Participatory Action Research: Sexual and Reproductive Health and Rights of Young Refugees and Migrants

71

Tinashe Dune, Pranee Liamputtong, Syeda Zakia Hossain, Virginia Mapedzahama, Rashmi Pithavadian, Michaels Aibangbee, and Elias Mpofu

Contents

T. Dune (✉)
School of Health Sciences, Translational Health Research Institute, Diabetes, Obesity and Metabolism Translational Research Unit, Western Sydney University, Penrith, NSW, Australia
e-mail: t.dune@westernsydney.edu.au

P. Liamputtong
College of Health Sciences, VinUniversity, Hanoi, Vietnam
e-mail: pranee.l@vinuni.edu.vn

S. Z. Hossain
School of Health Sciences, Faculty of Medicine and Health, University of Sydney, Sydney, NSW, Australia
e-mail: zakia.hossain@sydney.edu.au

V. Mapedzahama
African Women Australia Inc., Liverpool, NSW, Australia
e-mail: research@awau.org.au

R. Pithavadian
School of Health Sciences, Western Sydney University, Penrith, NSW, Australia
e-mail: r.pithavadian@westernsydney.edu.au

P. Liamputtong (ed.), *Handbook of Social Inclusion*,
https://doi.org/10.1007/978-3-030-89594-5_78

Abstract

This chapter discusses sexual and reproductive health and rights (SRHR) of young people of refugee/immigrant background in an Australian setting. This is a socio-economically vulnerable population and at risk for neglect of recognition of sexual and reproductive rights, or their right to make informed decisions regarding sexuality. This includes choices about if and when to become sexually active, with who, and in what way, relationship options and access to contraception even in marriage, including whether and when to have children et cetera. Applying a participatory action research approach, the authors provide an in-depth and step-wise SRHR exploration with a community of young people of refugee/immigrant background. The chapter highlights the role of participatory frameworks for sustainable rights protection systems and practices in diverse settings. The chapter draws on human rights theory and participatory research methods' central elements for addressing individual and community sexual and reproductive health concerns. The chapter also provides readers with tools to develop and implement rights-based sustainable SRHR with populations with historical vulnerability.

Keywords

Participatory action research · Young people · Migrant · Refugee · Sexual health · Reproductive health · Sexual and reproductive health rights

1 Introduction

When discussing sexuality and reproduction, readers will mostly likely have heard of the term sexual and reproductive health (SRH). Few will have come across the term sexual and reproductive health and rights (SRHR). Despite the recency of the

M. Aibangbee
School of Health Sciences, Western Sydney University, Penrith, NSW, Australia

Migrant and Refugee Mental Health, Anglicare Sydney, Sydney, NSW, Australia
e-mail: Michaels.aibangbee@anglicare.org.au

E. Mpofu
University of North Texas, Denton, TX, USA

University of Sydney, Sydney, NSW, Australia

University of Johannesburg, Johannesburg, South Africa

Western Sydney University, Sydney, NSW, Australia
e-mail: elias.mpofu@unt.edu

term, the concepts and health needs encompassed by it have been discussed and advocated for since the mid-1900s. The distinction between sexual and reproductive health and SRHR is an important one. Sexual and reproductive health is the state of physical, emotional, mental, and social well-being concerning all aspects of sexuality and reproduction, as well as concerning disease, dysfunction, and infirmity (Dune et al. 2017). Importantly, sexual and reproductive health can only be achieved through the recognition of sexual and reproductive rights (Cottingham et al. 2010). This refers to the right every indidvidual has to make informed decisions regarding what happens, and when, to their bodies. This includes choices about if and when to become sexually active, with who, and in what way; navigating respectful relationships and sexual coercion; options and access to contraception and reproductive healthcare; partners and marriage, including whether and when to have children; and access to the information, services, and resources to navigate these choices free from discrimination, violence, and coercion (Cottingham et al. 2010). For a background to SRHR, the seminal article by the United Nations from 75 years ago is referred.

The Universal Declaration of Human Rights in 1946 (UDHR 1946) has 30 fundamental rights which apply to all human beings. Workman (2019) affirms that the attainment of the SDG goals requires a human rights framework to facilitate improvements in sexual and reproductive health for all people and especially those from minority and marginalized populations. With this in mind, several overlapping and intersecting articles within the UDHR seek to provide support for SRHR. For instance, Article 3 indicates that all human beings have a right to life, liberty, and security of person. This is relevant to many areas of SRHR and especially to safety from sexual abuses or violations. Article 25.2 indicates that motherhood and childhood require special care and assistance. With regard to SRHR, this may include mothers' access to maternity service before, during, and after birth or child protection with regard to sanctions on child marriage. Article 26 supports the need for education for all. Comprehensive SRH education is, therefore, a right although many children in developed and developing countries are not provided with those opportunities (UN 2020).

The 30 articles of the UDHR are vital for holistic SRH and well-being with each being intertwined and in support of the others. As such, signatories to the UDHR are obliged to ensure that human rights are upheld through their ratification into national, state/provincial laws. While human rights are meant to apply to all, operationalizing these utopian ideals into legislation, policy, and practice is challenging for nation-states (Australian Human Rights Commission [AHRC] 2019). Conversely, this is because each nation-state has the autonomy to "choose" which human rights they feel they can realistically uphold, accept, reject, or ratify. For example, within Australia, there is no bill of rights; however, different constitutions and legislation promote some rights, while others, like some related to the rights of Indigenous Australians, are systematically undermined. There are five rights protected by the Australian Government, such as universal voting rights, rights to freedom of speech, rights to freedom of association, rights to freedom of religion, and rights to freedom from discrimination. Outside of these five rights, the Australian Government is the only sovereign nation-state without a national bill of rights (AHRC 2019). This dangerous approach has seen many minorities across many populations abused and exploited in Australia (AHRC 2019).

For those who are new to the concept of human rights, questions about how one can determine whether a human right is fulfilled may arise. The National Economic and Social Rights Initiative (NESRI) has developed a framework including six basic principles that help to determine whether an action or program aligns with human rights principles. These principles are as follows (NESRI 2019, p. 2):

1. **Universality**: Human rights must be afforded to everyone, without exception. The entire premise of the framework is that people are entitled to these rights simply by virtue of being human.
2. **Indivisibility**: Human rights are indivisible and interdependent, which mean that in order to guarantee civil and political rights, a government must also ensure economic, social, and cultural rights (and vice versa). The indivisibility principle recognizes that if a government violates rights such as health, it necessarily affects people's ability to exercise other rights, such as the right to life.
3. **Participation**: People have a right to participate in how decisions are made regarding the protection of their rights. This includes, but is not limited to, having input on government decisions about rights. To ensure human rights, governments must engage and support the participation of civil society on these issues.
4. **Accountability**: Governments must create mechanisms of accountability for the enforcement of rights. It is not enough that rights are recognized in domestic law or in policy rhetoric. There must actually be effective measures put in place, so that the government can be held accountable if those rights standards are not met.
5. **Transparency**: Transparency means that governments must be open about all information and decision-making processes related to rights. People must be able to know and understand how major decisions affecting rights are made and how public institutions, such as hospitals and schools, which are needed to protect rights, are managed and run.
6. **Non-discrimination**: Human rights must be guaranteed without discrimination of any kind. This includes not only purposeful discrimination, but also protection from policies and practices which may have a discriminatory effect.

Applying this approach to SRH reinforces that in order to achieve well-being in this area, human rights must be appropriately and thoroughly addressed. This is of course a tall order but not an impossible one. Using a human rights framework, therefore, helps to establish basic standards applicable to all human beings, regardless of their race, gender, ethnicity, or class, from all walks of life in relation to SRHR (Coomans et al. 2009). It sets the standards against which actions and programs can be assessed and helps to identify where further engagement is required in order to meet the goals of SRHR as outlined in the Sustainable Development Goals, for example.

To understand the wide-reaching and holistic implications of SRHR, this chapter will acclimate readers to this new terminology and explain how the concept supports sustainable community health approaches across diverse populations.

2 Defining Sexual and Reproductive Health

The term sexuality is a broad concept which has many meanings. According to the American Psychological Association (2012a, b), sexuality is a process with three stages: (1) desire (an interest in being sexual), (2) excitement (the state of arousal in response to sexual stimulation), and (3) orgasm (sexual pleasure's peak). It is clear that this definition limits sexuality to a model of function and possible dysfunction (similar to the medical model used in Western healthcare systems) which overlooks the psychological, social, cultural, and dynamic nature of human sexuality and sexual well-being (American Psychological Association 2012a, b). In order to acknowledge the complex and expansive nature of human sexuality, some scholars and educators describe sexuality as an array of human experiences that include family relationships, dating, physical development, sexual behavior, sexualization, sensuality, sexual health, reproduction, gender, and body image (Giorgio et al. 2013).

Furthermore, some sexuality educators use a model called the circles of sexuality. This model includes five interconnected circles which represent five broad areas of sexuality: sensuality, intimacy, sexual identity, sexual health and reproduction, and sexualization. In this model, sexuality is represented as much more than sexual arousal, intercourse, and orgasm. This way of thinking about sexuality highlights the importance of all the feelings, thoughts, and behaviors associated with being a certain gender, being attracted to someone, or being in a loving or intimate relationship (deFur 2012).

Accordingly, sexuality is a fundamental and natural part of being human across the lifespan and a fundamental part of human well-being and health. It is made up and informed by emotional, physical, and sociological factors. It includes nurturing and protecting the sexual and reproductive health of both you and your partner as well as getting the most from your sexual life while also feeling happy and confident about yourself (Dune and Liamputtong 2019). A key aspect of sexuality is sexual health. Although the term sexual health is also expansive and complicated, definitions are generally in agreement with one another. Sexual health, as defined on the World Health Organization website (2020), is:

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

In line with and in addition to the WHO definition of sexual health, the United Nations Population Fund website (UNFPA 2020) explains what sexual and reproductive health is and also how it can be maintained using a rights-based framework:

> Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby. Every individual has the right to make their own choices about their sexual and reproductive health. UNFPA, together with a wide range of partners, works toward the goal of universal access to sexual and reproductive health and rights, including family planning.

This definition extends past the notion of concepts of sexuality, sexual health, reproductive health, and human rights as independent. Importantly, the notion of human rights is central to sustainable community health – without which sexual and reproductive health cannot occur.

Further, SRHR highlights the realities of intersecting identities and the potential for compounded prejudice, discrimination, and oppression for marginalized populations. It, therefore, allows for the development of recommendations to advance theory, research, policy, and practice that acknowledge multiple and coexisting identities and experiences. SRHR, therefore, acknowledges that sexual and reproductive health is experienced by people with multiple identities and experiences. It is inherently intersectional and requires sustainable community health projects to address this multiplicity as well.

3 SRHR: A Brief History

The history of SRH is tied to state and federal family planning services initiatives. For instance, government-run family planning services were established across many nations from the 1950s (Visaria et al. 1999). While these programs were initially developed to manage population control in order to sustain economic growth and development, they opened doors for more holistic discussions about community needs and means of sustainable SRH development. Fast-forward to 40 years, developments with regard to SRH had significantly progressed. As a result, the International Conference on Population and Development (ICPD) in 1994 in Cairo, Egypt, marked a significant shift toward understanding SRH not only as a public health or economic issue but primarily as a fundamental human right (Fincher 1994; Glasier et al. 2006). By the end of the ICPD, a Program of Action (PoA) was developed and adopted by 179 countries ("Programme of Action (PDF)," September 1994). The PoA affirmed sexual and reproductive health as a universal human right and outlined global goals and objectives for improving SRH. Fundamental elements for such improvements were based on increasing free choice, women's empowerment, and viewing sexual and reproductive health in terms of physical and emotional well-being. The original PoA (1994) and a revision by the United Nations outlined a

series of goals, based on a central mission of achieving universal access to sexual and reproductive health globally ("Programme of Action (PDF)," September 1994; UNFPA 2010). Readers will appreciate there is still much to do toward the attainment of these goals. Aligned with the goals of the PoA, the Millennium Development Goals (MDGs) were developed in 2000 with SRHR being an important component to Goals 3, 4, and 5 (Glasier et al. 2006; Sachs and McArthur 2005). Upon the expiration of the MDGs and ICPD PoA in 2015, more explicit SRHR goals were included in the current Sustainable Development Goals (SDGs) which seeks to combat poverty by 2030 (Tangcharoensathien et al. 2015).

4 Sustainable Sexual and Reproductive Health and Rights with Refugee Immigrant Youth in Australia

In Australia, little is known about migrant and refugee youths' knowledge and agency related to SRHR in Greater Western Sydney because youths are rarely asked. Although sexual and reproductive well-being cannot be realized without SRHR – a fundamental human right – few studies have considered migrant and refugee youths' knowledge and agency in Greater Western Sydney. The little research conducted in this region (mostly by the authors of this chapter) on migrant and refugee youths' sexual and reproductive health (Dune et al. 2017; Hawkey et al. 2016; Mengesha et al. 2016, 2017a, b, 2018a, b; Wray et al. 2014) has mostly focused on the prevalence of unplanned pregnancy, having STIs, intergenerational issues, cross-cultural clashes, and constructions of sexual and reproductive health in relation to culture and/or religion. From this work, and that of others (Botfield et al. 2016a, 2017), it became clear that only by centering youth voices and moving away from a deficit model of adolescence, migrancy, and sexual and reproductive health could improvements in SRHR agency, decision-making, and well-being outcomes be optimized.

In order to better understand how SRH can be operationalized in ways that reflect human rights and intersectionality, some real-world examples of SRHR programming are instructive. The designed SRHR program, with young people from diverse backgrounds, aims to better understand and then address their SRHR needs. This project was funded by the Australian Research Council through their Discovery Project 2020 Grants (DP200103716). The project focused on Greater Western Sydney in Australia as an increasingly populated urban center with a high proportion of people from culturally and linguistically diverse, religious minority and low socioeconomic backgrounds.

4.1 Context of Study

Greater Western Sydney is one of the fastest growing and most diverse regions in Australia. The region's 2 million inhabitants make up about 9% of Australia's population and 44% of Sydney's population (ABS 2019; Dune et al. 2017). The

region grew at 2.1% in the last year and 1.6% per year for the past 10 years (ABS 2019). The region's population is projected to reach 3 million by 2036. The residents of Greater Western Sydney come from more than 170 countries and speak over 100 different languages (ABS 2017). Over 50% of the region's 2 million people are migrants or their descendants (ABS 2017). Further, 38% of the population speaks a language other than English at home and up to 90% in some suburbs. For instance, the suburb of Cabramatta has an 87.7% non-English-speaking population, the highest anywhere in Australia (except for remote Indigenous communities where Aboriginal languages are dominant). Other Western Sydney suburbs, Bankstown, and Canley Vale also have over 80% of a non-English-speaking background. While many of these communities are largely Australian-born (including Arabic speakers, with about 50% born here), Greater Western Sydney also remains the epicenter of Australian migration. It is a first port of call for many migrants. The top five countries of emigration between 2006 and 2011 were India, China, Iraq, the Philippines, and Vietnam (ABS 2019). As a result, Greater Western Sydney is a hotspot of intersectional disadvantages and significant strengths and resilience. There are increasing health and well-being services available to Greater Western Sydney communities, but little in the way of accessible and engaging SRHR supports for migrant and refugee youths and especially those experiencing multiple disadvantages.

It is important to acknowledge and address this epistemological gap in Greater Western Sydney – one of Australia's fastest growing regions. The project, therefore, explored migrant and refugee youths' (aged 16–24) understandings and experiences of sexual and reproductive health and rights (SRHR) – a gap identified in the authors' interdisciplinary pilot work (Ayika et al. 2018; Dune and Mapedzahama 2017; MacPhail et al. 2017).

4.2 Aims of the SRHR Program

To best understand the SRHR of young people of refugee/immigrant background, this project drew on the author's' interdisciplinary pilot work and used participatory action research (PAR) to address the following study aims:

1. Investigate migrant and refugee youths' understanding of and experiences with sexual and reproductive health and rights.
2. Identify the barriers and facilitators migrant and refugee youths perceive to sexual and reproductive well-being, decision-making, and agency.
3. Map the socioecological factors that characterize youth sexual and reproductive health and rights and their support needs, literacy, service utilization, availability, and accessibility.
4. Develop a human rights-based and youth-determined model for policy and programming aimed at improving youth sexual and reproductive health agency and well-being.

4.3 Approach and Significance

The project centered SRHR as a fundamental human rights issue critical to the realization of other human rights such as equality, autonomy, privacy, and non-discrimination (Cottingham et al. 2010). Human rights are at the core of SRHR and PAR with their focus on the relationship between **self-determination** and health outcomes. This relationship is of great significance to migrant and refugee youth and has given the range of challenges they encounter which interfere with their ability to make informed and agentic sexual and reproductive health decisions (Botfield et al. 2017).

Key socioecological and intersecting challenges faced by these youths include cross-cultural, intergenerational, socioeconomic, religious, and language clashes, among others (Dune et al. 2017). These challenges result in the silencing of migrant and refugee youth, leading to feelings of disempowerment and ultimately disengagement from services and supports designed to assist them in their **SRH decision-making** (Botfield et al. 2016a). As a result, little is known about these young people's understanding of, and importantly their ability to exert their sexual and reproductive health and rights. With a greater understanding (of the socioecological and intersecting factors that influence **SRHR agency** and decision-making), a feasible model that acknowledges youth human rights could be developed. Given that 60% of Australia's population growth is through migration, much can be learnt about sustainable SRHR practices which can be translated and applied to other regions locally, nationally, and internationally.

Exploring migrant and refugee youths' SRHR is a critical issue at a critical age where life-altering sexual and reproductive health decisions are expected to be made. However, youth in general and migrant and refugee youth, in particular, are often unsure of what rights they have and/or how to exert them in relation to other people, services, and information (Mberu et al. 2014). The impacts of this dearth in knowledge and agency include difficulty acquiring contraception, unplanned pregnancies, unmanaged sexually transmitted infections (STIs), limited understanding and reporting of sexual coercion/abuse, and isolation of gender and sexuality diverse youth (Dune et al. 2017; McMichael and Gifford 2009).

For example, in Australia, migrant and refugee youths are reported to have lower levels of sexual and reproductive health knowledge and literacy, higher rates of unplanned and teenage pregnancy, and longer lasting treatable STIs than their non-migrant counterparts (McMichael and Gifford 2010). Further, research indicates that migrant and refugee youths in Australia experience limited access to and knowledge of the health and social services that cater to their sexual and reproductive health needs (Dune et al. 2021). This research reflects similar trends in Greater Western Sydney (Dune et al. 2017). Take STI notifications, for example. Chlamydia is on the rise in Australia, with a 10% increase in notifications between 2017 and 2018. The risk for chlamydia is highest in people aged 15–24 years old with 80% of cases occurring in this age group. While underreporting is typical, women are more likely to be diagnosed than men. Gonorrhea is also on the rise with a 14% increase

between 2017 and 2018. Young women aged 15–19 years are more likely to be diagnosed than young men in this particular age group. Overall, three quarters of cases occur in the 15- to 34-year-old age group. Syphilis infection also increased by 24% between 2017 and 2018 with young people being increasingly represented in notifications (Healthed 2019).

Increased youth STI notifications also mean increased migrant and refugee youth STI notifications. However, unlike their non-migrant counterparts, migrant and refugee youths are less likely to know they have an STI, know where and how to get tested, and thus more likely pass it on to others or suffer complications from an untreated infection (Botfield et al. 2016a, 2017). Several Australian and many international studies, on sexual and reproductive health, help us estimate and understand migrant and refugee youth sexual and reproductive behavior and outcomes. However, few in Australia and none in Greater Western Sydney focus on the role of SRHR as defined by youth in their health behavior and outcomes. An issue is addressed in this project by centering the voices of migrant and refugee youth in Greater Western Sydney.

5 SRHR Improves Health Outcomes for Migrants and Refugees and Minority Youths

Most SRHR decisions are made as a consequence of a negotiation process between the person and the surrounding environment (Asghari-Fard and Hossain 2017). For youth, all of these SRHR choices must be made in tandem with other life decisions like what to do about drugs, alcohol, and other risk-taking behavior; peer pressure, body changes, image, and self-esteem; increasing independence and distancing from one's family and community; and identifying their sexual and gender identity – not to mention having to concurrently figure out their education and career pathways that will determine the trajectory of most of their adult lives.

Given the multitude of variables young people contend with, the importance of them finding ways to make potentially less onerous more informed decision-making cannot be underrated. Research indicates that youths whose SRHR are addressed through education, health promotion, and inclusive practices demonstrate increased health literacy and safer sex practices and develop an improved understanding of how and where to seek help for sexual and reproductive health issues (Mpofu et al. 2014). Importantly, international programs that sought to improve the SRHR knowledge, agency, and self-determination of minority groups often employed strengths-based and PAR strategies to learn, develop, and evaluate outcomes (Caldwell et al. 2004). In doing so, it supported minority groups' empowerment, sense of involvement, as well as an agency over themselves and their sexual well-being. This project drew on this evidence, highlighting the importance of exploring the ways that migrant and refugee youth perceive these concepts and identify the factors that influence their sexual and reproductive well-being.

6 The Intersecting Social Ecology of SRHR for Migrants and Refugees and for Youth

Like their non-migrant counterparts, migrant and refugee youth SRHR are influenced by a range of socioecological factors. These include societal, community, organizational, interpersonal, and individual variables that act as either barriers or facilitators to SRHR (Mengesha et al. 2017b). At the broader social level, migrant and refugee youths are influenced by cultural norms and beliefs from their culture of origin as well as from Australian culture (Dune and Mapedzahama 2017). These may clash, resulting in difficulties exerting their SRHR while simultaneously maintaining anonymity (Dune et al. 2017). Societal constructions of migrants and refugees may also influence this cohort's sense of belonging and inclusion. Where the sense of belonging and inclusion is low, migrants and refugees may disengage from SRHR opportunities and organizations for fear of prejudicial treatment.

At an organizational level, migrants and refugee youth may not know where, how, and when to access services or may not have the finances to do so (Botfield et al. 2017). The organizations that youths do encounter (schools, GPs, school counselors) may not know where to direct them and/or which supports will facilitate rather than act as a barrier to SRHR. For instance, family planning organizations may not be as accessible as hoped given that 46% of teenagers who accessed *Family Planning* services in 2012 reported having learned about their services through "word of mouth" (Family Planning Victoria 2015). However, as a result of interpersonal issues like language barriers, discriminatory behavior from others, and stigma, migrant and refugee youth may not feel safe talking to other youth about their sexual and reproductive health issues (Asghari-Fard and Hossain 2017; Botfield et al. 2016a). Further, across Australia, sexual and reproductive health education is, to a limited extent, taught in schools – particularly at senior levels – but varies in its breadth and depth across schools and states (Dune and Mapedzahama 2017). In such settings, social pressure may restrict migrant and refugee youths from seeking more information on topics they would like to learn more about. Importantly, information about SRHR may be perceived as unhelpful and in poor consideration of migrant and refugee youth needs (Dune and Mapedzahama 2017). Moreover, existing sexual and reproductive health education for youth are often developed with minimal, if any, direct input from young people themselves. This is despite the fact that research suggests that when services are based on user-centric perspectives, they are more accessible and therefore utilized (Botfield et al. 2016a, b, 2017) – an issue this project addresses.

Youths who are deeply embedded in their cultural and/or religious communities may struggle to find opportunities to speak to someone they know or an impartial support person about their SRHR (Dune et al. 2017). This is because they may fear their family and community becoming aware and the sanctions that may follow. This tension is highlighted by intergenerational understandings and experiences of SRHR (Botfield et al. 2018; Dune et al. 2017). For instance, research indicates that in the first few years of arrival, 1st-generation skilled Zimbabwean migrants found how

Australian culture constructed and dealt with sexuality to be confronting and at odds with their beliefs and ways of understanding sexuality (Dune et al. 2015). As a result, families experienced conflict when trying to educate their 1.5-generation migrant children about sexual and reproductive health from a Shona-Zimbabwean lens within contemporary Australia (Dune et al. 2015). Further, 1st-generation migrant parents and 1.5-generation migrant children indicated that many parents expected these children to comply with constructions of sexuality from their country of origin more than their 2nd-generation children (Dune et al. 2015). A similar finding was observed among the 2nd-generation Iranians living in Australia (Asghari-Fard and Hossain 2017). Notable expectations included avoiding interactions with members of the opposite sex (especially enforced with girls); restrictions on participation in youth peer events (e.g., birthday parties, sleepovers, or group excursions); and restrictions on engagement with LGBTIQ people, information, or media. Given the influence of family on young people, centering their perspectives and ideas about how to seek SRHR support under these circumstances is paramount to addressing their sexual and reproductive health well-being needs.

Individual factors that influence migrant and refugee youth include their sex, gender, sexual orientation, age, acculturation, visa status, and level of education. These factors determine the interpersonal, organizational, and societal expectations placed upon them, including the way that their sexual and reproductive well-being manifests. For instance, girls (whether migrant or otherwise) are often expected by society to be responsible for fertility control and any issues therein (Ekstrand et al. 2007). This study explores this socioecological phenomenon concerning socio-demographic variables, like sex and gender, to determine the role it may play in migrant and refugee youths SRHR. Further, migrant communities with strong sex and gender role delineations may find the acceptance of sexuality and gender diversity challenging (Minichiello et al. 2014). Further, one's visa status may come with unexpected social prejudices like the pejorative constructions of people who seek asylum (Schuster 2011). So, while the aforementioned factors and influences can be inferred about migrant and refugee youth in Greater Western Sydney, no study had previously mapped the social ecology of migrant and refugee youth with regard to SRHR. Gaining clarity in this regard, through a participatory approach, helped to determine the role of these factors on migrant and refugee youths' understandings and experiences of SRHR – necessary information toward improving youth sexual and reproductive health well-being.

7 Theoretical and Conceptual Frameworks Relevant to Sexual and Reproductive Health and Rights with Migrant and Refugee Youth

Given that migrant and refugee youths' sexual and reproductive health and well-being are determined by SRHR (a human rights concept with a multitude of influential variables), **socioecological theory** helps to organize and, therefore, understand the intersectional contents of migrant and refugee youths' constructs and experiences

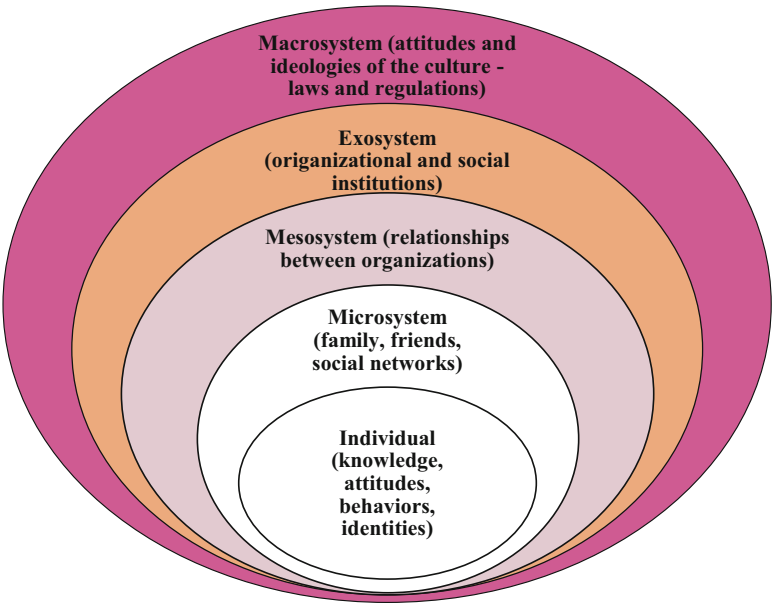

Fig. 1 Socioecological theory

(Mengesha et al. 2017b). Socioecological theory supports the development of an evidence base around migrant and refugee youth SRHR as it centers the individual and their intersectionality. It also considers not only the role but also the salience and interactions between individual, interpersonal, community, organizational, and societal factors (see Fig. 1). This theoretical framework, therefore, provides both a strategy for exploring SRHR and a system that helps to explain it (Mengesha et al. 2017b).

A clearer understanding of the contents of migrant and refugee youths' constructs and experiences allows for a better understanding of how their SRHR needs can be addressed within a **human rights-based approach**. This project uses a human rights-based approach as its conceptual model. This approach highlights the importance of empowering rights holders (migrant and refugee youth) and supporting duty bearers (researchers, policy-makers and enforcers, services providers) through capacity building. This approach centers accountability, equality, non-discrimination, participation, universality, and indivisibility as principles necessary toward improving well-being (Australian Human Rights Commission 2019) (see Fig. 2). To advance youth sexual and reproductive health and well-being, these principles will serve as a guide for structure, execution and evaluation of the project, its findings, its outcomes, and dissemination strategies (Office of the High Commissioner 2012). Such an approach ensured that the project developed a migrant and refugee youth SRHR model that was aligned with human rights principles in a valid and reliable way. The project drew on the National Economic and Social Rights Initiative human rights framework, introduced above, which supports the rigor and replicability of the project in other locations and populations.

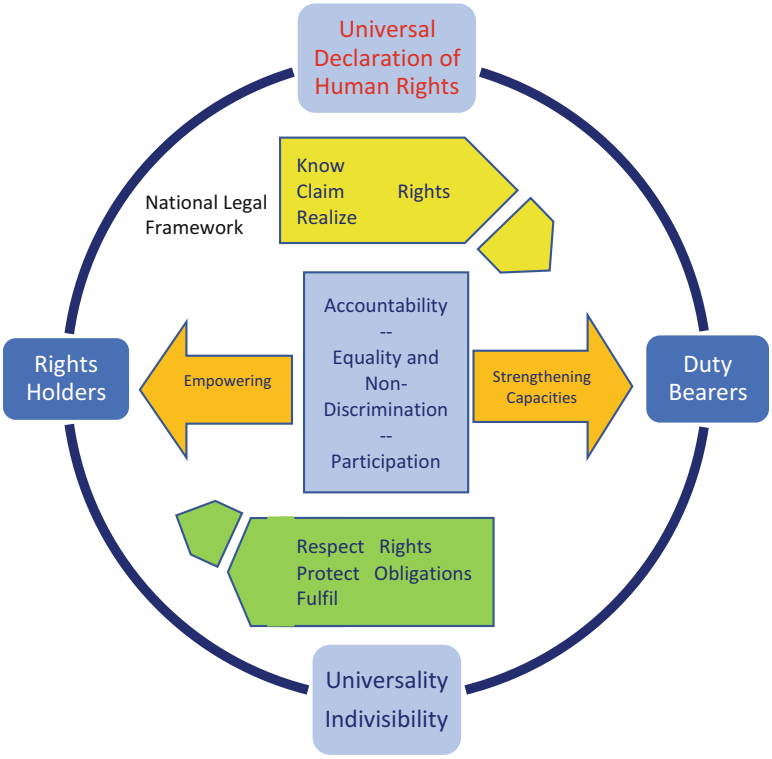

Fig. 2 Human rights-based framework for project development, Implementation and Evaluation

8 Participatory Action Research (PAR) with Migrant and Refugee Youths

To appropriately implement and evaluate this project, a convergent parallel **mixed methods design** was used. Within a participatory action research (PAR) model, this involved the use of qualitative focus groups and interviews, a quantitative survey, and state-of-the-art concept mapping approaches (Mpofu et al. 2014) to explore migrant and refugee youth SRHR. In line with a socioecological approach, this design ensured that the data addressed was interpreted as a whole system of knowledge. A systemic integration and interpretation of the findings was integral to the development of the youth-determined SRHR model that aligned with a holistic human rights-based approach. This research design also helped to provide evidence on the ways that youth feel most empowered to be agents of their own sexual and reproductive health and well-being.

To ensure that SRHR programming is holistic and relevant to policy and practice, an experienced team with expertise in the particular area of SRH and population group is necessary. In addition to all members of the research team being of migrant

backgrounds (from Africa, India, and Thailand), the team has produced impactful, theory-driven, and policy-relevant outcomes using PAR, human rights, and sociological theory to study sexual and reproductive health constructs, experiences, and needs with migrant and refugee youths in local, national, and international settings (Dune et al. 2017; Mengesha et al. 2017a; Mpofu et al. 2005, 2011, 2012, 2014). The authors' lived experiences and well-established and proven collaborative strengths was employed to effectively produce significant outcomes from this project and with the communities involved.

8.1 Methods for Engaging in Sustainable Community Sexual and Reproductive Health and Rights

There were five phases to this SRHR project which the team has successfully piloted with migrant and refugee youth in Greater Western Sydney. The **piloting** of methods for use within community projects is central to their future success when scaling to larger populations. Without evidence-based and piloted methods, teams run the risk of implementing strategies that communities experience as dominating and paternalistic. While programs may run in the short term from such approaches, evidence suggests that they are rarely successful or sustainable in the long run. Each phase of the project was underpinned by a community-driven and engaged approach such that the processes for increasing SRHR supports in and by the community could continue well after the initial project ceased.

8.1.1 Phase 1: Community Engagement

The project began by recruiting the **Advisory Committee** through the research team's networks. The committee was made up of 10 community leaders and 15 support service providers, researchers and/or policy-makers, and organizational leads from within Greater Western Sydney and included central policy-makers from across Australia. In addition to being partners on relevant previous pilot projects, their input was integral to the participatory action research framework used in this project. They also ensured that the project had representative engagement from migrant and refugee communities in Greater Western Sydney, which supported the development of a culturally responsive, youth-determined, and youth-centric SRHR model of care. Committee meetings were held four times a year to ensure that the project was regularly reporting back and receiving feedback from stakeholders on the ground.

In line with PAR, the Advisory Committee was asked to help in selecting a convenience sample of 22 young people (aged 16–24) from diverse migrant and refugee and sociodemographic backgrounds to act as remunerated (in cash) **Youth Project Liaisons**. These youths helped to recruit for and facilitate the youth focus groups (described below). The Youth Project Liaisons also helped with recruitment through their networks for the other parts of the project; co-facilitated the concept mapping workshops; provided feedback on the project findings; identified key issues to be addressed within the SRHR model; reviewed and provided feedback on an

accessible version of the SRHR model of care; and assisted with the dissemination of youth-friendly versions of the project findings.

Many projects do not pay participants and where payment occurs, vouchers are often used. However, cash remuneration for the Youth Project Liaisons was integral and aligned with PAR and human rights approach as it values their time, knowledge, input, and utmost their participation. Although vouchers are a common form of participation recognition, research has indicated that youths, and especially those from low socioeconomic and minority backgrounds, find vouchers inaccessible and inconvenient. Insisting on the use of vouchers in research with marginalized and vulnerable populations, for fear that use of cash funds cannot be controlled, is paternalistic and reinforces the myth that youths are unable to make choices (Bonevski et al. 2014). Conversely, cash incentives have been found to be more effective than non-cash incentives across the life of a project (Bonevski et al. 2014). By using cash remuneration, a youth-responsive form of participation acknowledgment (Bonevski et al. 2014), this project was able to recruit a significant number of migrant and refugee youth to participate.

8.1.2 Phase 2: Brainstorming: Focus Group Protocol, Concept Mapping, and Questionnaire Development

Once the Advisory Committee and Youth Project Liaisons were recruited, they were asked to participate in an online forum workshop. A face-to-face half-day workshop was originally planned. However, this plan had to be changed due to the recent crisis of COVID-19. Youth Project Liaisons were also asked to bring a friend of migrant and/or refugee background to the workshop to help balance out the number of youth and committee members and to ensure that diverse perspectives were represented. The inclusion criteria for youths in all parts of the project were the following: (1) being aged 16–24, (2) self-identifying or have a parent who identifies as a migrant or refugee, and (3) living in Greater Western Sydney for the past 12 months. Migrant and refugee peers also received cash to acknowledge their time and travel. Before the project commenced, these workshops were needed to collectively brainstorm key concepts and items for the development of the focus group protocol, concept mapping inclusions, and the questionnaire.

During this phase of the project, two systematic literature reviews were conducted that explored (1) youths' constructions and recommendations around SRHR among minority youth and (2) existing guidelines to engage young people in youth-led SRHR programs. These helped the team to contextualize the ways in which SRHR was understood by young people internationally and to identify key socioecological factors and human rights principles relevant in other contexts that may be relevant in the Australian context. A scoping review was also conducted to map existing youth SRHR related policies and programming in Australia and Greater Western Sydney onto human rights principles. This allows a better understanding of the key areas for development as well as processes that support refugee and migrant youth SRHR.

8.1.3 Phase 3: Data Collection

During this phase, ten concept mapping focus groups were run with 10 youths in each. These *focus groups* were recruited, organized, and facilitated by the Youth Project Liaisons, who recruited their peers via convenience sampling. The focus groups lasted 120–150 mins and explored the youths' understandings, experiences, barriers, and facilitators relating to SRHR. The Youth Project Liaisons were also part of a yearly focus group, conducted by the migrant PhD student, on their experiences of engaging in a PAR project and its alignment to human rights principles.

During the focus groups, participants engaged in a method called "concept mapping." This method involves participants sorting and rating statements on a particular topic to help researchers to better understand participant perspectives. The statements emerging from Phase 2 (Brainstorming) were edited to ensure grammatical clarity and printed onto palm cards. During the focus groups, participants were asked to sort by grouping statements into piles, and rate the statements "in a way that makes sense to you." They then generated labels for those statement clusters. Participants then rated the importance of each statement within the clusters using a 5-point Likert scale (1 = low, 5 = high). Concept mapping therefore enabled a participant-centered theory construction in relation to SRHR. Using Concept Systems software, the emergent content and meaning clusters (akin to themes or factors) were translated into maps (or models) that define the participants' constructions about SRHR.

All focus groups were audio-recorded and transcribed verbatim so that the research team could review them in-depth and focus on what the youths were saying instead of being preoccupied with taking notes. Given that all information is relevant when working with communities, the Advisory Committee meetings also served as focus groups to better understand stakeholder perspectives on the issues faced by migrant and refugee youth with regard to SRHR. Meeting notes served as valuable qualitative data.

The research team also aimed to conduct an online quantitative survey based on the outcomes from Phase 2 (Brainstorming). Before launching the survey, the Youth Project Liaisons and one of their migrant and refugee peers were asked to pilot the questionnaire and to rate (on a 5-point Likert scale) the readability, clarity, and wording of the questions on sensitive issues. Their feedback was then used to finalize the survey. The survey was then deployed for completion by 500 migrant and refugee youth who were recruited using social media and word of mouth via the Youth Project Liaisons.

The data from this large group survey was used to provide a broader context for understanding the socioecological factors that influence youths' SRHR and well-being in Greater Western Sydney. It will also allow for greater diversity and representation across ethnicity, religion, socioeconomic levels, and other demographic variables. Administering the survey to 500 CALD youth also ensures 95% power with a confidence interval of 4.38. Participants were recruited using the same strategies as the concept mapping (above) and were given the chance of winning one of five $100 Visa EFTPOS cards.

8.1.4 Phase 4: Data Analysis, Synthesis, and Interpretation

Qualitative Data Analysis

The data will be thematically analyzed by identifying topics and substantive categories within participants' accounts concerning the study's objectives. In addition, *Quirkos* (qualitative data management software) will be used to ascertain topical responses and emergent substantive categories, coding particularly for word repetition, direct and emotional statements, and discourse markers including intensifiers, connectives, and evaluative clauses. Given *Quirkos*' interactive interface, the Youth Project Liaisons will attend a workshop where they will be taught basic qualitative analysis principles and then work in groups of two to analyze one of five focus group transcripts. The codes they come up with contribute to the overall thematic analysis of the qualitative data.

Mixed Methods Analysis

Data from the concept mapping will be subjected to a variety of analyses using Concept Systems software. This includes multidimensional scaling (MDS) and hierarchical cluster analysis (HCA) to create cluster rating maps (Mpofu et al. 2014). Concept Systems uses a non-metric approach to MDS so that considerably smaller samples can result in reliable and reproducible maps. We will use a "Go zone" analysis to assess the convergence in MDS representation of content items clustered for conceptual similarity. The policy feasible supports from the "Go zone" analysis will be considered for the cross-walking exercise described in Phase 5. Further, the feasibility consensus from cross-walk adaptation will be assessed using Cohen's kappa statistic.

Quantitative Data Analysis

The mediation of the emergent socioecological factors by SRHR constructs and sociodemographic characteristics will also be analyzed. To further the understanding of how socioecological variables influence the importance of youth SRHR, both bivariate and multivariate analyses will be undertaken to predict factors affecting the decision on sexual and reproductive health choices, service utilization, sexual and reproductive rights knowledge, and practices among migrant/refugee youth. Tests of partial mediation will also be conducted to assess the difference between models controlling for sociodemographic characteristics by calculating the standard error (SE) of the mediation effect: $SE = \sqrt{(b_2)^2(Seb_2)^2 + (b_3)^2}$.

D) The analyzed data will be synthesized by the research team to produce youth and community-friendly summaries of the findings for stakeholder review and feedback. *Triangulating the findings* from the qualitative analysis with the tests of mediation and the mixed method concept mapping analysis ensures that a holistic perspective of a migrant and refugee youth SRHR is presented within this new evidence base. Quantitative results will assist in predicting participants' knowledge of SRHR and related behaviors.

8.1.5 Phase 5: SRHR Model Development

Once all the data are analyzed and interpreted using human right and sociological methods, the SRHR model development will progress through the following stages:

1. The Advisory Committee, Youth Project Liaisons, and one of their invited peers will review the project findings and make suggestions on key aspects to address within the youth SRHR model in a half-day workshop.
2. The research team will then apply this feedback in the development of the youth SRHR model.
3. The Advisory Committee, Youth Project Liaisons, and one of their invited peers will again review the model and provide feedback in a half-day workshop. This will include a *feasibility analysis* where participants rate each of the SRHR recommendations (using a 5-point Likert scale) in terms of the feasibility of their integration into existing sexual and reproductive health policy and programming. Further, the feasible SRHR model recommendations will then undergo *difficulty indexing* where they will be rated (using a 5-point Likert scale) on the difficulty youth may experience in trying to access them. In line with a human rights approach, the research team will support participants to conduct a *cross-walk analysis*, a process used to cross-reference or align the major findings with the youth-determined SRHR model contents and recommendations.
4. The research team will then make the recommended emendations and prepare the youth SRHR model for finalization and dissemination.

8.2 Dissemination of the Findings

Sharing the outcomes of this project will include the typical list of peer-reviewed journal articles, book chapters, conference presentations, a project report, and a dissemination forum. In line with the PAR and human rights approaches used in this project, the research team will also be seeking to engage youth in the development of a SRHR resource that was easily accessible and engaging. As such, the Youth Project Liaisons will be tasked with scripting, directing, shooting, and editing a short YouTube video on the project findings and the SRHR model. Visual and media arts undergraduate students from Western Sydney University will be given the opportunity to work on the production of this video in partial fulfillment of their degree. Given the importance of social media and accessible content to everyone, this form of dissemination can quickly and easily attract a variety of stakeholders to learn more about the project. This technique also draws in potential collaborators who would like to work on implementing this study's approaches and/or SRHR model into policy or programming and supporting a sustainable approach to youth SRHR in Greater Western Sydney.

9 Conclusion and Future Directions

This chapter has introduced readers to sexual and reproductive health and rights (SRHR) needs, processes, and outcomes for youth refugee/immigrants to Australia. It provided definitions to help readers understand the distinction between sexual and reproductive health and SRHR. Importantly, sexual and reproductive health can only be achieved through the recognition of sexual and reproductive rights. This refers to the right every individual has to make informed decisions regarding what happens, and when, to their bodies. To help readers understand SRHR, the role of human rights, and their intersectionalities, the research team presented on SRHR implementing with the youth of refugee/immigrant background in the Greater Western Sydney region of Australia.

The project demonstrated the social, cultural, and economic benefit of using a human rights and participatory action research (PAR) model to unearth as yet unavailable evidence on migrant and refugee youths' sexual and reproductive health agency. Socially, the project values migrant and refugee youth voices and involvement by centering human rights instead of focusing only on health outcomes. This is important given that migrant and refugee youth face a multitude of challenges that limit their sexual and reproductive self-determination. This project demonstrated that addressing young people's barriers to self-determination can facilitate better understandings of how such barriers limit their ability to make fully informed self-determined sexual and reproductive health decisions. The use of human rights to inform sustainable community SRHR programming is also of cultural benefit as it supports empowerment. In this project, the use of a human rights framework sends a social and cultural message that migrant and refugee youths are of value and that their decisions matter not only to themselves but also to the future of Australia.

A focus on SRHR and not only SRH supports sustainable community health by improving individuals' sense of worth, value, and belonging, which, in turn, improves social, cultural, and economic participation due to an improved sense of relevance and agency. With this type of empowerment comes considerable economic benefits as agentic sexual and reproductive health decision-making reduces a diverse range of financial and social costs across the lifespan.

References

ABS. (2017). Greater Western Sydney Australian Bureau of Statistics 2017. http://stat.abs.gov.au/itt/r.jsp?RegionSummary&region=1GSYD&dataset=ABS_REGIONAL_ASGS&geoconcept=REGION&datasetASGS=ABS_REGIONAL_ASGS&datasetLGA=ABS_NRP9_LGA&regionLGA=REGION&regionASGS=REGION

ABS. (2019). Greater Western Sydney. http://stat.abs.gov.au/itt/r.jsp?RegionSummary&region=1GSYD&dataset=ABS_REGIONAL_ASGS&geoconcept=REGION&datasetASGS=ABS_REGIONAL_ASGS&datasetLGA=ABS_NRP9_LGA&regionLGA=REGION&regionASGS=REGION

American Psychological Association. (2012a). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67*(1), 10–42. https://doi.org/10.1037/a0024659.

American Psychological Association. (2012b). *Sexual response cycle*. APA dictionary of psychology. https://dictionary.apa.org/sexual-response-cycle

Asghari-Fard, M., & Hossain, S. Z. (2017). Identity construction of second-generation Iranians in Australia: Influences and perspectives. *Social Identities, 23*(2), 126–145.

Australian Human Rights Commission. (2019). *Human rights based approaches*. Retrieved 19 Feb, from https://www.humanrights.gov.au/human-rights-based-approaches

Ayika, D., Dune, T., Firdaus, R., & Mapedzahama, V. (2018). A qualitative exploration of post-migration family dynamics and intergenerational relationships. *SAGE Open, 8*(4), 2158244018811752.

Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I., & Hughes, C. (2014). Reaching the hard-to-reach: A systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC Medical Research Methodology, 14*(1), 42.

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2016a). Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: A structured scoping review. *Sexual Health, 13*(1), 1–9.

Botfield, J. R., Zwi, A. B., & Newman, C. E. (2016b). Young migrants and sexual and reproductive healthcare. In *Handbook of migration and health*. Cheltenham: Edward Elgar Publishing.

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2017). Drawing them in: Professional perspectives on the complexities of engaging 'culturally diverse' young people with sexual and reproductive health promotion and care in Sydney, Australia. *Culture, Health & Sexuality, 19*(4), 438–452.

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2018). Engaging migrant and refugee young people with sexual health care: Does generation matter more than culture? *Sexuality research and social policy, 15*(4), 398–408.

Caldwell, L., Smith, E., Wegner, L., Vergnani, T., Mpofu, E., Flisher, A. J., & Mathews, C. (2004). Health wise South Africa: Development of a life skills curriculum for young adults. *World Leisure Journal, 46*(3), 4–17.

Coomans, F., Grunfeld, F., & Kamminga, M. T. (2009). Methods of Human Rights 0Research: A Primer. *Human Rights Quarterly, 32*, 179–186.

Cottingham, J., Kismodi, E., Hilber, A. M., Lincetto, O., Stahlhofer, M., & Gruskin, S. (2010). Using human rights for sexual and reproductive health: Improving legal and regulatory frameworks. *Bulletin of the World Health Organization, 88*, 551–555.

deFur, K. M. (2012). Getting to the good stuff: Adopting a pleasure framework for sexuality education. *American Journal of Sexuality Education, 7*(2), 146–159.

Dune, T. M., & Liamputtong, P. (2019). Gender and sexuality as social determinants of health. In P. Liamputtong (Ed.), *Social determinants of health* (pp. 215–242).

Dune, T., & Mapedzahama, V. (2017). Culture clash: Shona (Zimbabwean) migrant women's experiences with communicating about sexual health and wellbeing across cultures and generations. *African Journal of Reproductive Health, 21*(1), 18–29. https://search.proquest.com/docview/1933248735?accountid=36155.

Dune, T., Mapedzahama, V., Hawkes, G., Minichiello, V., & Pitts, M. (2015). African migrant women's understanding and construction of sexuality in Australia. *Advances in Social Sciences Research Journal, 2*(2), 38–50.

Dune, T., Perz, J., Mengesha, Z., & Ayika, D. (2017). Culture clash? Investigating constructions of sexual and reproductive health from the perspective of 1.5 generation migrants in Australia using Q methodology. *BMC Reproductive Health, 14*(50), 1–13.

Dune, T., Ayika, D., Thepsourinthone, J., Mapedzahama, V., & Mengesha, Z. (2021). The Role of Culture and Religion on Sexual and Reproductive Health Indicators and Help-Seeking Attitudes amongst 1.5 Generation Migrants in Australia: A Quantitative Pilot Study. *International Journal of Environmental Research and Public Health, 18*(3), 1341. https://doi.org/10.3390/ijerph18031341

Ekstrand, M., Tydén, T., Darj, E., & Larsson, M. (2007). Preventing pregnancy: A girls' issue. Seventeen-year-old Swedish boys' perceptions on abortion, reproduction and use of contraception. *The European Journal of Contraception & Reproductive Health Care, 12*(2), 111–118.

Family Planning Victoria. (2015). *Teenage pregnancy.* Victoria State Government. Retrieved January 24th, from https://www.betterhealth.vic.gov.au/health/healthyliving/teenage-pregnancy

Fincher, R. A. (1994). International conference on population and development. *Journal of Environmental Law and Policy, 24*, 309.

Giorgio, M. M., Kantor, L. M., Levine, D. S., & Arons, W. (2013). Using chat and text technologies to answer sexual and reproductive health questions: Planned parenthood pilot study. *Journal of Medical Internet Research, 15*(9), e203.

Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2006). Sexual and reproductive health: A matter of life and death. *The Lancet, 368*(9547), 1595–1607.

Hawkey, A. J., Ussher, J. M., Perz, J., & Metusela, C. (2016). Experiences and constructions of menarche and menstruation among migrant and refugee women. *Qualitative Health Research*. 1049732316672639.

Healthed. (2019). *STI Rates in Australia*. Healthed. Retrieved 21 Feb, from https://www.healthed.com.au/clinical-articles/brief-update/sti-rates-in-australia/

MacPhail, C., Dune, T., Dillon, G., Rahman, S., Khanam, R., Jenkins, L., Britton, M., Green, B., Edwards, C., & Stevenson, A. (2017). Knowledge and attitudes to sexual health and STI testing for students at an Australian regional university: A cross-sectional study. *Journal of the Australian and New Zealand Student Services Association, 49*(1), 36–48.

Mberu, B., Mumah, J., Kabiru, C., & Brinton, J. (2014). Bringing sexual and reproductive health in the urban contexts to the forefront of the development agenda: The case for prioritizing the urban poor. *Maternal and Child Health Journal, 18*(7), 1572–1577. https://doi.org/10.1007/s10995-013-1414-7.

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

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

Mengesha, Z., Dune, T., & Perz, J. (2016). Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review. *Sexual Health, 13*(4), 299–310.

Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2017a). Challenges in the provision of sexual and reproductive health care to refugee and migrant women: A Q methodological study of health professional perspectives. *Journal of Immigrant and Minority Health, 20*(2), 1–10.

Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2017b). Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socioecological analysis of health care professional perspectives. *PLoS One, 12*(7), e0181421.

Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2018a). Preparedness of health care professionals for delivering sexual and reproductive health care to refugee and migrant women: A mixed methods study. *International Journal of Environmental Research and Public Health, 15*(1), 174. https://doi.org/10.3390/ijerph15010174.

Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2018b). Talking about sexual and reproductive health through interpreters: The experiences of health care professionals consulting refugee and migrant women. *Sexual & Reproductive Healthcare, 16*, 199–205.

Minichiello, V., Dune, T., Disogra, C., & Marino, R. (2014). Male sex work from Latin American perspectives. *Male sex work and society, 363*, 362–395.

Mpofu, E., Caldwell, L., Smith, E., Flisher, A., Mathews, C., Wegner, L., & Vergnani, T. (2005). Rasch modeling of the structure of health risk behavior in South African adolescents. *Journal of Applied Measurement, 7*(3), 323–334.

Mpofu, E., Dune, T. M., Hallfors, D. D., Mapfumo, J., Mutepfa, M. M., & January, J. (2011). Apostolic faith church organization contexts for health and wellbeing in women and children. *Ethnicity & Health, 16*(6), 551–566.

Mpofu, E., Mutepfa, M. M., & Hallfors, D. D. (2012). Mapping structural influences on sex and HIV education in church and secular schools in Zimbabwe. *Evaluation & the Health Professions, 35*(3), 346–359.

Mpofu, E., Hallfors, D. D., Mutepfa, M. M., & Dune, T. M. (2014). A mixed methods mapping of church versus secular school messages to influence sexual decision making as perceived by Zimbabwean orphan girl students. *Journal of Mixed Methods Research, 8*(4), 363–376.

NESRI. (2019). *Human rights assessment of the medicare for all act of 2019*. https://dignityandrights.org/wp-content/uploads/2019/11/NESRI_MFA_assessment.pdf

Office of the High Commissioner. (2012). *Human rights indicators: A guide to measurement and implementation*. United Nations. Retrieved 20 February, from https://www.ohchr.org/Documents/Publications/Human_rights_indicators_en.pdf

Programme of Action (PDF). (1994 September). International Conference on Population and Development, Cairo.

Sachs, J. D., & McArthur, J. W. (2005). The millennium project: A plan for meeting the millennium development goals. *The Lancet, 365*(9456), 347–353.

Schuster, L. (2011). Turning refugees into 'illegal migrants': Afghan asylum seekers in Europe. *Ethnic and Racial Studies, 34*(8), 1392–1407.

Tangcharoensathien, V., Mills, A., & Palu, T. (2015). *Accelerating health equity*. Retrieved 2020, from https://www.unfpa.org/sexual-reproductive-health

UN. (2020). *Universal declaration of human rights*. United Nations. https://www.un.org/en/universal-declaration-human-rights/.

United Nations Commission on Human Rights. (1946). *Universal Declaration of Human Rights*.

UNFPA. (2010). *UNFPA Welcomes Extension of ICPD Programme of Action Beyond 2014* [Press release]. https://www.unfpa.org/press/unfpa-welcomes-extension-icpd-programme-action-beyond-2014

UNFPA. (2020). *Sexual & reproductive health*. https://www.unfpa.org/sexual-reproductive-health

Visaria, L., Jejeebhoy, S., & Merrick, T. (1999). From family planning to reproductive health: Challenges facing India. *International Family Planning Perspectives, 25*, S44–S49.

Workman, A. (2019). Are Australian public discourses on intimate partner violence LGBTIQ inclusive? [Doctoral dissertation, Western Sydney University]. Research Direct. http://hdl.handle.net/1959.7/uws:52888

World Health Organisation (2020 January 28–31). *Defining sexual health: report of a technical consultant on sexual health*. Geneva. https://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health.pdf

Wray, A., Ussher, J. M., & Perz, J. (2014). Constructions and experiences of sexual health among young, heterosexual, unmarried Muslim women immigrants in Australia. *Culture, Health & Sexuality, 16*(1), 76–89. https://doi.org/10.1080/13691058.2013.833651.