

# Talking to migrant and refugee young people about sexual health in general practice

Jessica R Botfield, Christy E Newman, Melissa Kang, Anthony B Zwi

## Background and objectives

Young people are an important group to target with health promotion and preventive healthcare. This paper focuses on the engagement of migrant and refugee young people with sexual and reproductive healthcare in general practice.

## Method

Semi-structured first interviews (n = 27; 16 female, 11 male) and follow-up interviews (n = nine; six female, three male) were undertaken with migrant and refugee young people aged 16–24 years living in Sydney.

## Results

The majority of participants had seen a general practitioner (GP) for general health issues. However, most were reluctant to discuss sexual health with a practitioner whom they described as their 'family doctor', primarily because of concerns about judgement and confidentiality. Most described negative experiences with GPs for sexual health matters, including not being listened to or being rushed through the appointment.

## Discussion

There appears to be a lack of effective engagement with migrant and refugee young people by GPs in relation to sexual health. Building the skills and confidence of GPs to work with this group and promote sexual health and wellbeing should be considered, and efforts should be made to communicate confidentiality and trustworthiness.

**GENERAL PRACTICE** is the cornerstone of primary healthcare in Australia. Although young people often avoid healthcare and face a number of access barriers,<sup>1–3</sup> general practitioners (GPs) remain the service providers most significant to promoting the health of young people,<sup>2,4</sup> including their sexual and reproductive health.<sup>5–7</sup> To support access, however, health services must be known by and acceptable to young people.<sup>5,8</sup> Given that nearly half of Australian people were born overseas or have one or both parents born overseas,<sup>9</sup> health services must embrace the full range of cultural and language backgrounds that feature among Australian youth.<sup>4,10</sup>

Health services must also address the extremely varied health experiences and multifaceted health needs<sup>11</sup> of 'culturally and linguistically diverse' young people, including migrants, refugees and international students. Some of their needs will be much the same as those of other young people. National data show, for example, that young people in Australia have persistently high notification rates for some sexually transmissible infections.<sup>12</sup> A survey of secondary students (of which 15% spoke a language other than English at home) reported 13% of sexually active students used no contraception the last time they engaged in sexual activity.<sup>13</sup> Other research suggests young people from 'culturally diverse' backgrounds can have reduced sexual health literacy and increased rates of unwanted pregnancies and sexually transmissible infections.<sup>14–16</sup> The little that is known regarding how these groups make use of services for sexual and reproductive health reinforces a narrative of low awareness and

underuse,<sup>17–21</sup> although there is minimal empirical evidence to inform and support this narrative in practice.

This paper reports on a subset of interview data from a larger study on the complexities and opportunities for engaging migrant and refugee young people with sexual and reproductive healthcare. General practice was mentioned often by participants, who reported both positive and negative accounts that have important practice implications.

## Method

This exploratory, qualitative study was conducted in Sydney, New South Wales (NSW), the Australian city with the largest overseas-born population.<sup>9</sup> Ethics approval was received from the relevant health district, community organisation and university human research ethics committees. The research methods are briefly described here; further detail has been published elsewhere.<sup>22</sup>

Semi-structured interviews were undertaken in 2016–17 with 27 young people aged 16–24 years who self-identified as being from a migrant or refugee background and spoke a language other than English at home. We used non-probability purposive and snowball sampling,<sup>23</sup> and recruitment was facilitated by partner services, social media, the study website and word of mouth. A youth advisory group convened for the study provided feedback on the recruitment flyer and website.

Consenting participants undertook a first interview and completed a short questionnaire to record demographic

characteristics. Interviews explored the participants' views and experiences of accessing sexual and reproductive health information and care. Participants were also invited to participate in a follow-up interview at a later date to generate richer data through targeted and in-depth questioning. To ensure there was no pressure to participate further, participants were not actively followed up, which may have contributed to lower numbers of additional interviews. Interview guides were piloted and then used, with questions for follow-up interviews influenced by the first interview.

All interviews were audio-recorded, transcribed verbatim, de-identified and coded in NVivo 10. Thematic analysis was undertaken, as described by Braun and Clarke,<sup>24</sup> and iterative categorisation<sup>25</sup> was then applied to the coded data. In addition to earlier intercoder testing activities, final themes were discussed and agreed on by all authors. Key findings were also presented to the youth advisory group to elicit their observations and insights in relation to data interpretation and recommendations.

## Results

In total, 27 young people (16 female and 11 male) participated in a first interview and nine (six female and three male) in a follow-up interview. Participants' self-reported characteristics are documented in Table 1. In relation to their experiences with, and perceptions of, general practice, three themes were identified, as described below.

### 1. GPs are the first port of call for young people from diverse cultural backgrounds

Nearly all participants were familiar with general practice in Australia and, when discussing their use of health services, most reported having accessed either a family doctor (ie a GP who cared for their whole family) and/or non-family GPs, often through a medical centre. Several said they had been to a number of different GPs but 'were not satisfied' with those experiences and therefore did not maintain a regular GP.

When asked whether they knew of the different types of health services available for sexual and reproductive health issues, the majority mentioned general practice and had limited awareness of other services.

*... the GPs are the only people that we know. And it's a place that any young person, any person can go to, and they have the biggest capacity to actually help. (Liz, 21 years, African heritage)*

*I guess a GP just to start off, and then maybe ask them to refer me to other services. (Denise, 20 years, African heritage)*

Despite this general awareness and, in most cases, the previous use of at least one such service, many participants expressed a range of concerns regarding seeing a GP for sexual and reproductive health, as is discussed in the following two themes. The majority also reported not being able to discuss issues of sexuality or sexual health with their parents at all; other sources of information used are described in a separate paper.<sup>22</sup>

### 2. Family doctors may be 'too close for comfort' for young people with regard to sexual health

Those who had a family GP reported good relationships and generally positive experiences with regard to general health issues. For most, their family GP was from the same cultural background or community. This was seen as an advantage by some as it reduced language barriers and meant the doctor had a good understanding of their family, culture and community.

*I do go to my local GP and they are based in heavily cultural communities, so they are ... they do respect it, 'coz they're the same. (David, 20 years, southeast Asian heritage)*

*His background is Arabic, so he will understand us more than other doctors. We feel comfortable with him. (AJ, 19 years, Middle Eastern heritage)*

Despite these positive aspects, most reported they would not feel comfortable going to their family GP for sexual health matters. This general reluctance appeared to be attributable to a combination of factors. The first was fear of being judged by the family GP, particularly if they shared the same cultural background:

*I don't know, maybe they might sway me to another side because we're from the same ethnic cultural background, so they might sway me not to talk, not to talk about that. (Shirley, 18 years, Southeast Asian heritage)*

*My GP, I reckon wouldn't be so sensitive slash open (about sexual health) ... A bit more judgmental I reckon ... It's just the truth though, he has been judgmental in the past, so what difference is it to this situation. (James, 21 years, Southeast Asian heritage)*

Some participants reported unsatisfactory experiences when attempting to discuss sexual health matters with their family GP in the past:

*I have my normal GP ... I tried asking him about it before a few months ago, he wasn't really keen to look at my junk [genitals] ... [and] you know, my whole family goes there. (James, 21 years, Southeast Asian heritage)*

*... there was some weird things going [on] down there and I went to my family doctor and I made sure I never see her again, I've never seen her since then, and I was 16. (Liz, 21 years, African heritage)*

Closely intertwined with fear of judgement was a concern about confidentiality and a belief that a family GP might discuss these private matters with parents or other family members, whether intentionally or not:

*... my parents use the same GP ... he might just slip up. (Denise, 20 years, African heritage)*

*I was also worried because I was going to the ... to our family doctor, and I didn't really want to tell my mum about getting*

*my first Pap smear. (Sarah, 24 years, Southeast European heritage)*

*... my parents and the doctor are pretty close and, you know, when I was a kid, they discussed things and I don't know if that's still going on. (Diana, 18 years, Southeast/East Asian heritage)*

It was therefore apparent that although most participants described positive feelings towards their family GPs, there was considerable reluctance to see them for sexual health matters.

While a number of participants made it clear they know GPs must adhere to professional standards, including maintaining patient confidentiality, this did not alleviate fears that the alliances forged between older members of a community would take precedence over the privacy of a young person.

*I know GPs are confined by like confidentiality, [but] I still feel uncomfortable because that GP did actually know me from a very young age, she knew my family as well. (David, 20 years, Southeast Asian heritage)*

*[I would only be comfortable] if she's not associated with anyone I know. Like it wouldn't put me off that much, because I understand that she has her professional boundaries or obligations. So yeah, like it wouldn't stop me from sharing details or being open, but I think I would still feel a bit more uncomfortable than I would with other GPs. (Gloria, 22 years, East Asian heritage)*

*... if the person who was there wasn't African, then that would be okay ... you kind of know that it's going to go back to the community even though they're not meant to 'coz that's part of their profession ... and also, I mean, you feel a sense of judgement if you were to approach them 'coz there's that whole cultural aspect of not being sexually active. (Denise, 20 years, African heritage)*

**Table 1. Participant characteristics (as reported by participants)**

Characteristics	Female (n = 16)	Male (n = 11)	Total (n = 27)
<b>Age (years)</b>			
16–18	4	2	6
19–21	5	7	12
22–24	7	2	9
<b>Sexual attraction</b>			
Both sexes	4	3	7
Opposite sex only	12	5	17
Same sex only	0	3	3
<b>Time in Australia</b>			
<1 year	0	3	3
2–5 years	4	1	5
>6 years	6	3	9
Born in Australia	6	4	10
<b>Religious affiliation</b>			
Agnostic	0	1	1
Buddhist	1	2	3
Catholic	3	0	3
Christian	4	3	7
Greek Orthodox	1	0	1
Muslim	1	0	1
No religion	6	5	11
<b>Ethnicity/cultural background</b>			
African	3	0	3
Argentine	0	1	1
Asian	0	1	1
Asian/Chinese	0	1	1
Brazilian	0	1	1
Cambodian	1	1	2
Chinese	1	1	2
Chinese/Cambodian	1	0	1
Filipino	0	1	1
Greek	1	0	1
Hazara	0	1	1
Japanese	1	0	1
Kachin	1	0	1
Kenyan	1	0	1
Korean	2	1	3
Spanish	1	0	1
Syrian	0	1	1
Vietnamese	1	1	2
Vietnamese/Chinese	1	0	1
Not specified	1	0	1

### 3. Additional barriers to accessing GPs for sexual health

Most participants who had been to a GP for sexual health issues (whether they had a family GP or not) reported negative experiences. In addition to structural barriers such as long waiting times and cost, particularly for international students who had to pay for consultation costs even if they could subsequently claim some reimbursement from health insurers, participants told stories of GPs not listening properly or rushing them through the appointment. These experiences were raised more often by female participants and related to both male and female GPs:

*I went in there with the purpose of contraception ... But like I wasn't really educated about like I guess any other forms of contraception [besides the pill]. It was just sort of whatever the doctors prescribed, and yeah, in a way I think big medical centres like that are kind of like the McDonalds of medical care ... it can feel like a fast food service in a way. (Gloria, 22 years, East Asian heritage)*

*... all they would do is just prescribe me antibiotics for everything, but they don't actually look into it ... I feel like they don't care, all they do is prescribe you, give you, and tell you to pick it up. (Cath, 18 years, Southeast Asian heritage)*

Some of the young women felt their preferences were not taken into account when they tried to discuss their sexual and reproductive health needs with GPs:

*I told them to get me on the rod, I keep asking them and they're like, 'No you're too young, you know, you should keep trying the pill'. (Liz, 21 years, African heritage)*

*I went to a male doctor about my cramps, and he was like 'You don't feel that ... just practice a few breathing exercises, do a little bit of meditation, it's all right. You'll be fine'. (Julia, 22 years, East Asia heritage)*

*I had a GP who judged every answer I gave. I felt uncomfortable and had to lie. I never went back. (Mimi, 22 years, African heritage)*

Even if the GP was not previously known to the participant or their family, the perceived cultural background and/or religious beliefs of that GP also appeared to have a strong influence on participants' willingness to discuss sexual health issues with them.

*I went into the medical centre ... and then the lady that I got, out of all the people, she was Muslim so she was like in the hijab and innocent and holy. (Liz, 21 years, African heritage)*

*I'd prefer someone who should not be [from my country of origin] ... I'd prefer someone from a different culture ... Because someone professional from our community say it's a taboo within our community, so I'm not very comfortable talking with them. (Amir, 24 years, Middle Eastern heritage)*

For a few, sharing the same language as their family GP presented a barrier to initiating conversations about sexual health, even though for others this was seen as an advantage for general health concerns, as previously described.

*I think I'd be more comfortable going to an English-speaking [GP] because the one that we go to is [of East Asian background] and it might just be easier for me to talk about it in English rather than [East Asian language]. (William, 17 years, East Asian heritage)*

*In this case [for sexual health], if he is not Arabic that will be better ... I will not be shy as I will be with a GP that is Arabic ... it's more comfortable for me in English. (AJ, 19 years, Middle Eastern heritage)*

Many participants, both male and female, expressed a preference to see a female clinician for sexual and reproductive health matters, although several said they would see a male clinician if needed. One male participant preferred a male clinician, while others did not express a gender preference. As has been described elsewhere, however, there was a much clearer preference for a 'younger' clinician, as 'older' clinicians were perceived to

be more judgemental of young peoples' sexual lives.<sup>26</sup>

## Discussion

This study highlights the complexities of and opportunities for engaging migrant and refugee young people with sexual and reproductive healthcare in general practice. The majority of participants had experience with general practice, indicating this is a known and accessible health service setting for this group of young people. Further, a number of participants were positive about 'family doctors'. However, most expressed concerns about seeing GPs for sexual and reproductive health. For those with a family doctor, this was primarily because of fears about confidentiality or judgement, whereas those attending a more 'anonymous' GP associated this with not being listened to or being rushed.

Findings suggest that young people from diverse cultural and language backgrounds may be receiving fragmented care by seeing different GPs for different aspects of health or not seeing anyone at all for matters relating to sexuality, contraception and sexual health. This may also be the case for other marginalised groups in Australia. For example, people of minority sexual orientations and gender identities may have similar concerns regarding the potential for judgement when talking to GPs. While experiences of lesbian, gay, bisexual, transgender, queer or questioning, and intersex participants were not analysed separately in this study because of fairly small numbers, this has been reported elsewhere<sup>27</sup> and is likely to be compounded for young people of who also come from a non-English speaking migrant or refugee background.

As the Australian population becomes more diverse, so too does its health workforce, with the health system becoming increasingly reliant on health workers who are born and trained overseas.<sup>28</sup> This has helped to address current and projected shortages in clinical workforce, particularly in rural and remote areas.<sup>29</sup> In addition, the familiarity and connections that 'culturally diverse' GPs can build with the communities in which

they work help to generate trust and rapport through greater sensitivity to community needs, cultural norms and language nuances.

However, this proximity to the community may exacerbate barriers to access for some, with our findings suggesting young people may view family doctors or local GPs as being 'too close' to their family or community to be able to provide confidential and non-judgemental sexual and reproductive healthcare. There appears to be a tension between the role that community-immersed GPs play for families and communities, and their role in fulfilling the health needs of migrant and refugee young people. Many participants were aware that GPs are expected to maintain confidentiality and professional boundaries. However, separating this more culturally sensitive aspect of their health from their local doctors and their families, and preserving their own anonymity and autonomy, appeared to be paramount. While the concerns of young people in relation to confidentiality when it comes to sexual health are well documented,<sup>2,30,31</sup> this is likely to be heightened for those from migrant and refugee backgrounds. There may be additional concerns if an interpreter is required for the consultation,<sup>32</sup> although this was not raised by our study participants, who were all comfortable with the English language.

It is well known that GPs also face a range of barriers to effectively discussing sexual health, including time constraints, lack of confidence or knowledge, concerns about client embarrassment, and perceived gender barriers.<sup>33-36</sup> These issues may be compounded for clients who are young or from a migrant or refugee background. It is important, therefore, to explore how GPs can be better supported to manage sexual health consultations with young people from all backgrounds.

Practice nurses in general practice may be well positioned to have a greater role in sexual health information and care with this population. Practice nurses could be encouraged, supported and trained to contribute more to primary healthcare for young people<sup>37</sup> and to increase their

involvement in sexual healthcare,<sup>35</sup> potentially assuaging any residual concerns among young people that their confidentiality could be compromised.

There are several limitations to this study. Recruitment of a sample of migrant and refugee young people was purposely broad, as primary healthcare services do not limit their client groups by cultural background. Findings should therefore not be assumed to apply to specific subgroups, as numbers from each 'group' was small. Although we hoped to recruit some non-English speaking young people, all spoke English in addition to their first language/s. Finally, there will be limitations and influences relating to the role of the interviewer, who is female, in her late 20s and from an English-speaking background.

These accounts from young people highlight both the perceptions and lived experiences of this diverse group in seeing 'family doctors' and other GPs for sexual and reproductive health. There is an opportunity for GPs to better engage migrant and refugee young people and enhance communication regarding sexual and reproductive health. This could include initiating sexual health discussions during consultations, providing opportunistic sexual health information and support, and providing strong reassurances of confidentiality. It was clear that young people desired a GP who treated them with respect and empathy, was non-judgemental and took the time to listen to them.

## Conclusion

There appears to be a lack of effective engagement in general practice of migrant and refugee young people in relation to sexual and reproductive health. Although GPs are well known and largely accessible and have the potential to reach and support a number of young people, they may be underused by migrant and refugee young people for sexual and reproductive healthcare. Developing strategies to assist GPs to improve their capacity, communication and understanding of these issues would be of considerable value. Building the

skills and confidence of GPs (and other primary care staff) to work with young people from diverse backgrounds and promote their sexual health and wellbeing should be emphasised. GPs should be supported in reaching and engaging diverse populations of young people and providing a welcoming and acceptable service for all. These may otherwise be missed opportunities to engage young people in critical conversations around sexuality and health and to provide them with the information, care and support they need to enjoy their entitlement to happy and healthy sexual and reproductive health lives.

## Implications for general practice

General practice is known to be an important setting for young people to access information and services to support their sexual and reproductive health. This study highlights the importance of general practice for this subpopulation of young people from migrant and refugee backgrounds, many of whom find it very difficult to source information or support from family. However, engaging this group is made more complex if the practice or practitioner is perceived or known to have an association with the young person's family or community, and additional efforts must be made to communicate confidentiality and trustworthiness.

## Authors

Jessica R Botfield BN, MPH, MIPH, Health, Rights and Development (HEARD@UNSW), School of Social Sciences, UNSW Sydney, Kensington, NSW; Centre for Social Research in Health, UNSW Sydney, Kensington, NSW; Family Planning NSW, Ashfield, NSW. [jessica.botfield@unsw.edu.au](mailto:jessica.botfield@unsw.edu.au)

Christy E Newman BA, PhD, Centre for Social Research in Health, UNSW Sydney, Kensington, NSW. [c.newman@unsw.edu.au](mailto:c.newman@unsw.edu.au)

Melissa Kang MBBS, MCH, PhD, Faculty of Health, Australian Centre for Public and Population Health Research, UTS Sydney, NSW. [Melissa.Kang@uts.edu.au](mailto:Melissa.Kang@uts.edu.au)

Anthony B Zwi MB BCh, MSc, PhD, Health, Rights and Development (HEARD@UNSW), School of Social Sciences, UNSW Sydney, Kensington, NSW. [a.zwi@unsw.edu.au](mailto:a.zwi@unsw.edu.au)

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correspondence [ajgp@racgp.org.au](mailto:ajgp@racgp.org.au)