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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 refuge 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 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.

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's Health* 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 LGBTQ+ 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 and values		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)	3.73	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 e ects (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 in uences		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
	Con ict 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 di cult (64)	3.71	0.67
	Never having the 'talk' with my parents meant I was alienated and had to gure 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. Welch'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.

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 risks, 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,-reli gious 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 Pe 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.

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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.

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