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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 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]

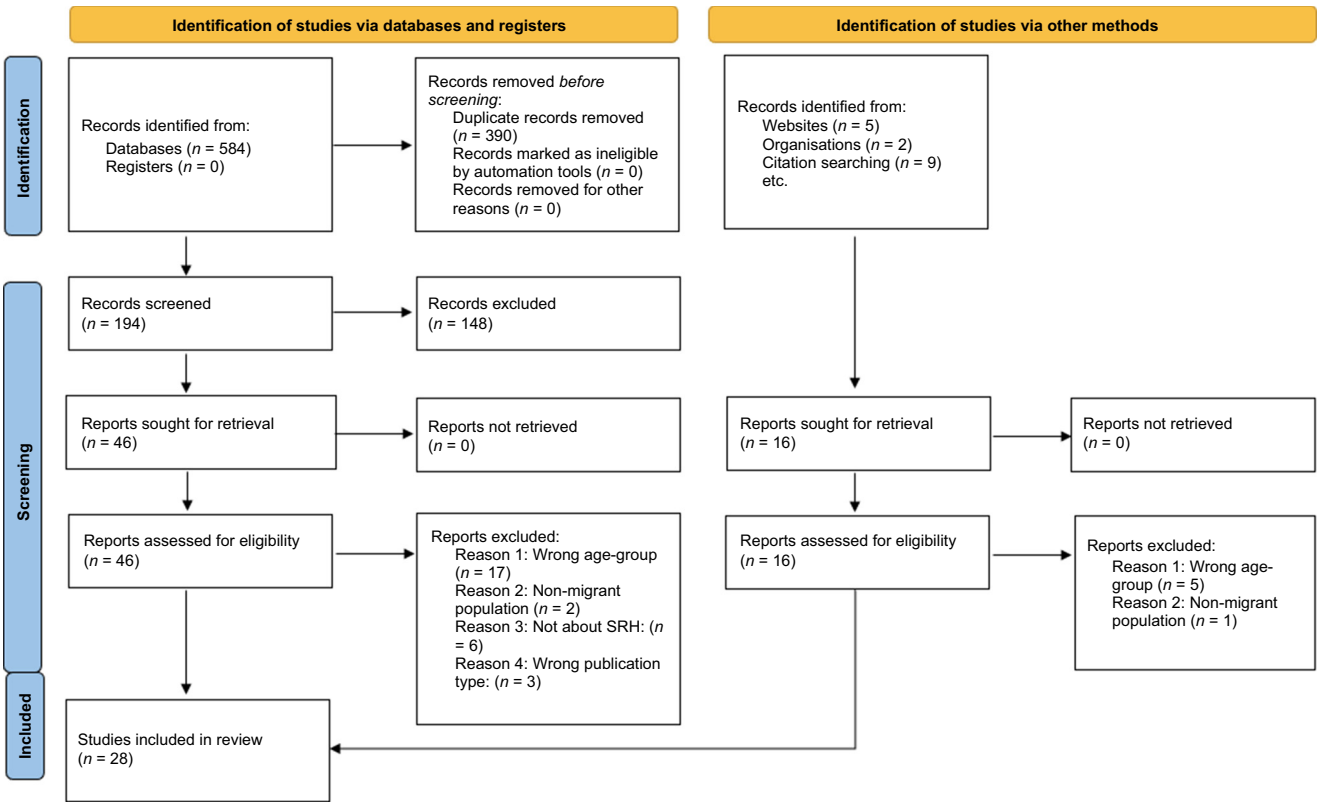

Fig. 1. Flow diagram of search and study inclusion process.

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 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.

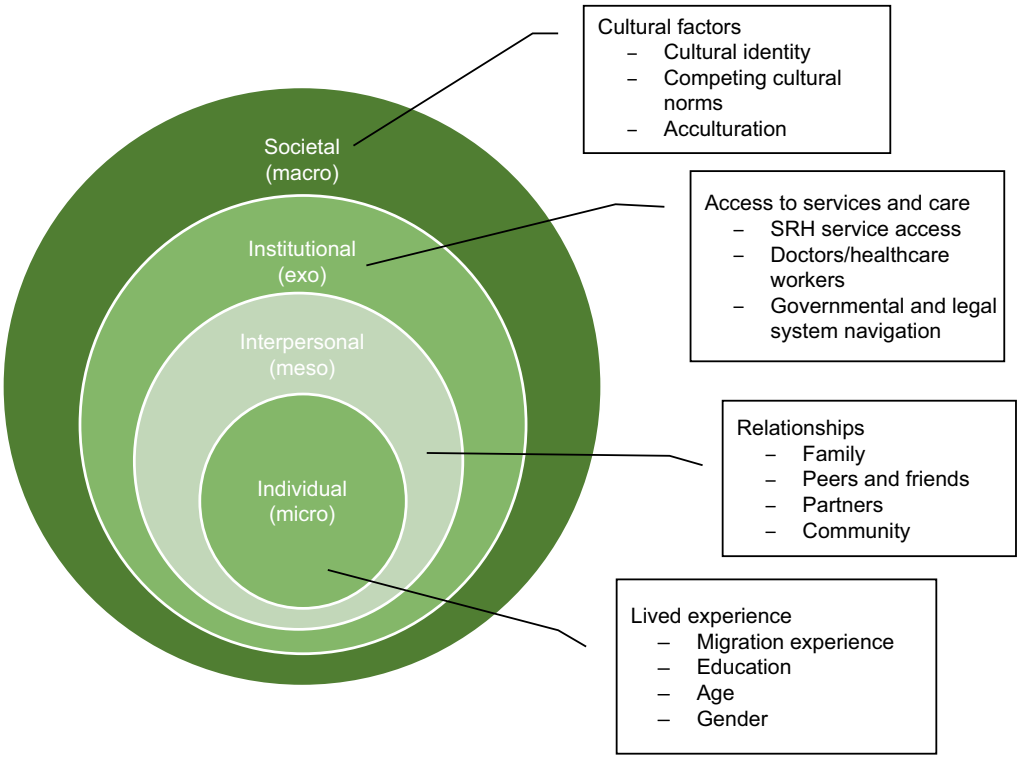

Fig. 2. Socioecological factor model.

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 pre-marital 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 pre-marital 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.

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