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SEXUAL HEALTH AMONG FEMALE REFUGEE YOUTH: AN ECOLOGICAL
APPROACH

by

JESSICA L. MILLER

Under the Direction of Kevin Swartout, PhD

ABSTRACT

Refugee youth face several sexual health challenges, and research investigating contributing factors has primarily focused on identifying contextual barriers. However, it is also important to investigate protective factors, as well as how both risk and protective factors work together across contexts. The present study explored facilitators and barriers to refugee youth sexual health and how they combine to predict behavior using thematic text analysis and narrative analysis of twelve in-depth interviews with female refugees ages 18-24. Findings revealed four primary themes: sex/relationship restrictions, judgment/disapproval, support, and youth reactions. The first three factors were present across multiple ecological levels, such as parents, peers, and culture. Furthermore, these contextual factors were related to one another, such that youth who violate sociocultural sex/relationship restrictions experience actual or anticipated judgment from others, which leads to fear, embarrassment, and risky sexual behavior. These findings have important implications for sexual health education interventions with refugee youth.

INDEX WORDS: Sexual health, Ecological systems theory, Refugee youth

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JESSICA L. MILLER

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

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Jessica Lynn Miller
2018

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1 INTRODUCTION

Refugee youth face many health challenges both pre- and post-resettlement. While there has been substantial research examining these challenges in many mental and physical health domains (e.g. Lustig et al., 2004; Davidson et al., 2004), sexual health issues have often been neglected. Studies investigating sexual health among refugee youth have frequently taken place prior to their resettlement (e.g. Benner et al., 2010), and those that have occurred post-resettlement are almost exclusively in Australia (e.g. McMichael, 2013). Findings from this literature have revealed that the contextual factors affecting sexual health include peer relationships, education, and culture (McMichael, 2009). However, it is important to identify not just the individual contextual factors themselves, but how these multiple factors *work together* to influence refugee youth's sexual health opinions and decisions. Moreover, extant research has focused primarily on barriers to refugee sexual health, such as physical, social, educational, and emotional barriers. Whereas it is important to study the challenges faced by this population, it is also valuable to explore protective factors to develop a more holistic understanding of their sexual health.

Failing to address these limitations has both theoretical and practical costs. The sexual health concerns of refugee youth likely differ from those of their American-born peers as the result of unique sociocultural and educational factors; not recognizing these differences could lead to research that fails to be applicable to young refugees. Furthermore, neglecting the needs of this specific population impedes the development of culturally appropriate interventions, which could contribute to higher rates of reproductive health problems, such as unplanned pregnancy and sexually transmitted diseases (STDs). The purpose of the present study is to address these limitations through an exploratory, qualitative approach. Specifically, the study

will investigate female refugee youth's perceptions of the barriers and facilitators of sexual health present in multiple environmental contexts.

1.1 Refugee Sexual Health Issues

Refugees face a variety of sexual health issues and are at higher risk for negative sexual health outcomes compared to native-born youth. One relevant metric is teenage pregnancy, which occurs at elevated rates for refugee populations. For example, Benner and colleagues (2010) found that Burmese refugees living in refugee camps in Thailand ages 15-19 had a pregnancy rate ranging from 60-80 per 1000 among the two camps surveyed, which is higher than the rate for the same age group in Thailand in 2012 (54 per 1000; UNICEF, 2015). Elevated rates of teenage pregnancy have also been reported among Sudanese refugee women resettled to Australia compared to native born Australians, demonstrating that a higher risk of teenage pregnancy is prevalent in both pre- and post-resettlement contexts (McMichael, 2013).

A second relevant metric for assessing risk is the rate of sexually transmitted diseases (STDs). Information on the prevalence of STDs among refugee youth is limited. One systematic review from sub-Saharan Africa found that most of the refugee camps surveyed had a lower prevalence of HIV infection than surrounding communities (Spiegel et al., 2007), a finding that points to resilience in this population. However, refugees may be at higher risk of developing STDs because of lack of protection. While more than half of refugee youth living in refugee camps in Thailand considered it important to use condoms to protect against STDs, only 35% of youth knew where to obtain them, and the majority of youth felt embarrassed to use them (Benner et al., 2010).

Lack of sexual health education may explain the increased risk of unplanned pregnancy in refugee youth. Many refugees experience disruptions in formal schooling because of

displacement, and even in the education they do receive, sexual health is often not prioritized (McMichael & Gifford, 2009). Extant research suggests that refugee youth have limited knowledge about reproductive health in several categories. First, many refugee youth have misconceptions about sex. For example, 81% of Burmese refugee youth in Thailand believed that the first time having sex cannot result in pregnancy (Benner et al., 2010). Researchers have also found that refugee youth are often unaware of specific STDs and their symptoms (McMichael & Gifford, 2009), as well as various methods of pregnancy prevention (Lazarus et al., 2006).

After resettlement, refugees also encounter a new set of laws and policies in their new country, and this includes rules related to sexual health issues which may be unfamiliar to them, such as laws around consent. Dhar and colleagues (2017) reported several misunderstandings about legal rights among refugee young women living in the United States. Some of these misconceptions are that male partners must consent to a woman having an abortion, unmarried women cannot access reproductive health services, and youth under the age of 18 are required to have a guardian in the room with them during their doctor's appointments (Dhar et al., 2017). These findings demonstrate that refugee youth are not always provided with sufficient information necessary to make healthy, empowered, and informed decisions about their sexual health.

1.2 Ecological Systems Theory

Sexual health issues among refugee youth are clearly a cause for concern, but there is only limited information available on the factors contributing to these problems, which reveals the need for a contextual approach. Bronfenbrenner's (1974; 1977; 1986) ecological systems theory offers a theoretical framework for understanding the various contexts that affect

individual development. The model includes five developmental systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The *microsystem* includes any settings which the person is an immediate part of, such as family, peers, and school.

Microsystems often interact with one another, and these interactions are referred to as the *mesosystem*. While the systems exerting direct influence on individuals are an essential part of the ecological systems approach, Bronfenbrenner's theory also accounts for contexts that have a more indirect effect. The *exosystem* describes the broader societal structures which comprise various microsystems. Examples of exosystems include neighborhood, government, and media. Even more general is the *macrosystem*, which is not itself a specific context, but instead encompasses the overall culture. In other words, "micro-, meso-, and exosystems are the concrete manifestations" of the macrosystem (Bronfenbrenner, 1977, p. 515). Lastly, the *chronosystem* refers to the changes to an individual's contexts over time, which may result from any number of life transitions such as starting school, getting married, or migrating to a new country.

The ecological systems theory posits that these nested ecological systems work together to shape the developmental process, and sexual health is one domain within this developmental process. The adolescent reproductive health literature has identified aspects of multiple microsystems (e.g. parental monitoring; Li, Stanton, & Feigelman, 2000), mesosystems (e.g. interaction between peer support and parent connection; Henrich, Brookmeyer, Shrirer, & Shahar, 2006), and exosystems (e.g. sexual content in the media; L'Engle, Brown, & Kenneavy, 2006) that are associated with sexual behavior. However, systematic reviews have found that research on adolescent sexual health is still primarily focused on individual-level correlates (Salazar et al., 2010; Shoveller, Johnson, Savoy, & Pietersma, 2006). A content analysis of

abstracts of research studies on the topic indicated that half of studies neglected contextual factors entirely and were instead limited to individual-level variables (Salazar et al., 2010), suggesting that there are still significant gaps in the understanding of how adolescent sexual health is influenced by more distant ecological systems and their interactions.

1.3 Microsystem

This limitation is even more substantial regarding research on sexual health among refugee youth, as no known study on this topic has taken an explicitly ecological approach. Nevertheless, the literature has considered how refugee youth's opinions and behaviors are influenced by several microsystems, such as family, peers, school, and healthcare settings. Parents, particularly mothers, are most frequently discussed within the family context, and are the source of much of the sexual health information refugee youth receive (Benner et al., 2010). However, refugee youth also mention that it is difficult to talk to their parents about sex and romantic relationships (McMichael & Gifford, 2009). Parents often emphasize the importance of placing education and career goals over dating, and may even forbid children from engaging in romantic relationships. Furthermore, many refugee families believe that sex outside of marriage is immoral and that following this rule is fundamental to upholding the family's reputation. Such beliefs were reported by participants of both genders from varied geographical regions including the Middle East, Southeast Asia, and Africa (McMichael & Gifford, 2009; 2010). Refugee youth also frequently seek information about sex from their peers. For example, Benner et al. (2010) found that friends were the most common source of sexual health information among young refugee men. While talking to peers may be less intimidating than talking to parents, refugee youth often do not trust the information as accurate (McMichael & Gifford, 2009).

School, on the other hand, is perceived by youth as an effective setting to learn about sexual health (McMichael, & Gifford, 2009). Dhar et al. (2017) found that female Bhutanese refugee youth discussed attending health classes that covered sexual health topics in both their countries of origin and in the United States. However, as is stated above, receiving sexual health education in a school setting does not apply to all refugees, as many have faced gaps in their education. Even when refugees were enrolled in formal schooling post-resettlement in the United States, some youth stated that they were pulled out of health class to attend English as a Second Language courses, which likely magnifies the gap in sexual health education (Dhar et al., 2017).

The healthcare setting is another microsystem particularly relevant to the subject of reproductive health. Refugee youth view doctors as experts on sexual health, however, research has cited several existing barriers to utilization, which may lead refugee youth to not seek services until there is an urgent problem (McMichael & Gifford, 2009). Certain barriers are logistical, such as difficulties with transportation and language (McMichael & Gifford, 2009). Even when these logistical issues are addressed, youth have additional concerns. For example, interpreters resolve the language barrier, but their presence creates concerns about confidentiality because interpreters are often members of the community and youth fear that they may inform their parents about the details of the appointment (McMichael & Gifford, 2009). Female refugees have an added worry about seeing male providers or interpreters (Jones, 1999). Taken together, the literature that references microsystems affecting refugee youth reveals that a variety of obstacles prevent youth from accessing and using the resources they consider to be most trustworthy, which may in turn encourage them to rely primarily on their peers for advice about their sexual health.

1.4 Macrosystem

Culture and its associated values have also received attention in research on sexual health among refugee youth, which constitutes the macrosystem in Bronfenbrenner's ecological systems theory. Abstinence from sex before marriage is highly valued in many non-Western cultures, and refugee youth emphasize its importance within their native cultures (McMichael & Gifford, 2010; Dhar et al., 2017). Youth who fail to abide by this cultural standard often experience shame from their family and community. The most salient example of this is unmarried pregnant women, who face particularly intense shame. Pregnancy outside of marriage is evidence of directly defying the value of abstinence, and moreover, women's virginity is especially highly valued (McMichael & Gifford, 2009; 2010; McMichael, 2013). The shame surrounding unmarried pregnant women expresses itself in a variety of different ways, including being gossiped about in the refugee community (McMichael & Gifford, 2010; Dhar et al., 2017), being kicked out of one's home (McMichael & Gifford, 2010; Dhar et al., 2017), losing one's reputation (McMichael, 2013), and reducing one's prospects for marriage (McMichael & Gifford, 2010).

1.5 Present Study

Research on sexual health among refugee youth has increased in recent years, but the literature is still sparse and many questions remain unanswered. While scholars have begun to explore the influence of family, peer, and school contexts on young refugees' sexual health, there has been less attention given to the ways in which these contexts work together to influence their opinions and decisions. Moreover, there is a dearth of research within this subject on broader contexts, such as community, culture, and religion. Approaching the topic from an ecological systems framework is one valuable way to address this gap, as it allows for a more intentional

focus on multiple ecological levels, particularly those that have received less research attention. Within these different ecological contexts, it is also important to investigate both facilitators and barriers to the sexual health of refugee youth, as these contexts likely each hold challenges and assets for this population.

This study focuses solely on female refugee youth, as research has demonstrated that refugee women are disproportionately affected by sexual health issues and their consequences, such as shame from unplanned pregnancy (McMichael & Gifford, 2010). Because of the exploratory nature of the study, qualitative methodology was chosen to allow for an in-depth investigation into the sexual health concerns of these women. Given the sensitivity of the topic, individual interviews were deemed most suitable as this format would allow participants to share their perspective without concern about evaluation or disclosure from other participants. No specific hypotheses are posited because of the study's exploratory nature and inductive approach, but two research questions have been established to guide the data analysis: 1) What are the facilitators and barriers to sexual health among refugee youth at multiple ecological levels? and 2) How do these facilitators and barriers work together to influence refugee youth sexual health? By investigating these questions, the present study seeks to better understand the contextual factors that affect refugee youth sexual health and in doing so, identify potential interventions to improve their sexual health outcomes and promote their broader well-being.

2 METHOD

2.1 Participants

Twelve in-depth interviews were conducted with female refugee young adults between the ages of 18-24. The countries of origin represented were Burma ($n = 6$), Central African Republic ($n = 2$), the Democratic Republic of Congo ($n = 3$), and Somalia ($n = 1$). Ten participants had lived in the United States for more than five years, while the other two participants had been resettled to America less than two years ago. Each participant was compensated with a \$20 gift card to a large retail chain, compensation deemed appropriate and non-coercive for this population (Schweitzer et al., 2007).

2.2 Recruitment Strategy

Health and wellness staff at International Rescue Committee Atlanta (IRC) collaborated with IRC's youth education department to recruit young refugee women from an offsite summer camp, afterschool programs, and a career mentoring program. Once youth education staff identified potential participants, they asked the participants for consent to be contacted by the researchers. After each potential participant gave verbal consent to youth education staff to be contacted for this project, youth education staff submitted the young person's contact information to health and wellness staff through a password protected Excel spreadsheet or by phone. Health and wellness research staff contacted young people who were interested in participating and scheduled a time to conduct the in-depth interviews.

2.3 Procedure

The interviews took place in a private room at the International Rescue Committee Atlanta office. First, the consent form was read aloud to participants and they then gave their verbal informed consent prior to beginning the interview. The following general topics of inquiry

were included in the interview guide: 1) perception of healthy relationships, 2) sexual health problems and unplanned pregnancy, 3) access to information about sexual health, and 4) facilitators and barriers to seeking sexual health services (See Appendix for the interview guide). The interviews were semi-structured, meaning the same questions were asked during each interview to maintain consistency, but the order of these questions was changed and follow-up questions were asked to maintain the natural flow of conversation. The duration of the interviews ranged from 30 to 60 minutes. After the interviews were completed, audio-recordings of the interviews were transcribed.

2.4 Data Analysis

2.4.1 *Thematic text analysis*

Data were first analyzed using thematic text analysis, a method of qualitative analysis that uses categorization to emphasize patterns identified across data (Braun & Clarke, 2006; Kuckartz, 2014). Thematic analysis is a flexible method, meaning that unlike certain qualitative analysis approaches that have a standard theoretical framework and procedure (e.g. grounded theory; Strauss, & Corbin, 1990), thematic analysis can be applied in a more varied way (Braun & Clarke, 2006). Several researchers offer guidelines for robust thematic analysis, and although the specific steps differ, the general process is consistent. For example, Kuckartz (2014) delineates several phases involved in thematic text analysis, including initial work with the text, development of main categories, first coding process, compilation of same-category passages, creation of sub-categories, second coding process, and category-based analysis. It is important to note that these phases are intended to be cyclical rather than linear, meaning that the various steps of the analytic process may be repeated to ensure the results fit the data and research question. The iterative nature of thematic analysis contributes to what Morse et al. (2002) entitle

verification, which is “the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity” (p. 17). Verification is broader than interrater reliability, and also includes checks such as sufficient sampling and researcher responsiveness to the data; engaging in these checks of reliability and validity throughout the process increases confidence in the analytic rigor of the research.

The analytic strategies of both Braun & Clarke (2006) and Kuckartz (2014) informed the analytic process, organized into four phases that are described below: 1) initial coding, 2) theme development, 3) thematic coding, and 4) theme-based analysis. NVivo software was used to organize and manage data analysis for the last two phases.

2.4.1.1 Initial coding

In the first stage, interview transcripts were coded line-by-line. During this initial coding, the words participants used were prioritized to ensure that the researcher created codes that came from the text itself rather than imposing existing theories onto the text. All of the transcript text was read to determine relevance to the present study’s research questions, but given that the interview guide included topics outside of contextual facilitators and barriers to sexual health, significant portions of the text were not coded for the current analysis.

2.4.1.2 Theme development

After the initial coding process was completed, all of the codes were sorted categorically to establish broader themes. According to Braun and Clark (2006), a theme is a “level of patterned response or meaning within the data set” (p. 10). Themes and sub-themes were established based on their significance to the research questions, rather than purely using frequency as a criterion for theme development. In the first attempt at sorting codes, the ecological contexts (e.g. parents, peers, culture) served as the themes, and the factors influencing

sexual health that were relevant to each context (e.g. relationship restrictions) served as the sub-themes. However, given that many of the same factors were raised across contexts, the researcher concluded that reversing this hierarchy would be a better approach, as it allowed for a comparison of the messages participants received from different contexts about a given issue. This meant that the factors themselves served as themes, and that the ecological contexts participants reported to be associated with each factor served as the sub-themes for that factor. A preliminary codebook was created at this stage, which included the theme/sub-theme name, the definition of each, and at least one example quote from the text. Memo writing (i.e., researcher's written observations about the data) was also used throughout this stage to record the development of themes and the relationships among them.

2.4.1.3 *Thematic coding*

Two members of the research staff then used the preliminary codebook to code three interviews (25% of the data) independently. Afterwards, the two members reviewed each other's coded transcripts and met to discuss discrepancies and reach consensus. There was strong agreement for all themes except for one (*dating restrictions*), and the definition of that theme was edited in order to clarify the inclusion criteria. The only other modification made to the codebook was the incorporation of one theme (*abstinence*) into another (*dating restrictions*), because after discussion the researchers decided that the former was a specific example within the latter category. After making these adjustments to the codebook, the primary researcher then used the final list of themes and sub-themes to code the transcribed texts from all twelve interviews.

2.4.1.4 Theme-based analysis

Once all data were coded, each theme was investigated to identify repeated ideas and any notable divergences. To analyze the data in this way, all of the passages that were assigned to a given theme were compiled together and examined to ensure that themes were internally homogenous, meaning that there was consistency among the passages (Patton, 1990). As themes were explored, summaries were composed for each theme and particularly representative examples of each were highlighted. Relationships among themes were also considered for the purpose of creating a broader thematic paradigm.

2.4.2 Narrative analysis

Because the emerging themes seemed to be related to one another in important ways, the researcher determined that it was important to directly investigate these relationships before creating a final thematic paradigm. A narrative approach was selected in order to develop a better understanding of individual participants' beliefs about how the messages they receive from different contexts influence their decisions about sexual health. To accomplish this goal, four transcripts (33% of the data) were explored in greater depth. Two transcripts were chosen because they were representative of the themes described above and gave particularly rich detail regarding the causal relationships among them. One transcript was distinctive in its response pattern and was intentionally selected to provide a different perspective. The final transcript was selected because the interviewee was unmarried and pregnant at the time of the interview, and the researcher wanted to capture her unique personal experience. As the researcher read each of the four transcripts, memos were written regarding each participant's perceptions of facilitators and barriers to sexual health and the relationships among them. Particular attention was paid to passages in which the participant directly discussed causal relationships among the themes

established during thematic text analysis. The researcher then composed a brief narrative summary of each of the four transcripts that were analyzed in this way.

2.4.3 Thematic paradigm

The information obtained from both the thematic text analysis and the narrative analysis were integrated to develop a final thematic paradigm. The paradigm depicts major themes and the relationships among them to establish a working conceptualization of female refugees' experiences of the factors that influence their sexual health decisions at multiple ecological levels.

3 RESULTS

The results of both the thematic text analysis and the narrative analysis are described below. Quotes are written exactly as participants said them, with the exception of the removal of filler words (e.g., like, um) to improve reading ease and flow. Given that English is not the participants' first language, there are several grammatical errors (e.g., subject-verb agreement errors), which were kept so as to minimize researcher modifications to the data.

3.1 Theme 1: Sex/Relationship Restrictions

Participants described a variety of sociocultural restrictions regarding sex and romantic relationships. These norms and restrictions were generally consistent across parents, religion, and culture, and are described below.

3.1.1 *Parents*

Several youth noted that their parents do not permit them to be in romantic relationships prior to marriage. For example, one woman stated:

Your parents don't allow you to have a boyfriend. They just want you to concentrate.

Some of them, they bring us here for education so we have to focus on our education.

– *Participant 2, Central African Republic*

Even if youth are allowed to date, they expressed that their parents expect to be heavily involved in the process, beginning with approval of their children's romantic partners. Many participants described that if they are dating someone (or are interested in dating someone), they are required to bring this person home to meet their parents to determine whether the relationship can continue:

A lady have a boyfriend then you have to introduce first to their parents and see if your parents like...if they agrees you can move further, but if they don't really agree, you have to stop. – *Participant 5, Burma*

Once youth are in a romantic relationship, they have a set of parental rules they are expected to obey. These rules center on youth's behavior in their relationship, such as where they can spend time together, appropriate displays of affection, and most importantly, abstinence before marriage. Avoiding premarital sex was emphasized in the sex education youth receive from their parents.

Of course, my family going to say to not have sex when I'm dating with him...My mom told me if a guy ask you, "Can I have sex with you?" while you're dating, that means that guy is not good for your future, so just leave him. Like that stuff. – *Participant 8, Burma*

Overall, refugee youth participants described that their parents play an important role in their children's dating relationships, both in determining whether they are allowed to date and, if so, setting rules for how to behave.

3.1.2 Religion and culture

While parents affect their children's dating relationships directly, participants also acknowledged ways in which broader contexts such as religion and culture influence their views on dating. Such issues often came up in discussions about cultural differences between the United States and the participants' countries of origin regarding sex and relationships.

Participants particularly emphasized that dating relationships are not acceptable in their culture and/or religion, and this was the case across all countries of origin represented in the sample, including Somalia, Burma, Democratic Republic of Congo, and Central African Republic. For example, one woman stated:

You know in United States, if you are teenager or adult so you can be in a relationship where in my country, my religion we cannot be in a relationship until you get married.

– *Participant 6, Central African Republic*

Although refugee youth conveyed that romantic relationships outside of marriage are typically still prohibited, there was also some indication that the enforcement of this standard may have become more lenient over time:

It's not only religion, but our culture. Our parents' parents believed that long ago, for Karen people...even, you hold your boyfriend's hand—they make you get married...so that culture still carries on today. So even now...if you have sex with that guy, you just have to get married. – *Participant 7, Burma*

This belief in the importance of abstinence from sex before marriage was repeatedly emphasized, and was discussed as a both a cultural and religious value that youth are expected to uphold. Several youth spoke in a way that suggested that they had adopted this value as their own, such as:

Young people, they might want to do some sex, I don't know, but [it] is good if they didn't do it. For us, for me, I'm Christian and I'm the real one...we are not allowed to sleep together or do sex before marriage. – *Participant 10, Burma*

3.2 Theme 2: Judgment and Disapproval

Restrictions on dating relationships were salient for refugee youth participants, which begs the question of what happens when youth do not follow their parents' rules or subscribe to the values of their religion or culture. Participants indicated that there are a range of consequences for youth when other people disapprove of their sex and relationship decisions, and the types of consequences vary based in part on the ecological context.

3.2.1 *Parents*

Refugee youth reported that judgment and disapproval from their parents is expressed both emotionally and behaviorally. Participants said that when refugee youth go against the family's established relationship rules and expectations (Theme 1), parents get angry and blame their children. Youth also described behavioral consequences from their parents, such as getting in trouble if their parents find out about a forbidden romantic relationship. The most severe consequences participants described were for unmarried pregnant girls, as evidenced by the following two excerpts:

Some fear their parents, because you know how African parents are. They are kind of hard. Some African parents are like, "You got pregnant?? Get the hell out of my house!" That is what happens. – *Participant 4, Democratic Republic of Congo*

They don't think about it, they just have sex. And then later on, they have a pregnant and parent know it. And they are really mad because the parent don't want that one.... When they tell the parent, they might slap her or something like that. She might cry because she done a bad thing. She didn't think about what the parents say. She don't obey.

– *Participant 1, Burma*

3.2.2 *Peers*

Refugee youth also experience and/or observe judgment and disapproval from their peers, although the way that disapproval is expressed in this context is very different than how it is experienced from their parents. Participants reported that refugee youth experience verbal criticism when they make decisions regarding sex and relationships that do not fit within sociocultural expectations (Theme 1). For example, they described girls being made fun of for being in a romantic relationship:

They [friends] go talk like, “That guy is not right for you.” They go start teasing you, they go saying bad words to you. They going to hate you for nothing because they think you are not perfect. – *Participant 9, Democratic Republic of Congo*

Youth also noted that unmarried pregnant girls are gossiped about and verbally harassed: Oh, what young people think is “she’s a bad girl,” and talk bad things about her. They be like “She’s a slut. I feel bad, she’s just going to have a baby, her life’s going to be messed up” like that stuff. – *Participant 8, Burma*

Refugee youth do not only have sociocultural norms from their country of origin; they also encounter new norms in the United States, and may face judgment if their behaviors regarding sex and relationships are different from those of other peers who were raised in the U.S.. Some participants described peer pressure to have a romantic relationship. For example, one woman stated:

Some of my friends are always like, “You have to show us your boyfriend!” You know, they want to know all the time. They make fun of you. If you don’t have a strong heart, you might end up in a relationship just to feel comfortable. – *Participant 4, Democratic Republic of Congo*

Another participant specifically referred to being made fun of by American friends: Sometimes you might have friends who are American friends and they might ask you “Have you ever had sex?” And when you say “no,” they will start laughing at you. – *Participant 12, Democratic Republic of Congo*

Taken together, these results suggest that the different cultural values around sex and relationships between one’s country of origin and America (Theme 1) make it difficult to subscribe to social norms from both cultures simultaneously, thereby also making it difficult to

fit in with friends from either. Refugee youth therefore risk bullying from peers whether dating or not dating, having sex or not having sex.

3.2.3 *Community*

Refugee youth also reported similar messages of disapproval from the broader communities in which they live. Participants described that judgment from the community is expressed verbally, which is similar to judgment from peers. There are a variety of behaviors that may lead to this verbal harassment, such as public displays of affection. One woman stated:

I mean even though you're dating and then, and while you're dating you hold hands and kiss in public...if my people see it they will talk bad things about you to all these people.

– *Participant 8, Burma*

Another participant who was unmarried and pregnant at the time of the interview relayed her personal experiences with judgment from the community:

Some people make fun of me. Some ask me...they call me, they mock me. They say, "You're going to finish your education before you get married, but now you're pregnant. Stop doing that." And then, anyway, they make fun of me because I'm not married and I just get pregnant. – *Participant 2, Central African Republic*

Participants' descriptions of the community's reactions to youth's behavior in intimate relationships suggests that refugee youth not only face judgment and disapproval from their most immediate contexts of family and friends, but also on a larger scale from the community as a whole.

3.3 **Theme 3: Support**

Despite the many ways in which refugee youth notice judgment and disapproval from their parents, peers, and broader community regarding certain sexual and affectionate behaviors,

this was not the only narrative. Participants described examples of receiving support for their sexual health concerns from parents, peers, and healthcare settings, as well as several ways that they would like to be supported.

3.3.1 Parents

Refugee youth often noted that their parents or other family members were the best people to go to if they had questions about sex. Several participants specified that they would seek out information from their mothers as opposed to their fathers. For example, one woman commented:

Maybe I should ask someone. “Mom, you are the first one who is give me birth. I have to know too. Can I know from you?” It’s a good thing that you learn from a parent, from mom. Especially mom. – *Participant 3, Somalia*

Although many people described that their parents were the best source for sex education, they also indicated that parents may not be willing to talk to their children about certain topics, or that youth might not feel comfortable asking their parents certain questions. The importance of parents being open-minded when talking to youth about sex was conveyed in the following example:

I mean, tell the parents, do that sex educations. Actually, it should be non-judgmental sex education. You don’t judge anyone by what they do. – *Participant 4, Democratic Republic of Congo*

Simply receiving sex education from parents, while sometimes reported to be helpful, is not enough. Youth also want their parents to be a supportive, approachable source for questions about sex and relationships.

3.3.2 Peers

The support that refugee youth received from their peers often involved help with accessing sexual health services. Several participants talked about the importance of informing their friends about what sexual health services are available and where to go to access them, noting that word-of-mouth recommendations are influential. One woman said:

She can trust that she's her friend or best friend...A person who is persuade, she has to be really good to her. So she can believe that person. Yeah. Some of them say, "Are you sure?" They don't believe it. "Are you sure it's a good clinic?" "Yeah, I've been here before. He give me good medicine and I'm better now. I know what I have to do." She can tell about it. – *Participant 1, Burma*

Additionally, refugee youth mentioned that they could be supportive in ways beyond simply providing information, such as accompanying a friend to the hospital or clinic. One participant also described taking the initiative to talk to her doctor on behalf of a pregnant friend:

I once talked to one of the doctors around when my friend got pregnant and I really wanted to get her to help. I talked to one of these doctors when I went to the hospital to get a shot, and they were so good. – *Participant 4, Democratic Republic of Congo*

Discussions of peer support suggest that youth view their peers as both sources of information and sources of encouragement when it comes to accessing sexual health services. Several of the examples of help from friends involved the helper taking the initiative to offer support to a friend who they felt was in need. Since refugee youth may be hesitant to reach out to peers out of fear of being judged (Theme 2), peers who do offer support may be particularly important for facilitating access to reproductive health resources.

3.3.3 *Healthcare*

Refugee youth described several ways that clinics and hospitals could increase their likelihood of using sexual health services. One strategy they suggested was clinic outreach to inform youth about what is available, through methods such as videos on YouTube, home visits, and outreach events. For example:

They [clinic] should...reach out to those communities. Let's say that you're going to...an apartment. You go during or after school. The young people are there. You do always exciting things, you bring pizza, and they are all there. They come for that. Then you talk to them one-on-one, you know? "This is what we do" and they get to know about it. Because if you don't have information about the clinic, how do they know that they offer these things? – *Participant 4, Democratic Republic of Congo*

Refugee youth also talked about what clinics can do to make them feel comfortable once they arrive. First impressions matter, and can be made more positive by having welcoming pictures on the wall and a friendly receptionist. Perhaps most emphasized was the importance of the quality of their interactions with healthcare providers. Participants shared that doctors and nurses should be friendly, encouraging, and non-judgmental, and that demonstrating these traits will help make patients feel more comfortable talking about sexual health:

I think they [providers] should say "This is not a big deal, if you're worried about it, we can help you out with it...if you worry about getting pregnancy, we can help you with what you want." – *Participant 10, Burma*

Some people are so nice, the way that they are talking to the people. They could do stuff. When the people in the clinic are nice and they do their job, other people will tell them about things. – *Participant 2, Central African Republic*

Overall, participants were able to offer some specific examples of support from parents, peers, and healthcare settings, but primarily described how they would like to be better supported.

3.4 Theme 4: Youth Reactions

Refugee youth not only discussed the messages that they receive from different ecological contexts, but also how these messages influence their behavior. They mentioned both behavioral consequences and emotional consequences.

3.4.1 Fear

Participants described being afraid of several different things related to sexual health. The fear that some of the youth conveyed was associated with their parents, such as being afraid to talk to parents about sex or, in the quote below, disclosing unplanned pregnancy:

When they know that she is pregnant, she has to tell someone. If she don't, it will be very hard for her. And very hard for the boyfriend. So they have to tell the parent, well, not the parent first because it's kind of scary. – *Participant 1, Burma*

Refugee youth are also afraid of other people in the community discovering their use of sexual health services, such as getting tested for STDs or using contraception. Two examples of this fear are described in the following examples:

One of the reasons that I think people are scared to get tested is—especially young people—because if they get tested their life is ruined, which means they might not get married or probably everyone will start laughing at them they because they were too dumb to notice that condoms are out there or maybe they will just feel left out from the community when they have the STD. – *Participant 12, Democratic Republic of Congo*

Fear. How to go to a supermarket and ask for a condom. Actually, people don't have that freedom. Especially the African community, we always say, "How do we do it? There is so much judgment. How will they see me do this thing?" At the end of the day, you fear having it. – *Participant 4, Democratic Republic of Congo*

The fear described in the above quotes is clearly linked to the possibility of judgment from other people (Theme 2), whether from parents, peers, or the community at large.

3.4.2 Embarrassment

Refugee youth participants also shared that the same things that make them feel afraid also make them feel embarrassed, such as using sexual health services. The link to judgment from peers and community (Theme 2) was again made in their descriptions of embarrassment:

I might even feel shy to go there [clinic] if my friends see me and they will say 'Oh, she's going there.'... I'm just thinking my friends might say, "Oh! What's she doing there? She's going to have sex." – *Participant 7, Burma*

They know if they do that they will getting embarrassed and things like that. So it's a little harder for them to go ahead and find out about sexual health services because they already have this feeling in them of if I do this then I happen to have this kind of thing, then people will start laughing at me. I'll just stay at home and not bother and things like that. – *Participant 12, Democratic Republic of Congo*

These quotes demonstrate that refugee youth's fear and embarrassment are associated with people in their various ecological contexts (e.g. fear of/embarrassment over others knowing that they have an STD).

3.4.3 Behaviors

Participants communicated that a wide variety of behaviors can result from judgment

(Theme 2), fear (Theme 4), or embarrassment (Theme 4). For example, refugee youth may hide dating relationships or sexual activity from their parents because they disagree with their parents' rules, but also feel ashamed about breaking them:

I think if they do something, what their parents don't like it, they'll feel embarrassing so they just do it behind, even though their parents don't like it. – *Participant 5, Burma*

Refugee participants also described different actions that unmarried pregnant women take. Abortion was brought up by several youth. Some mentioned that it is considered a sin within their religion, and thus believe it is wrong to have an abortion. However, multiple youth also said that pregnant youth choose this option, in part because they are afraid of their parents or other family and community members discovering their pregnancy. One woman stated:

Because of that fear, they end up aborting. They don't want their parents to know about it. So they do the abortion. Basically, that's how they react. – *Participant 4, Democratic Republic of Congo*

For unmarried pregnant youth whose pregnancy is already public, suicide was presented as a possibility. One youth presented a clear causal link, stating that being mocked by community members leads to feelings of shame, which in turn leads pregnant youth to commit suicide. She said:

Wherever you're passing, they say, "Oh look, she's pregnant when she's not married. Oh, look." It's like that. At the end of the time, you can feel ashamed. Sometimes they kill themselves because everyday, when I go to the market, "Oh look, she didn't get married, she get pregnant." They tell you like that. They get disappointed and they feel ashamed. At the end of time, she's pregnant but she kill herself. Because of they are pointing her every day, every time. – *Participant 3, Somalia*

The above quotes indicate that fear (Theme 4), embarrassment (Theme 4), and judgment (Theme 2) have several negative consequences for the well-being of refugee youth, some of which are extremely severe.

The thematic text analysis revealed multiple ecological facilitators and barriers related to refugee youth sexual health. Furthermore, these factors work together to affect their decisions. These connections and combinations were explored further in a narrative analysis.

3.5 Narrative Analysis

Narrative summaries for each of the four transcripts used for the narrative analysis are below. The summaries highlight the ways in which each participant discussed the themes from the thematic text analysis and the relationships among them, as well as any unique perspectives on ecological factors that contribute to sexual health.

3.5.1 Participant 4

Participant 4 gave especially compelling descriptions of each of the themes that emerged in the thematic text analysis. She described familial, religious, and cultural restrictions regarding not dating or having sex (Theme 1) and said that refugee youth defy these expectations when they come to the United States. A few reasons were provided for this behavior, including new cultural norms in America, peer pressure to be in a dating relationship, and seeking support that youth don't experience at home. When refugee youth do not subscribe to the values of their family, religion, and culture (e.g. having sex before marriage), participant 4 stated that some parents will punish their children (Theme 2) but that others will support them (Theme 3). She said that "it depends on their culture, their customs, their religion." However, the fear of judgment and disapproval from family, peers, and community is enough to stop them from buying contraception (Theme 4). As quoted above, participant 4 said, "Fear. How to go to a

supermarket and ask for a condom. Actually, people don't have that freedom. Especially the African community, we always say, 'How do we do it? There is so much judgment. How will they see me do this thing?'" At multiple points in the interview, she shared that she feels that the way to encourage youth to make healthy sexual decisions is to provide support through "non-judgmental sex education" from parents, school, and religious leaders (Theme 3).

3.5.2 Participant 10

Participant 10 referenced the same themes, and also discussed several causal connections among them. She described a direct link between refugee youth violating the religious and cultural value of abstinence before marriage (Theme 1) and judgment and disapproval from others (Theme 2): "They already get pregnant and they are not married. So no one going to like them anymore." This judgment and disapproval from parents, peers, and community members leads youth to feel scared (Theme 4), which in turn pushes them toward certain behaviors, such as having an abortion or committing suicide (Theme 4). For example, she said that "If their parents are really strict and they are really scared, I feel like they might kill themselves...because if their parents find out that they have a baby, like their parent might kick out. They're not going to like it." Avoiding sexual health services is another behavioral consequence of refugee youth being afraid of their parents. In order for youth to use sexual health services, she said that the clinic needs to "help them feel better, talk to them, and make them feel like this is a good thing, like this is not really bad" (Theme 3).

3.5.3 Participant 2

At the time of the interview, participant 2 was pregnant and unmarried, so in addition to providing information that was consistent with other participants, she also described her personal experiences. She shared that she had dated someone who did not have her parents' approval

(Theme 1). Early in the interview (prior to disclosing her pregnancy) she reported that parents make refugee youth feel guilty for unplanned pregnancy, and when later discussing her own experience, she shared that her parents disapproved of her decisions and pregnancy (Theme 2). As quoted above, she also stated that people in her community would “mock” and “make fun of” her for getting pregnant before marriage (Theme 2). When responding to a question about what might stop youth from using sexual health services, participant 2 expressed that youth “don’t want their parents to know because they are scared” (Theme 4), and that if they were to use these services, “they would worry about their parents yelling” and “worry about getting kicked out of the house” (Theme 2). In order to “feel comfortable” using these services, she felt that clinics should provide outreach and ensure that their staff are friendly (Theme 3).

3.5.4 Participant 7

The interview conducted with participant 7 was divergent from the others in that she mentioned her difficulty answering the interview questions multiple times. She provided clear rationale for this, saying things such as, “I don’t know much about the answers to these questions. I think the reason is we don’t talk about this with my friends because we’re more like religion.” Furthermore, when asked about who would be a good person to talk to if she had questions about sex she stated, “I will never ask someone about sex...I think that to me, it’s kind of rude and uncomfortable.” These and other quotes suggest that her upbringing in the Christian religion and Karen culture, as well as her own personal beliefs, have led her to not discuss sex and sexual health issues.

However, this does not mean the themes from the thematic analysis were entirely absent from participant 7’s interview. She mentioned that abstinence before marriage is important in her religion and culture (Theme 1) and that community members gossip about

unmarried pregnant women (Theme 2). She also provided an example of parents accepting an unmarried pregnant woman (Theme 3), and she discussed shame/embarrassment that results from having sex outside of marriage (Theme 4). Additionally, Participant 7 made a notable causal connection, stating, “I might even feel shy to go there [clinic] if my friends see me and they will say... ‘Oh! What’s she doing there? She’s going to have sex.’” This demonstrates that peer gossip after seeing her go to a health clinic (Theme 2) would lead her to feel embarrassed about seeking sexual health services (Theme 4).

3.6 Thematic Paradigm

The thematic text analysis and the narrative analysis together revealed that the qualitative themes participants raised are not independent of one another, but are instead connected in important ways that affect refugee youth’s sexual health decisions. The information from both analyses was used to develop a thematic paradigm depicting the ecological factors that contribute to refugee youth’s behavior and the causal relationships among them. (Figure 1). All arrows displayed in the figure are connections that participants themselves made during interviews.

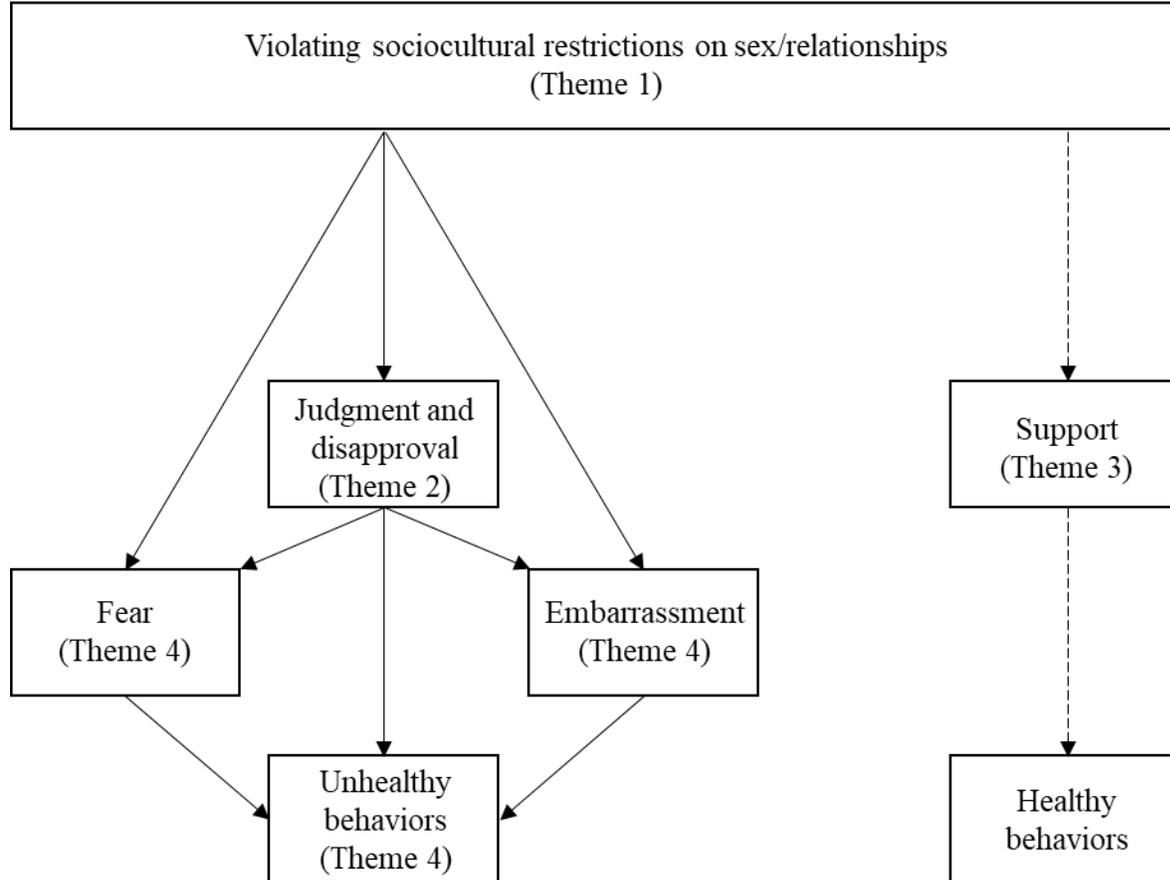


Figure 3.1 Final Thematic Paradigm

As presented in the paradigm, when refugee youth defy sociocultural expectations for sex and relationships, there are several possible outcomes. If their action is public knowledge, they often face judgment from parents, peers, and community members. Even when others are not aware of their behavior, refugee youth still describe feeling embarrassed and afraid of potential judgment. Both actual and anticipated judgment, as well as fear and embarrassment, can contribute to refugee youth engaging in unhealthy behavior. Sometimes these actions are specific to sexual health, such as choosing to avoid getting tested for STDs, but they can also affect other

domains, such as mental health. Despite these negative consequences, refugee youth suggested many forms of support that they feel would contribute to improved sexual health outcomes, including non-judgmental sex education, peer assistance, and clinic outreach.

4 DISCUSSION

The purpose of this study was to identify facilitators and barriers to refugee youth sexual health at multiple ecological levels and how these factors influence youth sexual health decision-making. Results revealed that sex/relationship restrictions, judgment/disapproval, and support were each present in multiple contexts (e.g. parents, peers, community, culture, and religion), and that youth reported several salient emotional and behavioral consequences of these factors. Furthermore, through both thematic text analysis and narrative analysis, notable causal relationships among the factors were identified which demonstrate how they work together to affect youth sexual health behavior.

First, findings indicated the significance of context for refugee youth sexual health outcomes. The ways in which these contexts affect youth vary based in part on their ecological level, as some levels have a more direct influence than others (Bronfenbrenner, 1977). Microsystems, such as parents and peers, have the most direct impact on youth. For example, parents provide rules regarding romantic relationships, and also deliver punishments when these rules are not followed. The exosystem, which in this study refers to the broader neighborhood/community, often has more general impact on an individual's reputation within that community. This is because community members not only judge youth directly, but also gossip about youth among themselves, which can lead to divisions within the community social structure.

Culture represents the macrosystem, and while people do not directly interact with the macrosystem, they still exist within it. Refugee youth describe that cultural values and expectations substantially affect their beliefs about sex and relationships, such as the importance of abstinence from sex before marriage. The salience of culture for refugee youth may partially

be because as new arrivals in the United States, they are surrounded by new cultural values that are different from (and at times contradictory to) those of their ethnic culture. The discrepancies between the two cultures likely make them more aware of macrosystem level factors than they would be otherwise, and results of this study demonstrate that their cultural awareness affects their views on sexual health. Together, these findings concerning the importance of cultural contexts are consistent with previous research on refugee sexual health, as other qualitative work with refugee youth has identified similar key factors within family, peer, and cultural contexts (e.g. McMichael & Gifford, 2009). Bronfenbrenner's (1977) ecological systems theory provides a helpful theoretical framework through which to organize and interpret results.

The results of this study also provided additional insight into the ways in which these factors combine and relate to one another to influence youth behavior. Causal statements made by refugee youth participants suggest that youth unhealthy decision-making is rooted in negative treatment from other people and negative emotions. Fear, embarrassment, and judgment lead them to engage in behaviors such as avoiding sexual health services, hiding things from their parents, having unwanted abortions, and committing suicide. Each of these components has been discussed in prior research with refugees resettled in Australia (McMichael & Gifford, 2009; 2010), but the links between them shown in the final thematic paradigm help to identify the pathways to sexual health outcomes.

Understanding these pathways also provides insight into potential points of intervention. Refugee youth noted that social support from parents, peers, and health clinics would make a positive difference, which is not surprising given evidence of social support as a protective factor for refugee youth in other domains of well-being, such as mental health (Fazel, Reed, Panter-Brick, & Stein, 2012). However, the placement of social support in the pathway also matters. Refugee

youth described social support as a replacement for judgment and disapproval, rather than as a way of helping them cope with it. In other words, social support would provide an alternative pathway: instead of judgment, fear, and embarrassment leading to unhealthy behaviors, social support from key people and systems would promote healthy decision-making, such as encouraging youth to use contraception and seek sexual health services.

4.1 Implications for Intervention

The results from this study demonstrate that while refugee youth experience several ecological factors that contribute to risky sexual behavior, they also believe that support has the potential to change these negative outcomes. Their ideas about both facilitators and barriers prompt several specific recommendations for interventions. Sexual health education programs are one area of intervention relevant to the current study. Comprehensive sexual education has significant benefits for youth sexual health outcomes (e.g. lower teenage pregnancy rates), as compared to abstinence-only education (Kohler, Manhart, & Lafferty, 2008). This study suggests that the setting within which youth receive this comprehensive sexual education is also important to consider. One participant specifically recommended that non-judgmental sexual education be offered by teachers, parents, and religious leaders, which stands in direct contrast with the judgment and disapproval that refugee youth often experience. If instead, refugee youth receive consistent messages across contexts that are both accurate and accepting, this may promote healthy behaviors, such as contraceptive use and help-seeking.

In order for information to be conveyed in a non-judgmental and informative way, it would be important for there to be training offered to those conveying the information, such as parents. Evidence from both majority and minority populations in the United States reveals that increased parent-child communication about sex is associated with decreased sexual risk-taking

(Coakley et al., 2017), and that parent interventions are effective in promoting parent-child communication (Santa Maria, Markham, Bluethmann, & Dolan Mullen, 2015). These interventions target a variety of outcomes such as communication skills, parent self-efficacy, and positive outcome expectations (Santa Maria, Markham, Bluethmann, & Dolan Mullen, 2015), and could be adapted for parents of refugee youth. When developing an intervention for this population, it would be especially important to consider refugee youth's perception of parent-child communication about sex. While many refugee youth in this study noted that their parents were not comfortable talking about sex, other participants shared that their parents do talk to them about sex, but that the conversations are not perceived as helpful. This demonstrates the need for alternative communication rather than simply increased communication, indicating that communication skills would be an especially important target in an intervention for parents of refugee youth.

Furthermore, findings about sociocultural expectations for sex and relationships demonstrate the importance of sexual education being culturally sensitive across settings. Educators working with refugee youth should be aware of the common cultural, religious, and familial expectations youth are confronted with. For example, refugee youth learn from multiple contexts that abstinence from sex before marriage is essential, and many of them have also adopted this as a personal value. Additionally, even older adolescents and young adults may not have been exposed to comprehensive sexual education. Given their cultural and religious values, learning about and discussing topics such as contraception may feel uncomfortable or inappropriate. For this reason, it would be important for comprehensive sexual education to directly address these values and describe abstinence as a valid and healthy choice, while also clearly communicating consent, contraceptive options, and sexual health outcomes.

Another potentially fruitful area for intervention involves the healthcare setting. Several suggestions were provided for how clinics could increase the likelihood of refugee youth accessing sexual health services, and these suggestions could be implemented within refugee communities. For example, several participants mentioned the importance of having friendly, competent healthcare providers who would offer sexual health services in a non-judgmental way. They also described the importance of having a youth-friendly space, including things such as welcoming pictures in the waiting room and feeling a sense of privacy. Another intervention idea raised in this study was clinic outreach for refugee youth, which would serve multiple purposes. First, outreach through events or media would raise awareness about the clinic and the sexual health services they provide. Additionally, clinics could use outreach events as an opportunity to present themselves as safe, friendly, and accepting, all of which are qualities youth mentioned as essential. Given the stigma around sex and sexual health services reported by refugee youth, it may be beneficial for clinic outreach to focus more on holistic well-being and address multiple health concerns, including but not limited to sexual health.

Using these suggested strategies for improved clinic support in combination would likely be most effective. A recent review article on strategies for improving adolescent sexual health services in low- and middle-income countries found that providing training for healthcare providers was not enough on its own; the most effective interventions also made adolescent-friendly changes to the clinic and successfully disseminated information about services (Denno, Hoopes, & Chandra-Mouli, 2015). For example, Okonofua and colleagues (2003) conducted a randomized controlled trial with Nigerian youth ages 14-20, and the implemented intervention included sexual health training for providers, “adolescent-friendly” certifications for clinics, sexual education in the school setting, and trained peer counselors. Intervention participants

showed increased sexual health knowledge, utilization of sexual health services, and condom usage compared to controls. While the United States is a high-income country, refugee youth resettled to the U.S. face many of the same barriers as adolescents in low- and middle-income countries, such as limited access to healthcare and disrupted education. The evidence on successful strategies to increase adolescents' use of sexual health services and improve their sexual health outcomes fits nicely with the ideas proposed by refugee youth participants in the present study, which suggests that an intervention that incorporates all of these strategies would be both well-received and effective.

4.2 Limitations and Future Directions

This study has limitations that should be addressed in future research. All interviews for the present study were conducted in English, and having conversational English ability as a study inclusion criterion is linked to two study limitations. First, English was not participants' first language. There were times during the interview when participants needed questions repeated or reworded, and certain responses were difficult to understand. Refugee youth likely would have found it easier to communicate in their first language, and may have answered questions differently if they had had the opportunity to do so. Second, refugee youth who speak English fluently typically have had longer residency in the U.S., and indeed in this sample the majority have lived in America for over five years. These refugee youth are likely more acculturated to American culture in terms of language, behavior, and identity than their refugee peers who have migrated more recently, and may therefore have a different perspective on sexual health and relationships. Future research should provide language interpretation as an option to allow refugee youth to communicate in the language they are most comfortable with. Encouraging

greater diversity in language would likely in turn generate a more diverse sample in terms of length of residency and level of acculturation.

Another limitation related to the study sample is that all the female refugee participants were ages 18-24, and their experiences of sexual health are likely different from younger adolescents. For example, refugee youth who are still in the early stages of puberty may be less concerned than participants in the present study about how their sexual health decisions affect future marriage prospects, but more concerned about immediate bodily changes. The chronosystem in Bronfenbrenner's (1977) ecological systems theory is applicable here, as it is important to take into consideration how life transitions such as puberty and marriage influence sexual health opinions and decisions. Investigating these chronosystem influences is a direction for future research.

Another limitation of the study is that it relied upon secondary data, which meant that the interview guide was not developed with the purpose of answering these research questions. While participants provided extensive information about the ecological factors that influence their sexual health decisions, they may have offered additional or alternative insights about facilitators and barriers to sexual health if asked about this topic more directly. In particular, future qualitative projects should ask refugee youth about how they handle 1) the inconsistent messages they receive about sexual health from different contexts (e.g. messages about dating from parents and friends) and 2) the consistent messages they receive from different contexts (e.g. messages about the importance of abstinence from religion and culture).

Lastly, asking a new research question of secondary data meant that there was valuable information youth discussed that was not included in the current study because it was not specific to the ecological factors that affect refugee youth sexual health. Participants also

discussed other topics, such as knowledge of STDs, what qualities they desire in a romantic partner, and individual-level factors that affect their sexual health decisions. Future research could use quantitative methods to increase understanding of which factors in which contexts predict youth sexual health decisions most strongly.

4.3 Conclusion

The present study found several facilitators and barriers to refugee youth sexual health, such as sex/relationship restrictions, judgment and disapproval, and support. These contextual factors were present across multiple ecological levels, including parents, peers, health clinics, community, religion, and culture. Furthermore, these factors work together to influence refugee youth's thoughts, feelings, and behaviors regarding sexual health. Refugee youth who violate familial or cultural expectations about sex and relationships often experience judgment from others, or feel fear and embarrassment over anticipated judgment. Judgment, whether actual or expected, can lead refugee youth to engage in unhealthy behaviors, such as not using contraception, avoiding sexual health services, or committing suicide. These are serious consequences, and understanding the pathways that lead to them provides important insight into how to intervene. Interventions should not only consider contextual factors, but should include them in the intervention process, as refugee youth described a need for greater support from parents, peers, and health clinics. Strong support from these contexts will help to empower refugee young women to make healthy decisions about sex, and in doing so, improve sexual health and foster holistic well-being.

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APPENDICES

Appendix A

Interview Guide

1. Who do you define as a girlfriend/boyfriend?
 - a. What does being in a healthy relationship mean to you?
 - b. How does the opinion of others in your community affect your view of relationships?
 - c. Are there cultural differences in the ways people with your ethnic background and “mainstream”/American culture approach sex and sexual activity in relationships? If so, what are they?
 - d. How do you know when you’re ready to have an intimate relationship?
2. What health problems could someone have from having sexual relationships?
 - a. What sexually transmitted diseases (STDs) can people get from having sex?
 - b. How can young people avoid or prevent STDs?
 - c. Is there anything that makes it difficult for young people to avoid getting STDs? If so, what?
 - d. Do you think that STDs are a problem for young people in your community? Why?
3. What do young people think about pregnancy among unmarried girls?
 - a. Is pregnancy among unmarried girls a problem for young people in your community?
 - b. What do unmarried girls do when they have an unplanned pregnancy? How does the community respond?
 - c. How do young people avoid getting pregnant?
 - d. What types of protection/contraception methods have you heard of?

- e. What might prevent young people in your community from using protection/contraception methods?
 - f. Who is responsible for protection/contraception methods?
4. How do young people learn about sexual health, such as preventing pregnancy and STDs?
Where do they get this information?
 - a. For young people in your community, what's the best place to go for information if you have questions about sex?
 - b. Who are good people to talk to if you have questions about sex? What makes these people trustworthy?
5. How do young people in your community find out about sexual health services? Where would people in your community go if they have an unplanned pregnancy, want to get contraception, or get tested/treated for an STD?
 - a. Do young people in your community use these services? Why?
 - b. What kinds of things would young people in your community worry about if they were to get services? What might stop them from going?
 - c. What kinds of things would a health center need to do/have to encourage young people to use their services?
 - d. What are some things that could help make a young person's visit a positive experience?