, p. 136), yet is variably experienced, being contextually grounded, mutable, and socially enmeshed.

Conclusion

This chapter introduces the key theoretical approaches underpinning this research. Together, these complementary frameworks allow a nuanced exploration of how MRY navigate myriad oppressions and privileges across multiple levels of lived experience. By drawing on these rich theoretical traditions, this research offers a socially, contextually grounded inquiry into how MRY make decisions about their sexual and reproductive lives. Either implicitly or explicitly, these frameworks address imbricated injustices, inequalities and the struggle for human rights. In explicating the myriad influences on decision-making, these theoretical frameworks map on to the “multiple standpoints” and “ways of seeing” that emerge from mixed methodology research (Greene, 2007, p. 20), explicated in the following chapter.

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[10] These theorisations invariably draw on established sociological theory including work from Bourdieu, Beck, and Giddens. I acknowledge that the theories I use emerge from a rich theoretical tradition, which I do not have the scope to do justice to within this thesis.

Chapter 4. Methodology: A mixed-methods transformative approach

"A mixed methods way of thinking... actively invites us to participate in dialogue about multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and cherished." (Greene, 2007, p. 20)

This chapter describes the research design and methodology used to examine MRY SRHR decision-making and agency. Chapter 3 outlined the theoretical frameworks underpinning this research; the present chapter expands on these frameworks, and how they relate to the methodology. This research employed a mixed methodology, consisting of three studies: 1) mixed methods group concept mapping (GCM), 2) quantitative survey methods, and 3) qualitative in-depth interview methods. The first two studies were conducted as part of the Australian Research Council (ARC) discovery grant project (DP200103716), while the qualitative interviews are a separate extension of this research (not funded by the ARC). This chapter includes a published book chapter outlining the GCM method (Napier-Raman, Rosas, et al., 2023).

This research followed a partially mixed, equal status, sequential design (Leech & Onwuegbuzie, 2009): meaning qualitative, mixed,[11] and quantitative methods were conducted separately (partially mixed), each of these methods hold equal weight (equal status), and were conducted one after the other (sequential). Each subsequent study was informed by the results of the previous one(s).

This chapter begins with an exposition of mixed methodology research, the philosophical standpoint of this research, participatory elements and ethical considerations. Each of the studies included in this research is then elaborated on. Firstly, I present GCM methods (Study 1). This is followed by an in-depth description of the quantitative survey and finally of the qualitative interview methods. Results of each study are presented in published or submitted

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[11] As will be discussed in the publication on GCM methods (below), concept mapping itself is a 'fully mixed' method, as the qualitative and quantitative components are conducted within one study. Thus, my overall thesis is 'partially mixed' in its incorporation of separately completed qualitative, quantitative and mixed methods studies, with one of the components being a *fully* mixed methods study.

journal articles in Chapters 5 (published), 6 (under review), and 7 (under review). These chapters thus include some repetition in descriptions of individual study methodologies, but the present chapter provides greater detail. Finally, this chapter concludes with an explication of researcher positionality and reflexivity.

Note on gender and language:
Inclusivity in language and research-design is particularly important for investigating SRH. In writing this thesis, I acknowledge the socially constructed nature of gender and the ways gender diverse and non-conforming identities can be obscured and erased in research. Gender-neutral language has been used where possible. Where gendered language is used, this is because participants have themselves identified as a particular gender. Moreover, gender is a significant determinant of health, and particularly SRH.

Research design: mixed methodology, transformative, participatory research

Mixed methodology research

Mixed methodology research can traverse disciplinary boundaries, allowing for multiple perspectives and providing rich data (Hesse-Biber & Johnson, 2016). A mixed methodology is thus ideal for this research, which seeks to merge disciplinary aspects of social sciences and health to reveal the diverse perspectives of MRY. Additionally, incorporating multiple methods allows for a comprehensive and broad examination of the research topic: integration of the rich, 'thick description' of qualitative research with the breadth and analytical rigour of quantitative research. Mixed methodology research provides often unexpected insight into different aspects of people's lived experiences and produces results that are usable in a range of scenarios, for a range of audiences (Cram & Mertens, 2016). This significantly extends the applicability and practicability of research.[12] Finally, mixed methodology research is particularly apposite to public health research, which requires inquiry across multiple dimensions (Israel et al., 2012). The health and well-being of MRY is informed by diverse,

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[12] A primary *personal* aim for this research is to have produced something that has the potential to benefit communities. Having a methodology that provides multiple forms of presenting data to prospective stakeholders and beneficiaries of this research was thus very important to me. I also wanted to ensure that there were aspects of my work that could be easily presented and delivered back to participants and their broader communities.

complex contextual factors and thus must be investigated in an equally nuanced, complex manner.

Philosophical assumptions – a transformative paradigm

Research using mixed methodologies requires a thorough explication of philosophical standpoints. Indeed, the very concept of 'mixed methodologies' has been critiqued as philosophically untenable due to the incompatible assumptions of qualitative and quantitative inquiry (Creswell & Plano Clark, 2018). Qualitative methods typically take a constructivist approach, assuming that reality is socially constructed (Creswell & Plano Clark, 2018; Hesse-Biber, 2016; Sweetman et al., 2010). Contrastingly, quantitative methods are typically guided by a post-positive paradigm which assumes reality is singular and discoverable/ analysable (Hesse-Biber, 2016). As such, mixed methodologies combine two seemingly antithetical epistemologies. Researchers using mixed methodology, however, reject this rigid oppositional thinking. Scholars such as Niglas, for example, assert that, rather than being dichotomous, philosophical approaches exist along a continuum (2010). Philosophical stances may also change *within* a single mixed methodology study, shifting epistemologies from more constructivist to more positivist depending on the research processes involved (Creswell & Plano Clark, 2018). This research engages a transformative paradigm, which embraces the notion of philosophical standpoints as mutable and existing along a continuum.

A transformative approach elucidates the ways multiple forms of reality are constructed based on the social and cultural positions of individuals. A transformative paradigm "assumes knowledge is not neutral and is influenced by human interests" (Sweetman et al., 2010). Knowledge, as such, is historically and socially situated (Held, 2019). Thus, the transformative paradigm used in this research has significant overlap with social constructionist approaches, examining how MRY understand and construct SRHR, and how this in turn shapes decision-making and agency (Pithavadian et al., 2023). The transformative paradigm centres on social justice and aims to use strengths-based approaches to centre the voices of marginalised groups (Cram & Mertens, 2016; Mertens et al., 2010)—aims that are highly compatible with the aims of the present research.

The transformative paradigm holds specific philosophical assumptions relating to axiology, ontology, epistemology, and methodology (Mertens, 2007; Mertens et al., 2010). Axiology, concerning values and ethics, is the principal belief system within a transformative paradigm:

the transformative axiological assumption interrogates the ethical consequences of power imbalances, including oppression, marginalisation and discrimination (Mertens et al., 2010). As such, transformative research is always concerned with redressing inequality (Cram & Mertens, 2016). Following from this axiological position, the transformative ontological assumption is that people hold multiple socially constructed versions of reality – as in a constructivist paradigm. However, the transformative paradigm interrogates why certain versions of reality are privileged and the consequences of this (Cram & Mertens, 2016), examining the social, cultural, political, ethnic, gender and other values underpinning dominant versions of reality (Mertens, 2007). Mixed methodology research is particularly useful in uncovering these different versions of reality, especially when researching populations that hold different worldviews (Cram & Mertens, 2016). Transformative epistemological orientations posit that knowledge must be produced through collaboration and relationships between researchers and participants (Cram & Mertens, 2016) and that knowledge is situated in contexts of power (Cram & Mertens, 2016; Mertens, 2012). Finally, the transformative methodological assumption is informed by the axiological, ontological and epistemological assumptions discussed above (Mertens, 2007, 2012).

Theoretical underpinnings

A transformative approach requires theoretical underpinnings such as the frameworks presented in Chapter 3. All the theoretical frameworks described in Chapter 3 emphasise individual positionality within particular social, cultural, political, legal, environmental, and economic contexts. Moreover, these theoretical frameworks either implicitly or explicitly expose and redress power imbalances and inequality (Chapter 3). These frameworks are thus *transformative* in nature.

The transformative paradigm elucidates strengths and resilience among marginalised groups (Mertens, 2012). As discussed in Chapter 3, particularly in the exposition of intersectionality frameworks, the present research attempts to highlight structural inequalities and oppression in ways that do not further marginalise MRY. Having a transformative paradigm underpinning the methodology helped ensure this focus on strengths within experiences of injustice throughout this research.

Participatory research

This research was informed by tenets of participatory research. Participatory action research (PAR) methods were employed in the overarching ARC project, with adult community and industry stakeholders and MRY informing design, data collection, analysis, and interpretation of findings. The ARC project sought to "develop a human rights-based and youth-determined model for policy and programming aimed at improving youth sexual and reproductive health agency and well-being" (Dune et al., 2022, p. 8). These participatory methods were strongly used in the GCM study.[13]

Participatory methods, which orient participants as active co-constructers of knowledge, are increasingly common in public health research (Baum et al., 2006; Israel et al., 2012). Such methods disrupt conventional researcher-subject hierarchies, privilege participant voices and have the primary aim of improving outcomes and experiences of the communities and individuals involved. These attributes align with the transformative paradigm, as well as key aspects of intersectionality and reproductive justice (Chapter 3). The publication included below (Napier-Raman, Rosas, et al., 2023), which describes GCM methods, provides greater detail on participatory research.

Advisory committee and youth project liaisons

The ARC project included an advisory committee of 34 key stakeholders who informed the project design, data collection and interpretation and application of results. Additionally, eight MRY acted as youth project liaisons (YPLs) who were involved in research design, recruitment, data collection and assessment of findings, primarily for the GCM study. Select advisory committee members and YPLs participated in the GCM study.

While YPLs were an integral part of the ARC project, particularly in the early stages of development, there was less engagement over time. As such, these youth were not significantly involved in recruitment or participation for the survey or interview studies presented here.

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[13] I avoid defining this research as "participatory action research" or another such formal method of participatory research. While this research was participatory in many aspects, restricted resources, time, sensitivity of the research topic and impacts of the COVID-19 pandemic precluded a fully participatory methodology. For example, while there were workshops as part of the ARC project to present findings back to MRY and key stakeholders, these were limited by participant fatigue and drop-out, and difficulties; lack of financial resources and the sensitivity of abortion research prevented follow-up workshops or collaborative reflection on results with participants. Interviewees (bar one) had no desire to collaborate on or review interview transcripts.

Ethical considerations

Various measures were taken to ensure that this research was conducted ethically.

Confidentiality and anonymity

Confidentiality and anonymity were maintained through all studies. GCM participants completed all activities anonymously online (see publication below). Similarly, survey data was anonymised and though participants had the option to submit an email for a prize draw, emails were not retained for data analysis. For interviews, participants had the option to conduct their interview online (which all participants chose), and to keep cameras off (which two participants chose). Video recordings were not retained. Transcriptions were immediately anonymised with pseudonyms and the removal of any potentially identifying data (specific locations, workplaces etc.).

Only members of the research team had access to data: for the first two studies, this included the ARC project chief investigators, while for the interviews, this included only myself and my primary supervisors.

Consent

Informed consent was obtained from participants in each study. GCM and survey participants accepted consent online before they could participate (Appendix C and survey instrument, Appendix E). Interview participants provided verbal consent. Digital participant information statements were provided to all prospective participants (see Appendix C). These provided a full description of study aims, participant requirements, risks and benefits. Participant information statements also provided information on services and support options for any potential distress arising from participating. Participants were additionally informed of the dissemination plans for the studies and asked if they would like to be contacted for future research and informed of results.

Withdrawal

Participants were able to withdraw from the research at any time. However, for the GCM and survey studies, due to anonymity, data once collected could not be identified and removed. Participants were informed that participation was voluntary and could be ceased at any point (see Appendix B). One interview participant requested to withdraw from the study following their interview. Their contact information and interview recording were immediately deleted.

Ethics approval

Ethics approval was obtained for all research. As part of the ARC project, Study 1 and 2 were covered by Western Sydney University Human Research Ethics Committee, approval number H13798 (Appendix B). The University of Sydney Human Research Ethics Committee covered the interview study, approval number 2022/921 (Appendix B).

Research setting

Australia has a significant migrant and refugee population: while Australia makes up just 0.3% of the global population, it is home to 2.8% of the world's migrants (Parkinson et al., 2023). Most of Australia's migrants live in New South Wales (NSW) and Victoria, and Sydney (NSW) has the highest proportion of migrants of any city in Australia (Australian Bureau of Statistics, 2021a). It was thus a concerted decision to conduct this research on Dharug and Gadigal land[14]: Sydney and greater Western Sydney, Australia.

The first two studies, conducted as part of the ARC project, included participants living in greater Western Sydney (Figure 4.1). Western Sydney has a particularly high percentage of migrant, non-English speaking and overseas-born residents (.id, 2023), and has 'pockets' of concentration of various ethnic/cultural groups (Dune et al., 2017). It was thus considered an ideal location for examining MRY SRHR.

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[14] The Dharug people are the original first nations inhabitants of greater Western Sydney, while the Gadigal people of the Eora nation are the first nations inhabitants of what is now central and inner Sydney.

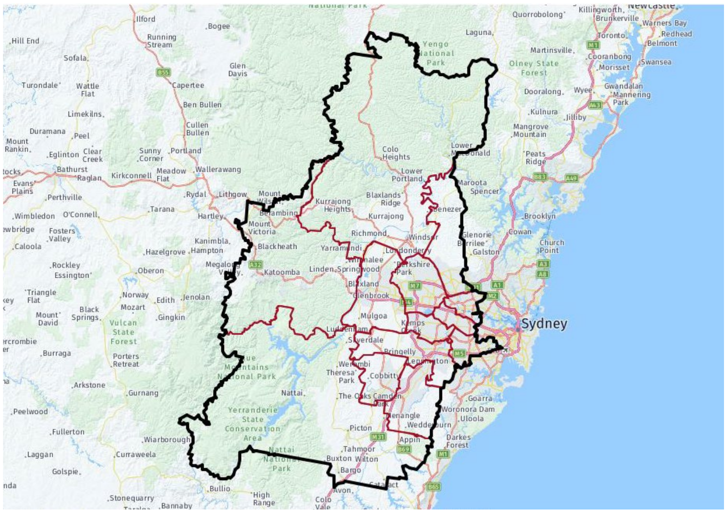

Figure 4.2 Map of Greater Western Sydney, NSW (.id, 2023)

Study 3 extended the area range to include participants from across the entire greater Sydney area. There were several reasons for this: a) to increase the potential participant base, given the specificity and sensitivity of the research subject (abortion experiences), b) to afford participants greater confidentiality in using a broader study location, mitigating concerns about risk of identification,[15] and c) to account for the finite number of abortion services across Sydney and within the Western Sydney area.

Study 1: Group concept mapping (GCM)

GCM is a complex, and relatively novel methodology. Unlike the more traditional survey and interview methods, GCM is still emerging as a method in health social sciences. Due to GCM's distinctive nature and methodological complexity, the following in-depth case study is included. See Appendices B-D for ethics approval, participant information and recruitment material. Results of this study are presented in Chapter 5.

Publication details:

Napier-Raman, S., Rosas, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., Dune, T., & Mapedzahama, V. (2023). Concept Mapping Method. In P. Liamputtong (Ed.), *Handbook of Social Sciences and Global Public Health* (pp. 899-923). Springer, Cham. https://doi.org/10.1007/978-3-030-96778-9_63-1

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[15] Of course, this research was conducted with multiple safeguards to ensure the anonymity and confidentiality of participants across all stages. See the section on qualitative interview methods, below, for further information.

Concept Mapping Method

Sharanya Napier-Raman, Scott Rosas, Syeda Zakia Hossain,
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Abstract

This chapter introduces group concept mapping and illustrates the merit of this methodology for global public health research. Group concept mapping is a mixed-methods participatory research approach that integrates qualitative conceptual data and rigorous multivariate statistical analysis, transforming abstract conceptual data into visual representations or "maps." The participatory nature of group concept mapping as well as its fully integrated mixed-methodology makes it a particularly useful methodology for public health research. Group concept mapping is a collaborative group process that seeks to build consensus between disparate perspectives within a group. It provides researchers with actionable, participant-determined research outcomes. Group concept mapping has been applied in social research across a range of disciplines, including public health, yet remains underutilized by health researchers. This chapter offers a guide for conducting the methodology, detailing the six key steps in group concept mapping: planning, generation, structuring, analysis, interpretation, and utilization. To illustrate group concept mapping in action, the chapter presents a case study using this methodology to examine the sexual and reproductive health decision-making of migrant and refugee youth in Australia. This case study provides evidence of the utility of group concept mapping for examining the complex social issues of public health research.

Keywords

Group concept mapping · Mixed methods · Participatory research · Global public health · Group conceptualization

Introduction

Conceptualization is a means of explicating complex social phenomena, achieved through reifying and making apparent the abstract imagery of a concept (Rosas 2016). Concepts are developed by individuals through a "contextual meaning-making" process by which links and connections are formed between ideas (Rosas 2016 p. 1405). Concepts acquire meaning through context: that is, their relationship to other concepts (Cossette 2002; Rosas 2016). Concept maps provide visual representations of cognitive models: how people understand phenomena in their lives. Concept mapping approaches seek to represent complex information (Davies 2011), and to map or pictorially represent a group or individual's understandings, or conceptualizations (Trochim and Kane 2005). As such, concept mapping is a method for explicating and making tangible abstract conceptual data (Rosas 2016). Group concept mapping (GCM), the focus of this chapter, is a mixed-methods participatory approach to research that integrates qualitative conceptual data and quantitative analysis.

Broadly speaking, concept mapping simply refers to the visual representation of ideas through maps. Several mapping approaches have been used in social science research (Davies 2011), of which group concept mapping (GCM) as described in this chapter is simply one. The specific methodology discussed here is the "structured conceptualization" process in which group procedures are combined with multi-dimensional statistical analyses (Trochim 1989; Trochim and Kane 2005; Trochim and Linton 1986). A collaborative group method which allows participants to be involved across the research process, GCM integrates diverse perspectives to develop a collective conceptual framework for understanding a particular topic (Kane and Rosas 2018).

As evidence of its broad appeal and utility, GCM has been used for research spanning myriad social science disciplines, with over 450 publications using the methodology (Trochim 2017). GCM has wide applicability and disciplinary scope, including psychology and mental healthcare (Corcoran 2005); program planning and evaluation (Barth 2004); education (Haymovitz et al. 2018); youth health (Hydeman et al. 2019; Minh et al. 2015), immigrant health (Ahmad et al. 2011), nutrition and wellness (Halberg et al. 2021; Keita et al. 2016; Macdiarmid et al. 2010); and bioeconomics (Berg et al. 2018). This form of applied social research continues to be adopted by social science researchers seeking community or stakeholder understandings.

Many facets of GCM, particularly the participant-oriented nature of the approach, make it a viable method for public health research (Burke et al. 2005). GCM allows for rigor and objectivity without compromising on the depth and complexity of conceptual data. Rigorous statistical approaches – multidimensional scaling and hierarchical cluster analysis – are used to develop abstract conceptual data into visual representations. This chapter introduces GCM as a method for conducting social sciences research in global public health. It argues that the key aspects of this particular methodology – being an integrated mixed-methods, non-hierarchical, participatory approach – make it particularly useful for conducting public health research and providing actionable outcomes.

Group Concept Mapping

Mapping tools allow complex data to be represented in a manageable, comprehensible way (Davies 2011). The term “concept mapping” has been applied to several different mapping techniques that constitute unique approaches to research and knowledge production. Mapping techniques such as mind-mapping (which involves free-form, visual representation of ideas) are often conflated under the banner of concept mapping, despite being distinct methods (Davies 2011). Consistent across such methods, however, is the aim of organizing and/or structuring knowledge, resulting in the visual representation of relationships between ideas. While concept mapping is often a broad descriptor, there are specifically defined methods which the name denotes: firstly, Novakian concept mapping and, secondly, the focus of this chapter, group concept mapping.

The form of concept mapping described in this chapter has many characteristics that make it distinct from Novakian mapping. Novakian mapping was originally developed in the late 1980s by Joseph D. Novak as a method for supporting meaningful learning (Novak and Cañas 2011). Novakian maps represent how an individual understands a given topic. They use a hierarchical structure, with broader, more overarching concepts at the top and successively more specific concepts placed below (Novak et al. 1983). Labelled linking lines are drawn between concepts to indicate relationships of concepts to one another (Novak et al. 1983). The authors use the name “*group* concept mapping” (GCM) to distinguish the methodology described here from Novakian and other concept mapping, as the GCM method is, fundamentally, a group process that represents the thinking of a collection of individuals (Kane and Rosas 2018).

Contemporaneous to the emergence of Novakian concept mapping, William Trochim developed the GCM method (Trochim 1989; Trochim and Kane 2005; Trochim and Linton 1986). Like Novakian concept mapping, GCM involves the production of maps that visually represent the relationship between concepts. GCM, however, is a method that represents the conceptual understandings of a group rather than that of an individual. While Novakian mapping can be used to capture how an individual understands and structures knowledge of a certain concept, GCM integrates individuals’ knowledge to create a shared mental model (Rosas 2016), or, in other words, “group wisdom” (Kane and Rosas 2018).

GCM attempts to make tangible and representable the intangible and multifarious conceptualization of a group. A group, as Rosas argues, can be considered a “socially-shared, distributive cognitive system” (2016, p. 1405). Group knowledge, shared and held by a collective, is not distributed evenly across individuals: group members do not necessarily hold the same knowledge, or the same amount of knowledge on a given topic (Kane and Rosas 2018; Rosas 2016). Effectively accessing and activating group knowledge requires a diversity of points of view, independence from each other's opinions, and a mechanism for aggregating private judgments into a collective decision (Surowiecki 2005). GCM offers a means for extracting and elucidating the complex, sometimes contradicting knowledge of many individuals. As such, GCM is highly useful in explicating complex social phenomena (Rosas 2016).

Moreover, GCM does not require a homogenous participant group. Therefore, the final maps do not present a homogenous group perspective. Instead, resulting maps demonstrate the understandings of a group of individuals, seeking consensus between dissimilar perspectives, while allowing for differences and conflicting views. This pluralism and heterogeneity are important for research that addresses complex and multifaceted issues (Albert and Burke 2014; Burke et al. 2005).

GCM is a multi-stage process in which participants firstly brainstorm items relevant to the area of interest (Kane and Rosas 2018; Kane and Trochim 2007, 2009; Rosas and Kane 2012; Trochim and Kane 2005). Participants then individually sort brainstormed items into groups based on similarity and rate each item on a scale determined by the project planners. Multivariate statistical analysis is used to transform data from the participant sorting and rating activities into concept maps. Unlike many other forms of concept mapping, GCM uses specific statistical processes which require software to run (Davies 2011; Kane and Trochim 2007). Finally, unlike Novakian maps, the maps produced in GCM are not hierarchical. Rather than a structured representation of superordinate and subordinate concepts, GCM is a representation of a set of networked ideas.

Key Characteristics of GCM

GCM has its origins in the 1980s, with Trochim's development of a method for program planning and evaluation (Trochim and Linton 1986). The following section addresses key characteristics of GCM concerning public health research.

Two key characteristics make GCM particularly suited to public health research – being a mixed-methods approach and being participatory.

Mixed-Methods

Concept mapping is an inherently mixed methodology, integrating qualitative and quantitative methods across the entire research process. Mixed-methods research offers a means of straddling disciplinary boundaries, opening research to multiple forms of knowledge and ways of seeing (Creswell and Plano Clark 2018; Hesse-Biber 2015; Liamputtong and Rice 2022). A core tenet of mixed-methods research is that, in engaging both qualitative and quantitative approaches, researchers can achieve a greater understanding of issues than solely quantitative or qualitative methods would allow (Creswell and Plano Clark 2018; Liamputtong and Rice 2022). Ideally, such research combines the strengths of both approaches – the breadth of quantitative data and the depth of qualitative data. Conclusions and inferences made in mixed-methods research emerge from these combined strengths and may offset limitations of the respective approaches. Further, in encouraging the “de-disciplining” of research (Hesse-Biber 2015), mixed-methods approaches invite pluralism, creativity, and diversity into the research process.

Such a methodology is particularly useful when examining complex, multifaceted issues, particularly those in public health. Health research often requires generalizable, replicable, objective data, while also requiring explanations and reasoning for these results. Proponents of mixed-methods approaches assert that such research is key to addressing health disparity and inequality, social and behavioral health determinants, and issues such as the rise of chronic health problems (Creswell and Plano Clark 2018; McBride et al. 2019).

While a mixed-methods study must merge qualitative and quantitative approaches, there are myriad design typologies and manners in which integration occurs (Teddlie and Tashakkori 2010). GCM can be considered a “fully mixed” method research design (Leech and Onwuegbuzie 2007, p. 267), with qualitative and quantitative data collection and analysis taking place throughout the research process. Others have argued GCM can be described as a sequential exploratory design with prioritization of quantitative data analysis (Hanson et al. 2005). Regardless of how GCM is typified, an argument can be made that the integration of qualitative and quantitative techniques and data are highly dependent, such that the absence of one would fundamentally change the end result.

Participatory

GCM is, fundamentally, a participatory method. GCM involves participants at each stage of the research process, ensuring a truly collaborative outcome. Participants determine the content of the resulting map(s). Kane and Rosas (2018, p. 7) note that a key tenet of GCM is the “participant as knowledge holder” – privileging the viewpoints of those who are most impacted by an issue.

Research with a participatory lens seeks to value, engage, include, and inform those whose lives and worlds are affected by the phenomena being studied. Participatory approaches ensure that research is relevant, useful, and comprehensible to those who are impacted by it (Olson and Jason 2015). Participants are drivers and owners of research processes and outputs, rather than passive research subjects (Minkler and Wallerstein 2008; Wallerstein and Duran 2010). Increasingly, public health research has incorporated participatory methods (Davis et al. 2012; Israel et al. 2012; Liamputtong 2020). Such research seeks to educate and effect change.

Importantly, participatory research is a means of empowering communities and individuals, subverting traditional power-dynamics that place researchers in control of knowledge. Rather, participatory research is reciprocal, operating on mutual sharing of knowledge (Liamputtong 2020; Minkler and Wallerstein 2008; Wallerstein and Duran 2010). As such, participatory research opens space for dialogue between those with different forms of expertise. Participants are considered experts in their own lived experiences (Olson and Jason 2015). Being able to participate in one's health is a right – one which can, and should, extend into health research (Villa-Torres and Svanemyr 2015).

As noted, GCM is a method that explicates the shared conceptualization of a *group* and thus can be particularly useful for investigating health issues at a societal level. Concordant with Participatory Action Research (PAR) principles, Rosas (2012) argues that GCM is an ecologically and experientially sensitive method that can be used to elicit and describe a relational worldview. It allows for theorizing anchored in people's experiences. Practically speaking, GCM provides for utility and validity of the collaborative research, by maximizing and varying participation. Not only is GCM a truly participatory method, it is also action-oriented, providing actionable outcomes (Albert and Burke 2014; Burke et al. 2005; Kane and Rosas 2018; Kane and Trochim 2009). Vaughn et al.'s (2017) review highlighted the use of GCM as a community-engaged methodology that supported building community cohesion and contributed to more relevant and targeted interventions and outcomes. Across more than 100 studies, they identified how GCM allows communities to be an active part of the entire research process, develop working relationships with researchers, and be directly involved in a process that can bring positive community change. GCM provides clear guidelines, based on participant perspectives, of ways to bring about necessary change. As Walker et al. (2014) note, where communities have ownership and control over research outcomes, this positively impacts uptake – and therefore success – of effective interventions.

Finally, the participatory nature of GCM accepts differences between individuals, while aiming to build consensus. GCM does not seek to impose homogeneity upon diverse and disparate stakeholder groups. Rather, GCM allows for and embraces points of difference (Minh et al. 2015). All participant voices are given credence.

Using GCM for Public Health Research

As a method, GCM is particularly suited to public health research, in particular where PAR is employed. The hallmarks of participatory approaches within public health research involve reflection, data collection, and action to improve health and reduce inequities by involving people who, in turn, take actions to improve their health. Adherence to PAR shows a commitment to democratic principles and strives to put the rhetoric of participation into action (Baum et al. 2006). GCM has, since its development, been used in health-adjacent research – initially with health program planning and evaluation (Walker et al. 2014). While there have been several GCM studies that have explored public health issues, the methodology remains largely under-utilized in this sphere (Walker et al. 2014). Public health issues span social, political, economic, and biomedical arenas and require research methods that can integrate and examine perspectives and factors from these often disparate areas (Israel et al. 2012; Walker et al. 2014). GCM is one such method.

The utility of GCM as a method for examining complex public health issues is demonstrated in Hydeman et al.'s study examining the needs of adolescent and young adult cancer survivors (2019). Participants consisted of young people diagnosed with cancer between the ages of 18 to 39 who were 2 years or more post-treatment. The study results revealed that survivors contend with ongoing physical and psychosocial concerns post-treatment – including navigating follow-up care, adjusting to life post-treatment, and continued physical, emotional, and cognitive effects of treatment – that are largely unaddressed by care providers (Hydeman et al. 2019). Findings provided suggestions for how future care can be developed to address the specific concerns of survivors.

Trochim et al. (2004), working with the Hawaii Department of Health, used GCM to plan a state-wide health improvement initiative. Unlike Hydeman et al.'s study, which focused on the needs of a particular participant group, this study involved a broad range of participants who were stakeholders in the area, including health professionals, leaders from community groups, grassroots leaders, and experts in community and systems change (Trochim et al. 2004). The study examined factors influencing individual behavior towards physical activity, tobacco, and nutrition. Findings were developed into a health-improvement plan with specific objectives that were immediately implemented (Trochim et al. 2004).

The authors' study – discussed in detail later in this chapter – used GCM to examine the sexual and reproductive health and rights decision-making of migrant and refugee youth in Australia.

Strengths of GCM

Trochim and Kane (2005) describe four key characteristics that make GCM particularly valuable in healthcare research. Firstly, GCM methods integrate multiple differing perspectives from participants of diverse interests and expertise. This core aspect of GCM allows healthcare problems to be examined from a broad range of viewpoints. As such, GCM methods do not reduce issues to a single perspective or narrative. To properly answer complex public health questions, an approach that allows for diverse, sometimes opposing, viewpoints and experiences is necessary. Secondly, GCM methods include the rigor and objectivity required of health research through the use of multivariate statistical techniques. Thirdly, GCM produces a series of maps that visually represent the compound perspectives of the study group. Importantly, these maps provide a visual representation of group conceptualization without erasing the heterogeneity and diversity of perspectives. Finally, the resulting maps provide clear guidelines and frameworks for action: GCM produces actionable outcomes which can guide program and intervention development.

Walker et al. (2014) highlight the participatory nature of GCM as the primary factor that makes it a valuable public health research method. As noted, this aspect of GCM means that participants – or, in other words, *communities* – have control and possession of actionable outcomes, which in turn increases the effectiveness and uptake of said outcomes.

Limitations of GCM

Like any methodology, GCM has certain drawbacks and challenges.

Firstly, GCM requires specific resources and/or expertise that may pose a barrier to researchers. Doing GCM well requires practical capacities for carrying out the research design, technical resources to manage the specific data collection and analytical tasks, and engagement expertise to ensure participants are supported through the entire process. GCM includes complex multivariate statistical analysis that requires computer-based software (Kane and Trochim 2007). The Concept System® groupwisdom™ software (2022) is specifically designed to run such analysis and can be used by researchers without specialized statistics training. Using this software, GCM is extremely accessible for researchers from a range of disciplinary backgrounds. Concept Systems software streamlines not only the analysis stages but all GCM stages (The Concept System® 2022). The Concept System® software, however, requires the purchase of a license(s) that may not be feasible depending on research budgets.

Alternately, data processing software such as SPSS (IBM Corp 2020) may be used to run analysis, as well as the myriad multivariate analysis programs available online (Kane and Trochim 2007). For this, extensive knowledge and experience in running multivariate analysis are required. A research team choosing to use one of these analysis methods would thus need an experienced statistician. Having an interdisciplinary research team that includes statisticians as well as researchers with other expertise is highly useful, particularly for public health research which ideally incorporates myriad perspectives and stances. Nevertheless, finding researchers with the right expertise is a restriction that must be acknowledged.

Similarly, the research team must also have a comprehensive understanding of concept mapping processes. Familiarizing oneself with GCM methods requires research and, ideally training, which can be both time-consuming and resource-intensive.

GCM methods also run the risk of participant fatigue (Walker et al. 2014). While allowing participant input and engagement at every stage makes GCM a truly participatory methodology, this can lead to participant burn-out. In-person workshops can be time-consuming. Large numbers of participants can also be difficult to organize and instruct. Moreover, should the project be run in-person, significant planning and organizing is required to set up spaces and times for data collection activities. In-person projects also limit the participant base to those in geographical proximity to the researchers.

GCM can be instead completed virtually via web-based technology. This removes geographical obstacles, potentially allowing a broader participant base. Web-based technology can also help prevent participant fatigue, as activities can be completed gradually over a period of time rather than having to be completed in one sitting. However, while virtual methods may be easier for geographically disparate groups and require less in terms of organizing physical meetings, online platforms may impede participant engagement. Furthermore, virtual methods do not allow the same group dynamics as in-person data collection (Walker et al. 2014). Thus, process results or outcomes that surface from engagement and interaction may be limited in virtual data collection.

Process: Stages of GCM Method

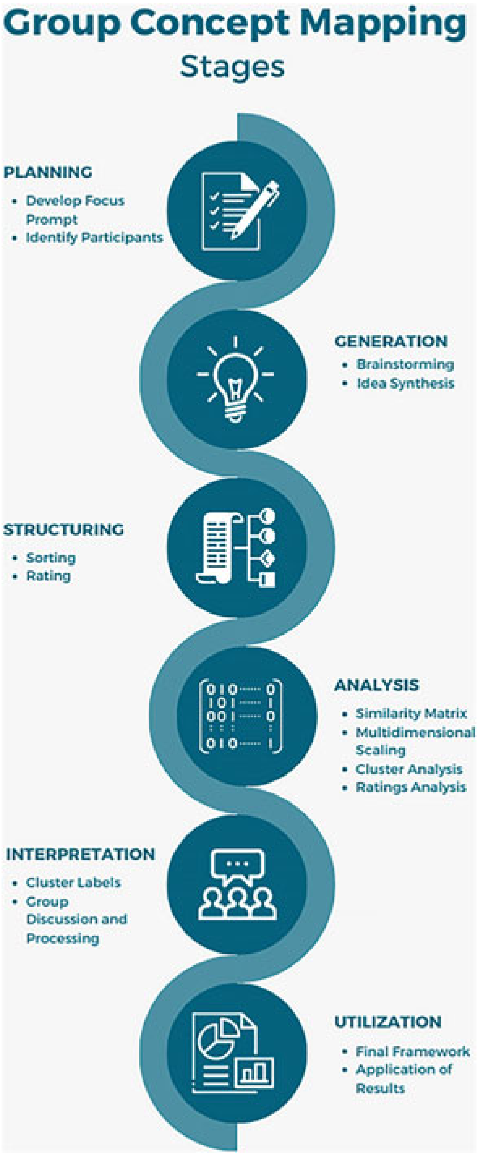
There are six primary stages involved in concept mapping, as summarized in Fig. 1: planning, generation, structuring, analysis, interpretation, and utilization (Kane and Trochim 2007).

Stage 1: Planning

The first stage of a GCM project involves the finalization of the project plan. During planning, researchers must clearly establish and define the aims and desired outcomes of the project, develop a corresponding focus prompt, identify participants, and determine the project timeline. Researchers outline desired outcomes and aims

Fig. 1 Group concept mapping stages

Figure 4.2



of a project and develop the project focus based on these outcomes. Once established, the focus is transformed into a "tightly aligned" prompt statement or question that will form the basis of the GCM activities (Kane and Rosas 2018, p. 24). Typically, the focus prompt is phrased as a directive or sentence-completion prompt. The prompt should be straightforward, written in simple language, and free from jargon. Further, the prompt statement or question should focus on a single concept, as double-barrelled prompts lead to confusion and loss of detail in responses (Kane and Trochim 2007).

Rating Questions

While defining the project outcomes, researchers also begin defining rating and participant demographic questions which are performed during stage 3 (structuring). Rating questions and scales are determined in line with desired goals, with a particular focus on who will be using the results and how. Rating questions are developed to measure any variable of interest to the given project, though an *importance* rating as such is particularly common:

> Rate each statement in terms of importance on a scale of one to five, with one being 'not at all important' and 5 being 'extremely important.'

Participants

Finally, participants are identified and recruited based on desired research outcomes. Kane and Trochim (2007) note that having a diverse participant group, consisting of a range of individuals associated with the research area, is ideal for conceptualization. GCM allows for and encourages the representation of a range of perspectives from individuals belonging to different groups that are engaged with the issue in question. For a given topic, the group of participants will ideally include stakeholders and interested parties that are engaged with the issue in different ways. Fundamental to this pluralism is the belief that all parties that are invested in an issue hold particular expertise, regardless of their profession. For public health research, this means looking beyond health professionals and engaging patients, families, caregivers, non-medical staff working in health spaces, community members and leaders, policymakers, funding bodies, researchers, and academics. However, where research aims demand, GCM can also be performed with a homogenous participant base (Kane and Trochim 2007).

GCM methods do not prescribe a particular number of participants: sample size again depends on research aims. Successful GCM projects have been completed with as few as 8–15 participants, while others have had hundreds (Kane and Trochim 2007). Sampling methods again are up to researchers' discretion depending on desired aims and outcomes. Generally, however, purposive sampling is an ideal method (Liamputtong 2020), as it allows for the final concept maps to represent the full range of diverse ideas and perspectives relevant to the issue (Kane and Trochim 2007).

Stage 2: Generation

Idea Generation Through Brainstorming

Following the preparation stage, the actual concept mapping process starts with the generation phase (Trochim 1989). The aim of the generation phase is to produce a set of items that encompass the entire conceptual range of the topic.

Most commonly, idea generation is accomplished through brainstorming activities in which participants respond to the focus prompt. The brainstorming method chosen can be decided based on research outcomes, resources, and feasibility: brainstorming can be completed in-person or remotely via the Internet, phone, or other communication methods; group sessions or individual responses can be used. Irrespective of the method, participants should be instructed to respond to the focus prompt with as many individual statements as possible, keeping each brainstormed statement to a single idea.

While brainstorming is commonly used and holds myriad benefits (Kane and Trochim 2007), idea generation can be achieved through other data collection methods – including in-depth interviews and focus group discussions (Liamputtong 2020) – or through a combination of brainstorming and other methods. Again, this is dependent on structural factors – such as resource accessibility and timelines – and research outcomes. For public health research projects, there are cases in which other methods of idea generation may be more suitable for the given research goals. In their study of African American and Hispanic men's prostate cancer screening decision-making, McFall et al. (2008) used data extracted from key informant interviews. Additionally, Anderson and Slonim (2017) have discussed adaptations to typical GCM generation processes specifically for public health research such as conducting multiple brainstorming sessions over time and generating statements from literature reviews, reports, and other relevant documents.

Idea Synthesis

Once ideas have been generated, idea synthesis is conducted to refine the generated data into a manageable statement set. The refined statement set will form the basis of the activities in the structuring stage (see below). There are no strict limits on the number of statements. However, as larger statement sets can lead to data repetition and make structuring activities more cumbersome, time-consuming, and risk participant fatigue, a set of 100 statements or less is ideal (Kane and Trochim 2007; Trochim 1989).

The aim of idea synthesis is to produce a manageable and comprehensible set of distinct ideas relevant to the research topic, with each statement being a single idea (Kane and Trochim 2007). Ideally, this process results in a final set of statements that are representative of the content domain produced during idea generation (Kane and Rosas 2018). Synthesis can be conducted by the research team, or by the participant group, or by selected participants as facilitated by the researcher. Idea synthesis can be achieved through a simple process of coding and editing the original raw statement set. Statements are coded by assigning keywords and then grouping keywords into themes/topics. From here the set can be cut down, firstly removing irrelevant and duplicate/similar statements. A systematic data reduction process that includes coding techniques helps ensure that the final statement set encompasses the entire conceptual domain of the research topic. Statements should also be edited for clarity and comprehension: correcting grammatical and spelling errors, removing jargon, simplifying language, and ensuring the statements appropriately respond to the focus prompt. Statements that contain two ideas can be split into two separate statements.

Stage 3: Structuring

The structuring stage of GCM consists of participant sorting and rating activities using the final synthesized statement set. At this stage, participants also complete demographic questions relevant to the research topic. These activities can be completed in-person with researchers holding sessions for participants to complete activities, virtually via online software, or both in combination.

Sorting

The sorting activity requires participants to sort statements into piles or groups based on perceived similarity. Each participant is provided with the refined statement list and instructed to individually sort the statements into groups based on what "makes sense" to them (Kane and Trochim 2009). Participants are instructed to label each pile based on the content. Generally, participants can group statements in whatever way makes sense to them, so long as statements are grouped based on conceptual similarity. However, all statements cannot be sorted into one single pile, nor can every statement be its own individual pile (though some statements can be grouped by themselves), and a statement cannot be placed in more than one pile (Kane and Trochim 2007, 2009). Participants should be instructed not to group statements based on value labels such as "importance" or "relevance," but on similarity. Moreover, miscellaneous or "other" piles with disparate statements that participants could not fit elsewhere should *not* be created (Kane and Trochim 2009).

Rating

The second structuring activity involves rating each individual item of the statement list, usually on a value or opinion rating. As discussed above, rating questions are determined by researchers based on desired outcomes. Ratings allow researchers to examine differences of opinion and values given to each of the generated statements (Kane and Trochim 2009). Typically, rating questions will take the form of a Likert-scale, although scaling options are flexible and can be aligned with the study purpose. Common rating questions include importance, usefulness, and feasibility.

Participant Questions

Demographic questions are used to perform subgroup analysis to examine the association between demographic characteristics and the concepts/themes (see analysis section). Data collected depends on research aims.

Stage 4: Analysis

The analysis stage incorporates qualitative data obtained during the previous stages with quantitative statistical analysis (Kane and Trochim 2009). Analysis transforms participant sorting and rating data into concept maps in three core steps: (1) the creation of a similarity matrix, (2) multi-dimensional scaling (MDS), and (3) hierarchical cluster analysis. Analysis can only feasibly be performed through computer programs. The groupwisdom™ platform has been explicitly designed for this process (The Concept System® 2022). However, programs such as SPSS, as well as a range of online multidimensional scaling software, can be used.

Similarity Matrix

The similarity matrix is a square matrix that indicates the number of participants who sorted each pair of statements together – i.e., how many times each statement was grouped with another statement (Kane and Trochim 2007, 2009). Each participant's sorting results are put into a square matrix of as many rows and columns as statements, with statement numbers across both axes. Statements sorted together are indicated by a 1, and statements that were not grouped together are indicated by a "0." The matrices for each individual are then combined to produce a group similarity matrix, which again has statement numbers across each axis. The numbers within the group similarity matrix indicate how many participants grouped each pair of statements together. A similarity matrix can be constructed using general statistical software or using the specific groupwisdom™ program.

Multidimensional Scaling (MDS)

Following the production of the similarity matrix, MDS is used to create a point map, where each statement is represented by a point on a map. MDS visually represents similarity within a dataset by presenting individual cases as points on a map, with distance between points indicating the similarity level. Similarity is indicated by proximity. MDS results in a two-dimensional point map where each point represents a statement and statements that were frequently grouped together by participants are closer together on the map, and those grouped together with less frequency are positioned further apart.

Bridging/Anchoring Analysis

Bridging and anchoring analysis refers to the positions of statements on the map and whether a statement is a "bridge" (having been sorted with statements spanning across the entire map) or an "anchor" (having been sorted largely with statements in its immediate vicinity). A bridging statement links distant areas on the map, while an anchoring statement reflects the conceptual content of the other statements around it (Kane and Trochim 2007). This analysis can provide a better understanding of the final map and the relation of different concepts.

Hierarchical Cluster Analysis

The final piece of analysis to create the concept map is to transform the point-map into a cluster-map by drawing boundaries around points that are conceptually similar. Hierarchical cluster analysis (HCA) using Ward's Algorithm is applied to the multidimensional scaling data and used to create clusters of points that are conceptually similar. Ward's algorithm is an agglomerative approach to HCA: it begins with each statement as its own individual cluster and successively agglomerates clusters until there is only one single cluster (Kane and Trochim 2007, 2009). At each stage, the number of clusters is reduced by one through a process of merging two clusters that are closest together.

From this cluster analysis, a cluster solution – that is, the number of clusters in the final concept map – must be chosen. The process of deciding the final cluster solution is qualitative: there is no right number of clusters nor any formula for determining this number. Instead, the decision is dependent again on research aims, particularly the level of detail and specificity desired, and the conceptual content of the clusters in each cluster solution. In a pooled analysis of 69 GCM studies, Rosas and Kane (2012) report the mean number of clusters as 8.93, with a range from 6 to 14 clusters across all studies.

A cluster solution with fewer clusters will provide broader, more overarching concepts while one with more clusters will have more detail and specificity. Too few clusters and the concepts will likely be too broad; too many clusters and the map may be too specific to be useful. Determining the cluster solution can be done by members of the research team alone or with a small focus group of participants providing feedback. A simple method for making the final decision is as follows (Fig. 2).

Once a labelled cluster solution is finalized, the result is a two-dimensional map that depicts the main concepts relevant to the research issue, as conceptualized by the participant group.

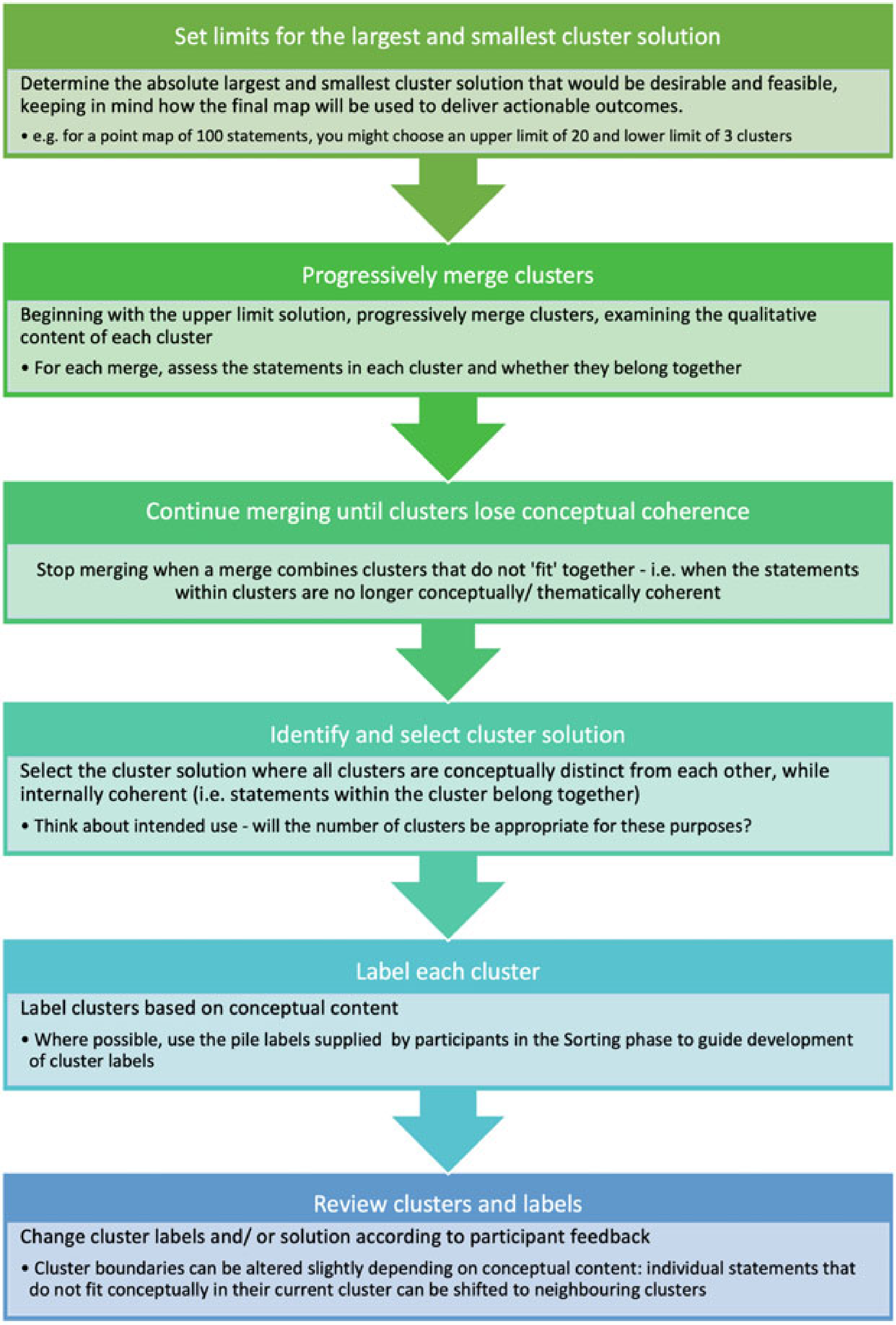
Other Analysis

Once the concept map has been created, additional analysis can be run to incorporate rating data. These analyses are used to provide further data in the interpretation stage (Stage 5). Rating data is aggregated across participants for each statement and, in turn, each cluster. This produces point rating maps and cluster rating maps which represent, respectively, the average rating of each statement (point) across the entire participant group and the average rating of each cluster (Kane and Trochim 2007).

Additionally, rating data can be used to produce pattern matches, which compare average cluster ratings. A pattern match can compare the average ratings between different demographic groups or can be used to compare two different rating variables or points in time. Go-Zones displays – bivariate quadrant graphs using rating data – can also be developed. Go-Zones illustrate the average rating of each statement compared to other statements. Typically, pattern matches are used to provide analysis between clusters, while Go-Zones provide more detail within single clusters (Kane and Trochim 2007).

Stage 5: Interpretation

Interpretation is a key part of the GCM process in which participants/stakeholders assess and examine the maps and graphs produced in the analysis stage. The



Set limits for the largest and smallest cluster solution

Determine the absolute largest and smallest cluster solution that would be desirable and feasible, keeping in mind how the final map will be used to deliver actionable outcomes.

- e.g. for a point map of 100 statements, you might choose an upper limit of 20 and lower limit of 3 clusters

Progressively merge clusters

Beginning with the upper limit solution, progressively merge clusters, examining the qualitative content of each cluster

- For each merge, assess the statements in each cluster and whether they belong together

Continue merging until clusters lose conceptual coherence

Stop merging when a merge combines clusters that do not 'fit' together - i.e. when the statements within clusters are no longer conceptually/ thematically coherent

Identify and select cluster solution

Select the cluster solution where all clusters are conceptually distinct from each other, while internally coherent (i.e. statements within the cluster belong together)

- Think about intended use - will the number of clusters be appropriate for these purposes?

Label each cluster

Label clusters based on conceptual content

- Where possible, use the pile labels supplied by participants in the Sorting phase to guide development of cluster labels

Review clusters and labels

Change cluster labels and/ or solution according to participant feedback

- Cluster boundaries can be altered slightly depending on conceptual content: individual statements that do not fit conceptually in their current cluster can be shifted to neighbouring clusters

Fig. 2 Steps for determining the cluster solution

Figure 4.3

interpretation stage is intended to garner participants' understanding of the maps and how they should be used.

Typically, the research team will hold live interpretation sessions with participants to present data. In this session, researchers systematically present the results, beginning with the synthesized statement list and then each of the different maps, clusters, and labels, pattern matches, and Go-Zones.

Participants are asked to provide feedback on the content and comprehensibility of the maps, as well as the implications of research findings. In some cases, the interpretation is the final stage in the GCM process. Typically, however, utilization – putting the findings into action – follows (Kane and Trochim 2007).

Stage 6: Utilization

The final phase of GCM is putting research into action. The direction taken depends on research aims and goals determined in the planning phase. The final concept map will, ideally, provide key areas for action, and ratings can be used to further guide action. Importance ratings, for example, will illustrate which concepts are most important to the participant group and, as such, indicate which areas to focus on (Kane and Trochim 2007).

Case Study: Migrant and Refugee Youth Sexual and Reproductive Health and Rights Decision-Making

The case study illustrates the use of concept mapping to examine sexual and reproductive health and rights (SRHR) among migrant and refugee youth (MRY) living in Western Sydney, Australia.[1] The authors will demonstrate how concept mapping methodologies can allow a rights-based approach to health research below. Conducted under pandemic conditions that precluded in-person data collection, this study illustrates the viability of GCM as a method of undertaking participatory research under pandemic restrictions. Data collection was carried out virtually using The Concept System® groupwisdom™ software (The Concept System® 2022).

Planning

The objectives of the study were to examine sexual and reproductive health (SRH) decision-making and agency among MRY and to identify barriers and facilitators that shape youth's SRH choices. As such, this study sought to examine MRY rights understandings and attainment regarding SRH. The broader desired outcomes were to improve SRHR outcomes for this population, guided by the GCM research findings. These objectives were transformed into a simple sentence completion prompt with a lead-in sentence providing participants with context:

> People have different ideas about sexual and reproductive health. Different things may influence the choices we make in our sexual life. Something that influences the way I make choices about my sexual life is. . . .

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[1] See Napier-Raman et al. for further details on this study and research findings (forthcoming).

At this stage, two main participant groups were defined: (1) migrant and refugee youth, aged 16–26, living in Greater Western Sydney, Australia, and (2) key informants in the subject area including clinicians, service providers, researchers, and academics. The decision to use only two groups was informed by our research objectives. The primary aim of the research was to examine MRY decision-making and agency, and therefore MRY voices were considered to be of primary importance.

A combination of snowball and purposive sampling was deemed best to reach participants (Liamputtong 2020). Due to pandemic restrictions, recruitment was completely virtual. Participants registered via a Qualtrics survey and were then emailed with further project information and instructions. The link to the registration survey was disseminated through personal and professional connections, health and social services, and via social media.

The researcher team also defined five simple demographic questions to be used: participant gender, age, ethnic/cultural background, employment status, and SRH service use. Two rating questions were developed. Firstly, importance ratings, using a 5-point Likert scale, were chosen. Secondly, an impact rating from -1 to +1 was defined for participants to rate whether each statement had a negative (-1), positive (1), or neutral (0) impact on their sexual health decision-making. These two ratings were closely aligned to the research aims: identifying which factors are most important in informing MRY sexual health decision-making, and secondly, whether each factor has a negative or positive impact on decision-making or, in other words, acts as a barrier or facilitator.

Generation

The idea generation phase consisted of online brainstorming via groupwisdom™. Participants were instructed to respond to the prompt as many times as possible with multiple statements, with guidelines that each response should be brief and focus on one point and to start a new response for each new point. Key informants were given a re-worded prompt with "I" and "my" replaced by "migrant and refugee youth" and "their" so that their responses also concerned MRY decision-making. Statements were also extracted from key literature and past focus groups from the broader study to ensure a comprehensive representation of key decision-making factors. The statements from secondary research were all extracted from quotes by MRY in other studies, ensuring that it was participant voices and perspectives rather than researchers being used.

The online brainstorming platform on groupwisdom™ simulates the collaborative nature of in-person brainstorming. As participants entered responses to the focus prompt, they were able to see the responses made by other participants. A total of 126 raw statements were generated.

Following idea generation, the research team carried out idea synthesis. Firstly, all major grammatical, spelling, or logical errors were corrected. Duplicate, incomplete, irrelevant, and unclear statements were removed. There were a significant number of statements that had to be split as they contained numerous ideas. The high number of these responses may have been due to the inability to oversee online brainstorming.

Statements were then assigned keywords and grouped into thematic codes by the researcher (SNR) to ensure full representation of all major themes in the final statement set. Subsequently, the research team reviewed codes and cooperatively selected a final set of 64 unique statements.

Structuring

A total of 42 MRY (including 31 from the generation phase) and 13 stakeholders participated in the structuring phase. This phase included sorting and rating the refined statement set. For sorting, participants organized statements into groups and labelled each group. Participants were instructed to sort statements based on similarity and common thematic content, not importance or value-based groupings. Participants then rated statements based on importance and impact. Firstly, participants gave each statement an importance rating using a 5-point Likert scale, where 1 is relatively unimportant and 5 very important. Secondly, participants rated whether each statement had a positive or negative impact on MRY decision-making, using a scale of −1 through 1, with −1 being negative impact, 0 being neutral or no impact, and +1 being positive.

The research team assessed sorting and rating data for usability. Sorting data that was incomplete was removed, as was data from participants who did not follow sorting instructions. For example, several participants grouped miscellaneous statements in "other" piles despite instructions to the contrary. Similarly, rating data were assessed to determine whether participants had correctly completed. Where it was clear participants had not attempted rating correctly (i.e., by rating every statement the same), these responses were excluded.

A crucial benefit to this virtual data collection method was anonymity. Given the sensitive nature of our research, the authors felt that regardless of pandemic restrictions, the anonymity allowed by virtual data collection was a significant asset to the research process.

Analysis

Concept Systems software was used to create graphical representations of the data through multidimensional scaling (MDS) and hierarchical cluster analysis (HCA) methods explained above. Additionally, Concept Systems software automatically calculates a stress value to assess the overall goodness of fit of the point map. Stress values range from 0 to 1, with values closer to 0 indicating a better fit. The point map generated from participant sorting data was used as the foundation for subsequent concept maps.

Tenets of parsimony were followed in selecting a solution: a six-cluster map was deemed the most simple, interpretable configuration that still held sufficient detail and conceptual coherence. To further coherence, clusters were reviewed for incongruous outlier statements that would be better placed in adjacent clusters. Two statements were shifted from their original cluster to neighboring clusters. Full details on the analysis and findings are available in Napier-Raman et al. (forthcoming).

Interpretation

Interpretation in this study consisted of a zoom session held with a select number of MRY. The session was conducted on Zoom and was recorded with participant consent.

Five MRY who had completed brainstorming, sorting, and rating were invited to discuss the results. Firstly, MRY asked to examine clusters and suggest cluster labels. They were then presented with the labels developed by the research team and discussed points of difference. In line with participant suggestions, changes were made to the initial labels for three clusters.

Additionally, participants were shown the final cluster-rating maps and pattern match and discussed how these aligned with their understandings. The interpretation session provided a means for assessing the validity of the final maps and the GCM process. Participants responded positively to the maps and findings, asserting that all the key areas informing their SRH decision-making were represented. Moreover, MRY found the final concept maps comprehensible and easy to interpret. MRY participants also had the opportunity to provide their explanations for the findings, particularly the differences between the two main participant groups (youth and key informants/professionals).

MRY were finally asked to discuss ideas for utilizing findings and possible avenues for policy and programming.

Utilization

The resulting maps will be used to inform policy and programming suggestions that are in line with MRY priorities and values. Briefly, six main concepts informing MRY decision-making were found: sexual risk and safe-sex practices, media influences, education and health service access, emotional intimacy and comfort, family and cultural influences, and social communication and observation. Of these, emotional intimacy and comfort and safe-sex practices were most important to youth when making decisions. These preliminary research findings provide a better understanding of the factors informing MRY decision-making, and therefore areas for services and programming to focus on.

Benefits of GCM in This Study

This study demonstrated the value and efficacy of using GCM methods for public health research. GCM was highly effective in elucidating how MRY make SRH decisions. A rights-based study such as this study, examining agency and decision-making, requires a compatible methodological approach. GCM methods ensure that participants have agency within the research process, and thus were ideal for this research. Having participants involved at multiple points through the project allowed for increased reflexivity into the research process and findings. As such, the authors could be certain that their findings accurately reflect the perspectives of the community that this research set out to support.

Another aspect of GCM that was particularly salient to the research aims was the production of easily comprehensible maps and graphs. GCM gave the research team a means for expressing complex findings in a simple and understandable manner. This is particularly useful for a population – such as migrant and refugee communities – with different language backgrounds, educational experiences, and literacy levels. The results of this study can be directly presented to and *used by* migrant and refugee communities. Given that language barriers can be significant in preventing SRH service engagement and care for migrant and refugee communities (Maheen et al. 2021; Mengesha et al. 2016), having a predominantly visual means for presenting data is extremely beneficial. In that effect, the research findings of this study are accessible to a broad population.

Finally, it would be remiss to not discuss the ways GCM allowed pandemic restrictions on research to be overcome. The COVID-19 pandemic has restricted and altered the way research, particularly in the social sciences, can be conducted (Howlett 2022). Global public health crises such as the COVID-19 pandemic can lead to services, care, and issues in unrelated health areas such as SRH being overlooked and ignored (Mackworth-Young et al. 2022). Having a means for continuing research and action in these areas is crucial. GCM proved to be a highly adaptable, flexible method. Using GCM allowed the authors to conduct SRH research among an under-served and under-represented population, despite the restrictions and challenges of a global pandemic. Nevertheless, socially distanced research did have limitations. The authors found that virtual methods reduced their ability to fully instruct and support participants as they completed activities. Unlike live in-person brainstorming sessions where participants could be reminded of instructions and informed if they were not following them, virtual data collection has limited opportunity for researcher maintenance. Similarly, mistakes and ineligible responses during the sorting and rating activities in this study may have been due to the lack of ability to guide participants in real time as they completed activities.

Conclusion and Future Directions

GCM is a mixed-methods, participatory approach to research that can be highly useful for addressing complex public health issues. This chapter provides an introduction to group concept mapping: a mixed-methods, participatory approach to research that combines qualitative conceptual data with rigorous statistical analysis. GCM provides a means for engaging participants throughout the research process, resulting in truly participant-oriented research.

GCM has a number of strengths as a method for conducting global public health research. It is a participatory method that empowers and engages participants. The research case study demonstrates the significant benefits of using GCM, particularly when engaging populations who are underrepresented. The adaptability of GCM was crucial to successfully conduct research under pandemic conditions.

As a methodology, the cost of GCM software and licenses is a limitation. The highly participatory nature of GCM also increases the chance of participant fatigue. Finally, while GCM allows for virtual methods of data collection, these have limitations due to the reduced interaction between researchers and participants. Nevertheless, GCM is a highly effective method for conducting public health research with actionable, participant-owned outcomes.

GCM has great potential for addressing current and emerging global public health issues. Contemporary researchers are faced with increasingly complex and intractable public health issues, impelled by the societal and environmental transformations brought by globalization. In this climate, methodologies such as GCM that enable researchers to fully grasp and examine the nuances and complexities of global health problems are invaluable. GCM provides researchers with the tools to examine public health issues as they are truly experienced: by a group or community, or *the public*. It allows for multiple perspectives, both through embracing a diverse participant-base, but also through utilizing interdisciplinary tools and methods. Moreover, GCM delivers actionable research outcomes, allowing public health researchers to put findings into practice. The past 2 years of the global pandemic have underlined the importance of global public health research while illustrating the need for such research to be dynamic, practical, and adaptable. GCM provides a method for conducting research even as the world and global society continue to undergo drastic changes, and centers this research on those who matter*: the public.*

References

Ahmad F, Mahmood S, Pietkiewicz I, McDonald L, Ginsburg O (2011) Concept mapping with South Asian immigrant women: barriers to mammography and solutions. J Immigr Minor Health 14(2):242–250. https://doi.org/10.1007/s10903-011-9472-7

Albert SM, Burke JG (2014) Methods for community public health research: integrated and engaged approaches. Springer Publishing Company, New York

Anderson LA, Slonim A (2017) Perspectives on the strategic uses of concept mapping to address public health challenges. Eval Program Plann 60:194–201. https://doi.org/10.1016/j.evalprogplan.2016.08.011

Barth MC (2004) A low-cost, post hoc method to rate overall site quality in a multi-site demonstration. Am J Eval 25(1):79–97. https://doi.org/10.1177/109821400402500106

Baum F, MacDougall C, Smith D (2006) Participatory action research. J Epidemiol Community Health (1979) 60(10):854–857. https://doi.org/10.1136/jech.2004.028662

Berg S, Cloutier LM, Bröring S (2018) Collective stakeholder representations and perceptions of drivers of novel biomass-based value chains. J Clean Prod 200:231–241. https://doi.org/10.1016/j.jclepro.2018.07.304

Burke JG, O’Campo P, Peak GL, Gielen AC, McDonnell KA, Trochim WMK (2005) An introduction to concept mapping as a participatory public health research method. Qual Health Res 15(10):1392–1410. https://doi.org/10.1177/1049732305278876

Corcoran K (2005) The Oregon mental health referral checklists: concept mapping the mental health needs of youth in the juvenile justice system. Brief Treat Crisis Interv 5(1):9–18. https://doi.org/10.1093/brief-treatment/mhi003

Cossette P (2002) Analysing the thinking of F.W. Taylor using cognitive mapping. Manag Decis 40 (2):168–182. https://doi.org/10.1108/00251740210422848

Creswell JW, Plano Clark VL (2018) Designing and conducting mixed methods research, 3rd edn. SAGE Publications, Thousand Oaks

Davies M (2011) Concept mapping, mind mapping and argument mapping: what are the differences and do they matter? High Educ 62(3):279–301. https://doi.org/10.1007/s10734-010-9387-6

Davis MV, Cilenti D, Gunther-Mohr C, Baker EL (2012) On linkages; participatory research partnerships: addressing relevant public health system challenges. Public Health Rep (1974) 127(2):230–235. https://doi.org/10.1177/003335491212700214

Halberg SE, Visek AJ, Blake EF, Essel KD, Sacheck J, Sylvetsky AC (2021) SODA MAPS: a framework for understanding caffeinated sugary drink consumption among children. Front Nutr 8:640531. https://doi.org/10.3389/fnut.2021.640531

Hanson WE, Creswell JW, Clark VL, Petska KS, Creswell JD (2005) Mixed methods research designs in counseling psychology. J Couns Psychol 52:224–235. https://doi.org/10.1037/0022-0167.52.2.224

Haymovitz E, Houseal-Allport P, Lee RS, Svistova J (2018) Exploring the perceived benefits and limitations of a school-based social–emotional learning program: a concept map evaluation. Child Sch 40(1):45–54. https://doi.org/10.1093/cs/cdx029

Hesse-Biber SN (2015) Introduction: navigating a turbulent research landscape: working the boundaries, tensions, diversity, and contradictions of multimethod and mixed methods inquiry. In: Hesse-Biber SN, Johnson RB (eds) The Oxford handbook of multimethod and mixed methods research inquiry. Oxford University Press, Oxford

Howlett M (2022) Looking at the 'field' through a Zoom lens: methodological reflections on conducting online research during a global pandemic. Qual Res: QR 22(3):387–402. https://doi.org/10.1177/1468794120985691

Hydeman JA, Uwazurike OC, Adeyemi EI, Beaupin LK (2019) Survivorship needs of adolescent and young adult cancer survivors: a concept mapping analysis. J Cancer Surviv 13(1):34–42. https://doi.org/10.1007/s11764-018-0725-5

IBM Corp (2020) IBM SPSS statistics for windows (version 27.0). IBM Corp, Armonk

Israel BA, Eng E, Schulz AJ, Parker EA (2012) Introduction to methods for CBPR for health. In: Israel BA, Eng E, Schulz AJ, Parker EA (eds) Methods for community-based participatory research for health. Wiley, Somerset

Kane M, Rosas S (2018) Conversations about group concept mapping: applications, examples, and enhancements. SAGE, Thousand Oaks

Kane M, Trochim WMK (2007) Concept mapping for planning and evaluation. SAGE, Thousand Oaks

Kane M, Trochim WM (2009) Concept mapping for applied social research. In: Rog D, Bickman L (eds) The SAGE handbook of applied social research methods, 2nd edn. SAGE Publications, Inc., Thousand Oaks, pp 435–474

Keita AD, Whittaker S, Wynter J, Kidanu TW, Chhay C, Cardel M, Gans KM (2016) Applying concept mapping methodology to identify the perceptions of risk and protective factors for childhood obesity among Southeast Asian refugees. J Health Care Poor Underserved 27(4): 1909–1933. https://doi.org/10.1353/hpu.2016.0171

Leech NL, Onwuegbuzie AJ (2007) A typology of mixed methods research designs. Qual Quant 43 (2):265–275. https://doi.org/10.1007/s11135-007-9105-3

Liamputtong P (2020) Qualitative research methods, 5th edn. Oxford University Press, South Melbourne

Liamputtong P, Rice ZS (2022) The science of words and the science of numbers: research methods in health. In: Liamputtong P (ed) Research methods and evidence-based practice, 4th edn. Oxford University Press, Docklands, pp 16–35

Macdiarmid JI, Loe J, Douglas F, Ludbrook A, Comerford C, McNeill G (2010) Concept mapping: an approach for developing an evaluation framework and realistic outcome indicators for community-based nutrition interventions. Proc Nutr Soc 69(OCE1). https://doi.org/10.1017/S0029665109993053

Mackworth-Young CRS, Mavodza C, Nyamwanza R, Tshuma M, Nzombe P, Chikwari C.D, Bernays S (2022) “Other risks don’t stop”: adapting a youth sexual and reproductive health intervention in Zimbabwe during COVID-19. Sex Reprod Health Matters 30(1). https://doi.org/10.1080/26410397.2022.2029338

Maheen H, Chalmers K, Khaw S, McMichael C (2021) Sexual and reproductive health service utilisation of adolescents and young people from migrant and refugee backgrounds in high-income settings: a qualitative evidence synthesis (QES). Sex Health 18(4):283–293. https://doi.org/10.1071/sh20112

McBride KA, MacMillan F, George ES, Steiner GZ (2019) The use of mixed methods in research. In: Liamputtong P (ed) Handbook of research methods in health social sciences. Springer Singapore, Singapore, pp 695–713

McFall SL, Ureda J, Byrd TL, Valdes A, Morales P, Scott DB et al (2008) What is needed for informed decisions about prostate cancer screening: perspectives of African-American and Hispanic men. Health Educ Res 24(2):280–291. https://doi.org/10.1093/her/cyn018

Mengesha ZB, Dune T, Perz J (2016) Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: a systematic review. Sex Health 13(4):299–310. https://doi.org/10.1071/sh15235

Minh A, Patel S, Bruce-Barrett C, O’Campo P (2015) Letting youths choose for themselves: concept mapping as a participatory approach for program and service planning. Fam Community Health 38(1):33–43. https://doi.org/10.1097/FCH.0000000000000060

Minkler M, Wallerstein N (2008) Community-based participatory research for health: from process to outcomes, 2nd edn. Jossey-Bass, San Francisco

Novak JD, Cañas AJ (2011) Applying educational tools and ideas in the corporate world. In: Moon B, Hoffman RR, Novak JD, Cañas AJ (eds) Applied concept mapping: capturing, analyzing, and organizing knowledge. CRC Press, Boca Raton

Novak JD, Gowin BD, Johansen GT (1983) The use of concept mapping and knowledge vee mapping with junior high school science students. Sci Educ 67(5):625–645. https://doi.org/10.1002/sce.3730670511

Olson BD, Jason LA (2015) Participatory mixed methods research. In: Hesse-Biber SN, Johnson RB (eds) The Oxford handbook of multimethod and mixed methods research inquiry. Oxford University Press, Oxford

Rosas SR (2012) The utility of concept mapping for actualizing participatory research. Cuadernos Hispanoamericanos de Psicología 12(2):7–24

Rosas SR (2016) Group concept mapping methodology: toward an epistemology of group conceptualization, complexity, and emergence. Qual Quant 51(3):1403–1416. https://doi.org/10.1007/s11135-016-0340-3

Rosas SR, Kane M (2012) Quality and rigor of the concept mapping methodology: a pooled study analysis. Eval Program Plann 35(2):236–245. https://doi.org/10.1016/j.evalprogplan.2011.10.003

Surowiecki J (2005) The wisdom of crowds. Anchor Books, New York

Teddlie C, Tashakkori A (2010) Overview of contemporary issues in mixed methods research. In: Tashakkori A, Teddlie C (eds) SAGE handbook of mixed methods in social & behavioral research, 2nd edn. SAGE Publications, Inc., Thousand Oaks

The Concept System® (2022) groupwisdom™. In (Build 2021.24.01 ed., pp. Web-based platform). Ithaca, NY

Trochim WMK (1989) An introduction to concept mapping for planning and evaluation. Eval Program Plann 12(1):1–16. https://doi.org/10.1016/0149-7189(89)90016-5

Trochim WMK (2017) Hindsight is 20/20: reflections on the evolution of concept mapping. Eval Program Plann 60:176–185. https://doi.org/10.1016/j.evalprogplan.2016.08.009

Trochim WMK, Kane M (2005) Concept mapping: an introduction to structured conceptualization in health care. Int J Qual Health Care 17(3):187–191. https://doi.org/10.1093/intqhc/mzi038

Trochim WMK, Linton R (1986) Conceptualization for planning and evaluation. Eval Program Plann 9(4):289–308. https://doi.org/10.1016/0149-7189(86)90044-3

Trochim WMK, Milstein B, Wood BJ, Jackson S, Pressler V (2004) Setting objectives for community and systems change: an application of concept mapping for planning a statewide health improvement initiative. Health Promot Pract 5(1):8–19; discussion 10. https://doi.org/10.1177/1524839903258020

Vaughn LM, Jones JR, Booth E, Burke JG (2017) Concept mapping methodology and community-engaged research: a perfect pairing. Eval Program Plann 60:229–237. https://doi.org/10.1016/j.evalprogplan.2016.08.013

Villa-Torres L, Svanemyr J (2015) Ensuring youth's right to participation and promotion of youth leadership in the development of sexual and reproductive health policies and programs. J Adolesc Health 56(1):S51–S57. https://doi.org/10.1016/j.jadohealth.2014.07.022

Walker RE, Jones JR, Burke JG (2014) Concept mapping for community perceptions. In: Burke JG, Albert S (eds) Methods for community public health research: integrated and engaged approaches. Springer Publishing Company, New York

Wallerstein N, Duran B (2010) Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. Am J Public Health 100:S40–S46

Study 2: Cross-sectional survey

A cross-sectional study design, one that analyses data at a single point in time, was chosen to add further statistical data to the GCM findings. While Study 1 examined key factors informing MRY decision-making, this cross-section survey reflected more broadly on the contexts and circumstances in which MRY make decisions. The survey primarily involved close-ended questions, with a small number of open-ended questions.

This study most strongly aligns with aims b) and c) of the overall research (Chapter 1), along with broader aims to examine understandings and experiences of SRHR among MRY. As with the GCM study, this survey was also designed in line with aims of the ARC project. As such, this study aimed to:

- examine migrant and refugee youth's sexual and reproductive health knowledge and literacy
- identify socioecological factors characterising migrant and refugee youth's sexual and reproductive health needs, service use and access

Sampling and recruitment

MRY, aged 15-27 years, living in Western Sydney, Australia took part in this study. Recruitment specified the age range of 16-26 years, however, three participants outside this range (two aged 15 years, and one aged 27 years) completed the survey and were included in analysis.[16]

The survey was disseminated via online links, QR code, digital and physical flyers (see Appendix D2). Snowball sampling methods were used. Participants who completed the GCM study were invited to participate and share the survey link. Additionally, over 60 community, health, social services, and youth support organisations were contacted. Most did not respond or declined involvement. Some organisations asserted that migrant and refugees were not a significant part of their clientele; others felt the research topic was too sensitive.

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[16] These participants were included for several reasons: firstly, participants were only one year outside the targeted sample range; ethics coverage by Western Sydney approved inclusion of these participants. Secondly, the number of eligible responses was very small overall, making inclusion of these additional responses particularly important. Thirdly, these participants all identified as male; male participants were under-represented in the survey sample, and exclusion of these outlier participants would have furthered skewed the sample.

Social media recruitment involved posting in community Facebook groups, on X (formerly Twitter) and Instagram. Attempts to post in Reddit groups were unsuccessful. Administrators of the Sydney sub-Reddit, for example, claimed that migrant issues were not relevant to people from Sydney. Physical flyers, containing a QR code and URL link to the survey were posted around university campuses, and disseminated at community events.

Instrument:

The survey instrument was developed from a previous pilot study performed in collaboration with Family Planning New South Wales (FPNSW) examining MRY contraceptive decision-making (Mpofu et al., 2021). This instrument was significantly expanded to examine broader aspects of SRHR, using results from the GCM study as a guide. The instrument was developed and disseminated using Qualtrics (2020, Provo, UT, USA) survey software. Multiple choice, Likert scale and open-text response questions were used. For full instrument, see Appendix E1.

The final instrument comprised of 57 items with an estimated completion time of 10-15 minutes, divided into the following sections:

- Demographics (9 items)
- Sexual behaviour and relationship status (13 items)
- Religious beliefs (7 items)
- Knowledge and use of contraception/ protection (9 items)
- Beliefs and attitudes (4 items)
- Knowledge sources & education (4 items)
- Service use and accessibility (8 items)
- Sexual and reproductive health rights (3 items)

The instrument was piloted with nine MRY who provided feedback on clarity, coherence, cultural appropriateness and sensitivity. Additionally, pilot participants advised on survey length and usability. The instrument was revised accordingly.

Survey completion:

Data collection occurred between February and September 2022. Recruitment material led directly to the Qualtrics survey page, accessible via smart phone, tablet, or computer.

Participants were given the opportunity to enter email details into a draw for one of five $100 gift vouchers. Before participants could proceed, they had to pass a captcha verification question.[17]

Data Analysis

Data cleaning

Perhaps due to recruitment via social media sites, including public Facebook groups, the survey was subject to huge numbers of fraudulent responses. As such, 675 responses were recorded, the vast majority of which were ineligible. All data were exported from Qualtrics as a .csv file and opened in Microsoft Excel for cleaning.

Fraudulent and ineligible responses

Fraudulent responses were identified using several criteria, based on those developed by Pozzar et al. (2020). Firstly, any rapid influx of responses within a short time-period was considered suspicious. For example, on May 9th, there were almost 250 responses within a few hours. These responses also often contained emails with unusual domains, for example zoho.com and gmx.com, and typically used the same address format: either *firstname-lastname-1234* or a series of random letters and numbers. While the survey was designed to be 10-15 minutes in length, these responses were completed in much shorter time frames (<5 minutes). Additionally, where emails contained names, these often appeared contradictory with participant demographic responses (see Figure 4.2). Responses were flagged if they were not internally coherent. Pozzar et al. also emphasise duplicate open-text responses as indicating fraudulent activities (2020). However, while there were some duplicate open-text responses, this was not to the extent described by Pozzar et al., perhaps because there were limited open-text questions in our survey instrument. There were also responses recorded in Chinese, which were removed.

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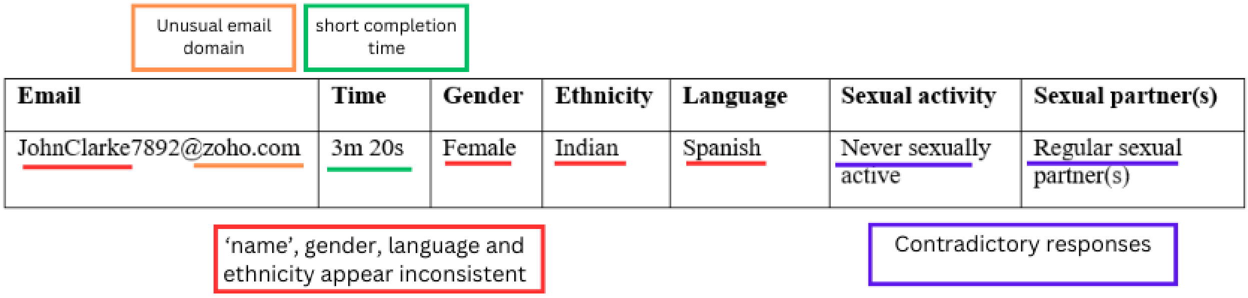
[17] Captcha refers to the Completely Automated Public Turing Test to tell Computers and Humans Apart, used to block spam and computer programs from accessing websites (such as an online survey).

Figure 4.2 Example of suspicious response



Unusual email domain

short completion time

Email	Time	Gender	Ethnicity	Language	Sexual activity	Sexual partner(s)
JohnClarke7892@zoho.com	3m 20s	Female	Indian	Spanish	Never sexually active	Regular sexual partner(s)

'name', gender, language and ethnicity appear inconsistent

Contradictory responses

I flagged suspicious responses, and then checked my decision to include or exclude the responses with the research team. Additionally, emails were sent to the flagged 'respondents', requesting verification that they met inclusion criteria and could be included in the data analysis and prize draw. Most did not respond, some responded in Chinese characters, or sent scam links. Responses were also removed if they were insufficiently complete (less than 60% of items answered).

Data preparation – recoding

Data preparation was conducted primarily by a statistician (JB) advising on the ARC project. Data were exported from Excel into SPSS software for management and analysis (IBM Corp, 2020). Excel raw data was converted into a labelled SPSS dataset. I then completed the final stage of transforming Qualtrics text variables into new numeric variables.

Statistical analysis

Preliminary descriptive statistical analysis was conducted for each measure.
After descriptive analysis, bivariate and multivariate analysis was conducted. Initial analyses examined acculturation (length of time in Australia, language spoken at home), sexual orientation, gender, and age using one-way ANOVA, independent samples *t*-test and Fisher's exact tests. Gender was selected as a measure for final analysis due to the significance of gender on various health outcomes, and the fact that SRH research is often highly gendered. Additionally, because gender analysis was not feasible in the GCM (see Chapter 5), the gender analysis of survey data was considered particularly important. As such, this study was able to bridge gaps in the previous study to provide deeper analysis of MRY SRHR decision-making. Chapter 6 thus comprises a gender analysis of MRY SRH experiences, behaviours, knowledge, attitudes and service use.

Gender analysis was bivariate, due to insufficient sample size (n = 1) of non-binary or gender non-conforming participants (see Chapter 6). Due to small sample size, categorical variables were examined using Fisher's exact test. Continuous variables were compared using independent samples *t*-test. Statistical significance was measured at a *p* value of .05.

Scale variables

Scale variables were created for overall contraceptive awareness, STI awareness, contraceptive use, and service use. Reliability was assessed using Cronbach's alpha. The scales for service use and contraceptive use proved insufficiently reliable, having an alpha below .60, and were therefore not used in any analysis.

In the contraceptive awareness section of the survey, participants were provided a list of 10 contraceptive methods and asked to select methods they had 'heard of'. For each item, responses were recorded as either 'yes' or 'no' and then coded as a 1 or 0 respectively in SPSS. These were summed to provide an overall contraceptive awareness score, with possible scores ranging from zero to ten (M = 6.98, Cronbach's α = .86).
The same methods were used to construct the STI awareness scale, measured using responses to a list of seven STIs. Scores could range from zero to seven (M = 5.66, Cronbach's α = .83).

Regression analysis

Additional logistic regression analysis was conducted and incorporated into bivariate and univariate analysis presented in the results chapter of this study (Chapter 6). This analysis was run using Statistica 14.0 (Tibco Software, 2020), and sampling adequacy was checked prior to analysis. To explore agency and safety in sexual encounters, regression analysis examined predictors of non-consensual sexual experiences, with the dependent variable being 'pressured into sex'. Independent variables were gender, place of birth (Australia or outside Australia), sexual orientation, and relationship status.

Open-text responses

Open-text responses were analysed in a separate Excel spreadsheet. For each question, broad themes were developed from the open-text responses and grouped responses accordingly. Where there were enough responses to make this possible, these responses were further grouped into sub-themes. For this study, open-text responses were primarily used to complement statistical analysis – full thematic analysis methods (discussed below) were thus not used.

Results of Study 2 are presented in Chapter 6.

Study 3: In-depth interviews

The final study involved qualitative in-depth interviews examining the abortion decision-making and experiences of MRY. This study was originally informed by grounded theory principles, attempting to generate theory from systematic qualitative analysis (Charmaz, 2014). Following these practices, interviews did not use existing frameworks for analysis or preconceived hypotheses. However, financial, resource and time constraints precluded a fully-fledged grounded theory methodology. Moreover, the strong theoretical frameworks underpinning the overall research (socioecology, intersectionality, reproductive justice, agency) meant that this study required a method that allowed existing theory to be acknowledged and incorporated (Braun & Clarke, 2006). As such, this study utilised in-depth interview methods, using reflexive thematic analysis. Data analysis was inductive, from the ground up. Theoretical frameworks did not guide analysis, but were applied following inductive analysis, where relevant. Socioecological analysis was used to structure and group *final* themes. The lack of pre-existing frameworks and codebooks foregrounded participant perspectives and allowed for surprising and unexpected data to emerge.

Instrument

A semi-structured interview guide was developed based on study aims and literature review findings (Chapter 2) (Napier-Raman et al., 2024). Four over-arching factors were explored in the interview guide: 1) abortion decision-making, 2) accessing and finding care, 3) experiences of care and interactions with healthcare workers, 4) barriers and facilitators to accessing abortion care (see Appendix E2). Questions on basic demographics and general abortion care (gestational stage, abortion type) were included at the start of the instrument.

Recruitment

Recruitment for this study was particularly challenging. A sample-size target of 10-15 participants was made during study design, with the expectation that this would be difficult to meet.

Recruitment materials primarily included physical and digital flyers (Appendix D3) displaying QR codes and hyperlinked URLs to the Qualtrics registration page as well as email and phone numbers of the primary researchers. All recruitment material included a study description detailing aims, inclusion criteria, methods, and information on compensation. The study registration page provided further information and links to the participant information statement. Prospective participants provided their name (optional) and email address.

Every abortion service in greater Sydney was contacted, of which two agreed to assist. I visited clinics, services, and organisations across Sydney. Additionally, state government youth networks and local health districts were contacted. These interactions, and their outcomes, were varied. While many providers were interested and passionate about the study, there were more that were non-responsive, dismissive, concerned by the subject matter, and even rude. As with previous studies, physical flyers were posted on university and TAFE (Technical and Further Education) campuses. A short editorial accompanied by recruitment details was published in the University of Sydney student newspaper (*Honi Soit)*.

In addition to these 'on the ground' methods, social media recruitment involved posts in community Facebook groups, on Instagram and on X. Additionally, I created an Instagram page dedicated to this study (Appendix D3), from which I posted about the study and contacted organisations, SRH pages and sexual health influencers requesting assistance. After six months with limited recruitment, paid Facebook advertisements were employed.

Data collection

This study relied on participant opt-in. Participants either directly contacted researchers or provided details to be contacted. Six participants signed up through the registration page, one participant was recruited directly through personal networks, and another made contact via text (SMS). Following initial contact/ expression of interest, participants were emailed further study information, the participant information statement, and asked about preferred interview mode and availability. All participants opted for virtual interviews and were emailed Zoom invites. Reminder emails were sent the day before and the day of the interview.

Two researchers conducted interviews – myself and my primary supervisor –, though two were conducted solely by me. Before beginning, participants were reminded of study aims and the interview outline, and informed they could stop at any time, choose to withdraw during or after the interview, and choose not to answer any questions. Interviews consisted of open-ended questions, loosely following the interview guide. To replicate methods of intensive interviewing (Charmaz, 2014), I allowed participants to lead conversation as much as possible. This varied depending on the level of participants' engagement and their comfort directing conversation. Nevertheless, all interviews covered the four key areas set out in the interview guide. Interviews ranged from 30 to 60 minutes. Participants were given a $40 digital gift card for their time.[18]

Immediately following each interview, I made general research notes, highlighting any particularly salient points and reflecting personal responses to the interview. Reflexivity was a key part of this study; throughout the interviews and analysis process, I was cognisant of my positionality as a researcher (see *Reflexivity and Researcher Positionality* below).

Data analysis

Transcription

All interviews were transcribed verbatim. The process of transcription is itself interpretive, thus comprising the first official stage of data interpretation (Clarke & Braun, 2013). Even when transcribing verbatim, punctuation and phrasing added is subject to the researcher's understanding. All participants were offered the opportunity to review and amend transcripts, which was considered important for producing participant-centred results. However, only one participant opted to review their transcript, and they made no changes. While I attempted to facilitate the participatory nature of this research, providing this opportunity to encourage co-creation of knowledge, this was not, in fact, what participants desired.[19]

To ensure transcriptions were as high quality and 'accurate'[20] as possible, I included all filler words, non-semantic sounds (i.e. "aah", "mm", "um"), grammatical errors, and inconsistencies within interviews – both my own, and participants'. The transcribing process

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[18] As this part of the study was not part of the original Australian Research Council project, payment was made using the University of Sydney Postgraduate Research Support Scheme funding. This funding was also used to pay for Facebook advertisements.

[19] This indicates a key issue in participatory research: such research relies on participants having the time, energy, resources, and desire to be continually actively engaged. As noted in the first part of this chapter, collaborative research requires significant effort – even labour – from participants, much more so than less democratic research processes.

[20] I use quotation marks around accurate because I am aware that transcription is an interpretive, subjective process and therefore 'accurate' transcription is perhaps not truly attainable (Clarke and Braun 2013).

allowed me to deeply immerse myself in the data and was particularly useful in identifying participant emotional tone and expression that I might have overlooked during the interview.

Reflexive thematic analysis

Interviews were analysed using reflective thematic analysis, as delineated by Braun and Clarke (Braun & Clarke, 2006, 2019; Braun et al., 2019; Clarke & Braun, 2013, 2017). Rather than analysis producing a complete or 'accurate' facsimile of the data, reflexive thematic analysis involves interplay between the data, the theoretical frames and assumptions of the analysis, and the researcher's sociocultural positionality and expertise (Braun & Clarke, 2019; Byrne, 2022). This offers a flexible means for systematically analysing data, using codes which can then be tied to overarching theoretical concerns (Braun & Clarke, 2012).

Data collection and analysis were concurrent: I began thematic analysis following the first interview, and analysis informed ongoing data collection, with subsequent interviews exploring emerging themes (Belgrave & Seide, 2019). Braun and Clarke describe a six-stage approach to reflexive thematic analysis: 1) data familiarisation, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) naming and defining themes, and 6) producing the report (2006, p. 87).

Following this approach, before embarking on coding, I familiarised myself with the data through repeatedly reading my field notes and interview transcripts, often listening to audio recordings of interviews while reading transcripts. This helped me develop a deep understanding of the data. Reflexive recording of field notes was also crucial for analytical reliability/ credibility – for example my presumptions that abortion would be inherently 'traumatic' and that participants would struggle over the decision did not actually appear in participants' narratives (see Chapter 7). Noting down my preconceptions (informed by my previous research, literature review, *and* personal conceptions of abortion) fostered a self-awareness that led me to be more open to data that did not conform to my expectations and stopped me from sublimating my own beliefs onto participants' narratives. Moreover, field notes allowed me to develop comparisons *between* interviews, contrasting different ways in which participants described their decisions.

Interview transcripts were uploaded to QSR's NVivo qualitative analysis software for coding (QSR International Pty Ltd, 2020). I undertook line-by-line coding, summarising data segments. This initial coding was primarily inductive: data-driven, from the ‘ground’ up. However, as Braun and Clarke note, researcher interpretations and subjectivity means that “we always bring something to the data” (2012, p. 58). Rather than summarising ‘accurately’, I positioned myself in this coding process as “a *storyteller*, actively engaged in interpreting data through the lens of their own cultural membership and social positionings, their theoretical assumptions and ideological commitments, as well as their scholarly knowledge” [original emphasis] (Braun et al., 2019, p. 848).

Given the small sample size of this study, I undertook initial coding twice, allowing a deep, reflexive engagement with my data. In so doing, I reflected on the ways my interpretation of the data changed and remained consistent between first and second coding, examining the ‘stories’ that emerged from the two coding sets (Braun & Clarke, 2019).

Following initial coding, I developed themes by collating and grouping codes around core organising concepts (Braun et al., 2019). Themes can be considered “analytic *outputs*”, patterns of meaning that are developed and actively created by the researcher through the coding process (Braun et al., 2019, p. 846). I therefore structured themes around shared *meaning* (Braun & Clarke, 2019). Nevertheless, there were certain themes that were more descriptive, expressing ‘surface’ meanings, while others were more analytical. This reflects Braun and Clarke’s assertion that thematic analysis methods do not demand a dichotomy between semantic and latent analysis but view these as existing along a continuum (2013). Following initial theme development, I reviewed and refined themes, comparing themes to coded extracts and the entire dataset (Braun & Clarke, 2006). While the names of themes were developed through this entire process, during this last stage, names were clarified, and the specific details of each theme defined. To aid in these stages of developing, reviewing, and refining themes, I created a table including codes, key quotes, thematic description and names of each theme.

In the final preparation of the results, themes were organised and presented under four overarching categories which related broadly to the socioecological framework used throughout this thesis: personal/ individual experiences, interpersonal and relational experiences, structural and institutional experiences, and socio-cultural experiences. These broader categories expanded on socioecological frameworks by incorporating aspects of intersectionality and reproductive justice theory and indicated the multifaceted nature of participants' abortion decision-making and experiences.

Ensuring trustworthiness

To ensure trustworthiness of data and analysis, I followed Nowell et al.'s trustworthiness guidelines (2017), informed by Lincoln and Guba's original criteria (1985). A significant part of these measures included the development of an 'audit trail' (Nowell et al., 2017), keeping records of field notes, interview transcripts and recordings made throughout study development and data collection. I undertook reflexive journalling throughout my candidature – often simply bullet-points relaying thought processes and research progress. These notes allowed me to crystalise personal beliefs, biases and positionality and critically reflect on how these might shape data analysis.

This study applied Lincoln and Guba's criteria for ensuring trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability (1985). *Credibility* was maintained through consistent appraisal and review of coding and thematic development between myself and my primary supervisors (SZH, MJL). I made efforts to include thick, rich description in my presentation of results (see Chapter 7) to meet *transferability* criteria (Nowell et al., 2017). *Dependability* included use of audit trails described above, thoroughly documenting my research process. Finally, I ensured *confirmability* of my analysis by including substantial quotations from participants in my results. This not only demonstrated that analysis accurately reflected data but allowed participant voices to feature strongly.

Interview results are presented in Chapter 7.

Reflexivity and researcher positionality

Crucial to this research has been an ongoing process of reflection on my positionality as a researcher.

Insider-Outsider positionality

An *insider* researcher is one who belongs to the population they are researching (Dwyer & Buckle, 2009). Being an insider may allow greater trust, acceptance and rapport between researchers and participants (Chavez, 2008; Dwyer & Buckle, 2009; Greene, 2014). This positionality can encourage more democratic forms of research, where there is less rigid distinction between researcher and participant and thus a less hierarchical relationship of researcher over research subject (Chavez, 2008). Insider researchers may more easily understand cultural cues and subtext, have deeper contextual and historical awareness of the subject matter, and be able to more readily identify trends and anomalies in the research data (Chavez, 2008). However, insider research is also critiqued for being overly subjective: prone to bias in analysis and participant selection (Chavez, 2008; Dwyer & Buckle, 2009). Belonging to the community one is studying can lead to split sympathies between social obligation and research integrity (Chavez, 2008).

The position of insider, however, is not clear-cut, and the opposition of insider and outsider is somewhat fallacious (Greene, 2014). There is no established 'level' of shared identity that begets insider status (Greene, 2014). Rather than attempting to quantify my 'insider-ness', I will simply note that labelling myself either 'insider' or 'outsider' would oversimplify my identity and position as a researcher. Instead, as Couture et al. suggest, I have attempted to be cognisant of my myriad intersecting identities throughout the research process, and how different aspects of my identity shape my interactions with the world around me (2012).

'Insider' characteristics

In conducting this research, I hold certain 'insider' characteristics: I am a mixed-race second-generation migrant, and, by the age range identified in this research, a 'youth'. I could, feasibly, participate in my own research. Being a woman is also a crucial part of my identity – one that I shared with many of my participants. These factors have inevitably influenced the way I conducted my research and how, in turn, my participants, informants and contacts responded to me. Being a somewhat 'insider' has made me neither a better nor worse researcher, simply "a different type of researcher" (Dwyer & Buckle, 2009, p. 56).

Migrant identity

As a young, second-generation migrant woman, my 'insider' characteristics brought a sense of shared understanding with participants. Many of the experiences my participants discussed – discomfort and silence around SRH, feeling inexperienced and unprepared, struggling to navigate relationships and intimacy – were similar to my own. In this way, I felt I had insight into – at least some of – what my participants were discussing. The shared aspects of identity between myself and participants may have encouraged them to be more open and comfortable in their engagement with the research and allowed an ease of rapport.

Additionally, the entirety of my research team – my supervisors and the ARC project chief investigators – were from migrant backgrounds.

However, as indicative of the mutability of 'insider' positionality, while some participants may have identified with my migrant status, to those who did not share my specific ethnic background, I may have been more 'outsider'. Being mixed-race, my whiteness may also have been a marker of 'otherness' to some participants.

Age

Belonging to the same age-group and generation as my participants presents another 'insider' characteristic. This is particularly relevant given Botfield et al.'s findings that age and generational sensibility is more pertinent to MRY identity than culture (2018). Additionally, studies examining access to SRH care have shown MRY perceive older providers as judgemental (Botfield et al., 2018; Rawson & Liamputtong, 2009). My age allowed me to avoid this association and potentially mitigated some of the inherent power inequities between researcher and participant. However, there is also the possibility that participants would have preferred a more seemingly 'experienced' researcher, or someone with clear authority. Having the support of my supervisor during interviews was crucial in these cases; it was also significant that my supervisor, like me, is female and from a migrant background.

Gender

There were times during this research where my gender identity, and the social norms associated with this, was beneficial. Often, women – particularly younger women – are seen as non-threatening and less intimidating. While I have not personally undergone abortion, and thus do not have an intimate understanding borne from lived experience, I believe my shared gender identity, migrant status and relative age was similarly beneficial in fostering a supportive interview environment for my participants.

Stigma

SRH stigma and taboo within migrant and refugee communities might also have led participants to believe that I, as a migrant, might share these attitudes. Zaidi notes that her interviews with South Asian youth regarding sexuality were sometimes inhibited by shared identity and participants' fear of judgement (Couture et al., 2012). I was also aware that my participants themselves had varying levels of comfort and diverse perspectives on SRH, including potential shame and stigma. In my research, I thus had to navigate presenting a respectful, non-judgemental attitude that did not exclude or upset participants of varying beliefs and backgrounds.

Insider research also holds risks of projection: imposing or interpreting one's own experiences onto those of participants (Chavez, 2008; Dwyer & Buckle, 2009). Researchers from marginalised and minority groups, particularly migrant communities, have particularly noted the burden of representation – the pressure to positively represent groups in ways that counter dominant negative stereotypes (Couture et al., 2012; Kusow, 2003). A crucial way in which I managed my expectations, beliefs and sense of 'duty' was through ongoing reflexive journalling on my research process. This involved reflecting upon my experiences as a migrant woman in Australia, including my SRH education (and the gaps in this education), and the attitudes of my family and broader social networks. I also interrogated the disconnection and alienation from mainstream (white) Australian discourses on sexuality and the internalised shame around SRH that I felt growing up.

Conclusion

This chapter expounds the methodology of this thesis. Following on from the theoretical frameworks established in Chapter 3, this chapter details the philosophical assumptions and broad methodological approach of this research. The methods of each research study described above correspond to the results presented in the subsequent three chapters. While each of the following chapters includes a truncated methods section, the present chapter offers necessary additional explication and grounds study methods in the broader theoretical frameworks, philosophical assumptions and researcher positionality intrinsic to this research.

Chapter 5. Mixed methods group concept mapping study

Chapter overview

Myriad intersecting socioecological factors inform MRY's decision-making around SRHR. Yet much of the existing scholarship on this population's SRH highlights barriers and repressions that lead to poor outcomes and vulnerabilities. This study shifts away from a deficit focus, centring strengths by examining how MRY make decisions about their sexual and reproductive lives. In illuminating factors that youth consider most important in their decision-making, this research offers invaluable insight into how best to engage and support this population. The findings presented here have significant implications for overcoming the deficits reported in previous scholarship.

This chapter includes a published journal article reporting on the GCM study. This study aimed to identify key factors migrant and refugee youth perceive as informing their sexual and reproductive health and rights wellbeing, decision-making and agency. The methods of this study, and the strength of a GCM approach, were thoroughly detailed in the previous chapter (Chapter 4) (Napier-Raman et al. 2023). Key findings are presented in the following publication and additional results discussed subsequently. Supplementary material from this study is affixed in Appendix F.

These findings were presented as an oral presentation at the Royal College of Paediatrics and Child Health *Adolescent Health Conference*, Birmingham, the United Kingdom, in November 2022.

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Sexual and reproductive health and rights decision-making among Australian migrant and refugee youth: a group concept mapping study

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ABSTRACT

Sexual and reproductive health (SRH) is a human right. Young people, particularly from marginalised groups such as migrant and refugees, are vulnerable to compromised sexual and reproductive health and rights. In this study, we aimed to identify socioecological factors influencing migrant and refugee youth SRH decision-making and compare perspectives of youth with key stakeholders. Data were collected using Group Concept Mapping (GCM), a mixed-methods participatory approach. Participants included migrant and refugee young people, aged 16–26 from Western Sydney ($n=55$), and key stakeholders comprising clinicians, service providers and researchers ($n=13$). GCM involved participants brainstorming statements about how migrant and refugee youth make SRH decisions. Participants then sorted statements into groups based on similarity, and rated statements on importance and impact. Multidimensional scaling and hierarchical cluster analysis were used to cluster statements into concept maps that represented participants' perspectives. The resulting maps comprised six clusters representing main concepts informing decision-making. The most important clusters were 'healthy relationships' and 'safe-sex practices'. Youth rated healthy relationships more important than stakeholders did. This study reveals factors informing migrant and refugee youth's decision-making. Future policy should go beyond biomedical constructions of SRH to incorporate emotional and relational factors, which young people consider to be equally important and beneficial to their agency.

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Introduction

Sexual and reproductive health (SRH) is a human right (Starrs et al. 2018). Sexual and reproductive health rights (SRHR) encompass autonomy and protection to make decisions about one's body and sexual life, and access to services and information that enable such decisions (Starrs et al. 2018). For young people, the transition from childhood to adulthood involves physiological, social and emotional changes (Starrs et al. 2018). SRH experiences during this period can influence future health and life paths (Patton et al. 2016). Consequently, ensuring youth's SRH well-being and rights is fundamental to the prosperity of future society and generations (Patton et al. 2016; Starrs et al. 2018). Youth decision-making and agency are tempered by socioecological factors, including individual experiences of change and transition, and contextual influences of a cultural, religious, economic, legal and political nature (Patton et al. 2016). Australian migrant and refugee youth, a socially marginalised group, have distinct needs, perspectives, strengths and experiences that shape SRHR decision-making.

Among youth, marginalised groups such as migrant and refugee youth face barriers to accessing medical care, information, and supplies (Robards et al. 2019; Kaczkowski and Swartout 2020). Compared with other Australian youth, migrant and refugee youth have limited knowledge and testing for sexually transmitted infections (STIs), higher pregnancy rates (McMichael and Gifford 2010), and lower rates of SRH service use (Botfield, Newman, and Zwi 2018). Moreover, migrant and refugee youth frequently experience inadequate SRH education (McMichael and Gifford 2009; Botfield, Zwi, et al. 2018; Wray, Ussher, and Perz 2014; Kaczkowski and Swartout 2020; Dhar et al. 2017), have low SRH knowledge (McMichael and Gifford 2010, 2009; Wray, Ussher, and Perz 2014; Kaczkowski and Swartout 2020), express uncertainty about legal and health systems (Chung et al. 2018; Botfield, Newman, Kang, et al. 2018; Dhar et al. 2017), and may experience difficulties navigating consensual relationships (McMichael and Gifford 2009; Wray, Ussher, and Perz 2014; Chung et al. 2018).

Migration and displacement often disrupt access to SRH services and education (Metusela et al. 2017). Upon resettlement, difficulties encountering unfamiliar and culturally incongruous legal, health and governmental systems further preclude SRHR (Mengesha, Dune, and Perz 2016). SRH is a contentious topic in many communities, and specific religious or cultural understandings of sexuality influence access, knowledge and attitudes (Dune et al. 2017; Udmuangpia et al. 2017). Migrant and refugee youth from a range of backgrounds report SRH taboos and stigma within their families and ethnic communities (Botfield, Zwi, et al. 2018; McMichael and Gifford 2010; Rawson and Liamputtong 2010; Wray, Ussher, and Perz 2014; Dhar et al. 2017; Udmuangpia et al. 2017). However, migrant and refugee populations are not homogeneous. The experiences of refugees – forced displacement, often hazardous resettlement journeys, and time in camps – may result in different outcomes and needs for migrants. While acknowledging this diversity, in this paper we use the broad, inclusive term 'migrant and refugee' to examine shared experiences in navigating key socioecological challenges.

The socioecological model (SEM) acknowledges the dynamic relationship between individuals and their environments as influencing health behaviour (Bronfenbrenner 1994). Accordingly, decision-making is determined by interaction of individual, interpersonal, institutional and societal level factors. This study takes a socioecological approach, examining the multifaceted nature of youth decision-making. In addition to navigating new experiences of physical, social and sexual maturation, migrant and refugee youth decision-making is likely shaped by cultural and ethnic positionality. Much existing Australian research on migrant and refugee SRH has emphasised culture and family, particularly culture-clash and parent–child relationships (McMichael and Gifford 2010; Dean et al. 2017; Dune et al. 2017). Discordance between cultural and religious values of origin and resettlement countries has typically been used to explain health behaviours such as low service engagement (Ussher et al. 2017). However, more recently, Botfield, Newman and Zwi found age and generational sensibility more salient to migrant and refugee youth identity and SRH attitudes than culture or community (2018). Similarly, the literature on culture-clash and intergenerational conflict tends to adopt a deficit approach, when it is youth agency, strengths and assets that should be acknowledged. We contribute to this literature base by focusing on strengths, examining how youth actively make decisions and enact agency around structural and social challenges.

Study context and population

The term 'youth' is fluid and variably defined. Moreover, understandings of life-stages are contextually and socioculturally determined. In this paper, we use the term youth to denote the broad transitional period between childhood and adulthood (UN n.d.). Participants in this study were aged 16–26 years, a range informed by study context. The age of consent in the state of New South Wales is 16 years. We extended the age range to 26 years to include emerging adulthood, reflecting recent trends on delayed leaving home (Qu 2019).

Over half of all Australians were born overseas or have a parent born overseas (ABS 2021), and 25% of youth in Australia aged 15–24 were born overseas (AIHW 2021). Western Sydney is one of Australia's fastest-growing regions, with a significant migrant and refugee community (.id 2023) Most research on migrant and refugee SRH in Western Sydney has followed a deficit model, focusing on culture-clash, STIs, unintended pregnancy, and service barriers (Wray, Ussher, and Perz 2014; Hawkey et al. 2017; Mengesha, Dune, and Perz 2016; Dune et al. 2017). Additionally, the limited research on migrant and refugee youth in Western Sydney regarding SRH has not highlighted agency and strengths. Understanding how migrant and refugee youth experience SRHR is crucial to developing rights-based programming to support agentic decision-making and improve health outcomes. Agency here refers to individuals' capacity 'to make purposeful choices and transform these into desired actions and outcomes' (Bell 2012, 283). Agentic SRH decision-making thus involves the ability to make informed, unrestricted choices about what happens, and when, to one's body, including whether and with whom to be sexually active. For migrant and refugee youth, contextual factors including stigma and structural inequality may lead to 'thin' forms of agency – or agency that is constrained or restricted (Bell 2012; Napier-Raman et al. 2023). Examining youth experiences from a strengths-based perspective reveals how young people navigate constraints to enact subtle agency, and the ways programming can be developed to support these processes.

This study aimed to (1) identify key factors – or barriers and facilitators – migrant and refugee youth perceive as informing their sexual and reproductive well-being and decision-making, and (2) understand the perspectives of stakeholders on migrant and refugee youth sexual and reproductive well-being and decision-making, and how this aligns with youth perspectives.

The study builds upon nascent scholarship highlighting migrant and refugee agency (Hawkey, Ussher, and Perz 2018; Ussher et al. 2017), focusing on the strengths and decision-making capabilities of migrant and refugee youth.

Methods

This study employed Group Concept Mapping (GCM) – a mixed-methods participatory approach integrating qualitative conceptual data and multivariate statistical analyses (Kane and Trochim 2007) – to examine migrant and refugee youth SRH decision-making. GCM is ideal for participatory research, centring participant voices by involving participants in each stage of the research (Kane and Trochim 2007). This study is part of a broader multistage project investigating migrant and refugee youth SRHR in Western Sydney (Pithavadian et al. 2023).

Participants

Study participants were young people self-identifying as migrants or refugees (including second-generation migrants), living in Western Sydney, and key stakeholders with expertise in SRH and/or migrant and refugee well-being. Passive snowball sampling was used to recruit participants. This involved re-inviting youth who had participated in previous stages of the broader project. Additionally, youth participants were asked to invite others in their social network who met the criteria to participate. Young people were also recruited from local health organisations, social media, and word of mouth. For stakeholders, inclusion criteria specified those working in the area of SRH, youth or adolescent health, migrant and refugee health or services. Stakeholders were contacted *via* email and invited to participate.

Procedure

Young people registered to participate *via* an online survey, where they were provided with participant information forms. Registered participants were then emailed instructions, a link to the activity webpage, and a de-identified username and password to access activities. Participants could not access activities until the consent statement – displayed upon login – was accepted. Young people were compensated with gift cards valuing $20 for generation activities, $40 for structuring activities, and $20 for interpretation. Stakeholders were not compensated. Ethics approval for this study was received from Western Sydney University (approval number H13798).

Data collection

GCM involves five primary stages: preparation, generation, structuring, representation and interpretation. In this study, data collection was carried out virtually using The

Concept System® groupwisdom™ software between July and October 2021 (The Concept System® 2022). All generating and structuring activities were conducted individually online.

Preparation involved the development of a focus prompt by the research team (SNR, EM, SZH, ML). Study objectives were developed into a simple sentence completion prompt with a lead-in sentence providing participants with context:

> People have different ideas about sexual and reproductive health. Different things may influence the choices we make in our sexual life. Something that influences the way I make choices about my sexual life is…

Generating

The generation phase consisted of anonymous online brainstorming. Participants were asked to respond to the focus prompt as many times as possible. Stakeholders were given a re-worded prompt with 'I' and 'my' replaced by 'migrant and refugee youth' and 'their'. To simulate in-person brainstorming, youth participants were able to view anonymous statements made by other youth participants, while stakeholders could view statements from other stakeholders. Additionally, statements from key literature and focus groups from the broader study were added to the brainstorming to ensure a comprehensive representation of SRH decision-making factors.

Both youth and stakeholder participants also answered five socio-demographic questions including age, gender, ethnic/cultural background, employment status and SRH service use. Forty youth and six stakeholders completed the brainstorming. A total of 126 raw statements – 94 from youth and 32 from stakeholders – was generated.

The research team then edited and refined raw statements. Major grammatical, spelling or logical errors were rectified. Duplicate, incomplete, irrelevant and unclear statements were removed. Statements were assigned keywords and grouped into thematic codes by one researcher (SNR) to ensure a full representation of all major themes in the final statement set. The research team reviewed codes and cooperatively selected a final set of 64 unique statements.

Structuring

A total of 42 migrant and refugee youth (including 31 from the generation phase) and 13 stakeholders participated in the structuring phase of the work. This phase included sorting and rating the refined statement set. For sorting, participants individually organised statements into groups and labelled each group. Participants were instructed to sort statements based on similarity and common themes, not importance or value-based groupings. Participants then rated statements based on importance and impact. First, participants gave each statement an importance rating using a 5-point Likert scale, where 1 is relatively unimportant and 5 very important. Second, participants rated whether each statement had a positive or negative impact on migrant and refugee youth decision-making, using a scale of −1 through 1, with −1 being negative impact, 0 being neutral or no impact, and +1 being positive.

The research team assessed sorting and rating data for usability: from sorting, two sorts were identified as incomplete, and seven did not follow grouping instructions. Fifty-two participant importance ratings and 41 impact ratings were usable.

Representation (analysis) and interpretation

Following completion of data collection (in October 2022), groupwisdom™ software was used to create graphical representations of the data through multidimensional scaling (MDS) and hierarchical cluster analysis (HCA) (The Concept System® 2022). These analyses are inbuilt in groupwisdom™ software and run automatically. MDS methods generate point maps from participant sorting data, where each point represents a statement. The proximity of points indicates how frequently participants grouped statements together. Additionally, groupwisdom™ software automatically calculates a stress value to assess overall goodness-of-fit of the point map (The Concept System® 2022). Stress values range from 0 to 1, with values closer to 0 indicating better fit. The point map generated from sorting data was used as the foundation for subsequent concept maps.

HCA based on Ward's algorithm was used to create boundaries around points that were conceptually similar, producing cluster maps (Kane and Trochim 2009). The research team began with a 15-cluster solution and successively decreased the number of clusters by 1 until an optimum solution was obtained. This process involved going from a more 'granular' solution of many clusters to a conceptually broad solution of fewer clusters, qualitatively assessing each configuration for the most appropriate conceptual fit of the data (Kane and Trochim 2009). Tenets of parsimony – seeking the simplest solution for presenting data – were followed in selecting a solution. Choosing the simplest solution was important to ensure findings could be easily and comprehensibly presented to migrant and refugee communities. A six-cluster map was deemed the most simple, interpretable configuration that still held sufficient detail and conceptual coherence. To further coherence, clusters were reviewed for incongruous outlier statements that would be better placed in adjacent clusters. Statements 1 and 3 were moved from Cluster 1 to Cluster 6, since the conceptual content of these statements more closely aligned with statements from Cluster 6. The research team gave each cluster an initial label based on thematic content of the statements within the cluster.

Three-dimensional cluster-ratings maps were created by overlaying average cluster ratings, based on average ratings of statements in each cluster. Cluster-rating maps were generated for Importance and Impact. A ladder graph representation, known as a 'pattern match' (The Concept System® 2022), was used to compare the relative importance and impact of each cluster, as well as the importance of clusters between young people and key stakeholders.

Following data analysis, an interpretation session was held with five young people who had completed previous activities. Youth were asked to examine clusters and suggest cluster labels. They were then presented with the labels developed by the research team and discussed points of difference. In line with participant suggestions, changes were made to the initial labels for three clusters. Participants were shown the final cluster-rating maps and pattern-match, and discussed how these aligned with their individual understandings. The session was conducted *via* Zoom and recorded with consent.

Findings

Participant demographics are detailed in Table 1. Most participants from both youth and stakeholder groups were female. Most migrant and refugee youth were of Asian background, with particularly large cohorts who identified as Vietnamese ($n = 12$), Chinese ($n = 8$) and Vietnamese-Chinese ($n = 3$). This potentially skewed results, over-representing Southeast and East Asian perspectives. Similarly, due to small sample size and overrepresentation of Asian participants, subgroup analysis on ethnicity was not possible. Almost 80% of youth had never attended a sexual health service. Three young women and two young men, aged 19–24 years, attended the follow-up interpretation session. A total of 13 stakeholders participated. They included researchers and academics in the fields of public health, migrant and refugee studies and SRH respectively ($n = 7$), SRH service providers ($n = 2$) social paediatricians ($n = 1$), youth/adolescent health specialists ($n = 1$), migrant and refugee service providers ($n = 1$) and university peer program coordinators ($n = 1$).

Table 5.1

Table 1. Demographic characteristics of migrant and refugee youth and key informants who completed structuring activities.

	Migrant and refugee youth ($n = 55$)	Key informants ($n = 13$)
Age	Range 16–26	
Mean (SD)	20.76 (2.2)	50.9 (13.7)
16–20	25	–
21–26	30	–
27–50	–	6
50+	–	7
Gender		
Female	42 (76%)	8 (62%)
Male	13 (24%)	5 (38%)
Employment		
Working full time	10	9
Working and studying	23	3
Studying	21	–
Unemployed	1	–
Other	–	1
Ethnicity/Background		
Asia	34	3
Pacific	2	1 (NZ)
Africa	8	2
Europe	6	5
Middle East	5	–
North American	–	1*
Service access		
Never	43	2
More than 6 months ago	10	9
In the last 2–6 months	2	2

*1 non-response.

Figure 1 presents the Importance cluster-rating map for all participants. The map had a stress value of 0.1992, indicating high internal validity. Cluster names, full statements and impact and importance ratings of individual statements and cluster averages are shown in Table 2. While cluster labels were developed from the thematic content within each cluster, rather than the SEM, we found that clusters included factors that spanned across all socioecological levels.

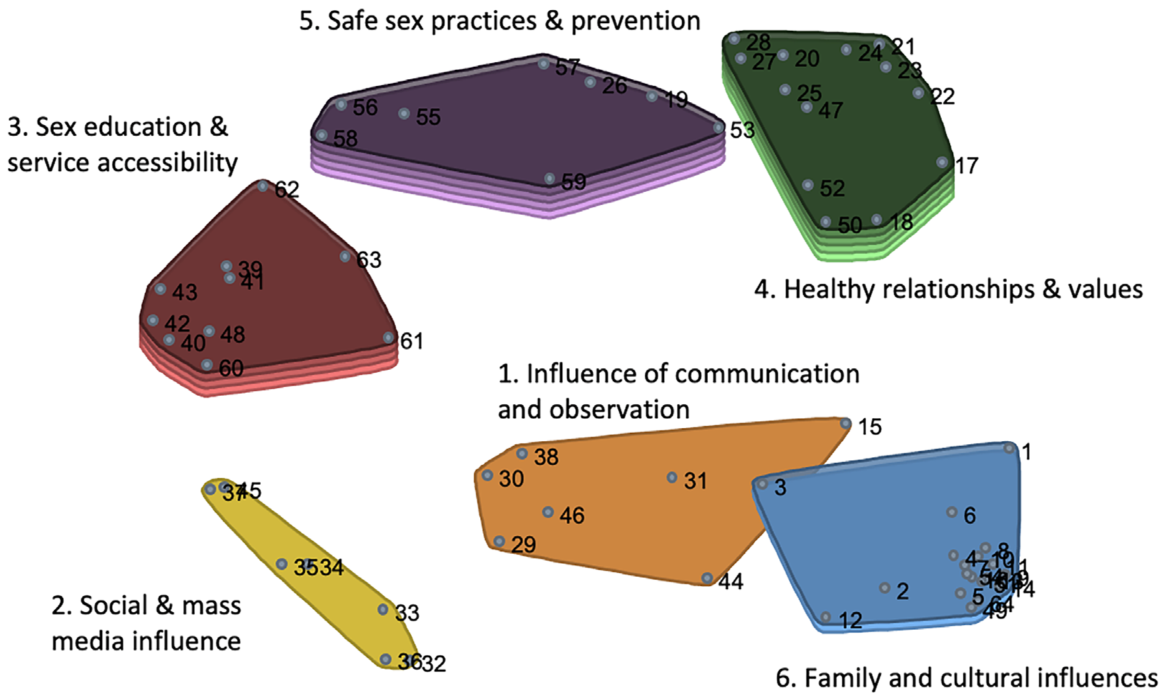

Figure 1. Importance cluster-rating map.

Figure 5.1

Table 5.2

Table 2. Cluster names, statements and ratings.

Cluster number and label	Statement (number)	Importance rating	Impact rating
1. Influence of communication and observation		3.42	0.26
	Fearing judgement from other people and gossip spreading about my sexual life (15)	3.65	−0.62
	Observing my friends, their choices and how that has impacted them (29)	3.77	0.46
	Conversations I have with my friends set limits of what is ‘normal’ and acceptable sexually (30)	3.59	0.41
	Talking to my close relatives (Including my siblings and cousins) (31)	3.08	0.41
	Being able to access culturally safe information from individuals I respect and who understand my concerns (44)	4.1	0.79
	Access to information in my home language/ mother tongue (46)	2.85	0.38
	Pornography or erotic fiction has changed my sexual preferences and influences my willingness to try to new things (38)	2.96	−0.03
2. Social and mass media influence		3.31	−0.09
	Social media makes it easy to access inappropriate/ harmful content (32)	3.83	−0.33
	My perspectives on sexual and reproductive health mostly come from social media (33)	2.92	−0.28
	Getting information from the experiences of social media influencers and their advice (34)	2.52	−0.18
	Not being able to tell if what I read on social media is factual and true or just opinion (35)	3.45	−0.54
	I am influenced by the media I consume (including film, music, social media and articles) (36)	3.4	−0.08
	Access to the internet and online information (37)	4.31	0.67
	Getting information from researching public forums and magazines like *Women'sHealth*and *Cosmopolitan* (38)	2.75	0.13

(*Continued*)

Table 2. Continued.

Cluster number and label	Statement (number)	Importance rating	Impact rating
3. Sex education and service accessibility		3.86	−0.04
	Sexual education about the right way to manage a relationship or get into one (39)	4	0.64
	The school education that I have been taught (40)	3.65	0.23
	Not being taught about sexual violence properly during school means I don't know how to recognise or deal with sexual violence (41)	3.98	−0.59
	Lack of education and knowledge about sex has limited my ability to make safe choices.(42)	3.52	−0.59
	Medical research and science, particularly when it comes to contraceptives and hygiene (43)	4.35	0.79
	Not having been taught about sexual and reproductive health on the spectrum of LGTBQI + issues (48)	3.56	−0.59
	Not knowing where to go for sexual health issues because I was never taught what services there are or how to use them (60)	3.59	−0.7
	Whether health service providers are making efforts to engage me as a culturally diverse young person (61)	3.92	0.58
	Not feeling comfortable telling a doctor/health-worker if I have concerns about my sexual health (63)	3.53	−0.67
	I only feel safe accessing health care if I'm sure that it will be confidential (62)	4.53	0.51
4. Healthy relationships, emotional security andvalues		4.1	0.65
	I think sexual health should be between you and your future spouse (17)	3.53	0.33
	I think you should find love before you have children (18)	3.81	0.46
	Knowing that both individuals need to be compatible to form healthy sexual relations (20)	4.1	0.72
	The level of trust between me and my partner and understanding what choices work for us (21)	4.65	0.97
	Knowing that my partner will value that I am able to reach sexual pleasure every time (22)	3.81	0.59
	Whether I have known my partner for a while and have genuine feelings for my partner (23)	4.27	0.79
	Finding a partner who respects my boundaries (24)	4.63	0.92
	Ensuring I am in a safe space and only opening up to those I trust (25)	4.49	0.95
	I have to be comfortable or ready for whatever new sexual experiences I am being confronted with (27)	4.23	0.82
	My mental health and physical health: if I feel well/happy/comfortable (28)	4.46	0.97
	Discovering my sexuality and sexual preferences (47)	4.08	0.79
	Feminism. My sexual choices are shaped by my feminist values (50)	3.48	0.56
	My safety as a woman, as I sometimes feel pressured to do things (52)	3.73	−0.39
5. Sexual risk, safe-sex practices and prevention		4.1	0.44
	Avoiding making any sexual decisions under any influence/alcohol because I fear that I will lose control (19)	3.73	0.36
	Making sure that my past negative experiences never happen again by learning ways to protect myself (26)	4.14	0.69
	As a woman I am afraid of being taken advantage of (53)	4	−0.38
	Using contraception to prevent pregnancy (55)	4.27	0.82
	Using protection to prevent STIs (56)	4.48	0.9

(*Continued*)

Table 2. Continued.

Cluster number and label	Statement (number)	Importance rating	Impact rating
	My safety, to prevent accidentally doing harm to my body during sex (57)	4.12	0.67
	Being afraid of contraception side effects (58)	3.59	−0.39
	Making sure that if I have kids, I teach myself about the signs of sexual abuse and can teach my children about reproductive health (59)	4.48	0.82
6. Social norms, family and cultural influences		3.48	−0.45
	If my parents found out I was sexually active, they'd lecture me about being too easy instead of discussing safe sex (2)	4	−0.62
	Sexual repression in migrant households means you don't know how to express yourself and you're scared of being judged or disowned (4)	3.87	−0.68
	Growing up in a conservative and religious household I was taught abstinence over safe practices (5)	3.61	−0.36
	My religious and conservative upbringing means I sometimes feel guilty about my sexual activity (6)	3.58	−0.41
	My religious upbringing plays a large part in the things I perceive as right or wrong (7)	3.47	−0.03
	My religion doesn't permit certain acts such as extra-/pre-marital sex and this serves to protect my health (8)	3.02	−0.1
	In my culture, sexual taboo means sexual life and even just talking about sex only happens after marriage (9)	3.43	−0.59
	Cultural insight can balance sexual life by teaching self-control (10)	3.23	0.23
	My fear of breaking the conservative norms that are upheld within my community (11)	3.52	−0.49
	Western culture and shows always make me feel bad for not being sexual and not wanting to have sexual relations (12)	2.96	−0.46
	Conflict between 'Australian/Western culture and ethnic culture as my family honours the traditional culture (13)	3.75	−0.54
	Cultural and religious stigmas shape my comfort with sexual choices (14)	3.53	−0.38
	In my community, getting pregnant when you're not married is so shameful, it's seen as the worst thing that could happen to anyone (16)	3.75	−0.54
	People in my culture thinking sex should only occur between male and female and that the LGBTQI + community is unnatural means I have to hide my true self (49)	3.42	−0.62
	In my culture, boys are seen as having 'needs' and can do anything, while girls being sexually active are seen negatively and not allowed (51)	3.37	−0.62
	Cultural beliefs that woman's worth and dignity come from being 'pure' and not sexually active have become embedded in my mentality (54)	3.17	−0.62
	Sensitivity in my culture about sexual and reproductive health means accessing services is really difficult (64)	3.71	−0.67
	Never having the 'talk' with my parents meant I was alienated and had to figure out my own sexuality and about sex on my own (3)	3.73	−0.59
	Feeling pressure/ stressed from parents always talking about my future spouse and marriage (1)	2.94	−0.54

Cluster 4, 'Healthy relationships, emotional security and values', and Cluster 5, 'Sexual-risk, safe sex practices and prevention', had the highest aggregate importance rating (4.1), while Cluster 2, 'Social and mass media influence', had the lowest. Cluster 4 again had the highest impact, with a value of 0.65 indicating the most positive overall impact, while Cluster 6, 'Social norms, family and cultural influences', had the lowest impact rating, a value of −0.45 indicating the most negative overall impact. Cluster 1 had the highest bridging value (0.9), indicating statements within it were frequently sorted with statements further away on the map. Clusters 2 and 5 had the next highest (0.76), followed by clusters 3 (0.69) and 4 (0.61). Cluster 6 had a significantly lower average bridging value (0.16), indicating that statements within the cluster were frequently grouped with the statements adjacent to them.

A pattern match comparing youth importance ratings to those of stakeholders is presented in Figure 2. Overall, there was a relatively strong positive correlation between migrant and refugee youth and stakeholder ratings ($r = 0.74$).

However, while migrant and refugee youth found relationships and values most important, followed by safe sex and prevention and then sex education and service accessibility, stakeholder ratings were the inverse. Welsh's *t*-tests found that the difference in ratings between youth and stakeholders was significant in clusters 4, t (24) = 3.3351, $p = 0.0028$, and 5, t (14) = 2.6191, p = 0.0202. As such, there was a significant difference between young people and stakeholders regarding the relative importance of healthy relationships and safe sex practices (Figure 2).

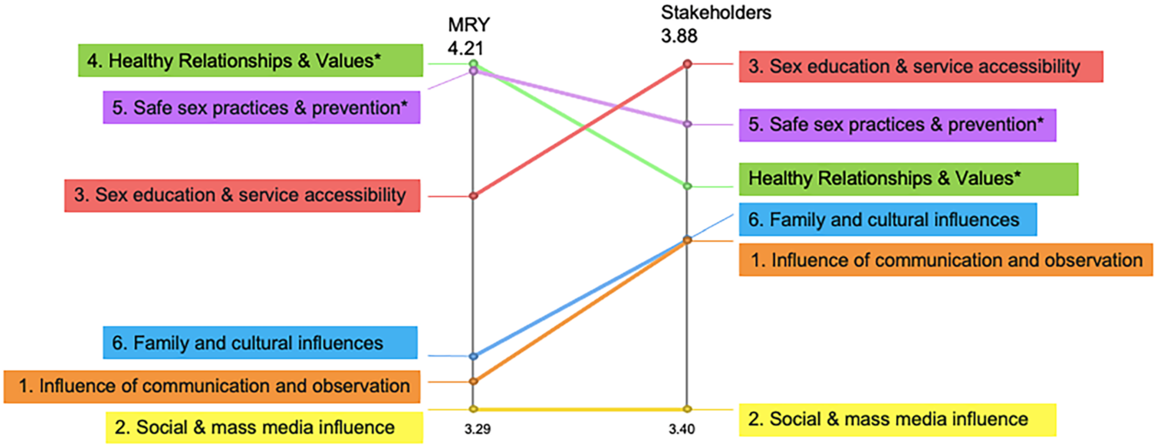

Figure 2. Importance pattern match.

Figure 5.2

Interpretation of maps

Migrant and refugee youth felt the results were representative of their perspectives, noting that 'the results pretty much line[d] up' with their understandings. The six clusters were validated as covering the main factors informing decision-making. In the cluster labelling activity, participants made three changes: cluster 4 was changed from 'Healthy relationships and values' to 'Healthy relationships, *emotional security,* and values, cluster 5 from 'Safe-sex practices and prevention' to '*Sexual risk,* safe-sex practices and prevention', and cluster 6 from 'Family and cultural influences' to '*Social norms,* family and cultural influences'.

Young people reported that social, cultural and religious factors were present in their lives, but ultimately not definitive of decision-making. They agreed with findings illustrated in the importance ratings: that religion, culture and social norms were not the most significant factors shaping decision-making. One young woman noted that 'social norms still weigh on you', but there are 'opportunities to break out from those restrictions and inform yourself using objective data and make your own choices'. Another young woman said, 'I still do have that cultural and family kinda guilt, religious kinda guilt that weighs down on me… but it doesn't hold me to like be at their expectations'.

When asked about possible outcomes from the research findings, migrant and refugee youth focused on improving education. Participants all agreed their school education lacked information on healthy relationships and boundaries, noting 'it would be cool to see sex-ed have more useful information'. All affirmed that high-school education had been predominantly focused on physical aspects. Even consent modules at universities[1] simply 'brushed over' the topic. There was a call for more inclusive education that was culturally sensitive and addressed gender and sexuality beyond cis-heterosexuality.

Discussion

Our findings reveal key factors shaping migrant and refugee youth SRH decision-making in Western Sydney, Australia. The study findings provide valuable data on the factors migrant and refugee youth consider most important, and as having the most positive impact on their decision-making. Cluster 4 (healthy relationships, emotional security and values, representing relational and interpersonal-level factors) and Cluster 5 (sexual risk, safe sex practices, and prevention, representing individual-level factors) were rated most important. Broadly, these clusters related to two connected aspects of SRH: physical safety and biomedical risk, and emotional safety and intimacy. Both Clusters 4 and 5 correlate with meso- and microsystem levels of the SEM (Bronfenbrenner 1994). The statement with the highest importance rating across the study, 'the level of trust between me and my partner', indicates the value migrant and refugee youth place on relational, affective aspects of SRH. Our findings suggest that migrant and refugee young people conceive SRH holistically, viewing social and emotional factors, and biomedical risk as equally integral parts of SRH. Decision-making processes thus do not consider simply physiological risk but also interpersonal consequences. These findings are consistent with other research showing that notions of social risk and relational factors feature prominently in migrant and refugee youth's understanding of SRHR (McMichael and Gifford 2010; Wray, Ussher, and Perz 2014; Dean et al. 2017; Kaczkowski and Swartout 2020).

It is significant that the two clusters rated most important by young people also had the highest positive impact rating on SRH well-being. For migrant and refugee youth, factors such as healthy relationships and sexual risk prevention that have a *positive* impact on SRH well-being are more important than factors that act as barriers. This supports a programming approach that is strengths-based rather than deficit-based. To engage this population effectively, SRH programmes should focus on supporting migrant and refugee youth to make positive health-affirming choices, centred on key areas of sexual safety, intimate relationships and emotional well-being.

By comparison, young people considered family and cultural factors less important than other factors. This differs from some of the existing literature on migrant and refugee youth SRH decisions, which stresses the importance of culture, family and community, and the perpetuation of stigma and taboos (Metusela et al. 2017; Napier-Raman et al. 2023; Dhar et al. 2017). Our findings are, however, consistent with literature from Botfield, Newman, and Zwi (2018) in which culture was *less* important than factors such as age and generational sensibility. This was reiterated by participants in the feedback session, who asserted that family, religious and community stigma did not ultimately prevent youth from making their own choices. Thus, while family, culture and social norms may pose barriers to migrant and refugee youth decision-making, many young people navigate and surpass them.

Youth navigated agency around the constraints placed on them by family, religious and cultural norms. These constraints related to broader macrosystem factors of social and cultural norms, as well as interpersonal level (microsystem) familial pressure to conform to these norms (Bronfenbrenner 1994). However, our findings offer a nuanced depiction of how migrant and refugee youth engage with family and cultural factors. Indeed, despite family and culture being less important, our findings illustrate the importance of social and interpersonal factors for youth SRH decision-making, which may be shaped by collectivist cultural values that prize social ties and relationships.

The overall strong positive correlation between youth and stakeholder importance ratings is encouraging and indicates that those working in the area have a good understanding of migrant and refugee youth decision-making and are thus well prepared to meet young people's needs. However, migrant and refugee youth place greater importance on healthy relationships than stakeholders do. While it is unsurprising that health and allied professionals privilege biomedical factors over the social and emotional aspects of SRH, the differences between participant groups suggest that migrant and refugee youth conceptualise SRH in a broader, more socially informed manner. Previous studies illustrate that migrant and refugee youth prioritise the relational aspects of SRH and are as (if not more) concerned with social risk as with physiological risk (Napier-Raman et al. 2023). Despite this, our findings reflect how healthcare workers, allied health professionals, social service providers and academics still privilege biomedical models of SRH. We acknowledge, however, that the stakeholder sample was small, and a broader group composed of more community organisers, policymakers and non-medical professionals may have yielded a wider range of results. The ethnicity of stakeholders must also be considered. There were five stakeholders from migrant backgrounds, being of Asian or African ethnicity. However, due to the small stakeholder sample-size, no further analyses on how ethnicity influenced stakeholder perspectives were conducted. Future research with a group of *entirely* migrant-background stakeholders might provide different perspectives.

Implications

Our findings indicate the need for care and programming that integrates social and emotional aspects of SRH. Not only will this help engage migrant and refugee youth, but it will ideally provide young people with the skills to make safe and healthy choices and articulate their needs and rights. For example, providing education that helps youth navigate intimate relationships will improve their ability to discuss consent, contraception and protection with partners – something that previous research has shown that many migrant and refugee youth struggle with (Napier-Raman et al. 2023). Australian migrant and refugee youth – both those educated in Australia and those educated overseas – have reported inadequate SRH education, with school education focusing on biomedical aspects and excluding information on relationships, consent and emotional support (Botfield, Zwi, et al. 2018; Rawson and Liamputtong 2010; McMichael and Gifford 2009; Napier-Raman et al. 2023). This was reaffirmed by participants in our feedback session, who reflected on the significant gaps in relationship education they received. A narrow, biomedically informed approach to SRH education and care will not adequately serve migrant and refugee youth.

Family and culture may have a less determinative impact on migrant and refugee youth choices than is often assumed. Previous research on Australian migrant and refugee youth attitudes towards SRH care and education provision has shown a varying desire for culturally *specific* services but a unanimous desire for culturally *sensitive* services (Napier-Raman et al. 2023). We further suggest that programming should consider the complex, multifaceted ways in which youth engage with culture. Taken in conjunction with previous research (Botfield, Newman, and Zwi 2018), our findings indicate that migrant and refugee youth do not necessarily feel 'trapped' or defined by their natal or familial culture. Migrant and refugee youth thus require care and services that are aware of culture, without being reductive. Culturally informed care should not assume young people are repressed by culture, but focus on how they navigate agency around values and mores.

Strengths and limitations

A unique strength of this study was the use of GCM for a youth-centric understanding of migrant and refugee youth SRHR. Young people were involved at multiple points throughout the research process, allowing their perspectives to be brought to the fore. We found the visual data representations useful in providing comprehensible, digestible means for presenting findings to migrant and refugee communities. The flexibility of GCM, which allowed us to conduct activities online, was crucial for research during a pandemic. The virtual nature of this study also allowed participant privacy, which is particularly relevant in research on sensitive issues.

This study adds to scholarship on the barriers and facilitators to migrant and refugee youth SRHR (McMichael and Gifford 2009; Botfield, Zwi, et al. 2018), revealing consistencies and disparities between youth and professional understandings. Much existing research on migrants and refugees, in Australia and other Western high-income countries such as Canada (Metusela et al. 2017; Ussher et al. 2017), the USA (Dhar et al. 2017; Kaczkowski and Swartout 2020) and Sweden (Udmuangpia et al. 2017; Causevic et al. 2022), has focused on issues of risk-taking, knowledge deficits, pregnancy and STIs, stigma and service barriers (McMichael and Gifford 2010; Wray, Ussher, and Perz 2014; Napier-Raman et al. 2023; Botfield, Zwi, et al. 2018). While some research has found resistance and rejection of repressive social norms (Ussher et al. 2017; Botfield, Newman, and Zwi 2018; Hawkey, Ussher, and Perz 2018), we build on this by explicitly repositioning migrant and refugee youth from being an 'at-risk' population to becoming agentic decision-makers.

However, this study also has limitations. Owing to software licence restrictions, data on only five demographic variables were collected; information on whether participants were migrants or refugees, first or second generation, was not recorded. We were unable to explore how decision-making might differ between migrant and refugee youth, and those born overseas or in Australia. Future studies should compare youth with different citizenship statuses and migration experiences.

Gender distribution was uneven, impeding gender-based analysis. A more representative sample, or a larger and more inclusive sample, may have produced different results. Overrepresentation of Southeast and East Asian participants may have skewed results, potentially limiting generalisability. Owing to this and the limited sample size, an analysis based on different ethnic backgrounds was unfeasible. However, although our sample was not directly proportional to Western Sydney's demographics, Southeast and East Asian-background individuals do comprise a large proportion of the regional population (.id 2023). Furthermore, our findings on the importance of social aspects of SRH are consistent with research involving young migrants and refugees to Australia from multiple backgrounds (Botfield, Newman, and Zwi 2018), including Vietnamese youth (Rawson and Liamputtong 2010), Middle Eastern youth (Wray, Ussher, and Perz 2014; McMichael and Gifford 2010), African youth (McMichael and Gifford 2010; Dean et al. 2017) and South Asian youth (Wray, Ussher, and Perz 2014), suggesting broad applicability.

Furthermore, the stakeholder group was small. A larger group with a greater diversity of expertise might provide more insight into whether certain professions or sectors are more in line with youth perspectives than others. While the large representation of researchers among stakeholders may have meant stakeholders had good contextual knowledge of migrant and refugee youth, this also brought limitations in terms of a lack of practical experience working with young people among stakeholders.

Software licence costs pose a barrier to widespread use of GCM. Additionally, researchers must first undergo GCM training, which is resource- and time-intensive. GCM is inaccessible without funding, training and support. Moreover, as other researchers have noted (Walker, Jones, and Burke 2014), the involvement of participants at multiple stages runs the risk of increasing fatigue and drop-out.

Conclusion

This study adds to scholarship on how Australian migrant and refugee young people make SRH decisions. SRH decision-making is informed by both relational and emotional factors, and more traditional physiological safety and risk-avoidance considerations. While social norms, family and cultural factors had an overall negative impact, migrant and refugee youth did not perceive these factors as highly important to their decision-making. Instead, young people navigate around sociocultural and familial restrictions, finding 'opportunities to break through' and make their own decisions. To best engage and support this population, policy and programming must look beyond narrowly medical constructions of SRH to incorporate emotional and relational factors, which migrant and refugee youth value as equally important and beneficial to their agency.

Note

1. Many major universities in Australia have online mandatory courses on sexual consent that students are required to complete.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Data availability statement

The participants of this study did not give written consent for their data to be shared publicly, so owing to the sensitive nature of the enquiry, supporting data are not available.

References

.idCommunity 2023. "2023. Western Sydney (LGA) | Community Profile." Accessed January 10 https://profile.id.com.au/cws.

Australian Bureau of Statistics. 2021. "Snapshot of Australia, 2021." Accessed July 20, 2023. https://www.abs.gov.au/statistics/people/people-and-communities/snapshot-australia/latest-release.

Australian Institute of Health and Welfare. 2021. "Australia's Youth." Accessed July 20, 2023. https://www.aihw.gov.au/reports/children-youth/australias-youth.

Bell, S. A. 2012. "Young People and Sexual Agency in Rural Uganda." *Culture, Health & Sexuality* 14 (3): 283–296. https://doi.org/10.1080/13691058.2011.635808

Botfield, J. R., C. E. Newman, M. Kang, and A. B. Zwi. 2018. "Talking to Migrant and Refugee Young People About Sexual Health in General Practice." *Australian Journal of General Practice* 47 (8): 564–569. https://doi.org/10.31128/ajgp-02-18-4508

Botfield, J. R., C. E. Newman, and A. B. Zwi. 2018. "Engaging Migrant and Refugee Young People with Sexual Health Care: Does Generation Matter More Than Culture?" *Sexuality Research and Social Policy* 15 (4): 398–408. https://doi.org/10.1007/s13178-018-0320-6

Botfield, J. R., A. B. Zwi, A. Rutherford, and C. E. Newman. 2018. "Learning About Sex and Relationships among Migrant and Refugee Young People in Sydney, Australia: 'I Never Got the Talk About the Birds and the Bees." *Sex Education* 18 (6): 1–16. https://doi.org/10.1080/14681811.2018.1464905

Bronfenbrenner, U. 1994. "*Ecological Models of Human Development*." In *International Encyclopedia of Education,* edited by T. Husen and N. Postlethwaite (2nd ed.) Oxford: Elsevier.

Causevic, S., M. Salazar, N. Orsini, A. Kågesten, and A. M. Ekström. 2022. "Sexual Risk-Taking Behaviors among Young Migrant Population in Sweden." *BMC Public Health* 22 (1): 625. https://doi.org/10.1186/s12889-022-12996-2

Chung, D., C. Fisher, C. Zufferey, and R. K. Thiara. 2018. "Preventing Sexual Violence against Young Women from African Backgrounds." *Trends and Issues in Crime and Criminal Justice no. 540*. Canberra, ACT: Australian Institute of Criminology.

Dean, J., M. Mitchell, D. Stewart, and J. Debattista. 2017. "Intergenerational Variation in Sexual Health Attitudes and Beliefs among Sudanese Refugee Communities in Australia." *Culture, Health & Sexuality* 19 (1): 17–31. https://doi.org/10.1080/13691058.2016.1184316

Dhar, C. P., D. Kaflay, N. Dowshen, V. A. Miller, K. R. Ginsburg, F. K. Barg, and K. Yun. 2017. "Attitudes and Beliefs Pertaining to Sexual and Reproductive Health among Unmarried, Female Bhutanese Refugee Youth in Philadelphia." *The Journal of Adolescent Health* 61 (6): 791–794. https://doi.org/10.1016/j.jadohealth.2017.06.011

Dune, T., J. Perz, Z. Mengesha, and D. Ayika. 2017. "Culture Clash? Investigating Constructions of Sexual and Reproductive Health from the Perspective of 1.5 Generation Migrants in Australia Using Q Methodology." *Reproductive Health* 14 (1): 50. https://doi.org/10.1186/s12978-017-0310-9

Hawkey, A. J., J. M. Ussher, J. Perz, and C. Metusela. 2017. "Experiences and Constructions of Menarche and Menstruation among Migrant and Refugee Women." *Qualitative Health Research* 27 (10): 1473–1490. https://doi.org/10.1177/1049732316672639

Hawkey, A. J., J. M. Ussher, and J. Perz. 2018. "Regulation and Resistance: Negotiation of Premarital Sexuality in the Context of Migrant and Refugee Women." *Journal of Sex Research* 55 (9): 1116–1133. https://doi.org/10.1080/00224499.2017.1336745

Kaczkowski, W. and K. M. Swartout. 2020. "Exploring Gender Differences in Sexual and Reproductive Health Literacy among Young People from Refugee Backgrounds." *Culture, Health & Sexuality* 22 (4): 369–384. https://doi.org/10.1080/13691058.2019.1601772

Kane, M. and W. M. K. Trochim. 2009. "Concept Mapping for Applied Social Research." In *The Sage Handbook of Applied Social Research Methods*, edited by Debra Rog and Leonard Bickman, 435–474. Thousand Oaks: SAGE.

Kane, M. and W. M. K. Trochim. 2007. "*Concept Mapping for Planning and Evaluation.*" *Applied Social Research Methods Series ;* V. 50. Thousand Oaks, California: SAGE.

McMichael, C. and S. Gifford. 2009. "It Is Good to Know Now…Before It's Too Late": Promoting Sexual Health Literacy Amongst Resettled Young People with Refugee Backgrounds." *Sexuality & Culture* 13 (4): 218–236. https://doi.org/10.1007/s12119-009-9055-0

McMichael, C. and S. Gifford. 2010. "Narratives of Sexual Health Risk and Protection Amongst Young People from Refugee Backgrounds in Melbourne, Australia." *Culture, Health & Sexuality* 12 (3): 263–277. https://doi.org/10.1080/13691050903359265

Mengesha, Z. B., T. Dune, and J. Perz. 2016. "Culturally and Linguistically Diverse Women's Views and Experiences of Accessing Sexual and Reproductive Health Care in Australia: A Systematic Review." *Sexual Health* 13 (4): 299–310. https://doi.org/10.1071/SH15235

Metusela, C., J. Ussher, J. Perz, A. Hawkey, M. Morrow, R. Narchal, J. Estoesta, and M. Monteiro. 2017. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women." *International Journal of Behavioral Medicine* 24 (6): 836–845. https://doi.org/10.1007/s12529-017-9662-3

Napier-Raman, S., S. Z. Hossain, M. J. Lee, E. Mpofu, P. Liamputtong, and T. Dune. 2023. "Migrant and Refugee Youth Perspectives on Sexual and Reproductive Health and Rights in Australia: A Systematic Review." *Sexual Health* 20 (1): 35–48. https://doi.org/10.1071/sh22081

Patton, G. C., S. M. Sawyer, J. S. Santelli, D. A. Ross, R. Afifi, N. B. Allen, M. Arora, P. Azzopardi, W. Baldwin, C. Bonell, et al. 2016. "Our Future: A Lancet Commission on Adolescent Health and Wellbeing." *Lancet* 387 (10036): 2423–2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Pithavadian, R., P. Liamputtong, E. Mpofu, S. Z. Hossain, M. Aibangbee, and T. Dune. 2023. "Sexual and Reproductive Health and Young People: A Social Science Approach." In *Handbook of Social Sciences and Global Public Health*, edited by Pranee Liamputtong. Cham: Springer. https://doi.org/10.1007/978-3-030-96778-9_108-1

Qu, L. 2019. "Young People Living with Their Parents." Australian Institute of Family Studies. Accessed July 16, 2023. https://aifs.gov.au/research/facts-and-figures/young-people-living-their-parents.

Rawson, H. A. and P. Liamputtong. 2010. "Culture and Sex Education: The Acquisition of Sexual Knowledge for a Group of Vietnamese Australian Young Women." *Ethnicity & Health* 15 (4): 343–364. https://doi.org/10.1080/13557851003728264

Robards, F., M. Kang, K. Steinbeck, C. Hawke, S. Jan, L. Sanci, Y. Y. Liew, M. Kong, and T. Usherwood. 2019. "Health Care Equity and Access for Marginalised Young People: A Longitudinal Qualitative Study Exploring Health System Navigation in Australia." *International Journal for Equity in Health* 18 (1): 41. https://doi.org/10.1186/s12939-019-0941-2

Starrs, A. M., A. C. Ezeh, G. Barker, A. Basu, J. T. Bertrand, R. Blum, A. M. Coll-Seck, A. Grover, L. Laski, M. Roa, et al. 2018. "Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-*Lancet* Commission." *Lancet* 391 (10140): 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9

The Concept System®. 2022. "Groupwisdom™." Web-based platform. Ithaca, NY.

Udmuangpia, T., E. Haggstrom-Nordin, C. Worawong, K. Tanglakmankhonge, and T. Bloom. 2017. "A Qualitative Study: Perceptions Regarding Adolescent Pregnancy among a Group of Thai Adolescents in Sweden." *Pacific Rim International Journal of Nursing Research* 21 (1): 75–87.

UN (United Nations). 2023. n.d"Youth". United Nations. Accessed July 16 https://www.un.org/en/global-issues/youth

Ussher, J. M., J. Perz, C. Metusela, A. J. Hawkey, M. Morrow, R. Narchal, and J. Estoesta. 2017. "Negotiating Discourses of Shame, Secrecy, and Silence: Migrant and Refugee Women's Experiences of Sexual Embodiment." *Archives of Sexual Behavior* 46 (7): 1901–1921. https://doi.org/10.1007/s10508-016-0898-9

Walker, R. E., R. J. Jones, and J. G. Burke. 2014. "Concept Mapping for Community Perceptions." In *Methods for Community Public Health Research: Integrated and Engaged Approaches*, edited by Jessica G. Burke and Steven Albert. New York: Springer.

Wray, A., J. M. Ussher, and J. Perz. 2014. "Constructions and Experiences of Sexual Health among Young, Heterosexual, Unmarried Muslim Women Immigrants in Australia." *Culture, Health & Sexuality* 16 (1): 76–89. https://doi.org/10.1080/13691058.2013.833651

Additional results

This section presents additional results that did not fit within the publication above. These results provide further insight into factors that are most important to MRY as well as the value of participatory research projects that centre youth voice.

Pattern-match and go-zone analysis

Figure 5.3 (Appendix F) presents additional 'Pattern Match' data comparing female and male participants' ratings on the importance of different SRH factors, revealing high agreement between genders. There was a very strong positive correlation ($r = .97$) between female and male importance ratings and no significant differences, suggesting that factors informing SRHR decision-making are similar between genders. Additional 'Go-Zone' analysis (Figure 5.4, Appendix F) identifies items that are highly important and have a positive impact on MRY SRHR decision-making: trust in relationships, being comfortable, having boundaries respected and STI protection. This bivariate Go-Zone graph provides key implications for strengths-based policy and programming – factors that are highly important and have a high positive impact on MRY decision-making should be the focus of future interventions.

Interpretation session – "what is important me"

Participant discussions in the interpretation session further elucidated what youth consider important in decision-making. MRY described the lack of salience that cultural and religious restrictions hold: "personally, cultural and religious views are kind of outdated and don't mesh with what is important to me, and what's the right decision to me". While all participants reflected that safe sex was important, definitions were variable and incorporated both physiological and relational aspects. One participant asserted "for me, safe sex means contraception" but was not surprised by other participants placing greater value on relationships because "contraception isn't for everyone". Another participant framed sexual safety through relationships, arguing "safe sex is about taking it slowly with your partner and making the right choices so it won't affect your future".

Participant feedback

MRY were also given the opportunity to provide feedback on their experiences participating in the GCM study (Appendix F, pp. 328-330). Of the 33 youth who provided feedback, all strongly (85%) or somewhat (15%) agreed that the activities were easy to understand and complete. All but one participant strongly (73%) or somewhat (24%) agreed that they were able to express important ideas and opinions in the GCM activities. Open text responses about what MRY enjoyed about the activities revealed that participants appreciated being able to “express myself” while also viewing “other’s perspectives on their own personal experiences”. Numerous participants described the activities as a valuable opportunity for self-reflection, allowing “evaluation of what is important to me”. Participants also enjoyed the anonymity of the research, which allowed them to “voice my opinion without feeling judged by anyone”. Most participants had no suggestions for improvements, though there were calls for more regular research and including “more questions” within the GCM activities. This feedback suggests that MRY desire spaces to express their opinions and opportunities to discuss and engage with SRHR.

As noted in the publication above, the multi-phase nature of GCM does create a risk of participant fatigue. However, this was not reflected in the feedback provided. Furthermore, an advantage of GCM is that new participants can join at any phase of the study, allowing for new recruitment to supplement any participant attrition. While there were nine participants who did not continue to the second phase of this study, eleven new participants were recruited to account for this.

Conclusion

This chapter presents results from the first study conducted as part of this doctoral research, using GCM methods to examine the factors informing MRY decision-making. These findings illustrate the need for policy and practice to incorporate a broad conceptualisation of SRHR that extends beyond traditional biomedical models. Assumptions that family and culture are preeminent in MRY decision-making and SRH experiences should be interrogated. In centring youth voices, this chapter illuminates MRY conceptions of “what is important to me”. The next chapter reports on the quantitative survey results, responding to feedback from participants requesting “more questions” (see above). While this GCM study indicated that female and male MRY have very similar conceptions of which factors are most important to SRHR decision-making, the next chapter will reveal that this similarity does not manifest in equal outcomes regarding knowledge, behaviour, attitudes and service access.

Chapter 6. Quantitative cross-sectional survey study

Chapter overview

Gender is a fundamental determinant of health that has been perennially central to SRHR approaches. Women have historically been the focus of SRH interventions, research and policy – due to the disproportionate burden of reproductive responsibility, gendered violence, assault and coercion. Literature examining gender and SRH among migrants and refugees has thus almost exclusively concentrated on women. This study contributes to existing scholarship by exploring the SRH outcomes and experiences of *both* female and male MRY. This allows explication of the diverse – even unexpected – ways gender intersects with other aspects of MRY identity and experience to inform SRHR outcomes. For MRY, gender norms manifest in multiple ways, limiting and facilitating agency. This chapter highlights the need to involve and engage MRY of all genders in SRHR.

In examining the gender dimensions of MRY's SRH behaviours, attitudes and experiences, this chapter builds on the previous chapter's discussion of decision-making and agency, explicating how a single individual-level factor may thin and thicken agency. While Chapter 5 revealed factors that MRY consider as being important and having a positive impact on SRHR decision-making, this chapter unpacks decision-making further by examining knowledge, attitudes, interpersonal experiences and service access that may shape MRY outcomes and decisions.

The included paper and additional results relate to the overall thesis research questions regarding how MRY understand and perceive SRHR (i), level of literacy and knowledge around SRH (iii), which socioecological factors shape needs (iv), and experiences of rights attainment (v). Bivariate statistical analysis with gender as the outcome variable was used to examine understandings and experiences of SRHR, knowledge, and rights-attainment. Multivariate regression analysis, using the dependent variable 'pressured into sex' and independent variables of gender, sexual orientation, relationship status and birthplace was conducted to examine rights attainment and agency.

The present chapter includes a manuscript published in the journal *Sexuality & Culture* focusing on gender dimensions of MRY SRHR. This manuscript has been revised according to reviewers' comments. Additional results are presented after the manuscript, with supplementary material provided in Appendix G. These results present additional gender results and select notable findings examining relationships between length of time in Australia and knowledge and attitudes.

These findings were presented as an oral presentation at the 18th Asia Pacific Socioecological Association Conference in Sydney, Australia, July 2023. They were additionally presented as a poster at the 2022 Royal College of Paediatrics and Child Health *Adolescent Health Conference* in Birmingham, the United Kingdom.

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ORIGINAL ARTICLE

Migrant and Refugee Youth's Sexual and Reproductive Health and Rights: A Gender Comparison of Knowledge, Behaviour, and Experiences

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Abstract

Young adulthood is a crucial life stage, during which major sexual and reproductive health (SRH) development occurs, and gender norms are often entrenched. Australian migrant and refugee youth (MRY) have particular SRH experiences and vulnerabilities such as under-use of services, higher rates of sexually transmitted infections (STIs), unplanned pregnancy, and experiences of community and family stigma. There is limited research on how gender intersects with ethnicity, migrant status and age to inform understandings and realisation of sexual and reproductive health and rights (SRHR). Explorations of how gender shapes SRHR have typically been unilateral, focusing on one gender: there is a significant gap in scholarship investigating gender differences among MRY experiences of SRHR. This study will fill this gap, contributing to conceptual knowledge about the experience of SRHR among migrant and refugee youth. This cross-sectional study collected data from 107 MRY aged 15–27 years, living in Western Sydney, Australia. An online survey – including multiple-choice, Likert-scale, and open-text questions – examining behaviour, knowledge, attitudes, service utilisation and rights awareness was used. Key measures included knowledge of various contraceptives and STIs; vaccination rates; attitudes towards SRH taboos; and service use. Participants were recruited using snowball and purposive sampling, incorporating recruitment via social media, community and social service organisations, and word of mouth. Univariate descriptive analysis and bivariate gender analysis were conducted using IBM SPSS. Most participants were female (69%). Non-consensual experiences were gendered: there was a significant association between gender and being pressured into sex ($p = < 0.001$), with 45% of females experiencing pressure compared with 9% of males, and males significantly more comfortable discussing consent with partners than females ($p = .011$). Knowledge outcomes were, however, poorer among males, who had significantly lower contraceptive awareness ($p = .023$), and lower STI awareness. Service access was conspicuously low, with three quarters

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of participants unaware of local SRH services. Male participants were significantly more likely to select *not applicable* when asked which services they had used, indicating non-use. In attitudes towards key SRH taboos, females were consistently more liberal than males. Male and female MRY have gender-specific SRHR vulnerabilities. Issues of consent disproportionately impact young women, while males have lower service access and SRH knowledge. Future policy development must consider shared experiences – engaging youth with services – and gender-specific needs – targeting young men in SRH education, addressing continued consent issues.

Keywords Sexual and reproductive health rights · Migrants · Refugees · Youth · Gender differences

SDG Keywords SDG3 Good health and well-being · SDG5 gender equality · SDG10 reduced inequalities

Introduction

Adolescence and young-adulthood are crucial life-stages, during which foundations for future health and wellbeing are established (Patton et al., 2016). During this period, gender norms and roles are internalised. Behaviours associated with future sexual and reproductive health (SRH) develop (Starrs et al., 2018). The physiological, emotional and social transitions of puberty and adolescence combined with limited SRH knowledge render young people vulnerable to poor SRH. This is especially so for youth from marginalised groups such as migrant and refugees, who have lived experiences that influence their attainment of sexual and reproductive health and rights (SRHR). Migrant and refugee communities in Australia often have specific cultural constructions of sexuality (Metusela et al., 2017; Napier-Raman et al., 2023) and low SRH service uptake (Botfield et al., 2018), which may lead to poorer SRH than the general population (McMichael & Gifford, 2010; Ussher et al., 2012). There has, however, been limited rights-based research – an approach framing SRH as a human right, examining individuals' attainment of this right – on the SRH of youth from these communities, particularly using gender comparisons. The intersections of gender, age and migrant and refugee experience are under-examined.

SRHR are essential to individuals' health and wellbeing, and generally benefit society (Starrs et al., 2018). These rights encompass decisions about one's body, reproductive and sexual life, and access to the services and information needed to support these decisions. While SRHR are universal, migrants and young people have particular needs (Starrs et al., 2018). Migrant and refugee youth (MRY) understandings of SRH risks are socially and culturally influenced; concerns about social consequences of sexual behaviour inform MRY decisions (Botfield et al., 2020; McMichael & Gifford, 2010; Meldrum et al., 2015; Napier-Raman et al., 2023). The notion of 'social risk' pervades MRY conceptions of sexuality. MRY often have limited SRH knowledge and education (Botfield et al., 2018c; Dean et al., 2017; McMichael & Gifford, 2009; Rawson & Liamputtong, 2010), which are likely to restrict informed decision-making (Napier-Raman et al., 2023). Stigma, shame and silence around SRH are common in many migrant and refugee communities, which affects how youth experience and understand SRHR (Botfield et al., 2020; McMichael & Gifford, 2009, 2010; Meldrum et al., 2015). There is notable under-use of SRH care and services among Australian MRY (Botfield et al., 2018b; Rawson & Liamputtong, 2009).

Sexual and reproductive health and rights are "inherently intersectional" (Dune et al., 2022, p. 6), necessitating research that addresses complexity within identities and experiences. MRY's experiences of SRHR are informed by the mutable ways in which aspects of their identity intersect (Collins & Bilge, 2016) – this research elucidates these intersections and experiences. We draw upon intersectionality theory to ground this research, explicating how gender interacts with MRY identity in dynamic ways. Adopting an "inclusive" approach to intersectionality (Garry, 2011, p. 826), this research examines intersecting oppressions *and* opportunities. The decision to focus on gender, rather than innumerable axes of identity, is a concerted effort to avoid an uncritical additive approach that tallies injustices (Garry, 2011; Hankivsky & Grace, 2016). Instead, we use the experiences of male and female MRY to explore how privileges and oppressions intersect in manifold, dynamic ways.

Realisation of SRHR is necessary for the achievement of gender equality. SRH studies that focus on gender tend to examine one gender (usually female) rather than multiple genders. Public health literature commonly uses the term *gender* in reference solely to women (Connell, 2012). Explorations of gender and SRH among migrants and refugees have largely focused on females (Chung et al., 2018; Manderson et al., 2002; Meldrum et al., 2015; Mengesha et al., 2017; Rawson & Liamputtong, 2009; Ussher et al., 2012; Wray et al., 2014). Women and girls are disproportionately impacted by gendered SRH inequities (Heise et al., 2019; Plesons et al., 2019). Not only do women bear the physiological reproductive burden,[1]but repressive gender norms, inequality and patriarchal power structures result in women disproportionately experiencing gender-based sexual violence, coercion, and other adverse SRH outcomes (Plesons et al., 2019). As such, historically SRH has been treated as a 'women's issue', neither a personal concern nor responsibility of males (Heise et al., 2019). Only recently have males been actively included in SRH care and research (Mengesha et al., 2023; Santa Maria et al., 2018). Gender norms and power structures influence young men's experiences as they do women's (Patton et al., 2018). Understanding how young men internalise, perform or resist dominant gender norms, and how these factors shape behaviours and experiences, is crucial to ensuring SRHR attainment for all.

Gender Differences in Migrant and Refugee Youth SRH

There is limited literature comparing the sexual and reproductive health experiences of MRY of different genders (Kaczkowski & Swartout, 2020). Some mixed gender studies of MRY SRH have discussed gender as a variable, though not as a consistent measure of analysis (Dean et al., 2017; Homma et al., 2013; Mengesha et al.,

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[1] We acknowledge that there are people who do not identify as female who have reproductive capability and who are often further marginalised for their gender identity.

2023; Tangmunkongvorakul et al., 2017); only Kaczkowski and Swartout's study of refugee youth in Atlanta has specifically focused on gender differences (2020). Among East Asian youth in Canada, Homma et al. found reasons for sexual abstinence differed by gender, with women significantly more likely to abstain due to religious beliefs, concerns about peer or familial disapproval, desire to prevent STIs and pregnancy, and a desire to wait until marriage (2013). Consistent with these concerns about peer and family disapproval, young refugee women in Melbourne are more concerned – and impacted – by social risks of unplanned pregnancy and STIs than their male counterparts (McMichael & Gifford, 2010). Data on gender differences regarding knowledge has been inconsistent. Some research has indicated female MRY have higher STI and HIV knowledge (Dean et al., 2017; Kaczkowski & Swartout, 2020), and know a greater range of contraceptives than males (Kaczkowski & Swartout, 2020). However, other findings reveal lower contraceptive awareness among female MRY (Botfield et al., 2018c; Tangmunkongvorakul et al., 2017), and fear of contraceptives solely among women (Botfield et al., 2018c; Kaczkowski & Swartout, 2020; Tangmunkongvorakul et al., 2017). While research has highlighted overall limited service engagement among MRY (Botfield et al., 2018b; McMichael & Gifford, 2009; Rawson & Liamputtong, 2009), gender differences have only been discussed by Kaczkowski and Swartout, reporting greater embarrassment and shame about accessing care among young women (2020). There are thus significant gaps in regards to how gender shapes service use among MRY, limited data on how attitudes and experiences are differentially experienced based on gender, and a need for further investigation of gender differences in knowledge.

The present study investigates Australian MRY's understanding of and experiences with SRHR. Migrants and refugees constitute a significant proportion of Australia's citizens, with over half of all Australians either born overseas or having at least one overseas-born parent (Australian Bureau of Statistics, 2021). While Australians enjoy a generally high standard of SRH, this is unevenly experienced, with young people and migrants having noted unmet needs (Bateson et al., 2019). Australia still lacks a national SRH strategy, the implications of which should be examined. As a highly multicultural nation with a relatively robust universal healthcare scheme, Australia offers a particularly apposite context for exploring how health rights of migrants and refugees are experienced in high-income contests.

Given the gaps identified in the literature, we examined the following research questions:

1. How does gender influence key SRH outcomes of knowledge, attitudes and experiences among MRY?
2. How are MRY SRHR needs and service access influenced by gender?

We determine how intersections of gender, age, life-stage and migrant or refugee identity shape SRH outcomes, exploring points of convergence and divergence between genders. We build on the diverse – sometimes contradictory – literature on how MRY differentially experience sexual and reproductive health rights based on gender; given the prevalence of 'social risk' in MRY conceptions of SRH, our exploration of "experiences" includes both sexual behaviours and interactions with peers, parents and community. While existing scholarship has highlighted knowledge deficits, service disengagement, and experiences and internalisation of stigma and taboo among MRY (Botfield et al., 2018b; McMichael & Gifford, 2009, 2010; Napier-Raman et al., 2023; Rawson & Liamputtong, 2009; Wray et al., 2014), how gender might contribute to these outcomes has yet to be fully explored. Taking a relational gender approach, where gender is understood as "embodied social structure" (Connell, 2012, 1675), our findings give insight into how female and male MRY[2] make decisions and engage with SRHR, providing directions for more accessible, comprehensive healthcare and policy.

Methods

This study is part of an Australian Research Council Discovery Grant project (DP200103716) examining MRY SRHR in Western Sydney, Australia.

Design and Participants

This study used a cross-sectional survey design. The sample comprised 107 migrant and refugee youth, aged 15–27 years and living in Greater Western Sydney, Australia (Table 1). Eligible participants were (1) of a migrant or refugee-background, having one or both parents identifying as a migrant or refugee, (2) youth aged 15–27, and (3) living in Greater Western Sydney. Youth were defined as aged 16–26 years, with eligibility based on this criterion. However, three participants completed the survey despite ages one year above or below the planned range. As these participants completed informed consent and were close in age to the intended range, their data were analysed.

The age range for this study reflects the age of consent in New South Wales, where this study was conducted (16 years). We chose to extend this to 26 years (and include the 27 year old participant) to reflect patterns of increasingly later transition to conventional markers of 'adulthood' such as employment and marriage (Patton et al., 2016). Sample size targets were calculated using the Australian Bureau of Statistics sample size calculator (2024). While a much larger target of 383 participants was established, we only received 107 eligible responses, reflecting the sensitivity of the research topic.

Instrument

An online self-completion survey was developed examining sexual and reproductive health and rights using multiple choice, Likert scale, and open-text responses. The instrument was adapted from a pilot survey developed from results of a qualitative study conducted by the co-authors examining MRY contraceptive use and awareness (Mpofu et al., 2021). Contraceptive awareness measures, demographic items,

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[2] Participants in this study identified as cis-males and females. Throughout this paper, the terms *male* and *female* refer to how study participants identified themselves.

Table 6.1

Table 1 Sample demographic characteristics [†]

	Female		Male	
	N	% females	N	% males
Ethnicity				
Asian	47	64	21	70
Middle Eastern	7	10	3	10
European	4	6	2	7
Pacific	5	7	1	3
American	4	6	1	3
Mixed	3	4	2	7
African	3	4	0	0
Years living in Australia				
Born in Australia	37	50	10	31
1 year	2	3	0	0
2–4 year	7	9	6	19
5–7 years	4	5	1	3
8–10 years	1	1	1	3
More than 10 years	23	31	14	44
Migration status				
Child of migrant or refugee	45	62	13	42
Migrant to Australia	18	25	16	52
Refugee to Australia	10	14	2	6
Education				
Tertiary	31	42	8	25
Secondary	37	50	19	59
Vocational	6	8	5	16
Employment				
Student only	14	19	12	38
Studying and employed	37	50	12	38
Employed fulltime	12	16	6	19
Employed part time	8	11	1	3
Unemployed	2	3	0	0
None of above or other	1	1	1	2
Living arrangements				
With parents	63	85	24	75
With other relatives	3	4	0	0
With housemates	3	4	6	16
Alone	2	3	2	6
None of above or other	3	4	1	3
Orientation				
Straight or heterosexual	53	72	23	72
Bisexual	13	18	0	0
Gay	0	0	2	6
Lesbian	1	1	0	0
Pansexual	2	3	0	0
Asexual	3	4	1	3
Prefer not to say	1	1	4	13
None or other	1	1	2	6

[†] Due to rounding, percentages do not sum to 100

service access and rights awareness measures were adopted from this pilot survey; items examining attitudes towards contraceptives were adapted to examine attitudes towards broader SRH issues. Items examining STI awareness, sexual behaviours, and sources of SRH information were adapted from the National Survey of Australian Secondary Students and Sexual Health (SSASH) (Power et al., 2022). The final instrument included 57 items covering demographics, sexual behaviour and relationship status, religious beliefs, contraceptive and STI awareness, SRH beliefs and attitudes, information sources, service use and SRH rights.

The survey was piloted with nine MRY who provided feedback around clarity, coherence and sensitivity. As per participants' feedback, we developed a shorter instrument and provided more nuance for certain questions.

Procedure

Participants were recruited using convenience and snowball sampling, and through social media, migrant centres, community services, university and public health networks. Social media recruitment involved posts in ethnic community groups and student groups. This may have led to an overrepresentation of participants from ethnic backgrounds with strong community networks (there were multiple Facebook groups for Indian and South Asian communities in Sydney, for example, but no Latin American groups), and a skew towards tertiary-educated participants. While a broad range of community organisations were contacted – women's health groups, local council organisations, LGBTQ+organisations, youth groups, migrant and refugee clinics and services – the most responsive were organisations catering to disadvantaged migrant and refugee communities, which may have produced unintended selection bias. The survey instrument was distributed via QR code and web-URL and required participants approximately 10–15 min to complete.

Analysis

Data analysis was conducted using SPSS version 29 (IBM Corp, 2020) and Statistica 14.0 (Tibco Software, 2020). A p value below 0.05 indicated statistical significance. Males and females were compared on sexual orientation, activity relationship status, sexual behaviour and experiences using Fisher's exact tests. Fisher's exact tests were used due the small sample size, providing precise p-values. Logistic regression analysis was conducted to identify predictors of experiencing pressure to have sex.

Scale variables were constructed for questions related to contraceptive awareness and STI awareness. For the contraceptive scale, participants were presented with a list of 10 contraceptive methods and asked to select contraceptive methods they had "heard of". Responses were recorded as *yes* or *no* for each item and coded 1 or 0 respectively and summed to provide a contraceptive awareness scale, score ranging 0 to 10. The scale validly was measured, with a Cronbach $\alpha=0.855$. The same methods were used for the STI awareness scale. Participants selected the STIs they had "heard of" from a list of seven (HIV/AIDS, Chlamydia, Gonorrhoea, HPV, Hepatitis A, B, and C). Responses were summed to give an STI score ranging from zero to seven (Cronbach $\alpha=0.833$). Additionally, scale variables for contraceptive and service usage were constructed and reliability of the scales were (Cronbach α < 0.06). Therefore, further analysis using contraceptive and service usage were not undertaken.

Because only male and female participants had sufficient sample size for analysis, independent samples t-tests were used for scale and Likert-type measures. Given study aims to examine gender differences in knowledge, t-tests were particularly useful in allowing comparison of means.

For the following analysis, length of time in Australia, age and ethnicity were controlled for but showed no significant relationship when combined with gender.

Ethical Considerations

Ethics Approval was obtained from the University of Western Sydney University (approval number H13798). Participant responses were anonymous; participants had the option of entering an email for a prize draw, but details were not retained for analysis. Participants had to read through and accept consent before they could begin the survey. Data was collected via a secure platform (Qualtrics), and once exported, stored in a password-protected OneDrive, accessible only by the researchers.

Results

Sample Description

107 participants returned analysable surveys. Most participants were female (69%, $n=74$). Almost one third were male ($n=32$), with one participant identifying as non-binary. Only data from male and female participants feature in most analyses, with the non-binary participant usually excluded owing to insufficient sample size for that gender category.

Mean age for the total sample was 20.97 years ($SD=2.48$, *Mdn* and mode = 21, range = 15 to 27, skewness = 0.09, $N=101$). Most participants identified as Asian, with other participants having Pacific Islander or African backgrounds or Middle Eastern or European backgrounds (Table 1). Most participants (84%) were nominally religious, largely Christian (43%) with smaller numbers of Muslim (15%) Buddhist (9%), Hindu (8%), Jewish (2%) or “other” (7%) adherences. 10% identified as atheist and 7% were agnostic. 85% of females and 83% of males identified as religious. Most of the sample were heterosexual; equal percentages of males and females were heterosexual. All participants who identified as bisexual were female. A Mann-Whitney test found no significant difference between the length of time females and males had lived in Australia, $p=.091$.

Knowledge and Awareness of Contraception and STIs

Table 2 shows the number and percentage of females who reported being aware of the contraceptive methods listed in the survey question. Females were aware of significantly more of the listed contraceptives ($M=7.30$, $SD=2.51$, $n=71$) compared with males ($M=5.89$, $SD=3.38$, $n=27$), $p=.027$, $d=0.47$.

Table 6.2

Table 2 Contraceptive awareness for females and males

	Female		Male			
	N	%	N	%	*p*	Φ
Abstinence	46	66	14	52	0.247	0.128
Condoms	69	97	24	89	0.126	0.168
Diaphragm	25	35	13	48	0.255	0.119
"Morning-after" pill	61	87	17	63	0.011*	0.273
Implant	49	69	18	67	0.813	0.023
Intra-uterine device	57	81	16	59	0.035*	0.230
Natural, e.g., cycle tracking	47	67	12	44	0.062	0.208
Contraceptive pill	66	94	18	67	0.001*	0.363
Ring	36	51	8	30	0.069	0.196
Withdrawal	61	87	19	70	0.073	0.198
Other	1	1	0	0	1.00	0.063
None	2	3	1	4	1.00	0.024

Table 6.3

Table 3 STI awareness for females and males

	Female		Male			
	N	%	N	%	*p*	Φ
Chlamydia	58	87	19	83	0.733	0.049
Gonorrhoea	53	79	19	83	1.00	0.038
HVP Human papilloma virus	48	72	13	57	0.203	0.141
Hepatitis A	56	84	16	70	0.225	0.152
Hepatitis B	53	79	17	74	0.577	0.054
Hepatitis C	52	78	16	70	0.574	0.082
HIV/AIDS	66	99	22	96	0.448	0.084

Table 2 shows significantly more awareness among females for the morning-after pill, intra-uterine device, contraceptive pill but none of the other listed methods. On the 10-item contraceptive awareness scale ($M=6.98$, Cronbach $\alpha=0.855$), male participants had significantly lower overall contraceptive awareness than females ($p=.027$, $d=0.474$). Males on average were aware of 5.89 contraceptives, whilst females were aware of 7.36.

Table 3 compares females and males on their awareness of STIs.

Knowledge regarding STIs was similar between genders. The most known STI was HIV/AIDS. Nevertheless, females had slightly higher, though not significant, awareness of STIs overall. On the 7-item STI awareness scale ($M=5.66$, Cronbach $\alpha=0.833$), female participants had heard of 5.76 STIs, while males had heard of 5.30 STIs [$t(88)=0.987$, $p=.327$, $d=0.238$].

Participants responded to three common misconceptions: the contraceptive pill (COCP) protects from STIs (Misconception 1), causes future infertility (Misconception 2), and only people who have lots of sex contract STIs (Misconception 3). Very few participants believed Misconception 1 (4%), but a similar proportion of female and male participants were not sure (13% and 15%). More males (12%) than females (4%) believed Misconception 3 or were not sure (23% of males, 12% of females). Misconception 2 was most believed among both genders. There was a significant association with a moderate effect between gender and knowledge of whether the contraceptive pill causes infertility (p=.036, Φ=0.262). Only one-third of males (35%) knew this was false, compared to almost two-thirds of females (62%), and 46% of males reported being not sure compared to just 22% of females.

Awareness of SRH rights was comparable between genders; half of female (46%) and male (50%) were aware of SRH rights. Both female and male participants reported feeling ‘somewhat confident’ in their SRH knowledge.

Sources of Information about Sexual and Reproductive Health

Table 4 compares females and males for sources of information about sexual and reproductive health.

Female and male participants both reported the internet, school, and friends as the top sources where they learned the most about SRH. There was a significant association between gender and learning about SRH from school (p=.026, Φ=0.240), with more males reporting school as a primary information source. Additional open-text sources information expanded on these areas, listing university, “social media” such as “Instagram” and “YouTube”, and “Magazine and books and community board advertisement”. On a scale from one (‘very difficult’), to five (‘very easy’), female (M=3.93, SD=1.01) and male (M=3.95, SD=1.11) participants reported that accessing SRH information was ‘somewhat easy’.

Attitudes

Sexual and Reproductive Health Rights

There was overall agreement between genders regarding the importance of SRH rights. Participants rated eight key rights on a scale from one (‘not at all important’) to five (‘extremely important’), and rated all rights, on average, as very to extremely important (Table 5). There was a significant difference in the perceived importance of the right to decide when and if to have children between female and male participants

Table 6.4

Table 4 Sexual and reproductive health information sources for females and males

	Female		Male			
	N	%	N	%	p	Φ
Doctor	13	19	2	9	0.339	0.122
Family Planning NSW	4	6	2	9	0.640	0.049
Friends	41	60	10	43	0.224	0.147
Parents	10	15	3	13	1.00	0.021
Partner	29	43	8	35	0.625	0.070
Relatives	4	6	2	9	0.640	0.049
School	38	56	19	83	0.026	0.240
Sexual health services	9	13	3	13	1.00	0.002
Youth worker	2	3	3	13	0.100	1.93
Web	52	76	16	70	0.582	0.069
Other	4	6	2	9	0.640	0.049

Table 6.5

Table 5 Importance of sexual and reproductive health rights for females and males

	Female		Male					
	M	*SD*	*M*	*SD*	*t*	df	*p*	*d*
Decide when and if to have children	4.72	0.63	4.38	0.80	2.027	84	0.046*	0.509
Decide when to become sexually active	4.61	0.83	4.60	0.60	0.047	82	963	0.012
Sexual health education and information	4.73	0.57	4.60	0.68	0.878	82	0.383	0.225
Access to contraception	4.78	0.49	4.65	0.59	1.001	82	0.320	0.256
Access to reproductive services and care	4.70	0.58	4.55	0.69	0.983	82	0.328	0.252
Safe and pleasurable sexual experiences	4.71	0.63	4.60	0.75	0.673	83	0.526	0.163
Choose sexual partner	4.85	0.48	4.75	0.44	0.803	83	0.424	0.205
Be free from discrimination	4.89	0.36	4.40	1.05	2.059	20.436	0.052	0.825

(Table 5), reflecting, perhaps, the reproductive burden falling on women. Nevertheless, as with all rights, males still considered this right very important.

Taboos and Shame

Participants reported attitudes towards various SRH rights and behaviours that are typically subject to stigma and taboo. These were recorded using a five-point Likert scale. Female participants ($M=4.13$, $SD=1.34$) were slightly more likely to 'strongly agree' (5) that premarital sex is acceptable than males ($M=3.80$, $SD=1.44$). The same trend was seen in female ($M=4.03$, $SD=1.29$) and male ($M=3.68$, $SD=1.44$) attitudes towards abortion acceptability. Female participants were also more likely to 'strongly disagree' (1) that sexual desire ($M=1.61$, $SD=0.95$) and STI contraction ($M=2.04$, $SD=1.22$) are shameful/ embarrassing than males ($M=1.92$, $SD=1.26$); ($M=2.12$, $SD=1.20$), indicating more liberal attitudes among women. For the gender comparison for each of these measures, $p \geq .210$, indicating no significant differences, though there were moderate effect sizes for abortion acceptability ($d=0.263$), acceptability of premarital sex ($d=0.243$), and belief that having sexual desire is shameful ($d=-0.296$). There was strong significant difference between male and female participants' attitudes towards whether LGBT+people should have equal rights ($p=.025$, $d=0.726$), with female participants ($M=4.62$, $SD=0.77$) more likely to 'strongly agree' than males ($M=3.92$, $SD=1.38$).

Experiences

Sexual Behaviours and Experiences

Engagement in sexual activity and relationships were similar between male and female participants, suggesting gender does not alter levels of sexual behaviour among MRY. Table 6 shows whole sample counts and percentages for selected variables referring to sexual behaviour. Almost half were sexually active, with most of those having a regular sexual partner. Just over three-quarters of female (27%) and male (26%) participants had never been sexually active. Only female ($n=5$) and non-binary ($n=1$) participants reported STI contraction. Interestingly, despite overall similarities in behaviours, consistently, a greater proportion males selected "prefer not to say" than female participants.

There was a significant difference between genders and having felt pressured into sex ($p = < 0.001$, $\Phi=0.356$), with almost half (45%) of female participants reporting feeling pressure compared to just 9% of males. Table 7 shows results for logistic regression that modelled the participants who reported feeling pressure to have sex, depending on whether the respondent was male or female, born in Australia (AU) or not, heterosexual or not, and in a relationship or not, independently of the other factors. Consistent with results of Fisher's exact tests, Table 7 shows females to have much higher rates of reporting being pressured into sex than males, controlling for the other listed factors. Having been born in Australia was also a significant risk factor for being pressured into sex. Sexual orientation and relationship status were not significantly related to having felt pressure to have sex.

Table 6.6

Table 6 Sexual behaviour and experiences †

	N	Percent
Sexually active		
Yes	46	43
Not now	22	21
Never	28	26
Prefer not to say	10	9
Sexual partners		
Regular sexual partner(s)	38	36
No sexual partner(s)	47	44
Casual sexual partner(s)	9	8
Prefer not to say	12	11
Virtual sexual activity		
Yes	24	22
No	71	66
Prefer not to say	12	11
Pornography use		
Yes	49	46
No	40	37
Prefer not to say	18	17
Pressured into sex		
Yes	37	35
No	59	55
Prefer not to say	11	10
Ever had an STI		
Yes	6	6
No	89	86
Prefer not to say	4	4
Don't know	5	5
Unplanned pregnancy (self or partner)		
Yes	6	6
No	85	82
Prefer not to say	4	4
Not applicable	9	9
Abortion (self or partner)		
Yes	4	4
No	86	83
Prefer not to say	4	4
Not applicable	10	10

Use of Contraception and Protection

Despite the significant difference in awareness of contraceptives, use was not different between genders, indicating that knowledge does not necessarily inform action. On a scale from one ('never') to four ('always'), MRY used contraception 'most of the time' [$t(62)=1.175$, $p=.244$, $d=0.327$], females were slightly more likely to use contraceptives ($M=3.09$, $SD=1.13$) than males ($M=2.72$, $SD=1.07$). However, both genders expressed general ambivalence about comfort having unprotected sex; on a scale of one ('strongly disagree') to five ('strongly agree'), participants felt

Table 6.7

Table 7 Logistic regression for pressured into sex by gender, place of birth, sexual orientation and relationship status

Factor	Pressured into sex		Total *N*	Odds ratio	−95% CI	+95% CI	*p*
	N	%					
Gender							
Female	31	47	66	6.02	1.59	22.77	0.008
Male	3	12	26				
Place of birth							
Born in AU	22	51	43	2.80	1.09	7.21	0.032
Not born in AU	12	24	49				
Sexual orientation							
Heterosexual	25	37	67	0.99	0.35	2.84	0.991
Not heterosexual	9	36	25				
Relationship status							
In relationship	21	46	46	1.87	0.73	4.81	0.192
Not in relationship	13	28	46				
Total	34	37	92				

neither agreed nor disagreed that they would be comfortable having unprotected sex [$t(89) = -0.782$, $p = .436$, $d = -0.189$]. Males were marginally more comfortable having unprotected sex (M = 3.09, SD = 1.28) than females (M = 2.8, SD = 1.43). This sense of ambivalence was perhaps related to the lack of concern in both genders around STI contraction, with males (M = 1.96, SD = 0.87) and females (M = 2.01, SD = 0.91) believing they were 'very unlikely' to ever have an STI.

Participants forewent protection and contraception for varying reasons. Most commonly, MRY reported not using STI protection because they trusted their partners were safe – a reason both female (37%) and male (26%) participants frequently selected. Regarding contraceptive use among sexually active participants, concerns about side effects were more a barrier for females (34%) than males (8%). Open-text responses on contraceptive non-use included issues around practicality – participants noting "Spontaneous places, no contraceptive available" – and physical discomfort. Similarly, being on the pill or having "forgotten/run out of my pill" were reasons given for non-use of both contraception *and* STI protection (despite the contraceptive pill not protecting from STIs). However, mirroring the findings about trusting partners, open-text reasons for non-use most frequently related to relationship factors. Participants described being in "monogamous" relationships where both partners had "done STI test" or were each other's first sexual partner. One participant described how, being long-distance "…we are doing it through video call and sexting. We keep it safe.". Others described abstinence within relationships: "My girlfriend and I have both tested negative and do not engage in intercourse. We also rarely have sex due to our low sex drives, so buying contraceptives would not be efficient."

Vaccination for STIs was not significantly associated with gender, though there was a moderate positive effect size for both HPV ($p = .097$, $\Phi = 0.221$) and Hepatitis B vaccination ($p = .093$, $\Phi = 0.228$), suggesting greater female vaccination. Female participants were more likely to be vaccinated for HPV (40% of females compared to 19% of males) and Hepatitis B (66% of females and 42% of males).

Social Interactions – Interpersonal Experiences

There were shared experiences regarding discomfort talking to parents about SRH – over half of participants reported being 'extremely uncomfortable'. On a Likert-scale from one ('extremely uncomfortable') to five ('extremely comfortable'), females and males were 'somewhat' to 'extremely uncomfortable' discussing SRH with parents (Table 8). Further, only 12% of females and 17% of males selected parents as who/where they would go for help with SRH concerns. Both female (M = 3.22, SD = 1.65) and male (M = 3.5, SD = 1.47) participants neither agreed nor disagreed that they could be open with family about their sexual orientation and gender identity.

Similarly, conflict between sexuality or gender identity[3] and their church, faith, family and/or cultural beliefs were experienced by a large minority of female (57%) and male (63%) participants. There was no relationship between gender and experiencing conflict. In open-text responses ($n = 29$) on how MRY dealt with this conflict, a significant proportion described silence and avoidance ($n = 12$): "keeping it a secret", "I just avoid it", "I hide it", "I'm never telling any of my family". Both female and male participants described setting "boundaries", removing themselves "from situations of judgement", and having to "cut…[people] off". Related were efforts MRY made to actively "ignore it [conflict]", "not to give it energy and time", and to remember "what matters is how I feel about me" ($n = 6$). Two participants tried to "explain my situation" and two described "avoiding being sexually active" and having to "suppress/conform". Others recounted considerable struggles: "I just can't", "I don't know how", "I cry about it".

As seen in Table 8, there was significant difference between female and male participants' comfort discussing SRH with friends ($p = < 0.001$, $d = 0.899$). There was also a significant difference between genders regarding ability to be open with friends about sexual orientation and gender identity [$t(27.139) = 2.712$, $p = .011$, $d = 0.870$]. Females were more likely to 'strongly agree' (5) they were able to be open with friends (M = 4.59, SD = 0.65) than males (M = 3.83, SD = 1.31).

Finally, both genders were most comfortable discussing SRH with partners (Table 8), though females reported greater comfort. This pattern, however, did not recur in conversations with partners about consent: there was a significant difference between genders [$t(84.17) = -2.601$, $p = .011$, $d = -0.438$]. Male participants were more likely to 'strongly agree' (5) they were comfortable discussing consent with partners (M = 4.70, SD = 0.47) than females (M = 4.26, SD = 1.10). While there was no significant difference between male and female participants' comfort saying "no" to partners [$t(89) = 0.965$, $p = .337$, $d = -0.233$], males again more strongly agreed they were comfortable (M = 4.65. SD = 0.57) than females (M = 4.47, SD = 0.84).

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[3] While this question inquired on gender and sexual orientation, responses included those from cis-heterosexual participants, and thus results reflect sexuality in a broad sense as including sexual behaviour and activity as well as orientation. As such, the proportion of participants experiencing conflict is greater than the proportion of LGBTQ + participants.

Table 6.8

Table 8 Comfort discussing sexual and reproductive health

	Female		Male					
	M	SD	M	SD	*t*	df	*p*	*d*
Doctors	3.18	1.05	3.23	1.15	−0.193	88	0.848	−0.047
Nurses	3.51	0.95	3.48	1.12	0.155	87	0.877	0.039
Friends	3.79	1.06	2.81	1.21	3.601	87	< 0.001*	0.899
Parent	1.63	1.02	1.95	1.28	-1.180	87	0.241	−0.294
Partner	4.40	0.83	3.86	1.2	1.931	26.244	0.064	0.582
Youth worker	2.88	1.09	2.43	1.21	1.630	87	0.107	0.408

Services Access and Needs

Awareness of Services and Needs met

Three quarters of female (72%) and male (77%) participants were unaware of any local SRH services. This lack of awareness was further evidenced by the two-fifths of participants who reported they 'don't know' how well current services meet their needs. Responses to how well services meet needs were similar between females and males, with very few (3% and 10% respectively) reporting their needs were met 'very well', and a larger proportion (21%, 14%) reporting their needs were met 'not well at all'.

Use of Services

Given the low rates of service knowledge, it is unsurprising that service use was generally low. However, there were significant gender differences in service use. There was a significant association between gender and selecting 'not applicable' when answering which services they had used ($p = .002$, $\Phi = 0.340$): 86% of male respondents selected 'not applicable', indicating non-use of services. There was a significant association between gender and having visited a general practitioner (GP) or doctor for SRH care ($p = .001$, $\Phi = 0.333$). Two fifths of female participants sought SRH care from GPs/doctors (Table 9), suggesting primary care is sought over specialist services.

Barriers to care

A small but notable proportion of females (15%) and males (23%) reported difficulty accessing SRH services. Two-fifths of both genders, however, answered 'not applicable' when asked if they had experienced difficulty accessing services, again suggesting non-use. Barriers to care were similar between genders – not knowing where services are located was the greatest barrier for both females (57%) and males (47%). Similarly, a third of female and male participants selected being embarrassed about being seen as a barrier. A much greater proportion of female participants (43%) selected being too shy/embarrassed to talk to healthcare workers as a care barrier than males (21%). Table 8 above, however, indicates neither females nor males were not particularly comfortable discussing SRH with doctors. Cost concerned similar proportions of female (23%) and male (32%) participants, as did uncertainty about eligibility (25%; 26%).

Open-text responses describing reasons for non-use included time commitments – "I am busy" – and perceived irrelevance: "don't need". Other participants described feeling "judged by them", one young woman describing being denied the contraceptive pill by a doctor because she was an "unmarried Indian girl living with her parents". Another participant wrote services "confuse" her, recounting how when she tried to get a pregnancy test from a women's health centre, "they basically said we don't have those and sent me off". One male participant described avoiding services to keep "things a secret from parents".

Table 6.9

Table 9 Services used by females and males

	Female		Male		p
	N	%	N	%	
Services used for SRH[†]					
Family planning NSW	5	8	1	5	1.000
Community health service	6	9	1	5	0.673
GP/ doctor	26	40	1	5	0.001*
Sexual health service	4	6	1	5	1.000
Not applicable (no services used)	31	48	19	86	0.002*

[†] Participants could select more than one option

Discussion

This study contributes to existing literature on the sexual and reproductive health and rights experiences and understandings of MRY, illustrating the ways gender shapes rights attainment. Our findings provide valuable data on the differences and consistencies in experiences between male- and female-identifying MRY. While female participants faced issues around consent and had higher rates of STIs, male participants had lower knowledge, vaccination rates, service use and peer support. Despite participants considering SRHR highly important, our findings reveal impediments to MRY's full realisation of their rights.

Knowledge

Existing literature involving MRY has highlighted SRH knowledge deficits – this study provides evidence of how such deficits might differ by gender. Consistently, female participants had higher contraceptive and STI awareness. Our findings contrast those of Tangmunkongvorakul et al. and Botfield et al. who report lower contraceptive awareness among female MRY than males (2017; 2018). Similarly, some research including migrant and refugee women has reported practices of intentional ignorance, where purity and virtue are maintained by avoiding SRH knowledge (Kaczkowski & Swartout, 2020; Meldrum et al., 2015; Wray et al., 2014). However, our findings are more consistent with research that has revealed young women's desire for SRH education and active attempts to inform themselves (McMichael & Gifford, 2009; Rawson & Liamputtong, 2010). Female participants in this research were not disengaging from SRH information, but in fact showed greater awareness of STIs and contraception than males. These findings may be a result of gender norms and sexual double-standards that place the burden of reproductive responsibility on women (Heise et al., 2019), leading female MRY to be more engaged with, and thus aware of, SRH.

Our findings of lower male SRH knowledge are consistent with literature reporting significant knowledge gaps in male migrant, refugee, and ethnic minority groups (Harvey et al., 2013; Richards et al., 2016). Furthermore, in contrast with Botfield et al. and Tangmunkongvorakul et al.'s findings regarding lower female contraceptive knowledge, other literature comparing gender outcomes of MRY has reported lower male SRH knowledge (Coleman & Testa, 2007; Dean et al., 2017; Kaczkowski &

Swartout, 2020). Lower STI knowledge among young men compared to women has also been found in the broader Australian youth population (Adam et al., 2019). The divergence in findings around gender and knowledge may be due to the heterogeneity of MRY identity and experience. Tangmunkongvorakul et al.'s research (2017), for example, was conducted in a significantly lower-income context than our study and involved undocumented cross-border migrants; the intersections of poverty, gender norms and precarity may explain why Tangmunkongvorakul et al.'s findings differ from ours.

Attitudes

Our findings suggest that female MRY may have more liberal attitudes towards SRH rights and behaviours. Existing literature on migrant and refugee SRH has emphasised stigma, repression, and taboo around *female* sexuality, with stigma and shame almost solely focusing on women (Ussher et al., 2012; Wray et al., 2014). Similarly, Coleman and Testa's research on ethnically diverse youth in the United Kingdom revealed more liberal attitudes among *males* (2007). However, in this study, male participants more strongly agreed that sexual desire and STI contraction were shameful and embarrassing and female participants appeared to have more liberal attitudes towards abortion, premarital sex, and LGBTQ+rights. The discordance between our findings and existing literature may simply be related to the greater knowledge of female participants in this research. Furthermore, though religiosity was consistent between genders, intersections between religion and MRY identity may have influenced attitudes. Our findings suggest that, despite female sexuality being the subject of stigma and censure, female MRY do not necessarily internalise these values.

Interpersonal Interactions

Our findings highlighted shared and divergent experiences between genders regarding interpersonal relationships and SRH. Female and male participants indicated discomfort discussing SRH with parents, a finding which is highly consistent with existing research (Botfield et al., 2018c; Rawson & Liamputtong, 2010; Wray et al., 2014). These findings suggest that MRY must rely on sources of support and information external to their parents. Scholarship on MRY information-seeking has indicated friends, while not always reliable, are crucial sources of SRH information and support (Botfield et al., 2018c; Burchard et al., 2011; McMichael & Gifford, 2009; Meldrum et al., 2015; Rawson & Liamputtong, 2010). Research examining how SRH is differentially experienced between female and male MRY has not explored peer-support: our findings that male participants were less comfortable discussing SRH and being open with friends are thus highly significant. This indicates that male MRY lack both parental *and* peer avenues for SRH information-seeking and support.

Sexual Experiences – Coercion and STI Contraction

Our findings reveal ongoing issues regarding sexual consent that disproportionately impact young women. Female participants were far more likely to be pressured into sex, and were less comfortable discussing consent with partners, indicating these young women's rights to bodily integrity and autonomy are significantly curtailed. While the discrepancies between female and male nonconsensual experiences may be explained male under-reporting – perhaps due to gender norms that stigmatise male sexual assault–, our findings are consistent with previous research. The term 'consent' is absent in much of the existing literature on MRY, however, descriptions of coercion are common (Botfield et al., 2018c; Chung et al., 2018; McMichael & Gifford, 2010; Wray et al., 2014). While Dean et al.'s study of young Sudanese Queenslanders found higher rates of unwanted sex among young men than women (2017), in most other research, sexual coercion – and violence – is experienced by migrant and refugee *women* (Botfield et al., 2018c; Chung et al., 2018; McMichael & Gifford, 2010; Wray et al., 2014). Among the broader Australian population, 45% of female secondary students reported experiencing unwanted sex – a number almost identical to the proportion of young women in this study who were pressured into sexual activity (Power et al., 2022). This suggests that our findings around female participants' compromised rights to bodily autonomy are not specific to MRY, but rather reflect systemic gender inequalities in Australia. In conjunction with broader Australian data, our findings illustrate the ways gender and age intersect to render young Australian women particularly vulnerable to non-consensual sexual experiences.

This research also identified STI rates and low vaccination uptake as key areas of concern. STI rates in this study were higher than those of Australian secondary students, of whom 2% reported having had an STI (Power et al., 2022). Similarly, rates in this study were higher than Chlamydia, Gonorrhoea, and HPV notifications per 100,000 among Australian 15–24 year olds (King et al., 2023). Our findings, with STI incidence solely among female and non-binary participants, suggest young migrant and refugee women and gender diverse people are particularly vulnerable to STI risk. These gender discrepancies are consistent with Dean et al.'s findings among Australian Sudanese youth, among whom 7% of females compared to 1% of males reported STI diagnosis (Dean et al., 2017). Such findings, however, may reflect limited STI testing among migrant and refugee young men, as has been previously reported among ethnic minority and immigrant men (Baroudi et al., 2022; Harvey et al., 2013; Kalmuss & Austrian, 2010; Mengesha et al., 2023). This may be particularly likely given the comparatively low service uptake among male participants in this study.

Vaccination rates were concerningly low for both genders. National immunisation data from 2021 shows 80% of Australian girls and 77% of Australian boys have had a full course of HPV vaccination by age 15 years (Hull et al., 2022). However, in this study only two-fifths of males and two-thirds of females reported being vaccinated, placing MRY well below national statistics. It is possible participants were unaware they received vaccinations in school,[4] leading to under-reporting. Given this was a highly religious sample, again, intersections between religion and MRY identity must be considered – though we found no significant relationship between religiosity and vaccination rates. Gender disparities in vaccination rates were also much greater in

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[4] Under the National Immunisation Program, Australian secondary school students receive free vaccinations at school for HPV, diphtheria-tetanus-pertussis and meningococcal.

this study than nationally (Hull et al., 2022). Low vaccination rates among male participants conform to a trend across this study of lower SRH engagement and awareness among males.

Service use

We found that MRY engagement with services was notably low. With three-quarters of participants unaware of local SRH services, it is unsurprising that not knowing where services were located was the greatest barrier. Low service uptake has consistently been found among MRY, with being unaware of services a recurring barrier in Australia (Botfield et al., 2018; Botfield, Zwi, Botfield et al., 2018a, b, c; McMichael & Gifford, 2009; Poljski et al., 2014), and other high-income countries (Harvey et al., 2013; Kaczkowski & Swartout, 2020), suggesting services are failing to engage MRY. While participants were not extremely uncomfortable with healthcare providers, our findings are consistent with previous scholarship that has illustrated MRY fear judgement and are embarrassed seeking care (Botfield, Newman, Kang et al., 2018; Kaczkowski & Swartout, 2020; Manderson et al., 2002; McMichael & Gifford, 2009; Rawson & Liamputtong, 2009).

Though low service uptake was ubiquitous, male participants had much lower engagement. It is well-established than men's health behaviour is characterised by low healthcare seeking, avoidance of preventative health measures, and risk-taking, and that these behaviours are used to display hegemonic masculine ideals (Connell, 2012; Courtenay, 2000). Gender norms that dictate men must be strong, invulnerable, and self-reliant mean help-seeking is perceived as emasculating (Courtenay, 2000). The adoption of traditional norms of masculinity is associated with SRH risk (Santa Maria et al., 2018). Moreover, low healthcare seeking among men generally intersects with the historic exclusion of men from SRH programming and attitudes that SRH is solely a women's issue, meaning men's SRH care access is *particularly* low (Kalmuss & Austrian, 2010; Mengesha et al., 2023).

Our findings mirror trends in general healthcare seeking between young men and women in Australia. In 2021-22, 62% of young Australian males (aged 15–24 years) compared to 83% of young females visited a GP (Australian Institute of Health and Welfare, 2023). In conjunction with the lower STI vaccination rates, and lower SRH awareness, the low service use in this study indicates a broader issue of under-engagement in SRH among male MRY. This may be linked to ideas about SRH help-seeking as particularly threatening to masculinity. In their study of Latino and black young men, Kalmuss and Austrian found under-utilisation of services was due to perceptions of SRH care as indicating sexual dysfunction (2010). Because masculinity is predicated on sexual functioning, being seen accessing SRH care would indicate impaired sexual function, and thus impaired masculinity (Kalmuss & Austrian, 2010).

Implications for Policy

Gender is an important dimension of SRH that must be considered in the development of policy and practice. Firstly, results indicate need to address ongoing issues around consent. While non-consensual experiences disproportionately burden young women, men must be strongly involved in efforts to ensure young people have safe, consensual experiences. Changes to Australia's national curriculum to include mandatory consent education in 2023 are a positive first step, but our findings affirm this is a systemic issue requiring continued efforts. This may involve expanding the education curriculum to more explicitly teach students how to better develop positive, healthy relationships and have conversations about SRH more broadly.

Concerted efforts should be made to improve service delivery for all MRY. Given most participants knew no local SRH services, outreach to inform MRY of the existence and accessibility of services is necessary. Again, education reform could involve teaching youth about services: what services exist, when to seek care, and how to access this care. Other outreach could involve drop-in services at schools, or community events. Social media advertising campaigns may also be particularly useful for outreach.

Furthermore, there must be more effort to include and engage young men in SRH, improving outcomes for all genders. Organising information sessions about SRH specifically for young men may be useful. Establishing male SRH services or having specific clinic hours where men's health issues are addressed could increase service engagement among male MRY. Future research should examine gendered use of services, and MRY perspectives on what would incentivise service uptake.

Finally, our findings present an opportunity to further strengths-based programming and interventions. The results on rights suggest that MRY, irrespective of gender, value SRH. Young women, despite experiencing higher rates of sexual coercion, STIs and facing unplanned pregnancy and abortion risks, had more knowledge and service engagement than their male counterparts. While this might be due to gender norms which have placed the burden of reproductive responsibility on women, these are positive outcomes which can be used to further empower young women. This could offer an opportunity to develop peer-education campaigns, with young women leading education. Policy and programming should seek to improve young male's engagement with and knowledge of SRH and support young people of all genders in using this knowledge to make positive, affirming health decisions.

Limitations

There are limitations to this study that warrant attention. A large proportion of participants were from an Asian background, potentially leading to an overrepresentation of these perspectives. Results may thus reflect experiences of Asian-background participants, limiting applicability of findings to broader MRY communities. A sampling strategy that includes targeted recruitment might be useful in future research to ensure a more representative sample.

This analysis did not compare differential experiences of migrants and refugees. This potentially obscures the exacerbated vulnerabilities that may come with refugee experiences, or specific outcomes relating to migrants and refugees. Future research should examine how different migration experiences – including those of student visa holders and temporary visa holders – inform SRH outcomes. Further, this research did not include a comparison group from the general youth population, requiring further research to fully examine the specific and common needs of different groups of youth.

A significant limitation is the lack of gender diverse perspectives in this study. While one non-binary participant completed the survey, this sample size was too statistically small to provide any analysis. For a comprehensive analysis of how gender intersects with migrant and refugee youth experiences, future research with a larger sample with gender diverse participants might provide better understanding of how gender intersects with MRY identity. Again, this would involve targeted recruitment. Partnering with organisations that provide support for gender diverse youth might allow for a greater engagement with gender diverse participants and attention to how these youth have specific needs.

Conclusions

This study provides insight into the myriad ways gender intersects with MRY identity to inform sexual and reproductive health outcomes, illustrating gender-specific needs and vulnerabilities. Our findings articulate ongoing issues with services and healthcare inadequately engaging young people from migrant and refugee backgrounds. In conjunction with previous scholarship, our research affirms the urgent need to improve healthcare policy and provision to more deliberately engage and involve MRY of all genders. Further, we highlight the exigency of addressing gendered outcomes: the lack of involvement and engagement of males in sexual and reproductive health, and pervasive issues around sexual consent among young women. Future research must examine MRY perspectives on how to best address these issues. Most importantly, our findings illuminate discordance between how important migrant and refugee youth consider sexual reproductive health and rights, and their actual attainment of these rights. Research and practice must seek to remedy this, empowering MRY attainment of sexual and reproductive health and rights.

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Data availability Data is not publicly available due to measures to ensure participant confidentiality.

Declarations

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

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

Conflicts of Interest There are no potential conflicts of interest.

References

Adam, P., de Wit, J., Ketsuwan, I., & Treloar, C. (2019). *Sexual health-related knowledge, attitudes and practices of young people in Australia: Results from the 2018 Debrief Survey*. Australian Government Department of Health. http://handle.unsw.edu.au/1959.4/unsworks_55103

Australian Bureau of Statistics (2021). *Snapshot of Australia, 2021*. ABS. Retrieved July 20, 2023 from https://www.abs.gov.au/statistics/people/people-and-communities/snapshot-australia/latest-release

Australian Bureau of Statistics (2024). *Sample Size Calculator*. https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Sample+Size+Calculator

Australian Institute of Health and Welfare (2023). *Health of young people*. https://www.aihw.gov.au/reports/children-youth/health-of-young-people

Baroudi, M., Nkulu-Kalengayi, F., Goicolea, I., Jonzon, R., San Sebastian, M., & Hurtig, A. K. (2022). Access of migrant youths in Sweden to sexual and Reproductive Healthcare: A cross-sectional survey. *International Journal of Health Policy and Management*, *11*(3), 287–298. https://doi.org/10.34172/ijhpm.2020.123

Bateson, D. J., Black, K. I., & Sawleshwarkar, S. (2019). The Guttmacher–Lancet Commission on sexual and reproductive health and rights: How does Australia measure up? *Medical Journal of Australia*, *210*(6), 250–252e251. https://doi.org/10.5694/mja2.50058

Botfield, J. R., Newman, C. E., Kang, M., & Zwi, A. B. (2018a). Talking to migrant and refugee young people about sexual health in general practice. *Australian Journal of General Practice*, *47*(8), 564–569. https://doi.org/10.31128/ajgp-02-18-4508

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2018b). Engaging migrant and refugee young people with sexual health care: Does generation matter more than culture. *Sexuality Research and Social Policy*, *15*(4), 398–408. https://doi.org/10.1007/s13178-018-0320-6

Botfield, J. R., Zwi, A. B., Rutherford, A., & Newman, C. E. (2018c). Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: 'I never got the talk about the birds and the bees'. *Sex Education*, *18*(6), 705–720. https://doi.org/10.1080/14681811.2018.1464905

Botfield, J. R., Newman, C. E., Bateson, D., Haire, B., Estoesta, J., Forster, C., & Moore, S., J (2020). Young migrant and refugee people's views on unintended pregnancy and abortion in Sydney. *Health Sociology Review*, *29*(2), 195–210. https://doi.org/10.1080/14461242.2020.1764857

Burchard, A., Laurence, C., & Stocks, N. (2011). Female international students and sexual health - a qualitative study into knowledge, beliefs and attitudes. *Australian Family Physician*, *40*(10), 817–820. https://pubmed.ncbi.nlm.nih.gov/22003488/

Chung, D., Fisher, C., Zufferey, C., & Thiara, R. (2018). Preventing sexual violence against young women from African backgrounds. *Trends and Issues in Crime and Criminal Justice*, *540*, 1–13.

Coleman, L., & Testa, A. (2007). Sexual health knowledge, attitudes and behaviours among an ethnically diverse sample of young people in the UK. *Health Education Journal*, *66*(1), 68–81. https://doi.org/10.1177/0017896907073789

Collins, P. H., & Bilge, S. (2016). *Intersectionality - key concepts*. Polity.

Connell, R. (2012). Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Social Science & Medicine*, *74*(11), 1675–1683. https://doi.org/10.1016/j.socscimed.2011.06.006

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health [Article]. *Social Science and Medicine*, *50*(10), 1385–1401. https://doi.org/10.1016/S0277-9536(99)00390-1

Dean, J., Mitchell, M., Stewart, D., & Debattista, J. (2017). Sexual health knowledge and behaviour of young Sudanese queenslanders: A cross-sectional study. *Sexual Health (14485028)*, *14*(3), 254–260. https://doi.org/10.1071/SH16171

Dune, T., Liamputtong, P., Hossain, S. Z., Mapedzahama, V., Pithavadian, R., Aibangbee, M., & Mpofu, E. (2022). Participatory Action Research: Sexual and Reproductive Health and Rights of Young Refugees and Migrants. In *Handbook of Social Inclusion: Research and Practices in Health and Social Sciences* (pp. 1–23). Springer. https://doi.org/10.1007/978-3-030-89594-5_78

Garry, A. (2011). Intersectionality, metaphors, and the multiplicity of gender. *Hypatia*, *26*(4), 826–850. https://doi.org/10.1111/j.1527-2001.2011.01194.x

Hankivsky, O., & Grace, D. (2016). Understanding and emphasizing difference and intersectionality in multimethod and mixed methods research. In S. N. Hesse-Biber & R. B. Johnson (Eds.), *The Oxford handbook of multimethod and mixed methods research inquiry* (online ed.). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199933624.013.8

Harvey, S. M., Branch, M. R., Hudson, D., & Torres, A. (2013). Listening to immigrant latino men in Rural Oregon:Exploring connections between culture and Sexual and Reproductive Health Services. *American Journal of Men's Health*, *7*(2), 142–154. https://doi.org/10.1177/1557988312463600

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., Darmstadt, G. L., Greene, M. E., & Hawkes, S. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. *The Lancet*, *393*(10189), 2440–2454. https://doi.org/10.1016/S0140-6736(19)30652-X

Homma, Y., Saewyc, E. M., Wong, S. T., & Zumbo, B. D. (2013). Sexual health and risk behaviour among east Asian adolescents in British Columbia. *The Canadian Journal of Human Sexuality*, *22*(1), 13–24. https://doi.org/10.3138/cjhs.927

Hull, B., Hendry, A., Dey, A., Brotherton, J., Macartney, K., & Beard, F. (2022). *Annual Immunisation Coverage Report 2021*. National Centre for Immunisation Research and Surveillance.

IBM Corp (2020). *IBM SPSS Statistics for Windows*. In (Version 27.0) IBM Corp.

Kaczkowski, W., & Swartout, K. M. (2020). Exploring gender differences in sexual and reproductive health literacy among young people from refugee backgrounds. *Culture Health & Sexuality*, *22*(4), 369–384. https://doi.org/10.1080/13691058.2019.1601772

Kalmuss, D., & Austrian, K. (2010). Real men Do… real men don't: Young latino and African American men's discourses regarding sexual Health Care utilization. *American Journal of Men's Health*, *4*(3), 218–230. https://doi.org/10.1177/1557988309331797

King, J., McManus, H., Kwon, A., Gray, R., & McGregor, S. (2023). HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2023. *Kirby Institute*. https://doi.org/10.26190/f5ph-f972

Manderson, L., Kelaher, M., Woelz-Stirling, N., Kaplan, J., & Greene, K. (2002). Sex, contraception and contradiction among young Filipinas in Australia. *Culture Health & Sexuality*, *4*(4), 381–391. https://doi.org/10.1080/13691050210000041034

McMichael, C., & Gifford, S. (2009). It is good to know Now… before it's too late: Promoting sexual health literacy amongst resettled young people with refugee backgrounds [Article]. *Sexuality and Culture*, *13*(4), 218–236. https://doi.org/10.1007/s12119-009-9055-0

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

Meldrum, R. M., Liamputtong, P., & Wollersheim, D. (2015). Sexual health knowledge and needs: Young Muslim women in Melbourne, Australia. *International Journal of Health Services*, *46*(1), 124–140. https://doi.org/10.1177/0020731415615313

Mengesha, Z., Perz, J., Dune, T., & Ussher, J. (2017). Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. *PLOS ONE*, *12*(7), e0181421–e0181421. https://doi.org/10.1371/journal.pone.0181421

Mengesha, Z., Hawkey, A. J., Baroudi, M., Ussher, J. M., & Perz, J. (2023). Men of refugee and migrant backgrounds in Australia: A scoping review of sexual and reproductive health research. *Sexual Health*, *20*(1), 20–34. https://doi.org/10.1071/SH22073

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J., & Monteiro, M. (2017). In my culture, we don't know anything about that: Sexual and Reproductive Health of migrant and Refugee women. *International Journal of Behavioral Medicine*, *24*(6), 836–845. https://doi.org/10.1007/s12529-017-9662-3

Mpofu, E., Hossain, S. Z., Dune, T., Baghbanian, A., Aibangbee, M., Pithavadian, R., Liamputtong, P., & Mapedzahama, V. (2021). Contraception decision making by culturally and linguistically diverse (CALD) Australian youth: An exploratory study. *Australian Psychologist*, *56*(6), 511–522. https://doi.org/10.1080/00050067.2021.1978814

Napier-Raman, S., Hossain, S. Z., Lee, M. J., Mpofu, E., Liamputtong, P., & Dune, T. (2023). Migrant and Refugee Youth Perspectives on Sexual and Reproductive Health and rights in Australia: A systematic review. *Sexual Health*, *20*(1), 35–48. https://doi.org/10.1071/sh22081

Patton, G. C., Sawyer, S. M., Ross, D. A., Viner, R. M., & Santelli, J. S. (2016a). From advocacy to Action in Global Adolescent Health. *Journal of Adolescent Health*, *59*(4), 375–377. https://doi.org/10.1016/j.jadohealth.2016.08.002

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E. M., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K., & Viner, R. M. (2016b). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet (British Edition)*, *387*(10036), 2423–2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Patton, G. C., Darmstadt, G. L., Petroni, S., & Sawyer, S. M. (2018). A Gender Lens on the Health and Well-being of young males. *Journal of Adolescent Health*, *62*(3), S6–S8. https://doi.org/10.1016/j.jadohealth.2017.06.020

Plesons, M., Cole, C. B., Hainsworth, G., Avila, R., Biaukula, K. V. E., Husain, S., Janušonytė, E., Mukherji, A., Nergiz, A. I., & Phaladi, G. (2019). Forward, together: A collaborative path to comprehensive adolescent sexual and reproductive health and rights in our time. *Journal of Adolescent Health*, *65*(6), S51–S62. https://doi.org/10.1016/j.jadohealth.2019.09.009

Poljski, C., Quiazon, R., & Tran, C. (2014). Ensuring rights: Improving Access to sexual and Reproductive Health Services for Female International Students in Australia. *Journal of International Students*, *4*(2), 150–163. https://doi.org/10.32674/jis.v4i2.475

Power, J., Kauer, S., Fisher, C., Bellamy, R., & Bourne, A. (2022). *The 7th National Survey of Australian Secondary Students and Sexual Health 2021* (ARCSHS Monograph Series, Issue 133). https://doi.org/10.26181/21761522.v2

Rawson, H. A., & Liamputtong, P. (2009). Influence of traditional Vietnamese culture on the utilisation of mainstream health services for sexual health issues by second-generation Vietnamese Australian young women. *Sexual Health*, *6*(1), 75–81. https://doi.org/10.1071/sh08040

Rawson, H. A., & Liamputtong, P. (2010). Culture and sex education: The acquisition of sexual knowledge for a group of Vietnamese Australian young women. *Ethnicity & Health*, *15*(4), 343–364. https://doi.org/10.1080/13557851003728264

Richards, M. J., Peters, M., Sheeder, J., & Kaul, P. (2016). Contraception and adolescent males: An opportunity for providers. *Journal of Adolescent Health*, *58*(3), 366–368. https://doi.org/10.1016/j.jadohealth.2015.10.011

Santa Maria, D., Rafferty, J., Lau, M., Guilamo-Ramos, V., Tebb, K., Chadi, N., Ambresin, A. E., Vyver, E., & Marcell, A. V. (2018). Advocating for adolescent and young adult male sexual and Reproductive Health: A position Statement from the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*, *63*(5), 657–661. https://doi.org/10.1016/j.jadohealth.2018.08.007

Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., Coll-Seck, A. M., Grover, A., Laski, L., Roa, M., Sathar, Z. A., Say, L., Serour, G. I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers, C., & Ashford, L. S. (2018). Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher-*Lancet* Commission. *The Lancet*, *391*(10140), 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9

Tangmunkongvorakul, A., Musumari, P. M., Srithanaviboonchai, K., Manoyos, V., Techasrivichien, T., Suguimoto, S. P., Ono-Kihara, M., Kihara, M., & Chariyalertsak, S. (2017). When I first saw a condom, I was frightened: A qualitative study of sexual behavior, love and life of young cross-border migrants in urban Chiang Mai, Thailand. *PLOS ONE*, *12*(8). https://doi.org/10.1371/journal.pone.0183255. Article e0183255.

Ussher, J. M., Rhyder-Obid, M., Perz, J., Rae, M., Wong, T. W. K., & Newman, P. (2012). Purity, privacy and procreation: Constructions and experiences of sexual and Reproductive Health in assyrian and Karen Women living in Australia. *Sexuality & Culture*, *16*(4), 467–485. https://doi.org/10.1007/s12119-012-9133-6

Wray, A., Ussher, J. M., & Perz, J. (2014). Constructions and experiences of sexual health among young, heterosexual, unmarried muslim women immigrants in Australia. *Culture Health and Sexuality*, *16*(1), 76–89. https://doi.org/10.1080/13691058.2013.833651

Additional results:

These additional results include analysis examining acculturation as well as further detail on specific gender analysis measures. Impact of acculturation on knowledge and attitudes is examined through participants' length of time in Australia, with comparison of those born in Australia, those having lived in Australia for 10 or more years, and those having lived in Australia for under 10 years. Open-text responses regarding participants' experiences of conflict are further analysed below. Full tabular data for this analysis is presented in Appendix G.

These additional results relate to the overall thesis research questions regarding how MRY understand and perceive SRHR (i), level of literacy and knowledge around SRH (iii), which socioecological factors shape needs (iv), and experiences of rights attainment (v).

Knowledge and awareness

Acculturation: time in Australia

Length of time in Australia had a significant impact on knowledge and awareness (Table 6.10, Appendix G), with MRY who were more newly arrived having lower knowledge. Respondents were grouped into three categories: those born in Australia, those living in Australia for over 10 years, and those living in Australia for under 10 years. One-way ANOVA tests revealed significant difference in the mean contraceptive awareness and STI awareness of the three groups. There was significant effect of time in Australia on mean contraceptive awareness ([F (2, 95) = 13.257], p = <.001). On the 10-item contraceptive awareness scale (see publication above), on average those born in Australia had heard of 7.9, while those living in Australia for over 10 years heard of 7.3, and those living in Australia for under 10 years heard of only 4.5. Tukey's HSD for multiple comparisons found that those in Australia for under 10 years had significantly lower mean contraceptive awareness scores than those born in Australia (<.001) and those living in Australia for 10+ years (<.001). Time in Australia also had a significant effect on overall STI awareness ([F (2, 88) = 8.767], p = <.001). On the 7-item STI awareness scale (see above), those born in Australia heard of 5.8 STIs, those having been in Australia for 10+ years knew 6.3, and those living in Australia for under 10 years knew 4.2. Again, Tukey's HSD found those living in Australia for under 10 years had significantly lower STI awareness scores than those born in Australia (.004) and those living in Australia for 10+ years (<.001).

Attitudes

Overall, MRY somewhat agreed that LGBTQ+ people should have equal rights (*M* = 4.44), that it is acceptable to have sexual experiences before marriage (*M* = 4.05) and acceptable to get an abortion if necessary (*M* = 3.95). MRY also somewhat disagreed that contracting an STI is shameful or embarrassing (*M* = 2.05) and that having sexual desires is shameful or embarrassing (*M* = 1.69).

Gender differences in attitudes towards SRH rights are fully reported in Appendix G, Table 6.11, showing female participants were more likely to agree to the acceptability of premarital sex and abortion, agree to equal rights for LGBT+ individuals, and disagree that STI contraction and sexual desire are shameful/ embarrassing.

One-way ANOVA tests found length of time in Australia had significant effect on agreement that LGBT+ people should have equal rights ([F (2, 90) = 4.164], *p* = .019), and on agreement with abortion acceptability ([F (2, 90) = 3.182], *p* = .046) (see Table 6.12). Participants born in Australia were significantly more likely to agree to equal rights for LGBT+ individuals than those having lived in Australia for under 10 years (*p* = .029). Similarly, MRY born in Australia were significantly more likely to agree that abortion is acceptable if necessary than those living in Australia for under 10 years (*p* = .038) (Table 6.12). For all attitudes measures, those who had arrived most recently to Australia had the least liberal attitudes: more likely to strongly *disagree* that premarital sex and abortion are acceptable and that LGBT+ people should have equal rights, and more likely strongly *agree* that sexual desire and STI contraction are shameful/embarrassing (see Table 6.12)

Services, sources of knowledge and help

Table 6.13 indicates top barriers to care by gender, with lack of location awareness by far the greatest barrier. Figure 6.1 (Appendix G), depicting MRY perceptions of how well current services meet their needs, reveals that almost one fifth (19%) felt their needs were met “not well at all”. A large minority (40%) did not know how well services meet MRY needs, reflecting lack of awareness and uptake of SRH care. The same proportion (40%) of MRY answered “not applicable” when asked about difficulty accessing service, again illustrating the lack of attempts to access services in the first place (Figure 6.2). One sixth of participants experienced barriers accessing services.

Conflict around sexuality

> *"I ignore the ones who do not support me; I am independent and value those who value me back."* – Anonymous participant, open-text response

Open-text responses regarding how participants dealt with conflict between their sexuality and their family, faith, church, cultural or ethnic tradition revealed a range of coping strategies (Table 6.14, Appendix G). Of the participants who provided responses, the most common methods for dealing with conflict were silence and avoidance: "keeping it secret" and avoiding conversations. Youth also actively ignored conflict, choosing "not to deal with them [family]" and trying to ignore "criticism and judgement from people around me". Related to this, many MRY described positive coping mechanisms, trying to "set boundaries", "face… [situations of judgement] with confidence", "stay positive as I have a clear goal in life", "value those who value me back" and "remember that what matters is how I feel about me". These practices of silence and disregarding negative external attitudes exhibit MRY's forms of 'thin' agency: finding ways to manage the stigma and judgement constraining their SRHR decision-making.[21] Conversely, some participants described suppressing their sexuality, struggling to cope, feelings of despondence, and lack of acceptance. While silence and avoidance were described by both heterosexual and LGBT+ participants, more challenging experiences of suppression, struggle and rejection appeared unique to LGBT+ youth (Table 6.12).

Conclusion

This chapter expands on the broad decision-making factors identified in the group concept mapping study, examining decisions around service access and sexual behaviour, as well as knowledge, attitudes and experiences informing decisions. Survey results elucidate how gender shapes attainment and understanding of SRHR in diverse, mutable ways. This study revealed stark inadequacies in current service provision, indicating an urgent need to improve MRY's awareness of and engagement with care. Additional results suggest that length of time in Australia positively influences knowledge levels and attitudes towards specific SRH rights/ behaviours. As with participants in the group concept mapping study (Chapter 5), survey participants found ways to navigate stigma and conflict around their SRH lives, expressing forms of 'subtle' or 'thin' agency.

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[21] For thorough explication of agency as applied in this research, see Chapter 3, theoretical frameworks.

Chapter 7. Qualitative in-depth interview study

Chapter overview

Abortion is a fundamental reproductive right and is both an exceedingly common and exceedingly controversial healthcare procedure. This final results chapter uses abortion access to examine SRHR decision-making and agency in action. This chapter reports on qualitative interviews conducted with migrant youth abortion-seekers. While the previous chapters examined SRH decision-making more broadly, the present chapter explores the decision-making involved in the realisation of a specific right. Chapter 5 identified factors informing SRHR decision-making and agency, highlighting aspects of particular import to MRY. Chapter 6 then provided more detail on specific decisions – such as service access, interpersonal behaviours – as well as the influence of gender on SRHR outcomes and experiences. The present chapter again offers greater depth on SRHR decision-making. Abortion is a healthcare procedure that typically – and in the present research entirely – concerns women and is therefore inherently gendered. This study thus implicitly builds on the previous chapter's analysis of gender, while furthering Chapter 5's exploration of factors that youth consider important in their SRH decision-making.

This chapter comprises an unpublished manuscript submitted to the journal *Sexuality Research and Social Policy.*

These findings were presented as an oral presentation at the Asia Safe Abortion Partnership (ASAP) *Abortion and Reproductive Justice Conference* in Bangkok, Thailand in February 2024.

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“There was no alternative choice” – Australian migrant youth’s abortion decision-making and experiences

Abstract

Introduction: Abortion is a deeply contested healthcare procedure. While abortion is decriminalised in Australia, there is limited information on the experiences of immigrant groups. Migrant youth have lower sexual health knowledge and service uptake than mainstream Australian youth and may have higher rates of unplanned pregnancy and contend with prevalent abortion stigma within their communities.

Methods: This study investigated abortion experiences and decision-making of Australian migrant youth, following a qualitative approach using in-depth semi-structured interviews. Interviews were conducted online between May-September 2023. Interviews were recorded and transcribed verbatim, and anonymised. Reflexive thematic analysis was used to analyse data.

Results: Participants (n = 8) identified as female and ranged from 19-26 years. Young women were South Asian, East Asian, European, and Latin American. Abortion decision-making and experiences were multifaceted. Participants were mostly certain about their decision, describing abortion as “an obvious choice”, and having “no regrets”. Other primary decision-making themes included age and unpreparedness; financial concerns; personal values; and relationships. Young women were deeply grateful for abortion care, reflecting positively on their experiences. However, participants experienced significant financial barriers. Stigma and secrecy were ubiquitous, and many participants lacked adequate support systems.

Conclusion: Participants navigated intersecting privileges and oppressions including age, gender, migrant identity, and economic status in accessing stigmatised healthcare.

Policy Implications: This study highlights the importance of accessible, affordable abortion care. Future care and policy should recognise the agency in migrant youth decision-making, the complex experiences of accessing abortion and the need for greater support for this group.

Introduction

The decision to undergo an abortion is multifaceted and complex, often informed by pragmatic consideration of personal and contextual circumstances (Lie et al., 2008). Fulfilment of rights to bodily autonomy and to choose if, and when, one has children rely on equitable access to safe abortion care. Globally, between 2015-2019, an estimated 73.3 million induced abortions occurred annually, with 61% of all unintended pregnancies resulting in abortion (Bearak et al., 2020). Yet abortion remains a highly contentious, stigmatised healthcare choice. Myriad intersecting factors across socioecological levels inform a pregnant person's decision to undergo abortion. For migrant and refugee youth (MRY), freedom to make decisions about their reproductive lives is shaped by structural inequalities, cultural and religious barriers and intertwined oppressions relating to class, race, migrant status, sexuality, gender and age (Ross & Solinger, 2017). Intersections of oppressions and privilege shape MRY experiences and elicit the need for reproductive justice approaches to sexual and reproductive health and rights (SRHR) (Collins & Bilge, 2016; Ross & Solinger, 2017).

Abortion is legal in Australia and, as of March 2024, fully decriminalised in every state (SBS News, 2024). However, access is variable, and legislation and regulation differ across states. There are no national data on abortion rates, with most states not collecting routine data, though Keogh et al. estimated that between 2017-18, there were 17.3 abortions per 1000 women aged 15–44 years (2021). Abortion care in Australia is largely privatised, and often profit-driven (Ireland et al., 2020). A 2017 study estimated median costs as $560AUD for medication and $470AUD for procedural abortions (Shankar et al., 2017). Inconsistent state legislature and health structures mean costs and accessibility vary widely.

Australian research indicates abortion care barriers persist despite decriminalisation (Haining et al., 2023). Much existing literature on Australian abortion-seeker perspectives and experiences has focused on rural and regional care, illustrating how geographical isolation and scarcity of services significantly impedes care access and decision-making (Cashman et al., 2021; Doran & Hornibrook, 2016; Hulme-Chambers et al., 2018; Ireland et al., 2020; Noonan et al., 2023). While geographical structural inequality impacting Australian abortion-seekers is well noted, how other marginalising factors such as ethnicity, age, and migrant status intersect to inform abortion decisions and experiences remains under studied.

Young people have particular sexual and reproductive health (SRH) needs, often having low SRH knowledge, less experience with health systems, contraceptive underuse, and difficulties navigating safe, consensual sexual relationships (Patton et al., 2016). While there is limited research on migrant and refugee abortion experiences in Australia, research on general practitioner (GP) provision of medication abortion indicates migrants present to services later than non-migrant abortion-seekers, experience access barriers due to stigma, and are susceptible to reproductive coercion (Singh et al., 2023). Providing adequate, culturally-safe information and care is precluded by language barriers and lack of training (Singh et al., 2023). Internationally, migrant and refugees across high *and* lower-income settings face significant barriers to abortion care (Napier-Raman et al., 2024). Thus, in seeking abortion care, MRY likely navigate factors concerning their life-stage in addition to specific barriers and experiences related to their migrant and refugee identity.

In Australia, MRY have low SRH service uptake and knowledge deficits that may increase rates of unintended pregnancy (Napier-Raman, Hossain, Lee, et al., 2023). Stigma around SRH is well-reported in migrant and refugee communities, particularly regarding abortion (Botfield et al., 2020). Recent research indicates, however, that MRY do not necessarily internalise stigma and make SRH decisions around family and cultural restrictions (Botfield et al., 2018; Napier-Raman, Hossain, Mpofu, et al., 2023). Botfield et al.'s study on MRY attitudes towards unintended pregnancy and abortion reveals abortion is deeply stigmatised in migrant and refugee communities, but for MRY preferable to non-marital pregnancy (2020).

Abortion decision-making is informed by multiple factors, grounded in the contextual experiences, and lived realities of abortion-seekers. Lie et al.'s review of abortion experiences reveals decision-making to be a "pragmatic" process of "negotiating finite household and psychosocial resources" (2008, p. 156). Kirkman et al's study of abortion-seekers in Victoria, Australia reported multifaceted decisions centring around personal life-circumstances, participants' capacity to be a good parent, reasons concerning partners, existing children and family, and financial concerns (2010). Outside Australia, migrant and refugee abortion decisions are informed by financial strain, economic and legal precarity, sociocultural factors such as stigma around pre-marital sex, and lack of family planning knowledge and access (Napier-Raman et al., 2024). Young abortion-seekers are often informed by their life-stage and advice and pressure from partners and parents (Ekstrand et al., 2009; Tatum et al., 2012).

This study explored the decision-making and experiences of abortion among Australian migrant youth. Sydney has the highest percentage of migrant residents of any Australian city (Australian Bureau of Statistics, 2021), and was thus an ideal study location. We aimed to investigate the following questions:

1. What factors inform migrant and refugee youth abortion decisions?
2. What factors shape migrant and refugee youth experiences of abortion?
3. How do migrant and refugee youth access and experience abortion services and care?

This research emerged from an Australian Research Council project examining the SRHR of first and second-generation migrants, thus contributing to scholarship on how individuals in structurally marginalised positions realise their reproductive rights.

Methods

A qualitative descriptive approach was used for this study, as little is known about the subjective experience of abortion and decision-making among MRY in Australia. Data were collected using in-depth semi-structured interviews and analysed using reflexive thematic analysis (Braun & Clarke, 2021; Clarke & Braun, 2013). Ethics approval was granted by the University of Sydney Human Research Ethics Committee [2022/921].

Participants

Participants were migrant youth, aged 16-26 years old, living in Sydney, who had accessed abortion care in the last five years. We aimed to recruit migrant *and* refugee background participants, however, no participants identified as refugees.

Data collection

A semi-structured interview guide was developed examining four over-arching factors: decision-making, trajectories of accessing abortion, experiences with care and care workers, and barriers and facilitators to abortion care. These factors were identified from an extensive literature review on abortion among migrants and refugees (Napier-Raman et al., 2024).

Dependability and transferability

We followed Nowell et al.'s guidelines for trustworthiness in thematic analysis, using tenets of credibility, transferability, dependability, and confirmability (2017). This included an "audit trail" of raw data (recordings and transcripts), alongside reflexive journalling and fieldnotes. Codes and themes were routinely discussed by primary researchers (SNR, SZH, MJL). Participants were offered the opportunity to revise transcripts; only one participant reviewed their transcript and made no amendments.

Procedure

Participants were recruited using purposive and snowball sampling. This was a particularly hard-to-reach population. Initially, we attempted recruitment through abortion clinics, health centres, community organisations, women's, youth, and migrant centres. While some services agreed to disseminate study details, most declined. Flyers were posted in public spaces, particularly university and community college campuses. Social media platforms were used to recruit – *X* (formerly *Twitter*), *Facebook*, *Reddit*, *Instagram*. Paid *Facebook* and *Instagram* advertisements were also used along with social networks.

Recruitment involved participant opt-in. Participants either directly contacted researchers via email or phone or submitted contact details through a Qualtrics registration page accessed via a web-link or QR-code. A full participant information statement was attached to the registration page and sent to all prospective participants.

Following verbal consent, interviews were conducted by two female researchers of migrant background (SNR, ZH). While participants were offered in-person or online interviews (via Zoom), all opted for online. Interviews lasted up-to 60 minutes in length. Interviews were recorded and transcribed verbatim. Before analysis, we assigned pseudonyms and removed all identifying data.

Analysis

Data collection and analysis were concurrent, analysis beginning following the first interview. Full transcripts were uploaded into NVivo Qualitative Analysis software and analysed following reflexive thematic analysis methods (Braun & Clarke, 2021). Following each interview, researchers made fieldnotes. Transcripts were read multiple times for familiarisation. Data familiarisation was followed by inductive line-by-line coding. Codes were then grouped and categorised into initial themes. Themes were reviewed and developed into more complex analytical themes, which were then refined and named (Braun & Clarke, 2021). Finally, inductive themes were organised into broad overarching categories relating to individual, interpersonal, institutional and societal factors.

Results:

Participants

A total of eight young women[22] participated (Table 1); a ninth interview was undertaken, but the participant subsequently withdrew consent, and all data were removed. Women were from a range of ethnic backgrounds and aged between 19 to 26 years old. One participant, Joyce[23], was a second-generation migrant; one participant, Michelle, had her abortion outside Australia, and identified as an international student; all other participants self-identified as migrants[24]. Most (n = 6) women were not living with their family at the time of the abortion. Three participants were religious: Zainab identified as Muslim, Vivian as "vaguely Catholic", while Ana said, "I'm a Christian, but I'm not", only identifying as Christian because of her family. There was a relatively even split between participants who had procedural and medication abortions. Ana had multiple abortions and was not certain if she had four or more. Ana and Sofia had previously experienced homelessness.

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[22] While we acknowledge that pregnant people who seek abortion may have a range of gender identities, all participants self-identified as female. Therefore, female pronouns and the term "women" will be used in the results and discussion section when referring to participants.

[23] All names are pseudonyms.

[24] Participants simply identified as 'migrants', having migrated to Australia in their lifetimes. However, most participants had spent a significant part of their childhood in Australia and may thus be considered 1.5 generation migrants.

Table 7.1

Table 1. Participant demographics

Pseudonym	Gender	Age	Age at abortion	Ethnic background	Birth country	Time in Australia	Abortion type
Michelle	Female	22	18	Hongkong Chinese	Hong Kong	3 years	Procedural
Sofia	Female	21	20	Kazakh, Ukrainian, Russian	Kazakhstan	17 years	Medication
Ana	Female	20	17-20 (multiple abortions)	Peruvian	Peru	6-8 years (unsure)	3 procedural, 1 medication
Vivian	Female	24	19	Vietnamese	Vietnam	17 years	Medication
Joyce	Female	26	26	Hong Kong Chinese	Australia	Since birth	Procedural
Dilipa	Female	19	18	Sri Lankan	Sri Lanka	10 years	Procedural
Zainab	Female	21	21	Pakistani	Pakistan	3 years	Medication
Elena	Female	24	22	Bulgarian	Bulgaria	17 years	Medication

Background knowledge

All young women described deficiencies in their SRH education and abortion knowledge. Women researched online to supplement education, including information on contraceptives, reproductive cycles, and fertility management. Michelle and Zainab had little to no SRH education in their home-countries, while Vivian was educated in an Australian Catholic school where SRH education was only available at an additional cost. Ana and Dilipa expressed disengagement during SRH education: “you don't really take it seriously”. Alongside variable knowledge, half the participants expressed aversion towards hormonal contraceptives, fearing side-effects and considering them “not natural” (Ana). Participants received no information about abortion at school. While some knew “a little bit” (Elena) about abortion before pregnancy, others “didn’t know what it was” (Michelle). Generally, “everything” women knew about abortion “was based off Google”.

Decision-making

Abortion decision-making was complex and multifaceted; while there were recurring themes across interviews, the importance of specific factors, and how they impacted decision-making varied. Decision-making was primarily shaped by individual and interpersonal-level factors. Societal and cultural factors influenced certain individual factors, such as personal beliefs and attitudes. All participants made their abortion decision before contacting healthcare professionals. Most young women wanted children in the future.

Individual and personal factors

Abortion - the only option

Young women felt abortion was the only option. Most participants described having no conflict over the decision, as Vivian noted “it wasn’t a hard decision to make… there was no alternative choice”. For some, they had considered abortion before becoming pregnant. Zainab, for example, felt that being prepared and considering pregnancy options “mentally, for a woman, it's really important”. Joyce made her abortion stance clear to partners:

> *It's something that I've been— talked a lot about with my partners as well. I'm saying, if anything happens like that in the future, I will always go down the route of abortion.*

Dilipa, however, had always believed she would keep a pregnancy:

> *I would have kept it. But I didn’t think that it would happen now…because it was all of a sudden, I was like, “no”.*

Other participants had never considered the possibility of pregnancy, but still felt abortion was the “obvious choice” (Vivian). Michelle noted her real decision regarded abortion method:

> *I just like didn't like really have a dilemma, I just like knew I had to either do medical or surgical um abortion anytime soon*

The only exception to this certainty was Ana, who, unlike other participants, felt very conflicted about her first abortion. In the end, Ana felt she “had no choice”.

> *…when I got pregnant for the first time. I didn't want to— I was unsure, like, if I wanted to keep it or not because it was like my first baby…it took me like 4 months to*

> *really know if I really wanted it, so it was like pretty late, it was like almost to the point where I couldn't have an abortion.*

Age, life-stage, and lack of preparedness

All participants mentioned their age as informing their decisions. Frequently, this was a broad statement about being “too young” (Dilipa). Not being “ready” or “prepared” for a child was repeated across interviews. Being too emotionally immature was discussed:

> *I'm not mentally prepared for that was the main thing. Because basically the psychological effect, like, I am not ready for it, because it's a big responsibility. –* Zainab

Others emphasised their life-stage and the belief that it was not the “right age” (Michelle). Many were still studying and/or unstably employed, which tied into financial considerations around decision-making:

> *…it was my age, life stage. The usual things that happen at 19. I was still at uni*[25] *at the time* – Vivian

Financial barriers

Financial strain was another crucial factor. Women repeatedly mentioned they could not afford to raise a child:

> *I'm not in a financial position… above all, it was probably finances* – Sofia

Many women were living out of home (n = 6), and already struggling financially. Dilipa described “living paycheck to paycheck”. Being under- or un-employed was common, Michelle noting:

> *…it's a huge sum of money when it comes to raising child. And as a zero-income 18 years old, I definitely wouldn't be able to afford it.*

The only participant who “wasn’t worried” about finances was Ana, who believed her partner’s mother would support her.

Cultural and personal values and ambitions

Women’s decisions were shaped by cultural values and personal beliefs around when, and in what contexts, a pregnancy should be continued. While these were individual values and beliefs, they were shaped by broader culture and social norms.

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[25] University

Conceptions of a nuclear family and relationship stability were important. Sofia strongly believed in “a family unit of a- like a mother and a father”, while Joyce emphasised values of commitment, heterosexuality, and marriage:

> *I don’t think, um, starting a family should be when you’re not in a proper committed, married, heterosexual relationship.*

Ana similarly did not want “a kid without a dad”. These beliefs were tied to cultural values and personal experiences. Joyce’s parents and culture condemned pre-marital sex and pregnancy. Sofia grew up without “a present father” and wanted differently for her own child.

These ideas of stability were related to standards of motherhood. Young women discussed desire “to give my child the best start” (Joyce), framing their decision as for the child’s best interests.

> *…if I bring a child, you know, at least I want it to be stable* – Dilipa

Women also discussed how personal ambitions and goals shaped decisions, asserting that pregnancy and childrearing would have interfered with their aspirations. Michelle described herself as “pro-life, but… pro- my life more”, her pregnancy occurring just before she started university, when there was “stuff” she “wanted to do”. Vivian similarly mentioned her accomplishments post-abortion:

> *I had the abortion in January or February. I landed a full-time permanent job here in July. I bought a house in 2019. If I had a child, those things would have* never *happened.*

For Zainab, however, her decision stood in contradiction to her Islamic faith:

> *…my beliefs doesn't kind of permit me, but still I made the decision.*

Ana similarly asserted “I still believe that it's not right to like, obviously, have abortions”. These were contradictions women negotiated. As such, Zainab found Quranic interpretations online by Muslim scholars who asserted abortion was permissible, which helped her resolve the conflict between her faith and her choice.

Abortion method: cost vs health

Decisions on abortion type were made on financial or wellbeing grounds. Some participants specifically mentioned avoiding unsafe methods. Ana and Dilipa chose their abortion type based on lowest price. For Ana, this was not always possible:

> *… there was plenty of times where I wanted to have a medical one, because it was cheaper, and I went to get my ultrasound, and I was literally like three months already… so that means I had to pay more extra, for like a surgical abortion…*

Three participants expressed health and wellbeing-centred preferences for medication abortion: Sofia “worried about scarring”, Vivian considered medication the “less stressful, less painful method”, and Zainab “wanted to do… it naturally”. Conversely, Joyce and Michelle both considered procedural abortions better for their wellbeing. Joyce was “very, very scared by some of the side effects” of medication, while Michelle followed her doctor’s advice:

> *…obviously I would put my well-being first and I’ll choose the abortion method that is best for my body.*

Interpersonal and relational factors

Family and social interactions

While relationships and social factors significantly shaped decisions, women were adamant that they made their decisions independently, irrespective of the opinions and wishes of others, including family, partners, and friends. Most participants stressed that their decision was their own. Even when people around them had opposing views, participants, like Elena, stated “I don't think it sort of influenced my decision”. As Dilipa mentioned:

> *I know it's the best thing for me at the moment, so I didn't really take other people's opinion to my mind, even if that was my partner. I was like, “I'm sorry, no.”*

Similarly, participants emphasised that the decision was “very personal” (Elena). Joyce described how secrecy shielded her from others’ opinions:

> *… as sad as it sounds, keeping it to myself helped. Because that allowed me to make the decision for myself and not being swayed by anyone else.*

While partners’ *opinions* were not necessarily significant in shaping decisions, relationship strength and stability were significant. Uncertainty about relationships was common. Michelle felt she was not with “the right partner”. Sofia felt her relationship was too new. Joyce and Ana were in unstable relationships:

> *I was in a toxic relationship, and I wasn't sure if the dad was gonna be good for my kid, so and— or me…* – Ana

Partners’ support did not determine women’s decisions but made the process easier. Two participants had partners who opposed their decision, though Dilipa’s partner eventually agreed “this is the right thing for us at the moment”. Joyce’s partner pushed her to continue the pregnancy, causing “a lot of arguments” during what was already “a very rocky time” in their relationship:

> *…he wanted to keep the child. I didn't want to. Um and that also impacted me mentally a lot, it made me feel a lot more guilt about going through the process of an abortion, and— but I still stuck to my guns…*

The role of family in decisions varied. While some women had strong support, others were mistreated for their decision, and others underwent abortion to keep their premarital sex and pregnancy secret from their family. Michelle’s family offered crucial support:

> *…they’re very strong on me doing abortion. The moment they heard about it they would be like “Yep you’re getting an abortion”. I think luckily that aligns with- with what I think as well…*

Elena and Dilipa had emotional support from their mothers, though only virtually, as both lived in their respective home countries. Elena’s mother was initially unsupportive but came around. Dilipa, however, felt her mother was supportive but unhappy:

> *…she supported me. But deep down I knew that, you know, she didn’t want to, but she didn’t say anything to me. And it’s also like the cultural barrier too, back there… But she just said that, you know, “it’s up to you: you, whatever you do, it’s fine.”*

Both Ana and Sofia were shunned by their family for their decisions. Ana’s aunt – her primary carer before she was kicked out of home at age 16 – stopped speaking to Ana because of her abortion:

> *…she’s Christian, so if I kill a kid, it’s like, a sin to her…*

Sofia’s mother pushed her to continue the pregnancy, offering to raise the child. Many women were subjected to anti-abortion spiritual beliefs by people in their lives. Joyce’s partner’s parents had “superstitious beliefs”, saying she was “throwing away the gift” and warning that “bad energy” from her abortion would continue into “the afterlife”. Similarly, Vivian’s mother previously told her “abortion creates a really bad karma”. Sofia’s extended family used “spiritual” and “cultural” beliefs to make her “feel bad”:

> *…my family gave me the threat of “…the universe is going to punish you by making you infertile in the next life…”, or “…this baby is going to grow up energetically*

> *beside you, with no like home and it is going to take energy from you for the rest of your life."*

For Joyce, keeping premarital sex and pregnancy secret from her family was her primary reason for seeking an abortion. Similarly, Vivian's "family would've been very mad" if they discovered her pregnancy.

> *This abortion, I couldn't tell my parents… that way they've brought me up in making me be like, "you can't ever like— you have to be married for that to happen" … I was very scared of ever having my stomach show* – Joyce

Experiences

Abortion experiences were influenced by individual, relational, structural, and societal factors.

Individual and personal factors

Physical experiences

Medication abortions were painful. Ana felt "sick, light-headed… cold and hot at the same time" and experienced vomiting. While most participants accepted this pain as a normal part of abortion, Sofia believed healthcare professionals underestimated women's pain:

> *…they do not take pain seriously most of the time… doctors under prescribe pain meds, for both IUD insertions and for abortions.*

Conversely, participants who had procedural abortions were surprised by how easy and painless their experiences were.

> *…the surgery was really quick: I went in for like, it feels like a nap, and came out. There's no pain* – Michelle

Ana had persistent bleeding and infection following her first abortion. However, she was unclear about what the complication entailed:

> *…there was some signs of like that something wasn't feeling right, where I had like pain in my stomach or like, there was this one time where I kept bleeding. And they gave me tablets… so tissue was like coming out… residue tissue… I think I did get an infection… I'm not sure.*

No other participants experienced complications.

Contradicting, complex emotions

Participants had complex, at times contradictory, emotional responses to abortion. For some, the experience was scary, particularly if they were alone during the procedure. Young women were worried about complications or infertility. Waiting times and uncertainty about the procedure increased anxiety.

All young women declined post-abortion counselling, though two participants discussed their abortion with personal therapists. Some declined counselling because they were not particularly emotionally affected. Dilipa "didn't feel anything that bad emotionally", while Elena felt "fine about it". Vivian's certainty in her decision meant she was largely unaffected:

> *I wasn't emotional, because I knew, I had come to terms, for a while, that that was— that's the next step… the decision was quite clear.*

For Zainab and Sofia, abortion disrupted their worldview and identity:

> *your world kind of moves around, it's like upside down* – Zainab

Sofia described having an "identity crisis", questioning her "value as a person" and "what you can bring to a person that you then bring into the world". Sofia's abortion intensified existing struggles around maturing, womanhood, and ambition:

> *I was quite career-driven for a long time, and then, when I got pregnant, I had this very sudden shift… now that I'm getting older and I'm realizing that I probably eventually will just be the wife and mother um [pause] that a lot of those sorts of goals aren't worth pursuing anymore.*

Guilt and sadness were common, though these feelings were generally temporary. Ana described being desensitised after multiple abortions:

> *…it's become so like um normal to me… my first one, it was like painful. 'Cause— in here [points to heart]. But my second one it was— third one, and then after that, it was just like it's, in a way it's like, it's not that I don't care. It's just that I don't want to just think about it because of the many times that I've done it.*

No regrets

Women asserted they made the right decision and had no regrets. Some reiterated the factors informing their decision-making, being unprepared, and at the wrong life-stage:

> *I don't [regret it] ... because I think it wasn't the right time for me. And I don't have regrets…* – Dilipa

Others spoke of their achievements post-abortion. Young women repeatedly described themselves as "incredibly lucky", "fortunate" "grateful", and "appreciative".

> *… I sound very um oblivious if I said like "no I never regret it", but, um, I was lucky that I did that.* – Michelle

Interpersonal and relational experiences

Support systems

Secrecy around abortion limited participants' support systems. Women were selective in who they disclosed to, though confidantes were not necessarily supportive. For participants with strong supports, these were crucial in helping them navigate the abortion experience. Michelle, for example described how her family provided both financial and emotional support, using scientific rationales to alleviate her guilt:

> *I think obviously talking to people that I trust, that gave me the biggest support… some of the doctors in my family I think, especially people in medical field could see things in a more logical way… my aunt break it down to me and be like, "it's just a cell…"*

While many young women avoided telling friends, for Joyce and Zainab, friends were crucial supports. Joyce's "very supportive" best friend drove her to her appointment and encouraged her decision. Joyce gained affirmation from friends of the same background after her abortion:

> *I had chosen people to tell who had come from similar background to me. So migrant family, similar upbringing, Asian parenting style… she was like, "yeah, I would never tell my parents as well"… 'cause of just how much pressure they put on you to be like the perfect daughter, the perfect Chinese daughter.*

Zainab had friends who previously underwent abortion who offered information and emotional support:

> *… they were really concerned, kept calling and showing interest, how I'm feeling. So it is really precious thing to do at that time.*

Partner support varied. Sofia and Zainab described their partners as "very supportive". Dilipa's partner, while initially against abortion, "was supportive after that" and paid for the procedure. Vivian’s partner supported her in decision-making but was not present or contactable during her abortion.

Many women had inadequate support. Elena, Ana, and Vivian were alone while undergoing medication abortion, which was a scary, painful, and unpleasant experience. Similarly, Dilipa, despite getting a procedural abortion, felt anxious and scared while alone in the waiting room for five hours. Vivian described the paradox of wanting secrecy, while needing support:

> *I was lucky enough, for some reason, that nobody bothered me… because I wanted to hide it… but also… nobody checked in on me.*

Joyce and Ana were in unstable relationships. Joyce’s partner did not want her to have an abortion, which “made it extra hard”:

> *…he was the one who picked me up as well, from the surgery, ‘cause he wanted to. And when I got into the car, he was like yelling at me…*

Ana’s partner, while not against her decision, “was really like emotionally like not there for me”. While other participants had some level of emotional support, Ana had “no one”, noting “I feel like no one really listens”.

Women emphasised the difficulty of being separated from families. Dilipa and Elena only had virtual support from their mothers.

> *… it's a bit difficult, or I think it's harder and more scary when you're sort of alone. Um and the reason is because you're not with your family.* – Elena

While Vivian was aware stigma within her home-country and culture might have precluded family support, she complained that “even if they were supportive, they wouldn’t be physically there.” Conversely, being separated from her family allowed Zainab the necessary freedom and privacy to have her abortion.

Several participants found support virtually. This included Facebook groups for abortion-seekers, YouTube videos, blogs, and podcasts discussing abortion experiences and information. Hearing other abortion-seekers share stories helped women feel less scared and isolated:

> *People going through the experience telling you how they felt and everything… you feel the connection. You don't know them, and you feel like what they have been through, and they kind of explain in a really good way.* – Zainab

Institutional and structural factors

Gratitude and positive experiences

Experiences with abortion care were overwhelmingly positive. While trajectories differed, all participants described accessing care as “really easy”. Two participants accessed public care: Elena was prescribed medication by her GP, and Sofia accessed a service for ‘at risk’ populations that she had links to because of her experiences being unhoused. Most women found private abortion services online:

> *It was just like, when you like make a booking for like to get your hair done or like, it's just simple like that.* – Ana

Michelle’s family, who were healthcare workers, helped organise care through their medical contacts.

Women felt very grateful for the quality of care and that care was available and easily accessible. Joyce compared her experience to barriers of abortion-seekers “born any time earlier”, and “felt incredibly grateful for myself”. Similarly, Zainab described how accessible care is in Australia compared to Pakistan:

> *…over here, like, you’ve got a lot of options… everything is from a proper pathways, and you’ve got like clinics over here, but not in our country… easier to access, easier to do everything on your own…*

Costs of abortion care

Despite ease of access logistically, cost posed a significant barrier. Costs varied immensely, from \$15AUD to \$2000AUD[26]. Interestingly, the young women who had experiences being unhoused had the lowest and highest care costs: while Sofia’s experiences meant she was “linked in” with services that gave her access to concessions and entitlements, Ana was “kicked out” of a “refuge for kids” and did not have access to (or awareness of) potential entitlements. Women spent their “entire savings”, having to “cut off some things”, and borrow money, but said they “had no choice”.

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[26] Approximately converts to \$10USD and \$1325USD respectively.

> *…to be honest, no matter how much the cost was, I was going to have to do it –* Vivian

Half the participants had financial support from family or partners; the others paid themselves. Ana's boyfriend lent her money conditionally:

> *…he was like, "I can give you money, but you have to pay me back". And it was like kind of depressing, because he is the one that got me pregnant in the first place.*

Michelle and Sofia, who eventually got support or subsidies were initially worried about affording "incredibly expensive" care (Sofia). Michelle wondered "oh my god… how I'm ever gonna like afford this?"

In contrast, Zainab felt care was "economical, reasonable… anyone can easily afford it". Elena and Dilipa were not on Medicare[27], and therefore experienced higher costs. Joyce was pleasantly surprised by the existence of a Medicare subsidy, while Ana protested Medicare covered "not a lot, just a little bit".

Societal factors

Social, cultural, and family anti-abortion attitudes

Societal-level factors included family, and social values, cultural perspectives around sexuality, premarital sex, and abortion.

For Michelle, "growing up in Asian culture" led her to feel she had "done something so bad to the point that it's just irreversible". Sofia noted that "the things that my mother told me about abortion" left her feeling "very conflicted… very confused… very guilty", and Joyce's "guilt" was exacerbated by her partner's lack of support.

Similarly, feelings of shame were centred on other people's responses or perceived responses towards abortion. Sofia feared abortion "tainted my social identity". Dilipa's shame manifested in being "embarrassed to tell other people, especially…from Sri Lanka". For Joyce, shame arose more from her premarital pregnancy and what she saw as a failure to be the "perfect Chinese daughter":

> *I've grown up being the obedient child who listens to everyone's opinion. And I don't know if that's like a migrant thinking, like an Asian thing. It's very hard to do the wrong thing and be proud of doing the wrong … I don't even know why I still see it as*

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[27]*Medicare* is the Australian universal health insurance scheme.

> *the wrong thing. I think it's the right thing. But getting pregnant outside of marri- marriage is the wrong thing.*

Stigma, taboo, and secrecy

Secrecy and silence were ubiquitous. While all participants told at least one person, they all intentionally kept their abortion secret from certain individuals. Even when some family members were supportive, there were others that participants could "never tell". Women described keeping their abortion "all to myself", secret "from everybody".

Women feared stigma and judgement if people discovered their abortion.

> *…if people here knew that I was terminating, they probably would just like, tell me to—, yeah, something colourful. There was that constant paranoia… So, I did try to keep it a secret.* – Sofia

Elena, however, was less concerned about judgement, but felt uncomfortable disclosing "something that's really personal". Elena told no one outside her mother about her abortion, and never informed the person involved in the pregnancy:

> *I just wasn't sort of comfortable with their input…the relationship wasn't that- that way where he was really around…*

Dilipa and Ana's silence around abortion was because they did not "want to look back at it". Aside from Michelle and Zainab, participants did not inform friends until after their abortion. Vivian waited five years before telling a friend, while Elena and Ana have told none. Participants felt their friends would not understand, Michelle asserting only people who had experienced abortion could empathise. Vivian believed her friends would see her differently:

> *…compared to my peers now, I'm quite stable… I have my own home in Sydney…I have a full-time, solid, and permanent job. So, a lot of them have this view that, you know, I'm this kind of a person, and I feel like if I told them about that experience, um, it would change their opinion of who I was.*

Ana did not have friends she could tell:

> *I didn't really have really good friends…it's friends to hang out with. But friends to rely on, or to like count on, it's not really.*

Discussion

Young migrant women's abortion decision-making was multifaceted, informed by various interrelated factors. Whilst women had limited SRH education, they made purposeful, pragmatic decisions, and were not regretful. Participants were grateful for the care they received, although emotional experiences of abortion were complex and at times contradictory. We discuss the findings under broad headings of individual, interpersonal, institutional, and societal level factors informing decision-making and experiences. These correspond broadly to the levels of the socioecological model (Bronfenbrenner, 1994), though our findings go beyond these, integrating aspects of intersectionality theory and reproductive justice.

Individual-level factors

Unsurprisingly, being young and unprepared was a dominant theme in women's decision-making, mirroring the experiences of other young abortion-seekers (Kirkman et al., 2010; Koiwa et al., 2024). For participants, this included emotional, psychological, and material individual-level factors of immaturity and inexperience, and limited financial capacity and employment.

Age and financial incapacity were connected to values around parenting and giving future children "the best start". Young women in the United Kingdom similarly draw on gendered concepts of good parenting as a method of resisting internalised stigma and morally justifying abortion decisions (Hoggart, 2017). However, while some participants in this study may have referenced the role of 'good mother', the need for moral justification was not evident. Even participants who felt guilty about their abortion did not try to justify their decision.

Young migrant abortion-seekers were clear and resolute in their decisions. Even Ana, who was uncertain about her first abortion did not experience conflict in subsequent abortions. This certainty contrasts other research. In Kirkman's study of Australian abortion-seekers, participants were much more conflicted about their decisions, with abortion framed as "a difficult solution to a problem" (2011, p. 121). This directly contrasts participants in this study who felt abortion was "not a hard decision". Our results counter assumptions that young people do not know their minds, or lack the capacity for agential, autonomous, considered decision-making.

Our findings do not deny the multiplicity of emotional responses: participants' certainty did not preclude complex, conflicting attitudes towards abortion. Women were, however, aware of and actively navigated tensions between beliefs and decisions – Zainab, for example, sought alternate Quranic interpretations to support her choice. These complexities point to the importance of reproductive justice frameworks that consider reproductive rights beyond liberal (White) feminist conceptions of "choice" (Ross & Solinger, 2017). A choice rhetoric fails to encapsulate the nuances of young women's experiences, particularly given discussions of having "no alternative choice" or the low contraceptive and SRH knowledge that potentially contributed to participants' unplanned pregnancies.

Interpersonal-level factors

This study elucidates a complex interplay between autonomy, agency, social ties, and support. Research on youth and migrant populations often highlights restricted agency and vulnerability to reproductive coercion. Migrant young women in this study, however, were adamant about having made their decisions autonomously. Young people, particularly teenagers, are often pressured into abortions by parents and partners (Ekstrand et al., 2009; Koiwa et al., 2024). Swedish teenagers who underwent an abortion, for example, described having reproductive responsibility without reproductive autonomy (Ekstrand et al., 2009). Australian providers report vulnerability to reproductive coercion among ethnic minority women, whose partners force them into continuing or aborting pregnancies (Tarzia et al., 2022). Unlike women seen by these providers, however, participants in this study did not depend on partners for finances or residency/citizenship, perhaps protecting them from vulnerability to coercion. Similarly, the relatively older age of young women in this study may have protected them from parental control.

Another potential protective factor was young women's strategic non-disclosure, a practice often used by recipients of stigmatised health care (Broussard, 2024). Similar to young abortion-seekers in Uganda, some participants discussed how secrecy was helpful in their autonomous decision-making (Cleeve et al., 2017). However, secrecy simultaneously barred women from social and emotional support. What was a protective mechanism in mitigating coercion and avoiding stigma also left participants scared, "vulnerable" and "lonely". Friends are often a crucial support for young abortion seekers (Mahanaimy & Moseson, 2023; Tatum et al., 2012). Similarly, given taboo and censorship in their families, migrant youth rely on friends for SRH advice, information, and support (Napier-Raman, Hossain, Lee, et al., 2023;

Napier-Raman, Hossain, Mpofu, et al., 2023). This was not the case for most women in this study. While strength and presence of support systems varied, women navigated abortion stigma, familial and sociocultural taboo and repression, family separation, and unsupportive platonic and romantic relationships. Our findings also revealed transnational intersections of the local and global: participants such as Elena received interpersonal support from family, but this was mediated by physical geographical separation. As such, our findings respond to Patil's call for intersectionality to acknowledge transnational dimensions, examining how oppression and privilege interact beyond and across the borders (2013).

Institutional-level factors

Consistent with other studies of non-migrant Australian abortion seekers (Doran & Hornibrook, 2016; Ireland et al., 2020), affording care was difficult, indicating a significant, problem with Australian abortion provision. Young women were left vulnerable by the cost of abortion care, unable to pay bills and forced to rely on "toxic" partners. Additional (potential) marginality arising from previous homelessness in fact helped Sofia gain access to affordable care. However, Ana's steep abortion fees reveal that the presence of support for the most marginalised groups is inconsistent and inadequate. These findings reveal the complexity of intersectional experiences: for these young women, the intersections of gender, migrant identity and homelessness had vastly different outcomes. Significantly, despite financial barriers, women did not seek illicit, unsafe abortion methods, consistent with other studies of migrants and refugees accessing abortion in high-income countries (Napier-Raman et al., 2024). This reflects what participants described as the 'luck' of being in Australia: unlike migrants in lower-income countries who can only access unsafe care (Asnong et al., 2018; Napier-Raman et al., 2024), women in this study could still access safe, formal medical care, even when financially challenging.

Both Australian research with non-migrants, and international research on migrant abortion-seekers have highlighted difficulty accessing services (Ireland et al., 2020; Napier-Raman et al., 2024; Noonan et al., 2023). However, we found young migrant women did not struggle navigating care. This may in part be attributed to the location of this study in metropolitan Sydney. While costly, services are still readily available. Had these women been living in rural or regional areas, their experiences might have been vastly different (Noonan et al., 2023). Additionally, participants were highly competent in finding care and information online. While young people are often disadvantaged due to lower knowledge and limited experience of health systems, age may have been a facilitator in this case. All participants were part of generation Z and have thus grown up using the internet. This digital literacy was also evident in young women's use of virtual support.

Societal-level factors

Stigma, taboo and secrecy around abortion were ubiquitous in this study, mirroring broader research on MRY experiences of SRH (Napier-Raman, Hossain, Lee, et al., 2023). Young women navigated social and cultural beliefs imposed by people around them, including spiritual beliefs and threats of punishment and abortion repercussions. Such cultural conceptions of abortion consequences and spiritual retribution have been described in other studies of migrant and refugee abortion attitudes (Asnong et al., 2018; Liamputtong, 2003). Women in this study, however, did not internalise these beliefs. This negotiation of beliefs reflects more recent research on how MRY navigate restrictions and make SRH decisions irrespective of cultural and familial stigma (Botfield et al., 2018; Napier-Raman, Hossain, Mpofu, et al., 2023). Strong et al.'s analysis of the intersectionality of abortion stigma proposes the notion of 'dual stigma', intersections between abortion stigma and stigma surrounding socially non-sanctioned pregnancies, such as pre-marital pregnancy among youth (2023). However, young women in this study in fact used abortion to *escape* the stigma of pre-marital sex and pregnancy. Joyce's discursive manipulation of abortion into the "right" thing, describing it as preventing the "wrong" thing – premarital pregnancy – parallels Botfield et al.'s findings on MRY perceiving abortion as morally worse than premarital pregnancy, but preferable (2020). While societal-level factors of cultural beliefs may inform young women's personal values, individual and interpersonal-level factors play a more significant part in women's decision-making.

Limitations

A key limitation was the sample size. Due to the highly sensitive topic, and the difficulties of engaging migrant youth, recruitment was challenging within this hidden population. It may be that those who participated were resilient, had agency and were clearer on how to make fertility choices compared to youths who did not participate. The small sample prevents generalisability and broad applicability of findings. Another limitation was the inability to recruit any participants between 16-18 years. As such, the results reflect the experiences and decision-making of legal adults (excepting Ana, who was 17 for her first abortion), and do not fully illustrate youth experiences. It is highly likely that the experiences of under-age migrant youth include more significant barriers to use of services, including coercion from family, community or health providers to have (or not have) an abortion. These experiences and age groups warrant further socioecological study. While there was a broad range of ethnicities in this sample, participants from the Middle East and Africa were absent, therefore excluding valuable perspectives.

Due to recruitment challenges, we used broad inclusion criteria. This meant that one participant underwent abortion overseas, reflecting care-experiences outside Australia. This study was intended to examine migrant and refugee youth, however, only migrants participated. Refugees are an even more hidden population and face greater challenges and vulnerabilities. Further research must be done to include first generation refugee young women and younger adolescents to better understand the challenges these populations face with the abortion and care service utilisation hence improving service provision and policymaking.

Finally, at the request of participants, this research was conducted online. While this may have allowed participants to feel more comfortable and assuaged privacy concerns, virtual research can be impersonal. Internet connection was poor in some interviews, with participants cutting out, or audio lagging. It is harder to build intimacy and trust, and to gauge emotion and tone through virtual methods, potentially limiting the depth of data.

Conclusions and policy implications

This study elucidates the abortion decision-making and experiences of young migrant women in Australia, highlighting the complex interplay of autonomy and structural vulnerability. Understanding the decision-making processes of these youth is essential in providing better care, support, and services. Policy and service delivery must address issues of cost and inadequate support highlighted in this study. Our findings reveal the ways migrant youth navigate structural barriers at multiple levels in their abortion-care seeking, negotiating intersections of stigma, social censure, isolation, and socioeconomic strain. Yet we also illustrate the significant strengths and capacity of these young people. Young women made autonomous decisions, shaped by myriad social, emotional, and material factors. Our findings affirm the reproductive agency of migrant youth, and the importance of supporting this agency.

References

Asnong, C., Fellmeth, G., Plugge, E., Wai, N. S., Pimanpanarak, M., Paw, M. K., Charunwatthana, P., Nosten, F., & McGready, R. (2018). Adolescents' perceptions and experiences of pregnancy in refugee and migrant communities on the Thailand-Myanmar border: a qualitative study. *Reprod Health*, *15*(1), 83. https://doi.org/10.1186/s12978-018-0522-7

Australian Bureau of Statistics. (2021). *Permanent migrants in Australia*. ABS. Retrieved 28 March 2024 from https://www.abs.gov.au/statistics/people/people-and-communities/permanent-migrants-australia/latest-release

Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019. *Lancet Glob Health*, *8*(9), e1152-e1161. https://doi.org/10.1016/s2214-109x(20)30315-6

Botfield, J. R., Newman, C. E., Bateson, D., Haire, B., Estoesta, J., Forster, C., & Schulz Moore, J. (2020). Young migrant and refugee people's views on unintended pregnancy and abortion in Sydney. *Health Sociology Review*, *29*(2), 195-210. https://doi.org/10.1080/14461242.2020.1764857

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2018). Engaging migrant and refugee young people with sexual health care: does generation matter more than culture. *Sexuality Research and Social Policy*, *15*(4), 398-408. https://doi.org/10.1007/s13178-018-0320-6

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative research in psychology*, *18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Bronfenbrenner, U. (1994). *Ecological Models of Human Development* (2nd ed.). International Encyclopedia of Education.

Broussard, K. (2024). Strategic (Non)Disclosure: Activation and Avoidance of Social Ties among Women Seeking Abortion. *Journal of Health and Social Behavior*, *0*(0), 00221465231215783. https://doi.org/10.1177/00221465231215783

Cashman, C., Downing, S. G., & Russell, D. (2021). Women's experiences of accessing a medical termination of pregnancy through a Queensland regional sexual health service: a qualitative study. *Sexual Health*, *18*(3), 232-238. https://doi.org/10.1071/SH20220

Clarke, V., & Braun, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*.

Cleeve, A., Faxelid, E., Nalwadda, G., & Klingberg-Allvin, M. (2017). Abortion as agentive action: reproductive agency among young women seeking post-abortion care in Uganda. *Culture, health & sexuality*, *19*(11), 1286-1300.

Collins, P. H., & Bilge, S. (2016). *Intersectionality*. Polity Press.

Doran, F. M., & Hornibrook, J. (2016). Barriers around Access to Abortion Experienced by Rural Women in New South Wales, Australia. *Rural and Remote Health*, *16*(1), 1-12. https://doi.org/10.22605/RRH3538

Ekstrand, M., Tydén, T., Darj, E., & Larsson, M. (2009). An Illusion of Power: Qualitative Perspectives On Abortion Decision-Making Among Teenage Women In Sweden. *Perspectives on sexual and reproductive health*, *41*(3), 173-180. https://doi.org/10.1363/4117309

Haining, C. M., Bowman-Smart, H., O'Rourke, A., de Crespigny, L., Keogh, L. A., & Savulescu, J. (2023). The ‘Institutional Lottery’: Institutional variation in the processes involved in accessing late abortion in Victoria, Australia [Article]. *Women's Studies International Forum*, *101*, Article 102822. https://doi.org/10.1016/j.wsif.2023.102822

Hoggart, L. (2017). Internalised abortion stigma: Young women's strategies of resistance and rejection. *Feminism & Psychology*, *27*(2), 186-202.

Hulme-Chambers, A., Temple-Smith, M., Davidson, A., Coelli, L., Orr, C., & Tomnay, J. E. (2018). Australian women's experiences of a rural medical termination of pregnancy service: A qualitative study. *Sexual & Reproductive Healthcare*, *15*, 23-27. https://doi.org/https://doi.org/10.1016/j.srhc.2017.11.008

Ireland, S., Belton, S., & Doran, F. (2020). 'I didn't feel judged': exploring women's access to telemedicine abortion in rural Australia. *Journal of Primary Health Care*, *12*(1), 49-56. https://doi.org/10.1071/HC19050

Keogh, L. A., Gurrin, L. C., & Moore, P. (2021). Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data. *Medical journal of Australia*, *215*(8), 375-376. https://doi.org/10.5694/mja2.51217

Kirkman, M., Rosenthal, D., Mallett, S., Rowe, H., & Hardiman, A. (2010). Reasons women give for contemplating or undergoing abortion: A qualitative investigation in Victoria, Australia. *Sexual & Reproductive Healthcare*, *1*(4), 149-155.

Kirkman, M., Rowe, H., Hardiman, A., & Rosenthal, D. (2011). Abortion is a difficult solution to a problem: A discursive analysis of interviews with women considering or undergoing abortion in Australia. *Women's Studies International Forum*, *34*(2), 121-129. https://doi.org/10.1016/j.wsif.2010.11.002

Koiwa, Y., Shishido, E., & Horiuchi, S. (2024). Factors Influencing Abortion Decision-Making of Adolescents and Young Women: A Narrative Scoping Review. *International Journal of Environmental Research and Public Health*, *21*(3), 288. https://www.mdpi.com/1660-4601/21/3/288

Liamputtong, P. (2003). Abortion-it is for some women only! Hmong women's perceptions of abortion. *Health Care for Women International*, *24*(3), 230-241. https://doi.org/10.1080/07399330390183543

Lie, M. L. S., Robson, S. C., & May, C. R. (2008). Experiences of abortion: A narrative review of qualitative studies. *BMC health services research*, *8*(1), 150. https://doi.org/10.1186/1472-6963-8-150

Mahanaimy, M., & Moseson, H. (2023). The Need for Social Support During Unintended Pregnancy Decision-Making: A Qualitative Analysis of In-Depth Interviews With Young People in California. *Emerging Adulthood*, *11*(2), 444-455. https://doi.org/10.1177/21676968221085815

Napier-Raman, S., Hossain, S. Z., Lee, M.-J., Mpofu, E., Liamputtong, P., & Dune, T. (2023). Migrant and Refugee Youth Perspectives On Sexual and Reproductive Health and Rights in Australia: A Systematic Review. *Sexual Health*, *20*(1), 35-48. https://doi.org/10.1071/sh22081

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2023). Sexual and reproductive health and rights decision-making among Australian migrant and refugee youth: a group concept mapping study. *Culture, Health & Sexuality*, 1-18. https://doi.org/10.1080/13691058.2023.2275303

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2024). Abortion Experiences and Perspectives Amongst Migrants and Refugees: A Systematic Review. *International Journal of Environmental Research and Public Health*, *21*(3), 312. https://www.mdpi.com/1660-4601/21/3/312

Noonan, A., Black, K. I., Luscombe, G. M., & Tomnay, J. (2023). "Almost like it was really underground": a qualitative study of women's experiences locating services for unintended pregnancy in a rural Australian health system. *Sexual and Reproductive Health Matters*, *31*(1), 2213899. https://doi.org/10.1080/26410397.2023.2213899

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847

Patil, V. (2013). From patriarchy to intersectionality: A transnational feminist assessment of how far we've really come. *Signs: Journal of women in culture and society*, *38*(4), 847-867.

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E. M., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K.,…Viner, R. M. (2016). Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet (British edition)*, *387*(10036), 2423-2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Ross, L., & Solinger, R. (2017). *Reproductive Justice: An Introduction* (1 ed.). University of California Press. https://www.jstor.org/stable/10.1525/j.ctv1wxsth

SBS News. (2024, 28 March). *WA becomes the final state to decriminalise abortion, as premier praises change*. sbs.com.au. Retrieved 4 April from https://www.sbs.com.au/news/article/wa-becomes-the-final-state-to-decriminalise-abortion-as-premier-praise-change/66e4g21aq

Shankar, M., Black, K. I., Goldstone, P., Hussainy, S., Mazza, D., Petersen, K., Lucke, J., & Taft, A. (2017). Access, equity and costs of induced abortion services in Australia: a cross-sectional study. *Australian and New Zealand journal of public health*, *41*(3), 309-314. https://doi.org/https://doi.org/10.1111/1753-6405.12641

Singh, R., Mazza, D., Moloney, L., Shankar, M., & Subasinghe, A. (2023). General practitioner experiences in delivering early medical abortion services to women from culturally and linguistically diverse backgrounds: A qualitative–descriptive study. *Australian Journal for General Practitioners*, *52*, 557-564. https://www1.racgp.org.au/ajgp/2023/august/delivering-early-medical-abortion-services-to-wome

Strong, J., Coast, E., & Nandagiri, R. (2023). Abortion, stigma, and intersectionality. In P. Liamputtong (Ed.), *Handbook of social sciences and global public health* (pp. 1579-1600). Springer, Cham. https://doi.org/10.1007/978-3-030-96778-9_103-1

Tarzia, L., Douglas, H., & Sheeran, N. (2022). Reproductive coercion and abuse against women from minority ethnic backgrounds: views of service providers in Australia. *Culture, health & sexuality*, *24*(4), 466-481. https://doi.org/10.1080/13691058.2020.1859617

Tatum, C., Rueda, M., Bain, J., Clyde, J., & Carino, G. (2012). Decisionmaking Regarding Unwanted Pregnancy among Adolescents in Mexico City: A Qualitative Study. *Studies in family planning*, *43*(1), 43-56. https://doi.org/10.1111/j.1728-4465.2012.00301.x

Additional results

While the above publication provides thorough analysis of young migrant women's abortion decision-making and overall experiences, this section offers further specific data on experiences and perceptions of abortion care. Many of these findings around acceptability of abortion care can be more broadly applied to SRH care (see discussion, Chapter 8, and policy and practice recommendations, Chapter 9).

Experiences of abortion care

Interactions with healthcare workers

> *"I think it's one of the best experience that I could have get at that time…the care that I get afterwards, like post procedure, was um very nice in a way? And they give even give me a lot of emotional comfort…"* – Michelle

As highlighted in the publication, young women had overall positive experiences of care and were deeply grateful to be able to access care. Interactions with healthcare workers (HCWs) were key to this positive experience, with participants consistently describing providers as "nice", "comforting", and "supportive". While the comfort provided by HCWs was crucial, some participants also appreciated that HCWs "didn't make a big deal out of it" (Dilipa), not subjecting them to extensive questioning and treating abortion like any other type of care.

Despite this strong positive response to abortion care, two participants did have negative experiences with broader care and social service providers. Joyce saw a general practitioner before her abortion who "was really cold and distant" and "made me feel a little bit crap". Nevertheless, Joyce did not consider this a result of stigma around "the whole abortion thing", but rather the provider's "poor bedside manner". Sofia encountered stigma when talking to a Centrelink[28] caseworker who assumed she would continue her pregnancy. On learning Sofia was seeking an abortion, the caseworker reacted poorly, saying "don't tell me *that*, I don't want to know *that*".

Privacy

> *"The privacy was very important. And anonymity…how they were giving me all the calls, the- the emails, the transaction details. That was all, yeah, hid- hidden from*

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[28] Centrelink is the Australian government social welfare payment program.

> *what the purpose was. Even the clinic itself. When I went, it just looked like a regular house…"* – Joyce

Participants were deeply appreciative of privacy measures taken by abortion providers. Documentation, correspondence and billing statements were all inconspicuous and did not identify abortion care as the relevant service. Young women also took various measures themselves to ensure confidentiality, including choosing services far from family and hiding the procedure from their health records.

Informed care

> *"…so the information they gave me was like more like what to bring and what not to eat, but I didn't know that I have to go in there and wait for that long. I didn't know that I have to go and see the doctors before going into the surgical, you know, room. And I had to see two doctors during that time…And then you go and put your, you know, take off your clothes and put the thingy on… And then they take you to the theatre, and then— I didn't know all of that…"* – Dilipa

Other elements of care were not as ubiquitously positive. Some participants felt providers "really did a really good explanation" and asserted they knew exactly what to expect from the procedure. Though most young women described being relatively well informed, Dilipa felt the information provided did not prepare her for the actual process and was left not knowing "what's gonna happen". Dilipa was in the waiting room for five hours, the lack of a clear timeline or awareness of the procedure leaving her "anxious". Vivian similarly felt that if she had "known more about it before hand", undergoing abortion "wouldn't have been such a nerve-wracking process". Limited understanding of post-abortion risk was evident in both Dilipa and Ana's experiences. Dilipa ignored the mass of written material she was sent about post-abortion risk, which she found overwhelming and scary. Ana, who experienced post-abortion complications, had very little certainty about what had gone wrong. Moreover, she was confused as to the treatment she received, describing that "they gave me tablets" and "I just got better from it, I guess?".

Aftercare and follow-up

> *"maybe if the doctor spoke to you afterwards and asked, "Okay, how are you feeling?", you know. 'Cause the nurses really didn't ask me how I'm feeling. They just ask me, "oh, are you bleeding?""* – Dilipa

As with information acquisition, young migrants' experiences with aftercare and follow-ups were varied. All young women were informed they had the option of post-abortion counselling. However, only half the participants received some form of aftercare or check-in. Zainab recalled her aftercare as "mentally…kind of counselling". Generally, however, aftercare was perfunctory—though participants did not all take issue with this: "with the aftercare, it was only a phone call. Which I kind of liked, because I was really done with the idea of going to doctors" (Sofia). Some women desired further emotional check-ups, with Dilipa wanting to be spoken to "afterwards", and Vivian wanting "some sort of support…during the time when the actual aborting happens". For Vivian, who underwent a medication abortion, being "young" and "a migrant" separated from family made her feel particularly alone and vulnerable. A "check in on a halfway mid-point sort of thing, at an emotional level would have been nice" (Vivian).

Contraceptive counselling and uptake

> *"I felt really, um nau—a lot of nausea, headaches. And I felt like my weight is dropping...after starting take—taking that, all these things started. And when I stop it, I got better."* – Zainab

All participants received some form of contraceptive counselling, though only Elena and Vivian followed through with providers' contraceptive suggestions. Zainab initially went on the contraceptive pill prescribed by the abortion providers but reported severe side-effects which forced her to discontinue use. Side-effects and a general mistrust of hormonal contraceptives were prevalent reasons for non-use and disengagement from contraceptive counselling. Sofia had "tried the pill, it's made me go crazy" and was unable to continue IUD insertion due to pain: "the pain was so bad, the doctor had to stop… all I was allowed was paracetamol. And I was screaming…the doctor said I- I was just not cooperating enough because of the pain". Ana and Joyce rejected hormonal contraceptives offered to them, Ana asserting that birth control is "not normal…not woman's nature", while Joyce did not "like to mess with my body hormonally". Only Vivian had a strong positive response to contraceptive counselling, relating that "they really went through and explained well". For Vivian, contraceptive counselling was particularly useful due to inadequate SRH education, providing information "which I really felt like I didn't get in my formative years".

Recommendations for policy and practice

> *"it would be really good if um in policy work for example, we have ways to reach out to those [migrant and refugee] communities…Just say, you know, "these things exist in Australia, if you need help, you can reach out""* – Vivian

Young women had several suggestions about how the experience of abortion decision-making and care could be improved for other young migrants. Consistently, participants made calls for better education. This included better reproductive education, Sofia bemoaning "we were not taught about cycles, we were not taught about ovulation or anything". Most young women felt that abortion should be addressed in school SRH education, comprising the physiological process of abortion and information on how to access care if necessary. Participants also suggested outreach from services and policymakers to inform MRY of abortion and other SRH services. Relationships education was also considered lacking, increasing women's vulnerability to unsupportive partners or unhealthy relationships. Ana wished she was taught about "boundaries and all that", describing how lack of education meant she was "easily manipulated" and "controlled" by her partner.

In terms of service delivery, better information provision and mid- and post-abortion check-ins were suggested. Sofia argued that abortions and IUD insertions require stronger pain medications, reflecting "they do not take pain seriously…they give you the minimum amount". Sofia considered this inadequate pain management a potential manifestation of abortion stigma: "sometimes it does feel like…maybe they're going to under prescribe pain medication because they want to punish you somehow".

Conclusion

This chapter presents the final data of this doctoral thesis: results from qualitative in-depth interviews with young migrant abortion-seekers. Using abortion as a case study, this chapter elucidates how young migrants make decisions around and actualise a specific SRH right. As with the previous chapters, youth's sense of autonomy in decision-making was evident, with young women adamant that their decision was their own. In contrast with findings from Chapter 6, abortion-seekers had little difficulty accessing services, indicating that when there is clear need for care, youth will make efforts to seek this out. Despite complex emotions around their abortion, young migrants did not regret nor doubt their decision because, due to myriad intersecting factors, "there was no alternative choice".

Chapter 8. Discussion

Chapter 7 presented the final study in this thesis, examining the actualisation of abortion rights among migrant youth. In this chapter, I return to the overall thesis aims and discuss synthesised findings of this research. I elucidate how this research contributes to existing scholarship, and areas of consistency and disparity between findings. This chapter concludes with an explication of the limitations and strengths of this research.

Aims and significance of research

The overall objectives of this research were to examine the sexual and reproductive health and rights decision-making and agency of migrant and refugee youth living in Sydney, Australia.

To achieve this, the specific aims of this research were to:

a) identify key factors MRY perceive as informing their SRHR wellbeing, decision-making and agency
b) examine MRY SRH knowledge and literacy
c) identify key socioecological factors characterising MRY's SRH needs, service use and access
d) provide in-depth explication of youth SRHR decision-making and agency in action

Each study addressed overall objectives while focusing on specific aims. The mixed methods GCM study (Study 1) primarily fulfilled aim a), examining key factors that MRY perceive as informing their SRHR wellbeing, decision-making and agency. The quantitative survey (Study 2) focused on aims b) and c), exploring SRH literacy, service use, behaviours and needs, and identifying gender as a key socioecological factor informing SRHR. The final study (Study 3) used qualitative in-depth interviews to fulfil aim d) – examining decision-making and agency through the actualisation of abortion rights. Through examining a specific right, Study 3 broadly addressed all of the above aims: identifying factors informing SRHR decision-making and agency regarding abortion use a), examining abortion and contraceptive knowledge and literacy b), and identifying socioecological factors informing abortion needs, and access and use of abortion services c). The two systematic literature reviews provided the necessary background to undertake the aforementioned studies and elucidated current research gaps addressed by this thesis.

In concert, these studies provided a comprehensive explication of the SRHR decision-making and agency of Australian MRY. This research contributes to a nascent body of rights-based scholarship examining the SRH of minoritised and marginalised groups.

Discussion of findings

This section discusses overarching themes through levels of the socioecological model. In line with past research with migrant and refugee communities, this research highlights the exigency of addressing SRHR across multiple socioecological levels (Keygnaert et al., 2014). Significantly, this dissertation suggests that the thus far predominant narratives of adverse cultural and familial influence should be treated with caution. MRY throughout this research negotiated shame, stigma and silence in myriad ways. Family and culture, while important to youth, were not primarily determinative of SRHR decisions. MRY encountered encroachments on their rights to SRH education, information, services, safe and pleasurable sexual experiences and the highest attainable standards of health – among other injustices. Yet, MRY also demonstrated various means of navigating these encroachments, exhibiting agency and diverse strengths.

Individual aspects: knowledge, gender & personal decision-making

This research illustrated how interactions between individual aspects of identity and personal experience shape MRY decision-making and agency. Three individual-level themes were prevalent across all studies: 1) knowledge, literacy and education; 2) gender norms; and 3) personal values and beliefs. Other aspects of identity such as age, migrant identity and ethnicity had varying significance on decision-making but were not as ubiquitously salient. Age, for example, only emerged as a core theme in interviews with abortion-seekers, who had strong values about the ‘right’ age to be a parent (Study 3). A sense of ‘migrant identity’ did not appear to significantly shape decision-making. While experiences specific to migrant and refugee populations – such as separation from familial supports (Study 3) – shaped SRHR experiences, MRY did not necessarily recognise migrant or refugee identity as something that strongly informed their decisions.

SRH knowledge, education and literacy

This research builds on existing scholarship that has reported inadequate SRH knowledge, education and literacy among migrant and refugee communities. Yet MRY also sought ways to supplement deficits and develop knowledge. As such, decision-making and agency were shaped by inadequate education and knowledge, but also by MRY's concerted efforts to ameliorate these inadequacies.

Knowledge

Results of both literature reviews indicated significant knowledge gaps (Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman et al., 2024), which were mirrored in the results of all three studies. GCM participants described not knowing or learning about sex, sexual violence, LGBTQ+ issues, and services, and reported a lack of familial guidance regarding SRH (Napier-Raman, Hossain, Mpofu, et al., 2023). There were survey participants who had heard of no contraceptives (Appendix E, Table 6.5), and males and newly arrived MRY had particularly low awareness of contraceptives and STIs (Chapter 6). Interview participants noted educational deficits and lacked knowledge of abortion before becoming pregnant (Chapter 7). These knowledge gaps are consistent with existing research regarding Australian MRY (Botfield, Zwi, et al., 2018; Dean et al., 2017a, 2017b; Manderson et al., 2002; McMichael & Gifford, 2009, 2010; Meldrum et al., 2015; Ngum Chi Watts et al., 2015; Rawson & Liamputtong, 2010; Wray et al., 2014), and MRY in other high-income countries (Kingori et al., 2018; Louie-Poon et al., 2021). Likewise, the broader Australian youth population experiences knowledge deficits around contraceptives (Ritter et al., 2015), HIV and STIs (Power et al., 2022).

However, MRY made concerted efforts to inform themselves, as encapsulated by GCM participants who described having "to figure out my own sexuality and about sex on my own" and asserted there are "opportunities to… inform yourself using objective data" (Napier-Raman, Hossain, Mpofu, et al., 2023, pp. 10, 12) (Chapter 5). Thus, while participants faced compromised SRHR regarding knowledge, which 'thinned' their agency (Klocker, 2007), they made efforts to navigate around this.

Literacy

Beyond knowledge, health literacy involves "the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Parker et al., 2003, p. 147). Fostering SRH literacy is essential in promoting engagement with health decision-making, and encouraging preventative health measures (Fleary et al., 2018; Lirios et al., 2023). In the present research, while MRY may have “heard of” contraceptives (Chapter 6), they may not have had the knowledge or capacity to correctly, confidently and safely use contraceptives. Fear, mistrust, and misconceptions around contraceptives were present across all three studies and both literature reviews (Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman et al., 2024), implying that MRY have insufficient understanding of the efficacy and safety of contraceptives, and subsequent apprehension towards contraceptive use. Survey results indicated that, compared to men, young women had greater awareness of contraceptives and were significantly less likely to believe misconceptions about the contraceptive pill causing infertility (Chapter 6). Yet half the interview participants expressed discomfort around hormonal contraceptives (Chapter 7), mirroring attitudes and beliefs among global migrant and refugee communities (Asnong et al., 2018; Hegde et al., 2012; Napier-Raman et al., 2024) and Australian MRY (Burchard et al., 2011; Napier-Raman, Hossain, Lee, et al., 2023; Ngum Chi Watts et al., 2014; Wray et al., 2014). There is, therefore, an apparent discrepancy between relatively high knowledge in the quantitative findings, and high apprehension in the qualitative findings. This reveals the importance of mixed methods research which combines “multiple ways of seeing” and allows for a better understanding of MRY attitudes (Greene, 2007, p. 20). MRY decision-making involves not only knowledge and awareness of SRH risks, but also includes attitudes towards contraceptives. As research with MRY in other high-income countries has shown, knowledge acquisition does not necessarily translate into protective SRH behaviours (Homma et al., 2013), indicating the need to further focus on MRY skills, capacity and desire to apply health knowledge.

Education

Continued deficiencies in SRH education are a fundamental violation of MRY’s rights to information and comprehensive education. The results of this research regarding SRH education are not novel (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12); dissatisfaction with formal education has been consistently reported among MRY (Botfield, Zwi, et al., 2018; Meldrum et al., 2015; Napier-Raman, Hossain, Lee, et al., 2023; Rawson & Liamputtong, 2010). Similarly, among the broader Australian youth population, SRH education has been experienced as lacking (Ezer et al., 2019). Less than one-quarter of youth in the latest *National Survey of Australian Secondary Students and Sexual Health* reported that their last SRH education class was ‘very’ or ‘extremely relevant’ to them (Power et al., 2022).

The results of all three studies confirm the literature review findings detailed in Chapter 2: while those educated outside Australia often have greater knowledge deficits, MRY experience inadequacies in their education irrespective of whether they are educated overseas or within Australia (Napier-Raman, Hossain, Lee, et al., 2023). There were interview participants – both educated overseas and within Australia – who received practically no SRH education and who described being disengaged from SRH education in school (Chapter 7). Australian non-migrant youth report similar disengagement (Litras et al., 2015), indicating the need for improved education delivery. Survey results showed that newer migrants, who would have had less opportunity (if any) to be educated in Australia, had significantly lower STI and contraceptive awareness than those born in Australia (Chapter 6). Consistent with past research, this affirms the need to provide additional support and better post-school education for MRY who are educated outside Australia *and* make improvements to the delivery and content of education within Australia.[29]

MRY also expressed desire for information beyond what was provided in formal education. Interviewees had no education on abortion, leaving them unprepared for unintended pregnancy. GCM participants expressed desire for school education to "have more useful information", teaching students to navigate relationships, intimacy and boundaries (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12). This finding mirrors those of Kedzior et al. reporting perspectives on SRH curriculum in South Australia: the most "useful" topic according to students was "relationships", followed by "safer sex" (2022). A desire for a more holistic approach to SRH education – one that includes relationships, emotional safety, and consent – has been continually expressed by Australian youth (Helmer et al., 2015; McKee et al., 2014; Waling et al., 2020). The present research indicates that school is a primary source of information for MRY (Chapter 6), yet school education is not necessarily meeting the needs of MRY.

Internet resources

Across all studies, MRY used digital resources for SRH information-seeking. While GCM results indicated that overall social and mass media influences were least important, having "[a]ccess to the internet and online information" was highly important, and had a strong

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[29] Beyond the scope of this research, but a crucial factor in future public health, is the impact of COVID-19 school closures on SRH literacy and outcomes. It can be expected that youth already disconnected in face-to-face SRH education would be even more so when they are removed from classroom settings.

positive impact on decision-making (Napier-Raman, Hossain, Mpofu, et al., 2023). Survey participants identified the internet as a top help-seeking source *and* information-source (Chapter 6), while abortion-seekers used the internet as a crucial source of abortion information, including finding services (Chapter 7). Using online resources to supplement inadequate school education is well-noted among Australian youth (Ezer et al., 2019; Graham et al., 2023) and may be particularly relied on by MRY who lack avenues for SRH discussions at home (Botfield, Zwi, et al., 2018; Napier-Raman, Hossain, Lee, et al., 2023).

While the internet and social media have been the subject of much concern regarding unfettered access to inappropriate, misleading and inaccurate SRH content (Albury & Hendry, 2023; Enomoto et al., 2017; McNee, 2024), this space also offers an opportunity for engaging youth. MRY were wary of digital misinformation and non-professional advice of influencers (Chapter 5), suggesting they do not uncritically believe digital sources. For MRY in this research, digital spaces offered avenues to mitigate the infringements on their rights to information and resources.

Gender

This research contributes to scholarship illustrating that gender oppression is not expressed and experienced uniformly or unidirectionally (Heise et al., 2019). Though gender inequality most significantly impacts women, restrictive gender norms “undermine the health and wellbeing of all people” (Heise et al., 2019, p. 2440) – a fact that was evident in the low SRH knowledge and engagement of male MRY (Chapter 6). Throughout this research, gender intersected with other aspects of oppression and opportunity to variably ‘thin’ and ‘thicken’ agency (Klocker, 2007). Interviews highlighted the disproportionate burden of reproductive responsibility (Chapter 7), elucidating the ways “biological sex interacts with the gender system to create a gendered person” (Heise et al., 2019, p. 2442). Yet the greater knowledge, service use, and vaccination among female survey participants suggests that this burden may result in greater engagement, and thus potential opportunities for SRH agency, among young women.

Culturally prescribed gender norms

Apparent throughout this research were the ways in which gender norms intersect with MRY identity to shape decision-making and agency. GCM participants highlighted sexual double-standards (Heise et al., 2019): gender norms demand women be “pure”, and female sexuality is “seen negatively” while “boys” are allowed to “do anything” (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 10). Much of the literature from high-income countries examining migrant and refugee SRH has emphasised these restrictive gender norms, examining the impact of cultural stigma, shame and taboo (Agbemenu, Hannan, et al., 2018; Dhar et al., 2017; Kaczkowski & Swartout, 2020; Metusela et al., 2017; Napier-Raman, Hossain, Lee, et al., 2023; Saharso et al., 2023; Ussher et al., 2012; Wray et al., 2014). Over half the studies in the literature review examining MRY SRHR included only female participants (Napier-Raman, Hossain, Lee, et al., 2023), who were disproportionately burdened by stigma and repression (Chung et al., 2018; Manderson et al., 2002; Meldrum et al., 2015; Rawson & Liamputtong, 2009; Wray et al., 2014), subject to patriarchal control (Chung et al., 2018; Wray et al., 2014), expected to maintain pre-marital chastity (McMichael & Gifford, 2010; Meldrum et al., 2015; Wray et al., 2014), and pressured to fulfil roles of marriage and childbearing (Botfield et al., 2020; Chung et al., 2018; Ngum Chi Watts et al., 2015). In interviews with abortion-seekers, the weight of these gender roles was encapsulated in Joyce’s description of being “the obedient child” and the pressure she felt to be “the perfect Chinese daughter” (Chapter 7, p. 189). Sofia similarly described how her abortion led her to embrace gender roles of future “wife and mother” and stop “pursuing” other “goals” (Chapter 7, p. 188).

However, despite pervasive gender norms, overall results suggested that female MRY do not necessarily internalise stigma and shame around sexuality – somewhat diverging from previous research. Among survey participants, women had *less* negative attitudes towards premarital sex, sexual desire, abortion, and STI contraction than men (Chapter 6). While abortion-seekers encountered stigma and feelings of shame and guilt, this was often attributed to, or exacerbated by, other people (Chapter 7). These somewhat discordant findings reveal the complexity of how MRY navigate gender norms and expectations. Young women related to gender norms in diverse, mutable ways: transgressing socially mandated role of ‘mother’ by undergoing abortion (Griffin et al., 2023), while embracing this role for future aspirations; feeling the pressure of purity mandates and the unfairness of sexual double-standards, while refusing to internalise these values.

Consent

Consistent with existing research among MRY and the broader Australian youth population (Chung et al., 2018; McMichael & Gifford, 2010; Power et al., 2022), issues around consent disproportionately impacted female participants. Experiences of coercion were established in the literature reviews, which indicated that navigating consensual relationships is particularly difficult for female MRY (Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman et al., 2024), and that abortion decisions are often shaped by experiences of forced sex and reproductive coercion (Napier-Raman et al., 2024). Statements by GCM participants describing how "as a woman" they felt "pressured to do things" and were "afraid of being taken advantage of" were mirrored in the high rates of female survey participants who were pressured into sexual activity (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9)(Chapter 5; Chapter 6). Issues around consent are linked to MRY's concerns about relational aspects of SRH: for MRY, navigating relationships and intimacy continues to be deeply important, yet elusive (Chung et al., 2018; McMichael & Gifford, 2010).

Despite nonconsensual experiences disproportionately impacting women, this did not necessarily translate to reproductive coercion. While literature review findings on migrant and refugee abortion highlighted non-consensual sexual experiences and reproductive coercion (Napier-Raman et al., 2024), in primary interview data, young women did not experience reproductive coercion (Chapter 7). Abortion-seekers were determined in their decisions and adamant about not being influenced by pressure from partners and family.

Engaging young men

This research highlights the exigency of engaging men in SRHR. While survey results of low male contraceptive knowledge, indicating disengagement from contraceptive decision-making, are discussed extensively in Chapter 6, the number of absent, unsupportive partners in the interviews with abortion-seekers also implies a lack of male involvement in reproductive decisions (Chapter 7). In line with other research stating that low contraceptive knowledge of ethnically diverse young men is associated with low participation in contraceptive decision-making (Richards et al., 2016), these findings suggest that men are not empowered and engaged as partners and co-decision-makers. Moreover, recruiting male MRY was particularly challenging, evinced by the low participation rates of males in the GCM and survey studies. This perhaps reflects assumptions that SRH is a 'female' issue, is not relevant or appropriate for men, and contravenes norms of masculinity (Kaczkowski & Swartout, 2020; Mengesha et al., 2023; Pettersson & Baroudi, 2024; Waling et al., 2023).

Disengagement from SRH has been found among Australian men generally, exacerbated by insufficient outreach from services and providers – general practitioners, for example, are less likely to broach SRH issues with male patients (Waling et al., 2023). Given the results of this research, combined with the (limited) existing research on male migrants and refugees (Mengesha et al., 2023), it is plausible that disengagement is even greater for male MRY. Indeed, migrant and refugee men have been identified as “a growing priority population for SRH” within Australia (Phillips et al., 2023, p. B).

However, rather than blaming male MRY for disengagement, this research can be considered strong evidence that policy, healthcare and services have failed to engage men in SRHR. Indeed, this research indicates that female *and* male MRY consider SRH rights highly important (Chapter 6) and value healthy relationships and sexual safety (Chapter 5) – results that are parallelled in Baroudi et al.’s findings that Arabic migrant men consider SRH “something essential in life” (2023, p. 3). The exclusion of men from SRH – particularly reproductive health – impacts people of all genders (Mengesha et al., 2023). Not only does this increase SRH risks for young men, but it intensifies the SRH burden on women and other genders, jeopardises the wellbeing of men’s partners, and hinders cooperative, equal intimate relationships. Importantly, issues of consent among young women in this research implicate young men: failing to position SRH as a concern for *all* genders precludes safe, positive, consensual experiences for young people and impedes gender equality.

Personal beliefs, values and attitudes

This research elucidated MRY attitudes towards SRHR, the aspects of SRH most important to them, and how personal beliefs shape behaviour. The high importance of SRH rights among survey participants confirm previous findings that young people deeply value SRH education, care access and wellbeing (McMichael & Gifford, 2009; Power et al., 2022). While some past research has highlighted intentional disengagement from SRH, particularly among migrant females (Poljski, 2011; Wray et al., 2014), MRY in the present research evinced positive attitudes towards, and strong desire for, SRHR. For example, even when abortion-seekers did not “really take… [SRH education] seriously”, they made efforts to educate themselves outside formal schooling (Chapter 7, p. 181).

Emotional, relational aspects of SRHR

Throughout this research, MRY placed strong value on healthy relationships and emotional aspects of SRHR. Literature review findings highlighted relational interdependence as key to MRY engagement with SRH: the significance of social and emotional risks and value of support systems (Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman et al., 2024). GCM results expanded on this, MRY placing the highest value on emotional, relational aspects of SRH (Napier-Raman, Hossain, Mpofu, et al., 2023). Further, among migrant abortion-seekers, values around healthy relationships and emotional wellbeing shaped abortion attitudes and decisions. The belief expressed by GCM participants that you should "find love before you have children" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9) were actualised in the decisions of young women who chose abortion because they were in relationships that were unstable, "toxic", or not "right" (Chapter 7, p. 185).

Shame & attitudes towards sexual behaviour

MRY had diverse perspectives on SRH, the acceptability of sexual activity, and taboo. Yet, consistently, this research indicated that shame and stigma were not necessarily internalised, but were social barriers that MRY actively negotiated. Despite shame and taboo being emphasised in literature on migrant and refugee SRH (see, for example: Agbemenu, Hannan, et al., 2018; Metusela et al., 2017; Ussher et al., 2017; Ussher et al., 2012), MRY survey participants *agreed* overall that premarital sex and abortion are acceptable and *disagreed* that STI contraction and sexual desire are shameful (Chapter 6). Similarly, while GCM participants asserted "sexual health should be between you and your future spouse", this was rated *less important* than having compatibility, comfort, trust, "genuine feelings" and a partner who "will value that I am able to reach sexual pleasure" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9). The literature review on migrant and refugee abortion illustrated how abortion decisions are negotiated around stigma and shame. Myriad 'exceptions' to abortion impermissibility were presented, and even in the most conservative communities, abortion was still practiced, just never discussed (Napier-Raman et al., 2024). Interviews further illuminated that abortion-seekers were aware of stigma and experienced varying degrees of guilt but did not let shame and taboos prevent them from accessing care (Chapter 7).

These findings have crucial implications for policy and practice (Chapter 9). Discourses that too strongly highlight shame – while often providing explication of sociocultural factors that

MRY navigate – may allow services, policy makers and providers to abdicate responsibility. In defining shame as a sole or primary barrier, poor outcomes are blamed on culture and the population in need (Martin et al., 2023). However, if, as this research suggests, shame is not a significant factor in MRY decision-making, then we must consider that structural failings contribute to service under-use and knowledge deficits of MRY.

Interpersonal and relational aspects: negotiating silence, support and self-reliance

An overarching theme in this research was the tensions between seeking support, negotiating interpersonal stigma and silence, and making autonomous decisions. For MRY, decision-making involved navigating relationships with family, partners and peers, which in turn were tempered by pervasive stigma and silence around SRH. This omnipresence of silence and secrecy has been noted in scholarship involving MRY within Australia and globally (Kingori et al., 2018; Morrison-Beedy et al., 2023; Napier-Raman, Hossain, Lee, et al., 2023). Nevertheless, in their negotiation of silence and support, MRY were adamant that their SRHR decisions were for themselves: "what matters is how I feel" (anonymous survey participant, Chapter 6). MRY thus constantly balanced desire for interpersonal support, the stigma surrounding SRHR, and their autonomy.

While silence around SRH has been associated with repression (Metusela et al., 2017; Ussher et al., 2017), MRY in this research were often strategic and intentional in their (non)-disclosure (Broussard, 2024). MRY used silence to protect themselves from stigma and allow them freedom to make decisions, silence thereby functioning as a form of agency in *in*action or "refusal" (Appleton, 2022, p. 153). Yet, while "keeping it a secret" protected MRY from conflict (Chapter 6, p. 157), secrecy simultaneously precluded MRY from SRH discussions, impeded support-systems and hindered knowledge-acquisition. Silence and secrecy, while most apparent at the interpersonal level, infiltrated all socioecological levels, in varying ways both suppressing and supporting rights attainment (McLeroy et al., 1988).

Friends and peers

MRY relied on friends for support and information. The transition to adulthood involves increased importance of peers, the impact of friends on health outcomes being stronger "than at any other time in the life course" (Patton et al., 2016, p. 2429). Friends can play a significant role in young people’s ability to navigate safe, positive sexual experiences (Byron, 2017), and represent trusted, emotionally safe sources of advice (Martin et al., 2023; Powell, 2008). Past research has indicated that, particularly given silence and taboo within community and family settings, MRY turn to peers for SRH conversations (Botfield, Zwi, et al., 2018; Burchard et al., 2011; McMichael & Gifford, 2009; Meldrum et al., 2015; Rawson & Liamputtong, 2010). It is therefore possible that intersections of life-stage and familial and cultural stigma bring increased reliance on peer-support.

Yet navigating stigma and peer support was complex. While MRY statements in the GCM study described “[o]bserving my friends” and having conversations with friends to determine what is sexually “‘normal’ and acceptable”, they also described fear of “judgement” and “gossip spreading” (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9). Lack of disclosure to peers was most notable among male MRY and female abortion-seekers. Male survey participants were far less comfortable, able to be open, and likely to seek help from friends than female counterparts (Chapter 6), while female abortion-seekers frequently felt friends would not understand and would be judgemental (Chapter 7). These experiences reflect the diverse ways gender and stigma intersect, with both abortion and male engagement with SRH producing stigma through violating gender norms. Abortion is stigmatised because it contravenes core cultural assumptions about gender, transgressing “ideals of womanhood” (Kumar et al., 2009, p. 4). Culturally prescribed notions of masculinity, celebration of male sexual prowess, stoicism and invulnerability preclude help-seeking and create stigma around male SRH issues (Connell, 2012; Connell & Messerschmidt, 2005; Kalmuss & Austrian, 2010; Peerson & Saunders, 2011). These findings highlight how individual-level aspects of gender identity interact with macro-level cultural gender norms to impact interpersonal-level behaviours and outcomes (Bronfenbrenner, 1994; McLeroy et al., 1988), affirming the need for multi-level approaches to care, support and policy (Chapter 9).

Intimate relationships

As noted, MRY considered relationships and healthy intimate partnerships significant aspects of SRH. For GCM participants, being able to “trust” partners and have boundaries respected were crucial and perceived as positively impacting SRH decision-making (Napier-Raman, Hossain, Mpofu, et al., 2023). The inverse of this was apparent among abortion-seekers who struggled with unsupportive partners and toxic relationships, making their decisions and experiences “extra hard” (Chapter 7, p. 190).

Despite importance placed on relationships, results suggest that navigating intimacy is a continued challenge for MRY. As such, MRY experience infringements on their rights to safe, positive sexual experiences, and to the information and resources necessary to achieve this (Starrs et al., 2018). The discrepancy between values and reality – desiring healthy relationships but being unable to fully realise this – evinces a clear priority for future policy and service provision (see Chapter 9).

Family

The literature reviews established that, for MRY, family is both a source of support and suppression – a finding reiterated through the three research studies.

Consonant with other research, silence around SRH was common in family contexts (Botfield, Zwi, et al., 2018; Kingori et al., 2018; Rawson & Liamputtong, 2009; Wray et al., 2014). GCM participants described "(n)ever having the 'talk' with my parents" and "repression in migrant households" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 10). As with past research, discussions MRY *did* have with family were not necessarily informative but focused on "abstinence" or involved a "lecture…about being too easy" (Meschke & Dettmer, 2012; Napier-Raman, Hossain, Mpofu, et al., 2023, p. 10). Given these statements, it is unsurprising that most survey participants were extremely uncomfortable discussing SRH with parents (Chapter 6). Thus, silence around SRH was both experienced and enacted by MRY, who made efforts to keep "things a secret from parents" (Chapter 6, p X).

Parent-child communication has been linked to myriad positive SRH outcomes and may improve young people's ability to navigate discussions with partners about sexual risk avoidance (Hicks et al., 2013), delay initiation of sexual intercourse, increase contraceptive use (Commendador, 2010), and reduce rates of unprotected sex (Hutchinson et al., 2003). Conversely, familial silence around SRH can isolate youth, stymie opportunities for knowledge-acquisition and limit avenues for support. Consequently, MRY articulated negative outcomes of familial silence: being "alienated" and having to "figure out my own sexuality and about sex on my own", being unaware of "how to express yourself", and fearing "being judged or disowned" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 10).

Keeping sexual behaviour secret from family was a motivator for SRH decisions, including care decisions. For survey respondents, keeping sexual activity secret was a reason for *avoiding* services, while for abortion-seekers, preventing discovery of premarital sex and pregnancy was a reason for *accessing* abortion services. Silence should thus not be uncritically conflated with passivity and lack of agency: silence is a strategic decision to protect MRY from shame, discomfort and condemnation. This reveals potential for policy makers and providers to engage MRY by presenting care as beneficial for maintaining secrecy. There might be greater uptake in contraceptive care, for example, if providers frame contraceptives as not just useful for preventing unplanned pregnancy, but in doing so, keeping sexual activity secret (Chapter 9).

While low SRH engagement, limited knowledge and adverse outcomes are frequently attributed to family repression and intergenerational tensions (Kingori et al., 2018; Meschke & Dettmer, 2012; Rogers & Earnest, 2014), MRY in this research were adamant about making decisions irrespective of family. GCM participants described being weighed down by "family kinda guilt", but still not conforming to "their expectations" (Napier-Raman, Hossain, Mpofu, et al., 2023, p.12), a sentiment echoed by abortion-seekers who "didn't really take other people's opinions to my mind" (Chapter 7, p. 185). This was repeated by survey participants who dealt with familial conflict around their sexuality by choosing to "not to deal with them" and "not to give it energy and time" (Chapter 6, p. 157). These findings offer a nuanced understanding of the interactions between youth and their families – one that goes beyond a reductive narrative of familial repression of agency. The efforts MRY went to ensure privacy indicate that family influenced *how* MRY approached decisions but did not prevent decisions.

Finally, on some occasions, family offered invaluable support, most evident in the experiences of abortion-seekers. While some participants faced negative reactions from family, others received emotional and financial support which improved their abortion experiences, reflecting well-established findings that social support has positive health implications (Cohen, 2004; Hatzenbuehler et al., 2013). Conversely, interviews revealed the impact of family separation on support systems. The literature review on migrant and refugee abortion highlighted how separation, in leaving pregnant people without caregiving support, influences abortion decisions (Napier-Raman et al., 2024). However, for young migrants in the primary research (Chapter 7), separation did not influence decision-making, but the *experience* of abortion, making it “harder and more scary” (Elena, Chapter 7, p. 190). Because family has typically been framed as an inhibitor of MRY SRH freedom, these results present a lesser-acknowledged aspect of MRY experiences: that separation curtails potential avenues for support. This may be intensified for particular groups, such as refugees or international students who often migrate alone (Poljski, 2011; Poljski et al., 2014; Thiel de Bocanegra et al., 2023).

Institutional aspects: navigating services and care

This research stresses that service underuse among MRY (Botfield et al., 2017; Botfield, Newman, et al., 2018; Rawson & Liamputtong, 2009) – and older migrant and refugee populations (Mengesha et al., 2017) – is an ongoing issue. Both GCM and survey participants reported low use of SRH services. Interviews with abortion-seekers imply, however, that MRY *will* access services when they feel this is necessary, suggesting that general low service use may be due to lack of perceived need. This attitude towards care is consistent with past research involving Australian MRY, where SRH preventative care is abjured and only issues deemed ‘serious’ warrant service access (Burchard et al., 2011; McMichael & Gifford, 2009). Lack of preventive care can be deleterious for numerous SRH issues, including risk of asymptomatic STIs being left untreated. Research with migrant and refugee populations has revealed prevalent beliefs that STI contraction is ‘obvious’ and only requires treatment if symptomatic (Davidson et al., 2022; Dean et al., 2017b; McMichael & Gifford, 2010). Literature review findings also established that MRY are often more concerned with pregnancy prevention and keeping sexual activity secret than STI contraction (Napier-Raman, Hossain, Lee, et al., 2023), which may explain participants’ limited use of services outside abortion care.

Lack of preventive care was further illustrated by low vaccination rates reported by survey participants (Chapter 6), which indicate a failure of service delivery and suggest that school-based vaccination programs may not reach MRY.[30] While the low rates reported may be because MRY are unaware that they have been vaccinated, this itself demonstrates an infringement on health rights. MRY have the right to be thoroughly informed about care they are receiving, have adequate information, and be aware of their health status.

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[30] The New South Wales government offers free in-school vaccination for HPV for all year 7 students. However, parental consent must be provided, which may be a barrier for MRY, and youth who arrive in Australia after year 7 miss out.

Barriers to sexual and reproductive healthcare

There were a range of factors impeding care accessibility, primarily around approachability, acceptability and affordability of services (Levesque et al., 2013).

Knowledge of services

Across all studies, including literature reviews (Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman et al., 2024), MRY had limited knowledge of services. Following Levesque et al.'s model of person-centred care,[31] MRY's inability to "actually identify that some form of services exists, can be reached, and have an impact on the health of the individual" indicates that current SRH care in Sydney is not approachable (2013, p. 5). For MRY, this was related to inadequate education: "not knowing where to go" for care because they were "never taught what services there are or how to use them" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9). Not understanding health system structures and the function of specific services is a noted barrier among migrant and refugee populations (Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman et al., 2024; Richters & Khoei, 2008), a finding encapsulated in one survey participant's assertion that services "confuse" her (Chapter 6, p. 159). Inadequate service awareness may also involve limited understanding of what SRH issues to access services for, and when to seek health support. However, despite lack of education and awareness, abortion-seekers proactively sought service information, accessing care when they had "no alternative choice" (Chapter 7). This evinces MRY agency in situations of necessity while highlighting the importance for reproductive justice approaches to redress "systemic inequality" and "reproductive restraints" limiting "people's decision-making" (Ross, 2017, pp. 291, 292). Care should not be only accessed when there is "no alternative choice" but should be readily approachable and available for all SRH issues and concerns.[32]

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[31] While Levesque et al. use the term "patient-centred" care, I have chosen to use the term "person-centred" as a less reductive way of acknowledging healthcare users. See, for example, Afulani, P. A., Nakphong, M. K., & Sudhinaraset, M. (2023). Person-centred sexual and reproductive health: A call for standardized measurement. *Health Expectations*, *26*(4), 1384-1390. https://doi.org/10.1111/hex.13781

[32] A reproductive justice approach would also interrogate why abortion care appears more readily and easily accessed than other forms of SRH care – and the implications of this. Reproductive justice highlights how policy, healthcare systems, economic inequality, and structural oppression enact population control and limit sexual and reproductive decision-making for the most marginalized. As such, a health system and material conditions that make abortion care more accessible for MRY than any other form of SRH care reflects policy priorities of limiting MRY reproduction over other aspects sexual and reproductive wellbeing.

Confidentiality concerns, stigma and shame

Acceptability of services was influenced by concerns around confidentiality and – to a lesser extent – embarrassment, shame and stigma. Privacy concerns have been a persistent service barrier for MRY within Australia and globally (Hawkey et al., 2018; Louie-Poon et al., 2021; Maheen et al., 2021; Napier-Raman, Hossain, Lee, et al., 2023; Richters & Khoei, 2008). While desire for confidentiality perhaps stems from SRH stigma, this research found embarrassment and shame were less prominent barriers than previously reported. Moreover, privacy concerns are not unique to MRY, with broader youth populations expressing similar concerns (Mazur et al., 2018). MRY did not perceive services as inappropriate or unacceptable, contrasting other research where migrants and refugees assert that SRH services compromise purity (Richters & Khoei, 2008; Ussher et al., 2012). Notably, despite research focusing on women's under-use due to chastity-imperatives and shame around female sexuality (Ussher et al., 2012; Wray et al., 2014), male MRY had lower service use in this research (Chapter 6). Nevertheless, discomfort talking to health providers and embarrassment being seen accessing services continue to be barriers to care for MRY (Kaczkowski & Swartout, 2020; Napier-Raman, Hossain, Lee, et al., 2023; Napier-Raman, Hossain, Mpofu, et al., 2023). Though care experiences of abortion-seekers were generally positive (Chapter 7), MRY seeking more general SRH care both anticipated and experienced stigma and judgement from healthcare professionals (Chapter 6, 7), consonant with experiences of other MRY in high-income countries (Maheen et al., 2021).

Affordability

As with other MRY in high-income countries (Maheen et al., 2021), participants expressed concerns about affordability (Chapter 6, 7). Interestingly, GCM participants did not discuss affordability, perhaps because services played a (concerningly) limited role their overall SRH decision-making.

Despite accessing a deeply stigmatised health care service, young abortion-seekers experienced affordability as a greater barrier than stigma or shame. In Australia, abortion is "the only commonly performed necessary health care procedure" that is not routinely provided for free by the public health system (Baird & Millar, 2019, p. 1121). Intersecting oppressions of age, employment status, stigma and migrant identity are exacerbated within the healthcare context of Australia's (largely) privatised abortion sector. This again reveals the importance of a reproductive justice approach to service-provision which acknowledges the need for economic justice and recognises how different aspects of identity and social position increase vulnerability (Chrisler, 2012; Ross, 2017). A "liberal discourse on abortion" and conflation of SRHR with 'choice' obscures the fact that access is not necessarily equitable (Baird & Millar, 2019, p. 1120). Though young women in this research were able to access abortion care, costs placed some participants in positions of heightened vulnerability and may preclude other MRY from accessing care.

Enablers to sexual and reproductive healthcare

Notwithstanding the evidence of low care engagement, interviews with abortion-seekers demonstrate that – at least in terms of abortion care – MRY who *do* seek care have generally positive experiences. This suggests that targeted abortion care is accessible and acceptable to MRY, but that care for broader SRH concerns may not be. Positivity around abortion care may also reflect gratitude due to the drastic, life-altering consequences of *not* being able to access abortion. Indeed, the literature review on migrant and refugee abortion revealed that even when abortion-seekers experienced mistreatment, they still expressed deep gratitude for their care (Napier-Raman et al., 2024).

Internet searching

For abortion-seekers, the internet was a significant enabler for accessing and obtaining information about abortion care. Given the utility of the internet for information-seeking among GCM and survey participants, digital resources have the potential to act as an enabler to care. Electronic medical portals are typically more patient-centred than non-digital methods, are convenient, and offer privacy (Zhao et al., 2017). For further discussion, see Chapter 9.

Cultural safety

Though culturally incongruent care and cultural proscriptions around SRH were not primary barriers identified in the survey, GCM participants did acknowledge "service providers making efforts to engage me as a culturally diverse young person" as an enabler (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9). Past research indicates MRY have diverse preferences around ethnicity and culture of providers, some feeling those of the same background understand their concerns better, while others fearing those of the same background would be judgemental or breach privacy (Maheen et al., 2021; Napier-Raman, Hossain, Lee, et al., 2023). Yet no participants in the present research expressed a desire for culturally-specific care, indicating that culturally sensitive –[33] but not necessarily specific – care is desirable (Napier-Raman, Hossain, Lee, et al., 2023).

Confidentiality as safety

Ensuring that care is confidential – and that this confidentiality is broadcast to MRY – is crucial. While past recommendations to assure youth of privacy *during* healthcare appointments are commendable (Maheen et al., 2021), this only succeeds with youth *already* accessing care. Thus, efforts to inform MRY about care must emphasise confidentiality (see Chapter 9). Moreover, given MRY "only feel safe accessing health care" if they are "sure it will be confidential" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9), confidentiality must be acknowledged as crucial to MRY constructions of SRH safety. SRH risk avoidance involves preventing social risk, protecting oneself from social stigma, ostracization, shame or embarrassment (Napier-Raman, Hossain, Lee, et al., 2023). As evidenced by abortion-seekers, privacy measures fundamentally improve MRY's experiences of care. Having providers make efforts "to engage me as a culturally diverse young person", while important, is *less* important than confidentiality (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9).

Macro-level: Cultural factors and social norms

Cultural and social norms

A preponderance of literature examining migrant and refugee SRH has fixated on culture (see, for example: Afroz et al., 2021; Agbemenu, Hannan, et al., 2018; Dune & Mapedzahama, 2017; Kingori et al., 2018; Metusela et al., 2017; Rawson & Liamputtong, 2010). Yet MRY in this research did not consider culture determinative of their SRH decision-making. Culture, religion and social norms *did* influence attitudes and values, fostered guilt and discomfort around SRH, and impeded openness. This did not, however, prevent MRY from engaging with SRHR around restrictions, avowing that "what matters is how I feel about me" (Chapter 6, p. 157).

Silence & stigma

Consistently, MRY linked silence around SRH to culture, family and social norms. As discussed above, MRY encountered silence in their communities and families, and in turn

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[33] For a more complex discussion of cultural competence, safety and sensitivity, see policy and practice recommendations, Chapter 9.

reproduced silence to keep their SRH decisions secret. However, this secrecy was not necessarily an indication of internalised stigma and shame, but a way to negotiate and protect themselves from cultural taboos. This reflects Botfield et al.'s findings that cultural silence was generated by taboos held by older family and community members, while MRY used secrecy to protect reputations and "prevent gossip and judgement" (Botfield, Newman, et al., 2018, p. 403).

Stigma has been recognised as a determinant of health (Hatzenbuehler et al., 2013). Consistent with existing scholarship on the negative impacts of SRH stigma, MRY in this research avoided care, had limited avenues for information, and lacked support systems due to stigma (Kingori et al., 2018; Maheen et al., 2021; Meschke & Dettmer, 2012; Wray et al., 2014). However, while a significant body of research has highlighted the prominent role of cultural chastity-imperatives, sexual shame and taboos (McMichael & Gifford, 2009; Meschke & Dettmer, 2012; Metusela et al., 2017; Ussher et al., 2017; Ussher et al., 2012; Wray et al., 2014), the present research found cultural stigma was not the primary factor informing MRY decision-making.

Negotiating cultural norms

MRY were highly cognisant of cultural, social, religious and familial taboos and pressures,[34] but described efforts to negotiate around this: "cultural and family kinda guilt, religious kinda guilt…weighs down on me…but it doesn't hold me to like be at their expectations" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12). This negotiation of cultural norms reflects an active process by which MRY determined and made decisions based on "what is important to me" (Chapter 5, p. 134). Frequently, MRY would draw upon discourses of individual choice and self-determination to describe their navigation of cultural norms (Mackenzie & Stoljar, 2000).

This research contributes to a growing body of literature that attempts to complicate assumptions about migrant and refugee relationships to culture. Botfield et al.'s research, for example, reflects on shared youth identity, proposing generation may "matter more than culture" (Botfield, Newman, et al., 2018, p. 398). Age and generation in Botfield's research

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[34] I refer here to culture, family, religion and social norms as these are undeniably enmeshed and participants themselves often grouped these factors together. See, for example, Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12 (Chapter 5).

were more definitive of identity: despite diverse ethnic and cultural backgrounds, MRY had more similarity in their SRH attitudes and experiences than difference (Botfield, Newman, et al., 2018; Botfield, Zwi, et al., 2018). While in the present research, age was only a prominent feature in the interviews (Chapter 7), Botfield's finding of shared experiences and attitudes across diverse cultural backgrounds was similarly evident.

Dune et al. (2017) suggest instead that religion is more salient than culture, positing that theories of "culture clash" may more aptly describe conflict between religious norms. Religion did not figure prominently in this research but was frequently discussed in conjunction with culture (see Chapter 5 groupings of statements related to family, culture and religion; and Chapter 7 discussions of spiritual and cultural anti-abortion beliefs). Blurred distinctions between religion and culture have been similarly noted in other research examining MRY conceptualisations of SRH (Meldrum et al., 2014; Saharso et al., 2023). Though diverging from Dune et al.'s conclusion that religiosity strongly influences decision-making, the present findings affirm the need for a more nuanced approach to culture and religion as factors shaping SRHR.

As this research has continually demonstrated, factors that influence decision-making across socioecological levels are themselves shaped by culture: knowledge acquisition is influenced by cultural stigma (Chapter 5), gender norms that shape healthcare access are influenced by cultural constructions of gender (Chapter 6), culturally predicated values inform SRH decisions (Chapter 7). Yet, as has been found among immigrant women and is apparent among the MRY participating in this research, a retention of "cultural attitudes" does not necessitate "cultural actions" (Agbemenu, Devido, et al., 2018, p. 703). Negotiating culture is thus an ineluctable part of the MRY experience, but not the sole – nor even the primary – determinant of SRHR attainment.

Culture clash?

Questions around 'culture clash' are a prominent feature of research with migrant and refugee communities, particularly regarding SRH issues (Afroz et al., 2021; Dune & Mapedzahama, 2017; Dune et al., 2017; Meldrum et al., 2014; Renzaho et al., 2017). Often, intergenerational tensions among migrant communities are theorised as emerging from dissonance between the values and practices of more rapidly acculturating youth and 'traditional' cultural values held by older generations (Dean et al., 2017a; Mansouri et al., 2015; Mulholland et al., 2021;

Renzaho et al., 2017; Rogers & Earnest, 2014). A clash as such was, however, not apparent in this research.

The present findings belie narratives that migrant and refugees are passive, unquestioning conduits of culture, reproducing structures which repress them (Hach, 2012). The "colloquial" assumption that mainstream Australian cultural values and attitudes are necessarily more progressive towards sexuality than those of migrants and refugees is also disputable and may lead "Australian society, policy and health care services" to "overlook their own conservatism around SRH" (Dune et al., 2017, p. 10). Moreover, as Miedma notes, "a singular emphasis on 'culture' – in its various guises – diverts attention from structural causes" of health inequities and adverse outcomes (2019, p. 220).

Conceptualising health

Just a decade ago, the *Lancet* commission on Culture and Health expounded the notion that "[i]deas about health are… cultural" (Napier et al., 2014, p. 1607), calling for a rejection of the "distinction between the objectivity of science and the subjectivity of culture" (Kristeva et al., 2018, p. 55).[35] The *Lancet* commission reflects growing recognition among health researchers and professionals that Western biomedicine is itself culturally constructed. Incongruity between different cultural conceptions of health has been used to explain service underuse and adverse outcomes among migrants and refugees – providers in host countries failing to comprehend needs, understandings of illness, and health approaches of these communities (Holmes, 2012; Napier et al., 2014; Pavlish et al., 2010). Often, this is framed as inherent incompatibility between migrant cultural models of wellbeing and Western biomedicine. Yet a simplistic view of 'migrant' culture as determining health behaviours erases other impacts of "local worlds" on health outcomes (Kleinman & Benson, 2019, p. 119); a failure to recognise biomedical perspectives as cultural can obfuscate how "the structure and culture of biomedicine… functions as a barrier to effective care" (Holmes, 2012, p. 880).

This research highlights the ways in which different models of health are imbricated in MRY constructions of SRHR. Participants drew on scientific discourses, placing high importance

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[35] I use 'just' to reflect that this has been a slow – and indeed ongoing – process to recognise that Western science and medicine are cultural products, reflecting and reinscribing cultural assumptions about how the world, health, illness and wellbeing work.

on “medical research and science” (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 9). MRY further used scientific language to distance themselves from what they perceived as harmful sociocultural norms, encapsulated in one participant’s description of how restrictive “norms” can be overcome through “using objective data” (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12). Interview participants similarly dichotomised ‘science’ and ‘culture’, dismissing “superstitious” “cultural” and “spiritual” beliefs about consequences of abortion. Michelle, for example, used scientific language of the foetus as “just a cell” and the expertise of “people in medical field” to assuage the guilt she felt around abortion from “growing up in Asian culture” (Chapter 7, p. 189, 192). MRY internalised notions of science and culture as oppositional – a false dichotomy that is itself a product of biomedical cultural assumptions –, while using discourses drawn from “the culture of biomedicine” to negotiate experiences of stigma and restriction (Kleinman & Benson, 2019, p. 118).

Nevertheless, the strong value MRY placed on affective aspects of SRH reflects a view of health that extends beyond conventional biomedical conceptions (Rocca & Anjum, 2020). A focus on adverse SRH outcomes has resulted in a medicalised approach to SRH in education and programming, prioritising prevention of unplanned pregnancy, STIs and HIV (Ford et al., 2019; Wellings & Johnson, 2013). Yet MRY clearly include relational and emotional wellbeing, interpersonal connections, pleasure, and effective communication in their conceptualisations of SRHR. While participants used scientific discourses to underpin certain decisions, they simultaneously conceptualised SRHR holistically, drawing upon different models of wellbeing. Moreover, MRY’s focus on relationships and interdependence while asserting self-assured choice reflect a divergence from western definitions of autonomy as self-reliance and independence (Chen et al., 2013). MRY thus integrated diverse beliefs and attitudes towards health into their constructions of SRHR – incorporating different worldviews and ‘versions’ of reality (Cram & Mertens, 2016). This stymies assumptions that there are fixed characteristics of ‘culture’ that can be used to predict how populations will respond, belying the reduction of culture “to a technical skill for which clinicians can be trained to develop expertise” (Kleinman & Benson, 2019, p. 116).

Strengths and limitations

This doctoral research contributes to the growing field of scholarship on MRY SRH. This research is, to our knowledge, the first to use an explicit focus on rights attainment – and, in consequence, strengths – to understand the SRH experiences of Australian MRY.

Limitations

This section discusses overall limitations. Limitations of specific studies are provided in each results chapter (5, 6, and 7), and are not further discussed here.

Sampling and recruitment

Engaging and recruiting MRY posed a consistent challenge. As such, data collection was extended beyond original timelines, representativeness of samples was compromised, and generalisability of the data was limited.

The sample across this research was not necessarily representative of MRY in Sydney. Despite a diverse range of participant backgrounds across studies, certain ethnicities were overrepresented (Vietnamese-background participants in Study 1), and others were underrepresented (African-background participants in Study 3). This precluded data comparison based on ethnic or cultural background. While results indicated significant shared experiences across different ethnic backgrounds, as has been found in previous research (Botfield, Newman, et al., 2018), there may be crucial ethnic differences in attitudes and behaviours that were overlooked.

Though there were strong rationales behind including both migrant and refugee participants (see Chapter 1), this potentially obfuscated diversity of experiences based on different citizenship statuses and arrival journeys. There is thus scope for further research that compares the experiences of refugees, migrants and different generations (first, second, 1.5) regarding SRHR.

Gender discrepancies and a lack of diversity was apparent in this research. Across all studies, there was only one non-cisgender participant who, due to statistical restrictions, could not be included in gender analysis (Chapter 6). Research findings – particularly concerning stigma and repression – might have been very different with a greater representation of gender diverse participants. There was also notable under-representation of male participants, which is a consistent issue in SRH research (Heise et al., 2019). Overall, a thorough exploration of the intersections of gender and MRY identity was hindered by difficulties in recruiting male MRY. Thus, while the present research added to the complexity of existing research on how MRY navigate gender norms around SRHR, results were still hampered by limited male perspectives. There is a clear need for further targeted research involving male MRY.

A noted risk of intersectional research can be the tendency towards an 'additive' approach, where different oppressions are simply added as though they are fixed social categories (Cho et al., 2013; Hankivsky & Grace, 2016). To avoid this risk, the present research did not seek to thoroughly examine *all* aspects of identity that could possibly inform decision-making. This did, however, mean that this research did not include an explicit analysis on aspects such as sexual orientation, religiosity, socioeconomic status or education level. These aspects of individual experience may have significant influence on decision-making and agency and thus should be further examined.

Stigmatised research

As has been articulated throughout this thesis, the sensitive nature of the research topic presented additional difficulties in engaging participants. Those with greater vulnerability to stigma may not have participated, given the confronting nature of the research. This may have resulted in a skewing of data, with those strongly opposed to or uncomfortable with SRHR not participating and thus not having their experiences represented.

Virtual research

Only the first phase of this research – GCM – was conducted during government mandated COVID-19 lock-down. Nevertheless, the entire research was informed by the pandemic. Virtual research was deemed the 'safest' and most feasible method in terms of public health risk, and the easiest in terms of reaching vast populations—yet brought its own risks.

The swathe of fraudulent responses to the quantitative survey reflects the difficulties of accountability and veracity in virtual data collection. The rapid influx of survey 'respondents' were most likely bots[36] or individuals using server farms (Pozzar et al., 2020).[37] While systematic efforts were taken to identify and remove fraudulent responses (Chapter 4), this took time and resources away from data collection and analysis.

Virtual research also relies on participants having access to technology and spaces to use that technology (Carter et al., 2021). In potentially excluding participants without digital access, this research is limited to the perspectives of those in relatively privileged positions and may contribute to inequalities between those with and without resources (Sieck et al., 2021). Moreover, faulty internet connection can disrupt research, leading to incomplete responses, incoherence, confusion and even participant distress.

Disengagement

This research relied heavily on social media and virtual recruitment methods, even though this potentially hindered building trust with participants. The compounding of stigma and virtual distance resulted in specific challenges regarding engagement, both in recruitment and in participation. Cancellations and non-attendance were particularly high for qualitative interviews. The ease and distance of virtual recruitment fosters a sense of informality which can lead to greater cancellation and no-shows (Topping et al., 2021).

Strengths

A major strength of this research is the multi-methods design – including the first GCM project to investigate Australian MRY experiences. Not only did methodological diversity allow for richness of data, but each study used a different scale of analysis – from broad socioecological determinants to articulation of a specific right. This research thus provides explication of overarching, socioecological factors informing general SRH decision-making (Chapter 5), which then provides context for particular SRH behaviours, help-seeking and attitudes, and how the individual-level factor of gender informs these (Chapter 6). These findings are then seen 'in action' with focused exploration of decision-making regarding a specific right (Chapter 7). This progressive 'zooming-in' on decision-making from broad to

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[36] A 'bot' – an abbreviated term for robot – refers to an automatic software program that simulates human behaviour or tasks; bots are, importantly, automated and intended to imitate human behaviours online, at very rapid rates. Bots are not inherently damaging – many major organisations and companies have chatbots that answer consumer questions, for example. However, in the case of my research, bots were used to complete multiple responses to the survey.

[37] An individual can use multiple virtual private servers to simultaneously complete multiple survey responses. Virtual private servers use one machine (i.e. a single piece of hardware) which hosts multiple virtual servers.

specific contributes to understandings of MRY SRHR and wider discourses around health rights and agency.

A focus on rights, agency and strength is also a crucial asset of this research, diverging from the deficits focus of much existing scholarship. The use of a rights-based approach, with attention to socioecological factors and intersections of opportunity and oppression, is critical in providing a complex, nuanced understanding of SRH decision-making. This research, hopefully, paves a path for youth empowerment and centring of MRY voices within research, policy and practice. The findings of this research, which have highlighted how youth navigate barriers, negotiate stigma and feel determined their decision-making, are an important addition to literature elucidating the discrimination and marginalisation faced by MRY.

Given the paucity of research on this topic, being able to recruit the numbers that we did is, in fact, a strength. This is particularly the case with abortion research, where even globally there was insufficient data on MRY abortion attitudes and experiences to conduct a literature review, resulting in an expanded scope of migrant and refugees of all ages (see Chapter 2)(Napier-Raman et al., 2024). Additionally, while numbers of male participants were low, existing research comparing male and female MRY regarding SRHR is markedly limited. This research is thus instrumental in furthering comprehensive understandings of how gender dimensions impact SRHR.

Finally, the ‘distance’ of virtual research provided advantages, especially given the sensitivity of the research. Virtual distance may have made the participant experience less intimidating, with MRY able to engage from a comfortable location of their own choosing. MRY reflections on GCM activities consistently highlight that anonymity increased freedom to express oneself: “I liked that it was anonymouse [sic]… I could be honest without a second thought” (Appendix E). Additionally, virtual data collection had benefits of reducing travel costs and times and allowing MRY greater autonomy over when and where they could participate. Those who might typically be barred from participation by scheduling conflicts could be involved. Online data collection thus allowed for specific perspectives and engagement that in-person research would not.

Conclusion

This chapter provides a thorough synthesis and discussion of the results of this research. In examining themes emerging across socioecological levels, I expound how myriad intersecting factors shape the decision-making and agency of MRY and how these findings confirm and contradict existing scholarship.

Most strikingly, this chapter has illuminated the myriad, nuanced ways MRY articulate agency in their decision-making: from outright rejection of cultural and familial pressure to strategic silences and intentional suppression. This chapter further highlights the complexity of MRY engagement with culture, family and interpersonal relationships. While cultural restrictions can be inimical to rights attainment, cultural values guide certain decisions and promote a positive orientation towards affective, interpersonal aspects of SRH. Family can be both a source of suppression and support. Interpersonal relations can be deeply important, yet not necessarily relied upon.

Despite evident experiences of vulnerability – manifest in inadequate SRH knowledge, low service access, and challenges navigating safe, consensual relationships – MRY assert a desire and endeavour to make their “own choices” (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12).

Chapter 9. Summary and Conclusion

This concluding chapter builds on the discussion in the previous chapter, highlighting the significance of research findings and presenting a series of strengths-based policy and practice implications. I close this chapter with a statement articulating the value of this research and the exigency of investing in migrant and refugee youth's sexual and reproductive health and rights.

Thesis summary

This thesis has used a rights-based approach to examine the sexual and reproductive health decision-making and agency of migrant and refugee youth living in Sydney, Australia.

The opening chapters – Chapters 1 through 4 – provided a topic overview, literature review, explication of theoretical underpinnings and outlined the methodology of this research. The introduction, which presented the subject matter and research significance (Chapter 1) was followed by two systematic reviews – one examining MRY SRHR generally, the other examining abortion among migrants and refugees – synthesising existing evidence and revealing literature gaps (Chapter 2). The results of these reviews comprised the first findings of this thesis. The first review revealed the importance and value MRY place on social, affective aspects of SRH, the ubiquity of silence in their communities and families, and the limitations of the SRH education that youth receive (Napier-Raman, Hossain, Lee, et al., 2023). The second review examined migrant and refugees' abortion experiences, attitudes and decision-making. The review identified key factors informing abortion decision-making, and how inequalities intersect to shape the actualisation of sexual and reproductive health rights (Napier-Raman et al., 2024). The literature review chapter was followed by an explication of the theoretical frameworks underpinning this research (Chapter 3). Chapter 4 included a description of the methods used in all three studies, beginning with a publication examining group concept mapping (GCM) methodology and its use in public health research (Napier-Raman, Rosas, et al., 2023). This was followed by a description of the quantitative survey methods (Study 2) and the in-depth interview methods (Study 3), and, finally, a statement of researcher positionality.

The following three chapters (5-7) presented study results. Chapter 5 comprised the results of the GCM study investigating factors informing SRHR decision-making among MRY (Study

1). This study revealed the strong importance of both sexual safety and risk prevention *and* emotional safety and relational wellbeing for MRY and highlighted key differences between youth and adult stakeholders' perceptions and attitudes. The results of the quantitative survey (Study 2) were presented in Chapter 6, explicating how gender informs MRY behaviour, decision-making, knowledge, service use, help-seeking and attitudes. This study highlighted gendered vulnerabilities: infringements on rights to safe, consensual sexual experiences among young women and significant knowledge deficits and limited service use among men. Results of Study 3 were presented in Chapter 7, which examined SRH decision-making and abortion experiences. Consistent with the previous chapters, youth in this study were adamant about making decisions unfettered by others' influence, averring autonomy in their abortion decision-making. While uncovering significant challenges encountered by these young women, Chapter 7 revealed the ways in which abortion-seekers negotiated barriers and sought necessary care. The findings from all three studies highlighted that culture and family influences, while often constituting barriers to SRHR, were not the determining factors in decision-making.

The discussion chapter (Chapter 8) presented the key findings of the research and compared them with the existing literature. The synthesised results from all three studies suggest that SRH decision-making among MRY is complex, manifold and involves mutable forms of agency. Chapter 8 highlighted the core factors informing MRY decision-making across socioecological levels, which contributed towards the development of policy and practice implications.

Empirical and theoretical contributions

This research offers significant theoretical and empirical contributions to the field of study. Theory was embedded throughout this research, from conception through every stage, in an iterative manner. This not only allowed for richness and depth in the findings and analysis, but also contributes to the evolution of these theories, having implications for future applications.

The socioecological model, used throughout this research, grounds the findings in context, allowing explication of how MRY's individual decision-making is informed by multiple factors at varying socioecological levels. This is crucial in reflecting the complexity of MRY decision-making and SRHR experiences. The use of socioecological theory enables this research to go beyond a singular focus on culture, family and community as constricting MRY's agency, revealing that decision-making is shaped by an interplay of multiple factors. In revealing that culture and family are *not* definitive of MRY decision-making, this research also counters narratives that blame SRH ill-health and supposed disengagement among MRY on culture and family, having significant implications for policy and practice. Findings across this thesis therefore highlight the importance of policy and practice being developed to reflect socioecological realities of MRY rather than focusing on single factors or single issues.

In combining socioecological approaches with intersectionality, this research examined the interrelated nature of different socioecological factors and how they intersect to shape SRHR attainment. This research revealed how intersections of age and migrant/refugee identity shape decision-making. These intersections brought vulnerabilities, with rights to SRH knowledge compromised by inadequacy of school education, limited knowledge related to inexperience and life-stage, and the lack of avenues for information within family or community due to cultural stigma and taboos. Rather than an additive approach, the focus on certain specific intersections of identity allowed this research to thoroughly explore the ways in which these intersections shape MRY SRHR. This allowed findings to reveal unexpected, dynamic ways in which gender intersects with MRY identity – how patriarchal structures and harmful gender norms lead to particular vulnerabilities in female and male MRY. These findings are crucial to fully understanding the complexity of gender oppression and the importance of inclusive intersectional SRH policy and programming that addresses the needs of people of all genders. In examining the transnational identities of MRY, this research also answers calls for intersectionality to explore the intersections of oppressions across borders (Patil, 2013; see Chapter 7). Furthermore, the intersectional approach used in this research was oriented around agency and strengths. While acknowledging marginalisation, findings also highlighted strengths in MRY's intersectional identities – the ability of youth, for example, to confidently use digital platforms for SRH help-seeking, often to enable the privacy desired due to cultural and familial stigma. This research offers an example for how future research can apply a strengths-oriented intersectional approach that acknowledges both oppression *and* opportunity.

In tandem with socioecological theory, the reproductive justice lens in this research highlighted how institutional (exo-system) aspects such as structural *in*justice can impact individual SRH outcomes – with the opacity of the healthcare system, costly privatised abortion care, limited education on services, and lack of outreach all creating barriers to care. This research is also significant in expanding the application of reproductive justice beyond original scope of reproductive injustice in black communities, indicating the utility and exigency of these approaches in research with migrant and refugee populations. In using reproductive justice frameworks, this research highlights the need for justice and rights in SRH policy, practice and programming.

Finally, this research is critical in its contribution to scholarship on agency, offering insight into how MRY articulate SRH agency. By using a multidisciplinary understanding of agency, drawing on sociology, health research, social geography, anthropology, feminism and psychology (see Chapter 3), this research offers a nuanced depiction of MRY agency. The integration of socioecological theory, reproductive justice and intersectionality into this exploration of MRY agency ensured that young people's lived realities were not obscured in this research. Such an approach allowed agency to be explored in contexts of restriction. This was most evident in the ways MRY negotiated silence and secrecy around SRHR – both being subject to silence and suppression *and* strategically using silence themselves to protect their social and emotional wellbeing.

This research thus offers theoretically grounded empirical evidence on how MRY make decisions and enact agency around SRHR, with crucial implications for policy and practice.

Implications for policy and practice

Despite strong evidence affirming the necessity of addressing social determinants of health (Baum et al., 2022; Commission on the Social Determinants of Health, 2008; Rao et al., 2012), health inequities persist and, globally, appear to be widening (Baum et al., 2022). In focusing on socioecological factors informing MRY decision-making and agency, this doctoral research indicates how key aspects of young people's lived experience and the social determinants surrounding them inform their health behaviours and outcomes. These findings offer directions for policy and practice to improve MRY's SRH outcomes and assist them in actualising their rights (Table 9.1).

Though this research centred strengths, inequities and health challenges facing MRY are apparent across findings – and are thoroughly detailed in past scholarship. The forthcoming policy and practice recommendations thus attempt to redress inequities within a distinctly strength and rights-oriented framework. Table 9.1 presents broad research implications for policy and practice to support MRY's realisation of key SRH rights. Significantly, MRY conceive *all* these rights as highly important (Chapter 6), indicating the need for interventions that address SRHR in entirety.

The present recommendations begin with a broad discussion of the need for strengths-based programming, followed by recommendations for three specific areas: 1) education, 2) services and care access, 3) digital resources. Given MRY decision-making is informed by factors across socioecological levels, interventions should target multiple levels. Moreover, this research indicates that future policy and practice should be holistic, integrating social, emotional, physiological and biomedical aspects of SRHR (see Table 9.1). Given Australia still lacks a national sexual and reproductive health strategy – yet has a national STI strategy – it is time, perhaps, to more strongly and comprehensively address sexual and reproductive health and rights.

Table 9.1 Policy implications for sexual and reproductive health rights

Right to…	Policy area	Implications
Sexual health education and information	Education Digital policy and infrastructure[38]	➢ Improved school education ➢ Alternative education contexts and modes of delivery ➢ Increased focus on relationships, intimacy and positive aspects of SRH in education ➢ Improving digital resources; development of digital health literacy
Be free from discrimination based on your gender, sexuality and/or sexual choice	Anti-discrimination Digital policy Education	➢ Including sexuality, gender identity in education ➢ Developing digital support spaces
Choose sexual partners	Education	➢ Skills-based education on navigating relationships ➢ Consent education in formal and informal education settings
Choose whether, when, and in what contexts, to be sexually active	Education	➢ Skills-based education on navigating intimacy, setting boundaries
Safe, pleasurable sexual experiences	Education	➢ Skills-based education on navigating intimacy, consent and setting boundaries ➢ Shifting from fear-based risk-focused SRH education
Choose whether, when, and by what means to have children, and how many	Healthcare Social services, social security	➢ Education on how and where to access reproductive care ➢ Affordable abortion care ➢ Economic support for: ❖ Those seeking abortion ❖ Those wanting to continue pregnancy
Access contraception	Healthcare Social services	➢ Various effective, accessible contraceptive options, including non-hormonal contraceptives ➢ Affordable/ free contraceptives ➢ Respectful contraceptive counselling ➢ Expanding contraception resupply service[39]
Access sexual and reproductive health services and care	Healthcare Digital policy	➢ Education on services ➢ Service outreach for STI testing, general SRH issues, pregnancy and abortion care ➢ Improved care ❖ Confidentiality, competence and cost ➢ Digital resources for support and care

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[38] The New South Wales government's digital policy includes various strategies including the *Internet of Things Policy* which seeks to improve information flow, tracking and data collection, the *NSW Connectivity Strategy* and the *Smart Infrastructure Policy.* See: Digital NSW (2024). *Policy | Digital NSW*. NSW Government. https://www.digital.nsw.gov.au/policy.

[39] The New South Wales government has just established a service which allows pharmacists resupply 12 months' worth of oral contraceptives without requiring a new script from a GP. Only those who have been taking the oral contraceptive pill for two years, as prescribed by a doctor, are eligible.

Strengths-oriented practice

Policy and practice outcomes are influenced by social constructions of specific target populations which “become embedded in policy as messages that are absorbed by citizens and affect their orientation and participation patterns” (Schneider & Ingram, 1993, p. 334). MRY are frequently socially constructed as an ‘at risk’, dependent population, which in turn shapes how they engage with care and approach SRHR (Schneider & Ingram, 1993). This research has highlighted the fallacy of characterising youth as risk-takers, incapable of making ‘rational’ decisions (Shoveller & Johnson, 2006). Instead of relying on deficit models confirming MRY’s incapacity, policy should be oriented towards strengths and agency. In shifting away from deficit models, a strengths-oriented approach not only avoids pathologizing MRY, but potentially mitigates stigma around SRH. This involves framing SRH as a positive, vital part of wellbeing rather than something inherently risky that needs to be ‘managed’. Given stigma can be considered a “fundamental cause” of inequality (Hatzenbuehler et al., 2013) – leading to social isolation, care avoidance and inadequate support –, there are decided advantages to approaches that reduce stigma.

This research has illuminated several strengths held by MRY that can be focused on in policy and practice. The value MRY place on interdependence and affective aspects of SRH can be used to promote healthy relationships and communication. Given MRY consider emotional and relational aspects of SRH highly important, educational interventions, resources, and outreach programs focusing on building relationship skills may yield greater engagement than current interventions. Such programming can help MRY have healthy relationships and attain rights to safe, pleasurable sexual experiences, and can build communication skills to allow open conversations about consent and sexual risk. Being able to comfortably navigate SRH conversations will, ideally, bring greater cooperative decision-making around contraceptives and protection and higher uptake of risk-avoidance methods.

In line with tenets of reproductive justice, policy should help MRY develop SRH agency (Kirkendall & Dutt, 2023). Despite barriers that ‘thinned’ their SRH agency, MRY in this research frequently demonstrated a strong sense of autonomy and internal resolve. Interventions should attempt to develop this sense of autonomy to extend to areas of SRHR that MRY were particularly vulnerable: consensual relationships, STI awareness and testing, and service access.

The significance of gender in shaping MRY decision-making within this research suggests the need for gender-transformative programming, focusing on capacity building and strengthening positive gender norms (Marcus et al., 2021). Programs incorporating gender equality, power relations, human rights, and using participatory methods are more likely to yield positive SRH outcomes for youth (Chandra-Mouli et al., 2015). Countering harmful gender norms, while strengthening positive norms, can have broad SRH benefits. Gender transformative policy approaches should focus on countering norms that discourage help-seeking and healthcare access among men, while maintaining and promoting the engagement of young women in SRH. Active efforts to engage men in SRH will help redress inequalities around gendered reproductive responsibility. Although disproportionate reproductive burden is placed on women, efforts to mitigate this should continue to promote women's autonomy while empowering men as co-operative partners in decision-making. Interventions and efforts to improve SRHR should both include gender equality goals *and* be implemented alongside broader efforts to transform harmful gender norms and masculinities (Brennan-Wilson et al., 2024).

Education reform and interventions

Existing literature and the results of the present research reveal that MRY's rights to SRH education, knowledge and necessary information are persistently impeded, evincing a pressing need to improve education (Table 9.1).

Improve and broaden educational content

Firstly, school curricula should be broadened to incorporate a greater focus on relational, affective aspects of SRHR. This should be centred on developing skills – teaching students how to have open conversations, build trust in relationships, identify unhealthy behaviours or relationship patterns, and to determine and establish personal boundaries. The recent introduction of mandatory consent education nation-wide is a crucial first step (Woodley et al., 2022). Given participants in this research would not have benefited from these curriculum changes, it is unclear whether the revised curriculum will have significant impact on MRY. However, while consent education is necessary, MRY indicated a broader desire for being taught to develop positive, healthy relationships. In line with the strength-based orientation of this research, education should not only address preventing negative sexual experiences, non-consensual encounters and SRH risk, but should teach students how to have *positive* experiences (Table 9.1) Teaching youth positive aspects of SRH and giving them the skills to ensure experiences are enjoyable and safe are essential for broad emotional, physiological, social and sexual wellbeing. Part of this should involve incorporating diverse sexualities and gender identities into mainstream education on how to have positive, affirming SRH experiences (Table 9.1). This would meet MRY's desire for SRH education to "have more useful information" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12). Given that survey results indicated school was a key source of information (Chapter 6), yet both GCM and interview participants highlighted inadequacy of schooling (Chapter 5, 7), improving content to reflect MRY values is crucial.

Diversify context and method of delivery

In addition to improving formal education, we should invest in alternative contexts and modes of delivery. This research found that MRY may miss out on key sexual and reproductive information due to disengagement in school settings (Chapter 7), inconsistencies and inadequacies in school SRH classes (Chapter 5, 7) and being educated in home countries with limited SRH education curricula (Chapter 7). Alternate sites for education provision include SRH information sessions in workplaces and tertiary/vocational education spaces, free courses through community centres, and information stalls at community events. Online resources, discussed further below, may also be key in delivering education to young "digital natives" (Haruna et al., 2018, p. 1), especially given MRY's use of internet information throughout this research. While SRH services may also be a useful avenue for education, the low awareness and uptake of services among MRY must be addressed before services can feasibly provide education.

Implications for care and service provision

This research, in line with existing scholarship, indicates MRY rights to SRH care and overall wellbeing are significantly compromised, with youth largely not even aware of services.

Increase awareness of services

MRY must be informed of their rights to SRH care and, subsequently, supported in realising these rights. Service improvements must begin with ensuring and improving MRY's awareness: how to access services, what different services provide, where services are located and when to access services (Chapter 8).

School education must include information about different SRH services, when and where to seek help, and how. Education should be area-specific to ensure that youth are aware of local services. General information about the Australian health system, the role of different services, allied health and care entitlements should also be part of the curriculum. Ensuring youth can easily navigate not just SRH care but the broader health system is essential for overall future societal wellbeing. As indicated above, education must be multi-sited, not simply school-based, to account for those who miss out on formal education. Potential avenues could be language specific classes and adult education settings including TAFE.

Service outreach

Persistent service under-use indicates the current model of provision is failing to engage MRY, suggesting the need for more concerted outreach efforts. Drop-in services at schools, community colleges (TAFE), and university campuses may be useful, but, as with school-based education, are only accessible to MRY engaged in these spaces. Another potential avenue for outreach is setting up mobile clinics at local community functions, festivals, markets or other such public events.

General practitioners (GPs) may play a key role in increasing SRH service use, given that on the limited occasions MRY *do* seek SRH care, it is often through GPs (Chapter 6). GPs are well positioned to broach topics of SRH with MRY or provide information about alternative SRH services. If conducted in a sensitive manner, having GPs raise SRH issues in general healthcare appointments may help youth overcome apprehension about discussing SRH with providers. General practice is an appropriate setting for preventive healthcare and care coordination, and Australian research has found that having a regular GP is associated with fewer barriers and more positive attitudes to health system navigation for young people (Kang et al., 2020). Furthermore, while literature review findings established that MRY may be uncomfortable discussing SRH with GPs due to connections with family or community (Napier-Raman, Hossain, Lee, et al., 2023), this discomfort can be evaded by having GPs refer MRY to other SRH services. As noted in Chapter 8, promoting care as a way of maintaining privacy around sexual activity may be a way to engage MRY. This offers a crucial avenue for engaging MRY with preventative care, which appears particularly low among this population.

Improve services: confidentiality, competence and cost

Improving services is redundant if MRY remain unaware of and disengaged from services. Nevertheless, in conjunction with efforts to increase awareness and access, this research provides several implications for improving service delivery. Moreover, ensuring services meet needs and priorities of MRY will, hopefully, encourage greater use in the long term – particularly if services adequately advertise that they are centred on youth priorities.

Firstly, MRY must be able to trust that providers will maintain and respect patient confidentiality. Somewhat paradoxically, this requires services to advertise confidentiality: MRY will only attend services if they are priorly informed that their privacy will be ensured. Any outreach efforts and education regarding services should highlight that 1) privacy legislations mandate privacy and non-disclosure of health information,[40] 2) Medicare maintains confidentiality for those above 14 years of age, and 3) MRY have rights to confidential care. Youth attending services should be provided instructions for how to manage health records, including hiding, removing and restoring documents from *My Health Record,*[41] or entirely deleting the record. Establishing discrete, inconspicuous SRH services may be useful – something that was particularly noted by abortion-seekers, who appreciated that clinics "just looked like a regular house" (Chapter 7). However, given MRY already have low service awareness, SRH services that are not clearly advertised may present another barrier. Another way to improve confidentiality and trust is to ensure providers themselves are sufficiently aware of privacy legislation and confidentiality obligations and have the support, skills and resources to implement necessary measures.

MRY in this research both expected *and* experienced stigma in their interactions with healthcare providers, suggesting further efforts must be made to guarantee acceptable, person-centred care. This requires sensitivity training and for providers to uphold standards of non-judgemental, supportive care. To mitigate expected stigma, youth must be assured that care will meet these standards, again requiring better outreach and information about services.

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[40] While there are exceptions to non-disclosure, such as referrals to specialists, cases of potential serious threat, or suspected misconduct, MRY are most concerned with family and community being informed of SRH issues and behaviours.

[41] *My Health Record* is a secure digital repository for health information and records. All Australian citizens have *My Health Record* unless they choose to opt-out. Individual records can only be viewed by the patient and their healthcare providers.

MRY conceptions of safety and risk must guide care. Considering MRY were concerned about both physical and emotional SRH safety, care must be delivered in a holistic manner. Engaging MRY with STI testing, for example, could be approached through broader discussions of relationship health and positive communication. MRY also expressed mistrust of hormonal conceptions, which must inform approaches to contraceptive counselling and broader reproductive care. While providers should deliver accurate information about hormonal contraceptives and dispel misconceptions, pushing hormonal contraceptives too strongly may alienate MRY. Contraceptive counselling must be centred on MRY's rights to make their *own* informed decisions about their reproductive lives. Practitioners must thus be prepared for, and accept, refusal of hormonal contraceptives and present viable alternatives – offering, for example, the copper IUD as a non-hormonal form of long-acting reversible contraceptive (LARC). Culturally safe care requires practitioners to be cognisant of, and attendant to, power imbalances between themselves and patients, particularly when working with vulnerable minoritised populations (Curtis et al., 2019). Providers must take efforts to ensure contraceptive counselling does not become contraceptive coercion.

This research highlights the need for service providers to look beyond essentialist narratives of culture and family as barriers to SRH engagement. While cultural sensitivity, competence, and safety are requisites for good healthcare (Curtis et al., 2019; Kirmayer, 2012), the present findings suggest that a fixation on "culture in terms of vulnerabilities" will not serve MRY's best interests (Kirmayer, 2012, p. 159). Given the findings that culture was not the most important aspect of MRY's SRHR constructions, cultural competence may not be sufficient. Services and programming must recognise "how "culture" and "structure" are mutually co-implicated in producing stigma and inequality" (Metzl & Hansen, 2014, p. 128). Service delivery must therefore account for economic, political, social, infrastructural aspects impeding MRY's engagement with care. For example, how structurally accessible clinics are, including opening hours, affordability, availability and cost of transport, must be examined; the evident failure of education to enable MRY to seek care must be redressed. This requires policy interventions at broader infrastructural levels such as improving public transport, improving health service literacy, and having public after-hours clinics. Indeed, ""cultural" barriers arise when structural forces manifest themselves in patterns of interpersonal communication and institutional practices", suggesting that a focus on culture as inhibiting SRH care will fail to reach the root of the problem (Metzl & Hansen, 2014, p. 130).

Furthermore, as has been asserted throughout this research, ‘safe’ care for MRY is not necessarily concerned with culture, but confidentiality (Chapter 5).

The newly established hormonal contraception resupply service goes towards mitigating structural barriers to SRH care. The service allows those who have been taking oral contraceptives (prescribed by a doctor) for at least two years to access resupplies from a pharmacy without having to receive a new prescription (NSW Health, 2024). In removing the need for repeated doctors’ appointments – which may be costly, time-consuming and inconvenient – this service has significant implications for increasing contraceptive access. Ensuring MRY are aware of such services is essential. Expanding this intervention to other contraceptives or using similar models for other SRH issues could help improve access.

A final recommendation for improving care is to ensure affordability. Policy should be developed to enable SRH services – including abortion services – are offered free, or heavily subsidised, to MRY. Shifting to greater public provision of abortion care is urgently needed: the implications of not being able to afford such care are life-altering, and the present research highlighted how high abortion costs increases vulnerability (Chapter 7). The Australian Capital Territory has recently made abortion and LARC provision free to residents – New South Wales should follow suit. Moreover, as the systematic review on migrant and refugee abortion experiences highlighted, those with more precarious citizenship statuses face greater vulnerability to rights violations (Napier-Raman et al., 2024). Making Medicare accessible to those lacking formal citizenship – such as temporary migrants and international students – is vital. Affordable (or free) care may also safeguard against confidentiality concerns, particularly for MRY who are financially dependent and would otherwise need external support (and thus disclosure) to pay for services.

Free services and STI testing clinics already exist across greater Sydney, yet MRY’s consistent concerns about costs indicate they are not aware of this. Information provided about services – in schools, community spaces, GP clinics – must emphasise that these are affordable (or free) and confidential. Moreover, MRY should be informed of rights and concession entitlements to subsidised care. This includes educating MRY on Medicare entitlements and how these can be claimed, other concessions they may be entitled to, and services that provide specialised free care for youth and/or migrants and refugees. Service providers should take initiative in care settings to inform MRY of any potential entitlements.

Digital resources

The internet and social media can have significant impact on public health (Schillinger et al., 2020); this research reveals the key role of digital resources in MRY information-seeking, help-seeking and support. Policy and practice should take advantage of MRY's apparent comfort and skill using digital resources (see, for example, Chapter 7). Given the ubiquity of internet help-seeking, it is also exigent to ensure that online information accessed by MRY is safe, accurate and supportive. Digital spaces are an ineluctable part of health in contemporary Australia and must be engaged with.

Improve digital information: accuracy, safety and accessibility

Given the utility of internet information for MRY – particularly to supplement inadequacies in school and home SRH education – there is an opportunity for improving existing online resources. This could involve optimising search results by sponsoring government and reputable medical webpages so that these appear first in searches. Additionally, this may require auditing and reviewing the current SRH information online to ensure youth are able to receive safe, accurate evidence on a range of issues. Consequently, resources should be developed for any topics that do not have adequate, reliable online information. Finally, establishing a verification system to indicate reputable websites would allow easy identification of reliable information (much like the 'blue tick' verification used on social media sites). This could help youth navigate the vast, indiscriminate content accessible via the internet. Given the proliferation of digital misinformation, verifiable, government-approved sources would be particularly beneficial (Enomoto et al., 2017; Pagoto et al., 2023).

Public SRH campaigns should take advantage of social media and youth's engagement in these spaces. Advertisements for SRH services and for information sites should be distributed across diverse platforms. Existing social media communities – such as student Facebook and Instagram groups/ pages – offer key platforms for SRH information campaigns. There is also an opportunity to use the existing platforms of established social media influencers to disseminate public health messaging. Potential partnerships between government health and popular influencers may allow information to reach broader audiences and help engage MRY.

Finally, digital interventions may be particularly useful in education settings – both formal and informal. There is evidence that 'gamification' of SRH content by using digital educational games can improve outcomes (Haruna et al., 2018). Digital SRH education games may be particularly useful for students who are disengaged in more traditional school contexts. They may similarly be promoted for MRY who miss out on schooling or have had inadequate SRH education.

Improve digital care and service provision

Evidently, COVID-19 expedited the digitalisation of healthcare, and this research further highlights the utility of digital resources for improving service delivery. As articulated by interview participants (Chapter 7), the internet is crucial resource for information, support, and finding care. Making services more easily discoverable online can help increase engagement. This may be especially so for SRH concerns that, unlike abortion, do not have an obvious, distinct service that youth will know to search for. Again, search engine optimisation and targeted advertising of services on social media platforms will increase visibility of services.

Significantly, however, MRY in this research expressed reservations regarding social media and the internet, indicating digital interventions should not replace in-person care (Chapter 5). Digital care should work *alongside* face-to-face care, with telehealth, hybrid and in-person services allowing MRY a broader range of options for healthcare engagement. In-person care could be improved by using digital forms prior to appointments where youth can submit sensitive concerns that they may feel less confident articulating face-to-face. Digital SRH chat-lines providing anonymous advice and information are a good addition to traditional in-person care. Using end-to-end encryption for such a service would further encourage MRY engagement.[42] Interventions such as SMS reminders and information about STI testing are also avenues for further investigation and potential investment.

The use of social media as a support-system by abortion-seekers indicates the need – and desire – for reliable, safe digital support resources (Chapter 7). Having a government supported platform where youth can interact safely and anonymously with other young people, and health professionals may be useful. A digital repository for SRH stories –

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[42] Encryption ensures privacy by preventing third parties from reading messages.

including, but not limited to, abortion stories – with a focus on experiences of diverse young people can offer crucial support, particularly for more stigmatised issues. Moreover, existing social media resources – such as the podcasts, vlogs, and online community groups used by abortion-seekers in Chapter 7 – should be promoted by service and education providers so other young people can benefit from this support. Online support platforms may be particularly beneficial for migrants and refugees separated from family and social networks.

Develop digital literacy

Promotion of digital resources should occur alongside investment into digital capacity-building, with interventions to help MRY develop digital health literacy. Poor digital health literacy can increase susceptibility to misinformation and subsequent negative health behaviours. Efforts must be taken to mitigate harm by ensuring youth have the skills and capabilities to find and assess accurate information and reputable sources (Freeman et al., 2018). The internet and social media should be framed, not as inherently suspect, but as a space that, if safely navigated, can help MRY realise their rights. If youth can be supported in learning to properly identify safe health information sources, the internet has invaluable potential for democratising SRH care and information access.

Ensure digital equity

For the above measures to have full effect, they must be implemented in concert with digital equity measures. Without efforts to ensure all people have equitable access to digital resources, digital interventions can increase inequalities (Sieck et al., 2021; Veinot et al., 2018). Those without reliable internet coverage, or lacking access to internet-enabled devices are barred from accessing electronic care portals and avenues for information-seeking (Veinot et al., 2018). Not only must we ensure equitable access to devices and resources, but any digital interventions must also be designed to be comprehensible and acceptable to individuals of varying literacy and education levels (Veinot et al., 2018). Digital equity measures reflect the central tenets of reproductive justice: SRHR attainment requires interventions that address fundamental structural, economic and sociopolitical inequalities that determine health.

Conclusion

This research offers a critical contribution to our understanding of agency and sexual and reproductive health and rights among migrant and refugee young people. For MRY, decision-making around SRHR is imbricated in myriad intertwining aspects of existence. The present research elucidates factors that inhibit and advance rights to SRH, and in so doing, illuminates how MRY can best be supported. Crucially, this research centres voices and perspectives of MRY, ensuring that the needs, desires and strengths of these young people are at the fore.

Despite social constructions of MRY as marginalised, vulnerable and prone to poor health behaviours, the youth in this research were adamant about making their own decisions to support their wellbeing and SRH. MRY negotiated complex intersecting injustices in contexts that thinned their agency, carving out space to "make" their "own choices" (Napier-Raman, Hossain, Mpofu, et al., 2023, p. 12). Rather than assuming the primacy of culture and family in MRY constructions and attainment of SRHR, researchers, policymakers and practitioners should note that these factors are only one part of youth's identities and life worlds. As such, we need to look beyond culture towards structural, social and political factors to reduce health inequalities.

As this research makes apparent, SRHR are elemental to the wellbeing of individuals and communities. Young people are our future – their wellbeing and rights are fundamental to enduring global prosperity. Migration and dispossession will continue to be central to the contemporary global landscape, and Australia must be prepared to embrace and support our diverse citizenry. Ensuring universal sexual and reproductive health rights is not merely a moral imperative nor an international political obligation, but an inexorable condition for future societal welfare. To meet this condition, we must look beyond easy explanations of culture and repression, extend our approach to incorporate more holistic constructions of SRHR and, most critically, we must listen when migrant and refugee youth tell us "what is important to me".

References

.id. (2023). Western Sydney (LGA) | Community Profile. profile.id.com.au. https://profile.id.com.au/cws

Abebe, T. (2019). Reconceptualising children's agency as continuum and interdependence. *Social Sciences*, *8*(3), 81. https://doi.org/10.3390/socsci8030081

Adewole, I., & Gavira, A. (2018). Sexual and reproductive health and rights for all: an urgent need to change the narrative. *The Lancet*, *391*(10140), 2585-2587. https://doi.org/10.1016/S0140-6736(18)30888-2

Afroz, T., Gele, A., & Thorsen, V. C. (2021). Culture clash of female Somali adolescents and sexual and reproductive health services in Oslo, Norway. *The European Journal of Contraception & Reproductive Health Care*, *26*(4), 296-302. https://doi.org/10.1080/13625187.2021.1895109

Afulani, P. A., Nakphong, M. K., & Sudhinaraset, M. (2023). Person-centred sexual and reproductive health: A call for standardized measurement. *Health Expectations*, *26*(4), 1384-1390. https://doi.org/10.1111/hex.13781

Agbemenu, K., Devido, J., Terry, M. A., Hannan, M., Kitutu, J., & Doswell, W. (2018). Exploring the Experience of African Immigrant Mothers Providing Reproductive Health Education to Their Daughters Aged 10 to 14 Years. *Journal of Transcultural Nursing*, *29*(2), 123-130. https://doi.org/10.1177/1043659616681848

Agbemenu, K., Hannan, M., Kitutu, J., Terry, M. A., & Doswell, W. (2018). "Sex Will Make Your Fingers Grow Thin and Then You Die": The Interplay of Culture, Myths, and Taboos on African Immigrant Mothers' Perceptions of Reproductive Health Education with Their Daughters Aged 10-14 Years. *Journal of Immigrant & Minority Health*, *20*(3), 697-704. https://doi.org/10.1007/s10903-017-0675-4

Albury, K., & Hendry, N. (2023). Information, influence, ritual, participation: Defining digital sexual health. *Journal of Sociology*, *59*(3), 628-645. https://doi.org/10.1177/14407833221136579

Anzaldúa, G. (2001). La Prieta. In C. E. Moraga & G. Anzaldúa (Eds.), *This bridge called my back : writings by radical women of color* (3rd ed.). Third Woman Press.

Appleton, N. S. (2022). Critical ethnographic respect: womens' narratives, material conditions, and emergency contraception in India. *Anthropology & Medicine*, *29*(2), 141-159. https://doi.org/10.1080/13648470.2020.1778427

Asad, T. (2000). Agency and pain: an exploration. *Culture and religion*, *1*(1), 29-60. https://doi.org/10.1080/01438300008567139

Asnong, C., Fellmeth, G., Plugge, E., Wai, N. S., Pimanpanarak, M., Paw, M. K., Charunwatthana, P., Nosten, F., & McGready, R. (2018). Adolescents' perceptions and experiences of pregnancy in refugee and migrant communities on the Thailand-Myanmar border: a qualitative study. *Reproductive Health*, *15*(1), 83. https://doi.org/10.1186/s12978-018-0522-7

Au, M., Anandakumar, A. D., Preston, R., Ray, R. A., & Davis, M. (2019). A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions. *BMC International Health and Human Rights*, *19*(1), 22. https://doi.org/10.1186/s12914-019-0206-6

Australian Bureau of Statistics. (2021a). *Permanent migrants in Australia*. ABS. Retrieved 28 March 2024 from https://www.abs.gov.au/statistics/people/people-and-communities/permanent-migrants-australia/latest-release

Australian Bureau of Statistics. (2021b). *Snapshot of Australia, 2021*. ABS. Retrieved July 20, 2023 from https://www.abs.gov.au/statistics/people/people-and-communities/snapshot-australia/latest-release

Australian Human Rights Commission. (2019). *Human rights based approaches*. https://humanrights.gov.au/our-work/rights-and-freedoms/human-rights-based-approaches

Australian Institute of Health and Welfare. (2021). *Australia's youth*. AIHW, Australian Government. https://www.aihw.gov.au/reports/children-youth/australias-youth

Australian Institute of Health and Welfare. (2024). *Health of young people*. AIHW, Australian Government. https://www.aihw.gov.au/reports/children-youth/health-of-young-people

Baird, B., & Millar, E. (2019). More than stigma: interrogating counter narratives of abortion. *Sexualities*, *22*(7-8), 1110-1126. https://doi.org/10.1177/1363460718782966

Bakhru, T. S. (2019). Thinking transnationally: reproductive justice in a globalized era. In T. S. Bakhru (Ed.), *Reproductive Justice and Sexual Rights* (pp. 3-12). Routledge. https://doi.org/10.4324/9781315099408

Baroudi, M., Goicolea, I., & Hurtig, A.-K. (2023). The good, the bad, and the why: How do Arabic-speaking migrant men perceive and experience information and services related to sexual and reproductive health in Sweden? *Journal of Migration and Health*, *7*, 100153. https://doi.org/10.1016/j.jmh.2023.100153

Baroudi, M., Nkulu-Kalengayi, F., Goicolea, I., Jonzon, R., San Sebastian, M., & Hurtig, A.-K. (2022). Access of Migrant Youths in Sweden to Sexual and Reproductive Healthcare: A Cross-sectional Survey. *International Journal of Health Policy and Management*, *11*(3), 287-298. https://doi.org/10.34172/ijhpm.2020.123

Bateson, D. J., Black, K. I., & Sawleshwarkar, S. (2019). The Guttmacher–Lancet Commission on sexual and reproductive health and rights: how does Australia measure up? *Medical journal of Australia*, *210*(6), 250-252.e251. https://doi.org/10.5694/mja2.50058

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of epidemiology and community health*, *60*(10), 854. https://doi.org/10.1136/jech.2004.028662

Baum, F., Townsend, B., Fisher, M., Browne-Yung, K., Freeman, T., Ziersch, A., Harris, P., & Friel, S. (2022). Creating political will for action on health equity: practical lessons for public health policy actors. *International Journal of Health Policy and Management*, *11*(7), 947. https://doi.org/10.34172/ijhpm.2020.233

Bay-Cheng, L. Y. (2019). Agency Is Everywhere, but Agency Is Not Enough: A Conceptual Analysis of Young Women's Sexual Agency. *The Journal of sex research*, *56*(4-5), 462-474. https://doi.org/10.1080/00224499.2019.1578330

Belgrave, L. L., & Seide, K. (2019). Grounded theory methodology: Principles and practices. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences*. Springer. https://doi.org/10.1007/978-981-10-5251-4_84

Bell, S. A. (2012). Young people and sexual agency in rural Uganda. *Culture, Health & Sexuality*, *14*(3), 283-296. https://doi.org/10.1080/13691058.2011.635808

Bhakuni, H. (2023). Reproductive justice: Non-interference or non-domination? *Developing World Bioethics*, *23*(2), 93-98. https://doi.org/10.1111/dewb.12317

Bilge, S. (2010). Beyond subordination vs. resistance: An intersectional approach to the agency of veiled Muslim women. *Journal of intercultural studies*, *31*(1), 9-28. https://doi.org/10.1080/07256860903477662

Bordonaro, L. I., & Payne, R. (2012). *Ambiguous agency: Critical perspectives on social interventions with children and youth in Africa* (Vol. 10, pp. 365-372): Taylor & Francis.

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2017). Drawing them in: professional perspectives on the complexities of engaging 'culturally diverse' young people with sexual and reproductive health promotion and care in Sydney, Australia. *Culture, Health & Sexuality*, *19*(4), 438-452. https://doi.org/10.1080/13691058.2016.1233354

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2018). Engaging migrant and refugee young people with sexual health care: does generation matter more than culture. *Sexuality Research and Social Policy*, *15*(4), 398-408. https://doi.org/10.1007/s13178-018-0320-6

Botfield, J. R., Newman, C. E., Bateson, D., Haire, B., Estoesta, J., Forster, C., & Schulz Moore, J. (2020). Young migrant and refugee people's views on unintended pregnancy and abortion in Sydney. *Health Sociology Review*, *29*(2), 195-210. https://doi.org/10.1080/14461242.2020.1764857

Botfield, J. R., Newman, C. E., Kang, M., & Zwi, A. B. (2018). Talking to migrant and refugee young people about sexual health in general practice. *Australian Journal of General Practice*, *47*(8), 564-569. https://doi.org/10.31128/ajgp-02-18-4508

Botfield, J. R., Zwi, A. B., Rutherford, A., & Newman, C. E. (2018). Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: 'I never got the talk about the birds and the bees'. *Sex Education*, *18*(6), 705-720. https://doi.org/10.1080/14681811.2018.1464905

Brandenberger, J., Tylleskär, T., Sontag, K., Peterhans, B., & Ritz, N. (2019). A systematic literature review of reported challenges in health care delivery to migrants and refugees in high-income countries-the 3C model. *BMC Public Health*, *19*, 1-11. https://doi.org/10.1186/s12889-019-7049-x

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

Braun, V., & Clarke, V. (2012). *Thematic analysis*. American Psychological Association. https://doi.org/10.1037/13620-004

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic Analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 843-860). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_103

Brennan-Wilson, A., Marques, M., Coates, A., Amin, A., Garry, J., Tomlinson, M., Nyembezi, A., George, A., & Lohan, M. (2024). Masculinities and sexual and reproductive health and rights: a global research priority setting exercise. *The Lancet Global Health*, *12*(5), e882-e890. https://doi.org/10.1016/S2214-109X(24)00053-6

Bronfenbrenner, U. (1994). *Ecological Models of Human Development* (2nd ed.). International Encyclopedia of Education.

Bronfenbrenner, U. (2005). *Making human beings human: Bioecological perspectives on human development*. Sage Publications.

Broussard, K. (2024). Strategic (Non)Disclosure: Activation and Avoidance of Social Ties among Women Seeking Abortion. *Journal of Health and Social Behavior*, *0*(0), 00221465231215783. https://doi.org/10.1177/00221465231215783

Burchard, A., Laurence, C., & Stocks, N. (2011). Female international students and sexual health - a qualitative study into knowledge, beliefs and attitudes. *Australian Family Physician*, *40*(10), 817-820. https://pubmed.ncbi.nlm.nih.gov/22003488/

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity*, *56*(3), 1391-1412. https://doi.org/10.1007/s11135-021-01182-y

Byron, P. (2017). Friendship, sexual intimacy and young people's negotiations of sexual health. *Culture, Health & Sexuality*, *19*(4), 486-500. https://doi.org/10.1080/13691058.2016.1239133

Carter, S. M., Shih, P., Williams, J., Degeling, C., & Mooney-Somers, J. (2021). Conducting qualitative research online: challenges and solutions. *The Patient-Patient-Centered Outcomes Research*, *14*(6), 711-718. https://doi.org/10.1007/s40271-021-00528-w

Cense, M. (2019). Rethinking sexual agency: Proposing a multicomponent model based on young people's life stories. *Sex Education*, *19*(3), 247-262. https://doi.org/10.1080/14681811.2018.1535968

Chandra-Mouli, V., Svanemyr, J., Amin, A., Fogstad, H., Say, L., Girard, F., & Temmerman, M. (2015). Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights? *Journal of Adolescent Health*, *56*(1), S1-S6. https://doi.org/10.1016/j.jadohealth.2014.09.015

Charmaz, K. (2014). *Constructing grounded theory* (2nd edition. ed.). SAGE.

Chavez, C. (2008). Conceptualizing from the inside: Advantages, complications, and demands on insider positionality. *The Qualitative Report*, *13*(3), 474-494. https://doi.org/10.46743/2160-3715/2008.1589

Chen, B., Vansteenkiste, M., Beyers, W., Soenens, B., & Van Petegem, S. (2013). Autonomy in family decision making for Chinese adolescents: Disentangling the dual meaning of autonomy. *Journal of Cross-Cultural Psychology*, *44*(7), 1184-1209. https://doi.org/10.1177/0022022113480038

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of women in culture and society*, *38*(4), 785-810. https://doi.org/10.1086/669608

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of women in culture and society*, *38*(4), 785-810. https://doi.org/10.1086/669608

Chrisler, J. C. (2012). Introduction: What is reproductive justice? *Reproductive Justice: A Global Concern*, 1-10. https://scholarship.law.wm.edu/wmjowl/vol20/iss1/2

Chung, D., Fisher, C., Zufferey, C., & Thiara, R. (2018). *Young Women from African Backgrounds and Sexual Violence*. Criminology Research Advisory Council. https://www.aic.gov.au/sites/default/files/2020-05/07-1213-FinalReport.pdf

Clarke, C. (2022). *CO3.5 Young people not in education or employment* (OECD Family Database). https://www.oecd.org/els/family/database.htm

Clarke, V., & Braun, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*.

Clarke, V., & Braun, V. (2017). Thematic analysis. *The journal of positive psychology*, *12*(3), 297-298. https://doi.org/10.1080/17439760.2016.1262613

Coffey, J., & Farrugia, D. (2014). Unpacking the black box: The problem of agency in the sociology of youth. *Journal of Youth Studies*, *17*(4), 461-474. https://doi.org/10.1080/13676261.2013.830707

Cohen, S. (2004). Social relationships and health. *American Psychologist*, *59*(8), 676. https://doi.org/10.1037/0003-066X.59.8.676

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual review of sociology*, *41*, 1-20. https://doi.org/10.1146/annurev-soc-073014-112142

Collins, P. H. (2019). *Intersectionality as Critical Social Theory*. Duke University Press. https://doi.org/10.2307/j.ctv11hpkdj

Collins, P. H., & Bilge, S. (2016). *Intersectionality*. Polity Press.

Commendador, K. A. (2010). Parental influences on adolescent decision making and contraceptive use. *Pediatric Nursing*, *36*(3). https://pubmed.ncbi.nlm.nih.gov/20687307/

Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Final report of the commission on social determinants of health*. Geneva, World Health Organization. https://iris.who.int/bitstream/handle/10665/69832/WHO_IER_CSDH_08.1_eng.pdf?sequence=1

Connell, R. (2012). Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Social Science & Medicine*, *74*(11), 1675-1683. https://doi.org/10.1016/j.socscimed.2011.06.006

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society*, *19*(6), 829-859. https://doi.org/10.1177/0891243205278639

Cottingham, J., Kismodi, E., Hilber, A. M., Lincetto, O., Stahlhofer, M., & Gruskin, S. (2010). Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. *Bulletin of the World Health Organization*, *88*, 551-555. https://doi.org/10.2471/BLT.09.063412

Couture, A. L., Zaidi, A. U., & Maticka-Tyndale, E. (2012). Reflexive accounts: An intersectional approach to exploring the fluidity of insider/outsider status and the researcher’s impact on culturally sensitive post-positivist qualitative research. *Qualitative Sociology Review*, *8*(1). https://doi.org/10.18778/1733-8077.8.1.05

Cram, F., & Mertens, D. M. (2016). Transformative and indigenous frameworks for multimethod and mixed methods research. In S. N. Hesse-Biber & R. B. Johnson (Eds.), *The Oxford handbook of multimethod and mixed methods research inquiry* (online ed.). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199933624.013.7

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford law review*, *43*(6), 1241-1299. https://doi.org/10.2307/1229039

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, *18*, 1-17. https://doi.org/10.1186/s12939-019-1082-3

Davidson, N., Hammarberg, K., Romero, L., & Fisher, J. (2022). Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: a systematic review. *BMC Public Health*, *22*(1), 403. https://doi.org/10.1186/s12889-022-12576-4

Dean, J., Mitchell, M., Stewart, D., & Debattista, J. (2017a). Intergenerational variation in sexual health attitudes and beliefs among Sudanese refugee communities in Australia. *Culture, Health and Sexuality*, *19*(1), 17-31. https://doi.org/10.1080/13691058.2016.1184316

Dean, J., Mitchell, M., Stewart, D., & Debattista, J. (2017b). Sexual health knowledge and behaviour of young Sudanese Queenslanders: a cross-sectional study. *Sexual Health (14485028)*, *14*(3), 254-260. https://doi.org/10.1071/SH16171

Department of Health. (2018). *Fourth National Sexually Transmissible Infections Strategy 2018-2022*. Australian Government Department of Health. https://www.health.gov.au/sites/default/files/documents/2022/06/fourth-national-sexually-transmissible-infections-strategy-2018-2022.pdf

Dhar, C. P., Kaflay, D., Dowshen, N., Miller, V. A., Ginsburg, K. R., Barg, F. K., & Yun, K. (2017). Attitudes and Beliefs Pertaining to Sexual and Reproductive Health Among Unmarried, Female Bhutanese Refugee Youth in Philadelphia. *Journal of Adolescent Health*, *61*(6), 791-794. https://doi.org/https://doi.org/10.1016/j.jadohealth.2017.06.011

Dune, T., & Mapedzahama, V. (2017). Culture Clash: Shona (Zimbabwean) Migrant Women's Experiences with Communicating about Sexual Health and Wellbeing across Cultures and Generations. *African Journal of Reproductive Health*, *21*(1), 18-29. https://doi.org/10.29063/ajrh2017/v21i1.1

Dune, T., Liamputtong, P., Hossain, S. Z., Mapedzahama, V., Pithavadian, R., Aibangbee, M., & Mpofu, E. (2022). Participatory Action Research: Sexual and Reproductive Health and Rights of Young Refugees and Migrants. In *Handbook of Social Inclusion: Research and Practices in Health and Social Sciences* (pp. 1-23). Springer. https://doi.org/10.1007/978-3-030-89594-5_78

Dune, T., Perz, J., Mengesha, Z., & Ayika, D. (2017). Culture Clash? Investigating constructions of sexual and reproductive health from the perspective of 1.5 generation migrants in Australia using Q methodology. *Reproductive Health*, *14*(1), 50. https://doi.org/10.1186/s12978-017-0310-9

Dwyer, S. C., & Buckle, J. L. (2009). The space between: on being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Enomoto, C., Noor, S., & Widner, B. (2017). Is social media to blame for the sharp rise in STDs? *Social Sciences*, *6*(3), 78. https://doi.org/10.3390/socsci6030078

Evans, K. (2002). Taking control of their lives? Agency in young adult transitions in England and the New Germany. *Journal of Youth Studies*, *5*(3), 245-269. https://doi.org/10.1080/1367626022000005965

Ezer, P., Kerr, L., Fisher, C. M., Heywood, W., & Lucke, J. (2019). Australian students' experiences of sexuality education at school. *Sex Education*, *19*(5), 597-613. https://doi.org/10.1080/14681811.2019.1566896

Family Planning NSW. (2018). *Sexual & Reproductive Health & Rights in the Sustainable Development Goals: A Shadow Report to Australia's Voluntary National Review*. FPNSW. https://www.fpnsw.org.au/sites/default/files/assets/SDGs_ShadowReport2018.pdf

Fathalla, M. F., Sinding, S. W., Rosenfield, A., & Fathalla, M. M. (2006). Sexual and reproductive health for all: a call for action. *The Lancet*, *368*(9552), 2095-2100. https://doi.org/10.1016/S0140-6736(06)69483-X

Fisher, C. M., Waling, A., Kerr, L., Bellamy, R., Ezer, P., Mikolakczak, G., Brown, G., Carman, M., & Lucke, J. (2019). *6th National Survey of Australian Secondary Students and Sexual Health 2018*. Bundoora: Australian Research Centre in Sex, Health & Society, La Trobe University Retrieved from https://www.latrobe.edu.au/__data/assets/pdf_file/0004/1031899/National-Survey-of-Secondary-Students-and-Sexual-Health-2018.pdf

Fleary, S. A., Joseph, P., & Pappagianopoulos, J. E. (2018). Adolescent health literacy and health behaviors: A systematic review. *Journal of adolescence*, *62*, 116-127. https://doi.org/10.1016/j.adolescence.2017.11.010

Ford, J. V., Corona Vargas, E., Finotelli Jr, I., Fortenberry, J. D., Kismödi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2019). Why pleasure matters: Its global relevance for sexual health, sexual rights and wellbeing. *International Journal of Sexual Health*, *31*(3), 217-230. https://doi.org/10.1080/19317611.2019.1654587

Foucault, M. (1995). *Discipline and punish: the birth of the prison* (A. Sheridan, Trans.; 2nd ed.). Vintage Books.

Freeman, J. L., Caldwell, P. H., Bennett, P. A., & Scott, K. M. (2018). How adolescents search for and appraise online health information: A systematic review. *The Journal of pediatrics*, *195*, 244-255. e241. https://doi.org/10.1016/j.jpeds.2017.11.031

Garry, A. (2011). Intersectionality, metaphors, and the multiplicity of gender. *Hypatia*, *26*(4), 826-850. https://doi.org/10.1111/j.1527-2001.2011.01194.x

Giddens, A. (1984). *The constitution of society: outline of the theory of structuration*. Polity Press.

Ginsburg, F. D., & Rapp, R. (1995). *Conceiving the New World Order: The Global Politics of Reproduction*. University of California Press. https://search.alexanderstreet.com/view/work/bibliographic_entity%7Cbibliographic_details%7C1759337

Golden, S. D., & Earp, J. A. L. (2012). Social ecological approaches to individuals and their contexts: twenty years of health education & behavior health promotion interventions. *Health Education & Behavior*, *39*(3), 364-372. https://doi.org/10.1177/1090198111418634

Graham, S., Martin, K., Gardner, K., Beadman, M., Doyle, M. F., Bolt, R., Murphy, D., Newman, C. E., Bell, S., & Treloar, C. (2023). Aboriginal young people's perspectives and experiences of accessing sexual health services and sex education in Australia: A qualitative study. *Global Public Health*, *18*(1), 2196561. https://doi.org/10.1080/17441692.2023.2196561

Gray, C., Crawford, G., Maycock, B., & Lobo, R. (2021). Socioecological factors influencing sexual health experiences and health outcomes of migrant Asian women living in 'western'high-income countries: a systematic review. *International journal of environmental research and public health*, *18*(5), 2469. https://doi.org/10.3390/ijerph18052469

Greene, J. C. (2007). *Mixed methods in social inquiry* (1st ed.). Jossey-Bass.

Greene, M. J. (2014). On the inside looking in: Methodological insights and challenges in conducting qualitative insider research. *The Qualitative Report*, *19*(29), 1-13. https://doi.org/10.46743/2160-3715/2014.1106

Griffin, S., Melo, M. d., Picardo, J. J., Sheehy, G., Madsen, E., Matine, J., & Dijkerman, S. (2023). The role of gender norms in shaping adolescent girls' and young women's experiences of pregnancy and abortion in Mozambique. *Adolescents*, *3*(2), 343-365. https://doi.org/10.3390/adolescents3020024

Hach, M. (2012). *Common Threads: The sexual and reproductive health experiences of immigrant and refugee women in Australia*. MCHW.

Hankivsky, O., & Grace, D. (2015). Understanding and emphasizing difference and intersectionality in multimethod and mixed methods research. In S. N. Hesse-Biber & B. Johnson (Eds.), *The Oxford Handbook of Multimethod and Mixed Methods Research Inquiry*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199933624.013.8

Haruna, H., Hu, X., Chu, S. K. W., Mellecker, R. R., Gabriel, G., & Ndekao, P. S. (2018). Improving sexual health education programs for adolescent students through game-based learning and gamification. *International journal of environmental research and public health*, *15*(9), 2027. https://doi.org/10.3390/ijerph15092027

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American journal of public health*, *103*(5), 813-821. https://doi.org/10.2105/AJPH.2012.301069

Hawkey, A. J., Ussher, J. M., & Perz, J. (2018). Regulation and Resistance: Negotiation of Premarital Sexuality in the Context of Migrant and Refugee Women. *The Journal of Sex Research*, *55*(9), 1116-1133. https://doi.org/10.1080/00224499.2017.1336745

Hegde, S., Hoban, E., & Nevill, A. (2012). Unsafe abortion as a birth control method: Maternal mortality risks among unmarried Cambodian migrant women on the Thai-Cambodia border [Article]. *Asia-Pacific Journal of Public Health*, *24*(6), 989-1001. https://doi.org/10.1177/1010539511409024

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., Darmstadt, G. L., Greene, M. E., & Hawkes, S. (2019). Gender inequality and restrictive gender norms: framing the challenges to health. *The Lancet*, *393*(10189), 2440-2454. https://doi.org/10.1016/S0140-6736(19)30652-X

Held, M. B. (2019). Decolonizing research paradigms in the context of settler colonialism: An unsettling, mutual, and collaborative effort. *International Journal of Qualitative Methods*, *18*, 1609406918821574. https://doi.org/10.1177/1609406918821574

Helmer, J., Senior, K., Davison, B., & Vodic, A. (2015). Improving sexual health for young people: Making sexuality education a priority. *Sex Education*, *15*(2), 158-171. https://doi.org/10.1080/14681811.2014.989201

Hesse-Biber, S. N. (2016). Introduction: Navigating a turbulent research landscape: Working the boundaries, tensions, diversity, and contradictions of multimethod and mixed methods inquiry. In S. N. Hesse-Biber & R. B. Johnson (Eds.), *The Oxford handbook of multimethod and mixed methods research inquiry* (online ed.). Oxford University Press https://doi.org/10.1093/oxfordhb/9780199933624.013.1

Hesse-Biber, S. N., & Johnson, R. B. (2016). *The Oxford handbook of multimethod and mixed methods research inquiry*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199933624.001.0001

Hicks, M. S., McRee, A.-L., & Eisenberg, M. E. (2013). Teens talking with their partners about sex: The role of parent communication. *American Journal of Sexuality Education*, *8*(1-2), 1-17. https://doi.org/10.1080/15546128.2013.790219

Holmes, S. M. (2012). The clinical gaze in the practice of migrant health: Mexican migrants in the United States. *Social Science & Medicine*, *74*(6), 873-881. https://doi.org/10.1016/j.socscimed.2011.06.067

Homma, Y., Saewyc, E. M., Wong, S. T., & Zumbo, B. D. (2013). Sexual Health and Risk Behaviour among East Asian Adolescents in British Columbia. *The Canadian Journal of Human Sexuality*, *22*(1), 13-24. https://doi.org/10.3138/cjhs.927

Hutchinson, M. K., Jemmott III, J. B., Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother–daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: a prospective study. *Journal of Adolescent Health*, *33*(2), 98-107. https://doi.org/10.1016/S1054-139X(03)00183-6

IBM Corp. (2020). *IBM SPSS Statistics for Windows*. In (Version 27.0) IBM Corp.

Iqbal, M. P., Walpola, R., Harris-Roxas, B., Li, J., Mears, S., Hall, J., & Harrison, R. (2022). Improving primary health care quality for refugees and asylum seekers: A systematic review of interventional approaches. *Health Expect*, *25*(5), 2065-2094. https://doi.org/10.1111/hex.13365

Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2012). *Methods for Community-Based Participatory Research for Health* (2nd ed.). John Wiley & Sons, Inc. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=7103486

Kaczkowski, W., & Swartout, K. M. (2020). Exploring gender differences in sexual and reproductive health literacy among young people from refugee backgrounds. *Culture, health & sexuality*, *22*(4), 369-384. https://doi.org/10.1080/13691058.2019.1601772

Kalmuss, D., & Austrian, K. (2010). Real Men Do…Real Men Don't: Young Latino and African American Men's Discourses Regarding Sexual Health Care Utilization. *American Journal of Men's Health*, *4*(3), 218-230. https://doi.org/10.1177/1557988309331797

Kang, M., Robards, F., Luscombe, G., Sanci, L., & Usherwood, T. (2020). The relationship between having a regular general practitioner (GP) and the experience of healthcare barriers: a cross-sectional study among young people in NSW, Australia, with oversampling from marginalised groups. *BMC Family Practice*, *21*(1), 220. https://doi.org/10.1186/s12875-020-01294-8

Kedzior, S. G., Calabretto, H., Drummond, H., Oswald, T. K., Lassi, Z. S., Moore, V. M., & Rumbold, A. (2022). Student perspectives on a state-wide relationships and sexual health programme in South Australian schools, 2006–2017. *Sex Education*, *22*(4), 465-480. https://doi.org/10.1080/14681811.2021.1954897

Keygnaert, I., Vettenburg, N., Roelens, K., & Temmerman, M. (2014). Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *BMC Public Health*, *14*, 1-13. https://doi.org/10.1186/1471-2458-14-416

King, J., McManus, H., Kwon, A., Gray, R., & McGregor, S. (2023). *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2023*. Kirby Institute. https://doi.org/10.26190/f5ph-f972

Kingori, C., Ice, G. H., Hassan, Q., Elmi, A., & Perko, E. (2018). 'If I went to my mom with that information, I'm dead': sexual health knowledge barriers among immigrant and refugee Somali young adults in Ohio. *Ethnicity & Health*, *23*(3), 339-352. https://doi.org/10.1080/13557858.2016.1263285

Kirkendall, A., & Dutt, A. (2023). Refugee women's pregnancy and childbirth experiences in the US: Examining context through a reproductive justice framework. *Feminism & Psychology*, *33*(4), 529-549. https://doi.org/10.1177/09593535221149166

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149-164. https://doi.org/10.1177/1363461512444673

Kismödi, E., Corona, E., Maticka-Tyndale, E., Rubio-Aurioles, E., & Coleman, E. (2017). Sexual rights as human rights: A guide for the WAS declaration of sexual rights. *International Journal of Sexual Health*, *29*(sup1), 1-92. https://doi.org/10.1080/19317611.2017.1353865

Kleinman, A., & Benson, P. (2019). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. In J. Oberlander, M. Buchbinder, L. R. Churchill, S. E. Estroff, N. M. P. King, B. F. Saunders, R. P. Strauss, & R. L. Walker (Eds.), *The*

Social Medicine Reader, Volume II, Third Edition: Differences and Inequalities. Duke University Press. https://doi.org/10.1215/9781478004363

Klocker, N. (2007). An example of 'thin' agency: Child domestic workers in Tanzania. In R. Panelli, S. Punch, & E. Robson (Eds.), *Global perspectives on rural childhood and youth* (pp. 100-111). Routledge.

Kristeva, J., Moro, M. R., Ødemark, J., & Engebretsen, E. (2018). Cultural crossings of care: An appeal to the medical humanities. *Medical Humanities*, *44*(1), 55-58. https://doi.org/10.1136/medhum-2017-011263

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, *11*(6), 625-639. https://doi.org/10.1080/13691050902842741

Kusow, A. M. (2003). Beyond indigenous authenticity: Reflections on the insider/outsider debate in immigration research. *Symbolic Interaction*, *26*(4), 591-599. https://doi.org/10.1525/si.2003.26.4.591

Leech, N. L., & Onwuegbuzie, A. J. (2009). A typology of mixed methods research designs. *Quality & Quantity*, *43*, 265-275. https://doi.org/10.1007/s11135-007-9105-3

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*, 1-9. https://doi.org/10.1186/1475-9276-12-18

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Lirios, A., Mullens, A. B., Daken, K., Moran, C., Gu, Z., Assefa, Y., & Dean, J. A. (2023). Sexual and reproductive health literacy of culturally and linguistically diverse young people in Australia: a systematic review. *Culture, Health & Sexuality*, *26*(6), 790-807. https://doi.org/10.1080/13691058.2023.2256376

Litras, A., Latreille, S., & Temple-Smith, M. (2015). Dr Google, porn and friend-of-a-friend: where are young men really getting their sexual health information? *Sexual Health*, *12*(6), 488-494. https://doi.org/10.1071/SH15055

Lorde, A. (1984). *Sister Outsider: Essays and Speeches*. Crossing Press.

Louie-Poon, S., Rehmani, M., Kennedy, M., Scott, S., Salami, B., Vallianatos, H., & Meherali, S. (2021). Understanding sexual and reproductive health needs of immigrant adolescents in Canada: A scoping review. *Canadian Journal of Human Sexuality*, *30*(3), 374-386. https://doi.org/10.3138/cjhs.2021-0006

Mackenzie, C., & Stoljar, N. (2000). *Relational autonomy: feminist perspectives on automony, agency, and the social self*. Oxford University Press. (2000)

Mackenzie, C., & Stoljar, N. (2000). *Relational autonomy: feminist perspectives on automony, agency, and the social self*. Oxford University Press. (2000)

Maheen, H., Chalmers, K., Khaw, S., & McMichael, C. (2021). Sexual and reproductive health service utilisation of adolescents and young people from migrant and refugee backgrounds in high-income settings: a qualitative evidence synthesis (QES). *Sexual Health*, *18*(4), 283-293. https://doi.org/10.1071/SH20112

Mahmood, S. (2011). *Politics of piety: the islamic revival and the feminist subject* (Revised ed.). Princeton University Press. https://doi.org/10.1515/9781400839919

Mahmood, S. (2016). Feminist theory, embodiment, and the docile agent: Some reflections on the Egyptian Islamic revival. In *Readings in the Theory of Religion* (pp. 206-240). Routledge.

Manderson, L., Kelaher, M., Woelz-Stirling, N., Kaplan, J., & Greene, K. (2002). Sex, contraception and contradiction among young Filipinas in Australia. *Culture, Health & Sexuality*, *4*(4), 381-391. https://doi.org/10.1080/13691050210000041034

Mane, P., & Aggleton, P. (2019). Fostering change through the pursuit of practical justice in sexual and reproductive health and rights. In *Practical Justice: Principles, Practice and Social Change* (pp. 228-240). Routledge.

Mansouri, F., Ben-Moshe, D., & Johns, A. (2015). *Intergenerational relations in newly-arrived communities in Victoria: a pilot study report*. Ethnic Communities' Council of Victoria. https://apo.org.au/node/58375

Marcus, R., Samuels, F., Jalal, S., & Belachew, H. (2021). *Gender-Transformative Programming*. UNICEF Office of Research - Innocenti. https://www.unicef.org/lac/en/media/43146/file

Martin, K., Bryant, J., Beetson, K., Wilms, J., Briggs, T., Treloar, C., & Newman, C. (2023). Normalising sex and resisting shame: young Aboriginal women's views on sex and relationships in an urban setting in Australia. *Journal of Youth Studies*, 1-17. https://doi.org/10.1080/13676261.2023.2225422

Matich, P., Harvey, C., Page, P., Johnston, K., Jukka, C., Hollins, J., & Larkins, S. (2015). Young people's perceptions of sexual and reproductive health in regional and rural Queensland: capturing the views of adolescents through reference groups and a user-friendly electronic survey. *Sexual Health*, *12*(3), 231-239. https://doi.org/10.1071/SH13131

Mazur, A., Brindis, C. D., & Decker, M. J. (2018). Assessing youth-friendly sexual and reproductive health services: a systematic review. *BMC health services research*, *18*, 1-12. https://doi.org/10.1186/s12913-018-2982-4

McAuliffe, M., & Oucho, L. A. (2024). *World migration report 2024*. International Organisation for Migration (IOM). https://publications.iom.int/books/world-migration-report-2024

McKee, A., Watson, A.-F., & Dore, J. (2014). ‘It's all scientific to me’: focus group insights into why young people do not apply safe-sex knowledge. *Sex Education*, *14*(6), 652-665. https://doi.org/10.1080/14681811.2014.917622

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health education quarterly*, *15*(4), 351-377. https://doi.org/10.1177/109019818801500401

McMichael, C. (2013). Unplanned but not unwanted? Teen pregnancy and parenthood among young people with refugee backgrounds. *Journal of Youth Studies*, *16*(5), 663-678. https://doi.org/10.1080/13676261.2012.744813

McMichael, C., & Gifford, S. (2009). "It is Good to Know Now...Before it's Too Late": Promoting sexual health literacy amongst resettled young people with refugee backgrounds. *Sexuality and Culture*, *13*(4), 218-236. https://doi.org/10.1007/s12119-009-9055-0

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

McNee, R. (2024). Tackling contraceptive misinformation on social media. *BMJ*, *384*. https://doi.org/10.1136/bmj.q472

Meldrum, R. M., Liamputtong, P., & Wollersheim, D. (2015). Sexual Health Knowledge and Needs: Young Muslim Women in Melbourne, Australia. *International Journal of Health Services*, *46*(1), 124-140. https://doi.org/10.1177/0020731415615313

Meldrum, R., Liamputtong, P., & Wollersheim, D. (2014). Caught between two worlds: Sexuality and young Muslim women in Melbourne, Australia. *Sexuality & culture*, *18*, 166-179. https://doi.org/10.1007/s12119-013-9182-5

Mengesha, Z., Hawkey, A. J., Baroudi, M., Ussher, J. M., & Perz, J. (2023). Men of refugee and migrant backgrounds in Australia: a scoping review of sexual and reproductive health research. *Sexual Health*, *20*(1), 20-34. https://doi.org/10.1071/SH22073

Mengesha, Z., Perz, J., Dune, T., & Ussher, J. (2017). Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. *PLOS ONE*, *12*(7), e0181421-e0181421. https://doi.org/10.1371/journal.pone.0181421

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research*, *1*(3), 212-225. https://doi.org/10.1177/155868980730281

Mertens, D. M. (2012). Transformative mixed methods: Addressing inequities. *American Behavioral Scientist*, *56*(6), 802-813. https://doi.org/10.1177/0002764211433797

Mertens, D. M., Bledsoe, K. L., Sullivan, M., & Wilson, A. (2010). Utilization of mixed methods for transformative purposes. In A. Tashakkori & C. Teddlie (Eds.), *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (2nd ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781506335193

Meschke, L. L., & Dettmer, K. (2012). 'Don't cross a man's feet': Hmong parent-daughter communication about sexual health. *Sex Education*, *12*(1), 109-123. https://doi.org/10.1080/14681811.2011.609038

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J., & Monteiro, M. (2017). "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. *International Journal of Behavioral Medicine*, *24*(6), 836-845. https://doi.org/10.1007/s12529-017-9662-3

Metzl, J. M., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126-133. https://doi.org/10.1016/j.socscimed.2013.06.032

Miedema, E. (2019). 'Culturespeak'is everywhere: an analysis of culturalist narratives in approaches to sexuality education in Mozambique. *Comparative Education*, *55*(2), 220-242. https://doi.org/10.1080/03050068.2018.1541658

Mitchell, K. R., Lewis, R., O'Sullivan, L. F., & Fortenberry, J. D. (2021). What is sexual wellbeing and why does it matter for public health? *The Lancet Public Health*, *6*(8), e608-e613. https://doi.org/10.1016/S2468-2667(21)00099-2

Morison, T. (2021). Reproductive justice: Revitalising critical reproductive health research. In K. Chamberlain & A. Lyons (Eds.), *Routledge international handbook of critical issues in health and illness* (pp. 169-182). Routledge.

Morison, T., & Le Grice, J. S. (2023). Reproductive Justice: Illuminating the Intersectional Politics of Sexual and Reproductive Issues. In E. L. Zurbriggen & R. Capdevila (Eds.), *The Palgrave Handbook of Power, Gender, and Psychology* (pp. 419-435). Palgrave Macmillan Cham. https://doi.org/10.1007/978-3-031-41531-9_23

Morris, J. L., & Rushwan, H. (2015). Adolescent sexual and reproductive health: The global challenges. *International Journal of Gynecology & Obstetrics*, *131*, S40-S42. https://doi.org/10.1016/j.ijgo.2015.02.006

Morrison-Beedy, D., Wegener, R., Ewart, A., Ross, S., & Spitz, A. (2023). Reflections from Refugee Adolescent Girls on Participation in a US-Based Teen Sexual Health Promotion Project. *Journal of Immigrant & Minority Health*, *25*(3), 680-684. https://doi.org/10.1007/s10903-022-01415-8

Mpofu, E., Hossain, S. Z., Dune, T., Baghbanian, A., Aibangbee, M., Pithavadian, R., Liamputtong, P., & Mapedzahama, V. (2021). Contraception decision making by Culturally and Linguistically Diverse (CALD) Australian youth: an exploratory study. *Australian Psychologist*, *56*(6), 511-522. https://doi.org/10.1080/00050067.2021.1978814

Mulholland, M., Robinson, K., Fisher, C., & Pallotta-Chiarolli, M. (2021). Parent-child communication, sexuality and intergenerational conflict in multicultural and multifaith communities. *Sex Education-Sexuality Society and Learning*, *21*(1), 44-58. https://doi.org/10.1080/14681811.2020.1732336

Multicultural Youth Advocacy Network (MYAN). (2023). *Data snapshot on youth settlement trends 2020-21*. https://myan.org.au/wp-content/uploads/2023/11/Data-Snapshot-on-Youth-Settlement-Trends-2021-2022.pdf

Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., Guesnet, F., Horne, R., Jacyna, S., & Jadhav, S. (2014). Culture and health. *The Lancet*, *384*(9954), 1607-1639. https://doi.org/10.1016/S0140-6736(14)61603-2

Napier-Raman, S., Hossain, S. Z., Lee, M.-J., Mpofu, E., Liamputtong, P., & Dune, T. (2023). Migrant and Refugee Youth Perspectives On Sexual and Reproductive Health and Rights in Australia: A Systematic Review. *Sexual Health*, *20*(1), 35-48. https://doi.org/10.1071/sh22081

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Dune, T. M., Liamputtong, P., & Mapedzahama, V. (2022). Migrant and refugee youth perspectives on sexual and reproductive health and rights in Australia: A systematic review protocol. *Pacific Health Dialog*, *21*(9). https://doi.org/https://doi.org/10.26635/phd.2022.135

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2024). Abortion Experiences and Perspectives Amongst Migrants and Refugees: A Systematic Review. *International Journal of Environmental Research and Public Health*, *21*(3), 312. https://www.mdpi.com/1660-4601/21/3/312

Napier-Raman, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., & Dune, T. (2023). Sexual and reproductive health and rights decision-making among Australian migrant and refugee youth: a group concept mapping study. *Culture, Health & Sexuality*, 1-18. https://doi.org/10.1080/13691058.2023.2275303

Napier-Raman, S., Rosas, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., Dune, T., & Mapedzahama, V. (2023). Concept mapping method. In P. Liamputtong (Ed.), *Handbook of social sciences and global public health* (pp. 899-923). Springer, Cham. https://doi.org/10.1007/978-3-030-96778-9_63-1

Napier-Raman, S., Rosas, S., Hossain, S. Z., Mpofu, E., Lee, M.-J., Liamputtong, P., Dune, T., & Mapedzahama, V. (2023). Concept Mapping Method. In P. Liamputtong (Ed.), *Handbook of social sciences and global public health* (pp. 899-923). Springer, Cham. https://doi.org/10.1007/978-3-030-96778-9_63-1

Ngum Chi Watts, M. C., Liamputtong, P., & Carolan, M. (2014). Contraception knowledge and attitudes: Truths and myths among African Australian teenage mothers in Greater Melbourne, Australia. *Journal of Clinical Nursing*, *23*(15-16), 2131-2141. https://doi.org/10.1111/jocn.12335

Ngum Chi Watts, M. C., Liamputtong, P., & McMichael, C. (2015). Early motherhood: a qualitative study exploring the experiences of African Australian teenage mothers in greater Melbourne, Australia. *BMC Public Health*, *15*(1), 873. https://doi.org/10.1186/s12889-015-2215-2

Ngum Chi Watts, M. C., McMichael, C., & Liamputtong, P. (2015). Factors Influencing Contraception Awareness and Use: The Experiences of Young African Australian mothers. *Journal of Refugee Studies*, *28*(3), 368-387. https://doi.org/10.1093/jrs/feu040

Niglas, K. (2010). The multidimensional model of research methodology: an integrated set of continua. In A. Tashakkori & C. Teddlie (Eds.), *SAGE Handbook of mixed methods in social & behavioral research* (2 ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781506335193

Njeze, C., Bird-Naytowhow, K., Pearl, T., & Hatala, A. R. (2020). Intersectionality of resilience: a Strengths-Based case study approach with Indigenous youth in an urban Canadian context. *Qualitative Health Research*, *30*(13), 2001-2018. https://doi.org/10.1177/1049732320940702

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847

NSW Health (2024) *Hormonal contraception resupply service – information for the community.* https://www.health.nsw.gov.au/pharmaceutical/Pages/hormonal-contraception-community.aspx

Ortner, S. B. (2006). Power and Projects: Reflections on Agency. In *Anthropology and Social Theory: Culture, Power, and the Acting Subject* (pp. 129-154). Duke University Press. https://doi.org/10.1515/9780822388456-008

Pagoto, S. L., Palmer, L., & Horwitz-Willis, N. (2023). The Next Infodemic: Abortion Misinformation. *J Med Internet Res*, *25*, e42582. https://doi.org/10.2196/42582

Parker, R. M., Ratzan, S. C., & Lurie, N. (2003). Health Literacy: A Policy Challenge For Advancing High-Quality Health Care. *Health Affairs*, *22*(4), 147-153. https://doi.org/10.1377/hlthaff.22.4.147

Parkinson, M., Howe, J., & Azarias, J. (2023). *Review of the migration system: final report, March 2023*. Department of Home Affairs (Australia). https://www.homeaffairs.gov.au/reports-and-pubs/files/review-migration-system-final-report.pdf

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E. M., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K.,…Viner, R. M. (2016). Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet (British edition)*, *387*(10036), 2423-2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Pavlish, C. L., Noor, S., & Brandt, J. (2010). Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Social Science & Medicine*, *71*(2), 353-361. https://doi.org/10.1016/j.socscimed.2010.04.010

Payne, R. (2012). 'Extraordinary survivors' or 'ordinary lives'? Embracing 'everyday agency'in social interventions with child-headed households in Zambia. *Children's Geographies*, *10*(4), 399-411. https://doi.org/10.1080/14733285.2012.726071

Peerson, A., & Saunders, M. (2011). Men's Health Literacy in Australia: In Search of a Gender Lens [Article]. *International Journal of Men's Health*, *10*(2), 111-135. https://doi.org/10.3149/jmh.1002.111

Pettersson, J., & Baroudi, M. (2024). Exploring barriers and strategies for improving sexual and reproductive health access for young men in Sweden: Insights from healthcare providers in youth clinics. *Sexual & Reproductive Healthcare*, *39*, 100942. https://doi.org/10.1016/j.srhc.2023.100942

Phillips, T. R., Chow, E. P. F., & Coombe, J. (2023). Emerging sexual and reproductive health in Australia and New Zealand: gaps, challenges and solutions. *Sexual Health*, -. https://doi.org/https://doi.org/10.1071/SH23156

Pithavadian, R., Liamputtong, P., Mpofu, E., Hossain, S. Z., Aibangbee, M., & Dune, T. (2023). Sexual and reproductive health and young people: a social science approach. In P. Liamputtong (Ed.), *Handbook of Social Sciences and Global Public Health* (pp. 1627-1647). Springer, Cham. https://doi.org/10.1007/978-3-031-25110-8_108

Digital NSW (2024). *Policy | Digital NSW*. NSW Government. https://www.digital.nsw.gov.au/policy

Poljski, C. (2011). *On your own: Sexual and reproductive health of female international students in Australia*. MCWH: Melbourne.

Poljski, C., Quiazon, R., & Tran, C. (2014). Ensuring Rights: Improving Access to Sexual and Reproductive Health Services for Female International Students in Australia. *Journal of international students*, *4*(2), 150-163. https://doi.org/10.32674/jis.v4i2.475

Powell, E. (2008). Young people's use of friends and family for sex and relationships information and advice. *Sex Education*, *8*(3), 289-302. https://doi.org/10.1080/14681810802218171

Power, J., Kauer, S., Fisher, C., Bellamy, R., & Bourne, A. (2022). *The 7th National Survey of Australian Secondary Students and Sexual Health 2021* (ARCSHS Monograph

Series, No. 133). The Australian Research Centre in Sex, Health and Society, La Trobe University. https://doi.org/10.26181/21761522.v2

Pozzar, R., Hammer, M. J., Underhill-Blazey, M., Wright, A. A., Tulsky, J. A., Hong, F., Gundersen, D. A., & Berry, D. L. (2020). Threats of bots and other bad actors to data quality following research participant recruitment through social media: Cross-sectional questionnaire. *Journal of Medical Internet Research*, *22*(10), e23021. https://doi.org/10.2196/23021

Price, K. (2020). What is reproductive justice? How women of color activists are redefining the pro-choice paradigm. *Meridians*, *19*(S1), 340-362. https://doi.org/10.2979/meridians.2010.10.2.42

QSR International Pty Ltd. (2020). *NVivo* (Version 12) Lumivero. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Qu, L. (2019). *Young People Living with their Parents*. Australian Institute of Family Studies. Retrieved July 16 2023 from https://aifs.gov.au/research/facts-and-figures/young-people-living-their-parents

Rao, T. S. S., Gopalakrishnan, R., Kuruvilla, A., & Jacob, K. S. (2012). Social determinants of sexual health. *Indian journal of psychiatry*, *54*(2), 105-107. https://doi.org/10.4103/0019-5545.99527

Rawson, H. A., & Liamputtong, P. (2009). Influence of traditional Vietnamese culture on the utilisation of mainstream health services for sexual health issues by second-generation Vietnamese Australian young women. *Sexual Health*, *6*(1), 75-81. https://doi.org/10.1071/sh08040

Rawson, H. A., & Liamputtong, P. (2010). Culture and sex education: the acquisition of sexual knowledge for a group of Vietnamese Australian young women. *Ethnicity & Health*, *15*(4), 343-364. https://doi.org/10.1080/13557851003728264

Refugee Council of Australia. (2019). *Who is a refugee under law?* https://www.refugeecouncil.org.au/who-is-a-refugee/

Renzaho, A. M. N., Dhingra, N., & Georgeou, N. (2017). Youth as contested sites of culture: The intergenerational acculturation gap amongst new migrant communities—Parental and young adult perspectives. *PLOS ONE*, *12*(2), e0170700. https://doi.org/10.1371/journal.pone.0170700

Richards, M. J., Peters, M., Sheeder, J., & Kaul, P. (2016). Contraception and Adolescent Males: An Opportunity for Providers. *Journal of Adolescent Health*, *58*(3), 366-368. https://doi.org/10.1016/j.jadohealth.2015.10.011

Richters, J., & Khoei, E. M. (2008). Concepts of sexuality and health among Iranian women in Australia. *Australian Family Physician*, *37*(3).

Ringrose, J. (2007). Troubling agency and ‘choice’: A psychosocial analysis of students' negotiations of Black Feminist ‘intersectionality’ discourses in Women's Studies. *Women's Studies International Forum*, *30*(3), 264-278. https://doi.org/10.1016/j.wsif.2007.04.001

Ritter, T., Dore, A., & McGeechan, K. (2015). Contraceptive knowledge and attitudes among 14–24-year-olds in New South Wales, Australia. *Australian and New Zealand journal of public health*, *39*(3), 267-269. https://doi.org/10.1111/1753-6405.12367

Rocca, E., & Anjum, R. L. (2020). Complexity, reductionism and the biomedical model. In *Rethinking causality, complexity and evidence for the unique patient: A CauseHealth resource for healthcare professionals and the clinical encounter* (pp. 75-94). Springer, Cham. https://doi.org/10.1007/978-3-030-41239-5_5

Rogers, C., & Earnest, J. (2014). A cross-generational study of contraception and reproductive health among Sudanese and Eritrean women in Brisbane, Australia. *Health Care for Women International*, *35*(3), 334-356. https://doi.org/http://dx.doi.org/10.1080/07399332.2013.857322

Rogers, H. J., Hogan, L., Coates, D., Homer, C. S., & Henry, A. (2020). Responding to the health needs of women from migrant and refugee backgrounds—Models of maternity and postpartum care in high-income countries: a systematic scoping review. *Health & social care in the community*, *28*(5), 1343-1365. https://doi.org/10.1111/hsc.12950

Ross, L. J. (2017). Reproductive justice as intersectional feminist activism. *Souls*, *19*(3), 286-314. https://doi.org/10.1080/10999949.2017.1389634

Ross, L., & Solinger, R. (2017). *Reproductive Justice: An Introduction* (1 ed.). University of California Press. https://www.jstor.org/stable/10.1525/j.ctv1wxsth

Saharso, S., van Hoogstraaten, J., Claassen, R., & Jokic, M. (2023). No sex before marriage? Migrant youth navigating restrictive norms regarding premarital relationships. *Ethnic and Racial Studies*, *46*(14), 3145-3165. https://doi.org/10.1080/01419870.2023.2168130

Sallis, J. F., & Owen, N. (2015). Ecological Models of Health Behaviour. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health Behavior and Health Education: Theory, Research, and Practice* (5 ed., pp. 43-64). Jossey-Bass/Wiley.

SBS News. (2024, 28 March). *WA becomes the final state to decriminalise abortion, as premier praises change*. sbs.com.au. https://www.sbs.com.au/news/article/wa-becomes-the-final-state-to-decriminalise-abortion-as-premier-praise-change/66e4g21aq

Schillinger, D., Chittamuru, D., & Ramírez, A. S. (2020). From “infodemics” to health promotion: a novel framework for the role of social media in public health. *American Journal of Public Health*, *110*(9), 1393-1396. https://doi.org/10.2105/AJPH.2020.305746

Schneider, A., & Ingram, H. (1993). Social construction of target populations: implications for politics and policy. *American Political Science Review*, *87*(2), 334-347. https://doi.org/10.2307/2939044

Selberg, R., Kolankiewicz, M., & Mulinari, D. (2023). Introduction: Reproductive Justice and Transnational Feminism. In R. Selberg, M. Kolankiewicz, & D. Mulinari (Eds.), *Struggles for Reproductive Justice in the Era of Anti-Genderism and Religious Fundamentalism* (pp. 1-9). Springer International Publishing. https://doi.org/10.1007/978-3-031-31260-1_1

Shoveller, J. A., & Johnson, J. L. (2006). Risky groups, risky behaviour, and risky persons: Dominating discourses on youth sexual health. *Critical Public Health*, *16*(1), 47-60. https://doi.org/10.1080/09581590600680621

Sieck, C. J., Sheon, A., Ancker, J. S., Castek, J., Callahan, B., & Siefer, A. (2021). Digital inclusion as a social determinant of health. *NPJ Digital Medicine*, *4*(1), 52. https://doi.org/10.1038/s41746-021-00413-8

Smith, R. (2018). Human rights based approaches to research. In L. McConnell & R. Smith (Eds.), *Research methods in human rights* (pp. 6-23). Routledge.

Souleymanov, R., Akinyele-Akanbi, B., Njeze, C., Ukoli, P., Migliardi, P., Kim, J., Payne, M., Ringaert, L., Restall, G., & Larcombe, L. (2023). Migration and health study: a socio-ecological analysis of sexual health among migrants in Manitoba, Canada. *BMC Public Health*, *23*(1), 2438. https://doi.org/10.1186/s12889-023-17379-9

Spencer, G., & Doull, M. (2015). Examining concepts of power and agency in research with young people. *Journal of Youth Studies*, *18*(7), 900-913. https://doi.org/10.1080/13676261.2014.1001827

Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., Coll-Seck, A. M., Grover, A., Laski, L., Roa, M., Sathar, Z. A., Say, L., Serour, G. I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers, C., & Ashford, L. S. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-*Lancet* Commission. *The Lancet*, *391*(10140), 2642-2692. https://doi.org/10.1016/S0140-6736(18)30293-9

Sully, E. A., Biddlecom, A., Darroch, J. E., Riley, T., Ashford, L. S., Lince-Deroche, N., Firestein, L., & Murro, R. (2020). *Adding it up: investing in sexual and reproductive health 2019*. Guttmacher Institute. https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019

Sweetman, D., Badiee, M., & Creswell, J. W. (2010). Use of the transformative framework in mixed methods studies. *Qualitative Inquiry*, *16*(6), 441-454. https://doi.org/10.1177/1077800410364610

The Royal Australasian College of Physicians. (2015). *Position Statement: Sexual and Reproductive Health Care for Young People*. https://www.racp.edu.au/docs/default-source/policy-and-adv/achshm/sexual-and-reproductive-health-care-for-young-people-position-statement.pdf

Thiel de Bocanegra, H., Goliaei, Z., Khan, N., Banna, S., Behnam, R., & Mody, S. K. (2023). Refugee Women's receptiveness for virtual engagement on reproductive health during the COVID-19 pandemic. *International Journal of Behavioral Medicine*, *30*(3), 366-375. https://doi.org/10.1007/s12529-022-10097-3

Topping, M., Douglas, J., & Winkler, D. (2021). General considerations for conducting online qualitative research and practice implications for interviewing people with acquired brain injury. *International Journal of Qualitative Methods*, *20*, 16094069211019615. https://doi.org/10.1177/16094069211019615

Tsai, J., Becker, D., Sussman, S., Bluthenthal, R., Unger, J., & Schwartz, S. J. (2016). Acculturation and risky sexual behavior among adolescents and emerging adults from immigrant families. In S. J. Schwartz & J. Unger (Eds.), *The Oxford Handbook of Acculturation and Health* (pp. 301-326). https://doi.org/10.1093/oxfordhb/9780190215217.013.21

Tudge, J. R., Mokrova, I., Hatfield, B. E., & Karnik, R. B. (2009). Uses and misuses of Bronfenbrenner's bioecological theory of human development. *Journal of family theory & review*, *1*(4), 198-210. https://doi.org/10.1111/j.1756-2589.2009.00026.x

United Nations High Commissioner for Refugees. (2024). *Global Trends: Forced displacement in 2023*. United Nations High Commissioner for Refugees. https://www.unhcr.org/global-trends-report-2023

United Nations Population Fund. (2004). *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf

United Nations Population Fund. (2016). *ICPD Beyond 2014, High-Level Global Commitments: Implementing the Population and Development Agenda* (978-1-61800-880-0). UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/ICPD_UNGASS_REPORT_for_website.pdf

United Nations. (2024). *Definitions | Refugees and Migrants*. https://refugeesmigrants.un.org/definitions

United Nations. (n.d.). *Youth*. https://www.un.org/en/global-issues/youth

Ussher, J. M., Perz, J. M., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of Sexual Behavior*, *46*(7), 1901-1921. https://doi.org/10.1007/s10508-016-0898-9

Ussher, J. M., Rhyder-Obid, M., Perz, J., Rae, M., Wong, T. W. K., & Newman, P. (2012). Purity, Privacy and Procreation: Constructions and Experiences of Sexual and Reproductive Health in Assyrian and Karen Women Living in Australia. *Sexuality & Culture*, *16*(4), 467-485. https://doi.org/10.1007/s12119-012-9133-6

Veinot, T. C., Mitchell, H., & Ancker, J. S. (2018). Good intentions are not enough: how informatics interventions can worsen inequality. *Journal of the American Medical Informatics Association*, *25*(8), 1080-1088. https://doi.org/10.1093/jamia/ocy052

Villa-Torres, L., & Svanemyr, J. (2015). Ensuring youth's right to participation and promotion of youth leadership in the development of sexual and reproductive health policies and programs. *Journal of Adolescent Health*, *56*(1), S51-S57. https://doi.org/10.1016/j.jadohealth.2014.07.022

Waling, A., Bellamy, R., Ezer, P., Kerr, L., Lucke, J., & Fisher, C. (2020). 'It's kinda bad, honestly': Australian students' experiences of relationships and sexuality education. *Health Education Research*, *35*(6), 538-552. https://doi.org/10.1093/her/cyaa032

Waling, A., James, A., & Fairchild, J. (2023). Expert Stakeholders' Perspectives on How Cisgender Heterosexual Boys and Young Men Navigate Sex and Intimacy in Australia: A Case for "Heterosexual Intimacies" in Policy and Practice. *Sexuality Research and Social Policy*, *20*(1), 315-328. https://doi.org/10.1007/s13178-022-00700-3

Wellings, K., & Johnson, A. M. (2013). Framing sexual health research: adopting a broader perspective. *The Lancet*, *382*(9907), 1759-1762. https://doi.org/10.1016/S0140-6736(13)62378-8

White, K., Ocampo, M., & Scarinci, I. C. (2017). A socio-ecological approach for examining factors related to contraceptive use among recent Latina immigrants in an emerging

Latino state. *Women & Health*, *57*(7), 872-889. https://doi.org/10.1080/03630242.2016.1206056

Woodley, G., Jacques, C., Jaunzems, K., & Green, L. (2022). Mandatory consent education is a huge win for Australia–but consent is just one small part of navigating relationships. *The Conversation*. https://theconversation.com/mandatory-consent-education-is-a-huge-win-for-australia-but-consent-is-just-one-small-part-of-navigating-relationships-177456

World Health Organization. (2001). *The second decade: improving adolescent health and development*. https://iris.who.int/bitstream/handle/10665/64320/WHO_FRH_ADH_98.18_Rev.1.pdf?sequence=1

World Health Organization. (2017). *Promoting the health of refugees and migrants: framework of priorities and guiding principles to promote the health of refugees and migrants*. https://www.who.int/docs/default-source/documents/publications/promoting-health-of-refugees-migrants-framework-and-guiding-principles.pdf?sfvrsn=289d4ae6_1

World Health Organization. (2023). *Investing in sexual and reproductive health and rights: essential elements of universal health coverage* https://www.who.int/publications/m/item/investing-in-sexual-and-reproductive-health-and-rights-essential-elements-of-universal-health-coverage

Wray, A., Ussher, J. M., & Perz, J. (2014). Constructions and experiences of sexual health among young, heterosexual, unmarried Muslim women immigrants in Australia. *Culture, Health and Sexuality*, *16*(1), 76-89. https://doi.org/10.1080/13691058.2013.833651

Yamin, A. E., & Boulanger, V. M. (2013). Embedding sexual and reproductive health and rights in a transformational development framework: lessons learned from the MDG targets and indicators. *Reproductive health matters*, *21*(42), 74-85. https://doi.org/10.1016/S0968-8080(13)42727-1

Zhao, P., Yoo, I., Lavoie, J., Lavoie, B. J., & Simoes, E. (2017). Web-Based Medical Appointment Systems: A Systematic Review. *Journal of Medical Internet Research* *19*(4), e134. https://doi.org/10.2196/jmir.6747

10. Appendix

Appendix A. Systematic review protocol

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Systematic Review **OPEN ACCESS**

Migrant and refugee youth perspectives on sexual and reproductive health rights in Australia: a systematic review protocol.

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ABSTRACT:

Background: Migrant and refugee youth (MRY) in Australia face specific experiences that inform their sexual and reproductive health and rights. Migrant and refugee communities experience poorer health outcomes, have lower health service uptake and have culturally-informed understandings of sexual health. Additionally, youth are particularly vulnerable to poor sexual health. This paper details a study protocol for a systematic review of evidence on how Australian MRY understand and construct sexual and reproductive health and rights.

Methods: A systematic review of available literature will be conducted and reported as per Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. A systematic search of nine databases – Medline, EMBASE, CINAHL, APAIS, ProQuest, PsycInfo, Web of Science, SCOPUS, and PubMed – from January 2000 onwards will be undertaken. Hand searches for further relevant studies, including grey literature, will be conducted. Two reviewers will independently screen titles, abstracts and full-text articles against selection criteria. The Mixed Method Appraisal Tool (MMAT) will be used to assess the quality of included studies. Thematic synthesis methods will be used for data extraction and synthesis, aided by QSR NVivo 12.

Discussion: The proposed systematic review will synthesize evidence on how Australian migrant and refugee youth construct and understand sexual and reproductive health and rights, as well as the factors shaping these constructions. The synthesis will fill existing gaps in understandings of how migrant and refugee youth make decisions and understand their rights. In examining Australian migrant and refugee youth, the review will have specific relevance to the Asia-Pacific region. Gaining youth perspectives will provide crucial information on how practice and policy can be improved to deliver to this population.

Key words: migrant, refugee, young people, Australia, sexual and reproductive health, rights

INTRODUCTION

Australia has a culturally diverse populace – migrants constitute 30% of the population, and just under half of all Australians have a parent born overseas or were born overseas themselves. [1] Migrant and refugee youth (MRY) comprise a considerable proportion of Australia's youth. Despite distinct circumstances, upbringing and backgrounds, MRY encounter similar experiences regarding health and access.[2] These youth face myriad complex socio-ecological challenges, ranging from communication barriers to cultural and religious clashes and conflict with both parents and broader communities.[3-5] Differing acculturation

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rates and perspectives between generations, whereby community values and expectations from home countries are more firmly held by parental generations than youth,[6] can incite clashes around freedom and sexual attitudes.[7, 8] With regards to sexual and reproductive health (SRH), research indicates Australian MRY hold lower levels of health literacy, higher rates of unplanned pregnancy and longer-lasting treatable sexually transmitted infections (STIs) than non-migrant counterparts.[9] This is compounded by a noted under-utilisation of services.[2, 10] MRY face specific vulnerabilities and experiences due to their life stage and cultural/ethnic background. This shapes how MRY encounter and articulate their sexual and reproductive health rights (SRHR). Adolescent and young adult health and wellbeing have significant, lasting impacts on individuals' life trajectories.[11]

Accordingly, youth health is key to future generations' welfare and sustainable development.[11, 12] Despite this, young people have traditionally been overlooked and are only more recently being centred in social health and global policy.[12, 13] The *Lancet* commission on adolescent health notes a triple-return from investing in young people's health: present benefits to youth, flow-on benefits into adulthood, and the health of their children.[12, 13] SRH is a crucial aspect of individual wellbeing that has been shown to engender broad social and economic benefits.[13, 14] Accordingly, ensuring young people's SRH benefits the development of future global society.[12, 13]

Youth, however, are particularly vulnerable to SRH risks. Various factors – from limited knowledge and access to information, services and contraceptives, to the physical, social and emotional challenges of the transition to adulthood – impede SRH.[15] In Australia, youth bear a disproportionate burden of STI incidence – 75% of Chlamydia cases occur among people aged 15-24, over half of Gonorrhoea cases and a third of Syphilis cases occur in people under 29.[16] Additionally, most STI infections among young Australians remain undiagnosed and untreated.[16] It is likely STI rates are similarly high for MRY. However, MRY have less knowledge of services and disease testing, increasing the risk of conditions going untreated and worsening.[10, 17] Migrant and refugee populations in Australia face poor general health outcomes and barriers to equity.[18] Low SRH service uptake – fuelled by structural barriers, linguistic challenges and cultural sensitivity – heightens health risks.[19, 20] Life trajectories, particularly displacement and migration, shape SRH knowledge and understandings.[21] Moreover, many cultures have specific constructions of SRH, including taboos and certain expectations around sexual activity.[22] MRY thus navigate myriad socioecological factors experienced by migrant and refugee Australians and young Australians.[18] Interactions between these factors can be used to examine and explain MRY's engagement with SRHR.

Sexual and reproductive health itself can only be attained through the realisation of sexual and reproductive health rights.[14] SRHR are not uniformly enshrined in international law, but are pieced together from across international Human Rights frameworks.[23] This includes rights surrounding reproduction – the right to choose when and if to have children –, but also a range of sexual rights regarding making informed decisions about what happens, and when, to one's body.[24, 25] SRHR are broad, encompassing rights to sexual health and wellbeing as well as satisfying, safe sexual life, rights to bodily integrity, choice of partner, gender identity and sexual orientation. Access to services, education and information are also vital sexual rights.[14, 24, 26]

Given these expansive and nebulous definitions, an investigation of how populations themselves understand and experience these rights is crucial. UNFPA's 2021 "My Body is My Body" report revealed significant barriers to rights attainment for youth across the Asia-Pacific region, including inadequate care, education, contraceptive access and bodily autonomy.[27] In Australia, there is a marked gap in data surrounding SRHR, particularly of minority groups, which belies widespread articulation of rights.[28] The proposed review will provide information on how to best support MRY from the perspectives of MRY themselves. By determining how youth make choices and construct understandings, we can facilitate improvements to services, policies, and programming. Revealing how SRHR are understood and articulated by MRY will ensure rights are better operationalised. Moreover, the review will contribute to broader discourses surrounding rights and how they can be made actionable. Given Australia's role as a key player in the Asia-Pacific region, examining how MRY in

Australia experience and construct SRHR can have wider implications on regional health outcomes and understandings.

AIMS AND RATIONALE

This review will identify and synthesise literature on MRY's views on sexual and reproductive health and rights in Australia. The review will focus on MRY's perspectives and what factors shape these perspectives. The following questions will guide our review:

a) How do migrant and refugee background youth construct or understand sexual and reproductive health and rights in Australia?

b) What socioecological factors contribute to these young people's SRHR constructions?

Examining how marginalised groups define and experience rights provides insight into how socioecological factors influence sexual and reproductive wellbeing. To our knowledge, no review has synthesised the perspectives of Australian MRY on SRHR. Indeed, no research has specifically examined the rights – neither attainment nor understanding – of this population regarding sexual health. The proposed review will synthesise existing literature and infer understandings and constructions of rights among MRY. The review will explore key perspectives and understandings of SRH. Additionally, we aim to determine how sexual health choices and agency are articulated—in other words, how rights are expressed.

Finally, the review will illuminate knowledge gaps to guide further research. There remains a paucity of research on how Australian youth experience SRH and their understanding of SRHR.[29] MRY are an underrepresented population within the already underrepresented area of youth SRHR. A comprehensive understanding of how MRY make decisions and hold and understand rights is currently lacking and is needed.

METHODS

The systematic review will be conducted and reported in line with Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines.[30] This protocol has been registered with PROSPERO: CRD42021241213.

Search Strategy

Studies will be primarily identified through structured searches across nine key databases: Medline, EMBASE, CINAHL, APAIS, ProQuest, PsycInfo, Web of Science, SCOPUS, and PubMed. Additionally, searches of grey literature will be undertaken. Reference lists of included studies will be examined for any studies not identified through searches.

A search strategy has been developed with guidance from a research librarian. Search terms include key terms relating to four subjects: 'sexual health', 'youth'/ 'young people', 'migrant(s)' and 'refugee(s)', and 'Australia'. Where possible, Medical Subject Headings (MeSH) will be used. An initial pilot search across EMBASE, Medline, CINAHL and PsycInfo was conducted, using the above key terms and the term 'rights', but produced insufficient results. Following consensus between two reviewers, the term 'rights' and any variants were removed from the search strategy. Details of the search strategy are shown in **Table 1**.

Results from each database search will be uploaded to EndNote X9 reference manager and duplicate records removed.[31]

Study Selection

Inclusion and exclusion criteria are detailed in **Table 1**. Eligible papers must examine MRY's perspectives, experiences, and understandings of sexual and reproductive health and/or rights. Given the specificity of this review, studies where migrant and refugee youth are subgroups of the study population may still contribute significant insights. Therefore, papers that meet only one of the two population criteria – being a) youth, and b) migrant/refugee background – will be included if they contain data on migrant and/or refugee youth perspectives.

To ensure a comprehensive selection, the review will take a broad definition of youth, including studies where the population is described as 'youth', 'young adult', 'young people' or another such term (i.e. young women), or where the population is in the age range of 15-26.

Screening

Following removal of duplicates using Endnote X9, records will be uploaded to Covidence Systematic Review software for screening.[32] The screening will be undertaken in two stages by two independent reviewers (SNR and SZH).

Reviewers (SNR & SZH) will screen the title and abstracts of records and vote to discard any that do not fit inclusion criteria. Disagreements will be resolved through discussion and consensus between reviewers. If consensus is not reached, a third researcher (ML) will ascertain eligibility.

Table 1: Inclusion / exclusion criteria and keywords.

Parameters	**Inclusion**	**Exclusion**	**Key Terms/ Strategy**
Location	Australia		Australia*
Language	English	Non-English	English only selected
Date	Published 2000-	Published before 2000	Date restrictions: Jan 01 2000-
Population	Studies including migrant and/or refugee and/or asylum seeker youth, including international students living in Australia	Studies solely focusing on non-migrant/refugee youth; studies focusing	"young adult" OR adolescen* OR "adolescent behaviour" OR "young people" OR youth OR juvenile OR teen* AND migrant* OR immigrant* OR refugee* OR "culturally and linguistically diverse" OR CALD **AND**
Outcome	Studies examining participants' perspectives, experiences, and attitudes towards SRH	Studies not concerned with SRH; studies not examining participants' views or perspectives	"sexual health" OR "sex education" OR "reproductive health" OR "reproductive service*" OR "family planning" OR "sexual health service" OR contracepti* OR "contraceptive behaviour" OR "unplanned pregnancy" OR abortion OR "sexually transmitted disease" OR sexuality OR "sexual behaviour"
Study Design	Primary qualitative, mixed methods and/or quantitative studies and grey literature	Purely epidemiological studies (disease incidence, morbidity, treatment rates) Abstract-only papers, reviews, pamphlets, protocols, opinion pieces or letters;	NA

Two reviewers (SNR and SZH) will then screen full texts of the remaining records using the same criteria. Disagreements will be resolved in the same manner. From pilot searches, we anticipate several studies will include relevant data on MRY without this being the specific study population. These will be included where data relating to MRY perspectives can be identified and separated from data relating to other participants. For example, all-age studies of migrant and refugee populations may include data separated by age group or data attributed to participants of a certain age. In such cases, quotes and data from participants of the appropriate age will be included in the review. Similarly, studies of Australian youth or 'minority' youth groups will be included if there is distinguishable data on migrant and refugee youth. Such studies may still hold useful data on youth perspectives and their views vis-a-vis other populations. Moreover, examining how such studies succeed or fail in addressing the specific perspectives of MRY will contribute to our assessment of knowledge gaps.

Quality Assessment

Quality assessment of included records will be conducted using the Mixed Methods Appraisal Tool (MMAT).[33] This will be undertaken independently by two reviewers (SNR & SZH). Differences between reviewers will be resolved through discussion and consensus. Any remaining disagreements will be resolved by a third reviewer (ML). Studies will be given an overall score based on a percentage of quality criteria met, where 1 criterion met is 20% and all 5 is 100%.[34] Authors will note lower quality studies and upon which criteria they fail, but will not exclude such studies to ensure no insights are overlooked.[35] Methodologically compromised studies may still contain data that contribute to the richness of the review, and will therefore be included.

As this review will examine perspectives, we anticipate studies will primarily be qualitative and mixed methods. However, quantitative studies will be included if they fit the selection criteria. MMAT allows the appraisal of five methodological categories: qualitative research, randomised controlled trials, non-randomised studies, quantitative descriptive studies, and mixed methods studies. All study types can be assessed within a single tool and, unlike other tools, MMAT includes specific criteria for mixed methods research.[33, 36] As such, this tool is most appropriate for our review.

DATA EXTRACTION & SYNTHESIS

Data extraction and synthesis will be guided by Thomas and Harden's thematic synthesis methods.[37]

Data extraction

For all records, a purposively designed form will be used to extract general study characteristics: date, author(s), setting, study design, data collection method(s), population characteristics, and sampling strategy. These will be presented in a table. Findings regarding the target population will be extracted verbatim from each record. For primary research studies, this will include relevant data under 'results' or 'findings' headings. Any direct participant quotes found in other sections of included studies will also be extracted. For grey literature, keyword searching will be used to identify relevant 'findings' to be extracted.

Data Synthesis

Thematic synthesis methods are particularly suited to studies of perspectives, such as those that will comprise this review.[37] QSR NVivo 12 will be used to facilitate synthesis.[38] Given this is a specific topic with a small pool of literature, we anticipate a small number of eligible records. An inclusive approach – being methodologically thorough, yet resource-intensive – is both feasible and necessary to ensure sufficient depth of results.[39]

Eligible records will examine participants views and perspectives and therefore, as we have mentioned above, be predominantly mixed-methods and qualitative.[40] This, combined with the relative paucity of relevant research, suggests there will be little quantitative data present, and any data will be significantly heterogeneous. Given the lack of a standardised measure on youth's perspectives, there is unlikely to be quantitatively aggregated data across studies, making meta-analysis unviable. Instead, the convergent qualitative synthesis will be undertaken, in which quantitative data will be transformed into qualitative findings.[41, 42] Tabular data will be translated into sentences.

The thematic synthesis will follow three stages. Firstly, the first author (SNR) will conduct line-by-line coding of all data. The synthesis will be inductive, with data guiding the development of themes rather than using pre-determined themes. [33] Once coded, text assigned to each code will be compared for consistency and to determine if additional coding is needed. The review team will assess codes and assigned text and make any necessary changes. Once codes are finalised, SNR will begin the second stage: developing descriptive themes. Codes will be grouped based on similarity and organised into themes, which will again be assessed by the review team. The final stage will involve 'going beyond' original study data to develop analytical themes.[37] This will include abstracting data to produce new interpretations that answer the review questions. The descriptive themes will infer youths' understanding of rights and the socioecological factors shaping these understandings. The codes and themes will be checked and validated by the second author (SZH) and confirmed by the research team members.

Rigour of the synthesis

We will employ a peer review process to ensure rigour. Peer review helps verify the sufficiency of the constructed codes and themes, thereby improving the validity of our findings. Peer review is a way of keeping the researcher honest and reducing bias.[43] Peers are members of the research team, who have reviewed this protocol.

DISCUSSION

This paper describes a protocol of a systematic review to fill research gaps concerning the sexual and reproductive health and rights of Australian MRY. To our knowledge, there are no existing reviews on SRHR perspectives of this population. While some literature examining the knowledge and understanding of MRY exist, there has been no systematic synthesis of this literature, and certainly no use of a rights-based framework to assess findings. The vulnerabilities of MRY to SRH-related problems and the under-utilisation of services evinces a need for further research and policy. Synthesising the perspectives and decision-making processes of youth on their sexual and reproductive health through reviewing existing data is crucial to improving services and access.

Gaining youths' perspectives is an essential step in creating participatory programming and practice. Research indicates that inclusive practices adopted to address youth's SRHR can yield improved outcomes, and internationally, programmes have effectively used participatory strategies to develop sexual and reproductive wellbeing.[44, 45] Moreover, participation can be considered a right that will only be attained by understanding youth's perspectives and hearing their voices.[25] Our review will focus on this process.

CONCLUSION

The proposed review will synthesise evidence on the understandings and constructions of sexual and reproductive health and rights among migrant and refugee youth as well as the socioecological factors that shape these constructions. This will provide conceptual understanding about sexual and reproductive health and rights among young people from refugee and migrant backgrounds that is currently lacking. The review will also provide insight into avenues of further research and as well as guidelines for improving policy and programming to better serve migrant and refugee communities. Findings may contribute to a broader regional understanding of how SRHR is held and constructed by minority groups.

Conflicts of Interest

The authors listed confirm there are no competing interests regarding this manuscript.

Funding

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Author Contributions

SNR, SZH and ML guided methodology. EM, TD, PL and VM contributed to writing and editing.

REFERENCES

1. Australian Bureau of Statistics. Cultural Diversity in Australia 2017. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Cultural%20Diversity%20Article~60.
2. Botfield JR, Newman CE, Zwi AB. Engaging Migrant and Refugee Young People with Sexual Health Care: Does Generation Matter More Than Culture? Sexuality Research and Social Policy 2018;15:398-408. DOI: 10.1007/s13178-018-0320-6.
3. Woodgate RL, Busolo DS. African Refugee Youth's Experiences of Navigating Different Cultures in Canada: A "Push and Pull" Experience. Int J Environ Res Public Health 2021;18:2063. DOI: 10.3390/ijerph18042063.
4. Mansouri F, Ben-Moshe D, Johns A. Intergenerational relations in newly-arrived communities in Victoria: a pilot study report. Australia: Ethnic Communities' Council of Victoria; 2015.
5. Dune T, Perz J, Mengesha Z, et al. Culture Clash? Investigating constructions of sexual and reproductive health from the perspective of 1.5 generation migrants in Australia using Q methodology. Reprod health 2017; 14:50. 2017/04/06. DOI: 10.1186/s12978-017-0310-9.
6. Renzaho AMN, Dhingra N,Georgeou N. Youth as contested sites of culture: The intergenerational acculturation gap amongst new migrant communities-Parental and young adult perspectives. PLoS One 2017; 12: e0170700-e0170700. DOI: 10.1371/journal.pone.0170700.
7. Dean J, Mitchell M, Stewart D, et al. Intergenerational variation in sexual health attitudes and beliefs among Sudanese refugee communities in Australia. Cult Health Sex 2017; 19: 17-31.
8. Rogers C and Earnest J. A cross-generational study of contraception and reproductive health among Sudanese and Eritrean women in Brisbane, Australia. Health Care Women Int 2014; 35: 334-356. DOI: http://dx.doi.org/10.1080/07399332.2013.857322.
9. McMichael C and Gifford S. Narratives of sexual health risk and protection amongst young people from refugee backgrounds in Melbourne, Australia. Cult Health Sex 2010; 12:263-277. DOI: 10.1080/13691050903359265.
10. Botfield JR, Zwi AB, Rutherford A, et al. Learning about sex and relationships among migrant and refugee young people in Sydney,

Australia: 'I never got the talk about the birds and the bees'. Sex educ 2018; 18: 705-720. DOI: 10.1080/14681811.2018.1464905.

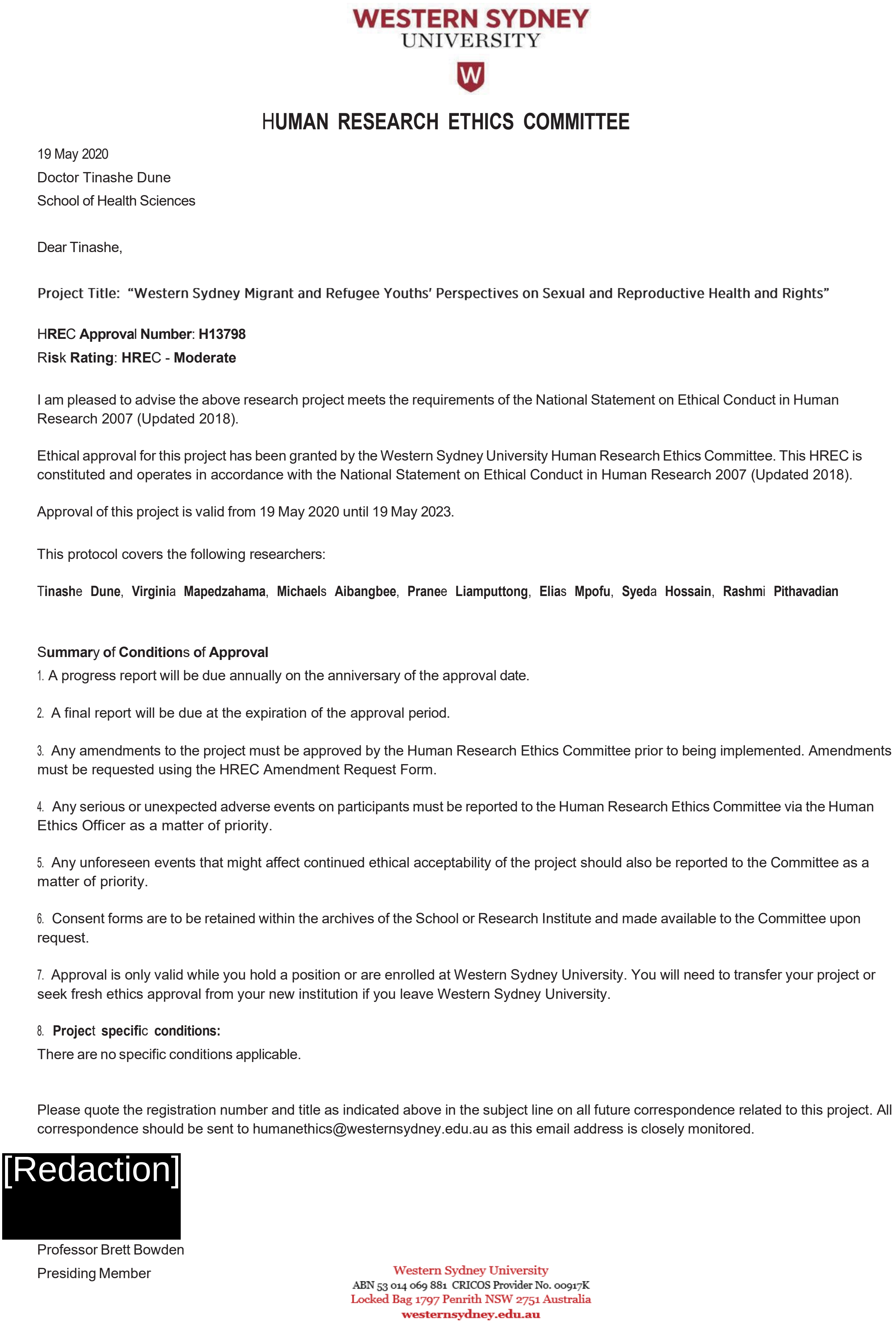
11. Kleinert S,Horton R. Adolescent health and wellbeing: a key to a sustainable future. Lancet 2016; 387: 2355-2356. DOI: 10.1016/S0140-6736(16)30297-5.
12. Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet 2016; 387: 2423-2478. DOI: 10.1016/S0140-6736(16)00579-1.
13. Patton GC, Sawyer SM, Ross DA, et al. From Advocacy to Action in Global Adolescent Health. J Adolesc Health 2016; 59: 375-377. DOI: 10.1016/j.jadohealth.2016.08.002.
14. Starrs AM, Ezeh AC, Barker G, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. The Lancet 2018; 391: 2642-2692. DOI: 10.1016/S0140-6736(18)30293-9.
15. The Royal Australasian College of Physicians. Position Statement: Sexual and Reproductive Health Care for Young People. Sydney, Australia: RACP; 2015.
16. Australian Government Department of Health. Fourth National Sexually Transmissible Infections Strategy 2018-2022. Canberra: Commonwealth of Australia as represented by the Department of Health; 2018.
17. Botfield JR, Newman CE, Zwi AB. Drawing them in: professional perspectives on the complexities of engaging 'culturally diverse' young people with sexual and reproductive health promotion and care in Sydney, Australia. Cult Health Sex 2017; 19: 438-452. 2016/09/27. DOI: 10.1080/13691058.2016.1233354.
18. Mengesha ZB, Perz J, Dune T, et al. Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. PLoS One 2017; 12: e0181421-e0181421. DOI: 10.1371/journal.pone.0181421.
19. Ilami A and Winter S. Iranian Migrants' Lived Experiences of Access to Sexual and Reproductive Healthcare Services in Western Australia: A Conventional Content Analysis. Sexuality Research & Social Policy 2020; 18: 533-546. DOI: 10.1007/s13178-020-00478-2.
20. Ussher JM, Rhyder-Obid M, Perz J, et al. Purity, Privacy and Procreation: Constructions and Experiences of Sexual and Reproductive Health in Assyrian and Karen Women Living in Australia. Sexuality & culture 2012; 16: 467-485. DOI: 10.1007/s12119-012-9133-6.
21. Odger A, Frohlick S and Lorway R. Re-Assembling "Risky" Subjects: African Migrant Youth in Winnipeg, Canada. Med Anthropol 2019; 38: 311-326. DOI: 10.1080/01459740.2018.1551390.
22. Metusela C, Ussher J, Perz J, et al. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. Int J Behav Med 2017; 24: 836-845. DOI: 10.1007/s12529-017-9662-3.
23. Oronje RN, Crichton J, Theobald S, et al. Operationalising sexual and reproductive health and rights in sub-Saharan Africa: constraints, dilemmas and strategies. BMC Int Health Hum Rights 2011; 11: S8. DOI: 10.1186/1472-698X-11-S3-S8.
24. Starrs AM and Ragnar A. Definitions and Debates: Sexual Health and Sexual Rights. Brown J World Aff 2016; 22: 7.
25. Chandra-Mouli VMBBMS, Svanemyr JPD, Amin APD, et al. Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights? J Adolesc Health 2015; 56: S1-S6. DOI: 10.1016/j.jadohealth.2014.09.015.
26. Ghebreyesus TA and Kanem N. Defining sexual and reproductive health and rights for all. Lancet 2018; 391: 2583-2585. DOI: 10.1016/S0140-6736(18)30901-2.
27. United Nations Population Fund. My Body is My Body, My Life is My Life: Sexual and reproductive health and rights of young people in Asia and the Pacific. New York: UNFPA; 2021.
28. Bateson DJ, Black KI and Sawleshwarkar S. The Guttmacher–Lancet Commission on sexual and reproductive health and rights: how does Australia measure up? Med J Aust 2019; 210: 250-252.e251. DOI: 10.5694/mja2.50058.
29. Australian Institute of Health and Welfare. Young Australians: their health and wellbeing. Canberra, AU: AIHW; 2011.
30. Moher D, Altman DG, Liberati A, et al. PRISMA Statement. Epidemiology (Cambridge, Mass)

2011; 22: 128-128. DOI: 10.1097/EDE.0b013e3181fe7825.

31. The EndNote Team. EndNote. EndNote X9 ed. Philadephia, PA: Clarivate; 2013.
32. Veritas Health Innovation. Covidence systematic review software. Melbourne, Australia.
33. Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Canada: Canadian Intellectual Property Office; 2018.
34. Pluye P, Gagnon M-P, Griffiths F, et al. A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed methods primary studies in Mixed Studies Reviews. Int J Nurs Stud 2009; 46: 529-546. DOI: 10.1016/j.ijnurstu.2009.01.009.
35. Hannes K. Chapter 4: Critical appraisal of qualitative research Key points. In: Noyes J, Booth A, Harden A, et al. (eds) Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions Cochrane Collaboration Qualitative Methods Group; 2011.
36. Hong QN, Gonzalez-Reyes A, Pluye P. Improving the usefulness of a tool for appraising the quality of qualitative, quantitative and mixed methods studies, the Mixed Methods Appraisal Tool (MMAT). J Eval Clin Pract 2018; 24: 459-467. DOI: 10.1111/jep.12884.
37. Thomas J and Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med Res Methodol 2008; 8: 45. DOI: 10.1186/1471-2288-8-45.
38. QSR International Pty Ltd. NVivo. 2020.
39. Noyes J, Lewin S. Supplemental Guidance on Selecting a Method of Qualitative Evidence Synthesis, and Integrating Qualitative Evidence with Cochrane Intervention Reviews. In: Noyes J, Booth A, Hannes K, et al. (eds) Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions Cochrane Collaboration Qualitative Methods Group; 2011.
40. Harden A, Garcia J, Oliver S, et al. Applying systematic review methods to studies of people's views: an example from public health research. Journal of epidemiology and community health (1979) 2004; 58: 794-800. DOI: 10.1136/jech.2003.014829.
41. Sandelowski M. Combining Qualitative and Quantitative Sampling, Data Collection, and Analysis Techniques in Mixed-Method Studies. Res Nurs Health 2000; 23: 246-255. DOI:10.1002/1098240X(200006)23:3<246: AID-NUR9>3.0.CO;2-H.
42. Pluye P and Hong QN. Combining the power of stories and the power of numbers: mixed methods research and mixed studies reviews. Annu Rev Public Health 2014; 35: 29-45. 2013/11/06. DOI: 10.1146/annurev-publhealth-032013-182440.
43. Liamputtong P. Qualitative Research Methods. Fifth edition. ed. Docklands, VIC: Oxford University Press; 2020.
44. Caldwell L, Smith E, Wegner L, et al. Health Wise South Africa: Development of a Life Skills Curriculum for Young Adults. World Leis J 2004; 46: 4-17. DOI: 10.1080/04419057.2004.9674362.
45. Mpofu E, Hallfors DD, Mutepfa MM, et al. A Mixed Methods Mapping of Church versus Secular School Messages to Influence Sexual Decision-Making as Perceived by Zimbabwean Orphan Girl Students. J Mix Methods Res 2014; 8: 363-376. 2014/12/23. DOI: 10.1177/1558689814539394.

Appendix B. Ethics

Appendix B1. Ethics approval Studies 1 & 2



WESTERN SYDNEY
UNIVERSITY

HUMAN RESEARCH ETHICS COMMITTEE

19 May 2020

Doctor Tinashe Dune
School of Health Sciences

Dear Tinashe,

Project Title: "Western Sydney Migrant and Refugee Youths' Perspectives on Sexual and Reproductive Health and Rights"

HREC Approval Number: H13798
Risk Rating: HREC - Moderate

I am pleased to advise the above research project meets the requirements of the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).

Ethical approval for this project has been granted by the Western Sydney University Human Research Ethics Committee. This HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).

Approval of this project is valid from 19 May 2020 until 19 May 2023.

This protocol covers the following researchers:

Tinashe Dune, Virginia Mapedzahama, Michaels Aibangbee, Pranee Liamputtong, Elias Mpofu, Syeda Hossain, Rashmi Pithavadian

Summary of Conditions of Approval

1. A progress report will be due annually on the anniversary of the approval date.

2. A final report will be due at the expiration of the approval period.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to being implemented. Amendments must be requested using the HREC Amendment Request Form.

4. Any serious or unexpected adverse events on participants must be reported to the Human Research Ethics Committee via the Human Ethics Officer as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.

7. Approval is only valid while you hold a position or are enrolled at Western Sydney University. You will need to transfer your project or seek fresh ethics approval from your new institution if you leave Western Sydney University.

8. **Project specific conditions:**

There are no specific conditions applicable.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to humanethics@westernsydney.edu.au as this email address is closely monitored.

[Redaction]

Professor Brett Bowden
Presiding Member

Western Sydney University
ABN 53 014 069 881 CRICOS Provider No. 00917K
Locked Bag 1797 Penrith NSW 2751 Australia
westernsydney.edu.au

WESTERN SYDNEY
UNIVERSITY

Ethics Reference: H13798
Expiry Date: 19 May 2023

HUMAN RESEARCH ETHICS COMMITTEE

13 July 2021

Associate Professor Tinashe Dune
School of Health Sciences

Dear Tinashe,

RE: Amendment Request to H13798

I wish to formally advise you that the Human Research Ethics Committee has approved your request to amend your approved research protocol H13798 "Western Sydney Migrant and Refugee Youths' Perspectives on Sexual and Reproductive Health and Rights".

The approved amendments are:

Add USyd Mphil student Sharanya Napier-Raman to the project team. Add Dr Mi-Joung Lee to the project as Miss Napier-Raman's USyd supervisor.

Change eligibility criteria: raise maximum age of eligibility from 24 years to 26 years.

Reimburse the MRY participants: $20 for phase 1 and $40 for phase 2.

Separation of the previously merged concept mapping focus groups into different participant groups for focus groups and concept mapping.

Updated documents:
Focus group PIS for MRY; Focus group recruitment script for MRY; YPL PIS; Online questionnaire recruitment script; Online questionnaire consent script; SRHR model development workshops recruitment script; Focus group guide; Concept mapping PIS
Concept mapping recruitment flyer; Concept mapping consent script.

Project specific approval conditions:

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to humanethics@westernsydney.edu.au as this email address is closely monitored.

Regards

[Redaction]

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Appendix B2. Ethics approval Study 3

THE UNIVERSITY OF
SYDNEY

Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Friday, 20 January 2023

Dr Syeda (Zakia) Hossain
Health Systems and Global Populations; Faculty of Medicine and Health
Email: zakia.hossain@sydney.edu.au

Dear Syeda (Zakia),

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows:

Project No.:	**2022/921**
Project Title:	**Migrant and refugee youth sexual and reproductive health and rights: Abortion care experiences and decision-making**
Authorised Personnel:	**Hossain Syeda (Zakia); Lee Mi-Joung; Mpofu Elias; Napier-Raman Sharanya;**
Approval Period:	**19/01/2023 to 19/01/2027**
First Annual Report Due:	**19/01/2024**

Documents Approved:

Date Uploaded	**Version Number**	**Document Name**
13/01/2023	v1	Revised PIS - Clean
05/11/2022		Interview Guide
05/11/2022		Participant Consent Sheet
05/11/2022		Qualtrics Registration Page for Participants

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
    - Serious or unexpected adverse events (which should be reported within 72 hours).
    - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of*

Research, applicable legal requirements, and with University policies, procedures and governance requirements.

- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

[Redaction]

[redacted]

Associate Professor Haryana Dillon
Chair
Human Research Ethics Committee (HREC 3)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's Australian Code for the Responsible Conduct of Research (2018)

Appendix C. Participant information

Appendix C1. Consent and participant information Study 1

Consent Form – Group Concept Mapping

Project Title: Western Sydney Migrant and Refugee Youths' Perspectives on Sexual and Reproductive Health and Rights

This study has been approved by the Human Research Ethics Committee at Western Sydney University. The ethics reference number is: **H13798**

I hereby consent to participate in the above named research project.

I acknowledge that:

- I have read the Participant Information Sheet (or where appropriate, have had it read to me) and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s
- The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to:

- Undertaking the online concept mapping activities
- Having my responses saved
    - I consent for my data and information provided to be used in this project and other related projects for an extended period of time.
    - I understand that my involvement is confidential and that the information gained during the study may be published and stored for other research use but no information about me will be used in any way that reveals my identity.
    - I understand that my participation in this study will have no effect on my relationship with the researcher/s, and any organisations involved, now or in the future.
    - I understand that while I can withdraw from this study at any time, I may be unable to withdraw the data that I may have previously provided. This is because data is not linked to my identity and will not be able to be separated from other participants' data.

By clicking 'Agree' you consent to participate and will be taken to the first activity.

What if I have a complaint?

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through Research Engagement, Development and Innovation (REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

THE UNIVERSITY OF SYDNEY

WESTERN SYDNEY UNIVERSITY

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Social Sciences in Health
Faculty of Medicine and Health

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Empowering Agency: Western Sydney Migrant and Refugee Youths' Perspectives on Sexual and Reproductive Health and Rights

PARTICIPANT INFORMATION STATEMENT

You have been invited to participate in an online concept mapping project to examine how migrant and refugee youth understand and experience sexual and reproductive health. This project is funded by the Australian Research Council and is being conducted by Western Sydney University and the University of Sydney. The results of this project will go towards improving sexual and reproductive health services for migrant communities.

About this study:

This study will examine migrant and refugee youth's understanding and experiences of sexual and reproductive health. You have been invited to participate in this study because you identify as having a migrant or refugee background, are aged 16-26 and have been living in the Greater Western Sydney region for the last year. This document will tell you about the research study, and help you decide if you want to take part in the research. Please read this sheet carefully before you participate in the online activities.

About the Researchers:

This study is part of a project on Migrant and Refugee Youth Sexual and Reproductive Health and Rights that is being undertaken by researchers from Western Sydney University (School of Science and Health & Translational Health Research Institute) and the University of Sydney (Faculty of Health Science & Faculty of Nursing and Midwifery). The project is funded by the **Australian Research Council.**

The researchers for this part of the study are Associate Professor Syeda Zakia Hossain (Discipline of Behavioural and Social Sciences in Health), Professor Elias Mpofu (..), Dr Mi-Joung Lee (Discipline of Physiotherapy) and Sharanya Napier-Raman (Student).

Sharanya Napier-Raman is conducting this study as part of a Masters degree in the Faculty of Medicine and Health at the University of Sydney. The research will take place under the supervision of Associate Professor Syeda Zakia Hossain, Professor Elias Mpofu and Dr Mi-Joung Lee.

Your Participation:

If you decide to take part in this study, you will be asked to complete two online activities. You will receive further information before you participate. You will be provided with a consent form and full terms and conditions before both phases of the project. You are encouraged to contact the researchers and ask questions to ensure you fully understand the requirements.

There will be two parts to this project, Phase 1 and Phase 2*, both of which will be undertaken online. You can complete all activities on a computer, laptop, phone or tablet. Responses will be anonymous. Your contact information will be used to send you links to the project activities, to give you access to the activities and to contact you regarding payment. You will use the email address you have provided to log in to the activities, but none of the responses you make will be linked to this address or any of your personal details. All data will be anonymous.

*Note: *Though we encourage participation in both phases, if you wish to take part in one phase, you do not have to take part in the next.*

Phase 1: Brainstorming

- Pay: $20
- Time commitment: approximately 30 minutes - 1 hour
- Dates: brainstorming will be open for completion between **May 10th to June 1st**
- Mode: all brainstorming will be online. You can complete this independently and at your own pace. You will be emailed a link to complete brainstorming.

Description:

You will receive an invitation link to participate in Phase 1 via email. From here, you will be asked to respond to a statement about how you make sexual and reproductive health decisions. You will be able to respond as many times as you like and can return to the page and add more responses any time between May 10 and June 1. Full instructions will be given when you begin the activity.

Phase 2: Organising (Demographic Questions, Sorting & Rating)

- Pay: $40
- Time commitment: 1-2 hours
- Dates: Phase 2 will be open for completion between **June 21st and July 16th**.
- Mode: all organising will be online. You can complete this independently and at your own point. You will be emailed a new link to complete these activities.

Description:

You will receive an invitation link to participate in Phase 2 via email. From here, you will be asked to complete three short activities. These can be done at your own time and returned to over any time within the completion period. Firstly, you will be asked to respond to some basic demographic questions (age, gender, ethnicity etc.). You will then begin an online sorting activity. You will be asked to sort a series of statements into groups depending on what statements you think belong together. In the final activity, you will be required to rate the statements from the last activity based on their importance to you and how they impact you. Full instructions will be given throughout the process.

All activities can be completed on a computer, laptop, tablet or smartphone. If you would prefer to complete activities in-person, you can also contact us directly and we can arrange a session.

Eligibility:

Youth aged 16-26 who identify as having a migrant or refugee background and have been living in the Greater Western Sydney area for at least 12 months are invited to participate. To be eligible, you or one or both of your parents must identify as a migrant or refugee.

Participation and Withdrawal:

Participation is entirely voluntary. Your decision to participate or not will not affect your current or future relationship with the researchers or anyone else at the University of Sydney. If you decide to take part in the study and then change your mind later, you are free to withdraw.

Completing the consent form and submitting responses for each phase of the study is indication of your consent. You can withdraw any time before you submit. If you choose to withdraw after your responses submitted, please let us know at the time you withdraw what you would like us to do with information we have collected about you up to that point.

Risks and Costs:

Aside from the time commitment, we do not expect any that there will be any risks or costs associated with taking part in this study. We recognise that sexual and reproductive health is a sensitive topic and participants may feel some discomfort or distress in examining this issue. If you do experience discomfort due to any of the information in the online activities, you are encouraged to seek support. You may like to receive support from the Sexual Health Australia Helpline (Metro callers: 9227 6178 and Country callers: 1800 198 205), Lifeline Australia (13 11 14), Beyond Blue (1300 22 4636), and 1800RESPECT (1800 737 732).

Benefits and Payment:

For participation in this study, you can receive a total of $60 -($20 for phase 1 and $40 for phase 2). Following your completion of each phase, you will be provided with payment via bank transfer.

In participating in this study, you will have the opportunity to engage with sexual and reproductive health issues and have your opinions heard. You will be encouraged to think about what sexual health means to you and how you could best be supported in your sexual health needs.

Your responses and participation will go towards informing researchers of how best to serve you and your communities.

Results & Data Use:

By providing your consent, you are agreeing to us collecting information about you for the purposes of this study outlined in this Participant Information Statement. Any information you provide us will be stored securely and we will only disclose it with your permission unless we are required by law to release information. Your privacy will be maintained throughout the course of this research and for the required data retention period.

Your responses will be used to develop cluster maps and charts that will visually represent perspectives and attitudes towards sexual and reproductive health.

The results of this study will be the basis of a master's thesis and will also be presented in journal publications, conference papers and other reports. Data from this study will be combined with findings from other parts of the project and used to inform the development of a human rights based model of sexual and reproductive health. These findings will be synthesised in a report that will be disseminated to community stakeholders, service providers, policy makers and researchers.

Access to Results:

You have the right to receive feedback about the overall results of this study. If you wish to receive feedback, tick the relevant box on the consent form. This feedback involves a one-page summary of the study's findings and conclusions. You will receive this feedback after the study is finished.

Telling Others:

You are welcome and encouraged to tell others about this study. Any migrant or refugee background youth living in Western Sydney who may be interested in this study can be forwarded the survey link: https://sydney.au1.qualtrics.com/jfe/form/SV_8vVdgqUGFiaY7hc

Alternatively, they can contact Sharanya Napier-Raman via phone – +61 412 283 794 – or email – snap3609@uni.sydney.edu.au if they wish to participate.

Contact & Further Information:

If you have any further questions after reading this information, you may contact Dr Zakia Hossain or Sharanya Napier-Raman. If you require any more information at any stage, please contact:

Sharanya Napier-Raman
Telephone: +61 412 283 794
Email: snap3609@uni.sydney.edu.au

Dr Zakia Hossain
Telephone: +61 2 9351 9340
Email: zakia.hossain@sydney.edu.au

Ethics & Concerns:

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of Western Sydney University. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in*

*Human Research {*2007). This statement has been developed to protect people who agree to take part in research studies.

If you have any complaints or reservations about the ethical conduct of this research, you may contact Western Sydney University's Ethics Committee through Research Engagement, Development and Innovation (REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

This study has been approved by the Western Sydney University Human Research Ethics Committee. The approval number is H13798.

WESTERN SYDNEY UNIVERSITY

THE UNIVERSITY OF SYDNEY

Participant Information Sheet

Project Title: Western Sydney Migrant and Refugee Youths' Perspectives on Sexual and Reproductive Health and Rights

Project Summary:

You are invited to participate in a study being conducted by Dr Tinashe, Prof Elias Mpofu, Dr Virginia Mapedzahama, Associate Professor Syeda Hossain, and Professor Pranee Liamputtong from Western Sydney University and the University of Sydney. The study aims to engage migrant and refugee youth in Western Sydney to investigate their experiences and understanding of sexual and reproductive health, and to develop a model to improve youth sexual and reproductive health agency.

How is the study being paid for?

This study is funded by the Australian Research Council Discovery grant.

What will I be asked to do?

The online survey will have several questions. The questions are designed to determine factors that influence your sexual and reproductive health and rights and to understand migrant and refugee youth's sexual and reproductive health and wellbeing in Greater Western Sydney.

How much of my time will I need to give?

The survey should only take about 15 minutes to complete. You can choose to provide your email to be placed into a draw to win one of five $100 GiftPay Voucher Cards. These can be redeemed across over 80 different stores, from Apple to Xbox. See website for full list: https://www.giftpay.com.au/business/egifts.aspx

What benefits will I, and/or the broader community, receive for participating?

You may benefit from the chance to interact and share common experiences with other migrant youth from Western Sydney. More broadly, your experiences and views will contribute to a better understanding of migrant youth's knowledge and experiences of the barriers and facilitators to sexual and reproductive health and rights. This increased understanding can help researchers to develop a human rights-based and youth-determined model for policy and programming aimed at improving youth sexual and reproductive health agency and wellbeing.

Will the study involve any risk or discomfort for me? If so, what will be done to rectify it?

We do not foresee any risk to you from participating in this study. There may be some discomfort or distress answering questions in the survey that trigger any negative experiences of sexual and reproductive health and rights, particularly with other people including romantic partners, friends, or health care providers. We also recognise that some people feel uncomfortable when responding to questions relating to sex and reproduction. If you find any parts of the survey distressing, you can receive immediate support from the Sexual Health Australia Helpline (Metro callers: 9227 6178 and Country callers: 1800 198 205), Lifeline Australia (13 11 14), Beyond Blue (1300 22 4636), and 1800RESPECT (1800 737 732).

How do you intend to publish or disseminate the results?

It is anticipated that the results of this research project will be published and presented in a variety of forums. You will not need to provide any personal information about yourself. You will never be identified in the results and publications from this study.

Will the data and information that I have provided be disposed of?

Please be assured that only the researchers will have access to the raw data you provide. However, your data may be used in related projects for an extended period of time around developing a youth determined model for policy. Your data may be retained for 5 years or longer, after which it will be securely disposed of.

Can I withdraw from the study?

Participation is entirely voluntary and you are not obliged to be involved. If you begin the survey and choose to not complete it, you can quit the survey at any time and your data will not be retained.

Can I tell other people about the study?

Yes, you can tell other people about the study by sending them the following link: https://sydney.au1.qualtrics.com/jfe/form/SV_em6XwCZcHZYUWcC to view and complete this survey.

What if I require further information?

Please contact Dr Tinashe Dune should you wish to discuss the research further before deciding whether or not to participate.

Dr Tinashe Dune, Chief Research Investigator, email: T.Dune@westernsydney.edu.au

What if I have a complaint?

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through Research Engagement, Development and Innovation (REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you may be asked to sign the Participant Consent Form. The information sheet is for you to keep and the consent form is retained by the researcher/s.

This study has been approved by the Western Sydney University Human Research Ethics Committee. The Approval number is H13798.

Participant Information Statement

Research Study: Migrant and Refugee Youth Sexual and Reproductive Health and Rights: Abortion Care

Associate Professor Syeda Zakia Hossain (Responsible Researcher)
Faculty of Medicine and Health
Phone: +61 433 545 532I Email: zakia.hossain@sydney.edu.au
Ms Sharanya Napier-Raman (PhD student) I Email: sharanya.napier-raman@sydney.edu.au

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1. What is this study about?

We are conducting a research study about migrant and refugee youth's experiences regarding accessing abortion care. The study aims to engage migrant and refugee youth who have accessed abortion care and investigate their experiences and decision-making during this process. Taking part in this study is voluntary.

Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

2. Who is running the study?

The study is being carried out by the following researchers:

- Associate Professor Syeda Zakia Hossain, Faculty of Medicine and Health, University of Sydney
- Dr Mi-Joung Lee, Faculty of Medicine and Health, University of Sydney
- Professor Elias Mpofu, Faculty of Medicine and Health, University of Sydney

Ms Sharanya Napier-Raman is conducting this study as the basis for the degree PhD at The University of Sydney.

3. Who can take part in the study?

We are seeking migrant and refugee background youth, aged 16-26, living in Sydney, Australia who have accessed abortion care services. This includes first generation migrants and refugees, or youth who have one or both parents who identify as a migrant or refugee.

Migrant and refugee youth have low engagement with sexual and reproductive health services, and limited sexual and reproductive health knowledge. However, there is no current Australian research on how migrant and refugee youth experience abortion care. This study will seek to engage this population and fill this research gap. The age-range included in this study has been chosen to be consistent with previous stages of research conducted by the investigators that have explored migrant and refugee sexual health and rights. A definition of migrant and refugee youth that includes those who are second generation has been used as, despite different lived experiences, barriers to care and knowledge are similar across this group.

4. What will the study involve for me?

If you decide to take part in this study, you will be asked to:

Take part in an in-person interview with one researcher.

- The interview will be semi-structured, based on an interview guide developed by the research team. You will be asked questions about your decision-making and experiences accessing and receiving care.
- The interview will cover:
    - Decision-making process, including social influences and information access
    - Access to information and care
    - Your experiences with the abortion process
    - Barriers and enablers to care
- Interviews will run for approximately 30-45 minutes
- Interviews will be held in person or via Zoom, depending on your preference
- In-person interviews will be held in a private room on the University of Sydney campus or a public space of your choosing (such as a public library)
- Interviews will be audio recorded
- You will be sent a transcript of your interview which you will be able to review and make changes to

5. Can I withdraw once I've started?

Being in this study is completely voluntary and you do not have to take part.

Your decision will not affect your current or future relationship with the researchers or anyone else at The University of Sydney.

If you decide to take part in the study and then change your mind you can withdraw by contacting Ms Sharanya Napier-Raman or Assoc Prof Zakia Hossain via phone or email. You may withdraw at any point during the interview process. If you withdraw before participating in an interview, no data will be collected about you. If you wish to withdraw after taking part in an interview, your data will be removed and not used in the analysis.

If you take part in an interview, you may refuse to answer any questions that you do not wish to answer. You may also choose to stop the interview temporarily and take a break, or stop the interview and reschedule for a time to complete it.

If you choose to withdraw, we will not collect any more information from you. Please let us know at the time you withdraw what you would like us to do with information we have collected about you up to that point. Your data will not be used in the analysis if you wish to withdraw.

6. Are there any risks or costs?

We understand that abortion is a sensitive topic and emotionally upsetting experience for some. There may be some discomfort or distress answering questions that trigger any negative memories related to your experiences with abortion care. If you find any parts of the interview experience distressing, you can receive immediate support from the Sexual Health Australia Helpline (Metro callers: 9227 6178 and Country callers: 1800 198 205), Lifeline Australia (13 11 14), Beyond Blue (1300 22 4636), and 1800RESPECT (1800 737 732).

You will also be able to have a support person present at your interview if you desire. Your support person can be present at the interview or on hand nearby or contactable via phone/ electronically.

7. Are there any benefits?

If you complete an interview, you will be compensated with a $40 Voucher card.

Additionally, you may benefit from the chance to share your experiences. More broadly, your experiences and views will contribute a better understanding of migrant and refugee youth's experiences of the barriers and facilitators to sexual and reproductive health care, specifically abortion services. This increased understanding can help researchers to develop a human rights-based and youth-determined model for policy and programming aimed at improving youth sexual and reproductive health agency and wellbeing. The research aims to help improve services and provision of abortion care to migrant and refugee communities.

8. What will happen to information that is collected?

By providing your consent, you are agreeing to us collecting information about you for the purposes of this study.

Any information you provide us will be stored securely and we will only disclose identifiable information with your permission, unless we are required by law to release information. We are planning for the study findings to be published.

You will not be individually identifiable in these publications.

Include other details about the collection, use and disclosure of participant information, **as applicable to your study**. This may include:

- Basic demographic details will be collected: your age, gender identity, ethnic background, migrant status and employment
- Additionally, interviews will be audio recorded and transcribed

- Audio recordings of the interview will be for analysis purposes only
- Electronic information will be uploaded and stored in a password-protected OneDrive using the University of Sydney's Enterprise licence. This will be accessible by the research team only.
- After a retention period of 5 years, all study material will be permanently deleted from all electronic databases.
- the results of this research project will be published and presented in a variety of forums, including conference presentations, peer reviewed journal articles and PhD thesis. Your responses will be anonymised, you will be given a pseudonym for any written materials. So, you will never be identified in the results and publications from this study.

9. Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. If you would like to receive feedback on overall study results, you can check the relevant box in the online consent form. This feedback will be in the form of a brief lay summary.

10. What if I would like further information?

When you have read this information, the following researcher/s will be available to discuss it with you further and answer any questions you may have:

- Ms Sharanya Napier-Raman, PhD candidate: sharanya.napier-raman@sydney.edu.au I +61 412 283 794

11. What if I have a complaint or any concerns?

The ethical aspects of this study have been approved by the Human Research Ethics Committee (HREC) of The University of Sydney [2022/921] according to the *National Statement on Ethical Conduct in Human Research {2007).*

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the University:

Human Ethics Manager
human.ethics@sydney.edu.au
+61 2 8627 8176

This information sheet is for you to keep

Appendix D. Recruitment material

Appendix D1. Recruitment material Study 1

WESTERN SYDNEY UNIVERSITY

THE UNIVERSITY OF SYDNEY

AUSTRALIAN RESEARCH COUNCIL FUNDED PROJECT

ARE YOU A MIGRANT OR REFUGEE BACKGROUND YOUTH?

Participate in an online activity examining your perspectives on sexual and reproductive health:

$20 FOR PARTICIPATION IN PHASE 1
GiftPay Voucher

$40 FOR PARTICIPATION IN PHASE 2
GiftPay Voucher

SCAN QR CODE TO REGISTER

YOU ARE ELIGIBLE IF YOU ARE:

- 16-26 years old
- From a migrant/ refugee background (even if you were born and raised in Australia)
- Live in the Greater Western Sydney area

CONTACT:

Dr Syeda Zakia Hossain: zakia.hossain@sydney.edu.au | +61 433 545 5332

Sharanya Napier-Raman: snap3609@uni.sydney.edu.au | +61 412 283 794

Appendix D2. Recruitment material Study 2

WESTERN SYDNEY UNIVERSITY

THE UNIVERSITY OF SYDNEY

Western Sydney Migrant and Refugee Youth:

Participate in an anonymous survey & have your say on your sexual & reproductive health and rights

Contact Sharanya Napier-Raman for further information: snap3609@uni.sydney.edu.au

Enter to win 1 of 5 $100 GiftPay Vouchers!

Western Sydney Migrant and Refugee-background Youth*

Participate in an anonymous survey & have your say on your sexual & reproductive health

Enter to win 1 of 5 $100 GiftPay Vouchers!

* If you are **aged 16-26**, live in **Western Sydney** and have **at least 1 parent** who identifies as a **migrant or refugee**

Contact Sharanya Napier-Raman for further information:
snap3609@uni.sydney.edu.au

Appendix D3. Recruitment material Study 3

THE UNIVERSITY OF SYDNEY

Participate in study on migrant & refugee youth abortion experiences & *get paid!*

About the study:

Researchers from the University of Sydney are examining migrant and refugee youth's experiences and decision-making when accessing abortion care.

We will be conducting interviews with migrant and refugee youth who have accessed abortion care. You will receive a **Westfield voucher** for participating.

Participate & receive a Westfield voucher!

SCAN HERE

OR CONTACT:

Ms Sharanya Napier-Raman:
snap3609@uni.sydney.edu.au
+61 412 283 794

Assoc Prof Zakia Hossain:
zakia.hossain@sydney.edu.au
+61 433 545 532

Are you eligible?

You can participate if you:

1. Are **16-26 years old**
2. Have at least one parent who identifies as a **migrant or refugee**
3. Have **accessed abortion care** in the last two years

Scan here to participate

Scan here to participate

Scan here to participate

Scan here to participate

Scan here to participate

Scan here to participate

Scan here to participate

Scan here to participate

Instagram recruitment – Study 3

Study on Migrant & Refugee Youth Abortion Experiences

Participate in an interview & receive a Westfield voucher!

This study has been approved by the University of Sydney Human Research Ethics Committee | Project no. 2022/921

Are you eligible?

You can participate if you:

1. Are **16-26 years old**
2. Have at least one parent who identifies as a **migrant or refugee**
3. Have **accessed abortion care** in Sydney

Researchers from the University of Sydney are examining migrant and refugee youth's experiences and decision-making when accessing abortion care.

We will be conducting interviews with migrant and refugee youth who have accessed abortion care.

Appendix E. Study instruments

Appendix E1. Survey instrument

Western Sydney Migrant and Refugee Youth Sexual and Reproductive Health and Rights

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Start of Block: Welcome

Welcome to this online survey on Western Sydney migrant and refugee youth sexual and reproductive health and rights.

Please read the Participant Information Sheet for a full description of this survey and research.

You can participate if:

1. You, or one or both of your parents, identify as a migrant or refugee
2. You are 16-26 years old
3. You have been living in the Greater Western Sydney area for the past 12 months or longer

---

Please provide your details if you wish to enter a draw to win a $100 Event Cinemas Movie Voucher

○ Email {1) ____

Please read through the following information.

Project Title: Western Sydney Migrant and Refugee Youths' Perspectives on Sexual and Reproductive Health and Rights

This study has been approved by the Human Research Ethics Committee at Western Sydney University. The ethics reference number is: H13798.

I hereby consent to participate in the above-named research project.

I acknowledge that:

- I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s
- The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to:

- Undertaking this survey
- I consent for my data and information provided to be used in this project and other related projects for an extended period of time.
- I understand that my involvement is confidential and that the information gained during the study may be published and stored for other research use but no information about me will be used in any way that reveals my identity.
- I understand that my participation in this study will have no effect on my relationship with the researcher/s, and any organisations involved, now or in the future.
- I understand that while I can withdraw from this study at any time, I may be unable to withdraw the data that I may have previously provided.

We encourage you to answer all questions, but responses are not compulsory.

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through Research Engagement, Development and Innovation {REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au.
Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Start of Block: Demographics

Q1 How old are you?

____

Q2 What gender do you identify as?

○ Female {1)

○ Male {2)

○ Transgender Female {3)

○ Transgender Male {4)

○ Non-binary/ non-conforming {5)

○ None of the above {please specify): {6)
____

○ Prefer not to say {7)

Q3 What is your current employment status?

○ Unemployed {1)

○ Student {2)

○ Working full time {3)

○ Working part time {4)

○ Studying and working {5)

○ None of the above {please specify) {6)
____

Q4 What is your highest level of education?

○ Primary {1)

○ Secondary {High School) {2)

○ Vocational {e.g. TAFE) {3)

○ Tertiary {University) {4)

Q5 What is your current living status?

- ○ Homeless {1)
- ○ living with parents {2)
- ○ living with other relatives {3)
- ○ living with friends/ housemates {4)
- ○ living alone {5)
- ○ None of the above: {please specify) {6) ____

Q6 What is your ethnic or cultural background? {e.g. Greek, Indian, Italian etc.)

____

Q7 What language{s) do you speak at home?

____

Q8 How long have you been living in Australia?

- ○ Born in Australia {1)
- ○ 1 year {2)
- ○ 2-4 years {3)
- ○ 5-7 years {4)
- ○ 8-10 years {5)
- ○ 10+ {6)

Q9 What is your migrant status?

- ○ Migrant {1)
- ○ Refugee {2)
- ○ Child of migrant/refugee {3)

Start of Block: Sexual behaviour and experiences

Q10 How do you describe your sexual orientation?

- ○ Asexual {1)
- ○ Bisexual {2)
- ○ Gay {3)

○ lesbian {4)

○ Straight/ Heterosexual {5)

○ Pansexual {6)

○ Queer {7)

○ None of the above {please specify): {8) ____

○ Prefer not to say {9)

Q11 Are you currently in a romantic or sexual relationship?

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

Q12 Are you currently sexually active?

○ Yes {1)

○ Not currently {2)

○ I have never been sexually active {3)

○ Prefer not to say {4)

Q13 Do you have:

○ Regular sexual partner{s) {1)

○ Casual sexual partner{s) {2)

○ No sexual partner{s) {3)

○ Prefer not to say {4)

Q14 Do you engage in sexual activities online or virtually? {e.g. over the phone, video calls, sexting)

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

Q15 Do you watch porn or sexually explicit videos?

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

Q16 Have you ever felt pressured into engaging in sexual activity?

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

Q17 Have you ever experienced an unplanned pregnancy {including getting your sexual partner pregnant)?

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

○ Not applicable {4)

Q18 Have you or your partner ever had an abortion?

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

○ Not applicable {4)

Q19 Have you ever had a sexually transmissible infection {STI)?

○ Yes {1)

○ No {2)

○ I don't know {3)

○ Prefer not to say {4)

Display This Question:

If Have you ever had a sexually transmissible infection {STI}? = Yes

Q20 What did you do about the sexually transmitted infection{s) you had?

○ Visited a GP {1)

○ Visited a sexual health clinic {2)

○ Visited Family Planning clinic {3)

○ Spoke to a friend {4)

○ Spoke to a family member {parent) {5)

○ Other {please specify) {6) ____

Q21 During the past 4 weeks, have you felt depressed, sad or anxious?

○ Yes {1)

○ No {2)

○ Prefer not to say {3)

Q22 How often do you feel:

	Never {1)	Sometimes {2)	About half the time {3)	Most of the time {4)	Always {5)
Calm {Q22_1)	○	○	○	○	○
Happy {Q22_2)	○	○	○	○	○
Energetic {Q22_3)	○	○	○	○	○
Anxious {Q22_4)	○	○	○	○	○
Angry {Q22_5)	○	○	○	○	○
Sad {Q22_6)	○	○	○	○	○

Start of Block: Religious Beliefs

Q23 What is your religious affiliation?

○ Christian {please specify denomination) {1)
____

○ Muslim {2)

○ Jewish {3)

○ Buddhist {4)

○ Hindu {5)

○ Atheist {6)

○ Agnostic {7)

○ Other {please specify) {9) ____________________

Q24 Which of the following describe your religious affiliation?
Please select all that apply

○ The same as your family {1)

○ Your family is religious but you are not {2)

○ An important part of your culture/ethnicity {3)

○ An important part of your social connection and relationships {4)

○ liberal/ Progressive {5)

○ Conservative/ Evangelical {6)

○ None of the above {6)

Q25 How would you describe your worship or attendance at a religious organisation

○ More than weekly {1)

○ Weekly {2)

○ Monthly {3)

○ Rarely {4)

○ Never {5)

Q26 Does religion play a role in your family life?

○ Yes {1)

○ No {2)

Q27 Would you describe your religious beliefs as

○ Very strong {1)

○ Slightly strong {2)

○ Moderately strong {3)

○ Not very strong {4)

○ Not religious {5)

Q28 Do you feel your sexual orientation and/or gender identity present conflict for you:

Please select all that apply

○ Within your family {1)

○ Within your faith {2)

○ Within your cultural/ethnic beliefs or tradition {3)

○ Within your church community {4)

○ No conflict {5)

○ Other situations {please specify) {6) ____

Display This Question:

If Do you feel your sexual orientation and/or gender identity present conflict for you:Please select... != No conflict

Q29 If so, how do you deal with this conflict?

____

Start of Block: Knowledge & Contraception/ protection

Q30 Which of the following contraceptive methods have you heard of?
Please select all that apply

○ Condoms {1)

○ Diaphragms {2)

○ Implants {3)

○ Contraceptive Pill {4)

○ Vaginal Rings {5)

○ Intrauterine devices {IUDs - e.g. hormonal or copper rod) {6)

○ Emergency contraception {aka morning after pill) {7)

○ Natural methods {e.g. cycle tracking) {8)

○ Pull-out method {9)

○ Abstinence {10)

○ Other {specify): {11) ____

○ None of the above {12)

Q31 Which of the following methods of contraception have you **used**:

Please select all that apply

○ Condoms {1)

○ Diaphragms {2)

○ The contraceptive pill {3)

○ Implants {4)

○ Vaginal Rings {5)

○ Intrauterine devices {IUDs - hormonal or copper rod) {6)

○ Emergency contraception {morning after pill) {7)

○ Natural methods {cycle tracking) {8)

○ Pull-out method {9)

○ Abstinence {10)

○ Other {specify) {11) ____

○ None of the above {12)

○ I am not sexually active {14)

Display This Question:
If Which of the following methods of contraception have you used:Please select all that apply != I am not sexually active

Q32 How often do you use contraception when you are with a sexual partner?

○ Always {1)

○ Most of the time {2)

○ Sometimes {3)

○ Never {4)

Display This Question:

If How often do you use contraception when you are with a sexual partner? != Always

And Which of the following methods of contraception have you used:Please select all that apply != I am not sexually active

Q33 On the occasions you do **not** use contraception, why not?
Please select all that apply:

○ I am not sexually active {1)

○ It is too expensive {2)

○ It is too inconvenient {3)

○ My partner and I are trying to have children {4)

○ I am not sure how or what to use {5)

○ It is against my culture and/ or religion {6)

○ I don't want people to see me buying contraception {7)

○ My partner does not want to {8)

○ I am not worried about getting pregnant or my partner getting pregnant {9)

○ It is too hard to remember {10)

○ I am worried about side effects {11)

○ Other {specify) {12) ____

○ Not applicable {13)

Q34 Which of the following sexually transmissible infections {STIs) have you heard of?
Please select all that apply

○ HIV/AIDS {1)

○ Chlamydia {2)

○ Gonorrhoea {3)

○ HPV {Human Papilloma Virus) {4)

○ Hepatitis A {5)

○ Hepatitis B {6)

○ Hepatitis C {7)

Q35 Have you received vaccinations for any of the following STIs?

	Yes {1)	No {2)	Not sure {3)
HPV {Cervical Cancer Vaccine) {1)	○	○	○
Hepatitis B {2)	○	○	○

Q36 How often do you use protection {for e.g. condoms or dental dams) to prevent sexually transmitted infections?

○ Always {1)

○ Most of the time {2)

○ Sometimes {3)

○ Never {7)

Q37 How likely do you think you are you to get an STI {sexually transmissible infection)?

○ Never {1)

○ Very unlikely {2)

○ Unlikely {3)

○ likely {4)

○ Very likely {5)

Display This Question:

If How often do you use protection {for e.g. condoms or dental dams} to prevent sexually transmitted... != Always

Q38 On the occasions you do not use protection, why not?
Please select all that apply:

○ I am not sexually active {1)

○ It is too expensive {2}

○ It is too inconvenient {3}

○ I am not sure how or what to use {4}

○ It is against my culture and/ or religion {5}

○ I don't want people to see me buying protection {6}

○ My partner does not want to {7}

○ I am not worried about STIs {8}

○ I am in a relationship and trust my partner is safe {9}

○ Other {specify} {10) ____

Start of Block: Beliefs & Attitudes

Q39 Are the following statements true or false?

	True {1)	False {2)	Not sure {3)
Taking the pill {oral contraceptives) will protect from getting sexually transmissible infections {STIs) {1)	○	○	○
Taking the pill will make it hard for a woman to have children later in life {2)	○	○	○
Only people who have lots of sex get STIs {3)	○	○	○

Q40 How much do you agree with the following statements?

	Strongly disagree {1)	Somewhat disagree {2)	Neither agree nor disagree {3)	Somewhat agree {4)	Strongly agree {5)
I think it is OK to have sexual experiences before getting married {1)	○	○	○	○	○

I think it is OK to get an abortion if necessary {2)	○	○	○	○	○
I think getting an STI is shameful or embarrassing {3)	○	○	○	○	○
I feel that having sexual desires is shameful or embarrassing {4)	○	○	○	○	○

Q41 How much do you agree with the following statements?

	Strongly disagree {1)	Somewhat disagree {2)	Neither agree nor disagree {3)	Somewhat agree {4)	Strongly disagree (5)
I would feel comfortable talking about consent with sexual partners	○	○	○	○	○
I would feel comfortable saying "no" if my partner wanted to have sex and I did not want to {2)	○	○	○	○	○
I would be comfortable having sex without using protection {3)	○	○	○	○	○

Q42 How much do you agree with the following statements?

	Strongly disagree {1)	Somewhat disagree {2)	Neither agree nor disagree {3)	Somewhat agree {4)	Strongly agree {5)
I can be open about my sexual orientation and/or gender identity with my family {1)	○	○	○	○	○
I can be open about my sexual orientation and/or gender identity with my friends {4)	○	○	○	○	○
lGBTQ+ people are accepted in my ethnic community {2)	○	○	○	○	○
I think lGBTQ+ people should have equal rights to non-lGBTQ+ people {3)	○	○	○	○	○

Start of Block: Knowledge Sources & Education

Q43 Where have you learnt the most about sex and reproductive health?
Please select all that apply

○ School sex education {1)

○ Friend{s) {2)

○ Parents or carers {3)

○ Sexual or romantic partner {4)

○ Other relatives {5)

○ Youth worker {6)

○ Sexual health service{s) {7)

○ Family Planning NSW {8)

○ GP/ family doctor {9)

○ Internet websites/ sources {10)

○ Other {please specify) {11) ____

Q44 How easy is it for you to get information about sexual health if you have questions or issues?

○ Very easy {1)

○ Somewhat easy {2)

○ Neither easy nor difficult {3)

○ Somewhat difficult {4)

○ Very difficult {5)

Q45 Do you feel that you have enough knowledge to make safe choices and have positive sexual experiences?

○ Yes {1)

○ No {2)

○ Unsure {3)

Q46 How confident are you in your sexual health knowledge?[1]

○ Very confident {1)

○ Somewhat confident {2)

---

[1] Reverse scored in data analysis: 1 = Very unconfident, 5 = very confident. Results in Chapter 6 reflect this scoring

○ Neither confident or unconfident {3)

○ Somewhat unconfident {4)

○ Very unconfident {5)

Start of Block: Service Use & Accessibility

Q47 Are you aware of any sexual health services in your area?

○ Yes {1)

○ No {2)

Q48 If you had a sexual health concern, where would you go for advice?
Please select all that apply

○ Intimate partner {e.g. partner, girlfriend, boyfriend, spouse, husband, wife) {1)

○ Parent {2)

○ Friend{s) {not related to you) {3)

○ Other relative/ family member {4)

○ GP/ Doctor {5)

○ Sexual health clinic {in Western Sydney) {6)

○ Sexual health clinic {outside of Western Sydney) {7)

○ Family Planning NSW {8)

○ Internet {9)

○ Community leader/ religious leader {10)

○ I would not seek help from anyone {11)

○ Other {specify) {12) ____

Q49 Have you ever used any of these services for a sexual health issue?

○ Family Planning NSW {1)

○ Community Health service {2)

○ GP/ family doctor {3)

○ Sexual health service {4)

○ Other {please specify) {5) ____

○ Not applicable {6)

Q50 Have you ever had difficulty accessing sexual health services?

○ No {1)

○ Yes {2)

○ Not applicable {3)

Q51 What things might stop you from visiting a sexual health clinic or family planning service?
Please select all that apply

○ I am not sure where these services are {1)

○ These services are too expensive {2)

○ These services are too far away from where I live {3)

○ These services do not cater well to people from my cultural group {4)

○ I am not sure how to make an appointment {5)

○ I am not sure if I am eligible for services {6)

○ I am embarrassed about being seen visiting these services {7)

○ I feel too shy/embarrassed to talk to doctors or health workers {8)

○ These services are not open at times that are convenient for me {9)

○ language barriers make it hard to discuss sexual health with doctors or health workers {10)

○ Other {please specify) {11) ____

Q52 How comfortable would you feel talking about sexual health with...

	Extremely comfortable {1)	Somewhat comfortable {2)	Neither comfortable nor uncomfortable {3)	Somewhat uncomfortable {4)	Extremely uncomfortable {5)
Doctor{s) {1)	○	○	○	○	○

Nurses {2)	○	○	○	○	○
Friend{s) {3)	○	○	○	○	○
Parents {4)	○	○	○	○	○
Intimate Partner {5)	○	○	○	○	○
Youth worker {6)	○	○	○	○	○

Q53 In your opinion, how well do current health and community services meet the sexual and reproductive health needs of migrant and refugee youth?

○ Very well {1)

○ Moderately well {2)

○ Slightly well {3)

○ Not well at all {4)

○ Don't know {5)

Q54 In your opinion, how well do current health and community services meet the sexual and reproductive health needs of lGBTQ+ youth?

○ Very well {1)

○ Moderately well {2)

○ Slightly well {3)

○ Not well at all {4)

○ Don't know {5)

Start of Block: Sexual and Reproductive Health Rights

Q55 Are you aware of sexual and reproductive health rights?

○ Yes {1)

○ No {2)

Q56 For the following questions, please rate each sexual and reproductive health right based on how important they are to you:

	Not at all important {1)	Slightly important {2)	Moderately important {3)	Very important {4)	Extremely important {5)
The right to decide when and if you have children {1)	○	○	○	○	○
The right to decide if and when you become sexually active {2)	○	○	○	○	○
The right to sexual health education and information {3)	○	○	○	○	○
The right to access contraception {4)	○	○	○	○	○
The right to access reproductive health services and care {5)	○	○	○	○	○
Right to have safe and pleasurable sexual experiences {6)	○	○	○	○	○
Right to choose your sexual partner {7)	○	○	○	○	○
Right to be free from discrimination based on your gender, sexuality and/or sexual choice {8)	○	○	○	○	○

Q57 How well do you think your sexual and reproductive health rights are met right now?

- ○ Extremely well {1)
- ○ Very well {2)
- ○ Moderately well {3)
- ○ Slightly well {4)
- ○ Not well at all {5)

Appendix E2. Interview guide

Interview Guide: Migrant and Refugee Youth Abortion Experiences

The following guide will be used to conduct interviews. The main questions (in bold) will be asked. Prompts and leading questions are *possible* questions that the interviewer will ask, depending on participants' responses to the main questions. It is likely that, in responses to main questions, participants will touch upon topics in the leading questions without the need for additional prompting. Which prompts are used, and whether they are used, will depend on participant answers to the main questions.

Introduction

- Introduce researchers
- Provide background on the research and aims; ask participant if they have any questions
- Remind participant that they can choose not to answer any questions, and they can end the interview at any point
- We have ethics approval from the University of Sydney
- How this will be used: thesis, publications
    - Policy implications, recommendations for future policy & research – international comparisons, nation-wide studies etc.
- Confirm consent for participating in interview and to being recorded (consent sheet and information statement given prior to interview)

1. **Participant background/ details**

I'd like to ask you a little bit about yourself:

- How old are you?
- What gender do you identify as?
- What country were you born in?
    - ➔ How long have you been in Australia? *(if not born here)*
- What is your ethnic or cultural background?
- What is your religion, if any?
- Are you currently working or studying?
- What method of abortion did you have? At how many weeks?

Thank you for answering the background questions, now I will be asking open-ended questions about your decision-making, experiences and access.

2. **Decision-making**

Question 2.1:
To start with I would like you to just tell me about your decision-making process. What led you to your choice to access abortion care?

Prompts/ leading questions:

- Was having an abortion something you had thought about much before you became pregnant?
    - Did you know much about abortion?

Social influence

- Did you discuss your choice with anyone?
    - Who?
    - What was your conversation about?
    - Was this conversation helpful in your decision-making?
    - Did this person try to influence your decision in a certain direction?
    - Did you have any friends who had also gone through an abortion?
- Did the opinions of other people influence your choice?
    - Did your family influence you?
    - Your partner?
    - Why/ why not?

Circumstantial influences: Financial/ socioeconomic; relationship dynamic; living situation etc.

- Were there any specific circumstances in your life at the time that influenced your decision?

Belief systems & values:

- Do you have any personal beliefs or values that influenced your decision-making?
    - How did your decision to have an abortion fit with your personal values, beliefs, or religious stance?

Question 2.2

Did you feel like you were able to make this decision freely?

Prompt: why or why not?

3. **Accessing services & journey to care**

Question 3.1 I'd like to hear about the process you went through to access care. Can you tell me how you went about finding and receiving abortion care?

Prompts

- What was the first thing you did when you decided you wanted an abortion, or began to consider having an abortion?
- Did you consider or attempt any other methods of ending the pregnancy?
    - Such as herbal remedies, traditional or folk methods?
- Where did you access information?
    - Did you speak to someone?
    - Did you use the internet?
- How easy was it to find information?
- Did you visit:
    - A GP?
    - A sexual health service?
    - A social service/ youth service?
- How did you contact the abortion clinic?
    - Was making a booking easy?

4. **Experiences with care**

Question 4.1:

How would you describe your general experience with abortion care and health services?

Prompts:

- What was good?
  - How easy was it to access?
- What could have been better?
- How was your experience with health workers/ service providers?
  - Clinicians?
  - Social workers?
  - Other staff involved in your abortion experience?
  - Were they approachable/ supportive etc.
  - Did you feel comfortable with service providers/
- Did you feel you were given enough information about the abortion process beforehand?
- Did you feel that you had appropriate information and care after the abortion?

5. **Barriers and Enablers**

Question 5.1
Were there things that helped you in your experience?

Prompts

- Were there particular supports you had during and after your abortion experience?
- Were there things or people that helped you access care?

Question 5.2
Were there any specific things that made your abortion experience more difficult?

Prompts:

- Was there anything that made your decision-making harder?
  - What was this?
- Was there something that made accessing services harder?

Conclusion:

a) Is there anything else you would like to discuss in relation to your abortion experience?
b) Do you have any questions for me?
c) Would you like to review and edit your interview transcript?
d) Would you like to be contacted with information about the results of this research?

Thank you so much for participating. Your interview will be kept strictly confidential. If any of this has been distressing for you, please make use of the services detailed in the Participant Information Statement:

Sexual Health Australia Helpline (Metro callers: 9227 6178 and Country callers: 1800 198 205), Lifeline Australia (13 11 14), Beyond Blue (1300 22 4636), and 1800RESPECT (1800 737 732)

Appendix F. Additional results Study 1

Figure 5.3 Pattern Match Analysis: Importance by gender

Correlations

	FEM	MAL
FEM	-	0.97
MAL	0.97	-

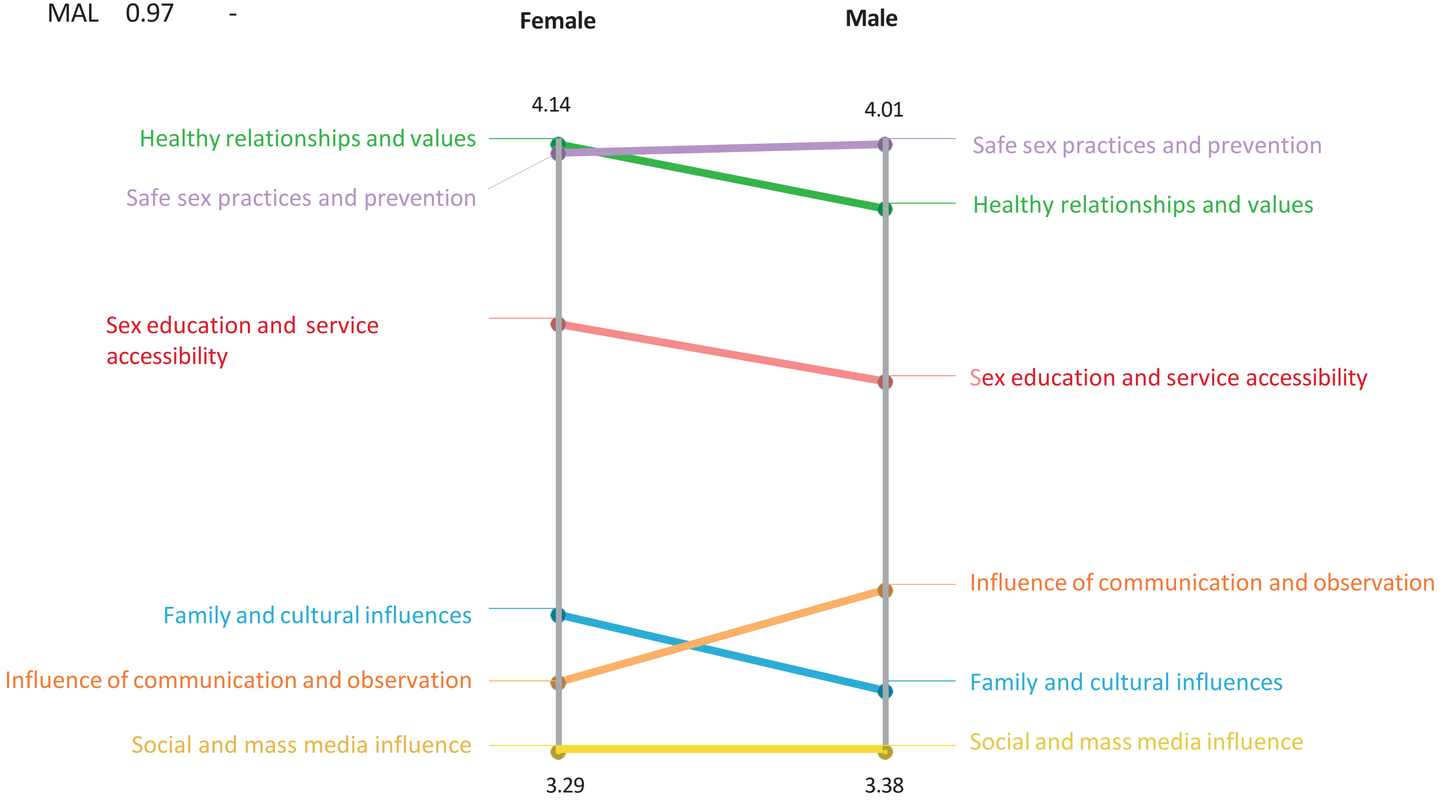
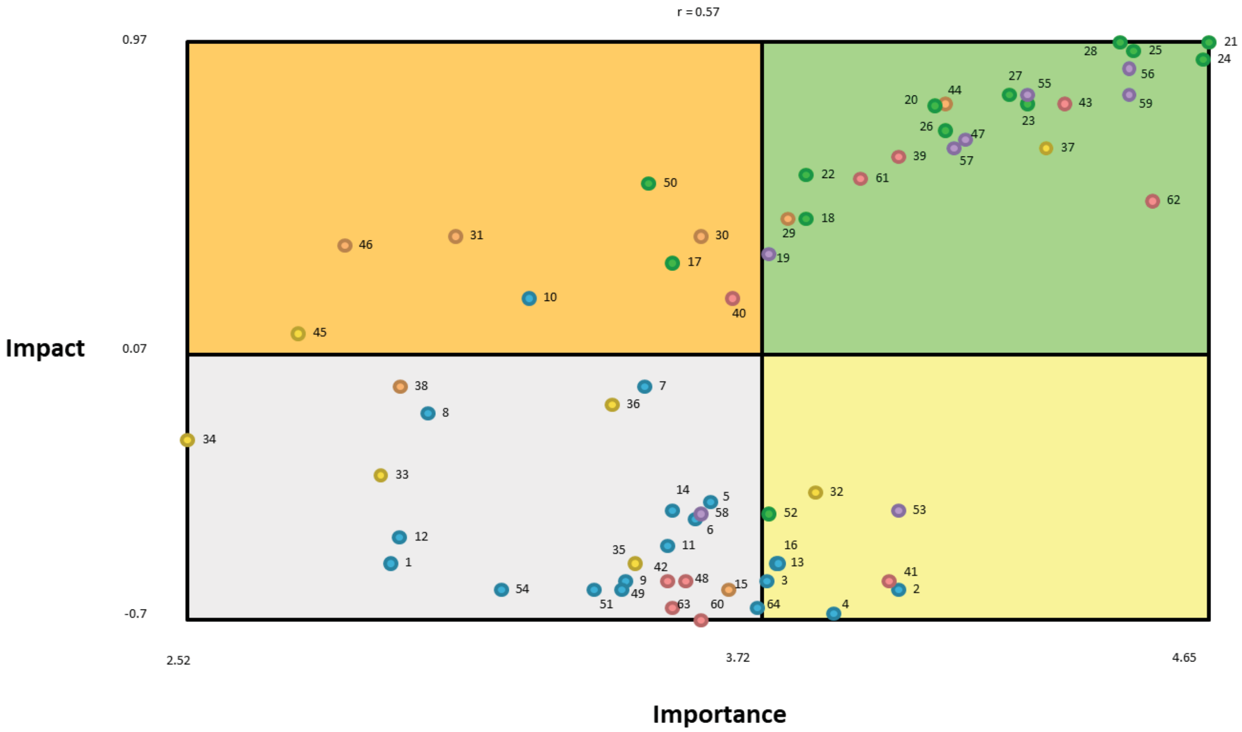


Figure 5.4 Go-Zone Analysis – Importance vs Impact

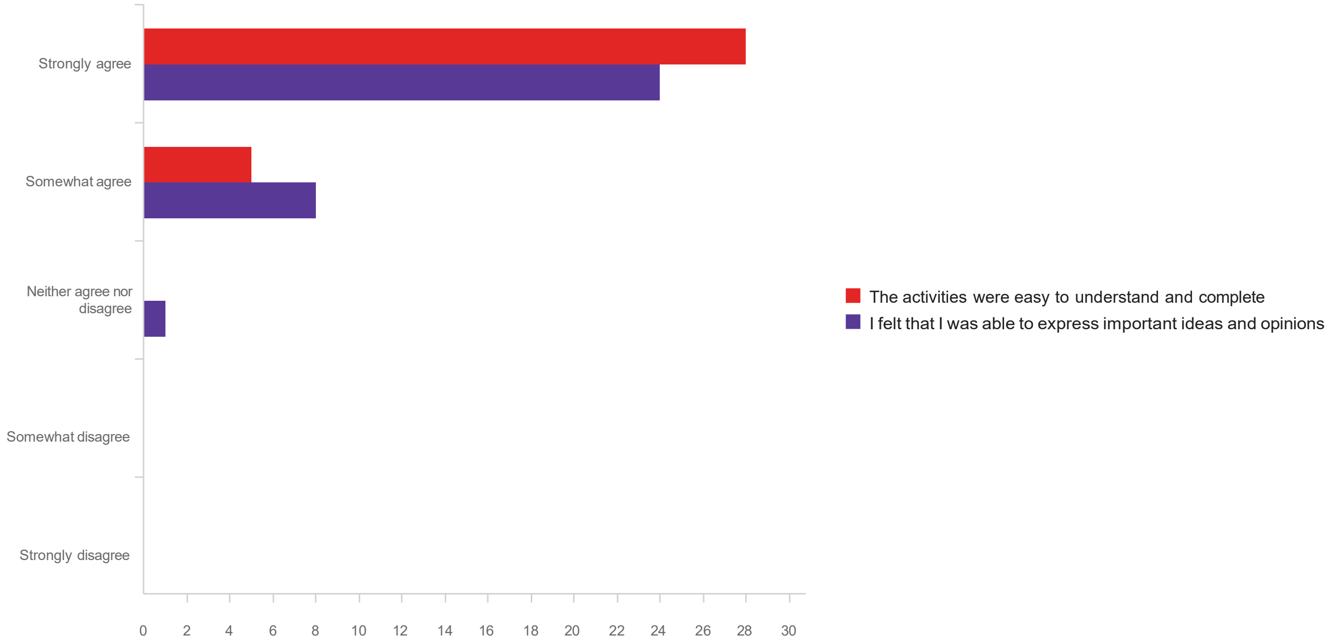


High (positive) impact, low importance	10. Cultural insight can balance sexual life by teaching self-control. 17. I think sexual health should be between you and your future spouse. 30. Conversations I have with my friends set limits of what is 'normal' and acceptable sexually. 31. Talking to my close relatives (Including my siblings and cousins). 40. The school education that I have been taught. 45. Getting information from researching public forums and magazines like Women's health and Cosmopolitan. 46. Access to information in my home language/ mother tongue 50. Feminism. My sexual choices are shaped by my feminist values.
High (positive) impact, high importance	18. I think you should find love before you have children. 19. Avoiding making any sexual decisions under any influence/ alcohol because I fear that I will lose control. 20. Knowing that both individuals need to be compatible to form healthy sexual relations. 21. The level of trust between me and my partner and understanding what choices work for us 22. Knowing that my partner will value that I am able to reach sexual pleasure every time. 23. Whether I have known my partner for a while and have genuine feelings for my partner. 24. Finding a partner who respects my boundaries. 25. Ensuring I am in a safe space and only opening up to those I trust. 26. Making sure that my past negative experiences never happen again by learning ways to protect myself. 27. I have to be comfortable or ready for whatever new sexual experiences I am being confronted with. 28. My mental health and physical health: if I feel well / happy / comfortable 29. Observing my friends, their choices and how that has impacted them. 37. Access to the internet and online information. 39. Sexual education about the right way to manage a relationship or get into one. 43. Medical research and science, particularly when it comes to contraceptives and hygiene. 44. Being able to access culturally safe information from individuals I respect and who understand my concerns. 47. Discovering my sexuality and sexual preferences. 55. Using contraception to prevent pregnancy. 56. Using protection to prevent STIs. 57. My safety, to prevent accidentally doing harm to my body during sex. 59. Making sure that if I have kids I teach myself about the signs of sexual abuse and can teach my

	children about reproductive health. 61. Whether health service providers are making efforts to engage me as a culturally diverse young person. 62. I only feel safe accessing health care if I'm sure that it will be confidential.
Low (negative) impact, high importance	1. Feeling pressure/ stressed from parents always talking about my future spouse and marriage. 5. Growing up in a conservative and religious household I was taught abstinence over safe practices. 6. My religious and conservative upbringing means I sometimes feel guilty about my sexual activity. 7. My religious upbringing plays a large part in the things I perceive as right or wrong. 8. My religion doesn't permit certain acts such as extra/pre-marital sex and this serves to protect my health. 9. In my culture, sexual taboo means sexual life and even just talking about sex only happens after marriage. 11. My fear of breaking the conservative norms that are upheld within my community. 12. Western culture and shows always make me feel bad for not being sexual and not wanting to have sexual relations. 14. Cultural and religious stigmas shape my comfort with sexual choices. 15. Fearing judgement from other people and gossip spreading about my sexual life. 33. My perspectives on sexual and reproductive health mostly come from social media. 34. Getting information from the experiences of social media influencers and their advice. 35. Not being able to tell if what I read on social media is factual and true or just opinion. 36. I am influenced by the media I consume (including film, music, social media and articles). 38. Pornography or erotic fiction has changed my sexual preferences and influences my willingness to try to new things. 42. Lack of education and knowledge about sex has limited my ability to make safe choices. 48. Not having been taught about sexual and reproductive health on the spectrum of LGTBQI+ issues. 49. People in my culture thinking sex should only occur between male and female and that the LGBTQI+ community is unnatural means I have to hide my true self. 51. In my culture, boys are seen as having 'needs' and can do anything, while girls being sexually active is seen negatively and is not allowed. 54. Cultural beliefs that woman's worth and dignity come from being 'pure' and not sexually active have become embedded in my mentality. 58. Being afraid of contraception side effects. 60. Not knowing where to go for sexual health issues because I was never taught what services there are or how to use them 63. Not feeling comfortable telling a doctor/healthworker if I have concerns about my sexual health. 64. Sensitivity in my culture about sexual and reproductive health means accessing services is really difficult.
Low (negative) impact, low importance	2. If my parents found out I was sexually active, they'd lecture me about being too easy instead of discussing safe sex. 3. Never having the "talk" with my parents meant I was alienated and had to figure out my own sexuality and about sex on my own. 4. Sexual repression in migrant households means you don't know how to express yourself and you're scared of being judged or disowned 13. Conflict between 'Australian/Western culture and ethnic culture as my family honours the traditional culture 16. In my community, getting pregnant when you're not married is so shameful, it's seen as the worst thing that could happen to anyone. 32. Social media makes it easy to access inappropriate/ harmful content. 41. Not being taught about sexual violence properly during school means I don't know how to recognise or deal with sexual violence. 52. My safety as a woman, as I sometimes feel pressured to do things. 53. As a woman I am afraid of being taken advantage of.

Group concept mapping participant feedback

We value your feedback on the activities you participated in. Please indicate your response to the following items.



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	The activities were easy to understand and complete	1.00	2.00	1.15	0.36	0.13	33
2	I felt that I was able to express important ideas and opinions	1.00	3.00	1.30	0.52	0.27	33

#	Field	Strongly agree		Somewhat agree		Neither agree nor disagree		Somewhat disagree		Strongly disagree		Total
1	The activities were easy to understand and complete	84.85%	28	15.15%	5	0.00%	0	0.00%	0	0.00%	0	33
2	I felt that I was able to express important ideas and opinions	72.73%	24	24.24%	8	3.03%	1	0.00%	0	0.00%	0	33

Showing rows 1 - 2 of 2

What did you like about completing the concept mapping activities?

It was my opinion which allowed me to state what I believe with no right or wrong answer.

It was straightforward and good to see other people's responses

Great tool for reflection and evaluation of what is important to me.

It was interesting seeing other responses

It was simple and easy to understand

It was easy to navigate and understand

I liked being able to map out my views

I liked that it was anonymouse, it felt like I could be honest without a second thought

There was a prompt and from that you could really go into a variety of details about ansything.

I appreciate that we were able to view other's perspectives on their own personal experiences.

I was able to express myself

I liked that I could see other peoples ideas/responses - it was super interesting to see how diverse and varied they were.

The different experiences and perspectives people had. Especially since we were of similar demographics.

Got the chance to express my opinion

Being able to have an outlet to say my opinion

Simple and easy to understand

Simple and easy

I was able to voice my opinion without feeling judged by anyone as it was online.

I enjoyed the fact that the question was direct. I also enjoyed seeing other people's responses

You can provide concise info without bombarding the reader

I like that we were able to give a statement on our opinion.

Very open minded

Seeing people's opionions

It allowed me to voice how I felt, and also showed me the views of other people.

You see similar perspective of other students and you can be honest with out feeling embarass.

Everyone is in it together to help others with Sexual reproductive health

it was very quick to complete and i was able to express my own opinions

Writing on a board and seeing other people's results

I like that we can express our personal opinions without being judged on and the fact that our comments are confidential made it easier to expressed myself

Comparing ideas on a broad level, opportunity to reflect on my experiences

What suggestions do you have to improve the concept mapping activities to centre youth voices?

I'm not sure at the moment, it seems quite good to me already

Have topics that relate to current ideas.

Nothing really

N/a, sorry :(

no suggestions, I think it was well done :)

None really, I think the questions were straightforward and well structured

perhaps have pictures or videos instead of a question

I actually don't know what to answer for this question because I thought that the activities were very concise and easily accessible enough to help centralise youth voices.

N/A

Nothing

More questions

Perhaps conducting these forms of surveys more regularly

Some definitions on what constitutes sexual and reproductive health as people have differing definitions. Also I think not having other responses there would help participants provide an unbiased/uninfluenced opinion

This was well executed

Getting together with people from the same culture

I would suggested maybe asking more questions within the mapping activities

N/A

not sure

Everything was great

none

Maybe more specific questions to target more areas of the question

5 Smile faces on how they see sexual reproductive and health now?

nothing needed to be improved

Having explicit instructions

Keep it this way. I like how it is now.

I can't think of any improvements right now

Table 6.10 Contraceptive and STI awareness by length of time in Australia

	Born in Australia			10+ years			Under 10 years			
	M	*SD*	N	*M*	*SD*	N	*M*	*SD*	N	*p*
Contraceptive awareness	7.9	2.1	43	7.3	2.6	34	4.5	3.1	21	<.001*
STI awareness	5.82	1.95	39	6.30	1.21	33	4.21	2.12	19	<.001*

Table 6.11 Attitudes towards SRH rights by gender

	Female			Male			*p*
	M	*SD*	N	*M*	*SD*	N	
OK to have premarital sex	4.13	1.34	67	3.80	1.44	25	.302
OK to get an abortion	4.03	1.29	67	3.68	1.44	25	.265
STI shameful/ embarrassing	2.04	1.22	67	2.12	1.20	25	.793
Sexual desire shameful/ embarrassing	1.61	0.95	67	1.92	1.26	25	.210
LGBT+ people should have equal rights	4.62	0.77	68	3.92	1.38	24	.025*

Table 6.12 Attitudes towards SRH rights by length of time in Australia

	Born in Australia			10+ years			Under 10 years			
	M	*SD*	N	*M*	*SD*	N	*M*	*SD*	N	*p*
OK to have premarital sex	4.44	1.10	41	3.79	1.60	33	3.68	1.34	19	.052
OK to have an abortion	4.27	1.25	41	3.88	1.34	33	3.37	1.34	19	.046*
STI shameful/ embarrassing	1.93	1.25	41	1.94	1.22	33	2.53	1.02	19	.162
Sexual desire shameful/ embarrassing	1.73	1.05	41	1.52	1.06	33	1.89	.99	19	.426
LGBT+ people should have equal rights	4.76	.66	41	4.27	1.21	33	4.05	1.08	19	.019*

Table 6.13 Barriers to service by gender

	Female		Male		*p*
	N	%	N	%	
Barriers to services					
Unsure where located	37	57	9	47	.601
Too shy/ embarrassed to talk to HCW*	28	43	4	21	.109
Embarrassed about being seen	20	31	8	32	.412
Too expensive	15	23	6	32	.548

*Healthcare worker

Figure 6.1. How well services meet needs of MRY

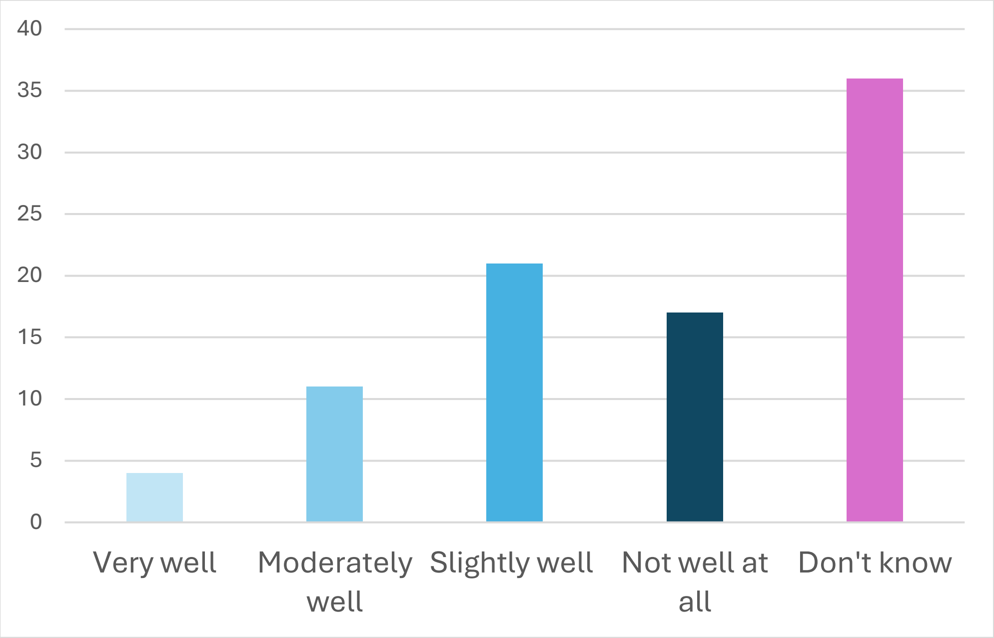


Figure 6.2. Experienced difficulties accessing services

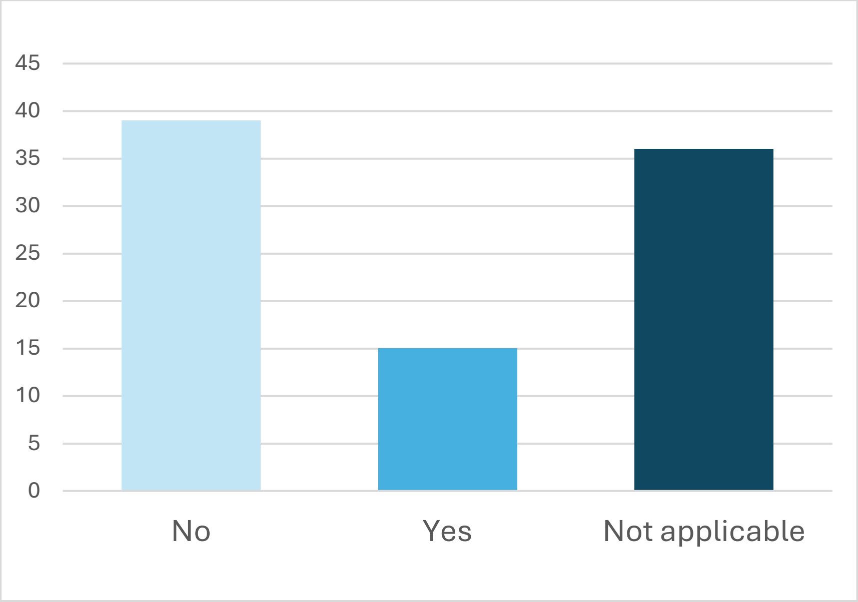


Table 6.14. Open-text responses: dealing with conflict within family, faith, church, culture/ethnic tradition

Conflict within	Participant gender	Participant sexuality	How conflict is dealt with	Theme
Church community	Female	Heterosexual	It’s pretty taboo to discuss so I just avoid it	Silence, avoidance
Faith, cultural/ethnic beliefs or tradition, church community	Male	Heterosexual	Proper communication and set boundaries for myself and my partner	Communication; boundary setting
Family	Female	Bisexual	Suppress/conform	Suppression
Family; faith; cultural/ethnic beliefs or tradition; church community	Female	Heterosexual	Do not address with family members	Silence, avoidance
Family; church community	Female	Bisexual	Left the church, remove myself from situations of judgement and if I have to face them again face them with confidence.	Avoidance; boundary setting
Faith	Female	Heterosexual	Mostly just ignore it	Ignoring
cultural/ethnic beliefs or tradition	Female	Heterosexual	By avoiding being sexually active	Abstinence, suppression
Family, faith, cultural/ethnic beliefs or tradition	Female	Pansexual	I choose not to give it energy and time.	Ignore
Faith	Female	Asexual	I try to explain my situation that the way I am is because of my trauma and that is why i’m asexual, but I think i have always known that I was	Communication
Family	Female	Heterosexual	I don't	Avoidance
Family, church community	Female	Bisexual	Keeping it a secret	Silence, avoidance

Family	Female	Heterosexual	I hide it	Silence
Faith	Male	Asexual	Sometimes I just can’t so I don’t even know that answer	Struggling to cope
Cultural/ethnic beliefs or tradition	Female	Bisexual	I ignore the ones who do not support me; I am independent and value those who value me back.	Ignoring others; prioritising oneself
Family	Female	Lesbian	Parents are not accepting	Being rejected
Family	Female	Bisexual	I cry about it	Sadness; struggling to cope
Family	Female	Bisexual	I choose not to deal with them honestly	Ignoring others
Family	Non-binary	Queer	I don't bring it up and I haven't told anyone	Silence
Family	Female	Bisexual	Explain patiently	Explain
Family	Male	Heterosexual	Keeping it secret	Silence
Family; cultural/ethnic beliefs or tradition	Female	Heterosexual	I try to ignore it most of the time, but I hear a lot of criticism and judgement from people around me	Ignoring others
Cultural/ethnic beliefs or tradition	Female	Bisexual	Try to remember that what matters is how I feel about me and that my parents don’t care	Prioritising oneself; ignoring others
Family	Female	Bisexual	I’m never telling any of my family. That’s the only way	Silence
Faith; cultural/ethnic beliefs or tradition	Male	Heterosexual	Pray and seek help	Prayer
Family	Female	Heterosexual	Secret	Silence

Family; cultural/ ethnic beliefs or tradition	Female	Heterosexual	I try to stay positive as I have a clear goal in life which is to become an dentist and be independent both financially and when making a decision. I am not married until i have an education and have built my career and have made this choice to break out of the traditional cycle of man controlling the money and decisions	Prioritising oneself; boundary setting; positivity
Family	Male	*Prefer not to say*	I don't know how to say	Uncertain
Family	Female	Bisexual	Limited verbal communication on the topic	Silence
Faith	Male	NA*	Idk **	Uncertain
Family; cultural/ethnic beliefs or tradition	Male	Gay	I've cut family off	Silence; no communication; boundary setting

* Participant did not report their sexuality
** "idk" is an internet abbreviation for "I don't know".